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Presidential Documents

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The President

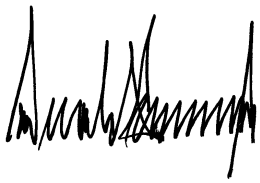
Presidential Determination No. 2018–05 of April 20, 2018

Eligibility of the Organisation Conjointe de Cooperation en Matiere d'Armement To Receive Defense Articles and Defense Services Under the Foreign Assistance Act of 1961, as Amended, and the Arms Export Control Act, as Amended

Memorandum for the Secretary of State

By the authority vested in me as President by the Constitution and the laws of the United States, including section 503(a) of the Foreign Assistance Act of 1961, as amended, and section 3(a)(1) of the Arms Export Control Act, as amended, I hereby find that the furnishing of defense articles and defense services to the Organisation Conjointe de Cooperation en matiere d'Armement will strengthen the security of the United States and promote world peace.

You are authorized and directed to transmit this determination to the Congress and publish this determination in the *Federal Register.*



THE WHITE HOUSE,
Washington, April 20, 2018

[FR Doc. 2018–09882
Filed 5–7–18; 8:45 am]
Billing code 4710–10–P

Presidential Documents

Presidential Determination No. 2018–06 of April 30, 2018

Presidential Determination on the Proposed Agreement Between the Government of the United States of America and the Government of the United Mexican States for Cooperation in Peaceful Uses of Nuclear Energy

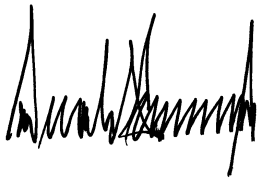
Memorandum for the Secretary of State [and] the Secretary of Energy

I have considered the proposed Agreement between the Government of the United States of America and the Government of the United Mexican States for Cooperation in Peaceful Uses of Nuclear Energy (the ''Agreement''), along with the views, recommendations, and statements from interested departments and agencies.

I have determined that the performance of the proposed Agreement will promote, and will not constitute an unreasonable risk to, the common defense and security.

By the authority vested in me as President by the Constitution and the laws of the United States, I hereby approve the proposed Agreement and authorize the Secretary of State to arrange for its execution, pursuant to section 123 b. of the Atomic Energy Act of 1954, as amended (42 U.S.C. 2153(b)).

The Secretary of State is authorized and directed to publish this determination in the *Federal Register.*



THE WHITE HOUSE,
Washington, April 30, 2018

[FR Doc. 2018–09883
Filed 5–7–18; 8:45 am]
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Presidential Documents

Presidential Determination No. 2018–07 of April 30, 2018

Presidential Determination on the Proposed Agreement Between the Government of the United States of America and the Government of the United Kingdom of Great Britain and Northern Ireland for Cooperation in Peaceful Uses of Nuclear Energy

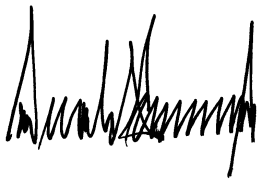
Memorandum for the Secretary of State [and] the Secretary of Energy

I have considered the proposed Agreement between the Government of the United States of America and the Government of the United Kingdom of Great Britain and Northern Ireland for Cooperation in Peaceful Uses of Nuclear Energy (the ''Agreement''), along with the views, recommendations, and statements from interested departments and agencies.

I have determined that the performance of the proposed Agreement will promote, and will not constitute an unreasonable risk to, the common defense and security.

By the authority vested in me as President by the Constitution and the laws of the United States, including section 123 b. of the Atomic Energy Act of 1954, as amended (42 U.S.C. 2153(b)), I hereby approve the proposed Agreement and authorize the Secretary of State to arrange for its execution.

The Secretary of State is authorized and directed to publish this determination in the *Federal Register.*



THE WHITE HOUSE,
Washington, April 30, 2018

[FR Doc. 2018–09885
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Presidential Documents

Proclamation 9741 of May 3, 2018

National Day of Prayer, 2018

By the President of the United States of America

A Proclamation

On this National Day of Prayer, we join together to offer gratitude for our many blessings and to acknowledge our need for divine wisdom, guidance, and protection. Prayer, by which we affirm our dependence on God, has long been fundamental to our pursuit of freedom, peace, unity, and prosperity. Prayer sustains us and brings us comfort, hope, peace, and strength. Therefore, we must cherish our spiritual foundation and uphold our legacy of faith.

Prayer has been a source of guidance, strength, and wisdom since the founding of our Republic. When the Continental Congress gathered in Philadelphia to contemplate freedom from Great Britain, the delegates prayed daily for guidance. Their efforts produced the Declaration of Independence and its enumeration of the self-evident truths that we all cherish today. We believe that all men and women are created equal and endowed by their Creator with certain inalienable rights, including life, liberty, and the pursuit of happiness. Prayer sustained us and gave us the strength to endure the sacrifices and suffering of the American Revolution and to temper the triumph of victory with humility and gratitude. Notably, as one of its first acts, our newly formed Congress appointed chaplains of the House of Representatives and Senate so that all proceedings would begin with prayer.

As a Nation, we have continued to seek God in prayer, including in times of conflict and darkness. At the height of World War II, President Franklin D. Roosevelt called for prayer ''for the vision to see our way clearly—to see the way that leads to a better life for ourselves and for all our fellow men—and to the achievement of His will to peace on earth.'' Decades later, following one of the darkest days in our Nation's history, President George W. Bush offered this prayer for our heartbroken country, mourning the precious souls who perished in the terrorist attacks on September 11, 2001: ''We ask Almighty God to watch over our Nation, and grant us patience and resolve in all that is to come. We pray that He will comfort and console those who now walk in sorrow. We thank Him for each life we now must mourn, and the promise of a life to come.''

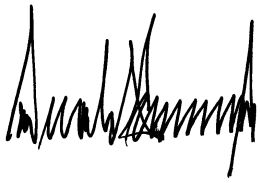
America has known peace, prosperity, war, and depression—and prayer has sustained us through it all. May our Nation and our people never forget the love, grace, and goodness of our Maker, and may our praise and gratitude never cease. On this National Day of Prayer, let us come together, all according to their faiths, to thank God for His many blessings and ask for His continued guidance and strength.

In 1988, the Congress, by Public Law 100–307, as amended, called on the President to issue each year a proclamation designating the first Thursday in May as a National Day of Prayer, ''on which the people of the United States may turn to God in prayer and meditation at churches, in groups, and as individuals.''

NOW, THEREFORE, I, DONALD J. TRUMP, President of the United States of America, do hereby proclaim May 3 as a National Day of Prayer. I encourage all Americans to observe this day, reflecting on the blessings our Nation has received and the importance of prayer, with appropriate

programs, ceremonies, and activities in their houses of worship, communities, and places of work, schools, and homes.

IN WITNESS WHEREOF, I have hereunto set my hand this third day of May, in the year of our Lord two thousand eighteen, and of the Independence of the United States of America the two hundred and forty-second.



[FR Doc. 2018–09893
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Presidential Documents

Executive Order 13831 of May 3, 2018

Establishment of a White House Faith and Opportunity Initiative

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to assist faith-based and other organizations in their efforts to strengthen the institutions of civil society and American families and communities, it is hereby ordered as follows:

Section 1. *Policy.* Faith-based and community organizations have tremendous ability to serve individuals, families, and communities through means that are different from those of government and with capacity that often exceeds that of government. These organizations lift people up, keep families strong, and solve problems at the local level. The executive branch wants faith-based and community organizations, to the fullest opportunity permitted by law, to compete on a level playing field for grants, contracts, programs, and other Federal funding opportunities. The efforts of faith-based and community organizations are essential to revitalizing communities, and the Federal Government welcomes opportunities to partner with such organizations through innovative, measurable, and outcome-driven initiatives.

Sec. 2. *Amendments to Executive Orders.* (a) Executive Order 13198 of January 29, 2001 (Agency Responsibilities With Respect to Faith-Based and Community Initiatives), Executive Order 13279 of December 12, 2002 (Equal Protection of the Laws for Faith-Based and Community Organizations), as amended by Executive Order 13559 of November 17, 2010 (Fundamental Principles and Policymaking Criteria for Partnerships with Faith-Based and Other Neighborhood Organizations), Executive Order 13280 of December 12, 2002 (Responsibilities of the Department of Agriculture and the Agency for International Development With Respect to Faith-Based and Community Initiatives), Executive Order 13342 of June 1, 2004 (Responsibilities of the Departments of Commerce and Veterans Affairs and the Small Business Administration with Respect to Faith-Based and Community Initiatives), and Executive Order 13397 of March 7, 2006 (Responsibilities of the Department of Homeland Security With Respect to Faith-Based and Community Initiatives), are hereby amended by:

(i) substituting ''White House Faith and Opportunity Initiative'' for ''White House Office of Faith-Based and Community Initiatives'' each time it appears in those orders;

(ii) substituting ''White House Faith and Opportunity Initiative'' for ''White House OFBCI'' each time it appears in those orders;

(iii) substituting ''Centers for Faith and Opportunity Initiatives'' for ''Centers for Faith-Based and Community Initiatives'' each time it appears in those orders; and

(iv) substituting ''White House Faith and Opportunity Initiative'' for ''Office of Faith-Based and Neighborhood Partnerships'' each time it appears in those orders.

(b) Executive Order 13279, as amended, is further amended by striking section 2(h) and redesignating sections 2(i) and 2(j) as sections 2(h) and 2(i), respectively.

Sec. 3. *White House Faith and Opportunity Initiative.* (a) There is established within the Executive Office of the President the White House Faith and Opportunity Initiative (Initiative).

(i) The Initiative shall be headed by an Advisor to the White House Faith and Opportunity Initiative (Advisor). The Advisor shall be housed in the Office of Public Liaison and shall work with that office and the Domestic Policy Council, in consultation with the Centers for Faith-Based and Community Initiatives established by Executive Order 13198, Executive Order 13280, Executive Order 13342, and Executive Order 13397, to implement this order.

(ii) The Initiative shall, from time to time and consistent with applicable law, consult with and seek information from experts and various faith and community leaders from outside the Federal Government, including those from State, local, and tribal governments, identified by the Office of Public Liaison, the Domestic Policy Council, and the Centers for Faith and Opportunity Initiatives. These experts and leaders shall be identified based on their expertise in a broad range of areas in which faith-based and community organizations operate, including poverty alleviation, religious liberty, strengthening marriage and family, education, solutions for substance abuse and addiction, crime prevention and reduction, prisoner reentry, and health and humanitarian services.

(iii) The Advisor shall make recommendations to the President, through the Assistant to the President for Domestic Policy, regarding changes to policies, programs, and practices that affect the delivery of services by faith-based and community organizations.

(iv) Executive departments and agencies (agencies) that lack a Center for Faith and Opportunity Initiative shall designate a Liaison for Faith and Opportunity Initiatives as a point of contact to coordinate with the Advisor in carrying out this order.

(v) All agencies shall, to the extent permitted by law, provide such information, support, and assistance to the Initiative as it may request to develop public policy proposals.

(b) To the extent permitted by law, the Initiative shall:

(i) periodically convene meetings with the individuals described in section 3(a)(ii) of this order;

(ii) periodically convene meetings with representatives from the Centers for Faith and Opportunity Initiatives and other representatives from across agencies as the Advisor may designate;

(iii) provide recommendations regarding aspects of my Administration's policy agenda that affect faith-based and community programs and initiatives;

(iv) help integrate those aspects of my Administration's policy agenda that affect faith-based and other community organizations throughout the Federal Government;

(v) showcase innovative initiatives by faith-based and community organizations that serve and strengthen individuals, families, and communities throughout the United States;

(vi) notify the Attorney General, or his designee, of concerns raised by faith-based and community organizations about any failures of the executive branch to comply with protections of Federal law for religious liberty as outlined in the Attorney General's Memorandum of October 6, 2017 (Federal Law Protections for Religious Liberty), issued pursuant to Executive Order 13798 of May 4, 2017 (Promoting Free Speech and Religious Liberty); and

(vii) identify and propose means to reduce, in accordance with Executive Order 13798 and the Attorney General's Memorandum of October 6, 2017, burdens on the exercise of religious convictions and legislative, regulatory, and other barriers to the full and active engagement of faith-based and community organizations in Government-funded or Government-conducted activities and programs.

Sec. 4. *Revocation of Executive Orders.* Executive Order 13199 of January 29, 2001 (Establishment of White House Office of Faith-Based and Community Initiatives), and Executive Order 13498 of February 5, 2009 (Amendments to Executive Order 13199 and Establishment of the President's Advisory Council for Faith-Based and Neighborhood Partnerships), are hereby revoked.

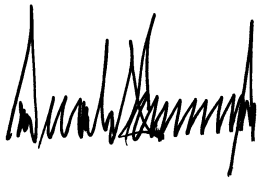
Sec. 5. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.



THE WHITE HOUSE,
May 3, 2018.

[FR Doc. 2018–09895
Filed 5–7–18; 8:45 am]
Billing code 3295–F8–P

Rules and Regulations

Federal Register

Vol. 83, No. 89

Tuesday, May 8, 2018

This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.

The Code of Federal Regulations is sold by the Superintendent of Documents.

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2018–0068; Product Identifier 2017–CE–049–AD; Amendment 39–19276; AD 2018–03–03 R1]

RIN 2120–AA64

Airworthiness Directives; Textron Aviation Inc. Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; request for comments.

SUMMARY: We are revising Airworthiness Directive (AD) 2018–03–03 for certain Textron Aviation Inc. Models 401, 401A, 401B, 402, 402A, 402B, 402C, 411, 411A, 414, 414A, 421, 421A, 421B, 421C, and 425 airplanes. AD 2018–03–03 required repetitively inspecting the left and the right forward lower carry through spar cap for cracks and replacing the carry through spar cap if cracks were found. This AD addresses the same unsafe condition and requires the same actions as AD 2018–03–03, but clarifies the compliance times for the initial inspection of the carry through spar cap. This AD was prompted by several reports of confusion in interpreting the compliance times for the initial inspection of the carry through spar cap. We are issuing this AD to eliminate confusion in interpreting the compliance times for this inspection.

DATES: This AD is effective May 23, 2018.

The Director of the Federal Register approved the incorporation by reference of certain other publications listed in this AD as of February 28, 2018 (83 FR 6114, February 13, 2018).

We must receive any comments on this AD by June 22, 2018.

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 final rule, contact Textron Aviation Inc., Textron Aviation Customer Service, One Cessna Blvd., Wichita, Kansas 67215; telephone: (316) 517–5800; email: *customercare@txtav.com;* internet: *www.txtav.com.* You may view this service information at the FAA, Policy and Innovation Division, 901 Locust, Kansas City, Missouri 64106. For information on the availability of this material at the FAA, call (816) 329–4148. It is also available on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0068.

Examining the AD Docket

You may examine the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0068; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this final rule, the regulatory evaluation, any comments received, and other information. The street address for Docket Operations (phone: 800–647–5527) is listed above. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Bobbie Kroetch, Aerospace Engineer, Wichita ACO Branch, 1801 Airport Road, Room 100, Wichita, Kansas 67209; telephone: (316) 946–4155; fax: (316) 946–4107; email: *bobbie.kroetch@faa.gov* or *Wichita-COS@faa.gov.*

SUPPLEMENTARY INFORMATION:

Discussion

We issued AD 2018–03–03, Amendment 39–19176 (83 FR 6114, February 13, 2018), (''AD 2018–03–03''), for certain Textron Aviation Inc. (Textron) (type certificate previously held by Cessna Aircraft Company) Models 401, 401A, 401B, 402, 402A, 402B, 402C, 411, 411A, 414, 414A, 421, 421A, 421B, 421C, and 425 airplanes. AD 2018–03–03 required repetitively inspecting the left and the right forward lower carry through spar cap for cracks and replacing the carry through spar cap if cracks were found. AD 2018–03–03 also required sending the inspection results to the FAA.

AD 2018–03–03 resulted from a report of a fully cracked lower forward carry through spar cap found on a Textron Model 402C airplane. Investigation revealed that the crack resulted from metal fatigue. At this time, the cracking has been found on only Model 402C airplanes. However, the carry through spar cap and surrounding structure on the other model airplanes included in AD 2018–03–03 are similar and the loads on the other model airplanes are similar to (or higher than) the Model 402C airplanes.

We issued AD 2018–03–03 to prevent failure of the carry through spar cap during flight. The unsafe condition, if not addressed, could result in loss of control.

Actions Since AD 2018–03–03 Was Issued

Since we issued AD 2018–03–03, we received numerous comments from owners/operators and maintenance staff stating the compliance times for the initial inspection of the carry through spar cap are confusing and asking for clarification. We also received an additional comment requesting clarification of the replacement requirement. AD 2018–03–03 specified replacing the carry through spar if cracks are found during any inspection of the carry through spar cap. Our intent was to require replacement of only the carry through spar cap if cracks are found, which decreases the burden to the owners/operators of the affected airplanes. We are issuing this AD to clarify the compliance times for the initial inspection of the carry through spar cap and to clarify the replacement requirement of the carry through spar cap.

Related Service Information Under 1 CFR Part 51

We reviewed Textron Aviation Multi-engine Mandatory Service Letter MEL–57–01 and Textron Aviation Conquest Mandatory Service Letter CQL–57–01, both dated December 18, 2017. As applicable, these service letters describe procedures for repetitively inspecting the forward lower carry through spar cap for cracks. This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

Other Related Service Information

We reviewed Textron Aviation Conquest Service Bulletin CQB–57–01, Textron Aviation Multi-engine Service Bulletin MEB–57–01, and Textron Multi-engine Service Bulletin MEB–57–02, all dated December 20, 2017. As applicable, these service bulletins provide the manufacturer's optional procedures for installing access panels for easier access to the forward lower carry through spar caps. This AD does not require installing the access panels.

FAA's Determination

We are issuing this AD because we evaluated all the relevant information and determined the unsafe condition described previously in AD 2018–03–03 is likely to exist or develop in other products of the same type design.

AD Requirements

This AD requires repetitively inspecting the left and the right forward lower carry through spar cap for cracks and replacing the carry through spar cap if cracks are found. This AD also requires sending the inspection results to the FAA.

Interim Action

We consider this AD interim action. Textron Aviation Inc. is evaluating the initial and repetitive inspection intervals, as well as designing a replacement lower carry through spar cap from an improved material. After the evaluations are complete and the design modification is developed, approved, and available, we may consider additional rulemaking.

FAA's Justification and Determination of the Effective Date

The FAA previously determined that the risk to the flying public justified waiving notice and comment prior to the adoption of AD 2018–03–03. This AD is being issued to clarify the compliance times for the initial inspection of the carry through spar cap found in 2018–03–03. Because the substance of AD 2018–03–03 remains the same, but for the clarification of compliance times for the initial inspection and clarification of the spar cap replacement, we find good cause that notice and opportunity for prior public comment are unnecessary. In addition, for the reasons stated above, we find 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 we did not provide you with notice and an opportunity to provide your comments before it becomes effective. However, we invite you to send any written data, views, or arguments about this final rule. Send your comments to an address listed under the **ADDRESSES** section. Include the docket number FAA–2018–0068 and Product Identifier 2017–CE–049–AD at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this final rule. We will consider all comments received by the closing date and may amend this final rule 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 final rule.

Costs of Compliance

We estimate that this AD affects 2,147 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
Inspect the left and the right forward lower carry through spar cap for cracks (without inspection access panels).	12 work-hours × $85 per hour = $1,020 per inspection cycle.	Not applicable	$1,020 per inspection cycle.	$2,189,940 per inspection cycle.

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

ON-CONDITION COSTS

Action	Labor cost	Parts cost	Cost per product
Replace carry through spar cap	800 work-hours × $85 per hour = $68,000	$5,000	$73,000

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.

This AD is issued in accordance with authority delegated by the Executive Director, Aircraft Certification Service, as authorized by FAA Order 8000.51C. In accordance with that order, issuance of ADs is normally a function of the Compliance and Airworthiness Division, but during this transition period, the Executive Director has delegated the authority to issue ADs applicable to small airplanes, gliders, balloons, airships, domestic business jet transport airplanes, and associated appliances to the Director of the Policy and Innovation Division.

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 part 39 of the Federal Aviation Regulations (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) 2018–03–03, Amendment 39–19176 (83 FR 6114, February 13, 2018) and adding the following new AD:

2018–03–03 R1 Textron Aviation Inc.: Amendment 39–19276; Docket No. FAA–2018–0068; Product Identifier 2017–CE–049–AD.

(a) Effective Date

This AD is effective May 23, 2018.

(b) Affected ADs

This AD replaces Airworthiness Directive (AD) 2018–03–03, Amendment 39–19176 (83 FR 6114, February 13, 2018) (''AD 2018–03–03'').

(c) Applicability

This AD applies to the following Textron Aviation Inc. (type certificate previously held by Cessna Aircraft Company) model airplanes, that are certificated in any category:

Table 1 to paragraph (c) of this AD – Affected Models and Serial Numbers

Model	Serial Numbers
401	401-0001 through 401-0322
401A	401A0001 through 401A0132
401B	401B0001 through 401B0221
402	402-0001 through 402-0322
402A	402A0001 through 402A0129
402B	402B0001 through 402B1384
402C	689, 402C0001 through 402C1020
411	411-0001 through 411-0250
411A	411-0251 through 411-0300
414	414-0001 through 414-0965
414A	414A0001 through 414A1212
421	421-0001 through 421-0200
421A	421A0001 through 421A0158
421B	421B0001 through 421B0970
421C	421C0001 through 421C1807
425	425-0001 through 425-0236

(d) Subject

Joint Aircraft System Component (JASC)/ Air Transport Association (ATA) of America Code 53, Fuselage.

(e) Unsafe Condition

This AD was prompted by several reports of confusion in interpreting the compliance times for the initial inspection of the carry through spar cap. We are issuing this AD to eliminate confusion in interpreting the compliance times for this inspection. The unsafe condition related to this AD was previously addressed in AD 2018–03–03.

(f) Compliance

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

(g) Inspection Criteria

For the inspections required in paragraphs (h), (i), (j) and (l) of this AD, do a detailed visual inspection of the left and right forward lower carry through spar cap for cracks. Using a 10X magnifier visually inspect the bottom surface of the carry through spar cap in the areas around the fasteners located just inboard of the left-hand and right-hand forward lower wing fittings. If a crack is not positively identified during the detailed visual inspection but is suspected or the area is questionable, before further flight, do a surface eddy current inspection of the suspected area. Do these inspections using the Accomplishment Instructions in Textron Aviation Multi-engine Mandatory Service Letter MEL–57–01 and Textron Aviation Conquest Mandatory Service Letter CQL–57–01, both dated December 18, 2017, as applicable.

(h) Initial Inspection for All Affected Airplanes With 24,975 Hours Time-In-Service (TIS) or More on the Carry Through Spar Cap

Within the next 25 hours TIS after February 28, 2018 (the effective date retained from AD 2018–03–03), do an initial detailed visual inspection following the instructions specified in paragraph (g) of this AD.

(i) Initial Inspection for All Affected Airplanes With Less Than 24,975 Hours TIS on the Carry Through Spar Cap

(1) *For Models 401, 401A, 401B, 402, 402A, 402B, 402C, 411, 411A, 414, 414A, 421, and 421A airplanes,* do an initial detailed visual inspection following the instructions specified in paragraph (g) of this AD at whichever of the compliance times in paragraphs (i)(1)(i) or (ii) of this AD occurs later. See figures 1 and 2 of paragraph (i)(1) of this AD for examples.

(i) Before or upon accumulating 15,000 hours TIS on the carry through spar cap; or

(ii) Within the next 50 hours TIS after February 28, 2018 (the effective date retained from AD 2018–03–03).

An airplane with 14,990 hours TIS on the carry through spar cap:

The airplane has 10 hours TIS before accumulating 15,000 hours TIS on the carry through spar cap, so "Within the next 50 hours TIS after February 28, 2018 (the effective date retained from AD 2018-03-03)" would be the "whichever of the compliance times in paragraphs (i)(1)(i) or (ii) of this AD occurs later." Therefore, the airplane must be inspected before accumulating 15,040 hours TIS on the wing carry through spar cap.

Figure 1 to paragraph (i)(1) of this AD

An airplane with 8,000 hours TIS on the carry through spar cap:

The airplane has 7,000 hours TIS before accumulating 15,000 hours TIS on the carry through spar cap, so the "Before or upon accumulating 15,000 hours TIS on the carry through spar cap" would be the "whichever of the compliance times in paragraphs (i)(1)(i) or (ii) of this AD occurs later." Therefore, the airplane must be inspected before or upon accumulating 15,000 hours TIS on the wing carry through spar cap.

Figure 2 to paragraph (i)(1) of this AD

(2) *For Models 421B and 421C airplanes,* do an initial detailed visual inspection following the instructions specified in paragraph (g) of this AD at whichever of the compliance times in paragraphs (i)(2)(i) or (ii) of this AD occurs later. See figures 3 and 4 to paragraph (i)(2) of this AD for examples.

(i) Before or upon accumulating 12,000 hours TIS on the carry through spar cap; or

(ii) Within the next 50 hours TIS after February 28, 2018 (the effective date retained from AD 2018–03–03).

An airplane with 11,980 hours TIS on the carry through spar cap:

The airplane has 20 hours TIS before accumulating 12,000 hours TIS on the carry through spar cap, so the "Within the next 50 hours TIS after February 28, 2018 (the effective date retained from AD 2018-03-03)" would be the "whichever of the compliance times in paragraphs (i)(2)(i) or (ii) of this AD occurs later." Therefore, the airplane must be inspected before accumulating 12,030 hours TIS on the wing carry through spar cap.

Figure 3 to paragraph (i)(2) of this AD

An airplane with 9,000 hours TIS on the carry through spar cap:

The airplane has 3,000 hours TIS before accumulating 12,000 hours TIS on the carry through spar cap, so the "Before or upon accumulating 12,000 hours TIS on the carry through spar cap" would be the "whichever of the compliance times in paragraphs (i)(2)(i) or (ii) of this AD occurs later." Therefore, the airplane must be inspected before or upon accumulating 12,000 hours TIS on the wing carry through spar cap.

Figure 4 to paragraph (i)(2) of this AD

(3) *For Model 425 airplanes,* do an initial detailed visual inspection following the instructions specified in paragraph (g) of this AD at whichever of the compliance times in paragraphs (i)(3)(i) or (ii) of this AD occurs later. See figures 5 and 6 to paragraphs (i)(3) of this AD for examples.

(i) Before or upon accumulating 11,000 TIS on the carry through spar cap; or

(ii) Within the next 50 hours TIS after February 28, 2018 (the effective date retained from AD 2018–03–03).

An airplane with 10,990 hours TIS on the carry through spar cap:

The airplane has 10 hours TIS before accumulating 11,000 hours TIS on the carry through spar cap, so the "Within the next 50 hours TIS after February 28, 2018 (the effective date retained from AD 2018-03-03)" would be the "whichever of the compliance times in paragraphs (i)(3)(i) or (ii) of this AD occurs later." Therefore, the airplane must be inspected before accumulating 11,040 hours TIS on the wing carry through spar cap.

Figure 5 to paragraph (i)(3) of this AD

An airplane with 2,000 hours TIS on the carry through spar cap:

The airplane has 9,000 hours TIS before accumulating 11,000 hours TIS on the carry through spar cap, so the "Before or upon accumulating 11,000 hours TIS on the carry through spar cap" would be the "whichever of the compliance times in paragraphs (i)(3)(i) or (ii) of this AD occurs later." Therefore, the airplane must be inspected before or upon accumulating 11,000 hours TIS on the wing carry through spar cap.

Figure 6 to paragraph (i)(3) of this AD

(j) Repetitive Inspections for All Affected Airplanes

If no cracks are found during the initial detailed visual inspections or the surface eddy current inspections required in paragraphs (h) and (i) of this AD, repetitively thereafter inspect at intervals not to exceed 50 hours TIS. Inspect following the instructions specified in paragraph (g) of this AD.

(k) Replacement of Carry Through Spar Cap for All Affected Airplanes

If cracks are found during any inspection required in paragraphs (h) through (j) and paragraph (l) of this AD, before further flight, replace the carry through spar cap.

(l) Initial and Repetitive Inspections of Newly Installed Carry Through Spar Cap for All Affected Airplanes

Do the initial and repetitive inspections following the instructions specified in paragraph (g) of this AD at the applicable compliance time in paragraphs (l)(1) through (3) of this AD. If any cracks are found during any inspection required by this paragraph, before further flight, replace the wing carry through spar cap.

(1) *For Models 401, 401A, 401B, 402, 402A, 402B, 402C, 411, 411A, 414, 414A, 421, and 421A airplanes,* initially inspect before or upon accumulating 15,000 hours TIS on the newly installed carry through spar cap and repetitively thereafter inspect at intervals not to exceed 50 hours TIS.

(2) *For Models 421B and 421C airplanes,* initially inspect before or upon accumulating 12,000 hours TIS on the newly installed carry through spar cap and repetitively thereafter inspect at intervals not to exceed 50 hours TIS.

(3) *For Model 425 airplanes,* initially inspect before or upon accumulating 11,000 hours TIS on the newly installed carry through spar cap and repetitively thereafter inspect at intervals not to exceed 50 hours TIS.

(m) Reporting Requirement for All Affected Airplanes

Within 30 days after each inspection required by paragraphs (h) through (j) and paragraph (l) of this AD, report the results of the inspection to the FAA representative identified in paragraph (r) of this AD using the undated Attachment (titled Spar Cap Inspection Results Form and Spar Cap Inspection Results Form Continued) to Textron Aviation Multi-engine Mandatory Service Letter MEL–57–01 and Textron Aviation Conquest Mandatory Service Letter CQL–57–01, both dated December 18, 2017, as applicable. Please identify AD 2018–03–03 in the subject line if submitted through email.

(n) Installation of Optional Access Panels All Affected Airplanes

Textron Aviation Conquest Service Bulletin CQB–57–01, Textron Aviation Multi-engine Service Bulletin MEB–57–01, and Textron Multi-engine Service Bulletin MEB–57–02, all dated December 20, 2017, provide the manufacturer's optional procedures for installing access panels for easier access to the forward carry through spar cap. This AD does not require installing the access panels, but does not restrict the owner/operator from doing so.

(o) Credit for Actions Done Following Previous Service Information for Affected Airplanes

This AD allows credit for the initial inspection of the forward lower carry through spar cap required in paragraphs (h) and (i) of this AD if done before February 28, 2018 (the effective date retained from AD 2018–03–03), using the following documents:

(1) *Models 401, 401A, 401B, 402, 402A, 402B airplanes:* Cessna Aircraft Company Model 401/402 Supplemental Inspection Document, Supplemental Inspection Number 57–10–10, dated June 3, 2002.

(2) *Model 402C airplanes:* Cessna Aircraft Company Model 402C Maintenance Manual, Supplemental Inspection Number 57–10–14, dated June 3, 2002.

(3) *Models 411 and 411A airplanes:* Cessna Aircraft Company Model 411, Supplemental Inspection Document, Supplemental Inspection Number 57–10–10, dated January 6, 2003.

(4) *Model 414 airplanes:* Cessna Aircraft Company Model 414 Supplemental Inspection Document, Supplemental Inspection Number 57–10–10, dated August 1, 2002.

(5) *Model 414A airplanes:* Cessna Aircraft Company Model 414A Supplemental Inspection Document, Supplemental Inspection Number 57–10–14, dated August 1, 2002.

(6) *Models 421, 421A, and 421B airplanes:* Cessna Aircraft Company Model 421 Supplemental Inspection Document, Supplemental Inspection Number 57–10–10, dated March 3, 2003.

(7) *Model 421C airplanes:* Cessna Aircraft Company Model 421C Supplemental Inspection Document, Supplemental Inspection Number 57–10–14, dated January 6, 2003.

(p) 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 15 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.

(q) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Wichita ACO Branch, 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 certification office, send it to the attention of the person identified in paragraph (r) of this AD.

(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.

(r) Related Information

For more information about this AD, contact Bobbie Kroetch, Aerospace Engineer, Wichita ACO Branch, 1801 Airport Road, Room 100, Wichita, Kansas 67209; telephone: (316) 946–4155; fax: (316) 946–4107; email: *bobbie.kroetch@faa.gov* or *Wichita-COS@faa.gov.*

(s) 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 February 28, 2018 (83 FR 6114, February 13, 2018).

(i) Textron Aviation Multi-engine Mandatory Service Letter MEL–57–01, dated December 18, 2017 (includes the undated Attachment titled Spar Cap Inspection Results Form and Spar Cap Inspection Results Form Continued).

(ii) Textron Aviation Conquest Mandatory Service Letter CQL–57–01, dated December 18, 2017 (includes the undated Attachment titled Spar Cap Inspection Results Form and Spar Cap Inspection Results Form Continued).

(4) For Textron Aviation service information identified in this AD, contact Textron Aviation Inc., Textron Aviation Customer Service, One Cessna Blvd., Wichita, Kansas 67215; telephone: (316) 517–5800; email: *customercare@txtav.com;* internet: *www.txtav.com.*

(5) You may view this service information at FAA, Policy and Innovation Division, 901 Locust, Kansas City, Missouri 64106. For information on the availability of this material at the FAA, call (816) 329–4148.

(6) 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 Kansas City, Missouri, on April 30, 2018.

Melvin J. Johnson,

Deputy Director, Policy & Innovation Division, Aircraft Certification Service.

[FR Doc. 2018–09601 Filed 5–7–18; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 97

[Docket No. 31190; Amdt. No. 3797]

Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures; Miscellaneous Amendments

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This rule establishes, amends, suspends, or removes Standard Instrument Approach Procedures (SIAPs) and associated Takeoff Minimums and Obstacle Departure Procedures (ODPs) for operations at certain airports. These regulatory actions are needed because of the adoption of new or revised criteria, or because of changes occurring in the National Airspace System, such as the commissioning of new navigational facilities, adding new obstacles, or changing air traffic requirements. These changes are designed to provide safe and efficient use of the navigable airspace and to promote safe flight operations under instrument flight rules at the affected airports.

DATES: This rule is effective May 8, 2018. The compliance date for each SIAP, associated Takeoff Minimums, and ODP is specified in the amendatory provisions.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of May 8, 2018.

ADDRESSES: Availability of matters incorporated by reference in the amendment is as follows:

For Examination

1. U.S. Department of Transportation, Docket Ops-M30, 1200 New Jersey Avenue SE, West Bldg., Ground Floor, Washington, DC, 20590–0001.

2. The FAA Air Traffic Organization Service Area in which the affected airport is located;

3. The office of Aeronautical Navigation Products, 6500 South MacArthur Blvd., Oklahoma City, OK 73169 or,

4. 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/code_of_federal_regulations/ibr_locations.html.*

Availability

All SIAPs and Takeoff Minimums and ODPs are available online free of charge. Visit the National Flight Data Center at *nfdc.faa.gov* to register. Additionally, individual SIAP and Takeoff Minimums and ODP copies may be obtained from the FAA Air Traffic Organization Service Area in which the affected airport is located.

FOR FURTHER INFORMATION CONTACT: Thomas J. Nichols, Flight Procedure Standards Branch (AFS–420), Flight Technologies and Programs Divisions, Flight Standards Service, Federal Aviation Administration, Mike Monroney Aeronautical Center, 6500 South MacArthur Blvd., Oklahoma City, OK 73169 (Mail Address: P.O. Box 25082, Oklahoma City, OK 73125) Telephone: (405) 954–4164.

SUPPLEMENTARY INFORMATION:

This rule amends Title 14 of the Code of Federal Regulations, Part 97 (14 CFR part 97), by establishing, amending, suspending, or removes SIAPS, Takeoff Minimums and/or ODPS. The complete regulatory description of each SIAP and its associated Takeoff Minimums or ODP for an identified airport is listed on FAA form documents which are incorporated by reference in this amendment under 5 U.S.C. 552(a), 1 CFR part 51, and 14 CFR part 97.20. The applicable FAA forms are FAA Forms 8260–3, 8260–4, 8260–5, 8260–15A, and 8260–15B when required by an entry on 8260–15A.

The large number of SIAPs, Takeoff Minimums and ODPs, their complex nature, and the need for a special format make publication in the **Federal Register** expensive and impractical. Further, airmen do not use the regulatory text of the SIAPs, Takeoff Minimums or ODPs, but instead refer to their graphic depiction on charts printed by publishers of aeronautical materials. Thus, the advantages of incorporation by reference are realized and publication of the complete description of each SIAP, Takeoff Minimums and ODP listed on FAA form documents is unnecessary. This amendment provides the affected CFR sections and specifies the types of SIAPs, Takeoff Minimums and ODPs with their applicable effective dates. This amendment also identifies the airport and its location, the procedure, and the amendment number.

Availability and Summary of Material Incorporated by Reference

The material incorporated by reference is publicly available as listed in the **ADDRESSES** section.

The material incorporated by reference describes SIAPS, Takeoff Minimums and/or ODPS as identified in the amendatory language for part 97 of this final rule.

The Rule

This amendment to 14 CFR part 97 is effective upon publication of each separate SIAP, Takeoff Minimums and ODP as Amended in the transmittal. Some SIAP and Takeoff Minimums and textual ODP amendments may have been issued previously by the FAA in a Flight Data Center (FDC) Notice to Airmen (NOTAM) as an emergency action of immediate flight safety relating directly to published aeronautical charts.

The circumstances that created the need for some SIAP and Takeoff Minimums and ODP amendments may require making them effective in less than 30 days. For the remaining SIAPs and Takeoff Minimums and ODPs, an effective date at least 30 days after publication is provided.

Further, the SIAPs and Takeoff Minimums and ODPs contained in this amendment are based on the criteria contained in the U.S. Standard for Terminal Instrument Procedures (TERPS). In developing these SIAPs and Takeoff Minimums and ODPs, the TERPS criteria were applied to the conditions existing or anticipated at the affected airports. Because of the close and immediate relationship between these SIAPs, Takeoff Minimums and ODPs, and safety in air commerce, I find that notice and public procedure under 5 U.S.C. 553(b) are impracticable and contrary to the public interest and, where applicable, under 5 U.S.C 553(d), good cause exists for making some SIAPs effective in less than 30 days.

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. 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. For the same

reason, the FAA certifies that this amendment will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 97

Air Traffic Control, Airports, Incorporation by reference, Navigation (air).

Issued in Washington, DC on April 20, 2018.

John S. Duncan,

Director, Flight Standards Service.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me,

Title 14, Code of Federal Regulations, Part 97 (14 CFR part 97) is amended by establishing, amending, suspending, or removing Standard Instrument Approach Procedures and/or Takeoff Minimums and Obstacle Departure Procedures effective at 0901 UTC on the dates specified, as follows:

PART 97—STANDARD INSTRUMENT APPROACH PROCEDURES

■ 1. The authority citation for part 97 continues to read as follows:

Authority: 49 U.S.C. 106(f), 106(g), 40103, 40106, 40113, 40114, 40120, 44502, 44514, 44701, 44719, 44721–44722.

■ 2. Part 97 is amended to read as follows:

Effective 24 May 2018

Anchorage, AK, Ted Stevens Anchorage Intl, Takeoff Minimums and Obstacle DP, Amdt 7B
Homer, AK, Homer, LOC RWY 4, Amdt 11A
Togiak Village, AK, Togiak, NDB–B, Amdt 1A, CANCELED
Togiak Village, AK, Togiak, NDB/DME–A, Amdt 1A, CANCELED
Togiak Village, AK, Togiak, RNAV (GPS) RWY 3, Amdt 1
Togiak Village, AK, Togiak, RNAV (GPS) RWY 21, Amdt 1
Togiak Village, AK, Togiak, Takeoff Minimums and Obstacle DP, Amdt 2
Little Rock, AR, Bill and Hillary Clinton National/Adams Field, RADAR–1, Amdt 17A, CANCELED
Craig, CO, Craig-Moffat, GPS RWY 7, Orig, CANCELED
Craig, CO, Craig-Moffat, GPS RWY 25, Orig, CANCELED
Craig, CO, Craig-Moffat, RNAV (GPS) RWY 7, Orig
Craig, CO, Craig-Moffat, RNAV (GPS) RWY 25, Orig
Craig, CO, Craig-Moffat, VOR RWY 7, Amdt 3
Craig, CO, Craig-Moffat, VOR RWY 25, Amdt 4
Titusville, FL, Arthur Dunn Air Park, RNAV (GPS) RWY 15, Orig-B, CANCELED
Titusville, FL, Arthur Dunn Air Park, RNAV (GPS) RWY 33, Orig-B, CANCELED
Titusville, FL, Arthur Dunn Air Park, RNAV (GPS)-A, Orig
Titusville, FL, Arthur Dunn Air Park, RNAV (GPS)-B, Orig
Kaunakakai, HI, Molokai, VOR OR TACAN–A, Amdt 17
Cherokee, IA, Cherokee County Rgnl, RNAV (GPS) RWY 18, Orig
Kewanee, IL, Kewanee Muni, RNAV (GPS) RWY 9, Amdt 1B
Coldwater, KS, Comanche County, RNAV (GPS) RWY 17, Orig-A
Coldwater, KS, Comanche County, RNAV (GPS) RWY 35, Orig-A
Monroe, LA, Monroe Rgnl, VOR RWY 4, Amdt 18A, CANCELED
Monroe, LA, Monroe Rgnl, VOR RWY 22, Amdt 5A, CANCELED
Detroit, MI, Coleman A Young Muni, NDB RWY 15, Amdt 23A, CANCELED
Detroit, MI, Coleman A Young Muni, RNAV (GPS) RWY 15, Orig-C
Detroit, MI, Coleman A Young Muni, RNAV (GPS) RWY 33, Orig-D
Detroit, MI, Detroit Metropolitan Wayne County, ILS OR LOC RWY 3R, ILS RWY 3R (SA CAT I), ILS RWY 3R (CAT II), ILS RWY 3R (CAT III), Amdt 18
Detroit, MI, Detroit Metropolitan Wayne County, ILS OR LOC RWY 4R, ILS RWY 4R (SA CAT I), ILS RWY 4R (CAT II), ILS RWY 4R (CAT III), Amdt 19
Detroit, MI, Detroit Metropolitan Wayne County, ILS OR LOC RWY 21L, ILS RWY 21L (SA CAT I), ILS RWY 21L (SA CAT II), Amdt 13
Detroit, MI, Detroit Metropolitan Wayne County, ILS OR LOC RWY 22L, ILS RWY 22L (SA CAT I), Amdt 32
Detroit, MI, Detroit Metropolitan Wayne County, ILS OR LOC RWY 27L, ILS RWY 27L (SA CAT I), ILS RWY 27L (SA CAT II), Amdt 5A
Detroit, MI, Detroit Metropolitan Wayne County, ILS PRM RWY 4R, ILS PRM RWY 4R (SA CAT I), ILS PRM RWY 4R (CAT II), ILS PRM RWY 4R (CAT III) (CLOSE PARALLEL), Amdt 3
Detroit, MI, Detroit Metropolitan Wayne County, ILS PRM RWY 22L (CLOSE PARALLEL), Amdt 2
Detroit, MI, Detroit Metropolitan Wayne County, ILS PRM Y RWY 4L (CLOSE PARALLEL),
Amdt 1A
Detroit, MI, Detroit Metropolitan Wayne County, ILS PRM Z RWY 4L, ILS PRM Z RWY 4L (CAT II), ILS PRM Z RWY 4L (CAT III), (CLOSE PARALLEL), Orig
Detroit, MI, Detroit Metropolitan Wayne County, ILS PRM Z RWY 22R, ILS PRM Z RWY 22R (SA CAT I), ILS PRM Z RWY 22R (SA CAT II), (CLOSE PARALLEL), Orig
Detroit, MI, Detroit Metropolitan Wayne County, ILS Y RWY 4L, Amdt 1A
Detroit, MI, Detroit Metropolitan Wayne County, ILS Z OR LOC RWY 4L, ILS Z RWY 4L (CAT II), ILS Z RWY 4L (CAT III), Amdt 4A
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (GPS) RWY 27L, Amdt 3A
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (GPS) RWY 27R, Amdt 3A
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (GPS) PRM Z RWY 4R, (CLOSE PARALLEL), Amdt 1
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (GPS) PRM Z RWY 22L, (CLOSE PARALLEL), Amdt 1
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (GPS) Z RWY 3R, Amdt 4
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (GPS) Z RWY 4R, Amdt 4
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (GPS) Z RWY 21L, Amdt 4
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (GPS) Z RWY 22L, Amdt 3
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) U RWY 4L, Orig
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) U RWY 22R, Orig
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) W RWY 3R, Orig
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) W RWY 21L, Orig
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) W RWY 22R, Orig
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) X RWY 3R, Orig
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) X RWY 4L, Orig
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) X RWY 4R, Orig
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) X RWY 21L, Orig
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) X RWY 22L, Orig
Detroit, MI, Detroit Metropolitan Wayne County, RNAV (RNP) X RWY 22R, Orig
Detroit/Grosse Ile, MI, Grosse Ile Muni, RNAV (GPS) RWY 4, Orig-A
Detroit/Grosse Ile, MI, Grosse Ile Muni, RNAV (GPS) RWY 22, Amdt 1A
Flint, MI, Bishop Intl, ILS OR LOC RWY 9, Amdt 23
Flint, MI, Bishop Intl, ILS OR LOC RWY 27, Amdt 6

Flint, MI, Bishop Intl, RNAV (GPS) RWY 9, Amdt 1B
Flint, MI, Bishop Intl, RNAV (GPS) RWY 27, Amdt 1A
Flint, MI, Bishop Intl, RNAV (GPS) RWY 36, Amdt 1A
Flint, MI, Bishop Intl, VOR RWY 18, Orig-B
Flint, MI, Bishop Intl, VOR RWY 36, Orig-A
Greenville, MI, Greenville Muni, RNAV (GPS) RWY 10, Amdt 1
Greenville, MI, Greenville Muni, RNAV (GPS) RWY 28, Amdt 1
Greenville, MI, Greenville Muni, VOR–A, Amdt 3
Muskegon, MI, Muskegon County, ILS OR LOC RWY 24, Amdt 6
Muskegon, MI, Muskegon County, ILS OR LOC RWY 32, Amdt 20
Muskegon, MI, Muskegon County, LOC BC RWY 14, Amdt 9B, CANCELED
Muskegon, MI, Muskegon County, RNAV (GPS) RWY 6, Amdt 2
Muskegon, MI, Muskegon County, RNAV (GPS) RWY 14, Amdt 1B
Muskegon, MI, Muskegon County, RNAV (GPS) RWY 24, Amdt 2
Muskegon, MI, Muskegon County, RNAV (GPS) RWY 32, Amdt 2C
Saginaw, MI, MBS Intl, RNAV (GPS) RWY 14, Amdt 2A
Saginaw, MI, MBS Intl, RNAV (GPS) RWY 32, Amdt 2A
Preston, MN, Fillmore County, RNAV (GPS) RWY 29, Amdt 1C
Aberdeen/Amory, MS, Monroe County, RNAV (GPS) RWY 18, Amdt 2
Aberdeen/Amory, MS, Monroe County, RNAV (GPS) RWY 36, Amdt 2
Aberdeen/Amory, MS, Monroe County, VOR RWY 18, Amdt 7A
Mc Comb, MS, Mc Comb/Pike County/John E Lewis Field, ILS OR LOC RWY 16, Amdt 1A
Mc Comb, MS, Mc Comb/Pike County/John E Lewis Field, RNAV (GPS) RWY 16, Amdt 2
Mc Comb, MS, Mc Comb/Pike County/John E Lewis Field, RNAV (GPS) RWY 34, Amdt 1
Mc Comb, MS, Mc Comb/Pike County/John E Lewis Field, Takeoff Minimums and Obstacle DP, Amdt 1
Elizabeth City, NC, Elizabeth City CG Air Station/Rgnl, ILS OR LOC RWY 10, Amdt 1C
Elizabeth City, NC, Elizabeth City CG Air Station/Rgnl, RNAV (GPS) RWY 1, Orig-D
Elizabeth City, NC, Elizabeth City CG Air Station/Rgnl, RNAV (GPS) RWY 10, Amdt 1C
Elizabeth City, NC, Elizabeth City CG Air Station/Rgnl, RNAV (GPS) RWY 19, Orig-C
Elizabeth City, NC, Elizabeth City CG Air Station/Rgnl, RNAV (GPS) RWY 28, Orig-B
Elizabeth City, NC, Elizabeth City CG Air Station/Rgnl, Takeoff Minimums and Obstacle DP,
Amdt 1A
Oxford, NC, Henderson-Oxford, LOC RWY 6, Amdt 2A
Oxford, NC, Henderson-Oxford, NDB RWY 6, Amdt 3A
Raleigh/Durham, NC, Raleigh-Durham Intl, ILS OR LOC RWY 5L, Amdt 5B
Raleigh/Durham, NC, Raleigh-Durham Intl, ILS OR LOC RWY 23R, ILS RWY 23R (CAT II), ILS RWY 23R (CAT III), Amdt 11C
Raleigh/Durham, NC, Raleigh-Durham Intl, RNAV (GPS) RWY 32, Orig-A
Raleigh/Durham, NC, Raleigh-Durham Intl, RNAV (GPS) Y RWY 5L, Amdt 1B
Raleigh/Durham, NC, Raleigh-Durham Intl, RNAV (GPS) Y RWY 23R, Amdt 1C
Raleigh/Durham, NC, Raleigh-Durham Intl, RNAV (RNP) Z RWY 5L, Amdt 2B
Raleigh/Durham, NC, Raleigh-Durham Intl, RNAV (RNP) Z RWY 5R, Amdt 2B
Raleigh/Durham, NC, Raleigh-Durham Intl, RNAV (RNP) Z RWY 23L, Amdt 2B
Raleigh/Durham, NC, Raleigh-Durham Intl, RNAV (RNP) Z RWY 23R, Amdt 2B
Raleigh/Durham, NC, Raleigh-Durham Intl, VOR RWY 5R, Amdt 13E
Raleigh/Durham, NC, Raleigh-Durham Intl, VOR RWY 23L, Amdt 14F
Raleigh/Durham, NC, Raleigh-Durham Intl, VOR RWY 32, Amdt 3E
Salisbury, NC, Mid-Carolina Rgnl, RNAV (GPS) RWY 2, Amdt 2
Gothenburg, NE, Gothenburg Muni, RNAV (GPS) RWY 3, Orig-C
Gothenburg, NE, Gothenburg Muni, RNAV (GPS) RWY 21, Orig-C
Gothenburg, NE, Gothenburg Muni, VOR–A, Amdt 3B
Saranac Lake, NY, Adirondack Rgnl, ILS OR LOC RWY 23, Amdt 10
Saranac Lake, NY, Adirondack Rgnl, LOC Y RWY 23, Orig-B, CANCELED
Saranac Lake, NY, Adirondack Rgnl, RNAV (GPS) RWY 5, Amdt 1C
Saranac Lake, NY, Adirondack Rgnl, RNAV (GPS) RWY 9, Amdt 1
Saranac Lake, NY, Adirondack Rgnl, RNAV (GPS) RWY 23, Orig-D
Saranac Lake, NY, Adirondack Rgnl, VOR RWY 9, Amdt 2B, CANCELED
Saranac Lake, NY, Adirondack Rgnl, VOR/DME RWY 5, Amdt 4B, CANCELED
Akron, OH, Akron Fulton Intl, LOC RWY 25, Amdt 14
Akron, OH, Akron Fulton Intl, NDB RWY 25, Amdt 15
Cleveland, OH, Burke Lakefront, ILS OR LOC RWY 24R, Amdt 1B
Cleveland, OH, Burke Lakefront, RNAV (GPS) RWY 24R, Orig-B
Cleveland, OH, Cleveland-Hopkins Intl, ILS OR LOC RWY 6L, ILS RWY 6L (CAT II), ILS RWY 6L (CAT III), Amdt 3
Cleveland, OH, Cleveland-Hopkins Intl, ILS OR LOC RWY 6R, ILS RWY 6R (SA CAT II), Amdt 22
Cleveland, OH, Cleveland-Hopkins Intl, ILS OR LOC RWY 24L, ILS RWY 24L (SA CAT II), Amdt 23
Cleveland, OH, Cleveland-Hopkins Intl, ILS OR LOC RWY 24R, ILS RWY 24R (SA CAT I), ILS RWY 24R (CAT II), ILS RWY 24R (CAT III), Amdt 6
Cleveland, OH, Cleveland-Hopkins Intl, ILS OR LOC RWY 28, Amdt 25
Cleveland, OH, Cleveland-Hopkins Intl, RNAV (GPS) RWY 10, Amdt 3C
Cleveland, OH, Cleveland-Hopkins Intl, RNAV (GPS) RWY 28, Amdt 3
Cleveland, OH, Cleveland-Hopkins Intl, RNAV (GPS) Y RWY 6L, Amdt 2
Cleveland, OH, Cleveland-Hopkins Intl, RNAV (GPS) Y RWY 6R, Amdt 3
Cleveland, OH, Cleveland-Hopkins Intl, RNAV (GPS) Y RWY 24L, Amdt 4
Cleveland, OH, Cleveland-Hopkins Intl, RNAV (GPS) Y RWY 24R, Amdt 4
Cleveland, OH, Cleveland-Hopkins Intl, RNAV (RNP) Z RWY 6L, Orig
Cleveland, OH, Cleveland-Hopkins Intl, RNAV (RNP) Z RWY 6R, Orig
Cleveland, OH, Cleveland-Hopkins Intl, RNAV (RNP) Z RWY 24L, Orig
Cleveland, OH, Cleveland-Hopkins Intl, RNAV (RNP) Z RWY 24R, Orig
Cleveland, OH, Cuyahoga County, ILS OR LOC RWY 24, Amdt 15B
Cleveland, OH, Cuyahoga County, RNAV (GPS) RWY 24, Amdt 1B
Toledo, OH, Toledo Express, ILS OR LOC RWY 7, Amdt 28A
Toledo, OH, Toledo Express, ILS OR LOC RWY 25, Amdt 8A
Toledo, OH, Toledo Express, RNAV (GPS) RWY 16, Orig-A
Toledo, OH, Toledo Express, RNAV (GPS) RWY 34, Orig-B
Toledo, OH, Toledo Express, VOR RWY 34, Amdt 7C
Waynesburg, PA, Greene County, COPTER RNAV (GPS) RWY 9, Orig
Chamberlain, SD, Chamberlain Muni, RNAV (GPS) RWY 13, Amdt 1
Chamberlain, SD, Chamberlain Muni, RNAV (GPS) RWY 31, Amdt 1
Beaumont, TX, Beaumont Muni, RNAV (GPS) RWY 13, Amdt 1
Beaumont, TX, Beaumont Muni, RNAV (GPS) RWY 31, Amdt 1
Beeville, TX, Beeville Muni, RNAV (GPS) RWY 12, Amdt 1
Beeville, TX, Beeville Muni, RNAV (GPS) RWY 30, Amdt 1
Big Lake, TX, Reagan County, Takeoff Minimums and Obstacle DP, Amdt 2
Fort Hood/Killeen, TX, Robert Gray AAF, ILS OR LOC RWY 15, Amdt 7

Fort Hood/Killeen, TX, Robert Gray AAF, ILS OR LOC RWY 33, Amdt 1C

Fort Hood/Killeen, TX, Robert Gray AAF, NDB RWY 15, Amdt 6A, CANCELED

Fort Hood/Killeen, TX, Robert Gray AAF, RADAR–1, Orig-A

Fort Hood/Killeen, TX, Robert Gray AAF, RADAR–2, Orig-A

Fort Hood/Killeen, TX, Robert Gray AAF, RNAV (GPS) RWY 15, Amdt 2

Fort Hood/Killeen, TX, Robert Gray AAF, RNAV (GPS) RWY 33, Amdt 1C

Salt Lake City, UT, Salt Lake City Intl, ILS OR LOC RWY 34R, ILS RWY 34R SA CAT I, ILS RWY 34R CAT II, ILS RWY 34R CAT III, Amdt 4C

Emporia, VA, Emporia-Greensville Rgnl, LOC RWY 34, Amdt 2

Elkins, WV, Elkins-Randolph Co-Jennings Randolph Fld, LDA–C, Amdt 8

Elkins, WV, Elkins-Randolph Co-Jennings Randolph Fld, RNAV (GPS) RWY 5, Orig-A

Elkins, WV, Elkins-Randolph Co-Jennings Randolph Fld, RNAV (GPS) RWY 14, Orig, CANCELED

Elkins, WV, Elkins-Randolph Co-Jennings Randolph Fld, RNAV (GPS) RWY 23, Orig-A

Elkins, WV, Elkins-Randolph Co-Jennings Randolph Fld, RNAV (GPS)-A, Orig-A

Cheyenne, WY, Cheyenne Rgnl/Jerry Olson Field, ILS OR LOC RWY 27, Amdt 36

Cheyenne, WY, Cheyenne Rgnl/Jerry Olson Field, RNAV (GPS) RWY 13, Amdt 2

Cheyenne, WY, Cheyenne Rgnl/Jerry Olson Field, RNAV (GPS) RWY 27, Amdt 1

Cheyenne, WY, Cheyenne Rgnl/Jerry Olson Field, RNAV (GPS) RWY 31, Amdt 2

RESCINDED: On April 9, 2018 (83 FR 15052), the FAA published an Amendment in Docket No. 31186, Amdt No. 3793, to Part 97 of the Federal Aviation Regulations under section 97.23. The following entry for Olympia, WA, effective May 24, 2018, is hereby rescinded in its entirety:

Olympia, WA, Olympia Rgnl, VOR–A, Amdt 2

[FR Doc. 2018–09566 Filed 5–7–18; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 97

[Docket No. 31191; Amdt. No. 3798]

Standard Instrument Approach Procedures, and Takeoff Minimums and Obstacle Departure Procedures; Miscellaneous Amendments

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This rule amends, suspends, or removes Standard Instrument Approach Procedures (SIAPs) and associated Takeoff Minimums and Obstacle Departure Procedures for operations at certain airports. These regulatory actions are needed because of the adoption of new or revised criteria, or because of changes occurring in the National Airspace System, such as the commissioning of new navigational facilities, adding new obstacles, or changing air traffic requirements. These changes are designed to provide for the safe and efficient use of the navigable airspace and to promote safe flight operations under instrument flight rules at the affected airports.

DATES: This rule is effective May 8, 2018. The compliance date for each SIAP, associated Takeoff Minimums, and ODP is specified in the amendatory provisions.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of May 8, 2018.

ADDRESSES: Availability of matter incorporated by reference in the amendment is as follows:

For Examination

1. U.S. Department of Transportation, Docket Ops-M30, 1200 New Jersey Avenue SE, West Bldg., Ground Floor, Washington, DC, 20590–0001;

2. The FAA Air Traffic Organization Service Area in which the affected airport is located;

3. The office of Aeronautical Navigation Products, 6500 South MacArthur Blvd., Oklahoma City, OK 73169 or,

4. 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/code_of_federal_regulations/ibr_locations.html.*

Availability

All SIAPs and Takeoff Minimums and ODPs are available online free of charge. Visit the National Flight Data Center online at *nfdc.faa.gov* to register. Additionally, individual SIAP and Takeoff Minimums and ODP copies may be obtained from the FAA Air Traffic Organization Service Area in which the affected airport is located.

FOR FURTHER INFORMATION CONTACT: Thomas J. Nichols, Flight Procedure Standards Branch (AFS–420)Flight Technologies and Procedures Division, Flight Standards Service, Federal Aviation Administration, Mike Monroney Aeronautical Center, 6500 South MacArthur Blvd., Oklahoma City, OK 73169 (Mail Address: P.O. Box 25082 Oklahoma City, OK 73125) telephone: (405) 954–4164.

SUPPLEMENTARY INFORMATION:

This rule amends Title 14, Code of Federal Regulations, Part 97 (14 CFR part 97) by amending the referenced SIAPs. The complete regulatory description of each SIAP is listed on the appropriate FAA Form 8260, as modified by the National Flight Data Center (NFDC)/Permanent Notice to Airmen (P–NOTAM), and is incorporated by reference under 5 U.S.C. 552(a), 1 CFR part 51, and 14 CFR 97.20. The large number of SIAPs, their complex nature, and the need for a special format make their verbatim publication in the **Federal Register** expensive and impractical. Further, airmen do not use the regulatory text of the SIAPs, but refer to their graphic depiction on charts printed by publishers of aeronautical materials. Thus, the advantages of incorporation by reference are realized and publication of the complete description of each SIAP contained on FAA form documents is unnecessary.

This amendment provides the affected CFR sections, and specifies the SIAPs and Takeoff Minimums and ODPs with their applicable effective dates. This amendment also identifies the airport and its location, the procedure and the amendment number.

Availability and Summary of Material Incorporated by Reference

The material incorporated by reference is publicly available as listed in the **ADDRESSES** section.

The material incorporated by reference describes SIAPs, Takeoff Minimums and ODPs as identified in the amendatory language for part 97 of this final rule.

The Rule

This amendment to 14 CFR part 97 is effective upon publication of each separate SIAP and Takeoff Minimums and ODP as amended in the transmittal. For safety and timeliness of change considerations, this amendment incorporates only specific changes contained for each SIAP and Takeoff Minimums and ODP as modified by FDC permanent NOTAMs.

The SIAPs and Takeoff Minimums and ODPs, as modified by FDC permanent NOTAM, and contained in this amendment are based on the criteria contained in the U.S. Standard for Terminal Instrument Procedures (TERPS). In developing these changes to SIAPs and Takeoff Minimums and ODPs, the TERPS criteria were applied only to specific conditions existing at the affected airports. All SIAP amendments in this rule have been previously issued by the FAA in a FDC NOTAM as an emergency action of immediate flight safety relating directly to published aeronautical charts.

The circumstances that created the need for these SIAP and Takeoff Minimums and ODP amendments require making them effective in less than 30 days.

Because of the close and immediate relationship between these SIAPs, Takeoff Minimums and ODPs, and safety in air commerce, I find that notice and public procedure under 5 U.S.C. 553(b) are impracticable and contrary to the public interest and, where applicable, under 5 U.S.C. 553(d), good cause exists for making these SIAPs effective in less than 30 days.

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. 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. For the same reason, the FAA certifies that this amendment will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 97

Air Traffic Control, Airports, Incorporation by reference, Navigation (Air).

Issued in Washington, DC on April 20, 2018.

John S. Duncan,

Director, Flight Standards Service.

Adoption Of The Amendment

Accordingly, pursuant to the authority delegated to me, Title 14, Code of Federal regulations, Part 97, (14 CFR part 97), is amended by amending Standard Instrument Approach Procedures and Takeoff Minimums and ODPs, effective at 0901 UTC on the dates specified, as follows:

PART 97—STANDARD INSTRUMENT APPROACH PROCEDURES

■ 1. The authority citation for part 97 continues to read as follows:

Authority: 49 U.S.C. 106(f), 106(g), 40103, 40106, 40113, 40114, 40120, 44502, 44514, 44701, 44719, 44721–44722.

■ 2. Part 97 is amended to read as follows:

§§ 97.23, 97.25, 97.27, 97.29, 97.31, 97.33, 97.35 [AMENDED]

By amending: § 97.23 VOR, VOR/DME, VOR or TACAN, and VOR/DME or TACAN; § 97.25 LOC, LOC/DME, LDA, LDA/DME, SDF, SDF/DME; § 97.27 NDB, NDB/DME; § 97.29 ILS, ILS/DME, MLS, MLS/DME, MLS/RNAV; § 97.31 RADAR SIAPs; § 97.33 RNAV SIAPs; and § 97.35 COPTER SIAPs, Identified as follows:

* * * Effective Upon Publication

AIRAC Date	State	City	Airport	FDC No.	FDC Date	Subject
24-May-18	RI	Newport	Newport State	8/4781	3/29/18	This NOTAM, published in TL 18–11, is hereby rescinded in its entirety.
24-May-18	AZ	Phoenix	Phoenix-Mesa Gateway.	7/3135	4/6/18	RNAV (GPS) RWY 12R, Amdt 1B
24-May-18	AZ	Phoenix	Phoenix-Mesa Gateway.	7/3136	4/6/18	RNAV (GPS) RWY 30L, Amdt 1B
24-May-18	OK	Norman	University of Oklahoma Westheimer.	7/4912	4/11/18	LOC RWY 3, Amdt 4
24-May-18	OK	Norman	University of Oklahoma Westheimer.	7/4913	4/11/18	RNAV (GPS) RWY 18, Amdt 2
24-May-18	OK	Ardmore	Ardmore Muni	7/5209	4/6/18	ILS OR LOC RWY 31, Amdt 5B
24-May-18	OK	Ardmore	Ardmore Muni	7/5213	4/6/18	RNAV (GPS) RWY 31, Amdt 1B
24-May-18	PA	Franklin	Venango Rgnl	7/6969	4/11/18	VOR RWY 21, Amdt 8A
24-May-18	CO	Rifle	Rifle Garfield County	7/7921	4/11/18	RNAV (RNP) Z RWY 26, Amdt 1B
24-May-18	MI	Allegan	Padgham Field	8/0101	4/6/18	RNAV (GPS) RWY 29, Orig
24-May-18	MI	Allegan	Padgham Field	8/0117	4/6/18	RNAV (GPS) RWY 11, Orig-A
24-May-18	MI	Allegan	Padgham Field	8/0119	4/6/18	VOR RWY 29, Amdt 14
24-May-18	MO	Fulton	Elton Hensley Memorial.	8/0231	4/6/18	Takeoff Minimums and Obstacle DP, Amdt 1
24-May-18	IN	Goshen	Goshen Muni	8/0233	4/6/18	Takeoff Minimums and Obstacle DP, Orig
24-May-18	TX	Longview	East Texas Rgnl	8/0245	4/6/18	ILS OR LOC RWY 13, Amdt 13A
24-May-18	NE	Grand Island.	Central Nebraska Rgnl	8/0251	4/6/18	ILS OR LOC RWY 35, Amdt 9F
24-May-18	KS	Topeka	Topeka Rgnl	8/0311	4/6/18	ILS OR LOC RWY 31, Amdt 10
24-May-18	CA	Upland	Cable	8/0674	4/11/18	VOR–A, Orig-A
24-May-18	MO	Charleston	Mississippi County	8/1039	4/6/18	Takeoff Minimums and Obstacle DP, Orig
24-May-18	AK	Mountain Village.	Mountain Village	8/1212	4/11/18	RNAV (GPS) RWY 2, Amdt 1A
24-May-18	KS	Wichita	Wichita Dwight D Eisenhower National.	8/1316	4/6/18	RNAV (RNP) Z RWY 19L, Amdt 1

AIRAC Date	State	City	Airport	FDC No.	FDC Date	Subject
24-May-18	KS	Wichita	Wichita Dwight D Eisenhower National.	8/1317	4/6/18	RNAV (GPS) Y RWY 19L, Amdt 2
24-May-18	AR	De Queen	J Lynn Helms Sevier County.	8/1950	4/11/18	RNAV (GPS) RWY 8, Orig-A
24-May-18	NM	Santa Fe	Santa Fe Muni	8/2099	4/11/18	Takeoff Minimums and Obstacle DP, Amdt 4
24-May-18	AK	Homer	Homer	8/2638	4/11/18	LOC BC RWY 22, Amdt 6
24-May-18	MO	Joplin	Joplin Rgnl	8/2770	4/9/18	RNAV (GPS) RWY 13, Orig-A
24-May-18	MO	Joplin	Joplin Rgnl	8/2771	4/9/18	RNAV (GPS) RWY 18, Orig-A
24-May-18	MO	Joplin	Joplin Rgnl	8/2772	4/9/18	RNAV (GPS) RWY 31, Amdt 1A
24-May-18	MO	Joplin	Joplin Rgnl	8/2773	4/9/18	RNAV (GPS) RWY 36, Orig-B
24-May-18	MO	Joplin	Joplin Rgnl	8/2774	4/9/18	LOC BC RWY 31, Amdt 21D
24-May-18	MI	Battle Creek.	W K Kellogg	8/3215	4/11/18	ILS OR LOC RWY 23R, Amdt 19
24-May-18	IL	Belleville	Scott AFB/MidAmerica	8/3218	4/11/18	ILS OR LOC RWY 32R, Orig-H
24-May-18	CO	Grand Junction.	Grand Junction Regional.	8/3221	4/11/18	ILS OR LOC RWY 11, Amdt 16B
24-May-18	OH	Jackson	James A Rhodes	8/3523	4/9/18	RNAV (GPS) RWY 1, Amdt 1D
24-May-18	OH	Jackson	James A Rhodes	8/3526	4/9/18	RNAV (GPS) RWY 19, Amdt 1C
24-May-18	OH	Jackson	James A Rhodes	8/3527	4/9/18	VOR/DME–A, Amdt 2B
24-May-18	IA	Shenandoah.	Shenandoah Muni	8/3555	4/9/18	RNAV (GPS) RWY 4, Orig
24-May-18	IA	Shenandoah.	Shenandoah Muni	8/3561	4/9/18	VOR/DME RWY 12, Amdt 4A
24-May-18	IA	Shenandoah.	Shenandoah Muni	8/3565	4/9/18	NDB RWY 4, Orig-B
24-May-18	NE	Gothenburg.	Gothenburg Muni	8/3991	4/11/18	Takeoff Minimums and Obstacle DP, Amdt 1A
24-May-18	MO	Joplin	Joplin Rgnl	8/4158	4/9/18	ILS OR LOC/DME RWY 18, Amdt 2A
24-May-18	NC	Charlotte	Charlotte/Douglas Intl	8/4264	4/17/18	Takeoff Minimums and Obstacle DP, Amdt 7
24-May-18	AK	Bethel	Bethel	8/4455	4/11/18	ILS Z OR LOC Z RWY 19R, Amdt 7E
24-May-18	ND	Dickinson	Dickinson—Theodore Roosevelt Rgnl.	8/4462	4/9/18	RNAV (GPS) RWY 32, Amdt 2
24-May-18	ND	Dickinson	Dickinson—Theodore Roosevelt Rgnl.	8/4479	4/9/18	RNAV (GPS) RWY 25, Orig-A
24-May-18	ND	Dickinson	Dickinson—Theodore Roosevelt Rgnl.	8/4480	4/9/18	ILS OR LOC RWY 32, Amdt 1B
24-May-18	IL	Lincoln	Logan County	8/4657	4/11/18	RNAV (GPS) RWY 3, Orig
24-May-18	IL	Lincoln	Logan County	8/4659	4/11/18	RNAV (GPS) RWY 21, Orig
24-May-18	IL	Lincoln	Logan County	8/4660	4/11/18	VOR RWY 3, Amdt 7
24-May-18	IL	Lincoln	Logan County	8/4661	4/11/18	NDB RWY 21, Amdt 2
24-May-18	TX	Amarillo	Rick Husband Amarillo Intl.	8/4668	4/13/18	LDA/DME RWY 22, Amdt 1
24-May-18	AR	Clinton	Holley Mountain Airpark.	8/4720	4/11/18	RNAV (GPS) RWY 23, Amdt 1A
24-May-18	AR	Clinton	Holley Mountain Airpark.	8/4721	4/11/18	RNAV (GPS) RWY 5, Amdt 1B
24-May-18	IA	Davenport	Davenport Muni	8/4775	4/6/18	ILS OR LOC RWY 15, Amdt 1B
24-May-18	IA	Davenport	Davenport Muni	8/4777	4/6/18	RNAV (GPS) RWY 3, Amdt 1C
24-May-18	IA	Davenport	Davenport Muni	8/4780	4/6/18	RNAV (GPS) RWY 15, Amdt 2B
24-May-18	IA	Davenport	Davenport Muni	8/4783	4/6/18	RNAV (GPS) RWY 21, Amdt 1D
24-May-18	IA	Davenport	Davenport Muni	8/4784	4/6/18	RNAV (GPS) RWY 33, Amdt 1C
24-May-18	IA	Davenport	Davenport Muni	8/4791	4/6/18	VOR RWY 3, Amdt 9A
24-May-18	IA	Davenport	Davenport Muni	8/4792	4/6/18	VOR RWY 21, Amdt 8B
24-May-18	MN	Austin	Austin Muni	8/4821	4/11/18	RNAV (GPS) RWY 17, Amdt 1B
24-May-18	PA	Allentown	Lehigh Valley Intl	8/5371	4/9/18	ILS OR LOC RWY 6, Amdt 23A
24-May-18	PA	Allentown	Lehigh Valley Intl	8/5372	4/9/18	ILS OR LOC/DME RWY 24, Amdt 1A
24-May-18	PA	Allentown	Lehigh Valley Intl	8/5373	4/13/18	RNAV (GPS) RWY 6, Amdt 1B
24-May-18	PA	Allentown	Lehigh Valley Intl	8/5374	4/9/18	RNAV (GPS) RWY 24, Amdt 1A
24-May-18	PA	Allentown	Lehigh Valley Intl	8/5375	4/9/18	RNAV (GPS) RWY 31, Amdt 2A
24-May-18	PA	Allentown	Lehigh Valley Intl	8/5376	4/9/18	VOR–A, Amdt 10
24-May-18	PA	Allentown	Lehigh Valley Intl	8/5390	4/9/18	TACAN–C, Orig
24-May-18	RI	Newport	Newport State	8/6556	4/11/18	VOR/DME RWY 16, Amdt 1B
24-May-18	ND	Casselton	Casselton Robert Miller Rgnl.	8/7299	4/11/18	RNAV (GPS) RWY 31, Amdt 1
24-May-18	ND	Casselton	Casselton Robert Miller Rgnl.	8/7300	4/11/18	VOR/DME RWY 31, Amdt 1A
24-May-18	SD	Huron	Huron Rgnl	8/7324	4/11/18	ILS OR LOC RWY 12, Amdt 10
24-May-18	SD	Huron	Huron Rgnl	8/7325	4/11/18	LOC/DME BC RWY 30, Amdt 13
24-May-18	SD	Huron	Huron Rgnl	8/7326	4/11/18	VOR RWY 12, Amdt 22
24-May-18	SD	Huron	Huron Rgnl	8/7327	4/11/18	RNAV (GPS) RWY 30, Amdt 1A
24-May-18	SD	Huron	Huron Rgnl	8/7328	4/11/18	RNAV (GPS) RWY 12, Orig
24-May-18	PA	New Castle	New Castle Muni	8/7350	4/6/18	NDB RWY 23, Amdt 3B
24-May-18	NE	Pender	Pender Muni	8/7569	4/11/18	Takeoff Minimums and Obstacle DP, Orig

AIRAC Date	State	City	Airport	FDC No.	FDC Date	Subject
24-May-18	TX	Mexia	Mexia-Limestone Co ..	8/7712	4/6/18	NDB–A, Amdt 4
24-May-18	TX	Mexia	Mexia-Limestone Co ..	8/7713	4/6/18	RNAV (GPS) RWY 36, Orig-A
24-May-18	OH	New Lexington.	Perry County	8/7718	4/6/18	VOR/DME RWY 26, Amdt 2
24-May-18	OH	New Lexington.	Perry County	8/7719	4/6/18	RNAV (GPS) RWY 26, Orig-A
24-May-18	NJ	Teterboro	Teterboro	8/8099	4/11/18	ILS OR LOC RWY 6, Amdt 29G
24-May-18	NJ	Teterboro	Teterboro	8/8101	4/11/18	COPTER ILS OR LOC RWY 6, Amdt 1F
24-May-18	NJ	Teterboro	Teterboro	8/8102	4/11/18	ILS OR LOC RWY 19, Orig-A
24-May-18	NJ	Teterboro	Teterboro	8/8105	4/11/18	RNAV (GPS) X RWY 6, Amdt 2
24-May-18	NJ	Teterboro	Teterboro	8/8106	4/11/18	RNAV (GPS) Y RWY 6, Amdt 2B
24-May-18	NJ	Teterboro	Teterboro	8/8121	4/11/18	VOR/DME RWY 6, Orig-D
24-May-18	NJ	Teterboro	Teterboro	8/8122	4/11/18	VOR RWY 24, Orig-D
24-May-18	LA	Ruston	Ruston Rgnl	8/8418	4/6/18	NDB RWY 18, Orig-D
24-May-18	LA	Ruston	Ruston Rgnl	8/8420	4/6/18	RNAV (GPS) RWY 18, Orig-A
24-May-18	LA	Ruston	Ruston Rgnl	8/8424	4/6/18	RNAV (GPS) RWY 36, Orig-A
24-May-18	MA	Hyannis	Barnstable Muni-Boardman/Polando Field.	8/8563	4/11/18	ILS OR LOC RWY 15, Amdt 5
24-May-18	MA	Hyannis	Barnstable Muni-Boardman/Polando Field.	8/8564	4/11/18	RNAV (GPS) RWY 15, Orig-A
24-May-18	WI	Milwaukee	Lawrence J Timmerman.	8/9042	4/9/18	RNAV (GPS) RWY 4L, Orig-B
24-May-18	WI	Milwaukee	Lawrence J Timmerman.	8/9044	4/9/18	RNAV (GPS) RWY 15L, Orig-B
24-May-18	WI	Milwaukee	Lawrence J Timmerman.	8/9051	4/9/18	RNAV (GPS) RWY 22R, Orig-C
24-May-18	NJ	Teterboro	Teterboro	8/9174	4/13/18	VOR/DME–B, Amdt 2D
24-May-18	WI	Milwaukee	Lawrence J Timmerman.	8/9495	4/9/18	VOR RWY 4L, Amdt 9B
24-May-18	WI	Milwaukee	Lawrence J Timmerman.	8/9497	4/9/18	LOC RWY 15L, Amdt 6B
24-May-18	MN	Mora	Mora Muni	8/9655	4/6/18	NDB RWY 35, Orig
24-May-18	MN	Mora	Mora Muni	8/9656	4/6/18	RNAV (GPS) RWY 35, Orig-A
24-May-18	MN	Mora	Mora Muni	8/9657	4/6/18	Takeoff Minimums and Obstacle DP, Orig
24-May-18	IA	Decorah ...	Decorah Muni	8/9849	4/6/18	RNAV (GPS) RWY 11, Orig-C

[FR Doc. 2018–09565 Filed 5–7–18; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Parts 11 and 101

[Docket No. FDA–2011–F–0172]

Menu Labeling: Supplemental Guidance for Industry; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notification of availability.

SUMMARY: The Food and Drug Administration (FDA or we) is announcing the availability of a guidance for industry entitled ''Menu Labeling: Supplemental Guidance for Industry.'' The guidance addresses stakeholder concerns regarding the implementation of nutrition labeling required for foods sold in covered establishments, includes expanded and new examples of alternatives to aid in compliance, identifies places where we intend to be more flexible in our approach, and advises of our intent to exercise enforcement discretion regarding nutrient declaration for ''calories from fat'' as part of the additional written nutrition information. The guidance also includes many graphical depictions to convey our thinking on various topics and to provide examples of options for implementation, and addresses calorie disclosure signage for self-service foods, including buffets and grab-and-go foods; reasonable basis, and the criteria for considering the natural variation of foods, when determining nutrition labeling for such foods; various methods for providing calorie disclosure information, including those for pizza; compliance and enforcement; and criteria for distinguishing between menus and other information presented to the consumer.

DATES: The announcement of the guidance is published in the **Federal Register** on May 8, 2018.

ADDRESSES: You may submit either electronic or written comments on FDA guidances at any time as follows:

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov.*
- If you want to submit a comment with confidential information that you

do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

- *Mail/Hand delivery/Courier (for written/paper submissions):* Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.
- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket No. FDA–2011–F–0172 for ''Menu Labeling: Supplemental Guidance for Industry.'' Received comments will be placed in the docket and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday.

- *Confidential Submissions*—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' We will review this copy, including the claimed confidential information, in our consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov.* Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your comments and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with 21 CFR 10.20 and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.gpo.gov/fdsys/pkg/FR-2015-09-18/pdf/2015-23389.pdf.*

Docket: For access to the docket to read background documents or the electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

You may submit comments on any guidance at any time (see 21 CFR 10.115(g)(5)).

Submit written requests for single copies of the guidance to the Office of Nutrition and Food Labeling (HFS–800), Center for Food Safety and Applied Nutrition, Food and Drug Administration, 5001 Campus Dr., College Park, MD 20740. Send two self-addressed adhesive labels to assist that office in processing your request. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the guidance.

FOR FURTHER INFORMATION CONTACT: Loretta A. Carey, Center for Food Safety and Applied Nutrition (HFS–820), Food and Drug Administration, 5001 Campus Dr., College Park, MD 20740, 240–402–2371.

SUPPLEMENTARY INFORMATION:

I. Background

We are announcing the availability of a guidance for industry entitled ''Menu Labeling: Supplemental Guidance for Industry.'' We are issuing this guidance consistent with our good guidance practices regulation (21 CFR 10.115). The guidance represents the current thinking of FDA on this topic. It does not establish any rights for any person and is not binding on FDA or the public. You can use an alternative approach if it satisfies the requirements of the applicable statutes and regulations. This guidance is not subject to Executive Order 12866.

In the **Federal Register** of December 1, 2014 (79 FR 71156), we published a final rule on nutrition labeling of standard menu items in restaurants and similar retail food establishments to implement the menu labeling provisions of section 403(q)(5)(H) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(H)). The menu labeling requirements are codified at Title 21 of the Code of Federal Regulations, § 101.11 (21 CFR 101.11).

In the **Federal Register** of May 4, 2017 (82 FR 20825), we published an interim final rule extending the compliance date to May 7, 2018. Our goals are to ensure that consumers are provided with consistent nutrition information they can use to make informed choices for themselves and their families, and to guide industry in clearly understanding the flexible ways in which the requirements can be implemented.

In the **Federal Register** of November 9, 2017 (82 FR 52036), we made available a draft guidance for industry entitled ''Menu Labeling: Supplemental Guidance for Industry'' and gave interested parties an opportunity to submit comments by January 8, 2018, for us to consider before beginning work on the final version of the guidance. The draft guidance addressed concerns raised by stakeholders regarding the implementation of nutrition labeling required for foods sold in covered establishments. It included expanded and new examples of alternatives to aid in compliance and identified places where we intend to be more flexible in our approach. The draft guidance also included many graphical depictions to convey our thinking on various topics and to provide examples of options for implementation. It addressed calorie disclosure signage for self-service foods, including buffets and grab-and-go foods; reasonable basis, and the criteria for considering the natural variation of foods; various methods for providing calorie disclosure information, including those for pizza; compliance and enforcement; and criteria for distinguishing between menus and other information presented to the consumer.

We received numerous comments on the draft guidance and have modified the final guidance where appropriate. Changes to the guidance include adding new questions and answers 3.4, 3.5, and 8.3 and Figures 12, 13, 16, 17, and 18. In addition, we made editorial changes to improve clarity in questions and answers 4.1, 5.4, 6.2, 7.1, 8.1, 10.1, and 10.2 and clarified the headings for the graphics in Figures 3 and 14.

In addition, the final guidance announces our intent to exercise enforcement discretion regarding the ''calories from fat'' nutrient declaration requirement as part of the additional written nutrition information required in § 101.11(b)(2)(ii)(A). As discussed in the final guidance, we are taking this position because the current science supports a view that the type of fat is more relevant with respect to the risk of chronic disease than the overall caloric fat intake, and to align with the final rule, ''Food Labeling: Revision of the Nutrition and Supplement Facts Labels'' (81 FR 33742, May 27, 2016). (Our current thinking on this issue is discussed in the preamble to the final rule titled, ''Food Labeling: Revision of the Nutrition and Supplement Facts Labels'' (81 FR 33742 at 33780 through

33781) now codified primarily at 21 CFR 101.9 and 101.36). With respect to our enforcement discretion policy pertaining to ''calories from fat'' declarations, this part of the guidance is immediately effective because we have determined that prior public participation is not feasible or appropriate (21 CFR 10.115(g)(2)). The guidance announced in this notice finalizes the draft guidance dated November 2017.

II. Paperwork Reduction Act of 1995

This guidance refers to previously approved collections of information found in FDA regulations. These collections of information are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). The collections of information in § 101.11(b)(2), (c)(3), and (d) have been approved under OMB control number 0910–0783.

III. Electronic Access

Persons with access to the internet may obtain the guidance at either *https://www.fda.gov/FoodGuidances* or *https://www.regulations.gov.* Use the FDA website listed in the previous sentence to find the most current version of the guidance.

Dated: May 3, 2018.

Leslie Kux,

Associate Commissioner for Policy.

[FR Doc. 2018–09725 Filed 5–7–18; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 147

[Docket Number USCG–2017–0446]

RIN 1625–AA00

Safety Zone; Appomattox FPS, Mississippi Canyon 437, Outer Continental Shelf on the Gulf of Mexico

AGENCY: Coast Guard, DHS.

ACTION: Final rule.

SUMMARY: The Coast Guard is establishing a permanent safety zone extending 500 meters around the Appomattox Floating Production System (FPS) facility located in Mississippi Canyon Block 437 on the Outer Continental Shelf (OCS) in the Gulf of Mexico. This action is necessary to protect the facility from all vessels operating outside the normal shipping channels and fairways that are not providing services to or working with the facility. Only vessels measuring less than 100 feet in length overall and not engaged in towing, attending vessels as defined in 33 CFR 147.20, or those vessels specifically authorized by the Eighth Coast Guard District Commander or a designated representative are permitted to enter or remain in the safety zone.

DATES: This rule is effective on May 8, 2018.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov,* type USCG–2017–0446 in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rule.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Ms. Laura Knoll, U.S. Coast Guard, District Eight Waterways Management Branch; telephone 504–671–2139, *Laura.B.Knoll@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
DHS Department of Homeland Security
FPS Floating production system
FR Federal Register
NPRM Notice of proposed rulemaking
OCS Outer Continental Shelf
§ Section
U.S.C. United States Code

II. Background Information and Regulatory History

Shell Exploration and Production Co. requested that the Coast Guard establish an Outer Continental Shelf (OCS) safety zone extending 500 meters from each point on the Appomattox Floating Production System (FPS) facility structure's outermost edge. In response to Shell Exploration and Production Co.'s request and on the basis of the District Commander's safety analysis, on March 20, 2018, the Coast Guard published a notice of proposed rulemaking (NPRM) titled Safety Zone; Appomattox FPS, Mississippi Canyon 437, Outer Continental Shelf on the Gulf of Mexico (83 FR 12144). There we stated why we issued the NPRM, and invited comments on our proposed regulatory action related to establishing the 500-meter safety zone. During the comment period that ended on April 19, 2018, we received no comments.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the Federal Register. Delaying the effective date of this rule would be contrary to the public interest because immediate action is needed to respond to the potential safety concerns and hazards that could occur within 500 meters of the facility.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under the authority provided in 14 U.S.C. 85, 43 U.S.C. 1333, and Department of Homeland Security Delegation No. 0170.1(90), and Title 33, CFR 147.1, 147.5, and 147.10. The District Commander determined that placing a safety zone around the facility will significantly reduce the threat of allisions, oil spills, and releases of natural gas, and thereby protect the safety of life, property, and living marine resources. The purpose of this rule is to protect the facility from all vessels operating outside the normal shipping channels and fairways that are not providing services to or working with the facility.

IV. Discussion of Comments, Changes, and the Rule

As noted above, we received no comments on our NPRM published on March 20, 2018. This regulatory text of this final rule contains one technical amendment. In the NPRM, we indicated that permission to enter the safety zone may be obtained from the District Commander or a designated representative in the discussion of the proposed rule but not the regulatory text. This final rule corrects the regulatory text to indicate that permission to enter the safety zone may be obtained from the District Commander or a designated representative.

This rule establishes a safety zone on the OCS in the deepwater area of the Gulf of Mexico at Mississippi Canyon Block 437. The area for the safety zone is 500 meters (1640.4 feet) from each point on the facility, which is located at 28°34′25.47″ N 87°56′03.11″ W. Only vessels measuring less than 100 feet in length overall and not engaged in towing, attending vessels as defined in 33 CFR 147.20, or those vessels specifically authorized by the Eighth Coast Guard District Commander or a designated representative are permitted to enter or remain in the safety zone.

V. 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, and we discuss First Amendment rights of protestors.

A. Regulatory Planning and Review

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. Executive Order 13771 directs agencies to control regulatory costs through a budgeting process. This rule has not been designated as a ''significant regulatory action,'' under Executive Order 12866. Accordingly, this rule has not been reviewed by the Office of Management and Budget (OMB), and pursuant to OMB guidance it is exempt from the requirements of Executive Order 13771.

This regulatory action determination is based on the safety zone's location and its distance from both land and safety fairways. This rule is not a significant regulatory action due to the location of the Appomattox FPS on the Outer Continental Shelf, and its distance from both land and safety fairways. Vessels traversing waters near the proposed safety zone are able to safely travel around the zone using alternate routes. Exceptions to this rule also include vessels measuring less than 100 feet in length overall and not engaged in towing and attending vessels as defined in 33 CFR 147.20. In addition, the Eighth Coast Guard District Commander or a designated representative will consider requests to enter or transit through the safety zone on a case-by-case basis.

B. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 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 no comments from the Small Business Administration on this rulemaking. 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.

While some owners or operators of vessels intending to transit the safety zone may be small entities, for the reasons stated in section V.A above, this rule will not have a significant economic impact on any vessel owner or operator.

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** section.

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.

C. 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).

D. Federalism and Indian Tribal Governments

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 is consistent with the fundamental federalism principles and preemption requirements described in Executive Order 13132.

Also, 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. If you believe this rule has implications for federalism or Indian tribes, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

E. 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.

F. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01 and Commandant Instruction M16475.1D, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (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 establishing a safety zone around an offshore deepwater facility. It is categorically excluded from further review under paragraph L60(a) of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 01. A Record of Environmental Consideration supporting this determination is available in the docket where indicated under **ADDRESSES**.

G. 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.

List of Subjects in 33 CFR Part 147

Continental shelf, Marine safety, Navigation (water).

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 147 as follows:

PART 147—SAFETY ZONES

■ 1. The authority citation for part 147 continues to read as follows:

Authority: 14 U.S.C. 85; 43 U.S.C. 1333; and Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 147.869 to read as follows:

§ 147.869 Safety Zone; Appomattox FPS Facility, Outer Continental Shelf on the Gulf of Mexico.

(a) *Description.* The Appomattox Floating Production System (FPS) system is in the deepwater area of the

Gulf of Mexico at Mississippi Canyon Block 437. The facility is located at 28°34′25.47″ N 87°56′03.11″ W (NAD 83), and the area within 500 meters (1640.4 feet) from each point on the facility structure's outer edge is a safety zone.

(b) *Regulation.* No vessel may enter or remain in this safety zone except the following:

(1) An attending vessel, as defined by 33 CFR 147.20;

(2) A vessel under 100 feet in length overall not engaged in towing; or

(3) A vessel authorized by the Eighth Coast Guard District Commander or a designated representative.

Dated: May 2, 2018.

Paul F. Thomas,

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

[FR Doc. 2018–09789 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 3

RIN 2900–AP23

Special Monthly Compensation for Veterans With Traumatic Brain Injury

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) amends its adjudication regulations to add an additional compensation benefit for veterans with residuals of traumatic brain injury (TBI). This final rule incorporates in regulations a benefit authorized by the enactment of the Veterans' Benefits Act of 2010. The Veterans' Benefits Act authorizes special monthly compensation (SMC) for veterans with TBI who are in need of aid and attendance, and in the absence of such aid and attendance, would require hospitalization, nursing home care, or other residential institutional care.

DATES: *Effective Date:* This final rule is effective June 7, 2018.

Applicability Date: The provisions of this final rule shall apply to all applications for benefits received by VA on or after October 1, 2011, or that were pending before VA, the United States Court of Appeals for Veterans Claims, or the United States Court of Appeals for the Federal Circuit on October 1, 2011.

FOR FURTHER INFORMATION CONTACT: Roselyn Tyson, Regulations Staff (211D), Compensation Service, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 461–9700. (This is not a toll-free telephone number.)

SUPPLEMENTARY INFORMATION: On December 21, 2016, VA published in the **Federal Register** (81 FR 93649) a proposed rule to amend 38 CFR 3.350 and 3.352 to add SMC for veterans with residuals of TBI. As explained in the proposed rule, section 601 of the Veterans' Benefits Act of 2010, Public Law 111–275 (the Veterans' Benefits Act) authorized SMC for veterans who, as the result of service-connected disability, are in need of regular aid and attendance for the residuals of TBI, and in the absence of such regular aid and attendance, would require hospitalization, nursing home care, or other residential institutional care. Effective October 1, 2011, section 601 authorized an additional monetary allowance for veterans with residuals of TBI who require this higher level of care but would not otherwise qualify for the benefit under 38 U.S.C. 1114(r)(2).

To date, VA has relied on non-regulatory guidance to implement section 601 of the Veterans' Benefits Act. By issuing this final rule, VA updates its adjudication regulations to reflect the authorization provided by section 601.

Response to Public Comments

As noted above, VA published the proposed rule in the **Federal Register** (81 FR 93649) on December 21, 2016. VA provided a 60-day public comment period, which ended on February 21, 2017, and received two comments. VA responds to all comments as follows. For the reasons set forth in the proposed rule and below, VA adopts the proposed rule as final, without changes.

Both commenters expressed support for the rulemaking, noting that SMC should be awarded for TBI. VA appreciates the time and effort expended by these commenters in reviewing the proposed rule and in submitting comments, as well as their support for this rulemaking.

One commenter stated that this rulemaking should restrict the use of SMC payments to treatment for TBI. The commenter noted that application for SMC funds should be made on a yearly basis and the funds should be applied specifically for medical care of the TBI. VA notes that it has no authority to direct how payments are used once awarded to a veteran; VA only has legal authority to determine benefit eligibility and entitlement.

The same commenter stated that application of SMC should be limited to claims where TBI that was incurred in the line of duty and was not a result of self-inflicted injury, and the veteran applying for the benefit was not dishonorably discharged. This commenter also appears to suggest that posttraumatic stress disorder (PTSD) be included in the definition of a TBI and provided examples of individuals who may have benefited from this approach.

While any injury outside the line of duty would not be service connected, we note that the occurrence of such an injury is interpreted very broadly. *See Holton* v. *Shinseki,* 557 F.3d 1362, 1366–67 (Fed. Cir. 2009) (explaining that an injury or disease will be deemed to have been incurred in the line of duty if it occurred at almost any time during a veteran's active service—even during authorized leave). With regard to the commenter's statement that self-inflicted injuries should not be the basis for service-connected TBI for SMC, we note that self-inflicted injuries generally would not be covered to the extent they constituted willful misconduct. Whether or not a given self-injury rises to the level of willful misconduct is a case specific factual determination that is separate from the level of compensation at stake, which is what is affected by this rule. *See* 38 CFR 3.301. While the commenter also expressed that SMC based on service-connected TBI should not be available to individuals with a dishonorable discharge, VA statutes and regulations preclude veteran status and benefits for individuals with a dishonorable discharge. 38 U.S.C. 101(2); 38 CFR 3.12(a). Finally, in response to the commenter's last assertion that VA should define whether PTSD ''is included under the definition of [TBI],'' we note that PTSD is already a disability available for VA service connection and rating as a mental disorder under 38 CFR 4.130, Diagnostic Code 9411. Therefore, VA already compensates veterans for service-connected PTSD, including with PTSD that is somehow causally related to TBI.

In any case, the general eligibility criteria for SMC and the definition of TBI are outside the scope of this rulemaking. Therefore, VA makes no change based on these comments.

The second commenter stated that veterans with TBI should have always qualified for maximum monthly relief. VA notes that SMC is authorized by statute, and prior to the enactment of the Veterans' Benefits Act, VA lacked the statutory authority to provide the level of SMC contemplated in the Act for TBI. The commenter also noted the length of time it took to authorize and implement SMC for TBI. As noted above, VA has to date relied on non-regulatory guidance to implement the statutory authorization for SMC for TBI.

Finally, the commenter stated that VA should provide coverage to veterans for all injuries, not just TBI. As noted above, the requirements for service connection, including for disabilities other than TBI, are beyond the scope of this rulemaking. Therefore, VA makes no change based on this comment.

Executive Orders 12866, 13563 and 13771

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a ''significant regulatory action'' requiring review by the Office of Management and Budget (OMB), unless OMB waives such review, as ''any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order''.

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined not to be a significant regulatory action under Executive Order 12866. VA's impact analysis can be found as a supporting document at *http://www.regulations.gov,* usually within 48 hours after the rulemaking document is published. Additionally, a copy of this rulemaking and its impact analysis are available on VA's website at *http://www.va.gov/orpm/,* by following the link for ''VA Regulations Published From FY 2004 Through Fiscal Year to Date.'' This final rule is not an E.O. 13771 regulatory action because this final rule is not significant under E.O. 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601–612). This final rule will directly affect only individuals and will not directly affect small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1532, requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

Although this document contains provisions constituting a collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), no new or proposed revised collections of information are associated with this final rule. The information collection requirements are currently approved by the Office of Management and Budget (OMB) and have been assigned OMB control number 2900–0721. Since this collection was revised several years after the implementation of the Veterans' Benefit Act of 2010 and VBA's interim guidance, VA concludes that any new respondents have been captured in the existing respondent numbers. See Regulatory Impact Analysis for a full explanation.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance number and title for the program affected by this document is 64.109, Veterans Compensation for Service-Connected Disability.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Jacquelyn Hayes-Byrd, Deputy Chief of Staff, Department of Veterans Affairs, approved this document on May 2, 2018, for publication.

List of Subjects in 38 CFR Part 3

Administrative practice and procedure, Claims, Disability benefits, Health care, Pensions, Radioactive materials, Veterans, Vietnam.

Dated: May 2, 2018.

Jeffrey M. Martin,

Impact Analyst, Office of Regulation Policy & Management, Office of the Secretary, Department of Veterans Affairs.

For the reasons stated in the preamble to this final rule, VA amends 38 CFR part 3 as follows:

PART 3—ADJUDICATION

Subpart A—Pension, Compensation, and Dependency and Indemnity Compensation

■ 1. The authority citation for part 3, subpart A, continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

■ 2. Amend § 3.350 by adding paragraph (j) and a parenthetical authority citation to read as follows:

§ 3.350 Special monthly compensation ratings.

* * * * *

(j) *Special aid and attendance benefit for residuals of traumatic brain injury (38 U.S.C. 1114(t)).* The special monthly compensation provided by 38 U.S.C. 1114(t) is payable to a veteran who, as the result of service-connected disability, is in need of regular aid and attendance for the residuals of traumatic brain injury, is not eligible for compensation under 38 U.S.C. 1114(r)(2), and in the absence of such regular aid and attendance would require hospitalization, nursing home care, or other residential institutional care. Determination of this need is subject to the criteria of § 3.352.

(1) A veteran described in this paragraph (j) shall be entitled to the amount equal to the compensation authorized under 38 U.S.C. 1114(o) or the maximum rate authorized under 38 U.S.C. 1114(p) and, in addition to such compensation, a monthly allowance equal to the rate described in 38 U.S.C. 1114(r)(2) during periods he or she is not hospitalized at United States Government expense. (*See* § 3.552(b)(2) as to continuance following admission for hospitalization.)

(2) An allowance authorized under 38 U.S.C. 1114(t) shall be paid in lieu of

any allowance authorized by 38 U.S.C. 1114(r)(1).

(Authority: 38 U.S.C. 501, 38 U.S.C. 1114(t))

■ 3. Amend § 3.352 by:

■ a. In paragraph (b)(1)(iii), removing the phrase ''paragraph (b)(2)'' and in its place adding the phrase ''paragraph (b)(3)'';

■ b. Redesignating paragraphs (b)(2) through (5) as (b)(3) through (6);

■ c. Adding new paragraph (b)(2);

■ d. In newly redesignated paragraph (b)(4), removing the phrase ''paragraph (b)(2)'' and in its place adding the phrase ''paragraph (b)(3)'';

■ e. Removing the parenthetical authority citation at the end of paragraph (b); and

■ f. Adding a parenthetical authority citation at the end of the section.

The additions read as follows:

§ 3.352 Criteria for determining need for aid and attendance and ''permanently bedridden.''

* * * * *

(b) * * *

(2) A veteran is entitled to the higher level aid and attendance allowance authorized by § 3.350(j) in lieu of the regular aid and attendance allowance when all of the following conditions are met:

(i) As a result of service-connected residuals of traumatic brain injury, the veteran meets the requirements for entitlement to the regular aid and attendance allowance in paragraph (a) of this section.

(ii) As a result of service-connected residuals of traumatic brain injury, the veteran needs a ''higher level of care'' (as defined in paragraph (b)(3) of this section) than is required to establish entitlement to the regular aid and attendance allowance, and in the absence of the provision of such higher level of care the veteran would require hospitalization, nursing home care, or other residential institutional care.

* * * * *

(Authority: 38 U.S.C. 501, 1114(r)(2), 1114(t))

■ 4. Amend § 3.552 by:

■ a. In paragraph (b)(2), removing ''38 U.S.C. 1114(r) (1) or (2)'' and adding in its place ''38 U.S.C. 1114(r)(1) or (2) or 38 U.S.C. 1114(t)'';

■ b. Removing the parenthetical authority citation at the end of paragraph (b); and

■ c. Adding a parenthetical authority citation at the end of the section.

The addition reads as follows:

§ 3.552 Adjustment of allowance for aid and attendance.

* * * * *

(Authority: 38 U.S.C. 5503(c))

[FR Doc. 2018–09736 Filed 5–7–18; 8:45 am]

BILLING CODE 8320–01–P

Proposed Rules

Federal Register
Vol. 83, No. 89
Tuesday, May 8, 2018

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 HOMELAND SECURITY

Office of the Secretary

6 CFR Part 5

[Docket No. DHS–2018–0014]

Privacy Act of 1974: Implementation of Exemptions; Department of Homeland Security/U.S. Immigration and Customs Enforcement-007 Criminal History and Immigration Verification (CHIVe) System of Records

AGENCY: Department of Homeland Security.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Department of Homeland Security (DHS) is giving concurrent notice of a modified, renamed, and reissued system of records pursuant to the Privacy Act of 1974 for the ''Department of Homeland Security/U.S. Immigration and Customs Enforcement-007 Alien Criminal Response Information Management System of Records'' and this proposed rulemaking. In this proposed rulemaking, the Department proposes to rename the system Criminal History and Immigration Verification, and exempt portions of the system of records from one or more provisions of the Privacy Act because of criminal, civil, and administrative enforcement requirements.

DATES: Comments must be received on or before June 7, 2018.

ADDRESSES: You may submit comments, identified by docket number DHS–2018–0014, by one of the following methods:

- *Federal e-Rulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* 202–343–4010.
- *Mail:* Philip S. Kaplan, Chief Privacy Officer, Privacy Office, Department of Homeland Security, Washington, DC 20528.

Instructions: All submissions received must include the agency name and docket number DHS–2018–0014. All comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided.

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: For general questions please contact: Amber Smith, (202–732–3300), *ICEPrivacy@ice.dhs.gov,* Privacy Officer, U.S. Immigration and Customs Enforcement, 500 12th Street SW, Washington, DC 20536. For privacy issues please contact: Philip S. Kaplan, *Privacy@hq.dhs.gov,* (202–343–1717), Chief Privacy Officer, Privacy Office, Department of Homeland Security, Washington, DC 20528.

SUPPLEMENTARY INFORMATION:

I. Background

In accordance with the Privacy Act of 1974, 5 U.S.C. 552a, DHS U.S. Immigration and Customs Enforcement (ICE) proposes to modify, rename, and reissue a current DHS Privacy Act system of records notice (SORN) titled, ''DHS/ICE–007 Alien Criminal Response Information Management (ACRIMe)'' 78 FR 10623 (Feb. 14, 2013). ICE had previously issued a Final Rule for this SORN on Aug. 31, 2009, published at 74 FR 45079. As a result of the modifications to this SORN, DHS/ICE is proposing to issue this new rule.

DHS/ICE update to ACRIMe includes several changes. First, the system of records is being renamed ''Criminal History and Immigration Verification (CHIVe)'' to better align with the purpose of the system. This system of records covers records documenting inquiries received from federal, state, and local law enforcement agencies so ICE can check the immigration status and criminal history of individuals who are arrested or otherwise encountered by those agencies; and other federal agencies for screening (including as part of background checks being conducted by those agencies) to inform those agencies' determinations regarding suitability for employment, access, sponsorship of an unaccompanied alien child, or other purposes or otherwise encountered by those agencies.

Second, DHS is adding a purpose of the system, as ICE will now screen individuals seeking approval from the Department of Health and Human Services (HHS) to sponsor an unaccompanied alien child, as well as other adult members of the potential sponsor's household, to verify or ascertain citizenship or immigration status, immigration history, and criminal history.

Third, DHS is clarifying that the Department may use information maintained in this system of records for other purposes consistent with its statutory authorities.

Fourth, this update adds a new category of individuals: Those seeking approval from HHS to sponsor an unaccompanied alien child and/or other adult members of the potential sponsor's household.

Fifth, DHS is adding one category of records to include biometrics for potential sponsors and/or other adult members of the potential sponsor's household. DHS has also modified a category of records to include citizenship or immigration status and criminal and immigration history information for sponsorship of unaccompanied alien children.

Sixth, DHS is adding one new routine use that would allow ICE to share from this system of records the results of screening of potential sponsors and adult members of their households with HHS to inform HHS's determination whether to grant sponsor applications. DHS is also modifying routine use (E) and adding routine use (F) to conform to Office of Management and Budget (OMB) Memorandum M–17–12 ''Preparing for and Responding to a Breach of Personally Identifiable Information'' (Jan. 3, 2017).

Seventh, DHS is revising the records retention periods so that they align with the records retention schedule approved by the National Archives and Records Administration (NARA).

Finally, DHS is modifying this SORN since this system will no longer store information pertaining to the collection, processing, and response to public tip information concerning customs and immigration violations, suspicious activity, or other law enforcement matters. ICE will continue to collect information about individuals reporting tips, the subjects of such tips, and any information ICE collects in following up on a tip in the DHS/ICE–016 FALCON Search and Analysis System of Records, 82 FR 20905 (May 4, 2017).

As a result, the following changes are being made: (1) Two categories of individuals are being removed from the system—individuals who report tips and individuals about whom those reports are made; (2) two categories of records are being removed from the system—those public tip records, which consist of information contained in tips received from the public or other sources regarding customs and immigration violations, other actual or potential violations of law, and suspicious activities; and also records created pertaining to ICE's follow-up activities regarding a tip; (3) one routine use is being removed from the system that allows DHS to disclose reports of suspicious activity, tips, potential violations of law, and other relevant information to external law enforcement agencies; and (4) four purposes for the collection of information are being removed from the system. Purpose (4) in the prior iteration of this SORN has been removed as it pertains to public tip records. Purposes (5), (6), and (7) have been removed since these purposes are more focused on ICE's Law Enforcement Support Center (LESC) rather than the system as a whole.

A more complete description of the changes to this SORN can be found in the publication of this modified SORN found elsewhere in the **Federal Register**. Further, this modified system of records and rule will be included in DHS's inventory of record systems.

II. Privacy Act

The Privacy Act embodies fair information practice principles in a statutory framework governing the means by which Federal Government agencies collect, maintain, use, and disseminate personally identifiable information. The Privacy Act applies to information that is maintained in a ''system of records.'' A ''system of records'' is a group of any records under the control of an agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual. In the Privacy Act, an individual is defined to encompass U.S. citizens and lawful permanent residents. Additionally, the Judicial Redress Act (JRA) provides a statutory right to covered persons to make requests for access and amendment to covered records, as defined by the JRA, along with judicial review for denials of such requests. In addition, the JRA prohibits disclosures of covered records, except as otherwise permitted by the Privacy Act.

The Privacy Act allows government agencies to exempt certain records from portions of the Act. If an agency claims an exemption, however, it must issue a Notice of Proposed Rulemaking to make clear to the public the reasons why a particular exemption is claimed.

DHS is claiming exemptions from certain requirements of the Privacy Act for DHS/ICE–007 Criminal History and Immigration Verification (CHIVe) System of Records. Some information in DHS/ICE–007 Criminal History and Immigration Verification (CHIVe) System of Records relates to official DHS national security, law enforcement, immigration, and intelligence activities. These exemptions are needed to protect information relating to DHS activities from disclosure to subjects or others related to these activities. Specifically, the exemptions are required to preclude subjects of these activities from frustrating these processes; to avoid disclosure of activity techniques; to protect the identities and physical safety of confidential informants and law enforcement personnel; to ensure DHS' ability to obtain information from third parties and other sources; to protect the privacy of third parties; and to safeguard classified information. Disclosure of information to the subject of the inquiry could also permit the subject to avoid detection or apprehension.

In appropriate circumstances, where compliance would not appear to interfere with or adversely affect the law enforcement purposes of this system and the overall law enforcement process, the applicable exemptions may be waived on a case by case basis.

A SORN for DHS/ICE–007 Criminal History and Immigration Verification (CHIVe) System of Records is also published in this issue of the **Federal Register**.

List of Subjects in 6 CFR Part 5

Freedom of information; Privacy.

For the reasons stated in the preamble, DHS proposes to amend chapter I of title 6, Code of Federal Regulations, as follows:

PART 5—DISCLOSURE OF RECORDS AND INFORMATION

■ 1. Revise the authority citation for Part 5 to read as follows:

Authority: 6 U.S.C. 101 *et seq.;* Pub. L. 107–296, 116 Stat. 2135; 5 U.S.C. 301. Subpart A also issued under 5 U.S.C. 552. Subpart B also issued under 5 U.S.C. 552a.

■ 2. In Appendix C to Part 5, revise paragraph 28. to read as follows:

Appendix C to Part 5—DHS Systems of Records Exempt From the Privacy Act

* * * * *

28. The DHS/ICE–007 Criminal History and Immigration Verification (CHIVe) System of Records covers electronic and paper records and will be used by DHS and its components. The DHS/ICE–007 Criminal History and Immigration Verification (CHIVe) System of Records covers information held by DHS/ICE in connection with its several and varied missions and functions, including, the enforcement of civil and criminal laws; investigations, inquiries, and proceedings there under; and national security and intelligence activities. The DHS/ICE–007 Criminal History and Immigration Verification (CHIVe) System of Records contains information that is collected by, on behalf of, in support of, or in cooperation with DHS and its components and may contain personally identifiable information collected by other Federal, state, local, tribal, foreign, or international government agencies. The Secretary of Homeland Security, pursuant to 5 U.S.C. 552a(j)(2), has exempted this system from the following provisions of the Privacy Act: 5 U.S.C. 552a(c)(3), (c)(4); (d); (e)(1), (e)(2), (e)(3), (e)(4)(G), (e)(4)(H), (e)(5), (e)(8); (f); and (g). Additionally, the Secretary of Homeland Security, pursuant to 5 U.S.C. 552a(k)(2), has exempted this system from the following provisions of the Privacy Act: 5 U.S.C. 552a(c)(3); (d); (e)(1), (e)(4)(G), (e)(4)(H); and (f). Exemptions from these particular subsections are justified, on a case-by-case basis to be determined at the time a request is made, for the following reasons:

(a) From subsection (c)(3) and (4) (Accounting for Disclosures) because release of the accounting of disclosures could alert the subject of an investigation of an actual or potential criminal, civil, or regulatory violation to the existence of that investigation and reveal investigative interest on the part of DHS as well as the recipient agency. Disclosure of the accounting would therefore present a serious impediment to law enforcement efforts and/or efforts to preserve national security. Disclosure of the accounting would also permit the individual who is the subject of a record to impede the investigation, to tamper with witnesses or evidence, and to avoid detection or apprehension, which would undermine the entire investigative process.

(b) From subsection (d) (Access to Records) because access to the records contained in this system of records could inform the subject of an investigation of an actual or potential criminal, civil, or regulatory violation to the existence of that investigation and reveal investigative interest on the part of DHS or another agency. Access to the records could permit the individual who is the subject of a record to impede the investigation, to tamper with witnesses or evidence, and to avoid detection or apprehension. From subsection (d) (Amendment to Records) because permitting amendment of records could interfere with ongoing investigations and law enforcement activities and would impose an unreasonable administrative burden by requiring investigations to be continually reinvestigated. In addition, permitting access and amendment to such information could disclose security-sensitive information that could be detrimental to homeland security.

(c) From subsection (e)(1) (Relevancy and Necessity of Information) because in the course of investigations into potential violations of federal law, the accuracy of information obtained or introduced occasionally may be unclear, or the information may not be strictly relevant or necessary to a specific investigation. In the interests of effective law enforcement, it is appropriate to retain all information that may aid in establishing patterns of unlawful activity.

(d) From subsection (e)(2) (Collection of Information from Individuals) because requiring that information be collected from the subject of an investigation would alert the subject to the nature or existence of the investigation, thereby interfering with that investigation and related law enforcement activities.

(e) From subsection (e)(3) (Notice to Subjects) because providing such detailed information could impede law enforcement by compromising the existence of a confidential investigation or reveal the identity of witnesses or confidential informants.

(f) From subsections (e)(4)(G), (e)(4)(H), (e)(4)(I), (Agency Requirements) and (f) (Agency Rules), because portions of this system are exempt from the individual access provisions of subsection (d) for the reasons noted above, and therefore DHS is not required to establish requirements, rules, or procedures with respect to such access. Providing notice to individuals with respect to existence of records pertaining to them in the system of records or otherwise setting up procedures pursuant to which individuals may access and view records pertaining to themselves in the system would undermine investigative efforts and reveal the identities of witnesses, and potential witnesses, and confidential informants.

(g) From subsection (e)(5) (Collection of Information) because with the collection of information for law enforcement purposes, it is impossible to determine in advance what information is accurate, relevant, timely, and complete. Compliance with subsection (e)(5) would preclude DHS agents from using their investigative training and exercise of good judgment to both conduct and report on investigations.

(h) From subsection (e)(8) (Notice on Individuals) because compliance would interfere with DHS's ability to obtain, serve, and issue subpoenas, warrants, and other law enforcement mechanisms that may be filed under seal and could result in disclosure of investigative techniques, procedures, and evidence.

(i) From subsection (g) (Civil Remedies) to the extent that the system is exempt from other specific subsections of the Privacy Act.

* * * * *

Philip S. Kaplan

Chief Privacy Officer, Department of Homeland Security.

[FR Doc. 2018–09906 Filed 5–7–18; 8:45 am]

BILLING CODE 9111–28–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2018–0327; Product Identifier 2018–CE–001–AD]

RIN 2120–AA64

Airworthiness Directives; Learjet, Inc. Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for certain Learjet, Inc. Models 28, 29, 31, 31A, 35, 35A, 36, 36A, 55, 55B, 55C, and 60 airplanes. This proposed AD was prompted by fatigue cracks initiating in the flap support structure due to repetitive flap loads, which has caused flap nose roller support bracket failure. This proposed AD would require replacement of the flap nose roller fitting, nose roller support bracket, and adjacent rib support structure with more robust components. We are proposing this AD to address the unsafe condition on these products.

DATES: We must receive comments on this proposed AD by June 22, 2018.

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:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this NPRM, contact Learjet, Inc., One Learjet Way, Wichita, Kansas 67209; telephone: 316–946–2000; email: *ac.ict@aero.bombardier.com;* internet: *https://www.bombardier.com.* You may view this service information at the FAA, Policy and Innovation Division, 901 Locust, Kansas City, Missouri 64106. For information on the availability of this material at the FAA, call (816) 329–4148.

Examining the AD Docket

You may examine the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0327; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this NPRM, the regulatory evaluation, any comments received, and other information. The street address for Docket Operations (phone: 800–647–5527) is listed above. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Tara Shawn, Aerospace Engineer, Wichita ACO Branch, 1801 Airport Road, Room 100, Wichita, Kansas 67209; telephone: (316) 946–4141; fax: (316) 946–4107; email: *tara.shawn@faa.gov* or *Wichita-COS@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposal. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2018–0327; Product Identifier 2018–CE–001–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this NPRM. We will consider all comments received by the closing date and may amend this NPRM 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 NPRM.

Discussion

We received a report of skewed flap and aileron binding due to fatigue cracks in the flap support structure caused by repetitive flap loads on a Learjet, Inc. Model 31A. As of June 2017, cracks in the flap support structure were reported (due to Alert Service Bulletins published in March 2017) on Models 31, 31A, 35A, 55, and 60 airplanes. Repetitive flap loads occur on all models identified by this proposed AD. Failure of the flap nose roller support bracket allows skewed flap and aileron binding, which can cause loss of roll control on approach. This condition, if not addressed, could result in loss of control.

Although there have been no reports of cracks on the Models 28, 29, 35, 36, 36A, 55B, and 55C airplanes, these airplanes do incorporate the same design flap support structure.

Related Service Information Under 1 CFR Part 51

We reviewed Bombardier Learjet 28/29 Service Bulletin (SB) 28/29–27–31 Recommended, dated September 11, 2017; Bombardier Learjet 31 SB 31–27–35 Recommended, dated September 11, 2017; Bombardier Learjet 35/36 SB 35/36 -27–50 Recommended, dated September 11, 2017; Bombardier Learjet 55 SB 55–27–41 Recommended, dated September 11, 2017; and Bombardier Learjet 60 SB 60–27–39 Recommended, Revision 1, dated January 15, 2018. For the applicable models, the service information describes procedures for replacement of the flap nose roller fitting, nose roller support bracket, and adjacent rib support structure with improved components. The service information also contains instructions to ensure correct flap alignment. This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination

We are proposing 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.

Proposed AD Requirements

This proposed AD would require accomplishing the actions specified in the service information described previously.

Differences Between This Proposed AD and the Service Information

The published service information does not list Models 31A, 35A, 36A, 55B, or 55C as affected models. However, the serial numbers in the service information does reflect these models. The serial numbers in the service information (except for Models 28/29) does not start with –001, but the effectivity in this AD starts with –001 for all models. The service information for all models also specifies to submit a compliance response form to the manufacturer; however, this AD does not require that action.

Costs of Compliance

We estimate that this proposed AD affects 706 airplanes of U.S. registry.

We estimate the following costs to comply with this proposed AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost *	Cost per product	Cost on U.S. operators
Replacement of flap nose roller fitting, nose roller support bracket, and adjacent rib support structure with improved components.	188 work-hours × $85 per hour = $15,980.	$12,213	$28,193	$19,904,258

* Parts cost is an average of the composite costs for replacement of all of the kits per airplane. Not all airplanes will need all kits, as credit is allowed for some previous installations.

INDIVIDUAL PARTS COST *

Kit No. (K/N)	Part cost
K/N 2381000–802	$827
K/N 2381000–804	822
K/N 2381000–806	780
K/N 2381000–808	793
K/N 2381000–809	1,358
K/N 2381000–810	1,358
K/N 2381000–811	1,822
K/N 2381000–817	1,674
K/N 2381000–818	1,432
K/N 2381000–819	1,415
K/N 2381000–820	1,912
K/N 2381000–821	1,912

* Parts required for replacement may vary for different models and different airplanes.

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.

This AD is issued in accordance with authority delegated by the Executive Director, Aircraft Certification Service, as authorized by FAA Order 8000.51C. In accordance with that order, issuance of ADs is normally a function of the Compliance and Airworthiness Division, but during this transition period, the Executive Director has delegated the authority to issue ADs applicable to small airplanes, gliders, balloons, airships, domestic business jet transport airplanes, and associated appliances to the Director of the Policy and Innovation Division.

Regulatory Findings

We determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would 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 this proposed regulation:

(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.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 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):

Learjet, Inc.: Docket No. FAA–2018–0327; Product Identifier 2018–CE–001–AD.

(a) Comments Due Date

We must receive comments by June 22, 2018.

(b) Affected ADs

None.

(c) Applicability

(1) This AD applies to the following Learjet, Inc. model airplanes that are certificated in any category:

Table 1 to paragraph (c) of this AD – Affected Models and Serial Numbers

Model	Serial Numbers (S/N)
Learjet Model 28	28-001 through 28-005
Learjet Model 29	29-001 through 29-004
Learjet Model 31	31-001 through 31-034
Learjet Model 31A	31-035 through 31-194
Learjet Model 35	35-001 through 35-059 that has been modified by SSK 0934, "Replacement of Wing Flap Assemblies"; and 35-060 through 35-066
Learjet Model 35A	35-067 through 35-676
Learjet Model 36	36-001 through 36-017 that has been modified by SSK 0934, "Replacement of Wing Flap Assemblies"
Learjet Model 36A	36-018 through 36-063
Learjet Model 55	55-001 through 55-126
Learjet Model 55B	55-127 through 55-134
Learjet Model 55C	55-135 through 55-147
Learjet Model 60	60-001 through 60-179

(d) Subject

Joint Aircraft System Component (JASC)/ Air Transport Association (ATA) of America Code 2750, TE Flap Control System.

(e) Unsafe Condition

This AD was prompted by reports of fatigue cracks initiating in the flap support structure due to repetitive flap loads. We are issuing this AD to require replacement of the flap nose roller fitting, nose roller support bracket, and adjacent rib support structure with more robust components. The unsafe condition, if not addressed, could cause flap nose roller support bracket failure and allow skewed flap and aileron binding, which could result in loss of roll control on approach with consequent loss of control.

(f) Compliance

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

(g) Corrective Action

(1) *For Models 28 and 29 airplanes:* (i) Within the next 24 months after the effective date of this AD or within the next 400 landings after the effective date of this AD, whichever occurs first, replace the nose roller fitting, nose roller support bracket, and adjacent rib support structure with replacements parts following the Accomplishment Instructions in Bombardier Learjet 28/29 Service Bulletin (SB) 28/29–27–31 Recommended, dated September 11, 2017.

(ii) Paragraph 3.B.(1) of the applicable SB for these models that have modified flap roller assemblies requires the operator to contact Learjet Inc. for repair instructions, and after receiving the repair instructions from Learjet, the operator will need to request an AMOC as specified in paragraph (j) of this AD in order to use the repair.

(2) *For Models 31 and 31A airplanes:* Within the next 24 months after the effective date of this AD or within the next 400 landings after the effective date of this AD, whichever occurs first, replace the nose roller fitting, nose roller support bracket and adjacent rib support structure with replacements parts following the Accomplishment Instructions in Bombardier Learjet 31 SB 31–27–35 Recommended, dated September 11, 2017.

(3) *For Models 35, 35A, 36, and 36A airplanes:* Within the next 24 months after the effective date of this AD or within the next 400 landings after the effective date of this AD, whichever occurs first, replace the nose roller fitting, nose roller support bracket and adjacent rib support structure with replacements parts following the Accomplishment Instructions in Bombardier Learjet 35/36 SB 35/36–27–50 Recommended, dated September 11, 2017.

(4) *For Models 55, 55B, and 55C airplanes:* Within the next 24 months after the effective date of this AD or within the next 400 landings after the effective date of this AD, whichever occurs first, replace the nose roller fitting, nose roller support bracket, and adjacent rib support structure with replacements parts following the Accomplishment Instructions in Bombardier Learjet 55 SB 55–27–41 Recommended, dated September 11, 2017.

(5) *For Model 60 airplanes:* Within the next 12 months after the effective date of this AD or within the next 200 landings after the effective date of this AD, whichever occurs first, replace the nose roller fitting, nose roller support bracket, and adjacent rib support structure with replacement parts following the Accomplishment Instructions in Bombardier Learjet 60 SB 60–27–39 Recommended, Revision 1, dated January 15, 2018.

(6) *For all airplanes:* The compliance times in this AD are presented in landings. If you do not keep a record of the total number of landings, then use a 1-to-1 conversion for hours time-in-service (TIS) to landings. Example: 20 hours TIS = 20 landings.

(7) *For Models 31, 31A, 35, 35A, 36, 36A, 55, 55B, 55C, and 60 airplanes:* Paragraph 3.B.(2) of the applicable SBs for these models that have modified flap roller assemblies requires the operator to contact Learjet Inc. for repair instructions, and after receiving the repair instructions from Learjet, the operator will need to request an alternative method of compliance (AMOC) as specified in paragraph (j) of this AD in order to use the repair.

(h) Credit for Previous Actions

For Model 60 airplanes: This AD allows credit for actions required in paragraph (g)(5) of this AD if done before the effective date

of this AD following Bombardier Learjet 60 SB 60–27–39 Recommended, Basic Issue, dated September 11, 2017.

(i) No Reporting Requirement

Although Bombardier Learjet 28/29 SB 28/29–27–31 Recommended, dated September 11, 2017; Bombardier Learjet 31 SB 31–27–35 Recommended, dated September 11, 2017; Bombardier Learjet 35/36 SB 35/36 -27–50 Recommended, dated September 11, 2017; Bombardier Learjet 55 SB 55–27–41 Recommended, dated September 11, 2017; and Bombardier Learjet 60 SB 60–27–39 Recommended, Revision 1, dated January 15, 2018, all specify to submit a compliance response form to the manufacturer per paragraph 3.E., this AD does not require that action.

(j) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Wichita ACO branch, 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 certification office, send it to the attention of the person identified in paragraph (k)(1) of this AD.

(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.

(k) Related Information

(1) For more information about this AD, contact Tara Shawn, Aerospace Engineer, Wichita ACO Branch, 1801 Airport Road, Room 100, Wichita, Kansas 67209; telephone: (316) 946–4141; fax: (316) 946–4107; email: *tara.shawn@faa.gov* or *Wichita-COS@faa.gov.*

(2) For service information identified in this AD, contact Learjet, Inc., One Learjet Way, Wichita, Kansas 67209; telephone: 316–946–2000; email: *ac.ict@aero.bombardier.com;* internet: *https://www.bombardier.com.* You may review this referenced service information at the FAA, Policy and Innovation Division, 901 Locust, Kansas City, Missouri 64106. For information on the availability of this material at the FAA, call (816) 329–4148.

Issued in Kansas City, Missouri, on April 30, 2018.

Melvin J. Johnson,

Deputy Director, Policy & Innovation Division, Aircraft Certification Service.

[FR Doc. 2018–09600 Filed 5–7–18; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2018–0396; Product Identifier 2017–NM–156–AD]

RIN 2120–AA64

Airworthiness Directives; Airbus Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for all Airbus Model A300 B4–600, B4–600R, and F4–600R series airplanes, and Model A300 C4–605R Variant F airplanes (collectively called Model A300–600 series airplanes), and Model A310 series airplanes. This proposed AD was prompted by a determination that new or more restrictive maintenance requirements and airworthiness limitations are necessary. This proposed AD would require revising the maintenance or inspection program, as applicable, to incorporate new or more restrictive maintenance requirements and airworthiness limitations. We are proposing this AD to address the unsafe condition on these products.

DATES: We must receive comments on this proposed AD by June 22, 2018.

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:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this NPRM, contact Airbus SAS, Airworthiness Office—EAW, 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 service information at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

Examining the AD Docket

You may examine the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0396; 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 NPRM, 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. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Dan Rodina, Aerospace Engineer, International Section, Transport Standards Branch, FAA, 2200 South 216th St., Des Moines, WA 98198; telephone and fax 206–231–3225.

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposal. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2018–0396; Product Identifier 2017–NM–156–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this NPRM. We will consider all comments received by the closing date and may amend this NPRM based on 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 NPRM.

Discussion

The European Aviation Safety Agency (EASA), which is the Technical Agent for the Member States of the European Union, has issued EASA Airworthiness Directive 2017–0202, dated October 12, 2017 (referred to after this as the Mandatory Continuing Airworthiness Information, or ''the MCAI''), to correct an unsafe condition for all Airbus Model A300 B4–600, B4–600R, and F4–600R series airplanes, and Model A300 C4–605R Variant F airplanes (collectively called Model A300–600 series airplanes), and Model A310 series airplanes. The MCAI states:

Maintenance requirements and airworthiness limitations for the Airbus

A310, A300–600 and A300–600ST family aeroplanes, which are approved by EASA, are currently defined and published in the Airbus A310 and A300–600 Airworthiness Limitations Section (ALS) documents. The System Equipment Maintenance Requirements (SEMR) for the Airbus A310 and A300–600, are specified in the Airbus A310 and Airbus A300–600 (including A300–600ST) ALS Part 4 documents. These instructions have been identified as mandatory for continuing airworthiness.

Failure to accomplish these instructions could result in an unsafe condition.

EASA previously issued AD 2013–0075 [which corresponds to FAA AD 2015–02–16, Amendment 39–18083 (80 FR 5028, January 30, 2015) (''AD 2015–02–16'')] to require the implementation of the maintenance requirements and associated airworthiness limitations as specified in Airbus A310 and A300–600 ALS Part 4 documents at Revision 02.

Since that [EASA] AD was issued, new or more restrictive maintenance requirements and airworthiness limitations were approved by EASA. Consequently, Airbus published Revision 03 of A310 and A300–600 ALS Part 4 documents, compiling all ALS Part 4 changes approved since previous Revision 02.

For the reasons described above, this new [EASA] AD retains the requirements of EASA AD 2013–0075, which is superseded, and requires the implementation of the actions specified in Airbus A310 ALS Part 4 Revision 03 and Airbus A300–600 ALS Part 4 Revision 03.

We are proposing this AD to mitigate the risks associated with the effects of aging on airplane systems. Such effects could change system characteristics, leading to an increased potential for failure of certain life-limited parts, and reduced structural integrity or controllability of the airplane. You may examine the MCAI in the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0396.

Relationship of Proposed AD to AD 2015–02–16

This NPRM would not supersede AD 2015–02–16. Rather, we have determined that a stand-alone AD would be more appropriate to address the changes in the MCAI. This NPRM would require revising the maintenance or inspection program, as applicable, to incorporate new or more restrictive maintenance requirements and airworthiness limitations. Accomplishment of the proposed actions would then terminate all requirements of AD 2015–02–16.

Related Service Information Under 1 CFR Part 51

Airbus has issued A310 Airworthiness Limitations Section (ALS) Part 4, ''System Equipment Maintenance Requirements (SEMR),'' Revision 03, dated August 28, 2017; and A300–600 Airworthiness Limitations Section (ALS) Part 4, ''System Equipment Maintenance Requirements (SEMR),'' Revision 03, dated August 28, 2017. This service information describes the revision of the maintenance or inspection program, as applicable, to incorporate new maintenance requirements and airworthiness limitations. These documents are distinct since they apply to different airplane models. This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination and Requirements of This Proposed AD

This product has been approved by the aviation authority of another country, and is approved for operation in the United States. Pursuant to our bilateral agreement with the State of Design Authority, we have been notified of the unsafe condition described in the MCAI and service information referenced above. We are proposing this AD because we evaluated all pertinent information and determined an unsafe condition exists and is likely to exist or develop on other products of these same type designs.

This proposed AD would require revisions to certain operator maintenance documents to include new actions (*e.g.,* inspections). Compliance with these actions is required by 14 CFR 91.403(c). For airplanes that have been previously modified, altered, or repaired in the areas addressed by this proposed AD, the operator may not be able to accomplish the actions described in the revisions. In this situation, to comply with 14 CFR 91.403(c), the operator must request approval for an alternative method of compliance according to paragraph (j)(1) of this proposed AD. The request should include a description of changes to the required actions that will ensure the continued operational safety of the airplane.

Differences Between This Proposed AD and the MCAI or Service Information

The MCAI specifies that if there are findings from the ALS inspection tasks, corrective actions must be accomplished in accordance with Airbus maintenance documentation. However, this proposed AD does not include that requirement. Operators of U.S.-registered airplanes are required by general airworthiness and operational regulations to perform maintenance using methods that are acceptable to the FAA. We consider those methods to be adequate to address any corrective actions necessitated by the findings of ALS inspections required by this proposed AD.

Costs of Compliance

We estimate that this proposed AD affects 127 airplanes of U.S. registry.

We estimate the following costs to comply with this proposed AD:

We have determined that revising the maintenance or inspection program takes an average of 90 work-hours per operator, although we recognize that this number may vary from operator to operator. In the past, we have estimated that this action takes 1 work-hour per airplane. Since operators incorporate maintenance or inspection program changes for their affected fleet(s), we have determined that a per-operator estimate is more accurate than a per-airplane estimate. Therefore, we estimate the total cost per operator to be $7,650 (90 work-hours × $85 per work-hour).

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.

This proposed AD is issued in accordance with authority delegated by the Executive Director, Aircraft Certification Service, as authorized by FAA Order 8000.51C. In accordance with that order, issuance of ADs is normally a function of the Compliance and Airworthiness Division, but during this transition period, the Executive Director has delegated the authority to issue ADs applicable to transport category airplanes to the Director of the System Oversight Division.

Regulatory Findings

We determined that this proposed AD would not have federalism implications

under Executive Order 13132. This proposed AD would 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 this proposed regulation:

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.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 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):

Airbus: Docket No. FAA–2018–0396; Product Identifier 2017–NM–156–AD.

(a) Comments Due Date

We must receive comments by June 22, 2018.

(b) Affected ADs

This AD affects AD 2015–02–16, Amendment 39–18083 (80 FR 5028, January 30, 2015) (''AD 2015–02–16'').

(c) Applicability

This AD applies to the Airbus airplanes identified in paragraphs (c)(1) through (c)(5) of this AD, certificated in any category, all manufacturer serial numbers.

(1) Model A300 B4–601, B4–603, B4–620, and B4–622 airplanes.

(2) Model A300 B4–605R and B4–622R airplanes.

(3) Model A300 F4–605R and F4–622R airplanes.

(4) Model A300 C4–605R Variant F airplanes.

(5) Model A310–203, –204, –221, –222, –304, –322, –324, and –325 airplanes.

(d) Subject

Air Transport Association (ATA) of America Code 05, Time Limits/Maintenance Checks.

(e) Reason

This AD was prompted by a determination that new or more restrictive maintenance requirements and airworthiness limitations are necessary. We are issuing this AD to mitigate the risks associated with the effects of aging on airplane systems. Such effects could change system characteristics, leading to an increased potential for failure of certain life-limited parts, and reduced structural integrity or controllability of the airplane.

(f) Compliance

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

(g) Revision of Maintenance or Inspection Program

Within 90 days after the effective date of this AD, revise the maintenance or inspection program, as applicable, to incorporate Airbus A310 Airworthiness Limitations Section (ALS) Part 4, ''System Equipment Maintenance Requirements (SEMR),'' Revision 03, dated August 28, 2017; or A300–600 Airworthiness Limitations Section (ALS) Part 4, ''System Equipment Maintenance Requirements (SEMR),'' Revision 03, dated August 28, 2017; as applicable. The initial compliance time for doing the revised actions is at the applicable time specified in Airbus A310 Airworthiness Limitations Section (ALS) Part 4, ''System Equipment Maintenance Requirements (SEMR),'' Revision 03, dated August 28, 2017, or A300–600 Airworthiness Limitations Section (ALS) Part 4, ''System Equipment Maintenance Requirements (SEMR),'' Revision 03, dated August 28, 2017, as applicable; or within 90 days after the effective date of this AD; whichever is later.

(h) No Alternative Actions or Intervals

After the maintenance or inspection program has been revised as required by paragraph (g) of this AD, no alternative actions (*e.g.,* inspections) or intervals may be used unless the actions and intervals are approved as an alternative method of compliance (AMOC) in accordance with the procedures specified in paragraph (j)(1) of this AD.

(i) Terminating Action for AD 2015–02–16

Accomplishing the actions required by this AD terminates all requirements of AD 2015–02–16.

(j) Other FAA AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Section, Transport Standards Branch, 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 Section, send it to the attention of the person identified in paragraph (k)(2) of this AD. 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.

(2) *Contacting the Manufacturer:* For any requirement in this AD to obtain corrective actions from a manufacturer, the action must be accomplished using a method approved by the Manager, International Section, Transport Standards Branch, FAA; or the European Aviation Safety Agency (EASA); or Airbus's EASA Design Organization Approval (DOA). If approved by the DOA, the approval must include the DOA-authorized signature.

(k) Related Information

(1) Refer to Mandatory Continuing Airworthiness Information (MCAI) EASA Airworthiness Directive 2017–0202, dated October 12, 2017, for related information. This MCAI may be found in the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0396.

(2) For more information about this AD, contact Dan Rodina, Aerospace Engineer, International Section, Transport Standards Branch, FAA, 2200 South 216th St., Des Moines, WA 98198; telephone and fax 206–231–3225.

(3) For service information identified in this AD, contact Airbus SAS, Airworthiness Office—EAW, 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 service information at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

Issued in Des Moines, Washington, on April 30, 2018.

Dionne Palermo,

Acting Manager, System Oversight Division, Aircraft Certification Service.

[FR Doc. 2018–09728 Filed 5–7–18; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2018–0397; Product Identifier 2017–NM–163–AD]

RIN 2120–AA64

Airworthiness Directives; Bombardier, Inc., Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for certain Bombardier, Inc., Model BD–700–1A10 and BD–700–1A11 airplanes. This proposed AD was prompted by a report of cracking at the fastener holes of the left-hand-side support bracket of the elevator bell crank for the control linkage in the vertical stabilizer. This proposed AD would require an eddy current inspection on certain support brackets of the elevator bell crank for any cracking at the fastener holes, a measurement to confirm that the fastener hole diameters are within tolerance, and replacement with a new support bracket of the elevator bell crank if necessary. We are proposing this AD to address the unsafe condition on these products.

DATES: We must receive comments on this proposed AD by June 22, 2018.

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:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this NPRM, 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 service information at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

Examining the AD Docket

You may examine the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0397; 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 NPRM, 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. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Neil Doh, Aerospace Engineer, Aviation Safety Section, FAA, Boston ACO Branch, 1200 District Avenue, Burlington, MA 01803; telephone: 781–238–7757; fax: 781–238–7199; email: *neil.doh@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposed AD. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2018–0397; Product Identifier 2017–NM–163–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this NPRM. We will consider all comments received by the closing date and may amend this NPRM based on 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 NPRM.

Discussion

Transport Canada Civil Aviation (TCCA), which is the aviation authority for Canada, has issued Canadian AD CF–2017–32, dated October 10, 2017 (referred to after this as the Mandatory Continuing Airworthiness Information, or ''the MCAI''), to correct an unsafe condition for certain Bombardier, Inc., Model BD–700–1A10 and BD–700–1A11 airplanes. The MCAI states:

> During a repair on an aircraft in-service, cracking was observed at the fastener holes of the left hand side elevator bell crank support bracket for the control linkage in the vertical stabilizer. Further investigation confirmed the presence of similar cracking on other aircraft on both the left and right hand side brackets. An investigation found that the fastener holes on some brackets did not conform to the required tolerance and fastener installation resulted in fastener hole cracks.
>
> This [Canadian] AD requires an inspection of both elevator bell crank support brackets, and replacement if they are found cracked or do not meet the required fastener hole tolerance. Left unrepaired, cracking of an elevator bell crank support bracket could lead to detachment of the bracket and loss of functionality of the elevator on the affected side, resulting in reduced controllability of the aircraft. Failure of both brackets could result in loss of pitch control of the aircraft.

You may examine the MCAI in the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0397.

Related Service Information Under 1 CFR Part 51

Bombardier, Inc., has issued Service Bulletin 700–27–5009, Revision 01, dated July 18, 2017; and Service Bulletin 700–27–6009, Revision 01, dated July 18, 2017. This service information describes an eddy current inspection on certain support brackets of the elevator bell crank for any cracking at the fastener holes, a measurement to confirm that the fastener hole diameters are within tolerance, and replacement with a new support bracket of the elevator bell crank. These documents are distinct since they apply to different airplane models. This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination and Requirements of This Proposed AD

This product has been approved by the aviation authority of another country, and is approved for operation in the United States. Pursuant to our bilateral agreement with the State of Design Authority, we have been notified of the unsafe condition described in the MCAI and service information referenced above. We are proposing this AD because we evaluated all pertinent information and determined an unsafe condition exists and is likely to exist or develop on other products of the same type design.

Costs of Compliance

We estimate that this proposed AD affects 109 airplanes of U.S. registry.

We estimate the following costs to comply with this proposed AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Inspection and measurement	10 work-hours × $85 per hour = $850	$19	$869	$94,721

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

ON-CONDITION COSTS

Action	Labor cost	Parts cost	Cost per product
Replacement	2 work-hours × $85 per hour = $170	$4,798	$4,968

According to the manufacturer, all of the costs of this proposed 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.

This proposed AD is issued in accordance with authority delegated by the Executive Director, Aircraft Certification Service, as authorized by FAA Order 8000.51C. In accordance with that order, issuance of ADs is normally a function of the Compliance and Airworthiness Division, but during this transition period, the Executive Director has delegated the authority to issue ADs applicable to transport category airplanes to the Director of the System Oversight Division.

Regulatory Findings

We determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would 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 this proposed regulation:

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.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 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):

Bombardier, Inc.: Docket No. FAA–2018–0397; Product Identifier 2017–NM–163–AD.

(a) Comments Due Date

We must receive comments by June 22, 2018.

(b) Affected ADs

None.

(c) Applicability

This AD applies to Bombardier, Inc., Model BD–700–1A10 and BD–700–1A11 airplanes, certificated in any category, serial numbers 9492 through 9711 inclusive, 9713 through 9717 inclusive, 9719 through 9726 inclusive, 9728, 9730, 9732, 9733, 9743, and 9751.

(d) Subject

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

(e) Reason

This AD was prompted by a report of cracking at the fastener holes of the left-hand-side support bracket of the elevator bell crank for the control linkage in the vertical stabilizer. We are issuing this AD to detect and correct any cracking in the support bracket of the elevator bell crank, which could lead to detachment of the bracket and loss of functionality of the elevator on the affected side, and result in reduced controllability of the airplane. Failure of both brackets could result in loss of pitch control of the airplane.

(f) Compliance

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

(g) Inspection, Measurement, and Corrective Action

Within 60 months after the effective date of this AD, or before accumulating 7,500 total flight cycles, whichever occurs first: Do an eddy current inspection of the support brackets of the elevator bell crank, part number (P/N) GD248–8750–3 and P/N GD248–8750–4, for any cracking at the fastener holes, and do a measurement to confirm that the fastener hole diameters are within tolerance, as applicable, in accordance with the Accomplishment Instructions of Bombardier Service Bulletin 700–27–5009, Revision 01, dated July 18, 2017 (for Model BD–700–1A11 airplanes), or

Bombardier Service Bulletin 700–27–6009, Revision 01, dated July 18, 2017 (for Model BD–700–1A10 airplanes). If any cracking is found or if any fastener hole is out of tolerance, before further flight, replace with a new support bracket, in accordance with the Accomplishment Instructions of Bombardier Service Bulletin 700–27–5009, Revision 01, dated July 18, 2017 (for Model BD–700–1A11 airplanes), or Bombardier Service Bulletin 700–27–6009, Revision 01, dated July 18, 2017 (for Model BD–700–1A10 airplanes).

(h) Credit for Previous Actions

This paragraph provides credit for actions required by paragraph (g) of this AD, if those actions were performed before the effective date of this AD using Bombardier Service Bulletin 700–27–5009, dated May 29, 2017, or Bombardier Service Bulletin 700–27–6009, dated May 29, 2017, as applicable.

(i) Other FAA AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, New York ACO Branch, 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 certification office, send it to ATTN: Program Manager, Continuing Operational Safety, FAA, New York ACO Branch, 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.

(2) *Contacting the Manufacturer:* For any requirement in this AD to obtain corrective actions from a manufacturer, the action must be accomplished using a method approved by the Manager, New York ACO Branch, FAA; or Transport Canada Civil Aviation (TCCA); or Bombardier, Inc.'s TCCA Design Approval Organization (DAO). If approved by the DAO, the approval must include the DAO-authorized signature.

(j) Related Information

(1) Refer to Mandatory Continuing Airworthiness Information (MCAI) Canadian AD CF–2017–32, dated October 10, 2017, for related information. This MCAI may be found in the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0397.

(2) For more information about this AD, contact Neil Doh, Aerospace Engineer, Aviation Safety Section, FAA, Boston ACO Branch, 1200 District Avenue, Burlington, MA 01803; telephone: 781–238–7757; fax: 781–238–7199; email: *neil.doh@faa.gov*.

(3) For information about AMOCs, contact Aziz Ahmed, Aerospace Engineer, FAA, New York ACO Branch, 1600 Stewart Avenue, Suite 410, Westbury, New York 11590; telephone: 516–287–7329; fax: 516–794–5531; email: *Aziz.Ahmed@faa.gov*.

(4) 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 service information at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

Issued in Des Moines, Washington, on April 30, 2018.

Dionne Palermo,

Acting Director, System Oversight Division, Aircraft Certification Service.

[FR Doc. 2018–09729 Filed 5–7–18; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2018–0366; Product Identifier 2017–NM–166–AD]

RIN 2120–AA64

Airworthiness Directives; ATR–GIE Avions de Transport Régional Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for all ATR–GIE Avions de Transport Régional Model ATR42–500 airplanes. This proposed AD was prompted by a determination that more restrictive maintenance requirements and airworthiness limitations are necessary. This proposed AD would require revising the maintenance or inspection program, as applicable, to incorporate new and/or more restrictive maintenance requirements and airworthiness limitations. We are proposing this AD to address the unsafe condition on these products.

DATES: We must receive comments on this proposed AD by June 22, 2018.

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:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this NPRM, contact ATR–GIE Avions de Transport Régional, 1, Allée Pierre Nadot, 31712 Blagnac Cedex, France; telephone +33 (0) 5 62 21 62 21; fax +33 (0) 5 62 21 67 18; email *continued.airworthiness@atr-aircraft.com*; internet *http://www.atr-aircraft.com*. You may view this service information at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

Examining the AD Docket

You may examine the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0366; 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 NPRM, 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. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Shahram Daneshmandi, Aerospace Engineer, International Section, Transport Standards Branch, FAA, 2200 South 216th St., Des Moines, WA 98198; telephone and fax 206–231–3220.

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposal. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2018–0366; Product Identifier 2017–NM–166–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this NPRM. We will consider all comments received by the closing date and may amend this NPRM based on 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 NPRM.

Discussion

The European Aviation Safety Agency (EASA), which is the Technical Agent

for the Member States of the European Union, has issued EASA Airworthiness Directive 2017–0222R1, dated December 15, 2017 (referred to after this as the Mandatory Continuing Airworthiness Information, or ''the MCAI''), to correct an unsafe condition for ATR–GIE Avions de Transport Régional Model ATR42–500 airplanes. The MCAI states:

The airworthiness limitations and certification maintenance requirements (CMR) for ATR aeroplanes, which are approved by EASA, are currently defined and published in the ATR42–400/–500 Time Limits (TL) document. These instructions have been identified as mandatory for continued airworthiness.

Failure to accomplish these instructions could result in an unsafe condition [*i.e.,* reduced structural integrity of the airplane].

Consequently, ATR published Revision 11 Temporary revision 01 of the ATR42–400/–500 TL document, which contains new and/or more restrictive CMRs and airworthiness limitations tasks.

For the reasons described above, this [EASA] AD requires accomplishment of the actions specified in the ATR42–400/–500 TL document Revision 11 Temporary revision 01, hereafter referred to as 'the TLD' in this [EASA] AD.

This [EASA] AD, in conjunction with two other [EASA] ADs related to ATR42–200/–300/–320 (EASA AD 2017–0221) and ATR72–101/–102/–201/–202/–211/–212/–212A (EASA AD 2017–0223) aeroplanes, retains the requirements of EASA AD 2009–0242 [which corresponds to FAA AD 2008–04–19 R1, Amendment 39–16069 (74 FR 56713, November 3, 2009)] and EASA AD 2012–0193 [which corresponds to FAA AD 2015–26–09, Amendment 39–18357 (81 FR 1483, January 13, 2016)]. Once all these three [EASA] ADs are effective, EASA will cancel EASA AD 2009–0242 and EASA AD 2012–0193.

This [EASA] AD is revised to provide the correct issue date (03 May 2017) of the TLD. The original [EASA] AD inadvertently referenced the EASA approval date for that document.

The required actions include revising the maintenance or inspection program, as applicable, to incorporate new and/or more restrictive maintenance requirements and airworthiness limitations. The unsafe condition is reduced structural integrity of the airplane.

You may examine the MCAI in the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0366.

Relationship Between Proposed AD and Certain Other ADs

This NPRM would not supersede AD 2008–04–19 R1 and AD 2015–26–09. Rather, we have determined that a stand-alone AD would be more appropriate to address the changes in the MCAI. This NPRM would require revising the maintenance or inspection program, as applicable. Accomplishment of the proposed actions would then terminate all requirements of AD 2008–04–19 R1 and AD 2015–26–09 for ATR–GIE Avions de Transport Régional Model ATR42–500 airplanes only.

In addition, we have determined that accomplishment of the proposed actions terminates all requirements of AD 2000–23–04 R1, Amendment 39–12174 (66 FR 19381, April 16, 2001).

Related Service Information Under 1 CFR Part 51

ATR–GIE Avions de Transport Régional has issued ATR42–400/–500, Time Limits Document (TL), Revision 11, dated May 5, 2015. This service information describes life limits and maintenance requirements for the affected airplanes.

ATR–GIE Avions de Transport Régional has issued ATR42–400/–500 Temporary Revision TR01/17, dated May 3, 2017, to the ATR42–400/–500 Time Limits Document (TL). This service information describes changes to life limits and maintenance requirements of certain tasks for the affected airplanes.

This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

FAA's Determination and Requirements of This Proposed AD

This product has been approved by the aviation authority of another country, and is approved for operation in the United States. Pursuant to our bilateral agreement with the State of Design Authority, we have been notified of the unsafe condition described in the MCAI and service information referenced above. We are proposing this AD because we evaluated all pertinent information and determined an unsafe condition exists and is likely to exist or develop on other products of the same type design.

This proposed AD would require revisions to certain operator maintenance documents to include new actions (*e.g.,* inspections). Compliance with these actions is required by 14 CFR 91.403(c). For airplanes that have been previously modified, altered, or repaired in the areas addressed by this proposed AD, the operator may not be able to accomplish the actions described in the revisions. In this situation, to comply with 14 CFR 91.403(c), the operator must request approval for an alternative method of compliance according to paragraph (k)(1) of this proposed AD. The request should include a description of changes to the required actions that will ensure the continued operational safety of the airplane.

Differences Between This Proposed AD and the MCAI or Service Information

The MCAI specifies that if there are findings from the airworthiness limitations section (ALS) inspection tasks, corrective actions must be accomplished in accordance with Airbus maintenance documentation. However, this proposed AD does not include that requirement. Operators of U.S.-registered airplanes are required by general airworthiness and operational regulations to perform maintenance using methods that are acceptable to the FAA. We consider those methods to be adequate to address any corrective actions necessitated by the findings of ALS inspections required by this proposed AD.

Airworthiness Limitations Based on Type Design

The FAA recently became aware of an issue related to the applicability of ADs that require incorporation of an ALS revision into an operator's maintenance or inspection program.

Typically, when these types of ADs are issued by civil aviation authorities of other countries, they apply to all airplanes covered under an identified type certificate (TC). The corresponding FAA AD typically retains applicability to all of those airplanes.

In addition, U.S. operators must operate their airplanes in an airworthy condition, in accordance with 14 CFR 91.7(a). Included in this obligation is the requirement to perform any maintenance or inspections specified in the ALS, and in accordance with the ALS as specified in 14 CFR 43.16 and 91.403(c), unless an alternative has been approved by the FAA.

When a type certificate is issued for a type design, the specific ALS, including revisions, is a part of that type design, as specified in 14 CFR 21.31(c).

The sum effect of these operational and maintenance requirements is an obligation to comply with the ALS defined in the type design referenced in the manufacturer's conformity statement. This obligation may introduce a conflict with an AD that requires a specific ALS revision if new airplanes are delivered with a later revision as part of their type design.

To address this conflict, the FAA has approved alternative methods of compliance (AMOCs) that allow operators to incorporate the most recent ALS revision into their maintenance/

inspection programs, in lieu of the ALS revision required by the AD. This eliminates the conflict and enables the operator to comply with both the AD and the type design.

However, compliance with AMOCs is normally optional, and we recently became aware that some operators choose to retain the AD-mandated ALS revision in their fleet-wide maintenance/inspection programs, including those for new airplanes delivered with later ALS revisions, to help standardize the maintenance of the fleet. To ensure that operators comply with the applicable ALS revision for newly delivered airplanes containing a later revision than that specified in an AD, we plan to limit the applicability of ADs that mandate ALS revisions to those airplanes that are subject to an earlier revision of the ALS, either as part of the type design or as mandated by an earlier AD.

This proposed AD therefore would apply to ATR–GIE Avions de Transport Régional Model ATR42–500 airplanes with an original certificate of airworthiness or original export certificate of airworthiness that was issued on or before the date of approval of the ALS temporary revision identified in this proposed AD. Operators of airplanes with an original certificate of airworthiness or original export certificate of airworthiness issued after that date must comply with the airworthiness limitations specified as part of the approved type design and referenced on the type certificate data sheet.

Costs of Compliance

We estimate that this proposed AD affects 4 airplanes of U.S. registry.

We estimate the following costs to comply with this proposed AD:

We have determined that revising the maintenance or inspection program takes an average of 90 work-hours per operator, although this figure may vary from operator to operator. In the past, we have estimated that this action takes 1 work-hour per airplane. Since operators incorporate maintenance or inspection program changes for their affected fleet(s), we have determined that a per-operator estimate is more accurate than a per-airplane estimate. Therefore, we estimate the total cost per operator to be $7,650 (90 work-hours × $85 per work-hour).

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.

This proposed AD is issued in accordance with authority delegated by the Executive Director, Aircraft Certification Service, as authorized by FAA Order 8000.51C. In accordance with that order, issuance of ADs is normally a function of the Compliance and Airworthiness Division, but during this transition period, the Executive Director has delegated the authority to issue ADs applicable to transport category airplanes to the Director of the System Oversight Division.

Regulatory Findings

We determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would 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 this proposed regulation:

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.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 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):

ATR–GIE Avions de Transport Régional: Docket No. FAA–2018–0366; Product Identifier 2017–NM–166–AD.

(a) Comments Due Date

We must receive comments by June 22, 2018.

(b) Affected ADs

This AD affects the ADs specified in paragraphs (b)(1), (b)(2), and (b)(3) of this AD.

(1) AD 2000–23–04 R1, Amendment 39–12174 (66 FR 19381, April 16, 2001) (''AD 2000–23–04 R1'').

(2) AD 2008–04–19 R1, Amendment 39–16069 (74 FR 56713, November 3, 2009) (''AD 2008–04–19 R1'').

(3) AD 2015–26–09, Amendment 39–18357 (81 FR 1483, January 13, 2016) (''AD 2015–26–09'').

(c) Applicability

This AD applies to ATR–GIE Avions de Transport Régional Model ATR42–500 airplanes, certificated in any category, with an original airworthiness certificate or original export certificate of airworthiness dated on or before May 3, 2017.

(d) Subject

Air Transport Association (ATA) of America Code 05, Time limits/maintenance checks.

(e) Reason

This AD was prompted by a determination that more restrictive maintenance requirements and airworthiness limitations are necessary. We are issuing this AD to prevent reduced structural integrity of the airplane.

(f) Compliance

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

(g) Maintenance or Inspection Program Revision

Within 90 days after the effective date of this AD, revise the maintenance or inspection program, as applicable, to incorporate the information specified in ATR42–400/–500, Time Limits Document (TL), Revision 11, dated May 5, 2015; and ATR42–400/–500 Temporary Revision TR01/17, dated May 3, 2017, to the ATR42–400/–500 Time Limits Document (TL). The initial compliance time for accomplishing the tasks is at the applicable times specified in ATR42–400/–500, Time Limits Document (TL), Revision 11, dated May 5, 2015; and ATR42–400/–500 Temporary Revision TR01/17, dated May 3, 2017, to the ATR42–400/–500, Time Limits

Document (TL); or within 90 days after the effective date of this AD; whichever occurs later, except for those certification maintenance requirements (CMRs) tasks identified in figure 1 to paragraphs (g) and (h) of this AD.

FIGURE 1 TO PARAGRAPHS (g) AND (h) OF THIS AD—GRACE PERIOD FOR CMR TASKS

CMR/ maintenance significant item (MSI) task	Compliance time
213100–2A 213100–2B 213100–3A 213100–3B	Within 550 flight hours or 90 days, whichever occurs first, after the effective date of this AD.

(h) Initial Compliance Times for Certain CMR Tasks

For the CMR tasks listed in figure 1 to paragraphs (g) and (h) of this AD, the initial compliance time for accomplishing the tasks is at the applicable time specified in ATR42–400/–500 Temporary Revision TR01/17, dated May 3, 2017, to the ATR42–400/–500 Time Limits Document (TL); or within the compliance time specified in figure 1 to paragraphs (g) and (h) of this AD; whichever occurs later.

(i) No Alternative Actions, Intervals, and/or Critical Design Configuration Control Limitations (CDCCLs)

After the maintenance or inspection program, as applicable, has been revised as required by paragraph (g) of this AD, no alternative actions (*e.g.,* inspections), intervals, and/or CDCCLs may be used unless the actions, intervals, and/or CDCCLs are approved as an alternative method of compliance (AMOC) in accordance with the procedures specified in paragraph (k)(1) of this AD.

(j) Terminating Action for Certain ADs

Accomplishing the actions required by paragraph (g) of this AD terminates all requirements of AD 2000–23–04 R1 and all requirements of the ADs specified in paragraphs (j)(1) and (j)(2) of this AD for ATR–GIE Avions de Transport Régional Model ATR42–500 airplanes only.

(1) AD 2008–04–19 R1.

(2) AD 2015–26–09.

(k) Other FAA AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Section, Transport Standards Branch, 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 Section, send it to the attention of the person identified in paragraph (l)(2) of this AD. 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.

(2) *Contacting the Manufacturer:* For any requirement in this AD to obtain corrective actions from a manufacturer, the action must be accomplished using a method approved by the Manager, International Section, Transport Standards Branch, FAA; or the European Aviation Safety Agency (EASA); or ATR–GIE Avions de Transport Régional's EASA Design Organization Approval (DOA). If approved by the DOA, the approval must include the DOA-authorized signature.

(l) Related Information

(1) Refer to Mandatory Continuing Airworthiness Information (MCAI) EASA AD 2017–0222R1, dated December 15, 2017, for related information. This MCAI may be found in the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2018–0366.

(2) For more information about this AD, contact Shahram Daneshmandi, Aerospace Engineer, International Section, Transport Standards Branch, FAA, 2200 South 216th St., Des Moines, WA 98198; telephone and fax 206–231–3220.

(3) For service information identified in this AD, contact ATR–GIE Avions de Transport Régional, 1, Allée Pierre Nadot, 31712 Blagnac Cedex, France; telephone +33 (0) 5 62 21 62 21; fax +33 (0) 5 62 21 67 18; email *continued.airworthiness@atr-aircraft.com;* internet *http://www.atr-aircraft.com.* You may view this service information at the FAA, Transport Standards Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

Issued in Des Moines, Washington, on April 27, 2018.

Michael Kaszycki,

Acting Director, System Oversight Division, Aircraft Certification Service.

[FR Doc. 2018–09731 Filed 5–7–18; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2017–1124; Product Identifier 2017–SW–073–AD]

RIN 2120–AA64

Airworthiness Directives; Airbus Helicopters

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for Airbus Helicopters Model AS332C, AS332C1, AS332L, and AS332L1 helicopters. This proposed AD would require inspecting the jettisoning mechanism of the left-hand (LH) and right-hand (RH) cabin sliding plug doors. This proposed AD is prompted by a report that during a scheduled inspection a cabin door failed to jettison. The actions of this proposed AD are intended to correct an unsafe condition on these products.

DATES: We must receive comments on this proposed AD by July 9, 2018.

ADDRESSES: You may send comments by any of the following methods:

- *Federal eRulemaking Docket:* Go to *http://www.regulations.gov.* Follow the online instructions for sending your comments electronically.
- *Fax:* 202–493–2251.
- *Mail:* Send comments to the U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590–0001.
- *Hand Delivery:* Deliver to the ''Mail'' address between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Examining the AD Docket

You may examine the AD docket on the internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2017–1124; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this proposed AD, the European Aviation Safety Agency (EASA) AD, the economic evaluation, any comments received, and other information. The street address for Docket Operations (telephone 800–647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

For service information identified in this proposed rule, contact Airbus Helicopters, 2701 N. Forum Drive, Grand Prairie, TX 75052; telephone (972) 641–0000 or (800) 232–0323; fax (972) 641–3775; or at *http://www.helicopters.airbus.com/website/en/ref/Technical-Support_73.html.*

You may review the referenced service information at the FAA, Office of the Regional Counsel, Southwest Region, 10101 Hillwood Pkwy, Room 6N–321, Fort Worth, TX 76177.

FOR FURTHER INFORMATION CONTACT: Matt Fuller, Senior Aviation Safety Engineer, Safety Management Section, Rotorcraft Standards Branch, FAA, 10101 Hillwood Pkwy., Fort Worth, TX 76177; telephone (817) 222–5110; email *matthew.fuller@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to participate in this rulemaking by submitting written comments, data, or views. We also invite comments relating to the economic, environmental, energy, or federalism impacts that might result from adopting the proposals in this document. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. To ensure the docket does not contain duplicate comments, commenters should send only one copy of written comments, or if comments are filed electronically, commenters should submit only one time.

We will file in the docket all comments that we receive, as well as a report summarizing each substantive public contact with FAA personnel concerning this proposed rulemaking. Before acting on this proposal, we will consider all comments we receive on or before the closing date for comments. We will consider comments filed after the comment period has closed if it is possible to do so without incurring expense or delay. We may change this proposal in light of the comments we receive.

Discussion

EASA, which is the Technical Agent for the Member States of the European Union, has issued EASA AD No. 2017–0022, dated February 8, 2017, to correct an unsafe condition for Airbus Helicopters (previously Eurocopter) Model AS332C, AS332C1, AS332L, and AS332L1 helicopters equipped with a cabin sliding plug door modified in accordance with Airbus Helicopters modification (MOD) 0722338. Helicopters with Eurocopter MOD 0725366 are exempt from the EASA AD's requirements.

EASA advises that the emergency jettison test of a cabin lateral sliding plug door failed during a scheduled inspection and test of the door's jettison mechanism. According to EASA, an investigation revealed that the jettison handle cable interfered with the cable clamps. EASA states that this condition could lead to jamming of the door jettisoning mechanism, preventing jettisoning of the affected door during an emergency, possibly obstructing evacuation of the occupants. The EASA AD consequently requires repetitive inspections of the jettisoning mechanism of the LH and RH door, followed by corrective actions if needed.

FAA's Determination

These helicopters have been approved by the aviation authority of France and are approved for operation in the United States. Pursuant to our bilateral agreement with France, EASA, its technical representative, has notified us of the unsafe condition described in its AD. We are proposing this AD because we evaluated all known relevant information and determined that an unsafe condition is likely to exist or develop on other products of the same type design.

Related Service Information Under 1 CFR Part 51

We reviewed Airbus Helicopters Alert Service Bulletin No. AS332–52.00.56, Revision 0, dated January 30, 2017, which specifies pulling on the inner jettison handle to determine whether the cables come into contact with the cable clamps. If there is contact, this service information specifies changing the position of the cable clamps to prevent interference.

This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

Other Related Service Information

We also reviewed Eurocopter Service Bulletin No. 332–52.00.28, Revision 1, dated April 29, 1998, which contains procedures to improve the door jettison system. Eurocopter identifies compliance with this service information as MOD 0725366.

Proposed AD Requirements

This proposed AD would require before flight over water or within 110 hours time-in-service (TIS), whichever occurs first, inspecting the jettisoning mechanism of the LH and RH cabin doors for correct operation by pulling on the inner jettison handle to determine whether the cable clamp contacts the top and bottom horizontal cables. If there is contact between cable clamp and the horizontal cables, this proposed AD would require changing the position of the cable clamps to remove any contact.

Differences Between This Proposed AD and the EASA AD

The EASA AD requires that the initial inspection occur during the next jettisoning test of the doors or within 110 flight hours, whichever occurs first, and thereafter during certain maintenance tasks. This proposed AD would require a one-time inspection within 110 hours TIS or prior to flying over water.

Costs of Compliance

We estimate that this proposed AD would affect 19 helicopters of U.S. Registry and that labor costs average $85 per work-hour. Based on these estimates, we expect that inspecting the jettisoning mechanism and changing the orientation of the cable clamps, if necessary, would require 4 work-hours. No parts would be required for a total cost of $340 per helicopter and $6,460 for the U.S. fleet.

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 proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would 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, I certify this proposed regulation:

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 to the extent that it justifies making a regulatory distinction; 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 an economic evaluation of the estimated costs to comply with this proposed AD and placed it in the AD docket.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 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):

Airbus Helicopters: Docket No. FAA–2017–1124; Product Identifier 2017–SW–073–AD.

(a) Applicability

This AD applies to Airbus Helicopters Model AS332C, AS332C1, AS332L, and AS332L1 helicopters, certificated in any category, with a cabin sliding plug door installed in accordance with Airbus Helicopters modification (MOD) 0722338, except helicopters with a plug door jettison system installed in accordance with MOD 0725366.

(b) Unsafe Condition

This AD defines the unsafe condition as failure of a cabin sliding door to jettison, which could prevent helicopter occupants from evacuating the helicopter during an emergency.

(c) Comments Due Date

We must receive comments by July 9, 2018.

(d) Compliance

You are responsible for performing each action required by this AD within the specified compliance time unless it has already been accomplished prior to that time.

(e) Required Actions

Within 110 hours time-in-service (TIS) or before the next operation over water, whichever occurs first, inspect the jettisoning mechanism of the left-hand and right-hand cabin doors for correct operation:

(1) Pull the jettisoning handle and determine whether the cable clamp contacts the top or bottom horizontal cables, using as a reference the photographs under paragraph 3.B.2 of Airbus Helicopters ASB No. AS332–52.00.56, Revision 0, dated January 30, 2017 (ASB).

(2) If there is contact between a cable clamp and a horizontal cable, before further flight, install both cable clamps as depicted in the bottom photograph under paragraph 3.B.2 of the ASB.

(f) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Safety Management Section, Rotorcraft Standards Branch, FAA, may approve AMOCs for this AD. Send your proposal to: Matt Fuller, Senior Aviation Safety Engineer, Safety Management Section, Rotorcraft Standards Branch, FAA, 10101 Hillwood Pkwy., Fort Worth, TX 76177; telephone (817) 222–5110; email *9-ASW-FTW-AMOC-Requests@faa.gov.*

(2) For operations conducted under a 14 CFR part 119 operating certificate or under 14 CFR part 91, subpart K, we suggest that you notify your principal inspector, or lacking a principal inspector, the manager of the local flight standards district office or certificate holding district office before operating any aircraft complying with this AD through an AMOC.

(g) Additional Information

(1) Eurocopter Service Bulletin No. 332–52.00.28, Revision 1, dated April 29, 1998, which is not incorporated by reference, contains additional information about the subject of this AD. For service information identified in this AD, contact Airbus Helicopters, 2701 N Forum Drive, Grand Prairie, TX 75052; telephone (972) 641–0000 or (800) 232–0323; fax (972) 641–3775; or at *http://www.helicopters.airbus.com/website/en/ref/Technical-Support_73.html.* You may review the referenced service information at the FAA, Office of the Regional Counsel, Southwest Region, 10101 Hillwood Pkwy., Room 6N–321, Fort Worth, TX 76177.

(2) The subject of this AD is addressed in European Aviation Safety Agency (EASA) AD No. 2017–0022, dated February 8, 2017. You may view the EASA AD on the internet at *http://www.regulations.gov* in the AD Docket.

(h) Subject

Joint Aircraft Service Component (JASC) Code: 5200, Doors.

Issued in Fort Worth, Texas, on May 1, 2018.

Lance T. Gant,

Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2018–09740 Filed 5–7–18; 8:45 am]

BILLING CODE 4910–13–P

SECURITIES AND EXCHANGE COMMISSION

17 CFR Part 210

[Release No. 33–10491; 34–83157; IC–33091; IA–4904; FILE NO. S7–10–18]

RIN 3235–AM01

Auditor Independence With Respect to Certain Loans or Debtor-Creditor Relationships

AGENCY: Securities and Exchange Commission.

ACTION: Proposed rule.

SUMMARY: The Securities and Exchange Commission (''Commission'') is proposing to amend its auditor independence rules to refocus the analysis that must be conducted to determine whether an auditor is independent when the auditor has a lending relationship with certain shareholders of an audit client at any time during an audit or professional engagement period. The proposed amendments would focus the analysis solely on beneficial ownership rather than on both record and beneficial ownership; replace the existing 10 percent bright-line shareholder ownership test with a ''significant influence'' test; add a ''known through reasonable inquiry'' standard with respect to identifying beneficial owners of the audit client's equity securities; and amend the definition of ''audit client'' for a fund under audit to exclude funds that otherwise would be considered affiliates of the audit client. The Commission is also requesting comment on certain other potential amendments to its auditor independence rules.

DATES: Comments should be received on or before July 9, 2018.

ADDRESSES: Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*http://www.sec.gov/rules/proposed.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number S7–10–18 on the subject line.

Paper Comments

- Send paper comments to Brent J. Fields, Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

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FOR FURTHER INFORMATION CONTACT: Giles T. Cohen, Deputy Chief Counsel, or Peggy Kim, Senior Special Counsel, Office of the Chief Accountant, at (202) 551–5300; Alison Staloch, Chief Accountant, Chief Accountant's Office, Division of Investment Management, at (202) 551–6918; or Joel Cavanaugh, Senior Counsel, Investment Company Regulation Office, Division of Investment Management, at (202) 551–6792, U.S. Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549.

SUPPLEMENTARY INFORMATION: We are proposing amendments to Rule 2–01 of Regulation S–X.[1]

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I. Background

A. The Loan Provision of Regulation S–X

We are proposing to amend certain provisions of our auditor independence rules. The Commission has long considered auditor independence to be essential to reliable financial reporting and critical to the effective functioning of the U.S. capital markets.[2] Independent auditors have an important public trust.[3] Many Commission regulations require entities to file or furnish financial statements that have been audited by an independent auditor; such entities include operating companies, registered investment companies, registered investment advisers, pooled investment vehicles,[4] and registered broker-dealers.[5]

The Commission's auditor independence standard is set forth in Rule 2–01 of Regulation S–X, which requires auditors[6] to be independent of their audit clients both ''in fact and in appearance.''[7] Rule 2–01(b) provides that the Commission will not recognize an accountant as independent with respect to an audit client if the accountant is not (or if a reasonable investor with knowledge of all relevant facts and circumstances would conclude that the accountant is not) capable of exercising objective and impartial judgment on all issues encompassed within the accountant's engagement.[8]

Rule 2–01(c) sets forth a nonexclusive list of circumstances that the Commission considers to be inconsistent with the independence standard in Rule 2–01(b), including certain direct financial relationships between an accountant and audit client and other circumstances where the accountant has a financial interest in the audit client.[9] In particular, the restriction on debtor-creditor relationships in Rule 2–01(c)(1)(ii)(A) (the ''Loan Provision'') generally provides that an accountant is not

[1] 17 CFR 210.2–01.

[2] *See generally* Proposed Rule: Revision of the Commission's Auditor Independence Requirements, Release No. 33–7870 (June 30, 2000) (''2000 Proposing Release''), *available at https://www.sec.gov/rules/proposed/34-42994.htm.*

[3] The U.S. Supreme Court in describing the independent auditor's responsibility, stated that the accountant's ''public watchdog'' function ''demands that the accountant maintain total independence from the client at all times and requires complete fidelity to the public trust.'' *United States* v. *Arthur Young,* 465 U.S. 805, 818 (1984).

[4] In this Release, we use the term ''pooled investment vehicle'' to refer to a limited partnership, limited liability company, or another type of pooled investment vehicle for which the pooled investment vehicle's investment adviser relies on paragraph (b)(4) of Rule 206(4)–2 (the ''Custody Rule'') under the Advisers Act. In general, paragraph (b)(4) of the Custody Rule provides conditions under which an investment adviser is not required to comply with provisions of the Custody Rule relating to the delivery of certain notices and account statements and is deemed to have complied with the surprise examination requirements of the rule with respect to an account that is a limited partnership, limited liability company or other pooled investment vehicle that is subject to audit (as defined in Rule 1–02(d) of Regulation S–X). In order to rely on this ''audit exception,'' the audit must be performed by an independent public accountant that: (i) Meets the standards in Rule 2–01(b) and (c) of Regulation S–X; and (ii) is registered with, and subject to regular inspection as of the commencement of the professional engagement period, and as of each calendar year-end, by the Public Company Accounting Oversight Board (''PCAOB'') in accordance with its rules. Many advisers to private funds rely on the audit exception. A ''private fund'' is an issuer that would be an investment company, as defined in Section 3 of the Investment Company Act, but for Section 3(c)(1) or 3(c)(7) of that Act. *See* Section 202(a)(29) of the Investment Advisers Act.

[5] For example, Items 25 and 26 of Schedule A to the Securities Act of 1933 (''Securities Act'') [15 U.S.C. 77aa(25) and (26)] and Section 17(e) of the Securities Exchange Act of 1934 (''Exchange Act'') [15 U.S.C. 78q] expressly require that financial statements be certified by independent public or certified accountants. In addition, Sections 12(b)(1)(J) and (K) and 13(a)(2) of the Exchange Act [15 U.S.C. 78l and 78m], Sections 8(b)(5) and 30(e) and (g) of the Investment Company Act of 1940 (''Investment Company Act'') [15 U.S.C. 80a–8 and 80a–29], and Section 203(c)(1)(D) of the Investment Advisers Act of 1940 (''Advisers Act'') [15 U.S.C. 80b–3(c)(1)] authorize the Commission to require the filing of financial statements that have been audited by independent accountants. Paragraph (f)(1) of Rule 17a–5 under the Exchange Act [17 CFR 240.17a–5(f)(1)] requires that for audits under paragraph (d) of Rule 17a–5 of broker-dealers registered with the Commission, an independent public accountant must be independent in accordance with Rule 2–01 of Regulation S–X. *See also id.* (discussing Rule 206(4)–2 under the Advisers Act).

[6] Rule 2–01 refers to ''accountants'' rather than ''auditors.'' We use these terms interchangeably in this Release.

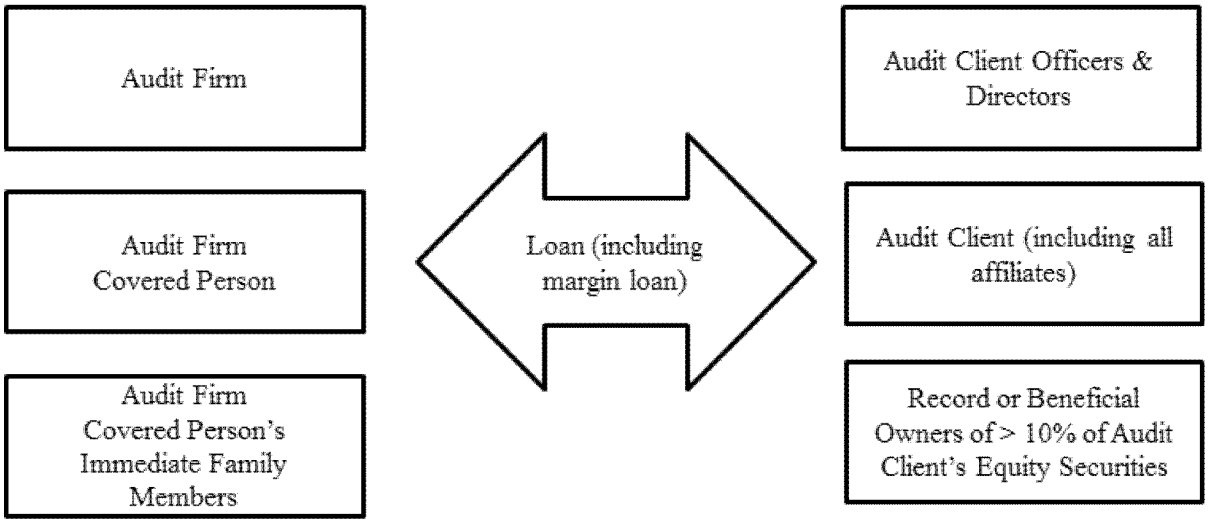
[7] *See* Preliminary Note 1 to Rule 2–01 and Rule 2–01(b) of Regulation S–X. *See also United States* v. *Arthur Young & Co.,* 465 U.S. 805, 819 n.15 (1984) (''It is therefore not enough that financial statements be accurate; the public must also perceive them as being accurate. Public faith in the reliability of a corporation's financial statements depends upon the public perception of the outside auditor as an independent professional.'').

[8] *See* Rule 2–01(b) of Regulation S–X.

[9] *See* Rule 2–01(c) of Regulation S–X; *see also Revision of the Commission's Auditor Independence Requirements,* Release No. 33–7919 (Nov. 21, 2000) [65 FR 76008 (Dec. 5, 2000)] (''2000 Adopting Release'') *available at https://www.sec.gov/rules/final/33-7919.htm,* at 65 FR 76009 (''The amendments [to Rule 2–01 adopted in 2000] identify certain relationships that render an accountant not independent of an audit client under the standard in Rule 2–01(b). The relationships addressed include, among others, financial, employment, and business relationships between auditors and audit clients . . . .'').

independent when (a) the accounting firm, (b) any covered person [10] in the accounting firm (*e.g.,* the audit engagement team and those in the chain of command), or (c) any of the covered person's immediate family members has any loan (including any margin loan) to or from (x) an audit client, or (y) an audit client's officers, directors, or (z) record or beneficial owners of more than 10 percent of the audit client's equity securities.[11] We note that simply because a lender to an auditor holds 10 percent or less of an audit client's equity securities does not, in itself, establish that the auditor is independent under Rule 2–01 of Regulation S–X. The general standard under Rule 2–01(b) and the remainder of Rule 2–01(c) still apply to auditors and their audit clients regardless of the applicability of the Loan Provision.

Figure 1. Loan Provision Relationships



Thus, in the above illustration, pursuant to the Loan Provision, a lending relationship between any entity in the left hand column and any entity in the right-hand column impairs independence, unless an exception applies.

When the Commission proposed the Loan Provision, it noted that a debtor-creditor relationship between an auditor and its audit client reasonably could be viewed as ''creating a self-interest that competes with the auditor's obligation to serve only investors' interests.'' [12] The Commission's concern about a competing self-interest extended beyond loans directly between the auditor and its audit client to loans between the auditor and those shareholders of the audit client who have a ''special and influential role'' with the audit client.[13] As a proxy for identifying a ''special and influential role,'' the Commission adopted a bright-line test for loans to or from a record or beneficial owner of more than 10 percent of an audit client's equity securities.[14]

Under Rule 2–01(f)(6) of Regulation S–X, the term ''audit client'' is defined to include any affiliate of the entity whose financial statements are being audited.[15] Rule 2–01(f)(4) provides that ''affiliates of the audit client'' include entities that control, are controlled by, or are under common control with the audit client. As a result, generally, an accounting firm is not independent under the Loan Provision if it has a lending relationship with an entity having record or beneficial ownership of more than 10 percent of the equity securities of either (a) the firm's audit client; or (b) any entity that is a controlling parent company of the audit client, a controlled subsidiary of the audit client, or an entity under common control with the audit client.

In addition, the term ''affiliate of the audit client'' includes each entity in an investment company complex (''ICC'') of which the audit client is a part.[16] Accordingly, in the ICC context, an accounting firm is considered not independent under the Loan Provision if it has a lending relationship with an entity having record or beneficial ownership of more than 10 percent of any entity within the ICC, regardless of

[10] *See* Rule 2–01(f)(11) of Regulation S–X.

[11] *See* 2000 Adopting Release, *supra* footnote 9, at 65 FR 76035.

[12] *See* 2000 Proposing Release, *supra* footnote 2, at 65 FR 76034–76035.

[13] *See* 2000 Adopting Release, *supra* footnote 9, at 65 FR 76035.

[14] The Commission proposed that the Loan Provision include a five-percent equity ownership threshold, but raised the threshold to 10 percent when it adopted the Loan Provision. *See* 2000 Adopting Release, *supra* footnote 9, at 65 FR 76035. As the basis for its use of a 10 percent threshold, the Commission pointed to similar 10 percent ownership thresholds elsewhere in the federal securities laws, including Rule 1–02(r) of Regulation S–X (defining ''principal holder of equity securities''), Rule 1–02(s) of Regulation S–X (defining ''promoter''), and Section 16 of the Exchange Act (requiring reporting to the Commission of beneficial ownership information by directors, officers and beneficial owners of more than 10 percent of any class of equity securities of an issuer). *Id.*

[15] *See* Rule 2–01(f)(6) of Regulation S–X.

[16] *See* Rule 2–01(f)(4)(iv) of Regulation S–X (defining ''affiliate of the audit client''). ''Investment company complex'' is defined in Rule 2–01(f)(14) of Regulation S–X to include: ''(A) An investment company and its investment adviser or sponsor; (B) Any entity controlled by or controlling an investment adviser or sponsor in paragraph (f)(14)(i)(A) of this section, or any entity under common control with an investment adviser or sponsor in paragraph (f)(14)(i)(A) of this section if the entity: (1) Is an investment adviser or sponsor; or (2) Is engaged in the business of providing administrative, custodian, underwriting, or transfer agent services to any investment company, investment adviser, or sponsor; and (C) Any investment company or entity that would be an investment company but for the exclusions provided by section 3(c) of the [1940 Act] that has an investment adviser or sponsor included in this definition by either paragraph (f)(14)(i)(A) or (f)(14)(i)(B) of this section.''

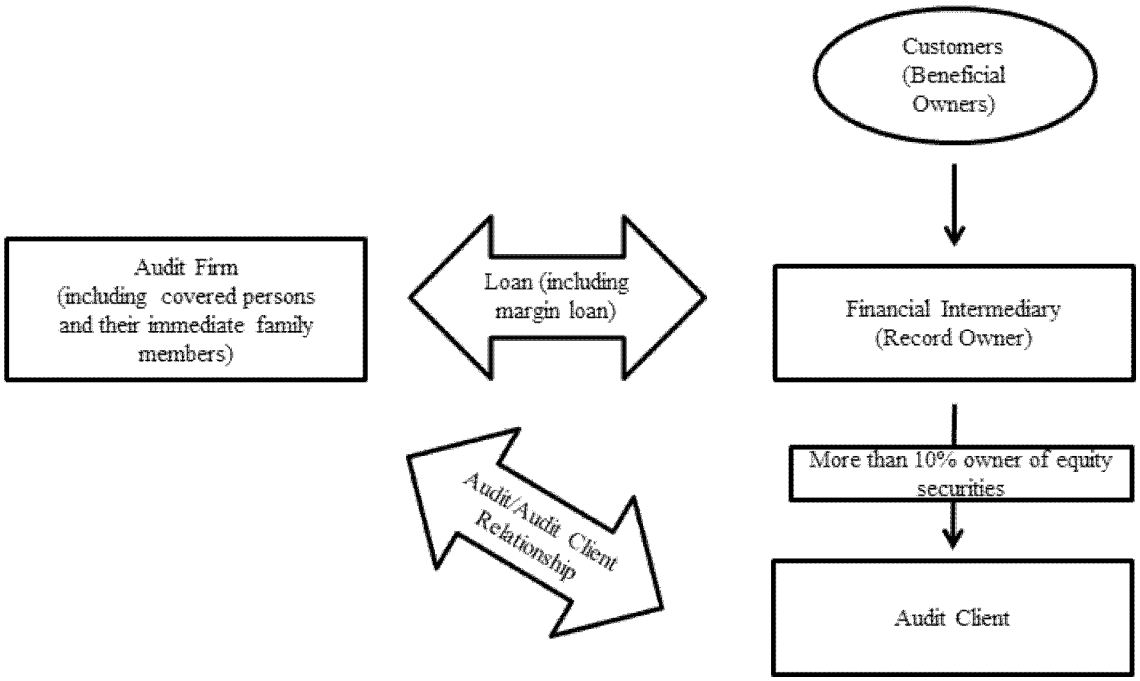
which entities in the ICC are audited by the accounting firm.

B. Application of the Current Loan Provision

The Commission has become aware that, in certain circumstances, the existing Loan Provision may not be functioning as it was intended, under current market conditions. It also presents significant practical challenges.[17] Registered investment companies, pooled investment vehicles, and registered investment advisers have articulated concerns about the Loan Provision in both public disclosures [18] and, together with their auditors, in extensive consultations with Commission staff.[19] It has become clear that there are certain fact patterns where an auditor's objectivity and impartiality is not impaired despite a failure to comply with the requirements of the Loan Provision. [20]

One challenge associated with the Loan Provision is that it applies to both ''record'' and ''beneficial'' owners of the audit client's equity securities. However, publicly traded shares, as well as certain fund shares, often are registered in the name of a relatively small number of financial intermediaries [21] as ''record'' owners for the benefit of their clients or customers. Certain of these financial intermediaries may also be lenders to public accounting firms or be affiliated with financial institutions that may be lenders to public accounting firms.[22] As a result, audit clients may have financial intermediaries that own, on a ''record'' basis, more than 10 percent of the issuer's shares and are also lenders to public accounting firms, covered persons of accounting firms, and their immediate family members, or are affiliated with companies that are lenders to public accounting firms (see Figure 2 below for illustration). However, these financial intermediaries are not ''beneficial'' owners. They also may not have control over whether they are ''record'' owners of more than 10 percent of the issuer's shares.

Figure 2. Audit Firm is not independent under the Loan Provision when a Financial Intermediary that is a lender to the Audit Firm is also a record owner of more than 10 percent of the equity securities of the Audit Client.



[17] The audit committees of registered investment companies may be focused on this issue because, under the Sarbanes-Oxley Act of 2002 (''Sarbanes-Oxley Act''), audit committees are responsible for the selection, compensation and oversight of such funds' independent auditors. *See* Rule 10A–3 under the Exchange Act [17 CFR 240.10A–3]. In addition, for audits conducted pursuant to PCAOB standards, the auditor is required to notify the audit committee of matters that may reasonably bear upon the independence of the auditor. *See* PCAOB Rule 3526.

[18] Several funds and investment advisers have noted concerns regarding the Loan Provision in their public filings with the Commission. *See, e.g.,* AIM Investment Securities Funds (Invesco Investment Securities Funds) Form N–CSR filed on May 12, 2016; Invesco Mortgage Capital Inc. Form 10–Q filed on May 10, 2016; iShares Trust Form N–CSR filed on June 6, 2016; Delaware Investments Colorado Municipal Income Fund, Inc. Form N–CSR filed on June 6, 2016; Goldman Sachs Trust Form N–CSR filed on June 6, 2016; Advent International Corp. Form ADV filed on March 30, 2016; NB Alternatives Advisers LLC Form ADV filed on June 29, 2016; Indaba Capital Management, L.P. Form ADV filed on March 30, 2016; and MFS Government Markets Income Trust Schedule 14A filed on August 31, 2016.

[19] Staff in the Office of the Chief Accountant (OCA staff) regularly engage in consultations with issuers regarding accounting, financial reporting, and auditing concerns or questions, including application of the auditor independence rules.

[20] Challenges associated with the Loan Provision have also arisen with issuers other than funds, although not to the same extent. For example, a foreign private issuer (''FPI'') and its external auditor encountered compliance issues with the Loan Provision as a result of the FPI's use of a depositary bank to hold its American Depositary Shares. In that case, the depositary bank was the record holder, but not the beneficial owner, of more than 10 percent of the underlying equity shares of the FPI while also having a lending relationship with the auditor. *See, e.g.,* JMU Ltd. Form 20–F, filed on May 26, 2017.

[21] *See infra* footnote 23.

[22] We note that the Loan Provision can be implicated by lending relationships between an auditing firm and those that control the record or beneficial owner of more than 10 percent of the shares of an audit client (*i.e.,* entities that are under common control with or controlled by the record or beneficial owner are not as such implicated by the Loan Provision).

For example, open-end funds, such as mutual funds, may face significant challenges, because the record ownership percentages of open-end funds may fluctuate greatly within a given period for reasons completely out of the control or knowledge of a lender who is also a fund shareholder of record. To be more specific, as a result of underlying customer activity in an omnibus account (such as when beneficial owners purchase or redeem their shares in an open-end fund) or as a result of the activity of other record or beneficial owners, the record ownership of a lender that is a financial intermediary holding fund shares for customers may exceed, or conversely fall below, the 10 percent threshold within a given period without any affirmative action on the part of the financial intermediary.[23] In this scenario, the financial intermediary's holdings might constitute less than 10 percent of a mutual fund and, as a result of subsequent redemptions by beneficial owners through other non-affiliated financial intermediaries, the same investment could then constitute more than 10 percent of the mutual fund. However, regardless of their diligence in monitoring compliance, the financial intermediary, the fund, or the auditor may not know that the 10 percent threshold had been exceeded until after the fact.

Another practical challenge is that the auditor independence rules' broad definition of the term ''audit client'' gives rise to results that are out of step with the purpose of the rule and that can have adverse effects when applied in the specific context of the Loan Provision. As described above, the Loan Provision applies not only to an entity that the audit firm is auditing but also to those entities that are ''affiliated'' with the audit client.[24] The auditor independence rules broadly define an ''affiliate of the audit client'' to include, among other things, both (a) an entity that is under common control with the audit client; and (b) each entity in an ICC when the audit client is part of that ICC.[25]

Open-end funds are often part of large and varied ICCs, and multiple accounting firms may be retained to perform audits of various entities within the ICC. If an accounting firm is not independent under the Loan Provision with respect to only one of a given ICC's funds, no fund or other entity in the ICC can engage or retain that accounting firm as an independent auditor consistent with Rule 2–01 of Regulation S–X. An auditor to one fund in an ICC thus must seek information regarding the record and beneficial owners of the equity securities of *all* of the other funds (and other entities) in the ICC and such owner's affiliates (see Figure 3 below for illustration). Other funds in the ICC that are not audited by the requesting auditor are not required to provide this information, and may only provide it, if at all, after negotiation and the establishment of information-sharing protocols, all of which can require substantial time and expense incurred by auditors and funds. Even where funds not audited by this auditor do provide information regarding the owners of their equity securities, the fact that fund shares often are held in omnibus accounts registered in the name of financial intermediaries creates further challenges in identifying the shares' beneficial owners to determine if they are lenders to the auditing firm that own more than 10 percent of the fund's equity securities.[26]

Further, not only loans to accounting firms but also loans to certain ''covered persons'' at such firms and their immediate family members may implicate the Loan Provision.[27] As a result, certain lending relationships with members of the audit engagement team, individuals generally in the supervisory reporting chain for the audit, certain accounting firm employees in the same primary office as the lead engagement partner, and other accounting firm employees—or with immediate family members of any of those persons—could be found to impair the audit firm's independence.[28]

[23] Financial intermediaries such as broker-dealers, banks, trusts, insurance companies and retirement plan third-party administrators perform the recordkeeping of open-end fund positions and provide services to customers, including beneficial owners and other intermediaries and, in most cases, aggregate their customer records into a single or a few ''omnibus'' accounts registered in the intermediary's name on the fund transfer agent's recordkeeping system. Shares of other types of registered investment companies, such as closed-end funds, also are frequently held by broker-dealers and other financial intermediaries as record owners on behalf of their customers, who are not required and may be unwilling to provide, information about the underlying beneficial owners to accounting firms, and particularly accounting firms that do not audit the fund. In addition, a financial intermediary may act as an authorized participant or market maker to an exchange-traded fund (''ETF'') and be the holder of record or beneficial owner of more than 10 percent of an ETF.

An open-end fund, or open-end company, is a management company that is offering for sale or has outstanding any redeemable securities of which it is the issuer. A closed-end fund, or closed-end company, is any management company other than an open-end company. *See* Section 5 of the Investment Company Act [15 U.S.C. 80a–5]. ETFs registered with the Commission are organized either as open-end management companies or unit investment trusts. *See* Section 4 of the Investment Company Act [15 U.S.C. 80a–4] (defining the terms ''management company'' and ''unit investment trust''). References to ''funds'' in this Release include ETFs, unless specifically noted.

[24] *See* Rule 2–01(f)(6) of Regulation S–X.

[25] *See* Rule 2–01(f)(4) of Regulation S–X, in which an ''affiliate of the audit client'' is defined to include the following:

(i) An entity that has control over the audit client, or over which the audit client has control, or which is under common control with the audit client, including the audit client's parents and subsidiaries;

(ii) An entity over which the audit client has significant influence, unless the entity is not material to the audit client;

(iii) An entity that has significant influence over the audit client, unless the audit client is not material to the entity; and

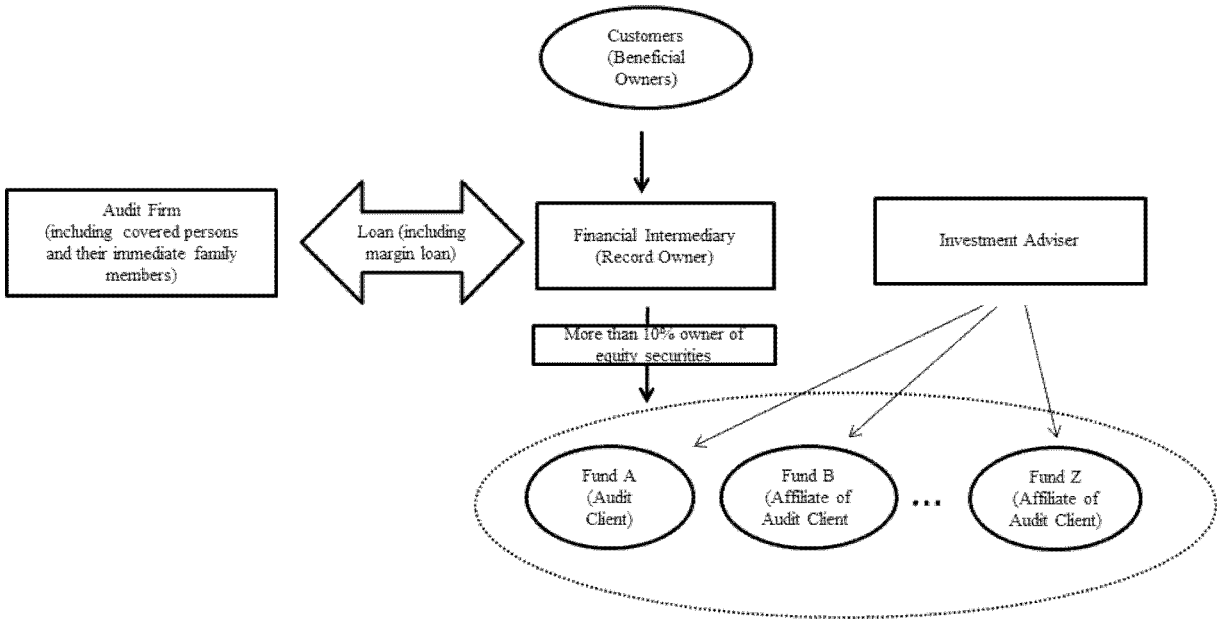
(iv) Each entity in the investment company complex when the audit client is an entity that is part of an investment company complex.

[26] In some cases, financial intermediaries such as broker-dealers or banks hold fund shares on behalf of other financial intermediaries, such as retirement plan administrators or other broker-dealers, creating multiple layers of intermediaries between the fund and the beneficial owners of its shares. *See also, e.g., Mutual Fund Redemption Fees,* Release No. IC–27504 (Sept. 27, 2006) [71 CFR 58257 (Oct. 3, 2006)] at 58258 (discussing application of Rule 22c–2 under the Investment Company Act to ''chains of intermediaries'').

[27] *See* Rule 2–01(c)(1)(ii) of Regulation S–X.

[28] *See* Rule 2–01(f)(11) of Regulation S–X (definition of ''covered persons'').

Figure 3. Audit Firm that has a loan with a Financial Intermediary that owns more than 10 percent of the equity securities of one Audit Client (Fund A) in an ICC is also not independent with respect to other funds in the ICC (Fund B through Fund Z). Since Audit Firm performs and issues an audit report for one fund in an ICC (Fund A), Funds B, C, D . . . and Z (other funds in the ICC) are also considered to be Audit Clients due to their affiliate status.



The Commission understands that accounting firms use loans to help finance their core business operations. Accounting firms frequently obtain financing to pay for their labor and out-of-pocket expenses before they receive payments from audit clients for those services. Accounting firms also use financing to fund current operations and provide capital to fund ongoing investments in their audit methodologies and technology. Accounting firms borrow from commercial banks or through private placement debt issuances, typically purchased by large financial institutions, both of which give rise to debtor-creditor relationships.[29] For creditor diversification purposes, credit facilities provided or arranged by commercial banks are often syndicated among multiple financial institutions, thereby expanding the number of lenders to an accounting firm. As a result, accounting firms typically have a wide array of lending arrangements. These arrangements facilitate firms' provision of audit services to investors and other market participants, but also multiply the number of lenders that may also be record or beneficial owners of securities in audit clients and that must be analyzed under the Loan Provision.

The current market conditions that have enabled these accounting firms' financing methods appear to have resulted in various scenarios in which the Loan Provision deems an accounting firm's independence to be impaired, notwithstanding that the relevant facts and circumstances regarding the relationships between the auditor and the audit client suggest that in most cases the auditor's objectivity and impartiality do not appear to be affected as a practical matter. Nevertheless, auditors and audit committees may feel obligated to devote substantial resources to evaluating potential instances of noncompliance with the existing Loan Provision, which could distract auditors' and audit committees' attention from matters that may be more likely to bear on the auditor's objectivity and impartiality.[30] Audit committees' receipt of a high volume of communications of such relationships may dilute the impact of communications that identify issues that may actually raise concerns about an auditor's independence.[31]

Similarly, numerous violations of the independence rules that no reasonable person would view as implicating an auditor's objectivity and impartiality could desensitize market participants to other, more significant violations of the

[29] The Commission further understands that insurance companies may purchase accounting firms' private placement notes. Insurance companies may also act as sponsors of insurance products, and may be record owners, on behalf of contract holders, of certain investment companies' equity securities.

[30] Auditors are required to communicate any relationships, including lending relationships, with the audit client that may reasonably be thought to bear on independence to the audit committee at least annually. *See, e.g.,* PCAOB Rule 3526 (requiring a registered public accounting firm, at least annually with respect to each of its audit clients, to: (1) Describe, in writing, to the audit committee of the audit client, all relationships between the registered public accounting firm or any affiliates of the firm and the audit client or persons in financial reporting oversight roles at the audit client that, as of the date of the communication, may reasonably be thought to bear on independence; (2) discuss with the audit committee of the audit client the potential effects of the relationships described in subsection (b)(1) on the independence of the registered public accounting firm; (3) affirm to the audit committee of the audit client, in writing, that, as of the date of the communication, the registered public accounting firm is independent in compliance with Rule 3520; and (4) document the substance of its discussion with the audit committee of the audit client.

[31] In this Release, we use the term ''audit committee,'' when referring to funds, generally to refer to audit committees established by a fund's board of directors or trustees or, where no formal audit committee exists as may be the case for certain private funds, for example, those responsible for the governance of the fund.

independence rules. Respect for the seriousness of these obligations is better fostered through limiting violations to those instances in which the auditor's independence would be impaired in fact or in appearance.

Moreover, searching for, identifying, and assessing noncompliance or potential non-compliance with the Loan Provision and reporting these instances to audit committees also may generate significant costs for entities and their advisers and auditors, which costs are ultimately borne by shareholders. These costs are unlikely to entail corresponding benefits to the extent that the Loan Provision's breadth identifies and requires analysis of circumstances that are unlikely to bear on the auditor's independence.

In addition, the compliance challenges associated with the Loan Provision can have broader disruptive effects, particularly for funds.[32] For example, in order for a registered open-end fund to make a continuous offering of its securities, it must maintain a current prospectus by periodically filing post-effective amendments to its registration statement that contain updated financial information audited by an independent public accountant in accordance with Regulation S–X.[33] In addition, the federal securities laws require that investment companies registered under the Investment Company Act transmit annually to shareholders and file with the Commission financial statements audited by an independent registered public accounting firm.[34] Accordingly, noncompliance with the auditor independence rules in some cases can result in affected funds not being able to sell shares, investors not being able to rely on affected financial statements, or funds (and, indirectly, but importantly, their investors) having to incur the costs of re-audits.

In order to provide time for the Commission to address these challenges, and recognizing that funds and their advisers were most acutely affected by the Loan Provision, the Commission staff issued a no-action letter to Fidelity Management & Research Company regarding the application of the Loan Provision (''Fidelity No-Action Letter'').[35] In the Fidelity No-Action Letter, the staff stated that it would not recommend enforcement action to the Commission, even though certain Fidelity entities identified in the letter used audit firms that were not in compliance with the Loan Provision, subject to certain conditions specified in the letter (*e.g.,* that notwithstanding such non-compliance, the audit firm had concluded that it is objective and impartial with respect to the issues encompassed within the engagement).[36] Staff continue to receive inquiries from registrants and accounting firms regarding the application of the Loan Provision, or clarification of the Fidelity No-Action Letter, and requests for consultation regarding issues not covered in the Fidelity No-Action Letter.

II. Proposed Amendments

A. Overview of the Proposed Amendments

Given the dynamics identified above, we are proposing amendments to Rule 2–01 of Regulation S–X that would result in a rule that we believe would effectively identify those debtor-creditor relationships that could impair an auditor's objectivity and impartiality, yet would not include certain extended relationships that are unlikely to present threats to objectivity or impartiality.[37] Specifically, we are proposing amendments that would:

- Focus the analysis solely on beneficial ownership;
- replace the existing 10 percent bright-line shareholder ownership test with a ''significant influence'' test;
- add a ''known through reasonable inquiry'' standard with respect to identifying beneficial owners of the audit client's equity securities; and
- amend the definition of ''audit client'' for a fund under audit to exclude from the provision funds that otherwise would be considered ''affiliates of the audit client.''

The proposed amendments are designed to better focus the Loan Provision on those relationships that, whether in fact or in appearance, could threaten an auditor's ability to exercise objective and impartial judgment. We also are soliciting input on other potential changes to the Loan Provision or Rule 2–01 of Regulation S–X that may be appropriate.

Given that compliance challenges associated with applying the Loan Provision have arisen with entities other than funds, the proposed amendments would apply broadly to entities beyond the investment management industry, including operating companies and registered broker-dealers.

B. Focus the Analysis Solely on Beneficial Ownership

Where a lender to an auditor holds more than 10 percent of the equity securities of that auditor's audit client either as a beneficial owner or as a record owner, the Commission's rules indicate that the auditor is not independent of the audit client. The record owner exceeding 10 percent may be a broker-dealer, custodian, or an intermediary omnibus account holder for its customers. Thus, as noted in Section I.B., the existing Loan Provision applies where a lender holds the audit client's equity securities of record, even though the lender may be unable to influence an audit client through its holdings of the audit client's equity securities, and may have no economic incentive to do so.[38]

[32] Registered investment advisers that have custody of client funds or securities also face compliance challenges from the Loan Provision. These advisers generally are required under the Custody Rule to obtain a surprise examination conducted by an independent public accountant or, for pooled investment vehicles, may be deemed to comply with the requirement by distributing financial statements audited by an independent public accountant to the pooled investment vehicle's investors. An auditor's inability, or potential inability, to comply with the Loan Provision raises questions concerning an adviser's ability to satisfy the requirements of the Custody Rule.

[33] *See generally* Section 10(a)(3) of the Securities Act [15 U.S.C. 77j(a)(3)] and Item 27 of Form N–1A.

[34] *See* Rules 30e–1 and 30b2–1 under the Investment Company Act.

[35] *See* No-Action Letter from the Division of Investment Management to Fidelity Management & Research Company (June 20, 2016) (''June 20, 2016 Letter''), *available at https://www.sec.gov/divisions/investment/noaction/2016/fidelity-management-research-company-062016.htm.* The June 20, 2016 Letter provided temporary no-action relief, and was to expire 18 months from the issuance date. On September 22, 2017, the staff extended the June 20, 2016 Letter until the effective date of any amendments to the Loan Provision adopted by the Commission that are designed to address the concerns expressed in the June 20, 2016 Letter. *See* No-Action Letter from the Division of Investment Management to Fidelity Management & Research Company (Sept. 22, 2017) (''September 22, 2017 Letter''), *available at https://www.sec.gov/divisions/investment/noaction/2017/fidelity-management-research-092217-regsx-rule-2-01.htm.*

[36] The June 20, 2016 Letter described the following circumstances, each of which could have potential implications under the Loan Provision: (i) ''An institution that has a lending relationship with an Audit Firm holds of record, for the benefit of its clients or customers (for example, as an omnibus account holder or custodian), more than 10 percent of the shares of a Fidelity Entity;'' (ii) ''An insurance company that has a lending relationship with an Audit Firm holds more than 10 percent of the shares of a Fidelity Fund in separate accounts that it maintains on behalf of its insurance contract holders;'' and (iii) ''An institution that has a lending relationship with an Audit Firm and acts as an authorized participant or market maker to a Fidelity ETF and holds of record or beneficially more than 10 percent of the shares of a Fidelity ETF.''

[37] *See* Rule 2–01(b) of Regulation S–X.

[38] The financial gain of beneficial owners is tied to the performance of their investment and as such, beneficial owners may have stronger incentives to influence the auditor's report. Record owners, on the other hand, likely do not benefit directly from the performance of securities of which they are

Continued

Under the proposed amendments, the Loan Provision would apply only to beneficial owners of the audit client's equity securities and not to those who merely maintain the audit client's equity securities as a holder of record on behalf of their beneficial owners.[39] We believe that tailoring the Loan Provision to focus only on the beneficial ownership of the audit client's equity securities would more effectively identify shareholders ''having a special and influential role with the issuer'' and therefore better capture those debtor-creditor relationships that may impair an auditor's independence.[40]

C. Significant Influence Test

Furthermore, we believe that the current bright-line 10 percent test may be both over- and under-inclusive as a means of identifying those debtor-creditor relationships that actually impair the auditor's objectivity and impartiality. For example, the existing Loan Provision applies even in situations where the lender may be unable to influence the audit client through its holdings.[41] In such circumstances, the lender's ownership of an audit client's equity securities alone would not threaten an audit firm's objectivity and impartiality. Conversely, the existing Loan Provision does not apply if the auditor's lender owns 10 percent or less of the audit client's equity securities, despite the fact that such an owner could exert significant influence over the audit client through contractual or other means.[42] A holder of 10 percent or less of an audit client's equity securities could, for example, have the contractual right to remove or replace a pooled investment vehicle's investment adviser. Although other portions of Rule 2–01 of Regulation S–X apply, the Loan Provision's existing 10 percent bright-line test by itself would not capture this debtor-creditor relationship even though the relationship potentially raises questions about an auditor's objectivity and impartiality.[43]

We therefore propose to replace the existing 10 percent bright-line test in the Loan Provision with a ''significant influence'' test similar to that referenced in other parts of the Commission's auditor independence rules.[44] Specifically, the proposed amendment would provide that an accountant would not be independent when the accounting firm, any covered person in the firm, or any of his or her immediate family members has any loan (including any margin loan) to or from an audit client, or an audit client's officers, directors, or beneficial owners (known through reasonable inquiry) of the audit client's equity securities where such beneficial owner has significant influence over the audit client.[45]

We believe the proposed significant influence test would more effectively identify shareholders ''having a special and influential role with the issuer'' and therefore would better capture those debtor-creditor relationships that may impair an auditor's independence.[46] This test focuses on a lender shareholder's ability to influence the policies and management of an audit client, based on a totality of the facts and circumstances. While this analysis would include a consideration of the lender's beneficial ownership level in an audit client's equity securities, a bright-line percentage ownership of an audit client's securities alone would no longer determine an auditor's independence with respect to an audit client.

Specifically, under the ''significant influence'' test we are proposing today, an audit firm, together with its audit client, would be required to assess whether a lender (that is also a beneficial owner of the audit client's equity securities) has the ability to exert significant influence over the audit client's operating and financial policies.[47] Although not specifically defined, the term ''significant influence'' appears in other parts of Rule 2–01 of Regulation S–X,[48] and we intend to use the term ''significant influence'' in the proposed amendment to refer to the principles in the Financial Accounting Standards Board's (''FASB's'') ASC Topic 323, Investments—Equity Method and Joint Ventures.[49] The concept of ''significant influence'' has been part of the Commission's auditor independence rules since 2000 and has been part of the accounting standards since 1971.[50] Given its use in other parts of the Commission's independence rules,[51] the concept of ''significant influence'' is one with which audit firms and their clients are already required to be familiar. While audit firms and audit committees of operating companies already should be familiar with application of the ''significant influence'' concept, this concept is not as routinely applied today in the investment fund context for financial reporting purposes.[52] Nonetheless, the concept of significant

record owners, and as such, they may have low incentives to affect the report of the auditor. For example, record holders' discretion to vote the shares on behalf of their beneficial owners is typically limited. *See* the New York Stock Exchange (NYSE) Rule 452. The NYSE allows brokers to vote on certain items on behalf of their clients, if the broker has received no voting instructions from those clients within 10 days of the annual meeting. Brokers are only allowed to cast these discretionary votes on ''routine'' matters, which are generally uncontested and do not include a merger, consolidation, or any matter which may affect substantially the rights or privileges of such stock. Rule 452 lists the types of matters that brokers may not vote without customer instructions, which include executive compensation or uncontested elections of directors (other than uncontested director elections of companies registered under the Investment Company Act of 1940).

[39] An equity holder who acquired such ownership by buying a certificated share would be both a record owner and a beneficial owner and thus would continue to be analyzed under the Loan Provision.

[40] *See* 2000 Adopting Release, *supra* footnote 9.

[41] *Cf.* Accounting Standards Codification (''ASC'') 323, *infra* footnote 49 (providing examples where a holder may *not* have significant influence).

[42] *Cf.* ASC 323, *infra* footnote 49 (providing examples where a holder may have significant influence).

[43] *See supra* Section I.A for a discussion of the general standard under Rule 2–01(b) of Regulation S–X.

[44] *See* Rule 2–01(c)(1)(i)(E)(1)(i), (E)(1)(ii), (E)(2), (E)(3), (f)(4)(ii) and (f)(4)(iii) of Regulation S–X.

[45] *See* proposed Rule 2–01(c)(1)(ii)(A) (replacing the phrase ''record or beneficial owners of more than ten percent of the audit client's equity securities'' with ''beneficial owners (known through reasonable inquiry) of the audit client's equity securities, where such beneficial owner has significant influence over the audit client''). Under the proposed amendments, the rule would continue to have exceptions for four types of loans: (1) Automobile loans and leases collateralized by the automobile; (2) loans fully collateralized by the cash surrender value of an insurance policy; (3) loans fully collateralized by cash deposits at the same financial institution; and (4) a mortgage loan collateralized by the borrower's primary residence provided the loan was not obtained while the covered person in the firm was a covered person. We discuss the proposed ''known through reasonable inquiry'' standard below. *See infra* section II.D.

[46] *See* 2000 Adopting Release, *supra* footnote 9, at 65 FR 76035 (describing the 10 percent bright-line test as identifying shareholders ''having a special and influential role with the issuer'' that ''would be considered to be in a position to influence the policies and management of that client.'').

[47] *See* ASC 323, *infra* footnote 49. *See also infra* Section II.C for a discussion of an audit client's operating and financial policies in the fund context.

[48] *See* Rule 2–01(c)(1)(i)(E)(''investments in audit clients'') and Rule 2–01(f)(4) of Regulation S–X (''affiliate of the audit client'' definition).

[49] *See* ASC 323 Investments—Equity Method and Joint Ventures (''ASC 323''). *See* 2000 Adopting Release, *supra* footnote 9, at 65 FR 76034, note 284 (referring to Accounting Principles Board Opinion No. 18, ''The Equity Method of Accounting for Investments in Common Stock'' (Mar. 1971), which was codified at ASC 323).

[50] *See* Accounting Principles Board (APB) Opinion No. 18 (March 1971) (''The Board concludes that the equity method of accounting for an investment in common stock should also be followed by an investor whose investment in voting stock gives it the ability to exercise significant influence over operating and financial policies of an investee even though the investor holds 50% or less of the voting stock.'').

[51] *See supra* footnote 44.

[52] *See* ASC 946. Financial Services—Investment Companies.

influence is applicable to funds under existing auditor independence rules.[53]

Under the proposed test, the ability to exercise significant influence over the operating and financial policies of an audit client would be based on the facts and circumstances, and under the existing accounting framework, could be indicated in several ways, including:

- Representation on the board of directors;
- Participation in policy-making processes;
- Material intra-entity transactions;
- Interchange of managerial personnel; or
- Technological dependency.[54]

The lender's beneficial ownership of an audit client's equity securities also would be considered in determining whether a lender has significant influence over an audit client's operating and financial policies.[55] Unlike the existing Loan Provision, however, the significant influence test would not set a bright-line threshold above which a lender is assumed to be in a position to influence the policies and management of that client. Instead, the proposed significant influence test would be consistent with ASC 323 by establishing a rebuttable presumption that a lender beneficially owning 20 percent or more of an audit client's voting securities is presumed to have the ability to exercise significant influence over the audit client, absent predominant evidence to the contrary.[56] Conversely, and consistent with ASC 323, under the proposed significant influence test, if the ownership percentage were less than 20 percent, there would be a rebuttable presumption that the lender does not have significant influence over the audit client, unless it could be demonstrated that the lender has the ability to exert significant influence over the audit client.[57] Thus, significant influence could exist in circumstances where ownership is less than 20 percent.

ASC 323 lists several indicators that, as applied to the proposed significant influence test, would suggest a shareholder that owns 20 percent or more of the audit client's voting securities nonetheless may be unable to exercise significant influence over the operating and financial policies of the audit client, including the following:

- Opposition by the audit client, such as litigation or complaints to governmental regulatory authorities, challenging the shareholder's ability to exercise significant influence;
- An agreement (such as a standstill agreement) under which the shareholder surrenders significant rights as a shareholder;
- Majority ownership of the audit client is concentrated among a small group of shareholders who operate the audit client without regard to the views of the shareholder;
- The shareholder needs or wants more financial information than is available to other shareholders, tries to obtain that information, and fails;[58] and
- The shareholder tries and fails to obtain representation on the audit client's board of directors.[59]

In the fund context, we believe that the operating and financial policies relevant to the significant influence test would include the fund's investment policies and day-to-day portfolio management processes, including those governing the selection, purchase and sale, and valuation of investments, and the distribution of income and capital gains (collectively ''portfolio management processes''). An audit firm could analyze whether significant influence over the fund's portfolio management processes exists based on an initial evaluation of the fund's governance structure and governing documents, the manner in which its shares are held or distributed, and any contractual arrangements, among any other relevant factors.

We believe that it would be appropriate to consider the nature of the services provided by the fund's investment adviser(s) pursuant to the terms of an advisory contract with the fund as part of this analysis. In circumstances where the terms of the advisory agreement grant the adviser significant discretion with respect to the fund's portfolio management processes and the shareholder does not have the ability to influence those portfolio management processes, significant influence generally would not exist. The ability to vote on the approval of a fund's advisory contract or a fund's fundamental policies on a *pro rata* basis with all holders of the fund alone generally should not lead to the determination that a shareholder has significant influence. On the other hand, if a shareholder in a private fund, for example, has a side letter agreement outside of the standard partnership agreement that allows for participation in portfolio management processes (including participation on a fund advisory committee), then the shareholder would likely have significant influence.

In circumstances where significant influence could exist, the audit firm would then evaluate whether an entity that is a beneficial owner of shares of a fund audit client has the ability to exercise significant influence over the fund and has a debtor-creditor relationship with the audit firm, any covered person in the firm, or any of his or her immediate family members.[60] If the auditor determines that significant influence does not exist based on the facts and circumstances at the time of the auditor's initial evaluation, we believe that the auditor should monitor the Loan Provision on an ongoing basis which could be done, for example, by reevaluating its determination when there is a material change in the fund's governance structure and governing documents, publicly available information about beneficial owners, or other information that may implicate the ability of a beneficial owner to exert significant influence of which the audit client or auditor becomes aware.

We believe that moving to a ''significant influence'' test would be advantageous. First, the ''significant influence'' test, which applies qualitative factors to broadly capture influence over an audit client, would be more effective in identifying lender shareholders that threaten an auditor's impartiality and independence than the current 10 percent bright-line test.

Second, the concept of ''significant influence'' already exists in the auditor independence rules and in ASC 323. For example, Rule 2–01(c)(1)(i)(E) of Regulation S–X, which generally governs investments in entities that invest in audit clients and investments in entities in which audit clients invest, requires the auditor to assess whether

[53] *See* Rule 2–01(c)(1)(i)(E)(1)(i), (E)(1)(ii), (E)(2), and (E)(3) of Regulation S–X.

[54] *See* ASC 323, *supra* footnote 49.

[55] The extent of a lender's ownership interest would be considered in relation to the concentration of other shareholders, but substantial or majority ownership of an audit client's voting stock by another shareholder would not necessarily preclude the ability to exercise significant influence by the lender. *See id.*

[56] ASC 323 contains a presumption that in the absence of predominant evidence to the contrary, an investor of 20% or more of the voting stock has the ability to exercise significant influence over the investee. *See* ASC 323–10–15–8. *See also* 2000 Adopting Release, *supra* footnote 9, at 65 FR 76034, note 497 and accompanying text.

[57] Under ASC 323, an investment of less than 20% of the voting stock shall lead to the presumption that an investor does not have the ability to exercise significant influence over the investee unless such ability can be demonstrated. *See* ASC 323–10–15–8.

[58] We recognize that there may be reasons other than a lack of influence—such as concerns under Regulation FD or the antifraud provisions of the federal securities laws generally—that might result in an issuer declining to provide financial information to a shareholder.

[59] *See* ASC 323–10–15–10.

[60] *See infra* Part II.D for a discussion of the proposed ''known through reasonable inquiry'' standard.

investments are material and whether the investment results in the ability to exercise significant influence over that entity.[61] Similarly, the ''affiliate of the audit client'' definition in the auditor independence rules requires that a determination be made as to whether there are entities over which the audit client has significant influence (unless the entity is not material to the audit client) or any entities that have significant influence over the audit client (unless the audit client is not material to the entity).[62] The parties that would be tasked with implementing a ''significant influence'' test in the Loan Provision—accounting firms, issuers and their audit committees—thus are already required to be familiar with this concept under the auditor independence rules. We believe that these entities likely would be able to leverage any existing practices, processes and controls for determining significant influence to comply with the proposed changes to the Loan Provision.

D. Reasonable Inquiry Compliance Threshold

As described above, another challenge in the application of the current Loan Provision involves the difficulty in accessing information regarding the ownership percentage of an audit client for the purposes of the current 10 percent bright-line test. For example, the shares of closed-end funds are commonly held of record by broker-dealers, which may be reluctant to share information about the underlying beneficial owners. In addition, also as indicated above, institutions may be the holder of record of shares in an audit client merely as custodian or as an omnibus account holder, adding a layer, and in some cases multiple layers, of complexity to obtaining information about the underlying beneficial ownership. Moreover, a beneficial owner may object to disclosure of its name, address, and securities position to the issuer, so that issuers may be unable to obtain the beneficial ownership information for these owners.[63]

We therefore propose to amend the Loan Provision to address the concerns about accessibility to records or other information about beneficial ownership by adding a ''known through reasonable inquiry'' standard with respect to the identification of such owners. Under this proposed amendment, an audit firm, in coordination with its audit client, would be required to analyze beneficial owners of the audit client's equity securities who are known through reasonable inquiry. We believe that if an auditor does not know after reasonable inquiry that one of its lenders is also a beneficial owner of the audit client's equity securities, including because that lender invests in the audit client indirectly through one or more financial intermediaries, the auditor's objectivity and impartiality is unlikely to be impacted by its debtor-creditor relationship with the lender. This ''known through reasonable inquiry'' standard is generally consistent with regulations implementing the Investment Company Act, the Securities Act and the Exchange Act,[64] and therefore is a concept that already should be familiar to those charged with compliance with the provision.

E. Excluding Other Funds That Would Be Considered Affiliates of the Audit Client

The current definition of ''audit client'' in Rule 2–01 of Regulation S–X includes all ''affiliates of the audit client,'' which broadly encompasses, among others, each entity in an ICC of which the audit client is a part. In the fund context, this expansive definition of ''audit client'' could result in non-compliance with the Loan Provision as to a broad range of entities, even where an auditor does not audit that entity.[65] Yet, in the investment management context, investors in a fund typically do not possess the ability to influence the policies or management of another fund in the same fund complex. Although an investor in one fund in a series company can vote on matters put to shareholders of the company as a whole, rather than only to shareholders of one particular series, even an investor with a substantial investment in one series would be unlikely to have a controlling percentage of voting power of the company as a whole.

Moreover, for the purposes of the Loan Provision, the inclusion of certain entities in the ICC as a result of the definition of ''audit client'' is in tension with the Commission's original goal to facilitate compliance with the Loan Provision without decreasing its effectiveness.[66] Indeed, auditors often have little transparency into the investors of other funds in an ICC (unless they also audit those funds), and

[61] *See* 2000 Adopting Release, *supra* footnote 9, at 65 FR 76034. Rule 2–01(c)(1)(i)(E) of Regulation S–X contains several provisions that use a materiality qualifier. For example, an accountant would not be independent if it ''[h]as any material investment in an entity over which an audit client has the ability to exercise significant influence. . . .'' *See* Rule 2–01(c)(1)(i)(E)(2) of Regulation S–X. Rule 2–01(c)(1)(i)(E) of Regulation S–X also contains a significant influence provision without a materiality qualifier, in which an accountant would not be independent of its audit client when the accountant ''[h]as the ability to exercise significant influence over an entity that has the ability to exercise significant influence over an audit client.'' *See* Rule 2–01(c)(1)(i)(E)(3) of Regulation S–X.

[62] *See* Rule 2–01(f)(4) of Regulation S–X.

[63] Pursuant to Rule 14a–13(b) under the Exchange Act, an issuer may obtain from broker-dealers and banks a list of the names, addresses and securities positions of only the beneficial owners who either have consented or have not objected to having such information provided to issuers. *See* 17 CFR 240.14a–13(b).

[64] *See, e.g.,* Rule 3b–4 under the Exchange Act (stating, with respect to the definition of foreign private issuer, that ''[i]f, after reasonable inquiry, you are unable to obtain information about the amount of shares represented by accounts of customers resident in the United States, you may assume, for purposes of this definition, that the customers are residents of the jurisdiction in which the nominee has its principal place of business.); Rule 144(g) under the Securities Act (noting, with respect to ''brokers' transactions'' that ''[t]he term brokers' transactions in section 4(4) of the [Securities] Act shall for the purposes of this rule be deemed to include transactions by a broker in which such broker: . . . (4) After reasonable inquiry is not aware of circumstances indicating that the person for whose account the securities are sold is an underwriter with respect to the securities or that the transaction is a part of a distribution of securities of the issuer''); Rule 502(d) under the Securities Act (stating, with respect to limits on resales under Regulation D, that ''[t]he issuer shall exercise reasonable care to assure that the purchasers of the securities are not underwriters within the meaning of section 2(a)(11) of the [Securities] Act, which reasonable care may be demonstrated by the following: (1) Reasonable inquiry to determine if the purchaser is acquiring the securities for himself or for other persons''). Registered investment companies also are subject to a similar requirement to disclose certain known beneficial owners. *See* Item 18 of Form N–1A (''State the name, address, and percentage of ownership of each person who owns of record or is known by the Fund to own beneficially 5% or more of any Class of the Fund's outstanding equity securities.''); and Item 19 of Form N–2 (''State the name, address, and percentage of ownership of each person who owns of record or is known by the Registrant to own of record or beneficially five percent or more of any class of the Registrant's outstanding equity securities.'').

[65] For example, under the current Loan Provision, an audit firm (''Audit Firm B'') could be deemed not to be independent as to an audit client under the following facts: Audit Firm A audits an investment company (''Fund A'') for purposes of the Custody Rule. A global bank (''Bank'') has a greater than 10 percent interest in Fund A. Bank is a lender to a separate Audit Firm B, but has no lending relationship with Audit Firm A. Audit Firm B audits another investment company (''Fund B'') that is part of the same ICC as Fund A because it is advised by the same registered investment adviser as Fund A. Under these facts, Audit Firm B would not be independent under the existing Loan Provision because the entire ICC would be tainted as a result of Bank's investment relationship with Fund A.

[66] *See* 2000 Adopting Release, *supra* footnote 9, at 76035 (The Commission, in adopting an ownership threshold of 10 percent, rather than the five percent proposed, stated that ''[w]e have made this change because we believe that doing so will not make the rule significantly less effective, and may significantly increase the ease with which one can obtain the information necessary to assure compliance with this rule.'').

therefore, are likely to have little ability to collect such beneficial ownership information.

As a result, we propose, for purposes of the Loan Provision, to exclude from the definition of audit client, for a fund under audit, any other fund that otherwise would be considered an affiliate of the audit client.[67] Thus, for example, if an auditor were auditing Fund ABC, a series in Trust XYZ, the audit client for purposes of the Loan Provision would exclude all other series in Trust XYZ and any other fund that otherwise would be considered an affiliate of the audit client. The proposed amendment would, without implicating an auditor's objectivity and impartiality, address the compliance challenges associated with the application of the Loan Provision where the audit client is part of an ICC, such as when an accountant is an auditor of only one fund within an ICC, and the auditor must be independent of every other fund (and other entity) within the ICC, regardless of whether the auditor audits that fund.

III. Request for Comment

We request and encourage any interested person to submit comments on any aspect of our proposed amendments, other matters that might have an effect on the proposed amendments, and any suggestions for additional changes to other parts of Rule 2–01 of Regulation S–X. We note that comments are of greatest assistance where accompanied by supporting data and analysis of the issues addressed in those comments.

We also specifically seek comment on the following changes to the Loan Provision:

1. Focus the Analysis Solely on Beneficial Ownership

○ Should the Loan Provision be analyzed by reference to beneficial owners rather than record owners? Why or why not?

○ Would eliminating the requirement to analyze record owners under the Loan Provision ease compliance challenges described above under Section 1.B.? Is there any further guidance the Commission should provide, or should the Commission consider alternatives?

○ Would eliminating the requirement to analyze record owners under the Loan Provision raise other concerns about the independence of auditors? If so, what concerns would it raise and why?

○ If the Commission merely amended the Loan Provision to provide for evaluation of the beneficial owner, rather than record owner, would other proposed amendments be necessary or appropriate? Why or why not?

2. ''Significant Influence'' Test

○ Should we amend the Loan Provision to replace the 10 percent bright-line test with a ''significant influence'' test? Why or why not?

○ Would the proposed reference to ASC's 323's provisions for ''significant influence'' effectively identify those lending relationships that may compromise auditor independence?

○ Would amending the Loan Provision to replace the 10 percent bright-line test with a ''significant influence'' test, along with the other proposed amendments, address the compliance challenges that we identify above?

○ Application of ''significant influence'' for financial reporting purposes and evaluation of auditor independence may not necessarily be congruent. Accordingly, does ASC 323—Investments—Equity Method and Joint Ventures, provide an appropriate framework for analyzing ''significant influence'' in the context of the Loan Provision? Why or why not?

○ Are there challenges associated with implementing the ''significant influence'' test that we should consider? Will accounting firms' and audit clients' relative experience with application of the ''significant influence'' test, given its use in other contexts, mitigate any such challenges? To what extent do audit clients lack experience with application of the significant influence test, and what costs would such audit clients bear in learning to apply the test? Will funds, which may have relatively less experience than operating companies with the significant influence test, face any particular challenges in applying the test?

○ Is the proposed ''significant influence'' test sufficiently clear? Are there specific circumstances for which we should provide additional guidance? For example, we discuss above the application of the significant influence test in the fund context. Is the guidance sufficiently clear? Would the application of the significant influence test as applied to funds be effective in addressing the compliance challenges generated by the current Loan Provision while also identifying debtor-creditor relationships that may bear on an auditor's independence with respect to a fund client? Why or why not? Is there further guidance that we should provide or other approaches that we should consider?

○ Should the ''significant influence'' test (or specific elements) be codified in our rules? Why or why not?

○ Authorized participants (''APs'') for ETFs deposit or receive basket assets in exchange for creation units of the fund. We believe that the deposit or receipt of basket assets by an AP that is also a lender to the auditor alone would not constitute significant influence over an ETF audit client. Should we provide additional guidance about the proposed ''significant influence'' test with respect to APs? Similarly, should we provide additional guidance about the proposed ''significant influence'' test with respect to a market maker that is also a lender to the auditor and that engages an AP on an agency basis to create or redeem creation units of the ETF on its behalf?

○ ASC 323 includes a rebuttable presumption of 20 percent. For purposes of the Loan Provision and the proposed significant influence test, should the rebuttable presumption be lower or higher than 20 percent? Would a lower threshold (*e.g.,* 10 percent) be more likely to capture relevant independence-impairing relationships, or to result in additional false positives that the proposed rule seeks to avoid? Would setting our threshold differently than ASC 323 diminish the benefits that we seek to achieve by using an existing standard—*e.g.,* by requiring the reperformance of certain analyses at a greater degree of sensitivity? How much more complex would it be to apply a threshold other than 20 percent? Are there further relevant facts about a lower or higher threshold that we should consider?

○ Would the proposed amendment raise any new concerns regarding auditor independence (*e.g.,* are there circumstances related to lending relationships in which an auditor's independence should be considered impaired that would not be identified under the proposed ''significant influence'' test)? Conversely, would the proposed ''significant influence'' test result in an auditor's independence being considered impaired in circumstances under which the auditor should otherwise be considered independent?

○ Should we consider alternatives to this test? If so, what tests should we consider, and what would be the anticipated costs and benefits? For example, should the modifier

[67] *See* proposed Rule 2–01(c)(1)(ii)(A)(2) of Regulation S–X: ''For purposes of paragraph (c)(1)(ii)(A) of this section, the term *audit client* for a fund under audit excludes any other fund that otherwise would be considered an *affiliate of the audit client.* The term *fund* means an investment company or an entity that would be an investment company but for the exclusions provided by section 3(c) of the Investment Company Act of 1940 (15 U.S.C. 80a–3(c)).''

''significant'' be removed, such that the test hinges on whether a lender shareholder has influence over an audit client? Why or why not? What is the difference between ''influence'' and ''significant influence'' in the auditor independent context and how does that difference inform the test?

○ Should the nature of the services provided by the investment adviser be part of the significant influence test as proposed? Why or why not?

3. ''Known Through Reasonable Inquiry''

○ Should the Loan Provision include a ''known through reasonable inquiry'' standard? Why or why not? What alternatives should we consider?

○ Would the proposed ''known through reasonable inquiry'' standard with respect to identifying beneficial owners help to address compliance challenges associated with the Loan Provision?

○ Are there specific circumstances for which we should provide additional guidance about the proposed ''known through reasonable inquiry'' standard?

○ Does the ''known through reasonable inquiry'' standard raise any new concerns regarding auditor independence (*e.g.,* are there circumstances related to lending relationships in which an auditor's independence should be considered impaired that would not be identified under the proposed amendment and the use of ''known through reasonable inquiry'' standard)?

○ Alternatively, should we amend the Loan Provision to apply the significant influence test to ''known beneficial owners'' of an audit client's equity securities, without also including a reasonable inquiry standard, consistent with the way beneficial owners are treated elsewhere in Regulation S–X (that is, when assessing compliance with the Loan Provision, the determination would encompass assessing whether the known beneficial owners have significant influence over the audit client)? [68]

4. Proposed Amendment To Exclude From ''Audit Client'' Other Funds That Would Be Considered an ''Affiliate of the Audit Client''

○ Should affiliates of an audit client be excluded from the definition of ''audit client'' as it relates to the Loan Provision? Why or why not?

○ Would the proposed amendment to exclude from the term ''audit client'' for a fund under audit any other fund that otherwise would be considered an ''affiliate of the audit client'' address compliance challenges associated with the Loan Provision while still effectively identifying lending relationships that may impair auditor independence?

○ Would the proposed amendment appropriately exclude funds of an ''investment company complex'' (other than the fund under audit) that are currently within the Loan Provision's ambit?

○ Alternatively, are there other changes we should consider to the Loan Provision to appropriately exclude certain affiliated funds?

In addition to any comments regarding the proposed amendments, we also seek comment on the following potential changes to the Loan Provision and to other provisions in Rule 2–01 that we considered but determined not to propose at this time.

A. Materiality

The proposed amendments to the Loan Provision do not consider whether the lender's investment in the equity securities of the audit client is material to the lender or to the audit client.[69] We believe that adding a materiality qualifier to the proposed significant influence test is unnecessary to achieve our goal of effectively and appropriately identifying lending relationships that could pose threats to auditor independence. Nevertheless, we request comment on whether there should be a materiality qualifier as part of the Loan Provision.

○ For example, should we include a provision for assessing materiality in the Loan Provision such that an auditor's independence would only be impaired as a result of certain relationships where the lender to the auditing firm has beneficial ownership in the audit client's equity securities and that investment is material to the lender or to the audit client (and the lender has the ability to exercise significant influence over the audit client)? Would that approach more effectively identify lending relationships that are likely to threaten the auditor's objectivity and impartiality? Would focusing on the perspective of the lender, the audit client, or both be the most effective barometer of independence?

○ If we were to add a materiality qualifier to the Loan Provision as described above, which qualitative and quantitative factors should be considered in making the materiality assessment? Would such a materiality assessment add unnecessary complexity to the significant influence analysis? Would a materiality qualifier tend to exclude most lending relationships from the Loan Provision? What guidance, if any, should the Commission provide?

B. Accounting Firms' ''Covered Persons'' and Immediate Family Members

The Loan Provision is implicated with respect to loans both to and from an accounting firm, and also any ''covered person'' in the firm or any of his or her immediate family members.[70] Some of the consultations the Commission staff have had with audit firms, funds, and operating companies involved lending relationships to or from covered persons or their immediate family members.

○ Should we amend the definition of ''covered person'' for purposes of the Loan Provision or elsewhere in the auditor independence rules, and if so, how should the definition of ''covered person'' be amended?

○ In particular, taking into account the proposed ''significant influence'' test, should we, for example, remove or revise the part of the current definition that includes any partner, principal, or shareholder from an ''office'' of the accounting firm in which the lead audit engagement partner primarily practices in connection with the audit? Should all of these persons practicing out of an office from which an audit is conducted be included? Should immediate family members be removed from the definition? Why or why not?

○ In addition, the Loan Provision provides that it does not apply to certain loans made by a financial institution under its normal lending procedures, terms, and requirements, such as automobile loans and leases

[68] Under Rule 1–02(r) of Regulation S–X, ''principal holder of equity securities,'' when used in respect of a registrant or other person named in a particular statement or report, is defined to mean: ''a holder of record or a *known* beneficial owner of more than 10 percent of any class of equity securities of the registrant or other person, respectively, as of the date of the related balance sheet filed.'' (emphasis added). This approach also would be consistent with the disclosure requirements for registered funds, which require a fund to disclose information about known beneficial owners of five percent or more of the fund's securities. *See* Item 18 of Form N–1A (''State the name, address, and percentage of ownership of each person who owns of record or is known by the Fund to own beneficially 5% or more of any Class of the Fund's outstanding equity securities.''); and Item 19 of Form N–2 (''State the name, address, and percentage of ownership of each person who owns of record or is known by the Registrant to own of record or beneficially five percent or more of any class of the Registrant's outstanding equity securities.'').

[69] Certain other provisions of the existing auditor independence rules utilize a materiality qualifier. For example, an accountant is deemed not to be independent if the accountant has ''any direct financial interest or *material* indirect financial interest in the accountant's audit client.'' *See* Rule 2–01(c)(1) of Regulation S–X. (emphasis added)

[70] *See* Rule 2–01(c)(1)(ii)(A) and (f)(11) of Regulation S–X.

collateralized by the automobile. Should we consider expanding or otherwise modifying the specific types of loans that will not implicate the Loan Provision, given that the Loan Provision applies to covered persons of the accounting firm and their immediate family members? For example, should the Loan Provision address student loans or partner capital account loans? If so, how should it address them? For example, should it exclude them altogether or exclude them under certain conditions? If so, under what conditions?

C. Evaluation of Compliance

Rule 2–01(c)(1) of Regulation S–X provides that an accountant is not independent if the accountant has an independence-impairing relationship specified in the rule at any point during the audit and professional engagement period. Some existing disclosure requirements require information about beneficial owners as of a specified date.[71]

○ Should the rule provide that auditor independence may be assessed in reliance on such disclosures? Should we make any changes related to the frequency with which, the date as of which, or circumstances under which, an auditor must assess compliance with the Loan Provision or other provisions of Rule 2–01 of Regulation S–X? More specifically, should we permit the Loan Provision or other financial relationships to be assessed at specific dates during the audit and professional engagement period, or the beginnings or ends of specific periods, or under specified circumstances? If so, what would be appropriate dates, periods, or circumstances?

We believe that if the auditor determines that significant influence over the fund's management processes could not exist,[72] the auditor could monitor its independence on an ongoing basis by reevaluating its determination in response to a material change in the fund's governance structure and governing documents, publicly available information about beneficial owners, or other information which may implicate the ability of a beneficial owner to exert significant influence of which the audit client or auditor becomes aware.

○ Would this approach be sufficient for evaluating compliance with the Loan Provision? Why or why not?

D. Secondary Market Purchases of Debt

The existing Loan Provision encompasses lending arrangements that may change depending upon secondary market purchases of syndicated or other debt. For example, audit firms may issue private placement notes for financing purposes, which could then be sold on the secondary market to new purchasers thereby creating new lending relationships between the audit firm and these new secondary market purchasers.

○ Should such secondary market relationships be taken into account or excluded from the Loan Provision? Do secondary market relationships raise concerns about auditor independence?

E. Other Changes to the Commission's Auditor Independence Rules

○ Should we make other changes to our auditor independence rules? If so, which rules and why?

○ Would our proposed amendments have any unintended impact on other professional standards that may exist, such as the requirements of the PCAOB, professional societies, or state boards of accountancy?

IV. Paperwork Reduction Act

The amendments we are proposing do not impose any new ''collections of information'' within the meaning of the Paperwork Reduction Act of 1995 (''PRA''),[73] nor do they create any new filing, reporting, recordkeeping, or disclosure requirements. Accordingly, we are not submitting the proposed amendments to the Office of Management and Budget for review in accordance with the PRA.[74] We request comment on whether our conclusion that there are no collections of information is correct.

V. Economic Analysis

The Commission is proposing to amend the Loan Provision in Rule 2–01 of Regulation S–X by: (1) Focusing the analysis solely on beneficial ownership; (2) replacing the existing 10 percent bright-line equity shareholder ownership test with a ''significant influence'' test; (3) adding a ''known through reasonable inquiry'' standard with respect to identifying beneficial owners of the audit client's equity securities; and (4) amending the definition of ''audit client'' for a fund under audit to exclude from the provision funds that otherwise would be considered affiliates of the audit client.

Under existing rules, the bright-line test does not recognize an accountant as independent if the accounting firm, any covered person in the firm, or any of his or her immediate family members has any loan to or from an audit client or an audit client's officers, directors, or record or beneficial owners of more than 10 percent of the audit client's equity securities. In terms of the scope of the ''audit client'' definition, the existing rule is generally broad, including as it relates to an audit client in an ICC.[75] As discussed above, Commission staff has engaged in extensive consultations with audit firms, funds, and operating companies regarding the application of the Loan Provision. These consultations revealed that a number of entities face significant practical challenges to compliance with the Loan Provision. These discussions also revealed that in certain scenarios, in which the Loan Provision was implicated, the auditor's objectivity and impartiality in performing the required audit and interim reviews were not impaired.

We are mindful of the costs imposed by and the benefits obtained from our rules and amendments.[76] The following economic analysis seeks to identify and consider the likely benefits and costs that would result from the proposed amendments, including their effects on efficiency, competition, and capital formation. The discussion below elaborates on the likely economic effects of the proposed rules.

A. General Economic Considerations

Given that the actions of fund and operating company management are not usually observable, the information contained in mandated financial reports is important to investors, because it serves as a summary measure of outcomes of managerial actions and

[71] *See e.g.,* Item 18 of Form N–1A and Item 19 of Form N–2.

[72] For funds, the auditor's initial determination would be based on an evaluation of a fund's governance structure and governing documents, the manner in which its shares are held or distributed, and any contractual arrangements, among any other relevant factors.

[73] 44 U.S.C. 3501 *et. seq.*

[74] 44 U.S.C. 3507(d) and 5 CFR 1320.11.

[75] *See supra* footnote 16 and accompanying text.

[76] Section 2(b) of the Securities Act [15 U.S.C. 77b(b)], Section 3(f) of the Exchange Act [17 U.S.C. 78c(f)], Section 2(c) of the Investment Company Act [15 U.S.C. 80a–2(c)], and Section 202(c) of the Investment Advisers Act [15 U.S.C. 80b–2(c)] require the Commission, when engaging in rulemaking where it is required to consider or determine whether an action is necessary or appropriate in the public interest, to consider, in addition to the protection of investors, whether the action will promote efficiency, competition and capital formation. Additionally, Section 23(a)(2) of the Exchange Act [15 U.S.C. 78w(a)(2)] requires us, when adopting rules under the Exchange Act, to consider, among other things, the impact that any new rule would have on competition and not to adopt any rule that would impose a burden on competition that is not necessary or appropriate in furtherance of the Exchange Act.

decisions.[77] However, financial reports are prepared by agents, and given the possibility that agents may have incentives to take actions that are not in the best interest of shareholders, agents may also have incentives to misreport such decisions and their outcomes. In order for the reported information to be useful to investors, it needs to be relevant and reliable. The independent audit of such information by impartial skilled professionals (*i.e.,* auditors) is intended to create reliability in financial reports.[78] Any potential conflicts of interest between companies or funds and their auditors may impair the objectivity and impartiality of the auditors in certifying the reported performance, thus lowering the credibility and usefulness of these disclosures to investors. Academic literature discusses and documents the importance of the role of auditors as an external governance mechanism for the firm.[79] These studies generally find that better audit quality improves financial reporting by increasing the credibility of the financial reports.

An accounting firm is not independent under the Loan Provision's existing bright-line shareholder ownership test if the firm has a lending relationship with an entity having record or beneficial ownership of more than 10 percent of the equity securities of either (a) the firm's audit client; or (b) any ''affiliate of the audit client,'' including, but not limited to, any entity that is a controlling parent company of the audit client, a controlled subsidiary of the audit client, or an entity under common control with the audit client. The magnitude of a party's investment in a company or fund is likely to be positively related with any incentive of that party to use leverage over the auditor with whom the party has a lending relationship, to obtain personal gain.

The 10 percent bright-line test in the Loan Provision does not, however, distinguish between holders of record and beneficial owners even though beneficial owners are more likely to pose a risk to auditor independence than record owners given that the financial gain of beneficial owners is tied to the performance of their investment, and as such, beneficial owners may have strong incentives to influence the auditor's report. Record owners, on the other hand, may not benefit from the performance of securities of which they are record owners, and as such, they may have low incentives to influence the report of the auditor. Both the magnitude as well as the type of ownership are likely to be relevant factors in determining whether incentives exist for actions that could impair auditor independence. Beneficial ownership of more than 10 percent of a company's or fund's equity securities by a lender to the company's or fund's auditor is likely to pose a more significant risk to auditor independence than record ownership of more than 10 percent of the company's or fund's securities by the same lender.

The current Loan Provision may in some cases over-identify and in other cases under-identify threats to auditor independence. The likelihood that the provision over-identifies threats to auditor independence will tend to be higher when the lender is not a beneficial owner of an audit client and does not have incentives to influence the auditor's report, but has record holdings that exceed the 10 percent ownership threshold. On the other hand, under-identification of the threat to auditor independence may occur when the lender is a beneficial owner—implying the existence of potential incentives to influence the auditor's report—and the investment is close to, but does not exceed, the 10 percent ownership threshold.[80]

We are not aware of academic studies that specifically examine the economic effects of the Loan Provision. The remainder of the economic analysis presents the baseline, anticipated benefits and costs from the proposed amendments, potential effects on efficiency, competition and capital formation, and alternatives to the proposed amendments.

B. Baseline

The proposed amendments would change the Loan Provision compliance requirements for the universe of affected registrants. We believe the main affected parties would be audit clients, audit firms, and institutions engaging in financing transactions with audit firms and their partners and employees. Other parties that may be affected are covered persons and their immediate family members. Indirectly, the proposed amendment would affect audit clients' investors.

We are not able to precisely estimate the number of current auditor engagements that would be immediately affected by the proposed amendments. Specifically, precise data on how audit firms finance their operations and how covered persons arrange their personal financing are not available to us and as such we are not able to identify pairs of auditors-institutions (lenders). Moreover, sufficiently detailed and complete data on fund ownership are not available to us, thus limiting our ability to estimate the prevalence/frequency of instances of significant fund ownership by institutions that are also lenders to fund auditors.

Although data on fund ownership are not readily available, academic studies of operating companies have shown that for a selected sample of firms, the average blockholder (defined as beneficial owners of five percent or more of a company's stock) holds about 8.5percent of a company's voting stock.[81] They also show that numerous banks and insurance companies are included in the list of blockholders. These findings suggest that the prevalence of instances of significant ownership by institutions that are also lenders to auditors could be high.

As mentioned above, the proposed amendments would impact audits for the universe of affected entities. The baseline analysis below focuses mainly on the investment management industry because that is where the most widespread issues with Loan Provision compliance have been identified to date; however, the proposed amendments would affect entities outside of this space.[82]

In Table 1, as of December 2017, there were around 12,000 fund series, with total net assets of $21 trillion, that file Form N–SAR with identified accounting firms.[83] In addition, there were 23

[77] We use the terms agent and manager interchangeably.

[78] *See* M. Defond & J. Zhang, *A Review of Archival Auditing Research,* 58 J. Acct. & Econ. 275–326 (2014).

[79] *See e.g.,* N. Tepalagul & L. Lin, *Auditor Independence and Audit Quality: A Literature Review,* 30 J. Acct. Audit. & Fin. 101–121 (2015); M. Defond & J. Zhang, *A Review of Archival Auditing Research,* 58 J. Acct. & Econ. 275–326 (2014); Y. Chen, S. Sadique, B. Srinidhi, & M. Veeraraghavan, *Does High-Quality Auditing Mitigate or Encourage Private Information Collection?;* and R. Ball, S. Jayaraman & L. Shivakumar, *Audited Financial Reporting and Voluntary Disclosure as Complements: A Test of the Confirmation Hypothesis,* J. Acct. & Econ. 53(1): 136–166 (2012).

[80] We are unable to estimate the extent to which the 10 percent ownership threshold may over- or under-identify threats to independence because public data do not exist.

[81] *See* Y. Dou, O. Hope, W. Thomas & Y. Zou, *Blockholder Heterogeneity and Financial Reporting Quality,* working paper (2013).

[82] According to the SEC's EDGAR database, during the period from January 1, 2017 to December 31, 2017, there were a total of 7,585 entities that filed at least one Form 10–K, 20–F, or 40–F, or an amendment to one of these forms. This total does not include investment companies and business development companies.

[83] There are certain limitations regarding information reported on Form N–SAR and, as a result, this does not include information for all registered investment companies. If we were to incorporate private funds, the number would be

accounting firms performing audits for these investment companies, though these auditing services were concentrated among the four largest accounting firms. Indeed, about 88 percent of the funds were audited by the four largest accounting firms, corresponding to 98percent of the aggregate fund asset value.[84]

TABLE 1—INVESTMENT COMPANY AUDITORS AND THEIR AUDITED FUND SERIES

[N–SARs filed for period dates: June 2017–December 2017]

Total number of Fund Series	11,666
Average number of Fund Series Per Auditor	507
Average Net Assets (in millions) Per Auditor	907,813
Four Largest Audit Firms	
Total number of Fund Series	10,177
Average number of Fund Series Per Auditor	2,544
Average Net Assets (in millions) Per Auditor	5,137,472
% of Four Audit Firms by Series	87
% of Four Audit Firms by Net Assets	98

One key feature of the current rule is that the scope of the auditor independence rules, including the Loan Provision, extends beyond the audit client to encompass affiliates of the audit client. According to Morningstar Direct, as of December 31, 2017, 586 out of 977 fund families[85] (excluding closed-end funds) have more than one fund, 180 have at least 10 funds, 59 have more than 50 funds, and 38 have more than 100 funds. According to the Investment Company Institute, also as of December 31, 2017, there were more than 11,188 open-end funds and around 5,500 closed-end funds, with many funds belonging to the same fund family. Given that many fund complexes have several funds with some complexes having several hundreds of funds, if any auditor is deemed not in compliance with the Loan Provision with respect to one fund, under the current rule it cannot audit any of the hundreds of other funds within the same ICC.

In response to compliance challenges and as discussed above, Commission staff issued the Fidelity No-Action Letter to provide relief from the uncertainty surrounding compliance with the Loan Provision. The Fidelity No-Action Letter, however, did not resolve all compliance uncertainty, was limited in scope and provided staff-level relief to the requestor based on the specific facts and circumstances in the request, and did not amend the underlying rule. Staff continues to receive inquiries from registrants and accounting firms regarding the application of the Loan Provision, clarification of the application of the Fidelity No-Action Letter, and requests for consultation regarding issues not covered in the Fidelity No-Action Letter. As a result of the remaining compliance uncertainty, auditors and audit committees may spend a significant amount of time and effort to comply with the Loan Provision.

C. Anticipated Benefits and Costs, and Unintended Consequences

1. Anticipated Benefits

Overall, we anticipate monitoring for non-compliance throughout the reporting period would be less burdensome for registrants under the proposed amendments. For example, based on the 10 percent bright-line test, an auditor may be in compliance at the beginning of the reporting period. However, the percentage of ownership may change during the reporting period, which may result in an auditor becoming non-compliant, even though there may be no threat to the auditor's objectivity or impartiality. Further, a higher threshold (20 percent) for presumed significant influence, as well as a qualitative framework for assessing what constitutes significant influence, could better identify a lack of independence.

There are also potential benefits associated with excluding record holders from the Loan Provision. Currently, the Loan Provision uses the magnitude of ownership by an auditor's lender as an indication of the likelihood of a threat to auditor independence regardless of the nature of ownership. From an economic standpoint, the nature of ownership also could determine whether incentives as well as the ability of the lender to use any leverage (due to the lending relationship) over the auditor exist that could affect the objectivity of the auditor. For example, a lender that is a record owner of the audit client's equity securities may be less likely to attempt to influence the auditor's report than a lender that is a beneficial owner of the audit client's equity securities. By taking into account the nature as well as the magnitude of ownership, the proposed amendments would focus on additional qualitative information to assess the relationship between the lender and the investee (*e.g.,* a company or fund). Thus, we believe that, where there may be weak incentives by the lender to influence the audit, as when the lender is only a holder of record, the proposed amendments would exclude relationships that are not likely to be a risk to auditor independence. The proposed amendments would thus provide benefits to the extent that they would alleviate compliance and related burdens that auditors and funds would otherwise undertake to analyze debtor-creditor relationships that are not likely to threaten an auditor's objectivity and impartiality. Affected registrants also would be less likely to disqualify auditors in situations that do not pose a risk to auditor independence, thereby reducing auditor search costs for these entities.

The potential expansion of the pool of eligible auditors also could result in better matching between the auditor and the client. For example, auditors tend to exhibit a degree of specialization in certain industries.[86] If specialized auditors are considered not to be independent due to the Loan Provision, then an auditor without the relevant specialization may be selected by companies to perform the audit. Such an outcome could impact the quality of the audit, and as a consequence negatively impact the quality of financial reporting, and therefore the users of information contained in audited financial reports. In addition, this outcome also may lead to less specialized auditors expending more time to perform the audit service, thereby increasing audit fees for registrants. We anticipate that the proposed amendments likely would positively impact audit quality for scenarios such as the one described above. Relatedly, if the proposed amendments expand the pool of eligible auditors, we expect increased competition among auditors, which could reduce the cost of audit services

significantly larger; the assets under management of private funds are also large.

[84] According to the 2017 PCAOB Annual Report, there were 535 audit firms registered with the PCAOB that have issued audit reports for issuers (of which 338 are domestic audit firms, with the remaining 197 audit firms located outside the United States). The concentration in the provision of audit services for investment companies is indicative of the overall market as well. According to a report by Audit Analytics, the four largest accounting firms audit 76% of accelerated and large accelerated filers, which account for 97.9% of the market capitalization for public companies. *See Who Audits Larger Public Companies-2016 Edition, available at http://www.auditanalytics.com/blog/who-audits-larger-public-companies-2016-edition.*

[85] These fund statistics are based on information available from Morningstar Direct, and may not represent the universe of fund companies.

[86] *See e.g.,* N. Dopuch & D. Simunic, *Symposium, Competition in Auditing: An Assessment,* Fourth Symposium on Auditing Research, p 401–450 (1982); and R.W. Knechel, V. Naiker & G. Pachecho, *Does Audit Industry Specialization Matter? Evidence from Market Reaction to Auditor Switches,* 26 Audit. J. Prac. & Theory 19–45 (2007).

to affected companies and, if such cost savings are passed through to investors, could result in a lower cost to investors. However, as discussed in Section V.B above, the audit industry is highly concentrated, and as a consequence, such a benefit may not be significant.[87]

Another potential benefit of the proposed amendments is that the replacement of the bright-line test with the significant influence test could potentially identify risks to auditor independence that might not have been identified under the existing 10 percent bright-line test. For example, a beneficial owner that holds slightly less than 10 percent of an audit client's equity securities is likely to have similar incentives and ability to influence the auditor's report than a beneficial owner that holds the same audit client's equity securities at slightly above the 10 percent threshold. The existing Loan Provision itself would differentially classify these two hypothetical situations, despite their similarity. To the extent that the proposed amendments are able to improve identification of potential risks to auditor independence through the use of qualitative criteria, then investors are likely to benefit from the proposed amendments. In the example above, under the proposed amendments, an audit firm would evaluate both beneficial owners to determine if they have significant influence, thus providing a consistent analysis under the Loan Provision for these economically similar fact patterns.

In addition, there may be instances in which non-compliance with the Loan Provision may occur during the reporting year, after an auditor is selected by the registrant or fund. Particularly for companies in the investment management industry, an auditor may be deemed to comply with the Loan Provision using the bright-line test when the auditor is hired by the fund but, due to external factors, such as redemption of investments by other owners of the fund during the period, the lender's ownership level may increase and exceed 10 percent. Such outcomes would be less likely under the proposed amendments, which take into account multiple qualitative factors in determining whether the Loan Provision is implicated during the period.[88] We anticipate that the proposed amendments would likely mitigate changes in auditors' independence status and mitigate any negative consequences that can arise from uncertainty about compliance and the associated costs to the funds or companies involved and their investors.

The proposed amendment to add a ''known through reasonable inquiry'' standard could potentially improve the practical application of the significant influence test. As described above, some of the challenges to compliance with the existing Loan Provision involve the lack of access to information about the ownership percentage of a fund that was also an audit client. If an auditor does not know that one of its lenders is also an investor in an audit client, including because that lender invests in the audit client indirectly through one or more financial intermediaries, the auditor's objectivity and impartiality may be less likely to be impacted by its debtor-creditor relationship with the lender. The proposed ''known through reasonable inquiry'' standard is generally consistent with regulations implementing the Investment Company Act, the Securities Act and the Exchange Act,[89] and therefore is a concept that already should be familiar to those charged with compliance with the provision. The proposed standard is expected to reduce the compliance costs for audit firms as they could significantly reduce their search costs for information and data to determine beneficial ownership. Given that this would not be a new standard in the Commission's regulatory regime, we do not expect a significant adjustment to apply the ''known through reasonable inquiry'' standard for auditors and their audit clients.

The proposal to amend the definition of ''audit client'' to exclude any fund not under audit but that otherwise would be considered an ''affiliate of the audit client'' could potentially lead to a larger pool of eligible auditors, potentially reducing the costs of switching auditors, and potentially creating better matches between auditors and clients. In addition, the larger set of potentially eligible auditors could lead to an increase in competition among auditors for clients, and improved matching between auditor specialization and client needs. Though the concentrated nature of the audit industry may not give rise to a significant increase in competition, the improved matching between specialized auditors and their clients should have a positive effect on audit quality.

The proposed amendments could also have a positive impact on the cost of audit firms' financing. The proposed amendments may result in an expanded set of choices among existing sources of financing. This could lead to more efficient financing activities for audit firms, thus potentially lowering the cost of capital for audit firms.[90] If financing costs for audit firms decrease as a result of the proposed amendments, then such savings may be passed on to the audit client in the form of lower audit fees. Investors also may benefit from reduced audit fees if the savings are passed on to investors. The Commission understands, however, that audit firms likely already receive favorable financing terms. Therefore, this effect may not be significant in practice.

The replacement of the bright-line 10 percent test with the significant influence test also potentially allows more financing channels for the covered persons in accounting firms and their immediate family members.[91] For example, the covered persons may not be able to borrow money from certain lenders due to potential non-compliance with the existing Loan Provision. A larger set of financing channels may potentially lead to lower cost of capital for covered persons, increasing their opportunities for investment.

2. Anticipated Costs and Potential Unintended Consequences

The proposed significant influence test may increase the demands on the time of auditors and audit clients to familiarize themselves with the test and gather and assess the relevant information to apply the test. However, given that the significant influence test has been part of the Commission's auditor independence rules since 2000 and has existed in U.S. GAAP since 1971, we do not expect a significant learning curve in applying the test. We also do not expect significant compliance costs for auditors to implement the significant influence test

[87] The proposed amendments could result in some crowding-out effect, as the four largest audit firms may be deemed to be independent with more clients under the proposed amendments, crowding out small audit firms. We discuss this effect in more detail in Section V.D below. However, we believe that better matching between auditor specialization and their clients and the reduced unnecessary auditor turnovers could potentially prevent audit quality decline and in the long run may improve audit quality.

[88] The concept of significant influence, as described in ASC Topic 323, Investments—Equity Method and Joint Ventures, incorporates a rebuttable presumption of significant influence once beneficial ownership exceeds 20% of an audit client's securities. We discuss the effects of this provision in Section II.C above.

[89] *See supra* footnote 64.

[90] Studies on capital markets across countries suggest that better access to financing leads to more investment efficiency. *See e.g.,* T. Rice & P. Strahan, *Does Credit Competition Affect Small-Firm Finance,* 65 J. Fin. 861–889 (2010); R. Mclean, T. Zhang & M. Zhao, *Why does the Law Matter? Investor Protection and its Effects on Investment, Finance, and Growth,* 67 J. Fin. 313–350 (2012); and J. Wurgler, *Financial Markets and the Allocation of Capital,* 58 J. Fin. 187–214 (2000).

[91] *See supra* footnote 11.

in the context of the Loan Provision given that they already are required to apply the concept in other parts of the auditor independence rules. We recognize that funds do not generally apply a significant influence test for financial reporting purposes. As such, despite the fact that they are required to apply the significant influence test to comply with the existing Commission independence rules, their overall familiarity in other contexts may be less. As a result, the proposed significant influence test may increase the demands on the time of funds and their auditors to gather and assess the relevant information and attendant costs.

The replacement of the bright-line threshold test with the significant influence test and the ''known through reasonable inquiry'' standard would introduce more judgment in the determination of compliance with the Loan Provision. As discussed earlier, the significant influence test contains multiple qualitative elements to be considered in determining whether an investor has significant influence over the operating and financial policies of the investee. These elements include, but are not limited to, representation on the board of directors; participation in policy-making processes; material intra-entity transactions; interchange of managerial personnel; and technological dependency. To the extent an auditor and audit client need to adjust their compliance activities to now focus on these new elements, there may be additional transition costs. The judgment involved in application of the significant influence test also could lead to potential risks regarding auditor independence. In particular, because the significant influence test relies on qualitative factors that necessarily involve judgment, there is a risk that the significant influence test could result in mistakenly classifying a non-independent auditor as independent under the Loan Provision. However, auditor reputational concerns may impose some discipline on the application of the significant influence test in determining compliance with the Loan Provision, thus mitigating this risk.

D. Effects on Efficiency, Competition and Capital Formation

The Commission believes that the proposed amendments are likely to improve the practicality of the Loan Provision, enhance efficiency of implementation, and reduce compliance burdens. They also may facilitate capital formation.

The proposed amendments may expand a particular audit client's choices by expanding the number of auditors that meet the auditor independence rules under the Loan Provision. As discussed earlier, the current bright-line test may be over-inclusive under certain circumstances. If more audit firms are eligible to undertake audit engagements without implicating the Loan Provision, then audit clients will have more options and as a result audit costs may decrease, although given the highly concentrated nature of the audit industry, this effect may not be significant. Moreover, the potential expansion of choice among eligible audit firms and the reduced threat of being required to switch auditors may lead to better matching between the audit client and the auditor. Improved matching between auditor specialties and audit clients could enable auditors to perform auditing services more efficiently, thus potentially reducing audit fees and increasing audit quality over the long term. Higher audit quality is linked to better financial reporting, which could result in a lower cost of capital. Reduced expenses and higher audit quality may decrease the overall cost of investing as well as the cost of capital, with potential positive effects on capital formation. However, due to the concentrated nature of the audit industry, we acknowledge that any such effects may not be significant.

The replacement of the existing bright-line test with the significant influence test could more effectively capture those relationships that may pose a threat to an auditor's objectivity and impartiality. To the extent that the proposed amendments do so, the quality of financial reporting is likely to improve, and the amount of board attention to independence questions when impartiality is not at issue is likely to be reduced, thus allowing a fund board to focus on its role as an independent check on fund management. An operating company's board might focus on hiring the best management, choosing the most value-enhancing investment projects, and monitoring management to maximize shareholder value. This sharpened focus could potentially benefit shareholders. Furthermore, we expect that improved identification of threats to auditor independence would increase investor confidence about the quality and accuracy of the information reported. Reduced uncertainty about the quality and accuracy of financial reporting should attract capital, and thus facilitate capital formation.

Under the proposed amendments, audit firms would potentially be able to draw upon a larger set of lenders. This potentially could lead to greater competition among the lending institutions, leading to lower borrowing costs for audit firms. Again, this could result in lower audit fees, lower fund fees, lower compliance expenses, and help facilitate capital formation, to the extent that lower borrowing costs for audit firms get passed on to their audit clients.

The proposed amendments also may potentially lead to changes in the competitive structure of the audit industry. We expect more accounting firms to be eligible to provide auditing services and be in compliance with auditor independence under the proposed amendments. If the larger audit firms are the ones more likely to engage in significant financing transactions and are more likely to not be in compliance with the existing Loan Provision, then these firms are more likely to be positively affected by the proposed amendments. In particular, these firms may be able to compete for or retain a larger pool of audit clients. At the same time, the larger firms' potentially increased ability to compete for audit clients could potentially crowd out the auditing business of smaller audit firms. However, we estimate that four audit firms already perform 88 percent of audits in the registered investment company space.[92] As a result, we do not expect any potential change in the competitive dynamics among auditors for registered investment companies to be significant.

E. Alternatives

The existing Loan Provision covers loans to and from the auditor by ''record or beneficial owners of more than 10 percent of the audit client's equity securities.'' As discussed earlier, record owners are relatively less likely to have incentives to take actions that would threaten auditor independence than are beneficial owners. An alternative approach to the proposed amendments would be to maintain the 10 percent bright-line test, but to distinguish between types of ownership under the 10 percent bright-line test and tailor the rule accordingly. For example, record owners could be excluded from the 10 percent bright-line test, to which beneficial owners would remain subject. The potential benefit of distinguishing

[92] The market share of the four largest accounting firms in other industries is significantly high as well. According to the sample of 7,180 registrants covered by Audit Analytics in 2016, the four largest accounting firms' mean (median) market share across industries (based on two digit standard industry code) is 58% (57%). The upper quartile is as high as 78% with low quartile of the distribution being 45%.

between types of ownership while retaining the 10 percent bright-line test is that applying a bright-line test would involve less judgment than the proposed significant influence test. Excluding record holders that may not have strong enough economic incentives or power to impair auditor independence could partially overcome the over-inclusiveness of the exiting rule. However, it still would not overcome the issues of over- or under-inconclusiveness with respect to beneficial owners.

A second alternative would be to use the materiality of a stock holding to the lender in conjunction with the significant influence test as a proxy for incentives that could threaten auditor independence. Specifically, the significance of the holding to the lender could be assessed based on the magnitude of the stock holding to the lender (*i.e.,* what percentage of the lender's assets are invested in the audit client's equity securities), after determining whether the lender has significant influence over the audit client. For example, two institutions that hold 15 percent of a fund may be committing materially different amounts of their capital to the specific investment. The incentives to influence the auditor's report are likely to be stronger for the lender that commits the relatively larger amount of capital to a specific investment. As such, the materiality of the investment to a lender with significant influence could be used as an indicator of incentives by the lender to attempt to influence the auditor's report. Materiality of a holding may better capture the incentives that could pose a threat to auditor independence. The potential cost to the auditors and audit clients could be that they need additional information and an additional layer of judgment in assessing their compliance with the Loan Provision. Also, given the size of most lenders, a materiality component might effectively exclude most, if not all, lending relationships that pose a threat to an auditor's objectivity and impartiality.

A third potential approach would be to assess the materiality of the lending relationship between the auditor and the lending institution. The materiality of the lending relationship between the lender and the auditor, from both the lender's and the auditor's point of views, could act as an indicator of the leverage that the lender may have if it attempts to influence the auditor's report. However, again, given the size of most impacted audit firms and lenders, a materiality component might effectively exclude most, if not all, lending relationships that pose a threat to an auditor's objectivity and impartiality.

F. Request for Comment

We request and encourage any interested person to submit comments regarding the proposed amendments and all aspects of our analysis of the potential effects of the amendments. Comments are particularly helpful to us if accompanied by quantified estimates or other detailed analysis and supporting data regarding the issues addressed in those comments. We also are interested in comments on the alternatives presented in this release as well as any additional alternatives to the proposed amendments that should be considered. To assist in our consideration of these costs and benefits, we specifically request comment on the following:

- The costs and benefits of the proposed amendment to eliminate the requirement that audit firms analyze record holders under the Loan Provision.
- The costs and benefits of the proposed significant influence test.
- The costs and benefits of the proposed addition of a ''known through reasonable inquiry'' standard in applying the significant influence test.
- The costs and benefits of the proposed exclusion of the funds (other than the fund under audit) from being considered an affiliate of the audit client.
- The effect of the proposed amendments on the competitive structure of the audit industry.
- The effect of the proposed amendments on the quality of financial reporting.
- The effect of the proposed amendments on audit quality.
- The effect of the proposed amendments on capital formation.
- The effect of the proposed amendments on audit firms and their covered persons' financing.

VI. Initial Regulatory Flexibility Act Analysis

The Regulatory Flexibility Act (''RFA'') [93] requires the Commission, in promulgating rules under section 553 of the Administrative Procedure Act,[94] to consider the impact of those rules on small entities. We have prepared this Initial Regulatory Flexibility Act Analysis (''IRFA'') in accordance with 5 U.S.C. 603. This IRFA relates to the proposed amendments to Rule 2–01 of Regulation S–X.

A. Reasons for and Objectives of the Proposed Action

As discussed above, the primary reason for, and objective of, the proposed amendments is to address certain significant compliance challenges for audit firms and their clients resulting from application of the Loan Provision that do not otherwise appear to affect the impartiality or objectivity of the auditor. Specifically, the proposed amendments would:

- Focus the analysis solely on beneficial ownership;
- replace the existing 10 percent bright-line shareholder ownership test with a ''significant influence'' test;
- add a ''known through reasonable inquiry'' standard with respect to identifying beneficial owners of the audit client's equity securities; and
- amend the definition of ''audit client'' for a fund under audit to exclude from the provision funds that otherwise would be considered affiliates of the audit client.

The reasons for, and objectives of, the proposed rules are discussed in more detail in Sections I and II above.

B. Legal Basis

We are proposing the amendments pursuant to Schedule A and Sections 7, 8, 10, and 19 of the Securities Act, Sections 3, 10A, 12, 13, 14, 17, and 23 of the Exchange Act, Sections 8, 30, 31, and 38 of the Investment Company Act, and Sections 203 and 211 of the Investment Advisers Act.

C. Small Entities Subject to the Proposed Rules

The proposed amendments would affect small entities that file registration statements under the Securities Act, the Exchange Act, and the Investment Company Act and periodic reports, proxy and information statements, or other reports under the Exchange Act or the Investment Company Act, as well as smaller registered investment advisers and smaller accounting firms. The RFA defines ''small entity'' to mean ''small business,'' ''small organization,'' or ''small governmental jurisdiction.'' [95] The Commission's rules define ''small business'' and ''small organization'' for purposes of the Regulatory Flexibility Act for each of the types of entities regulated by the Commission. Securities Act Rule 157 [96] and Exchange Act Rule 0–10(a) [97] defines an issuer, other than

[93] 5 U.S.C. 601 *et seq.*

[94] 5 U.S.C. 553.

[95] 5 U.S.C. 601(6).

[96] 17 CFR 230.157.

[97] 17 CFR 240.0–10(a).

an investment company, to be a ''small business'' or ''small organization'' if it had total assets of $5 million or less on the last day of its most recent fiscal year. We estimate that there are approximately 1,163 issuers, other than registered investment companies, that may be subject to the proposed amendments.[98] The proposed amendments would affect small entities that have a class of securities that are registered under Section 12 of the Exchange Act or that are required to file reports under Section 15(d) of the Exchange Act. In addition, the proposed amendments would affect small entities that file, or have filed, a registration statement that has not yet become effective under the Securities Act and that has not been withdrawn.

An investment company is considered to be a ''small business'' for purposes of the RFA, if it, together with other investment companies in the same group of related investment companies, has net assets of $50 million or less at the end of the most recent fiscal year.[99] We believe that the proposed amendments would affect small entities that are investment companies. Commission staff estimates that, as of December 31, 2017, there were 54 open-end investment companies (within 52 fund complexes) that would be considered small entities. This number includes open-end ETFs.[100]

For purposes of the RFA, an investment adviser is a small entity if it:

(1) Has assets under management having a total value of less than $25 million;

(2) did not have total assets of $5 million or more on the last day of the most recent fiscal year; and

(3) does not control, is not controlled by, and is not under common control with another investment adviser that has assets under management of $25 million or more, or any person (other than a natural person) that had total assets of $5 million or more on the last day of its most recent fiscal year.[101] We estimate that there are approximately 557 investment advisers that would be subject to the proposed amendments that may be considered small entities.[102]

For purposes of the RFA, a broker-dealer is considered to be a ''small business'' if its total capital (net worth plus subordinated liabilities) is less than $500,000 on the date in the prior fiscal year as of which its audited financial statements were prepared pursuant to Rule 17a–5(d) under the Exchange Act,[103] or, if not required to file such statements, a broker-dealer with total capital (net worth plus subordinated liabilities) of less than $500,000 on the last day of the preceding fiscal year (or in the time that it has been in business, if shorter); and that is not affiliated with any person (other than a natural person) that is not a small business or small organization.[104] As of the year end of 2017, there are approximately 1,042 small entity broker-dealers that may be subject to the proposed amendments.[105]

Our rules do not define ''small business'' or ''small organization'' for purposes of accounting firms. The Small Business Administration (SBA) defines ''small business,'' for purposes of accounting firms, as those with under $20.5 million in annual revenues.[106] We have limited data indicating revenues for accounting firms, and we cannot estimate the number of firms with less than $20.5 million in annual revenue. We request comment on the number of accounting firms with revenue under $20.5 million.

D. Projected Reporting, Recordkeeping and Other Compliance Requirements

The proposed amendments would not impose any reporting, recordkeeping, or disclosure requirements. The proposed amendments would impose new compliance requirements with respect to the Loan Provision.

Although we are proposing to replace the 10 percent bright-line test with a ''significant influence'' test that requires the application of more judgment, we believe that the proposed amendments would not significantly increase costs for smaller entities, including smaller accounting firms. The concept of ''significant influence'' already exists in the auditor independence rules and in U.S. GAAP,[107] and accounting firms, issuers and their audit committees are already required to apply the concept in these contexts and may have developed practices, processes or controls for complying with these provisions.[108] We believe that these entities likely would be able to leverage any existing practices, processes or controls to comply with the proposed amendments.

We also believe that the proposed ''known through reasonable inquiry'' standard would not significantly increase costs for smaller entities, including smaller accounting firms. The ''known through reasonable inquiry'' standard is generally consistent with regulations implementing the Investment Company Act, the Securities Act and the Exchange Act.[109] Smaller entities, including smaller accounting firms, should therefore already be familiar with the concept.

In addition, we believe that the proposed amendments to exclude record owners and certain fund affiliates for purposes of the Loan Provision would reduce costs for smaller entities, including smaller accounting firms.

Compliance with the proposed amendments would require the use of professional skills, including accounting and legal skills. The proposed amendments are discussed in detail in Section II above. We discuss the economic impact, including the estimated costs, of the proposed amendments in Section V (Economic Analysis) above.

E. Duplicative, Overlapping, or Conflicting Federal Rules

We believe that the proposed amendment would not duplicate, overlap or conflict with other federal rules.

F. Significant Alternatives

The RFA directs us to consider alternatives that would accomplish our stated objectives while minimizing any significant adverse impacts on small entities. In connection with the proposed amendments, we considered certain types of alternatives, including:

(1) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities;

(2) The clarification, consolidation or simplification of compliance and reporting requirements under the rule for small entities;

(3) The use of performance rather than design standards; and

[98] This estimate is based on staff analysis of XBRL data submitted with EDGAR filings of Forms 10–K, 20–F and 40–F and amendments filed during the calendar year of January 1, 2017 to December 31, 2017.

[99] 17 CFR 270.0–10(a).

[100] This estimate is derived from an analysis of data obtained from Morningstar Direct as well as data reported on Form N–SAR filed with the Commission for the period ending June 30, 2017.

[101] 17 CFR 275.0–7.

[102] This estimate is based on Commission-registered investment adviser responses to Form ADV, Part 1A, Items 5.F and 12.

[103] 17 CFR 240.17a–5(d).

[104] 17 CFR 240.0–10(c).

[105] This estimate is based on the most recent information available, as provided in Form X–17A–5 Financial and Operational Combined Uniform Single Reports filed pursuant to Section 17 of the Exchange Act and Rule 17a–5 thereunder.

[106] 13 CFR 121.201 and North American Industry Classification System (NAICS) code 541211. The SBA calculates ''annual receipts'' as all revenue. *See* 13 CFR 121.104.

[107] *See supra* footnote 48; *see also* ASC 323, *supra* footnote 49.

[108] Although the concept of ''significant influence'' is not as routinely applied today in the funds context for financial reporting purposes, nevertheless, the concept of significant influence is applicable to funds under existing auditor independence rules. *See supra* Section II.C.

[109] *See supra* footnote 64.

(4) An exemption from coverage of the rule, or any part of the rule, for small entities.

In connection with our proposed amendments to Rule 2–01 of Regulation S–X, we do not think it feasible or appropriate to establish different compliance or reporting requirements or timetables for small entities. The proposed amendments are designed to address compliance challenges for both large and small issuers and audit firms. With respect to clarification, consolidation or simplification of compliance and reporting requirements for small entities, the proposed amendments do not contain any new reporting requirements. While the proposed amendments would create a new compliance requirement that focuses on ''significant influence'' over the audit client to better identify those lending relationships that could impair an auditor's objectivity and impartiality, that standard is more qualitative in nature and its application would vary according to the circumstances. This more flexible standard would be applicable to all issuers, regardless of size.

With respect to using performance rather than design standards, we note that our proposed amendments establishing a ''significant influence'' test and adding a ''known through reasonable inquiry'' standard are more akin to performance standards. Rather than prescribe the specific steps necessary to apply such standards, the proposed amendments recognize that ''significant influence'' and ''known through reasonable inquiry'' can be implemented in a variety of ways. We believe that the use of these standards would accommodate entities of various sizes while potentially avoiding overly burdensome methods that may be ill-suited or unnecessary, given the facts and circumstances.

The proposed amendments are intended to address significant compliance challenges for audit firms and their clients, including those that are small entities. In this respect, exempting small entities from the proposed amendments would increase, rather than decrease, their regulatory burden relative to larger entities.

G. Solicitation of Comment

We encourage the submission of comments with respect to any aspect of this Initial Regulatory Flexibility Analysis. In particular, we request comments regarding:

- The number of small entities that may be subject to the proposed amendments;
- The existence or nature of the potential impact of the proposed amendments on small entities discussed in the analysis;
- How to quantify the impact of the proposed amendments; and
- Alternatives that would accomplish our stated objectives while minimizing any significant adverse impact on small entities.

Respondents are asked to describe the nature of any impact and provide empirical data supporting the extent of the impact. Such comments will be considered in the preparation of the Final Regulatory Flexibility Analysis, if the proposed amendments are adopted, and will be placed in the same public file as comments on the proposed amendments.

VII. Small Business Regulatory Enforcement Fairness Act

For purposes of the Small Business Regulatory Enforcement Fairness Act of 1996 (''SBREFA''),[110] the Commission must advise the Office of Management and Budget as to whether a proposed regulation constitutes a ''major'' rule. Under SBREFA, a rule is considered ''major'' when, if adopted, it results or is likely to result in:

- An annual effect on the economy of $100 million or more (either in the form of an increase or a decrease);
- A major increase in costs or prices for consumers or individual industries; or
- Significant adverse effects on competition, investment or innovation.

If a rule is ''major,'' its effectiveness will generally be delayed for 60 days pending Congressional review.

We request comment on whether our proposed amendments would be a ''major rule'' for purposes of SBREFA. We solicit comment and empirical data on:

- The potential effect on the U.S. economy on an annual basis;
- Any potential increase in costs or prices for consumers or individual industries; and
- Any potential effect on competition, investment or innovation.

We request those submitting comments to provide empirical data and other factual support for their views to the extent possible.

VIII. Statutory Basis

The amendment described in this release is being adopted under the authority set forth in Schedule A and Sections 7, 8, 10, and 19 of the Securities Act, Sections 3, 10A, 12, 13, 14, 17, and 23 of the Exchange Act, Sections 8, 30, 31, and 38 of the Investment Company Act, and Sections 203 and 211 of the Investment Advisers Act.

[110] Public Law 104–121, Tit. II, 110 Stat. 857 (1996).

List of Subjects in 17 CFR Parts 210

Accountants, Accounting, Banks, Banking, Employee benefit plans, Holding companies, Insurance companies, Investment companies, Oil and gas exploration, Reporting and recordkeeping requirements, Securities, Utilities.

In accordance with the foregoing, the Commission proposes to amend title 17, chapter II of the Code of Federal Regulations as follows:

PART 210—FORM AND CONTENT OF AND REQUIREMENTS FOR FINANCIAL STATEMENTS, SECURITIES ACT OF 1933, SECURITIES EXCHANGE ACT OF 1934, INVESTMENT COMPANY ACT OF 1940, INVESTMENT ADVISERS ACT OF 1940, AND ENERGY POLICY AND CONSERVATION ACT OF 1975

■ 1. The authority citation for part 210 continues to read as follows:

Authority: 15 U.S.C. 77f, 77g, 77h, 77j, 77s, 77z–2, 77z–3, 77aa(25), 77aa(26), 77nn(25), 77nn(26), 78c, 78j–1, 78*l*, 78m, 78n, 78o(d), 78q, 78u–5, 78w, 78*ll*, 78mm, 80a–8, 80a–20, 80a–29, 80a–30, 80a–31, 80a–37(a), 80b–3, 80b–11, 7202 and 7262, and sec. 102(c), Public Law 112–106, 126 Stat. 310 (2012), unless otherwise noted.

■ 2. Amend § 210.2–01 by revising paragraph (c)(1)(ii)(A) to read as follows:

§ 210.2–01 Qualifications of accountants.

* * * * *

(c) * * *

(1) * * *

(ii) * * *

(A) *Loans/debtor-creditor relationship.* (*1*) Any loan (including any margin loan) to or from an audit client, or an audit client's officers, directors, or beneficial owners (known through reasonable inquiry) of the audit client's equity securities where such beneficial owner has significant influence over the audit client, except for the following loans obtained from a financial institution under its normal lending procedures, terms, and requirements:

(*i*) Automobile loans and leases collateralized by the automobile;

(*ii*) Loans fully collateralized by the cash surrender value of an insurance policy;

(*iii*) Loans fully collateralized by cash deposits at the same financial institution; and

(*iv*) A mortgage loan collateralized by the borrower's primary residence

provided the loan was not obtained while the covered person in the firm was a covered person.

(*2*) For purposes of paragraph (c)(1)(ii)(A) of this section:

(*i*) The term *audit client* for a fund under audit excludes any other fund that otherwise would be considered an *affiliate of the audit client;*

(*ii*) The term *fund* means an investment company or an entity that would be an investment company but for the exclusions provided by Section 3(c) of the Investment Company Act of 1940 (15 U.S.C. 80a–3(c)).

* * * * *

By the Commission.

Dated: May 2, 2018.

Brent J. Fields,

Secretary.

[FR Doc. 2018–09721 Filed 5–7–18; 8:45 am]

BILLING CODE 8011–01–P

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

30 CFR Part 926

[SATS No. MT–036–FOR; Docket ID: OSM–2017–0001; S1D1S SS08011000 SX064A000 189S180110; S2D2S SS08011000 SX064A000 18XS501520]

Montana Regulatory Program

AGENCY: Office of Surface Mining Reclamation and Enforcement, Interior.

ACTION: Proposed rule; public comment period and opportunity for public hearing on proposed amendment.

SUMMARY: We, the Office of Surface Mining Reclamation and Enforcement (OSMRE), are announcing receipt of a proposed amendment to the Montana regulatory program (Montana program) under the Surface Mining Control and Reclamation Act of 1977 (SMCRA or the Act). Montana proposes an addition to the Montana Code Annotated, which requires the adoption of regulations pertaining to in situ coal gasification. This change was necessitated by a senate bill approved by the 2011 Montana Legislature. Montana also proposes revisions and additions to the Administrative Rules of Montana to satisfy the new statutory requirement.

This document provides the times and locations that the Montana program and this proposed amendment to Montana's program are available for your inspection; the comment period during which you may submit written comments on the amendment; and the procedures that we will follow for the public hearing, if one is requested.

DATES: We will accept written comments on this amendment until 4:00 p.m., m.d.t., June 7, 2018. If requested, we will hold a public hearing on the amendment on June 4, 2018. We will accept requests to speak at a hearing until 4:00 p.m., m.d.t. on May 23, 2018.

ADDRESSES: You may submit comments, identified by Docket Number OSM–2017–0001, by any of the following methods:

- *Mail/Hand Delivery:* 1999 Broadway, Suite 3320, Denver, CO 80202.
- *Fax:* (303) 293–5017.
- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.

Instructions: All submissions received must include the agency name and docket number for this rulemaking. For detailed instructions on submitting comments and additional information on the rulemaking process, see the ''Public Comment Procedures'' heading of the **SUPPLEMENTARY INFORMATION** section of this document.

Docket: For access to the docket to review copies of the Montana program, this amendment, a listing of any scheduled public hearings, and all written comments received in response to this document, you may go to the address listed below during normal business hours, Monday through Friday, excluding holidays. The full text of the program amendment is also available for you to read at *www.regulations.gov.* You may receive one free copy of the amendment by contacting OSMRE's Denver Field Division: Jeffrey Fleischman, Chief, Denver Field Division, Office of Surface Mining Reclamation and Enforcement, Dick Cheney Federal Building, POB 11018, 150 East B Street, Casper, Wyoming 82601–7032, Telephone: (307) 261–6550, Email: *jfleischman@osmre.gov.*

In addition, you may receive a copy of the proposed amendment from the Montana Department of Environmental Quality: Edward L. Coleman, Chief, Coal and Opencut Mining Bureau, Montana Department of Environmental Quality, P.O. Box 200901, Helena, Montana, 59620–0901, Telephone: (406) 444–4973, Email: *ecoleman@mt.gov.*

FOR FURTHER INFORMATION CONTACT: Howard Strand, Office of Surface Mining Reclamation and Enforcement, 1999 Broadway, Suite 3320, Denver, CO 80202, Telephone: (303) 293–5026, Email: *hstrand@osmre.gov.*

SUPPLEMENTARY INFORMATION:

I. Background on the Montana Program
II. Description of the Proposed Amendment
III. Public Comment Procedures
IV. Procedural Determinations

I. Background on the Montana Program

Section 503(a) of the Act permits a state to assume primacy for the regulation of surface coal mining and reclamation operations on non-federal and non-Indian lands within its borders by demonstrating that its program includes, among other things, state laws and regulations that govern surface coal mining and reclamation operations in accordance with the Act and consistent with the Federal regulations. See 30 U.S.C. 1253(a)(1) and (7). On the basis of these criteria, the Secretary of the Interior conditionally approved the Montana program on April 1, 1980. You can find background information on the Montana program, including the Secretary's findings, the disposition of comments, and conditions of approval of the Montana program in the April 1, 1980, **Federal Register** (45 FR 21560). You can also find later actions concerning the Montana program and program amendments at 30 CFR 926.15, 926.16, and 926.30.

II. Description of the Proposed Amendment

By letter dated February 27, 2017 (FDMS Document ID No. OSM–2017–0001–0002), Montana sent us a proposed amendment to its program under SMCRA (30 U.S.C. 1201 *et seq.*). The proposed changes are the result of a Montana state senate bill which required adoption of regulations pertaining to in situ coal gasification.

Specifically, Montana proposes to codify language from Senate Bill 292 under the Montana Strip and Underground Mine Reclamation Act. This language, approved by the 2011 Montana Legislature, directs the Montana Board of Environmental Review (BER) to adopt rules pertaining to in situ coal processing and provides that those rules may not be more stringent than the comparable federal regulations or guidelines. The Administrative Rules of Montana (ARMs) currently have two regulatory provisions, ARM 17.24.902 and ARM 17.24.904, that specifically address in situ coal gasification and that list subchapters of the ARMs that apply to in situ coal gasification. Following passage of Senate Bill 292, the Montana Department of Environmental Quality reviewed Montana's rules and determined that most of the rules relating to underground coal mining should apply to in situ operations. It recommended that, rather than adopting rules that would duplicate existing rules, BER should simply list the rules that would not apply to in situ operations. To reflect this approach,

Montana now proposes adding a new ARM 17.24.905, which specifies that the ARMs pertaining to air pollution control plans, monitoring for settlement of regraded areas, augering and remining do not apply to in situ coal gasification. Montana also proposes ministerial changes to ARM 17.24.902 and ARM 17.24.903 that reflect these exemptions. Finally, Montana proposes to allow the regulatory authority to apply other rules, which are not routinely applied to all in situ operations, on a mine-specific basis.

The full text of the program amendment is available for you to read at the locations listed above under **ADDRESSES** or at *www.regulations.gov*.

III. Public Comment Procedures

Under the provisions of 30 CFR 732.17(h), we are seeking your comments on whether the amendment satisfies the applicable program approval criteria of 30 CFR 732.15. If we approve the amendment, it will become part of the Montana program.

Electronic or Written Comments

If you submit written or electronic comments on the proposed rule during the 30-day comment period, they should be specific, confined to issues pertinent to the proposed regulations, and explain the reason for any recommended change(s). We appreciate any and all comments, but those most useful and likely to influence decisions on the final regulations will be those that either involve personal experience or include citations to and analyses of SMCRA, its legislative history, its implementing regulations, case law, other pertinent state or federal laws or regulations, technical literature, or other relevant publications.

We cannot ensure that comments received after the close of the comment period (see **DATES**) or sent to an address other than those listed (see **ADDRESSES**) will be included in the docket for this rulemaking and considered.

Public Availability of Comments

Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment including your personal identifying information, may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Public Hearing

If you wish to speak at the public hearing, contact the person listed under **FOR FURTHER INFORMATION CONTACT** by 4:00 p.m., m.d.t. on May 23, 2018. If you are disabled and need reasonable accommodations to attend a public hearing, contact the person listed under **FOR FURTHER INFORMATION CONTACT**. We will arrange the location and time of the hearing with those persons requesting the hearing. If no one requests an opportunity to speak, we will not hold a hearing.

To assist the transcriber and ensure an accurate record, we request, if possible, that each person who speaks at the public hearing provide us with a written copy of his or her comments. The public hearing will continue on the specified date until everyone scheduled to speak has been given an opportunity to be heard. If you are in the audience and have not been scheduled to speak and wish to do so, you will be allowed to speak after those who have been scheduled. We will end the hearing after everyone scheduled to speak and others present in the audience who wish to speak, have been heard.

Public Meeting

If only one person requests an opportunity to speak, we may hold a public meeting rather than a public hearing. If you wish to meet with us to discuss the amendment, please request a meeting by contacting the person listed under **FOR FURTHER INFORMATION CONTACT**. All such meetings are open to the public and, if possible, we will post notices of meetings at the locations listed under **ADDRESSES**. We will make a written summary of each meeting a part of the administrative record.

IV. Procedural Determinations

Executive Order 12866—Regulatory Planning and Review

This rulemaking is exempted from review by the Office of Management and Budget (OMB) under Executive Order 12866.

Other Laws and Executive Orders Affecting Rulemaking

When a state submits a program amendment to OSMRE for review, our regulations at 30 CFR 732.17(h) require us to publish a notice in the **Federal Register** indicating receipt of the proposed amendment, its text or a summary of its terms, and an opportunity for public comment. We conclude our review of the proposed amendment after the close of the public comment period and determine whether the amendment should be approved, approved in part, or not approved. At that time, we will also make the determinations and certifications required by the various laws and executive orders governing the rulemaking process and include them in the final rule.

List of Subjects in 30 CFR Part 926

Intergovernmental relations, Surface mining, Underground mining.

Dated: April 18, 2018.

David Berry,

Regional Director, Western Region.

[FR Doc. 2018–09768 Filed 5–7–18; 8:45 am]

BILLING CODE 4310–05–P

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

30 CFR Part 938

[PA–166–FOR; Docket ID: OSM–2017–0008 S1D1S SS08011000 SX064A000 189S180110; S2D2S SS08011000 SX064A000 18XS501520]

Pennsylvania Regulatory Program

AGENCY: Office of Surface Mining Reclamation and Enforcement (OSMRE), Interior.

ACTION: Proposed rule; reopening of the public comment period and notice of public hearing.

SUMMARY: We, the Office of Surface Mining Reclamation and Enforcement (OSMRE), are reopening the public comment period and will be holding a public hearing on the proposed amendment to the Commonwealth of Pennsylvania's approved regulatory program (the Pennsylvania program) published on March 12, 2018. The comment period is being reopened in order to afford the public additional time to comment and to allow for a public hearing. Approximately sixty citizens asked to both extend the comment period and for a public hearing. We are also notifying the public of the date, time, and location for the public hearing. Through this proposed amendment, Pennsylvania seeks to revise its Bituminous Mine Subsidence and Land Conservation Act (BMSLCA) to include language clarifying the circumstances where a finding of presumptive evidence of pollution is not warranted under the Commonwealth's Clean Streams Law.

DATES: We will accept written comments until 4 p.m., Eastern Standard Time (EST), June 7, 2018. The public hearing will be held on May 1,

2018, from 5:30 p.m. until 7:30 p.m. EST.

ADDRESSES: You may submit comments, identified by ''PA–166–FOR; Docket ID: OSM–2017–0008'', by either of the following two methods:

• *Federal eRulemaking Portal: http://www.regulations.gov.* The proposed rule has been assigned Docket ID: OSM–2017–0008. If you would like to submit comments through the Federal eRulemaking Portal, go to *http://www.regulations.gov* and follow the instructions.

• *Mail/Hand Delivery/Courier:* Mr. Ben Owens, Chief, Pittsburgh Field Division, Office of Surface Mining Reclamation and Enforcement, Three Parkway Center, Second Floor, Pittsburgh, PA 15220.

Instructions: For detailed instructions on submitting comments and additional information on the rulemaking process, see III. Public Comment Procedures in the **SUPPLEMENTARY INFORMATION** section of the proposed rule published on March 12, 2018.

Public Hearing: The public hearing will be held at the Double Tree by Hilton Pittsburgh-Green Tree, 500 Mansfield Avenue, Pittsburgh, Pennsylvania 15205; phone number: 412–922–8400, on Tuesday, May 1, 2018, from 5:30 p.m. to 7:30 p.m. EST. Those wishing to provide oral testimony need to register between 5:00 p.m. and 5:30 p.m.

Docket: For access to the docket to review copies of the Pennsylvania regulations, the relevant amendment, a listing of any scheduled public hearings, and all written comments received in response to this document, you must go to the address listed below during normal business hours, Monday through Friday, excluding holidays. You may receive one free copy of the amendment by contacting OSMRE's Pittsburgh Field Division; or the full text of the program amendment is available at *www.regulations.gov.*

In addition, you may review a copy of the amendment during regular business hours at one of the following locations:

Mr. Ben Owens, Chief, Pittsburgh Field Division, Office of Surface Mining Reclamation and Enforcement, Appalachian Regional Office, 3 Parkway Center, Second Floor, Pittsburgh, PA 15220, Telephone: (412) 937–2827, Email: *bowens@osmre.gov.*

Mr. William Allen, Chief, Permitting and Compliance, Bureau of Mining and Reclamation, Pennsylvania Department of Environmental Protection, Rachel Carson State Office Building, P.O. Box 8461, Harrisburg, PA 17105–8461, Telephone: (717) 783–9580, E-Mail: *wallen@pa.gov.*

FOR FURTHER INFORMATION CONTACT: Mr. Ben Owens, Chief, Pittsburgh Field Division, Telephone: (412) 937–2827. Email: *bowens@osmre.gov.*

SUPPLEMENTARY INFORMATION: On March 12, 2018, we published a proposed rule that would revise the Pennsylvania program. By letter dated August 4, 2017 (Administrative Record No. PA 899.00), Pennsylvania sent us an amendment to its program under SMCRA (30 U.S.C. 1201 *et seq.*). The Pennsylvania General Assembly recently amended the BMSLCA to include language clarifying the circumstances where a finding of presumptive evidence of pollution is not warranted under the Commonwealth's Clean Streams Law.

A. By way of State Bill 624, Pennsylvania proposes additional language to the BMSLCA, Section 5(i) that states: ''In a permit application to conduct bituminous coal mining operations, subject to this act, planned subsidence in a predictable and controlled manner which is not predicted to result in the permanent disruption of premining existing or designated uses of surface waters of the Commonwealth shall not be considered presumptive evidence that the proposed bituminous coal mining operations have the potential to cause pollution as defined in section 1 of the act of June 22, 1937 (Pub. L. 1987, No. 394), known as ''The Clean Streams Law''.

B. Further, Pennsylvania proposes additional language to BMSLCA, Section 5(j) as follows: ''The provisions of subsection (i) shall only apply if: (1) A person submits an application to conduct bituminous mining operations subject to this act to the department that provides for the restoration of the premining range of flows and restoration of premining biological communities in any waters of this Commonwealth predicted to be adversely affected by subsidence. The restoration shall be consistent with the premining existing and designated uses of the waters of this Commonwealth; and (2) the application is approved by the department.''

During the initial comment period, (Administrative Record Number PA 899.05), we received multiple citizen requests to extend the comment period and to hold a public hearing on the amendment. We are reopening the public comment period to afford the public more time to comment on the amendment and to allow enough time to schedule and hold the hearing. The date, time and location for the public hearing may be found under **DATES** and **ADDRESSES**.

The hearing will be open to anyone who would like to attend and/or testify. The primary purpose of the public hearing is to obtain your comments on the proposed rule so that we can prepare a complete and objective analysis of the proposal. Those wishing to provide oral testimony need to register between 5:00 p.m. and 5:30 p.m. at the hearing location. Other attendees are not required to register. Written testimony will also be accepted. The hearing officer will conduct the hearing and receive the comments submitted. Comments submitted during the hearing will be responded to in the preamble to the final rule, not at the hearing. We appreciate all comments, but those most useful and likely to influence decisions on the final rule will be those that either involve personal experience or include citations to, and analyses of, the Surface Mining Control and Reclamation Act of 1977, its legislative history, its implementing regulations, case law, other State or Federal laws and regulations, data, technical literature, or relevant publications.

At the hearing, a court reporter will record and make a written record of the statements presented. This written record will be made part of the administrative record for the rule. If you have a written copy of your testimony, we encourage you to give us a copy. It will assist the court reporter in preparing the written record. Any disabled individual who needs reasonable accommodation to attend the public hearing is encouraged to contact the person listed under **FOR FURTHER INFORMATION CONTACT**.

Dated: April 5, 2018.

Thomas D. Shope,

Regional Director, Appalachian Region .

[FR Doc. 2018–09767 Filed 5–7–18; 8:45 am]

BILLING CODE 4310–05–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 49

[EPA–HQ–OAR–2014–0606; FRL–9977–68–OAR]

RIN 2060–AT96

Amendments to Federal Implementation Plan for Managing Air Emissions From True Minor Sources in Indian Country in the Oil and Natural Gas Production and Natural Gas Processing Segments of the Oil and Natural Gas Sector

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The Environmental Protection Agency (EPA) is proposing three amendments to the existing National Oil and Natural Gas Federal Implementation Plan (National O&NG FIP) that applies to new true minor sources and minor modifications at existing true minor sources in the oil and natural gas production and natural gas processing segments of the oil and natural gas sector that are locating or expanding in Indian reservations or in other areas of Indian country over which an Indian tribe, or the EPA, has demonstrated the tribe's jurisdiction. The National O&NG FIP, which includes a mechanism for authorizing construction of true minor new and modified oil and natural gas sources, satisfies the minor source permitting requirement under the ''Federal Minor New Source Review (NSR) Program in Indian Country'' (referred to as the ''Federal Indian Country Minor NSR rule''). We are proposing two amendments to apply the National O&NG FIP to the Uintah and Ouray Reservation (U&O Reservation) portion of the intended Uinta Basin Ozone Nonattainment Area. We are also proposing a minor technical correction to fix a typographical error in a provision in the National O&NG FIP.

DATES:

Public hearing. A public hearing will be held May 30, 2018, at the EPA's Region 8 offices at 1595 Wynkoop Street, Denver, CO 80202. Please refer to the **SUPPLEMENTARY INFORMATION** section for additional information on the hearing.

Comments. The EPA must receive comments on this proposed action no later than July 2, 2018.

ADDRESSES:

Public hearing. The hearing will be held at the EPA's Region 8 offices at 1595 Wynkoop Street, Denver, CO 80202. The hearing will convene at 9:00 a.m. (local time). The EPA will end the hearing two hours after the last registered speaker has concluded their comments but no later than 4:00 p.m. (local time). There will be a lunch break from 1:00 p.m. to 2:00 p.m. (local time).

Because the hearing is being held at a United States government facility, individuals planning to attend must plan for enough time to enter the facility. All visitors must ensure they have a valid photo ID and must pass through security screening, comparable to screening at an airport, they will sign in and obtain a visitor pass. No large signs, cameras, banners and/or weapons will be allowed in to the facility.

Docket. The EPA has established a docket for this action under Docket ID No. EPA–HQ–OAR–2014–0606, at *http://www.regulations.gov.* Follow the online instructions for submitting comments. Once submitted, comments cannot be edited or removed from *Regulations.gov.* the EPA may publish any comment received to its public docket. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Multimedia submissions (audio, video, etc.) must be accompanied by a written comment. The written comment is considered the official comment and should include discussion of all points you wish to make. The EPA will generally not consider comments or comment contents located outside of the primary submission (*i.e.,* on the Web, Cloud, or other file sharing system). For additional submission methods, the full EPA public comment policy, information about CBI or multimedia submissions, and general guidance on making effective comments, please visit *https://www.epa.gov/dockets/commenting-epa-dockets.*

FOR FURTHER INFORMATION CONTACT: Mr. Christopher Stoneman, Outreach and Information Division, Office of Air Quality Planning and Standards (C–304–01), Environmental Protection Agency, Research Triangle Park, North Carolina, 27711, telephone number (919) 541–0823, facsimile number (919) 541–0072, email address: *stoneman.chris@epa.gov.*

Public hearing. The EPA will begin pre-registering speakers for the hearing upon publication of this document in the **Federal Register**. If you would like to speak at the public hearing, please register using the online registration form available at: *https://www.epa.gov/controlling-air-pollution-oil-and-natural-gas-industry.* You may also register by contacting Tonya Blatcher at (919) 541–1929 or by email at *blatcher.tonya@epa.gov.* To register to speak, we request the following information: The time you wish to speak, name, affiliation, email address, and telephone number. If you register to speak online, you do not need to call. If you require reasonable accommodations, such as the service of a translator, please let us know as soon as possible, but no later than May 22, 2018.

The last day to pre-register to register to speak at the hearing will be Tuesday, May 25, 2018. On May 28, 2018, the EPA will post a general agenda for the hearing that will list pre-registered speakers in approximate order. The general agenda will be posted at *https://www.epa.gov/controlling-air-pollution-oil-and-natural-gas-industry.* The EPA will make every effort to follow the schedule as closely as possible on the day of the hearing; however, please plan for the hearing to run either ahead of schedule or behind schedule. Additionally, requests to speak will be taken the day of the hearing at the hearing registration desk. The EPA will make every effort to accommodate all speakers who arrive and register, although preferences on speaking times may not be able to be fulfilled.

SUPPLEMENTARY INFORMATION: *Public hearing.* Each commenter will have 5 minutes to provide oral testimony. The EPA encourages commenters to provide the EPA with a copy of their oral testimony electronically (via email) or in hard copy form.

The EPA may ask clarifying questions during the oral presentations, but will not respond to the presentations at that time. Written statements and supporting information submitted during the comment period will be considered with the same weight as oral comments and supporting information presented at the public hearing. Commenters should notify Tonya Blatcher at (919) 541–1929 or by email at *blatcher.tonya@epa.gov* if they will need specific equipment, or if there are other special needs related to providing comments at the hearings. Verbatim transcripts of the hearings and written statements will be included in the docket for the rulemaking.

Please note that any updates made to any aspect of the hearing will be posted online at *https://www.epa.gov/controlling-air-pollution-oil-and-natural-gas-industry.* While the EPA expects the hearing to go forward as set forth above, please monitor our website or contact Tonya Blatcher at (919) 541–1929 or by email at *blatcher.tonya@epa.gov* to determine if there are any updates. The EPA does not intend to publish a document in the **Federal Register** announcing updates.

The EPA will not provide audiovisual equipment for presentations unless we receive special requests in advance. Commenters should notify Tonya Blatcher when they pre-register to speak that they will need specific equipment. If you require the service of a translator or special accommodations such as audio description, please pre-register for the hearing and describe your needs by May 22, 2018. We may not be able to arrange for accommodations without advance notice.

The information presented in this preamble is organized as follows:

I. General Information

A. What entities are potentially affected by this action?
B. Where can I get a copy of this document and other related information?
II. Purpose of this Proposed Action
A. Overview
B. Authority for Proposed Action
C. Rationale for Proposed Action
III. Background
A. FIPs Under the Indian Country Minor NSR Rule
B. Uinta Basin Air Quality and Intended Nonattainment Designation
IV. Summary of Proposed Amendments
V. Statutory and Executive Order Reviews
A. Executive Order 12866: Regulatory Planning and Review and Executive Order 13563: Improving Regulation and Regulatory Review
B. Executive Order 13771: Reducing Regulations and Controlling Regulatory Costs
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D. Regulatory Flexibility Act (RFA)
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G. Executive Order 13175: Consultation and Coordination With Indian Tribal Governments
H. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks
I. Executive Order 13211: Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution or Use
J. National Technology Transfer and Advancement Act (NTTAA)
K. Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations

I. General Information

A. What entities are potentially affected by this action?

Entities potentially affected by this proposal include the Ute Indian Tribe,[1] as well as new and modified true minor sources that are in the oil and natural gas production and natural gas processing segments of the oil and natural gas sector and are on Indian country[2] lands within the U&O Reservation. All of the Ute Indian Tribe Indian country lands of which the EPA is aware are located within the exterior boundaries of the Reservation, and these amendments will apply to all such lands. To the extent that there are Ute Indian Tribe dependent Indian communities under 18 U.S.C. 1151(b) or allotted lands under 18 U.S.C. 1151(c) that are located outside the exterior boundaries of the Reservation, those lands will not be covered by these amendments.[3] In addition, this proposed rule will not apply to any sources not on Indian country lands, including any areas within the exterior boundaries of the Reservation that are not Indian country lands.[4]

TABLE 1—SOURCE CATEGORIES AFFECTED BY THIS ACTION

Industry category	NAICS code [a]	Examples of regulated entities/description of industry category
Oil and Natural Gas Production/Operations	21111	Exploration for crude petroleum and natural gas; drilling, completing, and equipping wells; operation of separators, emulsion breakers, desilting equipment, and field gathering lines for crude petroleum and natural gas; and all other activities in the preparation of oil and natural gas up to the point of shipment from the producing property. Production of crude petroleum, the mining and extraction of oil from oil shale and oil sands, the production of natural gas, sulfur recovery from natural gas, and the recovery of hydrocarbon liquids from oil and natural gas field gases.
Crude Petroleum and Natural Gas Extraction	211111	Exploration, development and/or the production of petroleum or natural gas from wells in which the hydrocarbons will initially flow or can be produced using normal pumping techniques or production of crude petroleum from surface shales or tar sands or from reservoirs in which the hydrocarbons are semisolids.
Natural Gas Liquid Extraction	211112	Recovery of liquid hydrocarbons from oil and natural gas field gases; and sulfur recovery from natural gas.
Drilling Oil and Natural Gas Wells	213111	Drilling oil and natural gas wells for others on a contract or fee basis, including spudding in, drilling in, redrilling, and directional drilling.

[1] The Ute Indian Tribe is a federally recognized tribe organized under the Indian Reorganization Act of 1934, with a Constitution and By-Laws adopted by the Tribe on December 19, 1936, and approved by the Secretary of the Interior on January 19, 1937. *See* Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs, 82 FR 4915 (January 17, 2017); 48 Stat. 984, 25 U.S.C. 5123 (IRA); Constitution and By-Laws of the Ute Indian Tribe of the Uintah and Ouray Reservation, available at *https://www.loc.gov/law/help/american-indian-consts/PDF/37026342.pdf.*

[2] Indian country is defined at 18 U.S.C. 1151 as: (a) All land within the limits of any Indian reservation under the jurisdiction of the United States Government, notwithstanding the issuance of any patent, and, including rights-of-way running through the reservation, (b) all dependent Indian communities within the borders of the United States whether within the original or subsequently acquired territory thereof, and whether within or without the limits of a state, and (c) all Indian allotments, the Indian titles to which have not been extinguished, including rights-of-way running through the same.

[3] Under the Clean Air Act (CAA), lands held in trust for the use of an Indian tribe are reservation lands within the definition at 18 U.S.C. 1151(a), regardless of whether the land is formally designated as a reservation. *See* Indian Tribes: Air Quality Planning and Management, 63 FR 7254, 7258 (1998) (''Tribal Authority Rule''); *Arizona Pub. Serv. Co.* v. *EPA,* 211 F.3d 1280, 1285–86 (D.C. Cir. 2000). The EPA's references in this FIP to Indian country lands within the exterior boundaries of the U&O Reservation include any such tribal trust lands that may be acquired by the Ute Indian Tribe. In addition, in 2014, the U.S. Court of Appeals for the D.C. Circuit addressed EPA's authority to promulgate a FIP establishing certain CAA permitting programs in Indian country. *Oklahoma Dept. of Environmental Quality* v. *EPA,* 740 F. 3d 185 (D.C. Cir. 2014). In that case, the court recognized the EPA's authority to promulgate a FIP to directly administer CAA programs on Indian reservations, but invalidated the FIP at issue as applied to non-reservation areas of Indian country in the absence of a demonstration of an Indian tribe's jurisdiction over such non-reservation area. Because the current proposed rule would apply only on Indian country lands that are within the exterior boundaries of the U&O Reservation, *i.e.,* on Reservation lands, it is unaffected by the *Oklahoma* court decision.

[4] As a result of a series of federal court decisions, there are some areas within the exterior boundaries of the Uintah and Ouray Indian Reservation that are not Indian country lands. See *Ute Indian Tribe* v. *Utah,* 521 F. Supp. 1072 (D. Utah 1981); *Ute Indian Tribe* v. *Utah,* 716 F.2d 1298 (10th Cir. 1983); *Ute Indian Tribe* v. *Utah,* 773 F.2d 1087 (10th Cir. 1985) (en banc), cert. denied, 479 U.S. 994 (1986); *Hagen* v. *Utah,* 510 U.S. 399 (1994); *Ute Indian Tribe* v. *Utah,* 935 F. Supp. 1473 (D. Utah 1996); *Ute Indian Tribe* v. *Utah,* 114 F.3d 1513 (10th Cir. 1997), cert. denied, 522 U.S. 1107 (1998); *Ute Indian Tribe* v. *Utah,* 790 F.3d 1000 (10th Cir. 2015), cert. denied, 136 S. Ct. 1451 (2016); and *Ute Indian Tribe* v. *Myton,* 835 F.3d 1255 (10th Cir. 2016), cert. denied, 137 S. Ct. 2328 (2017).

TABLE 1—SOURCE CATEGORIES AFFECTED BY THIS ACTION—Continued

Industry category	NAICS code [a]	Examples of regulated entities/description of industry category
Support Activities for Oil and Natural Gas Operations	213112	Performing support activities on a contract or fee basis for oil and natural gas operations (except site preparation and related construction activities) such as exploration (except geophysical surveying and mapping); excavating slush pits and cellars, well surveying; running, cutting, and pulling casings, tubes, and rods; cementing wells, shooting wells; perforating well casings; acidizing and chemically treating wells; and cleaning out, bailing, and swabbing wells.
Engines (Spark Ignition and Compression Ignition) for Electric Power Generation.	22111	Provision of electric power to support oil and natural gas production where access to the electric grid is unavailable.

[a] North American Industry Classification System.

This list is not intended to be exhaustive, but rather provides a guide for readers regarding entities likely to be potentially affected by this action. To determine whether your facility could be affected by this action, you should examine the applicability criteria in the Federal Minor NSR Program in Indian Country and the National O&NG FIP (40 Code of Federal Regulations (CFR) 49153 and 49.101, respectively). If you have any questions regarding the applicability of this action to a particular entity, contact the appropriate person listed in the **FOR FURTHER INFORMATION CONTACT** section.

B. Where can I get a copy of this document and other related information?

In addition to being available in the docket, an electronic copy of this final rule will also be available on the World Wide Web. Following signature by the EPA Administrator, a copy of this final rule will be posted in the regulations and standards section of our NSR home page located at *http://www.epa.gov/nsr* and on the tribal NSR page at *https://www.epa.gov/tribal-air/tribal-minor-new-source-review.*

II. Purpose of This Proposed Action

A. Overview

In this action, the EPA is proposing to exercise its authority, in accordance with section 110(a)(2)(C) of the CAA and under sections 301(a) and 301(d)(4) of the CAA and 40 CFR 49.11 by amending the National O&NG FIP [5] to extend it to eligible true minor oil and natural gas sources in the Indian country portion of the intended Uinta Basin Ozone Nonattainment Area, which includes making it available as a mechanism for authorizing construction in that area. (The Indian country lands within the Uinta Basin to which these amendments would apply are on the U&O Reservation.)

The National O&NG FIP provides a mechanism for authorizing construction for eligible true minor oil and natural gas sources wishing to locate or expand in areas of Indian country designated as attainment, unclassifiable and attainment/unclassifiable. The counties in the Uinta Basin are currently designated as unclassifiable with respect to the 2008 ozone National Ambient Air Quality Standards (NAAQS) [6] and, as such, owners/operators of eligible oil and natural gas sources on Indian country lands within the U&O Reservation have been utilizing the National O&NG FIP's streamlined approach to satisfy permitting requirements since August 2, 2016, when the FIP became effective. However, the EPA has announced its intention to designate portions of the Uinta Basin, including the U&O Reservation, as nonattainment for the 2015 ozone NAAQS.[7] [8]

The Uinta Basin is a petroleum producing system that contains thousands of active oil and natural gas wells, and existing oil and natural gas production activity is the primary source of the emissions of concern for air quality: volatile organic compounds (VOC) and nitrogen oxides (NO_X), ozone precursors that react to form ozone in the presence of sunlight and widespread snow cover. The Uinta Basin's air quality problem is wintertime ozone caused by these existing sources' emissions. However, because the agency is under a court order to finalize the Basin's designation with respect to the 2015 ozone NAAQS by April 30, 2018,[9] and because the agency intends to designate some portions of the Basin as nonattainment, including portions of the U&O Reservation, under the National O&G FIP, in its current form, the Indian country portions of the Basin (U&O Reservation) will fall out of that FIP's coverage. Thus, the area will lack a streamlined mechanism to authorize construction of true minor new and modified oil and natural gas sources. This will immediately cause a disparity in the regulatory landscape facing such activity in the affected area, as compared to all other areas of Indian country that will remain covered by the FIP—even though the Basin's air quality problem that drives the impending nonattainment designation will not manifest until the winter.

With this proposed action, the EPA is proposing to ensure that the National O&NG FIP's requirements to comply with eight federal rules (and the mechanism for authorizing construction) will continue to apply on the U&O Reservation, recognizing that the geographically limited extension of the National O&NG FIP to the area is occurring while the EPA moves quickly to complete a separate rulemaking to

[5] "Federal Implementation Plan for True Minor Sources in Indian Country in the Oil and Natural Gas Production and Natural Gas Processing Segments of the Oil and Natural Gas Sector; Amendments to the Federal Minor New Source Review Program in Indian Country to Address Requirements for True Minor Sources in the Oil and Natural Gas Sector," U.S. Environmental Protection Agency, 81 FR 35943, June 3, 2016, *https://www.gpo.gov/fdsys/pkg/FR-2016-06-03/pdf/2016-11969.pdf.*

[6] "Air Quality Designations for the 2008 Ozone National Ambient Air Quality Standards; Implementation of the 2008 National Ambient Air Quality Standards for Ozone: Nonattainment Area Classifications Approach, Attainment Deadlines and Revocation of the 1997 Ozone Standards for Transportation Conformity Purposes," U.S. Environmental Protection Agency, 77 FR 30087, May 21, 2012, *https://www.gpo.gov/fdsys/pkg/FR-2012-05-21/pdf/2012-11618.pdf.*

[7] The EPA intends to make final designation determinations for the areas of the country addressed by the EPA responses to state and tribal area boundary recommendations (which cover the Uinta Basin region) no earlier than 120 days from the date (December 21, 2017) the EPA notified states and tribes of the agency's intended designations.

[8] "EPA Responses to Certain State Designation Recommendations for the 2015 Ozone National Ambient Air Quality Standards: Notice of Availability and Public Comment Period," U.S. Environmental Protection Agency, 83 FR 651, January 5, 2018, *https://www.gpo.gov/fdsys/pkg/FR-2018-01-05/pdf/2018-00024.pdf.*

[9] In re Ozone Designation Litigation, No. 17–cv–06900–HSG (N.D. Cal. March 12, 2018).

further address the air quality problem on the U&O Reservation.

The separate EPA rulemaking [10] addressing air quality is a reservation-specific FIP action that will contain requirements to reduce ozone-forming emissions from new, modified and existing oil and natural gas sources on Indian country lands within the U&O Reservation. The rulemaking will seek to achieve three goals for the Indian country portion of the Uinta Basin: (1) Clean air; (2) continued, uninterrupted development of the oil and natural gas resources; and (3) consistent CAA regulatory requirements between Indian country lands within the U&O Reservation and lands under state of Utah jurisdiction. Through that rulemaking, the EPA will address the Uinta Basin's particular situation in an area-specific manner; this proposal today seeks to bridge the gap in authority that the nonattainment designation will cause during the interim period where the designation will be in place, but the environmental needs requiring area-specific treatment have not yet materialized.

B. Authority for Proposed Action

CAA section 110(a)(2)(C) is part of the foundation for the minor NSR program, and it requires states to submit plans that include programs for the regulation of ''the modification and construction of any stationary source.'' [11] CAA section 110(c) authorizes the EPA to promulgate a Federal implementation plan in the absence of a satisfactory state plan. CAA section 301(a) generally authorizes the EPA to prescribe regulations as are necessary to carry out its functions under the Act.

Section 301(d) of the CAA authorizes the EPA to treat Indian tribes in the same manner as states and directs the EPA to promulgate regulations specifying those provisions of the CAA for which such treatment is appropriate. (CAA sections 301(d)(1) and (2)). It also authorizes the EPA, in circumstances in which the EPA determines that the treatment of Indian tribes as identical to states is inappropriate or administratively infeasible, to provide by regulation other means by which the EPA will directly administer the CAA. (CAA section 301(d)(4)). Acting principally pursuant to that authority, on February 12, 1998,[12] the EPA promulgated what we refer to as the Tribal Authority Rule (TAR). (40 CFR 49.1–49.11). In the TAR, we determined that it was appropriate to treat tribes in the same manner as states for all CAA and regulatory purposes except a list of specified CAA provisions and implementing regulations thereunder. (40 CFR 49.4).

The TAR preamble clarified that by including CAA section 110(c)(1) on the § 49.4 ''exception'' list, ''EPA is not relieved of its general obligation under the CAA to ensure the protection of air quality throughout the nation, including throughout Indian country.'' The preamble confirmed that the ''EPA will continue to be subject to the basic requirement to issue a FIP for affected tribal areas within some reasonable time.'' [13] The TAR includes a provision that provides the EPA the authority to promulgate a Federal implementation plan in the absence of a satisfactory tribal plan. (40 CFR 49.11(a)).

On August 21, 2006, the EPA proposed the regulation: ''Review of New Sources and Modifications in Indian Country'' (commonly referred to as the Federal Indian Country NSR rule).[14] With this proposed regulation, the EPA proposed to protect air quality in Indian country, as defined in 18 U.S.C. 1151, by establishing a FIP program to regulate, among other matters, the modification and construction of minor stationary sources consistent with the authorities and requirements of sections 301 and 110(a)(2)(C) of the CAA. We refer to this part of the Federal Indian Country NSR rule as the Federal Indian Country Minor NSR rule. Under the Federal Indian Country Minor NSR rule, we proposed to provide a mechanism for issuing pre-construction permits for the construction of new minor sources and certain modifications of major and minor sources in Indian country. We promulgated a final rule on July 1, 2011,[15] and the rule became effective on August 30, 2011. The Federal Indian Country Minor NSR rule applies to new and modified minor stationary sources and to minor modifications at existing major stationary sources located in Indian country where there is no EPA-approved program in place for all new and modified minor sources and minor modifications at major sources located in areas covered by the Federal Indian Country Minor NSR rule.

Tribes can elect to develop and implement their own EPA-approved program under the TAR,[16] but they are not required to do so.[17] In the absence of an approved program, the EPA implements this program. Alternatively, tribes can take delegation of the program from the EPA to assist the EPA with administration of the federal program, including acting as the Reviewing Authority for the EPA.

Under the Federal Indian Country Minor NSR rule, initially beginning September 2, 2014,[18] any new stationary source, that will emit, or will have the potential to emit, a regulated NSR pollutant in amounts that will be: (a) Equal to or greater than the minor NSR thresholds established in the Federal Indian Country Minor NSR rule; but (b) less than the amount that would qualify the source as a major source or a major modification for purposes of the Prevention of Significant Deterioration (PSD) or nonattainment major NSR programs, must apply for and obtain a minor NSR permit before beginning construction of the new source. Likewise, any existing stationary source (minor or major) must apply for and obtain a minor NSR permit before beginning construction (a physical or operational change) that will increase the allowable emissions of the stationary source by more than the specified threshold amounts, if the change does not otherwise trigger the permitting requirements of the PSD or

[10] The rulemaking is listed on the Office of Management and Budget's Unified Agenda of Regulatory and Deregulatory Actions. For more information, go to: *https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201710&RIN=2008-AA03.* In the Agenda, the rulemaking appears as: ''Federal Implementation Plan for Oil and Natural Gas Sources; Uintah and Ouray Indian Reservation in Utah.''

[11] Section 110(a)(2)(C) of the CAA requires state plans to include ''a program to provide for the . . . regulation of the modification and construction of any stationary source within the areas covered by the plan as necessary to assure that national ambient air quality standards are achieved, including a permit program as required in parts C and D of this subchapter.''

[12] ''Indian Tribes: Air Quality Planning and Management,'' U.S. Environmental Protection Agency, 63 FR 7254, February 12, 1998, *http://www.gpo.gov/fdsys/pkg/FR-1998-02-12/pdf/98-3451.pdf.*

[13] See CAA section 301(a) and 63 FR 7254, 7265, February 12, 1998, *http://www.gpo.gov/fdsys/pkg/FR-1998-02-12/pdf/98-3451.*

[14] ''Review of New Sources and Modifications in Indian Country,'' U.S. Environmental Protection Agency, 71 FR 48696, August 21, 2006, *https://www.gpo.gov/fdsys/pkg/FR-2006-08-21/pdf/06-6926.pdf.*

[15] ''Review of New Sources and Modifications in Indian Country,'' U.S. Environmental Protection Agency, 76 FR 38748, July 1, 2011, *https://www.gpo.gov/fdsys/pkg/FR-2011-07-01/pdf/2011-14981.pdf.*

[16] To obtain eligibility to develop and implement an EPA-approved plan, under the TAR a tribe must meet four requirements: (1) be a federally recognized tribe, (2) have a functioning government, (3) have the legal authority and (4) have the capacity to run the program. For more information, see 63 FR 7254, February 12, 1998, *http://www.gpo.gov/fdsys/pkg/FR-1998-02-12/pdf/98-3451.pdf.*

[17] Under tribal law, tribes may also be able to establish permit fees under a tribal permitting program, as do most states.

[18] For true minor sources in the oil and natural gas sector, this date was extended twice. The final date of October 3, 2016, was included in the National O&NG FIP.

nonattainment major NSR program(s).[19] The Federal Indian Country Minor NSR rule also created a framework for the EPA to streamline the issuance of pre-construction permits to true minor sources by using general permits.

In promulgating the National O&NG FIP we determined that it was appropriate to promulgate a FIP to remedy an existing regulatory gap with respect to oil and natural gas production and natural gas processing operations in areas covered by the Federal Indian Country Minor NSR rule where there is no EPA-approved plan in place. The authority that underlies and supports the National O&NG FIP (as well as the Federal Indian Country Minor NSR FIP) also authorizes this proposed action, which simply would amend the National O&NG FIP. In summary, just as we had the authority to establish the National O&NG FIP, we believe that we have authority under the CAA (sections 301(a), 301(d)(4) and 110(a)(2)(C)) and regulatory authority under the TAR (40 CFR 49.1–49.11) to carry out this action and extend the applicability of the National O&NG FIP to the Indian country portion of the Uinta Basin Ozone Nonattainment Area. As described above, the CAA provides broad authority to manage air resources throughout Indian country, regardless of area designation under the CAA. This is well established authority and we have exercised it on many occasions, including to regulate activity in areas of Indian country designated nonattainment. Foremost, the Agency is responsible for ensuring that NAAQS are achieved throughout Indian country and to implement CAA programs in Indian country that tribal governments do not elect to implement. This proposed action is consistent with and supported by our successful use of these authorities in these prior actions.

Finally, in light of the intended, pending final designation of nonattainment for the Uinta Basin for the 2015 ozone NAAQS, this action is consistent with the CAA general provisions for nonattainment areas in CAA sections 172(b) and 172(c), which include references to CAA section 110(a)(2), as well as the major source nonattainment NSR permitting program in CAA section 173. This proposed action is consistent with CAA section 110(a)(2)(C), which requires that implementation plans include programs for all areas (attainment and nonattainment) that provide for the regulation of the modification and construction of any stationary source ''as necessary to assure that national ambient air quality standards are achieved'' for the reasons discussed elsewhere in this document. In addition, CAA sections 172 and 173 provide that programs relating to permits to construct for major sources should take into consideration emissions from existing sources, as well as new or modified sources that ''are not major emitting facilities,'' *i.e.,* new or modified minor sources. Thus, the emissions from minor sources covered by this action would be considered in CAA section 173 major source permitting actions in the intended Uinta Basin Ozone Nonattainment Area, though they are not directly subject to regulation under CAA sections 172 and 173.[20]

C. Rationale for Proposed Action

In the preamble to the final National O&NG FIP, we made clear that we could extend the geographic coverage of the FIP to nonattainment areas, provided that we also addressed existing, new and modified sources in a separate, reservation-specific FIP. We stated the need to develop area-specific plans if and when areas of Indian country become nonattainment. Further, we specifically noted concern about the air quality problem in the Uinta Basin and indicated our intent to propose a separate reservation-specific FIP to address the issue.

The extension of the National O&NG FIP proposed in this document will, if finalized, provide coverage under the National O&NG FIP for Indian country portion of the intended Uinta basin Ozone Nonattainment Area after EPA's intended designation of portions of the Uinta Basin as being in nonattainment of the 2015 ozone NAAQS, which the EPA intends to issue by April 30, 2018. We indicated in the preamble to the final National O&NG FIP that we intended ''to potentially apply the national FIP's requirements as appropriate to nonattainment areas where the EPA has established a separate, area-specific FIP.''[21] The EPA does intend to do just that for the Indian country portion of the intended Uinta Basin Ozone Nonattainment Area, but in the meantime we are proposing this action. The agency believes that this approach is reasonable in light of the following considerations.

First, as noted above, the EPA is moving quickly to undertake a separate rulemaking to establish a U&O Reservation-specific FIP for the area. We intend to complete this other action—the U&O Reservation-specific FIP—before the start of the 2018–2019 winter ozone season in the Uinta Basin. Our intent is for the FIP to contain VOC emissions control requirements that will apply to existing, new and modified minor oil and natural gas sources on the U&O Reservation. Our intent is for some of those requirements (*i.e.,* VOC requirements on new and modified minor sources) to apply before the start of the 2018–2019 winter ozone season on the U&O Reservation, by which time we expect the final U&O Reservation-specific FIP to be effective with the requirements on existing oil and natural gas minor sources to follow. It should also be noted that preliminary monitoring data from the current 2017–2018 winter ozone season from across the region show values well below the 2015 ozone NAAQS.[22]

Second, the relatively short, initial period of time before a U&O Reservation-specific FIP is in place during which the National O&NG FIP will apply to the U&O Reservation (as part of the expected Uinta Basin Ozone Nonattainment Area), will be before the Uinta Basin winter ozone season. As noted above, the Uinta Basin does not have a summertime ozone air quality problem. We are, therefore, confident that—with this action—the eight emissions standards that apply to oil and natural gas sources under the National O&NG FIP will continue to be adequately protective of air quality in the U&O Reservation while we complete the separate rulemaking to establish a U&O Reservation-specific FIP, all of which we expect to occur before the start of the 2018–2019 winter ozone season in the Uinta Basin.

Finally, the two-part approach we are taking is similar to the process that occurs under the CAA when an area within a state is designated nonattainment: A plan addressing the air quality problem is not due to the EPA until a period of time after an area is designated nonattainment. Thus, the approach we are presenting here, we believe, is reasonable.

[19] A source may, however, be subject to certain monitoring, recordkeeping and reporting (MRR) requirements under the major NSR programs, if the change has a reasonable possibility of resulting in a major modification. A source may be subject to both the Federal Indian Country Minor NSR rule and the reasonable possibility MRR requirements of the major NSR program(s).

[20] The Federal Indian Country NSR rule also provides for major source permitting in nonattainment areas in Indian country. See 76 FR 38748, July 1, 2011, *https://www.gpo.gov/fdsys/pkg/FR-2011-07-01/pdf/2011-14981.pdf.*

[21] See 81 FR 35943, 35946, June 3, 2016, *https://www.gpo.gov/fdsys/pkg/FR-2016-06-03/pdf/2016-11969.pdf.*

[22] See spreadsheet titled: ''Uinta Basin Ozone Data, Dec. 2017-Feb. 2018,'' Docket No. EPA–HQ–OAR–2014–0606.

We also believe that this action—along with the EPA's related, forthcoming action to reduce oil and natural gas source emissions in the area—will address the air quality problem on the U&O Reservation, while maintaining a mechanism for authorizing construction that helps ensure continued oil and natural gas production on the U&O Reservation in compliance with the eight federal rules that apply to true minor oil and natural gas sources under the FIP.[23] Based on feedback from Ute Indian Tribe leadership, continued oil and natural gas production is important for the maintenance of the local tribal economy, as the Ute Indian Tribe is dependent upon oil and natural gas revenue for its economic prosperity. Because the action we propose today will avoid disruption of that activity during the period before the wintertime ozone problem manifests, while the EPA works to promulgate an area-specific protective measure to address that problem, the agency believes this course of action will appropriately protect the Basin's environment without causing unnecessary disruption to its economy.

We are proposing that the extension of the National O&NG FIP to eligible true minor oil and natural gas sources in the Indian country portion of the intended Uinta Basin Ozone Nonattainment Area be permanent. However, we also are seeking comment on whether, instead, it should be temporary and expire before the onset of the 2018–2019 ozone season. We seek comment on whether the extension should be temporary, in light of the facts surrounding the Uinta Basin's situation as described above and with respect to: (1) This proposed action, (2) its impending nonattainment designation, and (3) the forthcoming area-specific FIP.

In particular, we seek comment on how the EPA can protect air quality on the U&O Reservation and ensure continued oil and natural gas development under two general scenarios. In the first scenario, we finalize the extension as permanent, as proposed, but we do not complete the U&O Reservation-specific FIP by the start of the 2018–2019 Uinta Basin winter ozone season. A concern may be that continuing to allow the Uinta Basin Ozone Nonattainment Area to be covered by the National O&NG FIP in the absence of any emissions reductions that may be associated with the U&O Reservation-specific FIP. We seek comment relating to this scenario, including on what the Agency could do in this action, when finalized, to mitigate possible impacts.

In another scenario, we, instead finalize the extension as temporary and we set it to expire at the end of calendar year 2018, say, but we do not complete the U&O Reservation-specific FIP by the start of the 2018–2019 Uinta Basin winter ozone season. Here, the concern would be the effect on oil and natural gas activity on the U&O Reservation, if the area loses coverage under the National O&NG FIP. In the absence of other measures, sources in the Indian country portion of Uinta Basin Ozone Nonattainment Area (the U&O Reservation) would need to obtain source-specific minor source permits in order to construct and operate. Oil and natural gas owners and operators in the U&O reservation and the Ute Indian Tribe have significant concerns about delays associated with this type of permitting. As noted above, the Ute Indian Tribe relies on revenue from oil and natural gas activity for its livelihood and has expressed concerns about the lengthier timeframes associated with EPA approvals under source-specific permitting. We seek comment relating to this scenario, including on what the Agency could do to mitigate possible impacts.

III. Background

A. FIPs Under the Indian Country Minor NSR Rule

1. Federal Indian Country Minor NSR Rule

As noted above, CAA section 301(d)(4) authorizes the EPA to issue regulations directly administering, in Indian country, provisions of the Act. Exercising its authority, including its authority under 301(d)(4), the EPA promulgated the Federal Indian Country Minor NSR rule, a type of FIP. We identified a regulatory gap that could have the effect of adversely impacting air quality due to the lack of approved minor NSR permit programs to regulate construction of new and modified minor sources and minor modifications of major sources in areas covered by the Federal Indian Country Minor NSR rule. The EPA promulgated the FIP to ensure that air resources are protected by establishing a preconstruction permitting program to regulate emission increases resulting from construction and modification activities that are not already regulated by the major NSR permitting programs.

2. National O&NG FIP

Following the issuance of the Federal Indian Country Minor NSR FIP, EPA proposed the National O&NG FIP.[24] Because there were no currently approved TIPs specifically applying to the issuance of general permits with respect to the reduction of emissions related to oil and natural gas production facilities, we proposed a FIP to protect air quality in areas covered by the Federal Indian Country Minor NSR rule. The National O&NG FIP was published in final form on June 3, 2016.[25] The National O&NG FIP adopted legally and practicably enforceable requirements to control and reduce air emissions from oil and natural gas production.

The National O&NG FIP was developed to protect air quality in Indian country due to the impact of new true minor sources and minor modifications at existing true minor sources in the oil and natural gas production and natural gas processing segments of the oil and natural gas sector that are locating or expanding in an Indian reservation or in another area of Indian country over which a tribe, or the EPA, has demonstrated that the tribe has jurisdiction. The FIP applies to new and modified true minor sources that are located or expanding in such areas of Indian country designated as attainment, unclassifiable or attainment/unclassifiable. It currently does not apply to new and modified true minor sources that are located or expanding in such areas of Indian country designated nonattainment. However, this action proposes to extend the National O&NG FIP's geographic coverage to the Uinta Basin Ozone Nonattainment Area. The FIP does not apply to minor modification of major sources; such sources are required to obtain a source-specific permit prior to beginning construction, per the Federal Indian Country Minor NSR rule.

The National O&NG FIP fulfills the EPA's obligation under the Federal Indian Country Minor NSR rule to issue minor source NSR pre-construction permits to oil and natural gas sources. The National O&NG FIP provides a streamlined, alternative approach that

[23] This includes the EPA's New Source Performance Standards (NSPS) for oil and natural gas sources (40 CFR part 60, subpart OOOO) with affected facilities that commenced construction, modification or reconstruction after August 23, 2011. The standard includes emissions standards for VOC and sulfur dioxide (SO_2) from a number of units, including storage tanks, compressors, and pneumatic controllers.

[24] "Review of New Sources and Modifications in Indian Country: Federal Implementation Plan for Managing Air Emissions from True Minor Sources Engaged in Oil and Natural Gas Production in Indian Country," U.S. Environmental Protection Agency, 80 FR 56553, September 18, 2005, *https://www.gpo.gov/fdsys/pkg/FR-2015-09-18/pdf/2015-21025.pdf.*

[25] See 81 FR 35943, 35946, June 3, 2016, *https://www.gpo.gov/fdsys/pkg/FR-2016-06-03/pdf/2016-11969.pdf.*

fulfills the permitting requirement, while also ensuring air quality protection through requirements that are unambiguous and legally and practicably enforceable. The FIP approach is also transparent to the public: It is clear to the public what requirements will apply. The FIP reduces burden for sources and the Reviewing Authority and minimizes potential delays in new construction due to compliance with the minor NSR permitting obligation. True minor sources in the oil and natural gas production and natural gas processing segments of the oil and natural gas sector are required to comply with the FIP instead of obtaining a source-specific minor source permit, unless a source chooses to opt out of the FIP and to obtain a source-specific minor NSR permit instead.

Under the FIP, we require owners/operators of oil and natural gas production facilities and natural gas processing plants to comply with eight federal standards to reduce emissions of VOC, NO_X, SO_2, particulate matter (PM, PM_{10}, $PM_{2.5}$), hydrogen sulfide, carbon monoxide and various sulfur compounds from the following units/processes in the oil and natural gas production and natural gas processing segments of the oil and natural gas sector: Compression ignition and spark ignition engines; process heaters; combustion turbines; fuel storage tanks; glycol dehydrators; completion of hydraulically fractured oil and natural gas wells; reciprocating and centrifugal compressors (except those located at well sites); pneumatic controllers; pneumatic pumps; storage vessels; and fugitive emissions from well sites, compressor stations and natural gas processing plants. The oil and natural gas FIP requires compliance with five NSPS and three national emission standards for hazardous air pollutants (NESHAP).[26] These regulations are listed in Table 2.

The eight regulations and the provisions of each that are included in the oil and natural gas FIP are discussed in more detail in this section. The FIP's requirements include emission standards (that contain emission limitations), monitoring, testing, recordkeeping and reporting. For purposes of the National O&NG FIP, true minor sources must comply with these standards, as they currently exist or as amended in the future, except for those provisions that we specifically exclude under the National O&NG FIP (unless the source opts out of the FIP and obtains a source-specific permit or is otherwise required to obtain a source-specific permit by the Reviewing Authority). Sources subject to the National O&NG FIP would be subject to any future changes to the eight underlying EPA standards only if they undergo a future minor modification as a true minor source and would otherwise be subject to those future changes. (The National O&NG FIP does not change the applicability of the specified standards, nor does it relieve sources subject to the standards from complying with them, independently of the National O&NG FIP.)

TABLE 2—EIGHT FEDERAL RULES INCLUDED IN THE OIL AND NATURAL GAS FIP FOR INDIAN COUNTRY[27]

40 CFR part and subpart	Title of subpart	Potentially affected sources in the oil and natural gas production and natural gas processing segments of the oil and natural gas sector	Location
40 CFR part 63, subpart DDDDD.	National Emission Standards for Hazardous Air Pollutants for Major Sources: Industrial, Commercial, and Institutional Boilers and Process Heaters.	Process heaters	*http://www.ecfr.gov/cgi-bin/text-idx?SID=9f31077f895e9cb417f5386519941a47&mc=true&node=sp40.14.63.ddddd&rgn=div6.*
40 CFR part 63, subpart ZZZZ	Subpart ZZZZ—National Emissions Standards for Hazardous Air Pollutants for Stationary Reciprocating Internal Combustion Engines.	Reciprocating Internal Combustion Engines	*http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr;rgn=div6;view=text;node=40%3A14.0.1.1.1.1;idno=40;sid=e94dcfde4a04b27290c445a56e635e58;cc=ecfr.*
40 CFR part 60, subpart IIII	Standards of Performance for Stationary Compression Ignition Internal Combustion Engines.	Compression Ignition Internal Combustion Engines.	*http://www.ecfr.gov/cgi-bin/text-idx?SID=9f31077f895e9cb417f5386519941a47&mc=true&node=sp40.7.60.iiii&rgn=div6.*
40 CFR part 60, subpart JJJJ	Standards of Performance for Stationary Spark Ignition Internal Combustion Engines.	Spark Ignition Internal Combustion Engines	*http://www.ecfr.gov/cgi-bin/text-idx?SID=9f31077f895e9cb417f5386519941a47&mc=true&node=sp40.7.60.jjjj&rgn=div6.*
40 CFR part 60, subpart Kb	Standards of Performance for Volatile Organic Liquid Storage Vessels (Including Petroleum Liquid Storage Vessels) for Which Construction, Reconstruction, or Modification Commenced After July 23, 1984.	Fuel Storage Tanks	*http://www.ecfr.gov/cgi-bin/text-idx?SID=9f31077f895e9cb417f5386519941a47&mc=true&node=sp40.7.60.k_0b&rgn=div6.*
40 CFR part 60, subpart OOOOa.	Standards of Performance for Crude Oil and Natural Gas Facilities for which Construction, Modification, or Reconstruction Commenced after September 18, 2015.	Storage Vessels, Pneumatic Controllers, Compressors (Reciprocating and Centrifugal), Hydraulically Fractured Oil and Natural Gas Well Completions, Pneumatic Pumps and Fugitive Emissions from Well Sites and Compressor Stations.	*https://www.epa.gov/controlling-air-pollution-oil-and-natural-gas-industry/actions-and-notices-about-oil-and-natural-gas.*
40 CFR part 63, subpart HH	National Emission Standards for Hazardous Air Pollutants from Oil and Natural Gas Production Facilities.	Glycol Dehydrators	*http://www.ecfr.gov/cgi-bin/text-idx?SID=9f31077f895e9cb417f5386519941a47&mc=true&node=sp40.11.63.hh&rgn=div6.*

[26] Though this FIP only addresses new and modified true minor sources, it is important to note that NESHAPs not only apply to new sources but to existing sources as well.

TABLE 2—EIGHT FEDERAL RULES INCLUDED IN THE OIL AND NATURAL GAS FIP FOR INDIAN COUNTRY [27]—Continued

40 CFR part and subpart	Title of subpart	Potentially affected sources in the oil and natural gas production and natural gas processing segments of the oil and natural gas sector	Location
40 CFR part 60, subpart KKKK	Standards of Performance for New Stationary Combustion Turbines.	Combustion Turbines	*http://www.ecfr.gov/cgi-bin/text-idx?SID=4090b6cf5eea5cb67940a80906ff09a2&mc=true&node=sp40.7.60.kkkk&rgn=div6.*

3. National O&NG FIP and Areas of Comment the EPA Received Relevant to This Action

In the response to comments section of the preamble to the final rule establishing the National O&NG FIP, we addressed some issues that are related to this proposed action.[28] We provided that the FIP does not apply in a nonattainment area, but that it could, if we addressed existing sources in such an area.[29] We stated that, parallel to designating such an area is designated as nonattainment, we would promulgate an area-specific FIP for existing sources if we determine that it is ''necessary or appropriate'' to do so pursuant to the TAR.[30] We received comments concerning extending the geographic reach of the National O&NG FIP to nonattainment areas. Commenters were concerned with how permitting requirements would be satisfied in such areas during the transition period between the time an area is designated as nonattainment and the time a separate, area-specific FIP to control emissions adequately in such a nonattainment area is in place. The Uinta Basin was given as an example of where the absence of a streamlined means to satisfy permitting requirements during this transition period could pose problems. In response to the comments, we stated our intent to potentially apply the National O&NG FIP's requirements as appropriate to nonattainment areas, where the EPA has established a separate, area-specific FIP. As discussed earlier, our proposed approach here is slightly different, in that the extension of the National O&NG FIP to the Uinta Basin nonattainment area may precede the separate, area-specific FIP for that area. However, our plan is for the separate, area-specific FIP to be in place before the next winter ozone season. Because, as discussed above, ozone problems in the Uinta Basin are limited to the winter season, we believe this approach is appropriately protective of air quality, without unduly impeding oil and natural gas activity in Indian Country.

In addition, we received comments recommending that we add monitoring and modeling requirements to the National O&NG FIP. Our response to those comments included a discussion about the state of air quality in areas of Indian country with oil and natural gas activity. With respect to air quality in areas of Indian country with oil and natural gas development, we noted in June 2016 when we promulgated the National O&NG FIP that we were not seeing widespread air quality problems in Indian country due to oil and natural gas activity. We mentioned in June 2016 that, in all of Indian country, only two counties in the Uinta Basin (including land within the U&O Reservation) had air quality problems due to oil and natural gas activity. That is still the case and is discussed further in Section III.C. We had (and still have) sufficient concerns about the air quality impacts from existing sources in that area that we intend to soon propose a separate reservation-specific FIP, which, as noted above, is expected to be in place before next winter's ozone season.

B. Uinta Basin Air Quality and Intended Nonattainment Designation

On October 1, 2015, the EPA promulgated revised primary and secondary ozone NAAQS.[31] The EPA strengthened both standards to a level of 0.070 parts per million (ppm). In accordance with section 107(d) of the CAA, whenever the EPA establishes a new or revised NAAQS, the EPA must promulgate designations for all areas of the country for that NAAQS. The EPA must complete this process within 2 years of promulgating the NAAQS, unless the Administrator has insufficient information to make the initial designations decisions in that time frame. In such circumstances, the EPA may take up to 1 additional year to complete the designations. Under CAA section 107(d), states were required to submit area designation recommendations to the EPA for the 2015 ozone NAAQS no later than 1 year following promulgation of the standards (*i.e.,* by October 1, 2016).

On September 29, 2016, the state of Utah provided designation recommendations for counties in Utah based on air quality data from 2013–2015. The state recommended a designation of nonattainment for townships in the counties of Duchesne and Uintah under state air jurisdiction that are at and below the 6,000-ft elevation. On February 26, 2018, the state of Utah provided further input on the nonattainment boundaries. On September 27, 2016, the Ute Indian Tribe of the Uintah and Ouray Reservation recommended that the Indian country area at an unspecified distance around the Ouray ozone monitor in the Uinta Basin be designated as nonattainment for the 2015 ozone NAAQS based on air quality data from 2013–2015. However, the Tribe recommended a designation of attainment for all of Indian country in the Uinta Basin, assuming the EPA concurs with an exceptional event package submitted to the agency (by the Tribe) covering two days in June 2015.

On December 20, 2017, in our response to the state and tribal designation boundary recommendations, we indicated our intent to modify the state's and tribe's recommendations for the Uinta Basin area. We provided the intended

[27] Three of the eight rules are NESHAPs. Our basis for requiring compliance with NESHAPs in this rule that is designed to fulfill requirements of the Federal Indian Country Minor NSR rule is to address emissions of criteria pollutants. The requirements from the NESHAPs are included because they effectively control emissions of all VOC, not just those that are also hazardous air pollutants. VOC is an NSR-regulated pollutant of concern in the Federal Indian Country Minor NSR rule.

[28] 81 FR 35943, June 3, 2016, *https://www.gpo.gov/fdsys/pkg/FR-2016-06-03/pdf/2016-11969.pdf.*

[29] In the preamble to the final National O&NG FIP we also indicated as a general matter—and not in response to comments—that new and modified sources also need to be addressed in reservation-specific FIPs (in addition to existing sources) when considering whether to extend the geographic coverage of the National O&NG FIP to nonattainment area. 81 FR 35943, 35964, 35968, June 3, 2016, *https://www.gpo.gov/fdsys/pkg/FR–2016-06-03/pdf/2016-11969.pdf.*

[30] 63 FR 7254, February 12, 1998, *http://www.gpo.gov/fdsys/pkg/FR-1998-02-12/pdf/98-3451.pdf.*

[31] ''National Ambient Air Quality Standards for Ozone,'' U.S. Environmental Protection Agency, 80 FR 65292, October 26, 2015, *https://www.gpo.gov/fdsys/pkg/FR-2015-10-26/pdf/2015-26594.pdf.*

boundary in a Technical Support Document.[32] In short, the EPA's boundary for the intended nonattainment area for the Uinta Basin includes both state and Indian country lands within portions of Duchesne and Uintah Counties. A comment period followed the EPA's statement on its intended nonattainment boundaries for the Uinta Basin and other areas.[33]

IV. Summary of Proposed Amendments

This action proposes to amend the National O&NG FIP to extend its application to eligible true minor oil and natural gas sources in the Indian country portion of the intended Uinta Basin Ozone Nonattainment Area, which includes its mechanism for authorizing construction. We also are proposing to make a technical correction to fix a typographical error in § 49.101(c).

First, this action proposes to add a new subparagraph to the CFR, to be codified at § 49.101(e). In the new subparagraph, we are proposing to narrowly extend the geographic scope of the National O&NG FIP to cover eligible true minor oil and natural gas sources wishing to locate or expand in the Indian country portion (U&O Reservation) of the intended Uinta Basin Ozone Nonattainment Area.[34] This proposed extension of coverage to this one nonattainment area does not alter the FIP's current geographic coverage of attainment, unclassifiable and attainment/unclassifiable areas with regard to the rest of Indian country across the nation. The proposed, geographically limited extension is in addition to the current coverage. Under this proposed amendment, true minor oil and natural gas sources in the oil and natural gas production and natural gas processing segments of the oil and natural gas sector wishing to locate or expand in the Indian country portion of the intended Uinta Basin Ozone Nonattainment Area would also have to meet the criteria under § 49.101(b)(1) to qualify, except for § 49.101(b)(1)(v). Section 49.101(b)(1)(v) contains the requirement governing the primary geographic scope of the FIP and not its limited extension to the intended Uinta Basin Ozone Nonattainment Area, and, thus, would not be relevant for such sources. In other words, the new paragraph § 49.101(e) would displace existing § 49.101(b)(1)(v) for Indian country within the intended Uinta Basin Ozone Nonattainment Area—and *only* for that area of Indian country.

To accomplish this extension, it is also necessary to define the boundaries of the intended Uinta Basin Ozone Nonattainment Area to which the National O&G FIP would apply if the EPA finalizes this proposed rule. To accomplish this, the EPA proposes to incorporate the boundaries for the intended nonattainment area for the Uinta Basin, or areas within the Uinta Basin, as defined at 40 CFR part 81, Designations of Areas for Air Quality Purposes.[35] The regulatory and other processes that have occurred within and outside the EPA and between the EPA and state and tribal governments govern the development and final decision on the boundaries for the intended Uinta Basin Ozone Nonattainment Area and not this action.

Second, this action proposes a technical correction to § 49.101(c), which currently reads: ''*When must I comply with §§ 49.101 through 49.105*? You must comply with §§ 49.101 through 49.101 on or after October 3, 2016.'' This provision is supposed to reference §§ 49.101 through 49.105, as the title indicates. We are proposing to correct it to read: ''*When must I comply with §§ 49.101 through 49.105*? You must comply with §§ 49.101 through 49.105 on or after October 3, 2016.'' The EPA believes that this is a correction of a self-evident scrivener's error and does not constitute a substantive change of the existing regulatory provision.

V. Statutory and Executive Order Reviews

A. Executive Order 12866: Regulatory Planning and Review and Executive Order 13563: Improving Regulation and Regulatory Review

This action is not a significant regulatory action and was, therefore, not submitted to the Office of Management and Budget (OMB) for review.

B. Executive Order 13771: Reducing Regulations and Controlling Regulatory Costs

This action is expected to be an Executive Order 13771 deregulatory action. This proposed rule is expected to provide meaningful burden reduction by extending the streamlined authorization-to-construct method for true minor new and modified oil and natural gas sources. The streamlined authorization, which was established by the EPA in 2016, reduces the resource burden on the permitting authority and regulated community associated with submitting and reviewing permit applications for these sources in attainment and unclassifiable areas. This action proposes to extend the streamlined authorization to the intended Uinta Basin Ozone Nonattainment Area.

C. Paperwork Reduction Act (PRA)

This action does not impose any new information collection burden under the PRA. OMB has previously approved the information collection activities contained in the Federal Indian Country Minor NSR rule and has assigned OMB control number 2060–0003.[36] This action amends the National O&NG FIP which provides a mechanism for authorizing construction for true minor sources in the oil and natural gas production and natural gas processing segments of the oil and natural gas sector locating or located in areas covered by the Federal Indian Country Minor NSR rule to satisfy the requirements of that rule other than by obtaining a source-specific minor source permit. Because it substitutes for a source-specific permit, which would contain information collection activities covered by the Information Collection Request for Federal Indian Country Minor NSR rule issued in July 2011, neither the proposed amendments nor the National O&NG FIP impose any new obligations or enforceable duties on any state, local or tribal government or the private sector. In fact, the proposed amendments would have the effect of reducing paperwork burden on sources wishing to locate or expand in the Indian country portion of the Uinta Basin as the amendments provide an alternative to source-specific permitting for such sources.

D. Regulatory Flexibility Act (RFA)

I certify that this action will not have a significant economic impact on a substantial number of small entities under the RFA. In making this

[32] Utah: Northern Wasatch Front, Southern Wasatch Front, and Uinta Basin Intended Area Designations for the 2015 Ozone National Ambient Air Quality Standards Technical Support Document (TSD),'' U.S. Environmental Protection Agency, December 20, 2017, *https://www.epa.gov/sites/production/files/2018-01/documents/ut_120d_tsd.pdf.*

[33] 83 FR 651, January 5, 2018, *https://www.gpo.gov/fdsys/pkg/FR-2018-01-05/pdf/2018-00024.pdf.*

[34] Utah: Northern Wasatch Front, Southern Wasatch Front, and Uinta Basin Intended Area Designations for the 2015 Ozone National Ambient Air Quality Standards Technical Support Document (TSD),'' U.S. Environmental Protection Agency, December 20, 2017, *https://www.epa.gov/sites/production/files/2018-01/documents/ut_120d_tsd.pdf.*

[35] Ibid.

[36] Since the Federal Indian Country Minor NSR rule was promulgated, the Information Collection Request has been renewed and approved by OMB twice. The most recent approval extended the ICR until October 31, 2020. The ICR covers the activities of the National O&NG FIP. For more information, go to: *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201702-2060-005.*

determination, the impact of concern is any significant adverse economic impact on small entities. An agency may certify that a rule will not have a significant economic impact on a substantial number of small entities if the rule relieves regulatory burden, has no net burden or otherwise has a positive economic effect on the small entities subject to the rule. The EPA analyzed the impact on small entities of streamlined permitting under the Federal Indian Country Minor NSR rule [37] and determined that it would not have a significant economic impact on a substantial number of small entities. (By allowing sources to avoid having to obtain source-specific permits, this proposed action also would relieve regulatory burden.) This action merely implements a particular aspect of the Federal Indian Country Minor NSR rule. We have, therefore, concluded that this action will have no net regulatory burden for all directly regulated small entities.

E. Unfunded Mandates Reform Act (UMRA)

This action does not contain any unfunded mandates, as described in UMRA, 2 U.S.C. 1531–1538, and does not significantly or uniquely affect small governments. The action imposes no enforceable duty on any state, local or tribal government or the private sector. It simply modifies one option for sources to comply with the Federal Indian Country Minor NSR rule. The Federal Indian Country Minor NSR rule itself, not this proposed action, imposes the obligation that true minor sources in areas covered by the Federal Indian Country Minor NSR rule obtain a minor source NSR permit prior to commencing construction. This proposed action merely applies the National O&NG FIP to the U&O Reservation as part of the Uinta Basin Nonattainment Area, which includes a streamlined mechanism for authorizing construction for meeting the obligation of the Federal Indian Country minor NSR rule.

F. Executive Order 13132: Federalism

This action does not have federalism implications. It would 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.

G. Executive Order 13175: Consultation and Coordination With Indian Tribal Governments

This action has tribal implications. However, it will neither impose substantial direct compliance costs on federally recognized tribal governments, nor preempt tribal law. Consistent with the EPA Policy on Consultation and Coordination with Indian Tribes (May 4, 2011),[38] the EPA offered consultation on the concerns addressed in this proposed action, which include the lack of a streamlined permitting for the U&O Reservation should the area be designated nonattainment. The EPA conducted outreach on the issues addressed by the previous rule via ongoing monthly meetings with tribal environmental professionals in the development of the past proposed action,[39] and further as follows via: (1) Tribal consultation with the Ute Indian Tribe Business Committee on July 22, 2015; December 17, 2016; November 13, 2017; and March 22, 2018, regarding options that the EPA considered in addressing the Uinta Basin air quality concerns; (2) stakeholder meetings where the Tribe was included and participated in emissions contributions discussions specific to the EPA's strategy for addressing the Uinta Basin air quality concerns; (3) ongoing stakeholder working group meetings; and (4) tribally-convened stakeholder meetings on March 22, 2017, and June 1–2, 2017.

This action reflects tribal concerns about, and priorities for, developing a streamlined approach for permitting true minor sources in the oil and natural gas sector in areas covered by the Federal Indian Country Minor NSR rule in the intended Uinta Basin Ozone Nonattainment Area. As these amendments, if finalized, are implemented, we will continue to provide regular outreach to tribes to ensure we address issues concerning the FIP if and when they arise. The EPA is available for consultation with any interested tribe.

H. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks

This action is not subject to Executive Order 13045 because it is not economically significant as defined in Executive Order 12866, and because the EPA does not believe the environmental health or safety risks addressed by this action present a disproportionate risk to children.

I. Executive Order 13211: Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution or Use

This action is not subject to Executive Order 13211, because it is not a significant regulatory action under Executive Order 12866.

J. National Technology Transfer and Advancement Act (NTTAA)

This action does not involve technical standards.

K. Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations

As discussed in Section II.B, we believe that this action is reasonable in light of our intended, separate rulemaking to establish a reservation-specific FIP and the expected short period of time before these requirements would apply. Therefore, the EPA believes the amendments in this action will not have potential disproportionately high and adverse human health or environmental effects on minority, low-income or indigenous populations. Through these amendments, we seek: (1) To extend geographically the National O&NG FIP and its mechanism for authorizing construction that effectively provides a streamlined method for implementing a pre-construction permitting program for true minor sources in the oil and natural gas sector in areas covered by the Federal Indian Country Minor NSR rule, and (2) to pursue an approach that enables a streamlined process, which helps promote economic development by minimizing delays in new construction.

List of Subjects in 40 CFR Part 49

Environmental protection, Administrative practices and procedures, Air pollution control, Indians, Indians—law, Indians—tribal government, Intergovernmental relations, Reporting and recordkeeping requirements.

Dated: April 30, 2018.

E. Scott Pruitt,

Administrator.

For the reasons set forth in the preamble, 40 CFR part 49 is proposed to be amended as follows:

[37] "Review of New Sources and Modifications in Indian Country," U.S. Environmental Protection Agency, 76 FR 38748, July 1, 2011, *https://www.federalregister.gov/articles/2011/07/01/2011-14981/review-of-new-sources-and-modifications-in-indian-country.*

[38] For more information, go to: *https://www.epa.gov/tribal/epa-policy-consultation-and-coordination-indian-tribes.*

[39] These monthly meetings are general in nature, dealing with many air-related topics, and are not specific to this proposed action.

PART 49—INDIAN COUNTRY: AIR QUALITY PLANNING AND MANAGEMENT

■ 1. The authority citation for part 49 continues to read as follows:

Authority: 42 U.S.C. 7401, *et seq.*

Subpart C—General Federal Implementation Plan Provisions

■ 2. In § 49.101:
■ a. Revise paragraph (c).
■ b. Add paragraph (e).

The revision and addition read as follows:

§ 49.101 Introduction.

* * * * *

(c) *When must I comply with §§ 49.101 through 49.105*? You must comply with §§ 49.101 through 49.105 on or after October 3, 2016.

* * * * *

(e) Notwithstanding paragraph (b)(1)(v), oil and natural gas sources located in the Indian country portion of the Uinta Basin Ozone Nonattainment Area are subject to §§ 49.101 through 49.105 (except for paragraph (b)(1)(v)), provided subparagraphs (b)(1)(i)–(iv) are also satisfied.

■ 3. In § 49.102, add the definition ''Uinta Basin ozone nonattainment area'' in alphabetical order to read as follows:

§ 49.102 Definitions.

* * * * *

Uinta Basin ozone nonattainment area means the nonattainment area for the Uinta Basin, or such parts or areas of the Uinta Basin, as it is or may hereafter be defined at 40 CFR part 81, Designations of Areas for Air Quality Purposes.

[FR Doc. 2018–09652 Filed 5–7–18; 8:45 am]

BILLING CODE 6560–50–P

Notices

Federal Register

Vol. 83, No. 89

Tuesday, May 8, 2018

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

[Doc. Number: AMS–FTPP–18–0024]

Information Collection; United States Warehouse Act (USWA)

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Revision to and extension of a currently approved information collection; comment request.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, as amended, the Agricultural Marketing Service (AMS) is requesting comments from all interested individuals and organizations on an extension of a currently approved information collection process associated with the regulations, licensing, and electronic provider agreements issued pursuant to the United States Warehouse Act (''USWA''). The only revision to this information collection involves the transfer of functions from the Farm Service Agency to the Agricultural Marketing Service due to internal reorganization within the United States Department of Agriculture.

DATES: Comments on this Notice must be received by July 9, 2018.

ADDRESSES: You may submit comments on this Notice. All comments should reference the docket number AMS–FTPP–18–0024, the date, and page number of this issue of the **Federal Register**. All comments received will be posted without change, including any personal information provided, at *www.regulations.gov* and will be included in the record and made available to the public. You may submit comments by any of the following methods:

- *Federal eRulemaking Portal:* Go to *www.regulations.gov.* Follow the online instructions for submitting comments.
- *Mail, hand delivery, or courier:* Brandi Kujawa, United States Department of Agriculture, Agricultural Marketing Service, Fair Trade Practices Program, Warehouse Commodity and Management Division—Examination Branch, STOP 9148, P.O. Box 419205, Kansas City, MO 64141–9205.

Copies of the information collection may be requested by contacting Brandi Kujawa as provided below.

FOR FURTHER INFORMATION CONTACT: For specific questions related to collection activities, contact Brandi Kujawa, (816) 926–6582. Persons with disabilities who require alternative means for communication (Braille, large print, audio tape, etc.) should contact the USDA's TARGET Center at (202)720–2600 (Voice).

SUPPLEMENTARY INFORMATION:

Title: United States Warehouse Act (USWA).

OMB Control Number: 0581–0305.

Expiration Date of Approval: June 30, 2018.

Type of Request: Revision and extension of a currently approved information collection.

Abstract: AMS is responsible, as required by the USWA, 7 U.S.C. 241 *et seq.,* to license public warehouse operators that are in the business of storing agricultural products, to examine such federally-licensed warehouses and to license qualified persons to sample, inspect, weigh, and classify agricultural products. The AMS licenses under the USWA cover approximately half of all commercial grain and cotton warehouse capacities in the United States. The regulations that implement the USWA govern the establishment and maintenance of systems under which documents, including documents of title on shipment, payment and financing, may be issued or transferred for agricultural products. Some of these systems and documents issued may be electronic. The regulations are found at 7 CFR 735 *et seq.*

This information collection allows AMS to effectively administer the regulations, licensing, and electronic provider agreements and related reporting and recordkeeping requirements as specified in the USWA.

The forms in this information collection are used to provide those charged with issuing licenses under the USWA a basis to determine whether the warehouse and the warehouse operator meet application requirements to receive a license, and to determine compliance once the license is issued.

In keeping the public informed, this information collection request was previously approved by the Farm Service Agency (FSA) and due to an internal reorganization, the USWA functions were transferred to AMS. The OMB control number for the forms is currently 0581–0305. AMS is not making any changes to the burden hours in this request since the prior submission to OMB made by FSA.

For the following estimated total annual burden on respondents, the formula used to calculate the total burden hours is the estimated average time per response multiplied by the estimated total annual responses.

Estimate of Respondent Burden: Public reporting burden for collecting information under this notice is estimated to average 0.46 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collections of information.

Type of Respondents: Warehouse operators, electronic providers and producers participating in AMS or Commodity Credit Corporation programs.

Estimated Number of Respondents: 3,000.

Estimated Average Number of Responses per Respondent: 5.9574.

Estimated Total Annual Responses: 17,872.

Estimated Average Time per Response: 0.46.

Estimated Total Annual Burden on Respondents: 8,162.50 hours.

Comments are invited on all aspects of this information collection to help AMS to:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of the burden of the collection of information including the validity of the methodology and assumptions used;

(3) Evaluate the quality, utility, and clarity of the information technology; and

(4) Minimize the burden of the information collection on those who are

to respond through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

All comments received in response to this notice, including names and addresses when provided, will become a matter of public record. Comments will be summarized and included in the request for OMB approval of the information collection.

Dated: May 2, 2018.

Greg Ibach,

Under Secretary, Marketing and Regulatory Programs.

[FR Doc. 2018–09678 Filed 5–7–18; 8:45 am]

BILLING CODE 3410–02–P

DEPARTMENT OF AGRICULTURE

Food and Nutrition Service

Child Nutrition Programs: Income Eligibility Guidelines

AGENCY: Food and Nutrition Service, USDA.

ACTION: Notice.

SUMMARY: This notice announces the Department's annual adjustments to the Income Eligibility Guidelines to be used in determining eligibility for free and reduced price meals and free milk for the period from July 1, 2018 through June 30, 2019. These guidelines are used by schools, institutions, and facilities participating in the National School Lunch Program (and Commodity School Program), School Breakfast Program, Special Milk Program for Children, Child and Adult Care Food Program and Summer Food Service Program. The annual adjustments are required by section 9 of the Richard B. Russell National School Lunch Act. The guidelines are intended to direct benefits to those children most in need and are revised annually to account for changes in the Consumer Price Index.

DATES: *Implementation Date:* July 1, 2018.

FOR FURTHER INFORMATION CONTACT: Jessica Saracino, Program Monitoring and Operational Support Division, Child Nutrition Programs, Food and Nutrition Service, United States Department of Agriculture, 3101 Park Center Drive, Suite 628, Alexandria, Virginia 22302.

SUPPLEMENTARY INFORMATION: This action is not a rule as defined by the Regulatory Flexibility Act (5 U.S.C. 601–612) and thus is exempt from the provisions of that Act.

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507), no recordkeeping or reporting requirements have been included that are subject to approval from the Office of Management and Budget.

This notice has been determined to be not significant and was not reviewed by the Office of Management and Budget in conformance with Executive Order 12866. The affected programs are listed in the Catalog of Federal Domestic Assistance under No. 10.553, No. 10.555, No. 10.556, No. 10.558, and No. 10.559 and are subject to the provisions of Executive Order 12372, which requires intergovernmental consultation with State and local officials. (See 2 CFR part 415).

Background

Pursuant to sections 9(b)(1) and 17(c)(4) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(b)(1) and 42 U.S.C. 1766(c)(4)), and sections 3(a)(6) and 4(e)(1)(A) of the Child Nutrition Act of 1966 (42 U.S.C. 1772(a)(6) and 1773(e)(1)(A)), the Department annually issues the Income Eligibility Guidelines for free and reduced price meals for the National School Lunch Program (7 CFR part 210), the Commodity School Program (7 CFR part 210), School Breakfast Program (7 CFR part 220), Summer Food Service Program (7 CFR part 225) and Child and Adult Care Food Program (7 CFR part 226) and the guidelines for free milk in the Special Milk Program for Children (7 CFR part 215).

These eligibility guidelines are based on the Federal income poverty guidelines and are stated by household size. The guidelines are used to determine eligibility for free and reduced price meals and free milk in accordance with applicable program rules.

Definition of Income

In accordance with the Department's policy as provided in the Food and Nutrition Service publication Eligibility Manual for School Meals, ''income,'' as the term is used in this notice, means income before any deductions such as income taxes, Social Security taxes, insurance premiums, charitable contributions, and bonds. It includes the following: (1) Monetary compensation for services, including wages, salary, commissions or fees; (2) net income from nonfarm self-employment; (3) net income from farm self-employment; (4) Social Security; (5) dividends or interest on savings or bonds or income from estates or trusts; (6) net rental income; (7) public assistance or welfare payments; (8) unemployment compensation; (9) government civilian employee or military retirement, or pensions or veterans payments; (10) private pensions or annuities; (11) alimony or child support payments; (12) regular contributions from persons not living in the household; (13) net royalties; and (14) other cash income. Other cash income would include cash amounts received or withdrawn from any source including savings, investments, trust accounts and other resources that would be available to pay the price of a child's meal.

''Income'', as the term is used in this notice, does *not* include any income or benefits received under any Federal programs that are excluded from consideration as income by any statutory prohibition. Furthermore, the value of meals or milk to children shall not be considered as income to their households for other benefit programs in accordance with the prohibitions in section 12(e) of the Richard B. Russell National School Lunch Act and section 11(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1760(e) and 1780(b)).

The Income Eligibility Guidelines

The following are the Income Eligibility Guidelines to be effective from July 1, 2018 through June 30, 2019. The Department's guidelines for free meals and milk and reduced price meals were obtained by multiplying the year 2018 Federal income poverty guidelines by 1.30 and 1.85, respectively, and by rounding the result upward to the next whole dollar.

This notice displays only the annual Federal poverty guidelines issued by the Department of Health and Human Services because the monthly and weekly Federal poverty guidelines are not used to determine the Income Eligibility Guidelines. The chart details the free and reduced price eligibility criteria for monthly income, income received twice monthly (24 payments per year); income received every two weeks (26 payments per year) and weekly income.

Income calculations are made based on the following formulas: Monthly income is calculated by dividing the annual income by 12; twice monthly income is computed by dividing annual income by 24; income received every two weeks is calculated by dividing annual income by 26; and weekly income is computed by dividing annual income by 52. All numbers are rounded upward to the next whole dollar.

The numbers reflected in this notice for a family of four in the 48 contiguous States, the District of Columbia, Guam and the territories represent an increase of 2.0 percent over last year's level for a family of the same size.

Authority: Section 9(b)(1) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(b)(1)(A)).

INCOME ELIGIBILITY GUIDELINES

[Effective from July 1, 2018 to June 30, 2019]

Household size	Federal poverty guidelines	Reduced Price Meals—185%					Free Meals—130%				
	Annual	Annual	Monthly	Twice per month	Every two weeks	Weekly	Annual	Monthly	Twice per month	Every two weeks	Weekly
48 Contiguous States, District of Columbia, Guam, and Territories											
1	12,140	22,459	1,872	936	864	432	15,782	1,316	658	607	304
2	16,460	30,451	2,538	1,269	1,172	586	21,398	1,784	892	823	412
3	20,780	38,443	3,204	1,602	1,479	740	27,014	2,252	1,126	1,039	520
4	25,100	46,435	3,870	1,935	1,786	893	32,630	2,720	1,360	1,255	628
5	29,420	54,427	4,536	2,268	2,094	1,047	38,246	3,188	1,594	1,471	736
6	33,740	62,419	5,202	2,601	2,401	1,201	43,862	3,656	1,828	1,687	844
7	38,060	70,411	5,868	2,934	2,709	1,355	49,478	4,124	2,062	1,903	952
8	42,380	78,403	6,534	3,267	3,016	1,508	55,094	4,592	2,296	2,119	1,060
For each add'l family member, add	4,320	7,992	666	333	308	154	5,616	468	234	216	108
Alaska											
1	15,180	28,083	2,341	1,171	1,081	541	19,734	1,645	823	759	380
2	20,580	38,073	3,173	1,587	1,465	733	26,754	2,230	1,115	1,029	515
3	25,980	48,063	4,006	2,003	1,849	925	33,774	2,815	1,408	1,299	650
4	31,380	58,053	4,838	2,419	2,233	1,117	40,794	3,400	1,700	1,569	785
5	36,780	68,043	5,671	2,836	2,618	1,309	47,814	3,985	1,993	1,839	920
6	42,180	78,033	6,503	3,252	3,002	1,501	54,834	4,570	2,285	2,109	1,055
7	47,580	88,023	7,336	3,668	3,386	1,693	61,854	5,155	2,578	2,379	1,190
8	52,980	98,013	8,168	4,084	3,770	1,885	68,874	5,740	2,870	2,649	1,325
For each add'l family member, add	5,400	9,990	833	417	385	193	7,020	585	293	270	135
Hawaii											
1	13,960	25,826	2,153	1,077	994	497	18,148	1,513	757	698	349
2	18,930	35,021	2,919	1,460	1,347	674	24,609	2,051	1,026	947	474
3	23,900	44,215	3,685	1,843	1,701	851	31,070	2,590	1,295	1,195	598
4	28,870	53,410	4,451	2,226	2,055	1,028	37,531	3,128	1,564	1,444	722
5	33,840	62,604	5,217	2,609	2,408	1,204	43,992	3,666	1,833	1,692	846
6	38,810	71,799	5,984	2,992	2,762	1,381	50,453	4,205	2,103	1,941	971
7	43,780	80,993	6,750	3,375	3,116	1,558	56,914	4,743	2,372	2,189	1,095
8	48,750	90,188	7,516	3,758	3,469	1,735	63,375	5,282	2,641	2,438	1,219
For each add'l family member, add	4,970	9,195	767	384	354	177	6,461	539	270	249	125

Dated: April 18, 2018.

Brandon Lipps,

Administrator, Food and Nutrition Service.

[FR Doc. 2018–09679 Filed 5–7–18; 8:45 am]

BILLING CODE 3410–30–P

DEPARTMENT OF AGRICULTURE

Natural Resources Conservation Service

[Docket No. NRCS–2018–0002]

Lick Creek Watershed, Russell, Dickenson and Wise Counties, Virginia

AGENCY: Natural Resources Conservation Service, USDA.

ACTION: Notice of intent to deauthorize federal funding.

SUMMARY: Pursuant to the Watershed Protection and Flood Prevention Act of 1954 and the Natural Resources Conservation Service (NRCS) Guidelines, NRCS gives notice of the intent to deauthorize Federal funding for the Lick Creek Watershed project, Russell, Dickenson and Wise Counties, Virginia.

DATES: Interested persons are invited to submit comments within 60 days of this notice being published in the **Federal Register**.

ADDRESSES: Comments submitted in response to this notice should be sent to John Bricker, VA State Conservationist, 1606 Santa Rosa Road, Suite 209, Richmond, Virginia 23229. Telephone: (804) 287–1691 or email: *Jack.Bricker@va.usda.gov.*

FOR FURTHER INFORMATION CONTACT: For specific questions about this notice, please contact Wade Biddix, (804) 287–1675 or *Wade.Biddix@va.usda.gov.*

SUPPLEMENTARY INFORMATION: A determination has been made by John Bricker, NRCS State Conservationist in Virginia that the proposed works of improvement for the Lick Creek Watershed project will not be installed. The sponsoring local organizations have concurred in this determination and agree that Federal funding should be deauthorized for the project. Information regarding this determination may be obtained from John Bricker, NRCS State Conservationist in Virginia at the above address and telephone number.

No administrative action on implementation of the proposed deauthorization will be taken until 60 days after the date of this publication in the **Federal Register**.

[Catalog of Federal Domestic Assistance Program No. 10.904, Watershed Protection and Flood Prevention. Executive Order 12372 regarding State and local clearinghouse review of Federal and federally assisted programs and project is applicable]

Dated: March 1, 2018.

John A. Bricker,

VA State Conservationist.

[FR Doc. 2018–09677 Filed 5–7–18; 8:45 am]

BILLING CODE 3410–16–P

DEPARTMENT OF COMMERCE

Census Bureau

Proposed Information Collection; Comment Request; Current Population Survey, Annual Social and Economic Supplement

AGENCY: U.S. Census Bureau, Commerce.

ACTION: Notice.

SUMMARY: The Department of Commerce, 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.

DATES: To ensure consideration, written comments must be submitted on or before July 9, 2018.

ADDRESSES: Direct all written comments to Jennifer Jessup, Departmental Paperwork Clearance Officer, Department of Commerce, Room 6616, 14th and Constitution Avenue NW, Washington, DC 20230 (or via the internet at *PRAcomments@doc.gov*).

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Lisa Cheok, U.S. Census Bureau, ADDP/CPS HQ–7H136A, Washington, DC 20233–8400, (301) 763–3806 (or via the internet at *dsd.cps@census.gov*).

SUPPLEMENTARY INFORMATION

I. Abstract

The Census Bureau plans to request clearance from the Office of Management and Budget (OMB) for the collection of data concerning the Annual Social and Economic Supplement (ASEC) to be conducted in conjunction with the February, March, and April Current Population Survey (CPS). The Census Bureau has conducted this supplement annually for more than 50 years. The Census Bureau and the Bureau of Labor Statistics sponsor this supplement. The current clearance expires December 31, 2018.

The ASEC data collection was last redesigned in 2015. For 2019, the data collection questions and design will remain identical to the version fielded since 2015.

Information on work experience, personal income, noncash benefits, current and previous year health insurance coverage, employer-sponsored insurance take-up, and migration is collected through the ASEC. The work experience items in the ASEC provide a unique measure of the dynamic nature of the labor force as viewed over a one-year period. These items produce statistics that show movements in and out of the labor force by measuring the number of periods of unemployment experienced by people, the number of different employers worked for during the year, the principal reasons for unemployment, and part-/full-time attachment to the labor force. We can make indirect measurements of discouraged workers and others with a casual attachment to the labor market.

The income data from the ASEC are used by social planners, economists, government officials, and market researchers to gauge the economic well-being of the country as a whole, and selected population groups of interest. Government planners and researchers use these data to monitor and evaluate the effectiveness of various assistance programs. Market researchers use these data to identify and isolate potential customers. Social planners use these data to forecast economic conditions and to identify special groups that seem to be especially sensitive to economic fluctuations. Economists use ASEC data to determine the effects of various economic forces, such as inflation, recession, recovery, and so on, and their differential effects on various population groups.

The ASEC is the official source of national poverty estimates calculated in accordance with the Office of Management and Budget's Statistical Policy Directive 14. Two other important national estimates derived from the ASEC are real median household income and the number and percent of individuals without health insurance coverage.

The ASEC also contains questions related to: (1) Medical expenditures; (2) presence and cost of a mortgage on property; (3) child support payments; and (4) amount of child care assistance received. These questions enable analysts and policymakers to obtain better estimates of family and household income, and more precisely gauge poverty status.

II. Method of Collection

The ASEC information will be collected by both personal visit and telephone interviews in conjunction with the regular February, March and April CPS interviewing. All interviews are conducted using computer-assisted interviewing.

III. Data

OMB Control Number: 0607–0354.

Form Number: There are no forms. We conduct all interviewing on computers.

Type of Review: Regular submission.

Affected Public: Households.

Frequency: Annually

Estimated Number of Respondents: 78,000.

Estimated Time Per Response: 25 minutes.

Estimated Total Annual Burden Hours: 32,500.

Estimated Total Annual Cost to Public: There are no costs to the respondents other than their time.

Respondent's Obligation: Voluntary.

Legal Authority: Title 13, United States Code, Sections 141 and 182; and Title 29, United States Code, Sections 1–9.

IV. Request for Comments

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 (including hours and cost) 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.

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of this information collection; they also will become a matter of public record.

Sheleen Dumas,

Departmental Lead PRA Officer, Office of the Chief Information Officer.

[FR Doc. 2018–09762 Filed 5–7–18; 8:45 am]

BILLING CODE 3510–07–P

DEPARTMENT OF COMMERCE

Submission for OMB Review; Comment Request

The Department of Commerce will submit to the Office of Management and Budget (OMB) for clearance the following proposal for collection of

information under the provisions of the Paperwork Reduction Act.

Agency: U.S. Census Bureau.

Title: Annual Survey of School System Finances.

OMB Control Number: 0607–0700.

Form Number(s): F–33, F–33–L1, F–33–L2, F–33–L3.

Type of Request: Extension of a currently approved collection.

Number of Respondents: 3,681.

Average Hours per Response: 1 hour and 4 minutes.

Burden Hours: 3,951.

Needs and Uses: The U.S. Census Bureau, on behalf of the U.S. Department of Education's National Center for Education Statistics (NCES), requests an extension of approval for the Annual Survey of School System Finances, the source of the most comprehensive national data set on school district finances.

The Census Bureau collects these data from the universe of school districts using uniform definitions and concepts of revenue, expenditure, debt, and assets as defined by the NCES handbook *Financial Accounting for Local and State School Systems.* This survey and the Annual Surveys of State and Local Government Finances (OMB No. 0607–0585) are conducted as part of the Census Bureau's State and Local Government Finance program. Through this program, the Census Bureau collects data from cities, counties, states, and special district governments as well as local school systems in order to produce state and national totals of government spending. Local school system spending comprises a significant portion of total government spending. In 2015, public elementary-secondary expenditures accounted for 34 percent of local government spending.

This comprehensive and ongoing time series collection of local education agency finances, dating back to 1957, provides historical continuity in the state and local government statistics community. Education finance statistics provided by the Census Bureau allow for analyses of how public elementary-secondary school systems receive and spend funds and is vital for policy making. Increased focus on education has led to a demand for data reflecting student performance, graduation rates, and school finance policy—all of which are related to the collection of this local education finance data. State legislatures, local leaders, university researchers, and parents increasingly rely on data to make substantive decisions about education.

The Bureau of Economic Analysis (BEA) uses data from the survey to develop figures for the Gross Domestic Product (GDP). Elementary-secondary education finance data items specifically contribute to the estimates for National Income and Product Accounts (NIPA), Input-Output accounts (I–O), and gross domestic investments. BEA also uses the data to assess other public fiscal spending trends and events.

The NCES use these annual data as part of the Common Core of Data (CCD) program. The education finance data collected by the Census Bureau are the sole source of school district fiscal information for the CCD as well as for the publication of annual reports on the fiscal state of education.

Form (F–33) covers elementary-secondary education finance items. In practice, this form serves more as a data processing guide rather than as a data collection instrument because the Census Bureau relies heavily on collecting this public school system finance data centrally from state education agencies centrally via the internet using File Transfer Protocol (FTP). Supplemental forms are sent to school systems in states where the state education agency cannot provide information on assets (F–33–L1), indebtedness (F–33–L2), or both (F–33–L3).

The Census Bureau makes available detailed files for all school systems from its internet website, *https://www.census.gov/programs-surveys/school-finances.html.* That website currently contains data files and statistical tables for the 1992 through 2015 fiscal year surveys. Historical files and publications prior to 1992 are also available upon request for data users engaged in longitudinal studies. In addition to numerous academic researchers who use F–33 products, staff receive inquiries from state government officials, legislatures, public policy analysts, local school officials, non-profit organizations, and various Federal agencies.

Affected Public: State, local or tribal government.

Frequency: Annually.

Respondent's Obligation: Voluntary.

Legal Authority: Title 13 U.S.C., Sections 8(b), 161, and 182 (Census authority); Title 20 U.S.C., Sections 9543–44 (NCES authority).

This information collection request may be viewed at *www.reginfo.gov.* Follow the instructions to view Department of Commerce collections currently under review by OMB.

Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *OIRA_Submission@omb.eop.gov* or fax to (202)395–5806.

Sheleen Dumas,

Departmental Lead PRA Officer, Office of the Chief Information Officer.

[FR Doc. 2018–09766 Filed 5–7–18; 8:45 am]

BILLING CODE 3510–07–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[S–44–2018]

Approval of Subzone Status; Brose Tuscaloosa, Inc. Vance, Alabama

On March 6, 2018, the Executive Secretary of the Foreign-Trade Zones (FTZ) Board docketed an application submitted by the City of Birmingham, grantee of FTZ 98, requesting subzone status subject to the existing activation limit of FTZ 98, on behalf of Brose Tuscaloosa, Inc., in Vance, Alabama.

The application was processed in accordance with the FTZ Act and Regulations, including notice in the **Federal Register** inviting public comment (83 FR 10657, March 12, 2018). The FTZ staff examiner reviewed the application and determined that it meets the criteria for approval. Pursuant to the authority delegated to the FTZ Board Executive Secretary (15 CFR Sec. 400.36(f)), the application to establish Subzone 98E was approved on May 1, 2018, subject to the FTZ Act and the Board's regulations, including Section 400.13, and further subject to FTZ 98's 611.80-acre activation limit.

Dated: May 3, 2018.

Andrew McGilvray,

Executive Secretary.

[FR Doc. 2018–09758 Filed 5–7–18; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[S–39–2018]

Approval of Subzone Status; CEVA Freight LLC; Mount Juliet and Lebanon, Tennessee

On February 26, 2018, the Executive Secretary of the Foreign-Trade Zones (FTZ) Board docketed an application submitted by the Metropolitan Government of Nashville and Davidson County, grantee of FTZ 78, requesting subzone status subject to the existing activation limit of FTZ 78, on behalf of CEVA Freight LLC in Mount Juliet and Lebanon, Tennessee.

The application was processed in accordance with the FTZ Act and Regulations, including notice in the **Federal Register** inviting public comment (83 FR 8966, March 2, 2018). The FTZ staff examiner reviewed the application and determined that it meets the criteria for approval. Pursuant to the authority delegated to the FTZ Board Executive Secretary (15 CFR Sec. 400.36(f)), the application to establish Subzone 78K was approved on May 2, 2018, subject to the FTZ Act and the Board's regulations, including Section 400.13, and further subject to FTZ 78's 2,000-acre activation limit.

Dated: May 2, 2018.

Andrew McGilvray,

Executive Secretary.

[FR Doc. 2018–09753 Filed 5–7–18; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board [S–6–2018]

Approval of Expansion of Subzone 98D; Hyster-Yale Group, Inc.; Sulligent, Alabama

On January 10, 2018, the Executive Secretary of the Foreign-Trade Zones (FTZ) Board docketed an application submitted by the City of Birmingham, grantee of FTZ 98, requesting an expansion of Subzone 98D on behalf of Hyster-Yale Group, Inc., to include an additional site in Sulligent, Alabama. The existing subzone and the proposed site would be subject to the existing activation limit of FTZ 98.

The application was processed in accordance with the FTZ Act and Regulations, including notice in the **Federal Register** inviting public comment (83 FR 2424, January 17, 2018). The FTZ staff examiner reviewed the application and determined that it meets the criteria for approval. Pursuant to the authority delegated to the FTZ Board Executive Secretary (15 CFR Sec. 400.36(f)), the application to expand Subzone 98D was approved on May 1, 2018, subject to the FTZ Act and the Board's regulations, including Section 400.13, and further subject to FTZ 98's 611.80-acre activation limit.

Dated: May 3, 2018.

Andrew McGilvray,

Executive Secretary.

[FR Doc. 2018–09759 Filed 5–7–18; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–055]

Carton-Closing Staples From the People's Republic of China: Antidumping Duty Order

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: Based on affirmative final determinations by the Department of Commerce (Commerce) and the International Trade Commission (ITC), Commerce is issuing an antidumping duty order on carton-closing staples from the People's Republic of China (China).

DATES: Applicable May 8, 2018.

FOR FURTHER INFORMATION CONTACT: Irene Gorelik, AD/CVD Operations, Office VIII, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–6905.

SUPPLEMENTARY INFORMATION:

Background

In accordance with section 735(d) and 777(i)(1) of the Tariff Act of 1930, as amended (the Act), and 19 CFR 351.210(c), on March 28, 2018, Commerce published its affirmative final determination in the less than fair value (LTFV) investigation of carton-closing staples from China.[1] On April 30, 2018, the ITC notified Commerce of its final determination pursuant to section 735(b)(1)(A)(i) of the Act, that an industry in the United States is materially injured or threatened with material injury by reason of imports of carton-closing staples from China.[2]

Scope of the Order

The scope of the order is carton-closing staples. Carton-closing staples may be manufactured from carbon, alloy, or stainless steel wire, and are included in the scope of the investigation regardless of whether they are uncoated or coated, regardless of the type of coating.

Carton-closing staples are generally made to American Society for Testing and Materials (ASTM) specification ASTM D1974/D1974M–16, but can also be made to other specifications. Regardless of specification, however, all carton-closing staples meeting the scope description are included in the scope. Carton-closing staples include stick staple products, often referred to as staple strips, and roll staple products, often referred to as coils. Stick staples are lightly cemented or lacquered together to facilitate handling and loading into stapling machines. Roll staples are taped together along their crowns. Carton-closing staples are covered regardless of whether they are imported in stick form or roll form.

Carton-closing staples vary by the size of the wire, the width of the crown, and the length of the leg. The nominal leg length ranges from 0.4095 inch to 1.375 inches and the nominal crown width ranges from 1.125 inches to 1.375 inches. The size of the wire used in the production of carton-closing staples varies from 0.029 to 0.064 inch (nominal thickness) by 0.064 to 0.100 inch (nominal width).

Carton-closing staples subject to this order are currently classifiable under subheadings 8305.20.00.00 and 7317.00.65.60 of the Harmonized Tariff Schedule of the United States (HTSUS). While the HTSUS subheadings and ASTM specification are provided for convenience and for customs purposes, the written description of the subject merchandise is dispositive.

Antidumping Duty Order

In accordance with sections 735(b)(1)(A) and 735(d) of the Act, the ITC has notified Commerce of its final determination in this investigation, in which it found that imports of carton-closing staples from China are materially injuring or threatening material injury to a U.S. industry.[3] Therefore, in accordance with sections 735(c)(2) and 736(a) of the Act, we are publishing this antidumping duty order.

As a result of the ITC's final determination, in accordance with section 736(a)(1) of the Act, Commerce will direct U.S. Customs and Border Protection (CBP) to assess, upon further instruction by Commerce, antidumping duties equal to the amount by which the normal value of the merchandise exceeds the export price (or constructed export price) of the merchandise, for all relevant entries of carton-closing staples from China. These antidumping duties will be assessed on unliquidated entries from China entered, or withdrawn from

[1] *See Carton-Closing Staples from the People's Republic of China: Final Affirmative Determination of Sales at Less Than Fair Value,* 83 FR 13236 (March 28, 2018).

[2] *See* Letter to Gary Taverman, Acting Assistant Secretary of Commerce for Enforcement and Compliance, from Rhonda K. Schmidtlein, Chairman of the U.S. International Trade Commission, regarding carton-closing staples from China, dated April 30, 2018 (ITC Notification). *See also Carton-Closing Staples from China,* Inv. No. 731–TA–1359, USITC Pub. 4778, (April 2018) (Final).

[3] *See* ITC Notification.

warehouse, for consumption on or after November 3, 2017, the date on which Commerce published the *Preliminary Determination,*[4] but will not include entries occurring after the expiration of the provisional measures period and before publication of the ITC's final injury determination, as further described below.

Continuation of Suspension of Liquidation

In accordance with section 735(c)(1)(B) of the Act, we will instruct CBP to continue to suspend liquidation on entries of subject merchandise from China. We will also instruct CBP to require cash deposits equal to the estimated amount by which the normal value exceeds the U.S. price as indicated in the chart below. These instructions suspending liquidation will remain in effect until further notice.

Accordingly, effective on the date of publication of the ITC's final affirmative injury determination, CBP will require, at the same time as importers would normally deposit estimated duties on this subject merchandise, a cash deposit equal to the estimated antidumping duty margin as discussed above.[5] The ''China-wide'' rate applies to all exporters of subject merchandise not specifically listed in the table below.

Provisional Measures

Section 733(d) of the Act states that instructions issued pursuant to an affirmative preliminary determination may not remain in effect for more than four months, except where exporters representing a significant proportion of exports of the subject merchandise request Commerce to extend that four-month period to no more than six months. At the request of the exporters that account for a significant portion of carton-closing staples from China, we extended the four-month period to six months in the *Preliminary Determination* dated November 3, 2017.[6] Therefore, the extended period beginning on November 3, 2017, the date of publication of the *Preliminary Determination,* ended May 1, 2018. Furthermore, section 737(b) of the Act states that definitive duties are to begin on the date of publication of the ITC's final injury determination.

Therefore, in accordance with section 733(d) of the Act and our practice, we will instruct CBP to terminate the suspension of liquidation and to liquidate, without regard to antidumping duties, unliquidated entries of carton-closing staples from China entered, or withdrawn from warehouse, for consumption on or after May 2, 2018, the day after which the provisional measures expired, until and through the day preceding the date of publication of the ITC's final injury determinations in the **Federal Register**. Suspension of liquidation will resume on the date of publication of the ITC's final determination in the **Federal Register**.

Estimated Dumping Margin

Commerce determines that the estimated final dumping margins are as follows:

Producer	Exporter	Margin (percent)
Yueda Group: Shanghai Yueda Nails Co., Ltd., or Qiushan Printing Machinery Co., Ltd..	Yueda Group: Shanghai Yueda Nails Co., Ltd., or Fastnail Products Limited, or Wuhan FOPO Trading Co., Ltd., or China Dinghao Co., Limited.	263.40
Hangzhou Huayu Machinery Co., Ltd	Hangzhou Huayu Machinery Co., Ltd	115.65
The Stanley Works (Langfang) Fastening Systems Co., Ltd	The Stanley Works (Langfang) Fastening Systems Co., Ltd	115.65
China-Wide Entity		263.40

Notification to Interested Parties

This notice constitutes the antidumping duty order with respect to carton-closing staples from China, pursuant to section 736(a) of the Act. Interested parties may contact Commerce's Central Records Unit, Room B8024 of the main Commerce building, for copies of an updated list of antidumping duty orders currently in effect.

This order is issued and published in accordance with sections 736(a) of the Act and 19 CFR 351.211(b).

Dated: May 2, 2018.

Gary Taverman,

Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations, performing the non-exclusive functions and duties of the Assistant Secretary for Enforcement and Compliance.

[FR Doc. 2018–09754 Filed 5–4–18; 4:15 pm]

BILLING CODE 3510–DS–P

[4] *See Carton-Closing Staples from the People's Republic of China: Preliminary Affirmative Determination of Sales at Less Than Fair Value, Postponement of Final Determination and Extension of Provisional Measures,* 82 FR 51213 (November 3, 2017) (*Preliminary Determination*).

[5] *See* section 736(a)(3) of the Act.

[6] *See Preliminary Determination,* 82 FR at 51215.

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XG211

New England Fishery Management Council; Public Meeting

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of public hearings.

SUMMARY: The New England Fishery Management Council (Council) will hold six public hearings and one webinar to solicit Public comments on Draft Amendment 8 to the Atlantic Herring Fishery Management Plan (FMP).

DATES: Written Public comments must be received on or before 5 p.m. EST, June 25, 2018. The meetings will be held between May 22 and June 20, 2018. For specific dates and times, see **SUPPLEMENTARY INFORMATION.**

ADDRESSES: The hearing documents are accessible electronically via the internet *https://www.nefmc.org/library/amendment-8-2* or by request to Thomas A. Nies, Executive Director. New England Fishery Management Council, 50 Water Street, Mill 2, Newburyport, MA 01950; telephone: (978) 465–0492.

Meeting addresses: The meetings will be held in Narragansett, RI; Rockport, ME; Gloucester, MA; Philadelphia, PA; Portland, ME and Chatham, MA. For specific locations, see **SUPPLEMENTARY INFORMATION.**

Public comments: Mail to NEFMC, New England Fishery Management Council, 50 Water Street, Mill 2, Newburyport, MA 01950. Mark the outside of the envelope ''DEIS for Amendment 8 to the Atlantic Herring FMP''. Comments may also be sent via fax to 978–465–3116 or submitted via

email to *comments@nefmc.org* with ''DEIS for Amendment 8 to the Atlantic Herring FMP'' in the subject line.

FOR FURTHER INFORMATION CONTACT: Thomas A. Nies, Executive Director, New England Fishery Management Council; telephone: (978) 465–0492.

SUPPLEMENTARY INFORMATION:

Agenda

The agenda for the following six hearings is as follows: NEMFC staff will brief the public on the herring amendments and the contents of the DEIS prior to opening the hearing for public comments and the schedule is as follows:

Public Hearings: Locations, Schedules, and Agendas

1. *Tuesday, May 22, 2018 from 6–8 p.m.;* University of Rhode Island, 215 S. Ferry Road, Narragansett, RI 02882; phone: (401) 423–1943.
2. *Thursday, May 24, 2018 from 6–8 p.m.;* Samoset Hotel, 220 Warrenton Street, Rockport, ME 04856; phone: (207) 594–2511.
3. *Wednesday, May 30, 2018 from 6–8 p.m.;* Beauport Hotel; 55 Commercial Street, Gloucester, MA; phone: (978) 282–0008.
4. *Tuesday, June 5, 2018 from 4–5 p.m.;* DoubleTree by Hilton, 237 South Broad Street, Philadelphia, PA 19107; phone: (215) 893–1600.
5. *Tuesday, June 12, 2018 from 4–6 p.m.;* Holiday Inn By the Bay, 88 Spring Street, Portland, ME 04101; phone: (207) 775–2311.
6. *Tuesday, June 19, 2018 from 6–8 p.m.;* Chatham Community Center, 702 Main Street, Chatham, MA 02633; phone: (508) 945–5159.
7. *Wednesday, June 20, 2018 from 2–4 p.m.*—Webinar Registration— *https://attendee.gotowebinar.com/register/6985865165132506115.*

Call in information: (415) 930–5321; Access Code: 346–818–026.

Additional information on the review is available on the Council website, *www.nefmc.org.* The public also should be aware that the hearings will be recorded. Consistent with 16 U.S.C. 1852, a copy of the recording is available upon request.

Special Accommodations

These meetings are physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Thomas A. Nies, Executive Director, at (978) 465–0492, at least 5 days prior to the meeting date.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: May 3, 2018.

Tracey L. Thompson,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2018–09795 Filed 5–7–18; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XG214

Western Pacific Fishery Management Council; Public Meeting

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of a public meeting and hearing.

SUMMARY: The Western Pacific Fishery Management Council (Council) will hold a meeting of its Hawaii Archipelago Fishery Ecosystem Plan (FEP), American Samoa Archipelago FEP, and Mariana Archipelago FEP Advisory Panels (AP) to discuss and make recommendations on fishery management issues in the Western Pacific Region.

DATES: All APs will meet on Thursday, May 24, 2018, with the Hawaii Archipelago AP meeting from 9 a.m. to 11 a.m.; The American Samoa Archipelago FEP AP from 4:30 p.m. to 6:30 p.m.; The Guam Mariana Archipelago FEP AP meeting from 6 p.m. to 7:30 p.m.; and the Commonwealth of the Northern Mariana Islands (CNMI) Mariana Archipelago FEP AP meeting from 6 p.m. to 8 p.m. All times listed are local island times. For specific times and agendas, see **SUPPLEMENTARY INFORMATION.**

ADDRESSES: The Hawaii Archipelago FEP AP will meet at the Council Office, 1164 Bishop St., Suite 1400, Honolulu, HI 96813 and by teleconference. The teleconference will be conducted by telephone. The teleconference numbers are: U.S. toll-free: 1–888–482–3560 or International Access: +1 647 723–3959, and Access Code: 5228220; The American Samoa Archipelago FEP AP will meet at the Pacific Petroleum Conference Room, Utulei Village, American Samoa, 96799; The Guam Mariana Archipelago FEP AP will meet at the Guam Fishermen's Cooperative Association Lanai, Hagatna, Guam, 96913; and The CNMI Mariana Archipelago FEP AP will meet at the Micronesian Environmental Services Conference Room, Garapan, Saipan, CNMI, 96950.

FOR FURTHER INFORMATION CONTACT: Kitty M. Simonds, Executive Director, Western Pacific Fishery Management Council; telephone: (808) 522–8220.

SUPPLEMENTARY INFORMATION: Public comment periods will be provided in the agenda. The order in which agenda items are addressed may change. The meetings will run as late as necessary to complete scheduled business.

Schedule and Agenda for the Hawaii Archipelago FEP AP Meeting

Thursday, May 24, 2018, 9 a.m.–11 a.m.

1. Welcome and Introductions
2. Report on Previous AP Recommendations
3. Council Issues

A. Action Items

- i. Main Hawaiian Islands Bottomfish Annual Catch Limits (ACLs)
- ii. Options for an Aquaculture Management Program
- iii. Hawaii Longline Shallow-set Fishery Hard Cap Options
- iv. Framework for Managing Sea Turtle Interactions in the Hawaii Shallow-set Longline Fishery
- v. Ecosystem Component Species Classification
- vi. Evaluation of 2017 Catch to the 2017 ACLs

B. Other Items

- i. Draft 2017 Annual Stock Assessment and Fishery Evaluation (SAFE) Reports
- ii. Comments on List of Gears by Fisheries
- iii. Council Research Priorities
- a. Five-year Research Plan
- b. Cooperative Research
- c. Pelagic Fisheries Research Plan
- d. Management Strategy Evaluation (MSE) Priorities

4. Hawaii FEP AP Issues

A. Report of the Subpanels

- i. Island Fisheries Subpanel
- ii. Pelagic Fisheries Subpanel
- iii. Ecosystems and Habitat Subpanel
- iv. Indigenous Fishing Rights Subpanel

B. Other Issues

5. Public Comment
6. Discussion and Recommendations
7. Other Business

Schedule and Agenda for the American Samoa Archipelago FEP AP Meeting

Thursday, May 24, 2018, 4:30 p.m.–6:30 p.m.

1. Welcome and Introductions
2. Report on Previous AP Recommendations
3. Council Issues

A. Action Items

i. American Samoa Marine Conservation Plan
ii. Options for an Aquaculture Management Program
iii. American Samoa Large Vessel Prohibited Area
iv. Modification to U.S. Participating Territory Catch and Effort Limit Amendment 7 Framework
v. Ecosystem Component Species Classification
vi. Evaluation of 2017 Catch to the 2017 ACLs

B. Other Items

i. Draft 2017 Annual SAFE Reports
ii. Comments on List of Gears by Fisheries
iii. Council Research Priorities
a. Five-year Research Plan
b. Cooperative Research
c. Pelagic Fisheries Research Plan
d. MSE Priorities

4. American Samoa FEP AP Issues

A. Report of the Subpanels

i. Island Fisheries Subpanel
ii. Pelagic Fisheries Subpanel
iii. Ecosystems and Habitat Subpanel
iv. Indigenous Fishing Rights Subpanel

B. Other Issues

5. Public Comment
6. Discussion and Recommendations
7. Other Business

Schedule and Agenda for the Guam Mariana Archipelago FEP AP Meeting

Thursday, May 24, 2018, 6 p.m.–7:30 p.m.

1. Welcome and Introductions
2. Report on Previous AP Recommendations
3. Council Issues

A. Action Items

i. Modification to U.S. Participating Territory Catch and Effort Limit Amendment 7 Framework
ii. Options for an Aquaculture Management Program
iii. Ecosystem Component Species Classification
iv. Evaluation of 2017 Catch to the 2017 ACLs

B. Other Items

i. Draft 2017 Annual SAFE Reports
ii. Comments on List of Gears by Fisheries
iii. Council Research Priorities
a. Five-year Research Plan
b. Cooperative Research
c. Pelagic Fisheries Research Plan
d. MSE Priorities

4. Guam Mariana FEP AP Issues

A. Report of the Subpanels

i. Island Fisheries Subpanel
ii. Pelagic Fisheries Subpanel
iii. Ecosystems and Habitat Subpanel
iv. Indigenous Fishing Rights Subpanel

B. Other Issues

5. Public Comment
6. Discussion and Recommendations
7. Other Business

Schedule and Agenda for the CNMI Mariana Archipelago FEP AP Meeting

Thursday, May 24, 2018, 6 p.m.–8 p.m.

1. Welcome and Introductions
2. Report on Previous AP Recommendations
3. Council Issues

A. Action Items

i. Modification to U.S. Participating Territory Catch and Effort Limit Amendment 7 Framework
ii. Options for an Aquaculture Management Program
iii. Ecosystem Component Species Classification
iv. Evaluation of 2017 Catch to the 2017 ACLs

B. Other Items

i. Draft 2017 Annual SAFE Reports
ii. Comments on List of Gears by Fisheries
iii. Council Research Priorities
a. Five-year Research Plan
b. Cooperative Research
c. Pelagic Fisheries Research Plan
d. MSE Priorities

4. CNMI Mariana FEP AP Issues

A. Report of the Subpanels

i. Island Fisheries Subpanel
ii. Pelagic Fisheries Subpanel
iii. Ecosystems and Habitat Subpanel
iv. Indigenous Fishing Rights Subpanel

B. Other Issues

5. Public Comment
6. Discussion and Recommendations
7. Other Business

Special Accommodations

These meetings are physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Kitty M. Simonds, (808) 522–8220 (voice) or (808) 522–8226 (fax), at least 5 days prior to the meeting date.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: May 3, 2018.

Tracey L. Thompson,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2018–09797 Filed 5–7–18; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XG215

Fisheries of the Caribbean; Southeast Data, Assessment, and Review (SEDAR); Public Meeting

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of SEDAR 57 Data Webinar for Caribbean spiny lobster.

SUMMARY: The SEDAR 57 stock assessment process for Caribbean spiny lobster will consist of a Data Workshop, a series of data and assessment webinars, and a Review Workshop. See **SUPPLEMENTARY INFORMATION**.

DATES: The SEDAR 57 Data Webinar will be held May 23, 2018, from 1 p.m. to 2 p.m. Eastern Time.

ADDRESSES: The meeting will be held via webinar. The webinar is open to members of the public. Those interested in participating should contact Julie A. Neer at SEDAR (see **FOR FURTHER INFORMATION CONTACT**) to request an invitation providing webinar access information. Please request webinar invitations at least 24 hours in advance of each webinar.

SEDAR address: 4055 Faber Place Drive, Suite 201, North Charleston, SC 29405.

FOR FURTHER INFORMATION CONTACT: Julie A. Neer, SEDAR Coordinator; (843) 571–4366; email: *Julie.neer@safmc.net.*

SUPPLEMENTARY INFORMATION: The Gulf of Mexico, South Atlantic, and Caribbean Fishery Management Councils, in conjunction with NOAA Fisheries and the Atlantic and Gulf States Marine Fisheries Commissions have implemented the Southeast Data, Assessment and Review (SEDAR) process, a multi-step method for determining the status of fish stocks in the Southeast Region. SEDAR is a multi-step process including: (1) Data Workshop, (2) a series of assessment webinars, and (3) A Review Workshop. The product of the Data Workshop is a report that compiles and evaluates potential datasets and recommends which datasets are appropriate for

assessment analyses. The assessment webinars produce a report that describes the fisheries, evaluates the status of the stock, estimates biological benchmarks, projects future population conditions, and recommends research and monitoring needs. The product of the Review Workshop is an Assessment Summary documenting panel opinions regarding the strengths and weaknesses of the stock assessment and input data. Participants for SEDAR Workshops are appointed by the Gulf of Mexico, South Atlantic, and Caribbean Fishery Management Councils and NOAA Fisheries Southeast Regional Office, HMS Management Division, and Southeast Fisheries Science Center. Participants include data collectors and database managers; stock assessment scientists, biologists, and researchers; constituency representatives including fishermen, environmentalists, and NGO's; International experts; and staff of Councils, Commissions, and state and federal agencies.

The items of discussion during the Data Webinar are as follows:

Panelists will review the data sets being considered for the assessment and discuss initial modeling efforts.

Although non-emergency issues not contained in this agenda may come before this group for discussion, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically identified in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Fishery Conservation and Management Act, provided the public has been notified of the intent to take final action to address the emergency.

Special Accommodations

The meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to the Council office (see **ADDRESSES**) at least 5 business days prior to each workshop.

Note: The times and sequence specified in this agenda are subject to change.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: May 3, 2018.

Tracey L. Thompson,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2018–09798 Filed 5–7–18; 8:45 am]

BILLING CODE 3510–11–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XG223

Fisheries of the South Atlantic; South Atlantic Fishery Management Council; Public Meetings

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of meetings of the South Atlantic Fishery Management Council's Citizen Science Advisory Panel Action Teams.

SUMMARY: The South Atlantic Fishery Management Council (Council) will hold meetings of the following Citizen Science Advisory Panel Action Teams: Volunteers; Data Management; Projects/Topics Management; and Communication/Outreach/Education via webinar.

DATES: The Volunteers Team meeting will be held on Wednesday, May 30, 2018 at 10 a.m.; Data Management Team on Monday, June 4, 2018 at 10 a.m.; Projects/Topics Management Team on Wednesday, June 6, 2018 at 1 p.m.; and Communication/Outreach/Education Team on Friday, June 8, 2018 at 10 a.m. Each meeting is scheduled to last approximately 90 minutes. Additional Action Team webinar and plenary webinar dates and times will publish in a subsequent issue in the **Federal Register**.

ADDRESSES:

Meeting address: The meetings will be held via webinar and are open to members of the public. Webinar registration is required and registration links will be posted to the Citizen Science program page of the Council's website at *www.safmc.net.*

Council address: South Atlantic Fishery Management Council, 4055 Faber Place Drive, Suite 201, N Charleston, SC 29405.

FOR FURTHER INFORMATION CONTACT: Amber Von Harten, Citizen Science Program Manager, SAFMC; phone: (843) 302–8433 or toll free 866/SAFMC–10; fax: (843) 769–4520; email: *amber.vonharten@safmc.net.*

SUPPLEMENTARY INFORMATION: The Council created a Citizen Science Advisory Panel Pool in June 2017. The Council appointed members of the Citizen Science Advisory Panel Pool to five Action Teams in the areas of Volunteers, Data Management, Projects/Topics Management, Finance, and Communication/Outreach/Education to develop program policies and operations for the Council's Citizen Science Program.

Each Action Team will meet to continue work on developing recommendations on program policies and operations to be reviewed by the Council's Citizen Science Committee. Public comment will be accepted at the beginning of the meeting.

Items to be addressed during these meetings:

1. Discuss work on tasks in the Terms of Reference
2. Other Business

Special Accommodations

These meetings are physically accessible to people with disabilities. Requests for auxiliary aids should be directed to the Council office (see **ADDRESSES**) 3 days prior to the meeting.

Note: The times and sequence specified in this agenda are subject to change.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: May 3, 2018.

Tracey L. Thompson,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2018–09799 Filed 5–7–18; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XG 212

New England Fishery Management Council; Public Meeting

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice; public meeting.

SUMMARY: The New England Fishery Management Council (Council) is scheduling a public meeting of its Habitat Committee to consider actions affecting New England fisheries in the exclusive economic zone (EEZ). Recommendations from this group will be brought to the full Council for formal consideration and action, if appropriate.

DATES: This meeting will be held on Tuesday, May 22, 2018 at 9 a.m.

ADDRESSES: The meeting will be held at the Hotel Providence, 139 Mathewson Street, Providence, RI 02903; Phone: (401) 861–8000.

Council address: New England Fishery Management Council, 50 Water Street, Mill 2, Newburyport, MA 01950.

FOR FURTHER INFORMATION CONTACT: Thomas A. Nies, Executive Director,

New England Fishery Management Council; telephone: (978) 465–0492.

SUPPLEMENTARY INFORMATION:

Agenda

The Committee will recommend alternatives for further analysis in the clam dredge framework, based on tasking motions from the April 26 meeting. They will also develop Council comments to the Bureau of Ocean Energy Management in response to two offshore wind-related notices, New York Bight call for information and Massachusetts lease sale. Discuss other business as needed.

Although non-emergency issues not contained in this agenda may come before this group for discussion, those issues may not be the subject of formal action during these meetings. Action will be restricted to those issues specifically listed in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Act, provided the public has been notified of the Council's intent to take final action to address the emergency.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Thomas A. Nies, Executive Director, at (978) 465–0492, at least 5 days prior to the meeting date. Consistent with 16 U.S.C. 1852, a copy of the recording is available upon request.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: May 3, 2018.

Tracey L. Thompson,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2018–09796 Filed 5–7–18; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF DEFENSE

Office of the Secretary

Charter Renewal of Department of Defense Federal Advisory Committees

AGENCY: Department of Defense.

ACTION: Renewal of Federal Advisory Committee.

SUMMARY: The Department of Defense (DoD) is publishing this notice to announce that it is renewing the charter for the Air University Board of Visitors (''the Board'').

FOR FURTHER INFORMATION CONTACT: Jim Freeman, Advisory Committee Management Officer for the Department of Defense, 703–692–5952.

SUPPLEMENTARY INFORMATION: The Board's charter is being renewed in accordance with the Federal Advisory Committee Act (FACA) of 1972 (5 U.S.C., Appendix, as amended) and 41 CFR 102–3.50(d). The Board's charter and contact information for the Board's Designated Federal Officer (DFO) can be found at *http://www.facadatabase.gov/*.

The Board provides the Secretary of Defense and the Deputy Secretary of Defense, through the Secretary of the Air Force, independent advice and recommendations on educational, doctrinal, and research policies and activities of Air University.

The Board is composed of no more than 15 members who are eminent authorities in the fields of air power, defense, management, leadership, and academia, to include the President of the Naval Postgraduate School. All members of the Board are appointed to provide advice on behalf of the Government on the basis of their best judgment without representing any particular point of view and in a manner that is free from conflict of interest. Except for reimbursement of official Board-related travel and per diem, Board members serve without compensation. The public or interested organizations may submit written statements to the Board membership about the Board's mission and functions. Written statements may be submitted at any time or in response to the stated agenda of planned meeting of the Board. All written statements shall be submitted to the DFO for the Board, and this individual will ensure that the written statements are provided to the membership for their consideration.

Dated: May 3, 2018.

Shelly E. Finke,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2018–09752 Filed 5–7–18; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Office of the Secretary

Department of Defense Military Family Readiness Council; Notice of Federal Advisory Committee Meeting

AGENCY: Under Secretary of Defense for Personnel and Readiness, Department of Defense Military Family Readiness Council, Department of Defense.

ACTION: Notice of Federal Advisory Committee meeting.

SUMMARY: The Department of Defense (DoD) is publishing this notice to announce that the following Federal Advisory Committee meeting of the Department of Defense Military Family Readiness Council will take place.

DATES: Open to the public Wednesday, June 6, 2018 from 1 p.m. to 3:00 p.m.

ADDRESSES: 1155 Defense Pentagon PLC2 Pentagon Library and Conference Center, Room B6, Washington, DC 20301.

FOR FURTHER INFORMATION CONTACT: Dr. Randy Eltringham, (571) 372–5315 (Voice), (571) 372–0884 (Facsimile), OSD Pentagon OUSD P–R Mailbox Family Readiness Council, *osd.pentagon.ousd-p-r.mbx.family-readiness-council@mail.mil* (Email). Mailing address is Office of the Deputy Assistant Secretary of Defense (Military Community & Family Policy), Office of Family Readiness Policy, 4800 Mark Center Drive, Alexandria, VA 22350–2300, Room 3G15. Website: *https://www.militaryonesource.mil/web/mos/military-family-readiness-council.* The most up-to-date changes to the meeting agenda can be found on the website.

SUPPLEMENTARY INFORMATION: This meeting is being held under the provisions of the Federal Advisory Committee Act (FACA) of 1972 (5 U.S.C., Appendix, as amended), the Government in the Sunshine Act of 1976 (5 U.S.C. 552b, as amended), and 41 CFR 102–3.140 and 102–3.150.

Purpose of the Meeting: The Department of Defense (DoD) is publishing this notice to announce that the following Federal Advisory Committee meeting of the Department of Defense Military Family Readiness Council will take place. This meeting is not a Town Hall meeting. It is open to the public for the purpose of observing Council proceedings, deliberations and voting.

Agenda: Opening Remarks, Administrative Announcements, Review of Written Public Submissions, Presentation and Voting on FY2018 Recommendations, Presentation and Voting on Focus Area Topics for Review During FY2019, and Closing Remarks. Note: Exact order may vary.

Meeting Accessibility: This meeting is open to the public. Members of the public who are interested in attending this meeting must RSVP online to *osd.pentagon.ousd-p-r.mbx.family-readiness-council@mail.mil* no less than 5 business days prior to the meeting. Meeting attendee RSVPs should indicate if an escort is needed to the meeting location (non-CAC Card holders need an escort) and if handicapped accessible transportation is needed. Effective April

2, 2018, all visitors to the Pentagon must pre-register prior to entering the building. A full description of Pentagon pre-registration process requirements is posted on the Military Family Readiness Council web page for review and planning purposes. Please follow these instructions carefully. Otherwise, members of the public may be denied access to the Pentagon on the day of the meeting. Members of the public who are approved for Pentagon access should arrive at the Pentagon Visitors Center waiting area (Pentagon Metro Entrance) no later than 12:00 p.m. on the day of the meeting to allow time to pass through security check points and be escorted to the meeting location.

Written Statements: Persons interested in providing a written statement for review and consideration by Council members attending the June 6, 2018 meeting must do so no later than close of business Tuesday, May 22, 2018, through the Council mailbox at *osd.pentagon.ousd-p-r.mbx.family-readiness-council@mail.mil.* Written statements received after this date will be provided to Council members in preparation for the first meeting of FY2019. The Designated Federal Officer (DFO) will review all timely submissions and ensure submitted written statements are provided to Council members two weeks prior to the meeting that is subject to this notice. Written statements must not be longer than two type-written pages and should address the following details: Issue or concern, discussion, and a recommended course of action. Those who make submissions are requested to avoid including personal identifiable information (PII) such as names of adults and children, phone numbers, addresses, Social Security numbers and other contact information within the body of the written statement. Links or supporting documentation may also be included, if necessary, to provide brief appropriate historical context and background information.

Dated: May 2, 2018.

Shelly E. Finke,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2018–09688 Filed 5–7–18; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF EDUCATION

[Docket No.: ED–2018–ICCD–0055]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Demonstration Grants for Indian Children Application (1894–0001)

AGENCY: Department of Education (ED), Office of Elementary and Secondary Education (OESE)

ACTION: Notice

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, ED is proposing an extension of an existing information collection.

DATES: Interested persons are invited to submit comments on or before June 7, 2018.

ADDRESSES: To access and review all the documents related to the information collection listed in this notice, please use *http://www.regulations.gov* by searching the Docket ID number ED–2018–ICCD–0055. Comments submitted in response to this notice should be submitted electronically through the Federal eRulemaking Portal at *http://www.regulations.gov* by selecting the Docket ID number or via postal mail, commercial delivery, or hand delivery. *Please note that comments submitted by fax or email and those submitted after the comment period will not be accepted.* Written requests for information or comments submitted by postal mail or delivery should be addressed to the Director of the Information Collection Clearance Division, U.S. Department of Education, 400 Maryland Avenue SW, LBJ, Room 216–32, Washington, DC 20202–4537.

FOR FURTHER INFORMATION CONTACT: For specific questions related to collection activities, please contact Amalia Cuervo, 202–453–5612.

SUPPLEMENTARY INFORMATION: The Department of Education (ED), in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)), provides the general public and Federal agencies with an opportunity to comment on proposed, revised, and continuing collections of information. This helps the Department assess the impact of its information collection requirements and minimize the public's reporting burden. It also helps the public understand the Department's information collection requirements and provide the requested data in the desired format. ED is soliciting comments on the proposed information collection request (ICR) that is described below. The Department of Education is especially interested in public comment addressing the following issues: (1) Is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology. Please note that written comments received in response to this notice will be considered public records.

Title of Collection: Demonstration Grants for Indian Children Application (1894–0001).

OMB Control Number: 1810–0722.

Type of Review: An extension of an existing information collection.

Respondents/Affected Public: State, Local, and Tribal Governments.

Total Estimated Number of Annual Responses: 100.

Total Estimated Number of Annual Burden Hours: 4,000.

Abstract: The Office of Indian Education (OIE) of the Department of Education (ED) requests extension of the clearance for the Indian Education Demonstration Grant Application authorized under Title VI, Part A, of the Elementary and Secondary Education Act, as amended by the Every Student Succeeds Act. The Demonstration (CFDA 84.299A) program is a competitive discretionary grant program. The grantee applications submitted for this program are evaluated on the basis of how well an applicant addresses the selection criteria, and are used to determine applicant eligibility and amount of award for projects selected for funding.

The selection criteria used for the Demonstration Grant program include general selection criteria from 34 CFR 75.210 and selection criteria based on regulatory requirements in 34 CFR part 263, in accordance with 34 CFR 75.209(a).

Eligible applicants submit the information to describe the project for which funding is requested. The information provided by the applicant addresses the selection criteria for the program. The application is evaluated through a peer review process and an application's score is used to determine its ranking and selection for funding.

Dated: May 3, 2018.

Stephanie Valentine,

Acting Director, Information Collection Clearance Division, Office of the Chief Privacy Officer, Office of Management.

[FR Doc. 2018–09761 Filed 5–7–18; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. NJ18–13–000]

Oncor Electric Delivery Company LLC; Notice of Filing

Take notice that on April 25, 2018, Oncor Electric Delivery Company LLC submitted its tariff filing: Oncor Tex-La Tariff Rate Changes to be effective 3/27/2018.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the comment date. On or before the comment date, it is not necessary to serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the ''eFiling'' link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 5 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the eLibrary link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the website that enables subscribers to receive email notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please email *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5:00 p.m. Eastern Time on May 16, 2018.

Dated: May 2, 2018.

Kimberly D. Bose,

Secretary.

[FR Doc. 2018–09716 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings

Take notice that the Commission has received the following Natural Gas Pipeline Rate and Refund Report filings:

Filings Instituting Proceedings

Docket Numbers: RP12–609–000.
Applicants: Texas Gas Transmission, LLC.
Description: Report Filing: 2017 Operational Purchases and Sales Report.
Filed Date: 5/1/18.
Accession Number: 20180501–5011.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP13–212–000.
Applicants: Boardwalk Storage Company, LLC.
Description: Report Filing: 2017 Operational Purchases and Sales Report.
Filed Date: 5/1/18.
Accession Number: 20180501–5012.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP13–584–006.
Applicants: Columbia Gas Transmission, LLC.
Description: Compliance filing Revenue Sharing Report 2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5013.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–763–000.
Applicants: Gulf Crossing Pipeline Company LLC.
Description: § 4(d) Rate Filing: Amendment to Neg Rate Agmt (BP 37–27) to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5006.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–764–000.
Applicants: Gulf South Pipeline Company, LP.
Description: § 4(d) Rate Filing: Cap Rel Neg Rate Agmts (Atlanta 8438 to various eff 5–1–2018) to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5005.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–766–000.
Applicants: Gulf South Pipeline Company, LP.
Description: § 4(d) Rate Filing: Cap Rel Neg Rate Agmts (Southern 41616, 41617 to Emera 49472, 49471) to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5007.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–767–000.
Applicants: Texas Gas Transmission, LLC.
Description: § 4(d) Rate Filing: Cap Rel Neg Rate Agmts (RE Gas to BP 37151, 37152 eff 5–1–2018) to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5014.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–768–000.
Applicants: Equitrans, L.P.
Description: § 4(d) Rate Filing: Negotiated Capacity Release Agreements—5/1/2018 to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5015.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–769–000.
Applicants: Gulf South Pipeline Company, LP.
Description: § 4(d) Rate Filing: Cap Rel Neg Rate Agmts (Petrohawk 41455 releases eff 5–1–2018) to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5026.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–770–000.
Applicants: Gulf Crossing Pipeline Company LLC.
Description: § 4(d) Rate Filing: Cap Rel Neg Rate Agmts (Newfield 18 releases eff 5–1–2018) to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5033.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–772–000.
Applicants: Eastern Shore Natural Gas Company.
Description: § 4(d) Rate Filing: Baseline Tariff to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5285.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–773–000.
Applicants: Eastern Shore Natural Gas Company.
Description: Tariff Cancellation: Cancellation of FERC Gas Tariff, Third Revised Volume No. 1 to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5299.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–774–000.
Applicants: Gulfstream Natural Gas System, L.L.C.
Description: § 4(d) Rate Filing: 2018 GNGS TUP/SBA Filing to be effective 6/1/2018.
Filed Date: 5/1/18.

Accession Number: 20180501–5301.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–775–000.
Applicants: Southeast Supply Header, LLC.
Description: § 4(d) Rate Filing: 2018 SESH TUP/SBA Annual Filing to be effective 6/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5305.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–776–000.
Applicants: Sabal Trail Transmission, LLC.
Description: § 4(d) Rate Filing: 2018 Initial TUP/SBA Filing to be effective 6/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5306.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–777–000.
Applicants: Great Lakes Gas Transmission Limited Partnership.
Description: § 4(d) Rate Filing: Implementation of TC Plus to be effective 6/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5315.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–779–000.
Applicants: Enable Gas Transmission, LLC.
Description: § 4(d) Rate Filing: Negotiated Rate Filing—June 2018 Great Salt Plains 1010446 to be effective 6/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5347.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–780–000.
Applicants: Northern Natural Gas Company.
Description: § 4(d) Rate Filing: 20180501 Negotiated Rate to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5348.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–781–000.
Applicants: East Cheyenne Gas Storage, LLC.
Description: Compliance filing ECGS 2018 Operational Purchase & Sales.
Filed Date: 5/1/18.
Accession Number: 20180501–5364.
Comments Due: 5 p.m. ET 5/14/18.

Docket Numbers: RP18–782–000.
Applicants: Panther Interstate Pipeline Energy, LLC.
Description: Tariff Cancellation: PIPE Tariff Cancellation Filing to be effective 6/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5365.
Comments Due: 5 p.m. ET 5/14/18.

The filings are accessible in the Commission's eLibrary system by clicking on the links or querying the docket number.

Any person desiring to intervene or protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Regulations (18 CFR 385.211 and 385.214) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Dated: May 2, 2018.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2018–09750 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP18–6–000]

RH energytrans, LLC; Notice of Schedule for Environmental Review of the Risberg Line Project

On October 16, 2017, RH energytrans, LLC filed an application in Docket No. CP18–6–000 requesting a Certificate of Public Convenience and Necessity pursuant to section 7(c) of the Natural Gas Act to construct and operate certain natural gas pipeline facilities. The proposed project is known as the Risberg Line Project (Project), and would deliver up to 55,000 dekatherms per day of firm natural gas transportation service to Dominion Energy Ohio and other prospective customers.

On October 26, 2017, the Federal Energy Regulatory Commission (Commission or FERC) issued its Notice of Application for the Project. Among other things, that notice alerted agencies issuing federal authorizations of the requirement to complete all necessary reviews and to reach a final decision on a request for a federal authorization within 90 days of the date of issuance of the Commission staff's Environmental Assessment (EA) for the Project. This instant notice identifies the FERC staff's planned schedule for the completion of the EA for the Project.

Schedule for Environmental Review

Issuance of EA—June 29, 2018

90-Day Federal Authorization Decision Deadline—September 27, 2018

If a schedule change becomes necessary, additional notice will be provided so that the relevant agencies are kept informed of the Project's progress.

Project Description

RH energytrans, LLC's Risberg Line Project would involve modification and recertification of existing facilities and installation of new facilities. Activities associated with the modification and the recertification of existing facilities would include:

- Modifications at the existing County Line Compressor Station in Erie County, Pennsylvania;
- conversion of an existing 26.6-mile-long, 12-inch-diameter gathering pipeline to natural gas transmission service in Crawford and Erie Counties, Pennsylvania; and
- conversion of an existing 5.0-mile-long, 8-inch-diameter gathering pipeline to natural gas transmission service in Erie County, Pennsylvania.

New facilities that RH energytrans, LLC proposes to construct include:

- Meadville Compressor Station in Crawford County, Pennsylvania, including one 728 horsepower natural gas-fired reciprocating compressor unit;
- 650-foot-long, 12-inch-diameter lateral pipeline within the existing 12-inch-diameter gathering pipeline right-of-way;
- 28.3-mile-long, 12-inch-diameter pipeline in Erie County, Pennsylvania and Ashtabula County, Ohio (Risberg Pipeline); and
- North Kingsville Meter Station in Ashtabula County, Ohio.

Background

On November 21, 2017, the Commission issued a *Notice of Intent to Prepare an Environmental Assessment for the Proposed Risberg Line Project and Request for Comments on Environmental Issues* (NOI). The NOI was sent to affected landowners; federal, state, and local government agencies; elected officials; environmental and public interest groups; Native American tribes; other interested parties; and local libraries and newspapers. In response to the NOI, the Commission received comments from the U.S. Fish and Wildlife Service, Ohio Department of Natural Resources, and 29 individuals. A number of individuals submitted more than one comment. The comments included a variety of topics such as water resources, wetlands, vegetation, wildlife, land use, recreation, and socioeconomics, air quality and noise, reliability and safety, and alternatives.

The U.S. Army Corps of Engineers and Pennsylvania Fish and Boat Commission are cooperating agencies in the preparation of the EA.

Additional Information

In order to receive notification of the issuance of the EA and to keep track of all formal issuances and submittals in specific dockets, the Commission offers a free service called eSubscription. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries, and direct links to the documents. Go to *www.ferc.gov/docs-filing/esubscription.asp.*

Additional information about the Project is available from the Commission's Office of External Affairs at (866) 208–FERC or on the FERC website (*www.ferc.gov*). Using the eLibrary link, select General Search from the eLibrary menu, enter the selected date range and Docket Number excluding the last three digits (*i.e.,* CP18–6–000), and follow the instructions. For assistance with access to eLibrary, the helpline can be reached at (866) 208–3676, TTY (202) 502–8659, or at *FERCOnlineSupport@ferc.gov.* The eLibrary link on the FERC website also provides access to the texts of formal documents issued by the Commission, such as orders, notices, and rule makings.

Dated: May 1, 2018.

Kimberly D. Bose,

Secretary.

[FR Doc. 2018–09712 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER18–1163–001.
Applicants: Avista Corporation.
Description: Tariff Amendment: Avista Corporation Amendment to correct e-Tariff Viewer ER18–1163 to be effective 4/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5366.
Comments Due: 5 p.m. ET 5/22/18.

Docket Numbers: ER18–1494–000.
Applicants: Interstate Power and Light Company.
Description: § 205(d) Rate Filing: Amendment to IPL Wholesale Formula Rate Changes to be effective 5/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5322.
Comments Due: 5 p.m. ET 5/22/18.

Docket Numbers: ER18–1495–000.
Applicants: PJM Interconnection, L.L.C.
Description: § 205(d) Rate Filing: First Revised ISA SA No. 2987; Queue No. AC1–073 to be effective 4/4/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5335.
Comments Due: 5 p.m. ET 5/22/18.

Docket Numbers: ER18–1496–000.
Applicants: PJM Interconnection, L.L.C.
Description: § 205(d) Rate Filing: Original ISA, SA No. 5068; Queue No. AB1–081 to be effective 4/13/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5349.
Comments Due: 5 p.m. ET 5/22/18.

Docket Numbers: ER18–1497–000.
Applicants: Tucson Electric Power Company.
Description: § 205(d) Rate Filing: Service Agreement for Network Integration Transmission Service—TRICO to be effective 5/1/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5000.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–1498–000.
Applicants: Entergy Arkansas, Inc.
Description: § 205(d) Rate Filing: EAI et al Unit Power Sales and Designated Power Purchase Tariff Amendment to be effective 7/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5368.
Comments Due: 5 p.m. ET 5/22/18.

Docket Numbers: ER18–1499–000.
Applicants: PacifiCorp.
Description: § 205(d) Rate Filing: SRP Construct Agmt for Cove Fort Meter to be effective 7/2/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5379.
Comments Due: 5 p.m. ET 5/22/18.

Docket Numbers: ER18–1500–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 2825R5 KMEA and Westar Energy Meter Agent Agreement to be effective 6/1/2018.
Filed Date: 5/1/18.
Accession Number: 20180501–5405.
Comments Due: 5 p.m. ET 5/22/18.

Docket Numbers: ER18–1501–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 2450R2 KEPCO NITSA NOA to be effective 6/1/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5038.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–1502–000.
Applicants: Public Service Company of Colorado.
Description: § 205(d) Rate Filing: PSCo–BLDR–T–2018–1–Spec Study–486–0.0.0 to be effective 5/3/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5039.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–1503–000.
Applicants: International Transmission Company.
Description: § 205(d) Rate Filing: CIAC Agreement with DTE Electric Company to be effective 7/2/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5043.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–1504–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 2451R3 KEPCO NITSA NOA to be effective 6/1/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5049.
Comments Due: 5 p.m. ET 5/23/18.

The filings are accessible in the Commission's eLibrary system by clicking on the links or querying the docket number.

Any person desiring to intervene or protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Regulations (18 CFR 385.211 and 385.214) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Dated: May 2, 2018.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2018–09748 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP18–46–000]

Adelphia Gateway, LLC; Notice of Intent to Prepare an Environmental Assessment for the Proposed Adelphia Gateway Project, Request for Comments on Environmental Issues, and Notice of Public Scoping Sessions

The staff of the Federal Energy Regulatory Commission (FERC or Commission) will prepare an environmental assessment (EA) that will discuss the environmental impacts of the Adelphia Gateway Project involving construction and operation of facilities by Adelphia Gateway, LLC (Adelphia) in Delaware, Bucks, Chester, Montgomery, and Northampton Counties, Pennsylvania, and New Castle County, Delaware. The Commission will use this EA in its decision-making process to determine whether the project is in the public convenience and necessity.

This notice announces the opening of the scoping process the Commission will use to gather input from the public and interested agencies on the project. You can make a difference by providing us with your specific comments or concerns about the project. Your comments should focus on the potential environmental effects, reasonable alternatives, and measures to avoid or lessen environmental impacts. Your input will help the Commission staff determine what issues they need to evaluate in the EA. To ensure that your comments are timely and properly recorded, please send your comments so that the Commission receives them in Washington, DC on or before 5:00 p.m. Eastern Time on June 1, 2018.

If you sent comments on this project to the Commission before the opening of this docket on January 11, 2018, you will need to file those comments in Docket No. CP18–46–000 to ensure they are considered as part of this proceeding.

This notice is being sent to the Commission's current environmental mailing list for this project. State and local government representatives should notify their constituents of this proposed project and encourage them to comment on their areas of concern.

If you are a landowner receiving this notice, a pipeline company representative may contact you about the acquisition of an easement to construct, operate, and maintain the proposed facilities. The company would seek to negotiate a mutually acceptable agreement. However, if the Commission approves the project, that approval conveys with it the right of eminent domain. Therefore, if easement negotiations fail to produce an agreement, the pipeline company could initiate condemnation proceedings where compensation would be determined in accordance with state law.

Adelphia provided landowners with a fact sheet prepared by the FERC entitled ''An Interstate Natural Gas Facility On My Land? What Do I Need To Know?'' This fact sheet addresses a number of typically asked questions, including the use of eminent domain and how to participate in the Commission's proceedings. It is also available for viewing on the FERC website (*www.ferc.gov*).

Public Participation

For your convenience, there are four methods you can use to submit your comments to the Commission. The Commission will provide equal consideration to all comments received, whether filed in written form or provided verbally. The Commission encourages electronic filing of comments and has expert staff available to assist you at (202) 502–8258 or *FercOnlineSupport@ferc.gov.* Please carefully follow these instructions so that your comments are properly recorded.

(1) You can file your comments electronically using the *eComment* feature on the Commission's website (*www.ferc.gov*) under the link to *Documents and Filings.* This is an easy method for submitting brief, text-only comments on a project;

(2) You can file your comments electronically by using the *eFiling* feature on the Commission's website (*www.ferc.gov*) under the link to *Documents and Filings.* With eFiling, you can provide comments in a variety of formats by attaching them as a file with your submission. New eFiling users must first create an account by clicking on *eRegister.* If you are filing a comment on a particular project, please select ''Comment on a Filing'' as the filing type;

(3) You can file a paper copy of your comments by mailing them to the following address. Be sure to reference the project docket number (CP18–46–000) with your submission: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Room 1A, Washington, DC 20426.

(4) In lieu of sending written or electronic comments, the Commission invites you to attend one of the public scoping sessions its staff will conduct in the project area, scheduled as follows:

Date and time	Location
Wednesday, May 30, 2018, 5:00–9:00 p.m	Homewood Suites by Hilton, Allentown Bethlehem Center Valley, 3350 Center Valley Parkway, Center Valley, PA 18034, (610) 351–6400.
Thursday, May 31, 2018, 5:00–9:00 p.m	Clarion Hotel Philadelphia Airport, 76 Industrial Highway, Route 291, Essington, PA 19029, (610) 521–9600.

The primary goal of these scoping sessions is to have you identify the specific environmental issues and concerns that should be considered in the EA to be prepared for this project. Individual verbal comments will be taken on a one-on-one basis with a court reporter. This format is designed to receive the maximum amount of verbal comments, in a convenient way during the timeframe allotted.

Each scoping session is scheduled from 5:00 p.m. to 9:00 p.m. Eastern Time. You may arrive at any time after 5:00 p.m. There will not be a formal presentation by Commission staff when the session opens. If you wish to speak, the Commission staff will hand out numbers in the order of your arrival. Comments will be taken until 9:00 p.m. However, if no additional numbers have been handed out and all individuals who wish to provide comments have had an opportunity to do so, staff may conclude the session at 8:00 p.m. Please see appendix 1 for additional information on the session format and conduct.[1]

[1] The appendices referenced in this notice will not appear in the **Federal Register**. Copies of the appendices were sent to all those receiving this notice in the mail and are available at *www.ferc.gov* using the link called ''eLibrary'' or from the Commission's Public Reference Room, 888 First Street NE, Washington, DC 20426, or call (202) 502–8371. For instructions on connecting to eLibrary,

Your scoping comments will be recorded by the court reporter (with FERC staff or representative present) and become part of the public record for this proceeding. Transcripts will be publicly available on FERC's eLibrary system (see below for instructions on using eLibrary). If a significant number of people are interested in providing verbal comments in the one-on-one settings, a time limit of 5 minutes may be implemented for each commenter.

It is important to note that verbal comments hold the same weight as written or electronically submitted comments. Although there will not be a formal presentation, Commission staff will be available throughout the comment session to answer your questions about the environmental review process.

Please note this is not your only public input opportunity; please refer to the review process flow chart in appendix 2.

Summary of the Proposed Project

Adelphia proposes to acquire and convert an existing oil pipeline and an existing dual-phase oil and natural gas pipeline to natural gas only, and construct and operate new natural gas pipelines, compressor stations, meter stations, and appurtenant facilities in Delaware, Bucks, Chester, Montgomery, and Northampton Counties, Pennsylvania, and New Castle County, Delaware. The Adelphia Gateway Project would provide about 175 million standard cubic feet of natural gas per day to the greater Philadelphia industrial region with potential to serve additional markets in the northeast.

Specifically, the Adelphia Gateway Project would consist of the construction of the following facilities:

- One new 5,625 horsepower (hp) compressor station in Delaware County, Pennsylvania (Marcus Hook Compressor Station);
- one new 5,625 hp compressor station in Bucks County, Pennsylvania (Quakertown Compressor Station);
- 0.25 mile of new 16-inch-diameter pipeline lateral in Delaware County, Pennsylvania and New Castle County, Delaware (Parkway Lateral);
- 4.5 miles of new 16-inch-diameter pipeline lateral in Delaware County, Pennsylvania (Tilghman Lateral);
- one new interconnect each in Montgomery County and Bucks County, Pennsylvania;
- three new interconnects in New Castle County, Delaware;
- three new interconnects in Delaware County, Pennsylvania;
- eight new blowdown assemblies (one in Delaware County, two in Montgomery County, and five in Chester County, Pennsylvania);
- one new mainline valve in Delaware County, Pennsylvania; and
- one temporary wareyard in Delaware County, Pennsylvania.

Additionally, the Adelphia Gateway Project would require the acquisition and use of the following existing facilities:

- 4.4 miles of existing 20-inch-diameter natural gas pipeline in Northampton County, Pennsylvania;
- 84 miles of existing 18-inch-diameter pipeline (the northern 34-mile segment was used to transport oil and natural gas, and the southern 50-mile segment was used to transport fuel oil); and
- four existing meter stations in Bucks, Delaware, and Northampton Counties, Pennsylvania.

The general location of the project facilities is shown in appendix 3.

Land Requirements for Construction

Construction of the proposed facilities would disturb about 42 acres of land for the proposed aboveground facilities and the pipelines. Following construction, Adelphia would maintain about 9 acres for permanent operation of the project's facilities; the remaining acreage would be restored and would revert to former uses. The majority of the proposed right-of-way for the pipelines are collocated with existing roads, power lines, and other pipeline rights-of-way.

The EA Process

The National Environmental Policy Act (NEPA) requires the Commission to take into account the environmental impacts that could result from an action whenever it considers the issuance of a Certificate of Public Convenience and Necessity. NEPA also requires us [2] to discover and address concerns the public may have about proposals. This process is referred to as scoping. The main goal of the scoping process is to focus the analysis in the EA on the important environmental issues. By this notice, the Commission requests public comments on the scope of the issues to address in the EA. We will consider all filed comments during the preparation of the EA.

In the EA, we will discuss impacts that could occur as a result of the construction and operation of the proposed project under these general headings:

- Geology and soils;
- water resources and wetlands;
- fisheries, vegetation, and wildlife;
- endangered and threatened species;
- cultural resources;
- socioeconomics;
- land use;
- air quality and noise;
- public safety; and
- cumulative impacts

We will also evaluate reasonable alternatives to the proposed project or portions of the project, and make recommendations on how to lessen or avoid impacts on the various resource areas.

The EA will present our independent analysis of the issues. The EA will be available in the public record through eLibrary. We will publish and distribute the EA to the public for an allotted comment period. We will consider all comments on the EA before making our recommendations to the Commission. To ensure we have the opportunity to consider and address your comments, please carefully follow the instructions in the Public Participation section, beginning on page 2.

With this notice, we are asking agencies with jurisdiction by law and/or special expertise with respect to the environmental issues of this project to formally cooperate with us in the preparation of the EA.[3] Agencies that would like to request cooperating agency status should follow the instructions for filing comments provided under the Public Participation section of this notice.

Consultations Under Section 106 of the National Historic Preservation Act

In accordance with the Advisory Council on Historic Preservation's implementing regulations for section 106 of the National Historic Preservation Act, we are using this notice to initiate consultation with the applicable State Historic Preservation Offices (SHPO), and to solicit their views and those of other government agencies, interested Indian tribes, and the public on the project's potential effects on historic properties.[4] We will

refer to the last page of this notice. Public Reference Room, 888 First Street NE, Washington, DC 20426, or call (202) 502–8371. For instructions on connecting to eLibrary, refer to the last page of this notice.

[2] We, us, and our refer to the environmental staff of the Commission's Office of Energy Projects.

[3] The Council on Environmental Quality regulations addressing cooperating agency responsibilities are at Title 40, Code of Federal Regulations, Part 1501.6.

[4] The Advisory Council on Historic Preservation's regulations are at Title 36, Code of Federal Regulations, Part 800. Those regulations define historic properties as any prehistoric or historic district, site, building, structure, or object included in or eligible for inclusion in the National Register of Historic Places.

define the project-specific Area of Potential Effects (APE) in consultation with the SHPOs as the project develops. On natural gas facility projects, the APE at a minimum encompasses all areas subject to ground disturbance (examples include construction right-of-way, contractor/pipe storage yards, compressor stations, and access roads). Our EA for this project will document our findings on the impacts on historic properties and summarize the status of consultations under section 106.

Environmental Mailing List

The environmental mailing list includes: Federal, state, and local government representatives and agencies; elected officials; environmental and public interest groups; Native American Tribes; other interested parties; and local libraries. This list also includes all affected landowners (as defined in the Commission's regulations) who are potential right-of-way grantors, whose property may be used temporarily for project purposes, or who own homes within certain distances of aboveground facilities, and anyone who submits comments on the project. We will update the environmental mailing list as the analysis proceeds to ensure that we send the information related to this environmental review to all individuals, organizations, and government entities interested in and/or potentially affected by the proposed project.

Copies of the EA will be sent to the environmental mailing list for public review and comment. If you would prefer to receive a paper copy of the document instead of the CD version or would like to remove your name from the mailing list, please return the attached Information Request (appendix 4).

Becoming an Intervenor

In addition to involvement in the EA scoping process, you may want to become an ''intervenor'' which is an official party to the Commission's proceeding. Intervenors play a more formal role in the process and are able to file briefs, appear at hearings, and be heard by the courts if they choose to appeal the Commission's final ruling. An intervenor formally participates in the proceeding by filing a request to intervene. Instructions for becoming an intervenor are in the ''Document-less Intervention Guide'' under the ''e-filing'' link on the Commission's website. Motions to intervene are more fully described at *http://www.ferc.gov/resources/guides/how-to/intervene.asp.*

Additional Information

Additional information about the project is available from the Commission's Office of External Affairs, at (866) 208–FERC, or on the FERC website at *www.ferc.gov* using the eLibrary link. Click on the eLibrary link, click on General Search and enter the docket number, excluding the last three digits in the Docket Number field (*i.e.,* CP18–46). Be sure you have selected an appropriate date range. For assistance, please contact FERC Online Support at *FercOnlineSupport@ferc.gov* or toll free at (866) 208–3676, or for TTY, contact (202) 502–8659. The eLibrary link also provides access to the texts of formal documents issued by the Commission, such as orders, notices, and rulemakings.

In addition, the Commission offers a free service called eSubscription which allows you to keep track of all formal issuances and submittals in specific dockets. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries, and direct links to the documents. Go to *www.ferc.gov/docs-filing/esubscription.asp.*

Finally, public sessions or site visits will be posted on the Commission's calendar located at *www.ferc.gov/EventCalendar/EventsList.aspx* along with other related information.

Dated: May 1, 2018.

Kimberly D. Bose,

Secretary.

[FR Doc. 2018–09719 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP18–118–000]

Rover Pipeline LLC; Notice of Intent To Prepare an Environmental Assessment for the Proposed UGS-Crawford Meter Station Project, and Request for Comments on Environmental Issues

The staff of the Federal Energy Regulatory Commission (FERC or Commission) will prepare an environmental assessment (EA) that will discuss the environmental impacts of the UGS-Crawford Meter Station Project involving construction and operation of facilities by Rover Pipeline LLC (Rover) in Jefferson County, Ohio. The Commission will use this EA in its decision-making process to determine whether the project is in the public convenience and necessity.

This notice announces the opening of the scoping process the Commission will use to gather input from the public and interested agencies on the project. You can make a difference by providing us with your specific comments or concerns about the project. Your comments should focus on the potential environmental effects, reasonable alternatives, and measures to avoid or lessen environmental impacts. Your input will help the Commission staff determine what issues they need to evaluate in the EA. To ensure that your comments are timely and properly recorded, please send your comments so that the Commission receives them in Washington, DC on or before 5:00 p.m. Eastern Time on May 31, 2018.

If you sent comments on this project to the Commission before the opening of this docket on March 15, 2018, you will need to file those comments in Docket No. CP18–118–000 to ensure they are considered as part of this proceeding.

This notice is being sent to the Commission's current environmental mailing list for this project. State and local government representatives should notify their constituents of this proposed project and encourage them to comment on their areas of concern.

If you are a landowner receiving this notice, a pipeline company representative may contact you about the acquisition of an easement to construct, operate, and maintain the proposed facilities. The company would seek to negotiate a mutually acceptable agreement. However, if the Commission approves the project, that approval conveys with it the right of eminent domain. Therefore, if easement negotiations fail to produce an agreement, the pipeline company could initiate condemnation proceedings where compensation would be determined in accordance with state law.

Rover provided landowners with a fact sheet prepared by the FERC entitled An Interstate Natural Gas Facility On My Land? What Do I Need To Know? This fact sheet addresses a number of typically asked questions, including the use of eminent domain and how to participate in the Commission's proceedings. It is also available for viewing on the FERC website (*www.ferc.gov*).

Public Participation

For your convenience, there are three methods you can use to submit your comments to the Commission. The Commission encourages electronic filing of comments and has expert staff available to assist you at (202) 502–8258 or *FercOnlineSupport@ferc.gov.* Please

carefully follow these instructions so that your comments are properly recorded.

(1) You can file your comments electronically using the *eComment* feature on the Commission's website (*www.ferc.gov*) under the link to *Documents and Filings.* This is an easy method for submitting brief, text-only comments on a project;

(2) You can file your comments electronically by using the *eFiling* feature on the Commission's website (*www.ferc.gov*) under the link to *Documents and Filings.* With eFiling, you can provide comments in a variety of formats by attaching them as a file with your submission. New eFiling users must first create an account by clicking on *eRegister.* If you are filing a comment on a particular project, please select ''Comment on a Filing'' as the filing type; or

(3) You can file a paper copy of your comments by mailing them to the following address. Be sure to reference the project docket number (CP18–118–000) with your submission: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Room 1A, Washington, DC 20426.

Summary of the Proposed Project

Rover proposes to construct, own, and operate a new meter station on its Burgettstown Lateral in Jefferson County, Ohio. The UGS-Crawford Meter Station Project would receive up to 350 million cubic feet per day of natural gas. According to Rover, its project would respond to proven market demand for additional receipt point facilities from the Marcellus and Utica Shale supply areas.

The UGS-Crawford Meter Station Project would consist of an ultrasonic meter skid and ancillary facilities, as well as a new permanent access road.

The general location of the project facility is shown in appendix 1.[1]

Land Requirements for Construction

Construction of the proposed facilities would disturb about 3.6 acres of land for the aboveground facility. Following construction, Rover would maintain about 0.9 acre for permanent operation of the project's facilities; the remaining acreage would be restored and revert to former uses. In addition, a new permanent access road, approximately 25 feet wide and 100 feet long (covering approximately 0.1 acre of land), would be constructed and maintained. The proposed Project site and all workspaces would be within the existing Burgettstown Lateral right-of-way.

The EA Process

The National Environmental Policy Act (NEPA) requires the Commission to take into account the environmental impacts that could result from an action whenever it considers the issuance of a Certificate of Public Convenience and Necessity. NEPA also requires us [2] to discover and address concerns the public may have about proposals. This process is referred to as ''scoping.'' The main goal of the scoping process is to focus the analysis in the EA on the important environmental issues. By this notice, the Commission requests public comments on the scope of the issues to address in the EA. We will consider all filed comments during the preparation of the EA.

In the EA we will discuss impacts that could occur as a result of the construction and operation of the proposed project under these general headings:

- Geology and soils;
- vegetation and wildlife;
- endangered and threatened species;
- cultural resources;
- land use;
- air quality and noise;
- public safety; and
- cumulative impacts

We will also evaluate reasonable alternatives to the proposed project or portions of the project, and make recommendations on how to lessen or avoid impacts on the various resource areas.

The EA will present our independent analysis of the issues. The EA will be available in the public record through eLibrary. Depending on the comments received during the scoping process, we may publish and distribute the EA to the public for an allotted comment period. We will consider all comments on the EA before making our recommendations to the Commission. To ensure we have the opportunity to consider and address your comments, please carefully follow the instructions in the Public Participation section, beginning on page 2.

With this notice, we are asking agencies with jurisdiction by law and/or special expertise with respect to the environmental issues of this project to formally cooperate with us in the preparation of the EA.[3] Agencies that would like to request cooperating agency status should follow the instructions for filing comments provided under the Public Participation section of this notice.

Consultations Under Section 106 of the National Historic Preservation Act

In accordance with the Advisory Council on Historic Preservation's implementing regulations for section 106 of the National Historic Preservation Act, we are using this notice to initiate consultation with the applicable State Historic Preservation Office (SHPO), and to solicit their views and those of other government agencies, interested Indian tribes, and the public on the project's potential effects on historic properties.[4] We will define the project-specific Area of Potential Effects (APE) in consultation with the SHPO as the project develops. On natural gas facility projects, the APE at a minimum encompasses all areas subject to ground disturbance (examples include construction right-of-way, contractor/pipe storage yards, compressor stations, and access roads). Our EA for this project will document our findings on the impacts on historic properties and summarize the status of consultations under section 106.

Environmental Mailing List

The environmental mailing list includes federal, state, and local government representatives and agencies; elected officials; Native American Tribes; and local libraries. This list also includes all affected landowners (as defined in the Commission's regulations) who are potential right-of-way grantors, whose property may be used temporarily for project purposes, or who own homes within certain distances of aboveground facilities, and anyone who submits comments on the project. We will update the environmental mailing list as the analysis proceeds to ensure that we send the information related to this environmental review to all individuals, organizations, and government entities interested in and/or potentially affected by the proposed project.

If we publish and distribute the EA, copies of the EA will be sent to the

[1] The appendices referenced in this notice will not appear in the **Federal Register.** Copies of appendices were sent to all those receiving this notice in the mail and are available at *www.ferc.gov* using the link called eLibrary or from the Commission's Public Reference Room, 888 First Street NE, Washington, DC 20426, or call (202) 502–8371. For instructions on connecting to eLibrary, refer to the last page of this notice.

[2] We, us, and our refer to the environmental staff of the Commission's Office of Energy Projects.

[3] The Council on Environmental Quality regulations addressing cooperating agency responsibilities are at Title 40, Code of Federal Regulations, Part 1501.6.

[4] The Advisory Council on Historic Preservation's regulations are at Title 36, Code of Federal Regulations, Part 800. Those regulations define historic properties as any prehistoric or historic district, site, building, structure, or object included in or eligible for inclusion in the National Register of Historic Places.

environmental mailing list for public review and comment. If you would prefer to receive a paper copy of the document instead of the CD Version, or would like to remove your name from the mailing list, please return the attached Information Request (appendix 2).

Becoming an Intervenor

In addition to involvement in the EA scoping process, you may want to become an intervenor which is an official party to the Commission's proceeding. Intervenors play a more formal role in the process and are able to file briefs, appear at hearings, and be heard by the courts if they choose to appeal the Commission's final ruling. An intervenor formally participates in the proceeding by filing a request to intervene. Instructions for becoming an intervenor are in the Document-less Intervention Guide under the e-filing link on the Commission's website. Motions to intervene are more fully described at *http://www.ferc.gov/resources/guides/how-to/intervene.asp.*

Additional Information

Additional information about the project is available from the Commission's Office of External Affairs, at (866) 208–FERC, or on the FERC website at *www.ferc.gov* using the eLibrary link. Click on the eLibrary link, click on General Search and enter the docket number, excluding the last three digits in the Docket Number field (*i.e.,* CP18–118). Be sure you have selected an appropriate date range. For assistance, please contact FERC Online Support at *FercOnlineSupport@ferc.gov* or toll free at (866) 208–3676, or for TTY, contact (202) 502–8659. The eLibrary link also provides access to the texts of formal documents issued by the Commission, such as orders, notices, and rulemakings.

In addition, the Commission offers a free service called eSubscription which allows you to keep track of all formal issuances and submittals in specific dockets. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries, and direct links to the documents. Go to *www.ferc.gov/docs-filing/esubscription.asp.*

Finally, public sessions or site visits will be posted on the Commission's calendar located at *www.ferc.gov/EventCalendar/EventsList.aspx* along with other related information.

Dated: May 1, 2018.

Kimberly D. Bose,

Secretary.

[FR Doc. 2018–09720 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. NJ18–14–000]

Oncor Electric Delivery Company LLC; Notice of Filing

Take notice that on April 25, 2018, Oncor Electric Delivery Company LLC submitted its tariff filing: Oncor TFO Tariff Rate Changes to be effective 3/27/2018.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the comment date. On or before the comment date, it is not necessary to serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the eFiling link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 5 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the eLibrary link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the website that enables subscribers to receive email notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please email *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5:00 p.m. Eastern Time on May 16, 2018.

Dated: May 2, 2018.

Kimberly D. Bose,

Secretary.

[FR Doc. 2018–09717 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. CP18–37–000 and CP18–38–000]

Sierrita Gas Pipeline LLC; Notice of Schedule for Environmental Review of the Sierrita Compressor Expansion Project

On December 21, 2017, Sierrita Gas Pipeline LLC (Sierrita) filed an application in Docket No. CP18–37–000 requesting a Certificate of Public Convenience and Necessity pursuant to Section 7(c) of the Natural Gas Act to construct and operate certain natural gas pipeline facilities. Additionally, in Docket No. CP18–38–000, Sierrita is requesting an amendment to its Section 3 authorization and its Presidential Permit. The proposed project is known as the Sierrita Compressor Expansion Project (Project), in which Sierrita would increase the design capacity of existing Line No. 2177 to 627,000,000 cubic feet per day at its border crossing into Mexico in Pima County, Arizona.

On January 5, 2018, the Federal Energy Regulatory Commission (Commission or FERC) issued its Notice of Applications for the Project. Among other things, that notice alerted agencies issuing federal authorizations of the requirement to complete all necessary reviews and to reach a final decision on a request for a federal authorization within 90 days of the date of issuance of the Commission staff's Environmental Assessment (EA) for the Project. This instant notice identifies the FERC staff's planned schedule for the completion of the EA for the Project.

Schedule for Environmental Review

Issuance of EA—June 13, 2018
90-Day Federal Authorization Decision Deadline—September 11, 2018

If a schedule change becomes necessary, additional notice will be provided so that the relevant agencies are kept informed of the Project's progress.

Project Description

Sierrita proposes to construct in Pima County, Arizona one 15,900 horsepower compressor station, suction and discharge piping, and ancillary facilities on its existing Line No. 2177; one 10-

inch meter at its existing San Joaquin Meter Station; as well as relocate an existing mainline valve and pipeline inspection tool.

Background

On February 2, 2018, the Commission issued a *Notice of Intent to Prepare an Environmental Assessment for the Proposed Sierrita Compressor Expansion Project and Request for Comments on Environmental Issues* (NOI). The NOI was sent to affected landowners; federal, state, and local government agencies; elected officials; environmental and public interest groups; Native American tribes; other interested parties; and local libraries and newspapers. In response to the NOI, the Commission received comments from Pima County (Office of Sustainability & Conservation, the Regional Flood Control District, the Development Services Department, and the Regional Wastewater Reclamation Department); the Altar Valley Conservation Alliance; and the U.S. Environmental Protection Agency. The primary issues raised by the commentors regarded purpose and need, alternatives, pipeline safety, water resources, air quality, biological resources and invasive species, hazardous materials, cultural resources, cumulative impacts, restoration and post-construction monitoring, outdoor lighting, and impacts on existing utility lines.

Additional Information

In order to receive notification of the issuance of the EA and to keep track of all formal issuances and submittals in specific dockets, the Commission offers a free service called eSubscription. This can reduce the amount of time you spend researching proceedings by automatically providing you with notification of these filings, document summaries, and direct links to the documents. Go to *www.ferc.gov/docs-filing/esubscription.asp.*

Additional information about the Project is available from the Commission's Office of External Affairs at (866) 208–FERC or on the FERC website (*www.ferc.gov*). Using the eLibrary link, select General Search from the eLibrary menu, enter the selected date range and Docket Number excluding the last three digits (*i.e.,* CP18–37), and follow the instructions. For assistance with access to eLibrary, the helpline can be reached at (866) 208–3676, TTY (202) 502–8659, or at *FERCOnlineSupport@ferc.gov.* The eLibrary link on the FERC website also provides access to the texts of formal documents issued by the Commission, such as orders, notices, and rule makings.

Dated: May 1, 2018.

Kimberly D. Bose,

Secretary.

[FR Doc. 2018–09718 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. NJ18–12–000]

Oncor Electric Delivery Company LLC; Notice of Filing

Take notice that on April 23, 2018, Oncor Electric Delivery Company LLC submitted its tariff filing: Oncor TFO Tariff Rate Changes to be effective 11/27/2017.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the comment date. On or before the comment date, it is not necessary to serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the eFiling link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 5 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the eLibrary link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the website that enables subscribers to receive email notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please email *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5:00 p.m. Eastern Time on May 14, 2018.

Dated: May 2, 2018.

Kimberly D. Bose,

Secretary.

[FR Doc. 2018–09715 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. NJ18–11–000]

Oncor Electric Delivery Company LLC; Notice of Filing

Take notice that on April 23, 2018, Oncor Electric Delivery Company LLC submitted its tariff filing: Oncor Tex-La Tariff Rate Changes to be effective 11/27/2017.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the comment date. On or before the comment date, it is not necessary to serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the eFiling link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 5 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the ''eLibrary'' link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the website that enables subscribers to receive email notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please email *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5:00 p.m. Eastern Time on May 14, 2018.

Dated: May 2, 2018.

Kimberly D. Bose,

Secretary.

[FR Doc. 2018–09714 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP18–251–000]

Portland Natural Gas Transmission System; Notice of Application

Take notice that on April 20, 2018, Portland Natural Gas Transmission System (Portland Natural Gas), 700 Louisiana Street, Suite 700, Houston, TX 77002–2700, filed an application under section 7(c) of the Natural Gas Act (NGA) and Parts 157 and 284 of the Commission's rules and regulations for Phase I of the Portland Xpress Project. Portland Natural Gas requests authorization to increase the certificated capacity on its wholly-owned north system from Pittsburg, New Hampshire, to Westbrook, Maine, by 39.841 million cubic feet per day (MMcf/d), and to increase the certificated capacity on its system facilities jointly-owned with Maritimes & Northeast Pipeline, L.L.C. from Westbrook, Maine to Dracut, Massachusetts by 1.641 MMcf/d, effective November 1, 2018, all as more fully described in the application which is on file with the Commission and open to public inspection. The filing may also be viewed on the web at *http://www.ferc.gov* using the eLibrary link. Enter the docket number excluding the last three digits in the docket number field to access the document. For assistance, contact FERC at *FERCOnlineSupport@ferc.gov* or call toll-free, (866) 208–3676 or TTY, (202) 502–8659.

Additionally, pursuant to section 3 of the NGA (15 U.S.C. 717b), Part 153 of the Commission's regulations, Executive Order 10485, as amended by Executive Order 12038, and Secretary of Energy Delegation Order No. 0204–112, Portland Natural Gas requests authorization to increase its import and export capacity from 210 MMcf/d to 274.216 MMcf/d. Portland Natural Gas also proposes to amend its Presidential Permit issued on September 24, 1997, as amended on November 18, 2003, and on November 28, 2017, to reflect the increase mentioned above.[1]

Portland Natural Gas states that it's Phase I of the Portland XPress Project would expand gas service delivery options for the New England market. Portland Natural Gas proposes no construction or modifications to its existing system or border crossing facilities in connection with this request, and as such, there are no costs associated with the project.

Any questions regarding this application should be directed to Robert Jackson, Manager, Certificates & Regulatory Administration, Portland Natural Gas Transmission System, 700 Louisiana Street, Suite 700, Houston, Texas 77002–2700, or call (832) 320–5487, or email: *robert_jackson@transcanada.com.*

Pursuant to section 157.9 of the Commission's rules (18 CFR 157.9), within 90 days of this Notice, the Commission staff will either: Complete its environmental assessment (EA) and place it into the Commission's public record (eLibrary) for this proceeding; or issue a Notice of Schedule for Environmental Review. If a Notice of Schedule for Environmental Review is issued, it will indicate, among other milestones, the anticipated date for the Commission staff's issuance of the final environmental impact statement (FEIS) or EA for this proposal. The filing of the EA in the Commission's public record for this proceeding or the issuance of a Notice of Schedule for Environmental Review will serve to notify federal and state agencies of the timing for the completion of all necessary reviews, and the subsequent need to complete all federal authorizations within 90 days of the date of issuance of the Commission staff's FEIS or EA.

There are two ways to become involved in the Commission's review of this project. First, any person wishing to obtain legal status by becoming a party to the proceedings for this project should, on or before the comment date stated below file with the Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426, a motion to intervene in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the NGA (18 CFR 157.10). A person obtaining party status will be placed on the service list maintained by the Secretary of the Commission and will receive copies of all documents filed by the applicant and by all other parties. A party must submit 7 copies of filings made in the proceeding with the Commission and must mail a copy to the applicant and to every other party. Only parties to the proceeding can ask for court review of Commission orders in the proceeding.

However, a person does not have to intervene in order to have comments considered. The second way to participate is by filing with the Secretary of the Commission, as soon as possible, an original and two copies of comments in support of or in opposition to this project. The Commission will consider these comments in determining the appropriate action to be taken, but the filing of a comment alone will not serve to make the filer a party to the proceeding. The Commission's rules require that persons filing comments in opposition to the project provide copies of their protests only to the party or parties directly involved in the protest.

Persons who wish to comment only on the environmental review of this project should submit an original and two copies of their comments to the Secretary of the Commission. Environmental commentors will be placed on the Commission's environmental mailing list, will receive copies of the environmental documents, and will be notified of meetings associated with the Commission's environmental review process. Environmental commentors will not be required to serve copies of filed documents on all other parties. However, the non-party commentors will not receive copies of all documents filed by other parties or issued by the Commission (except for the mailing of environmental documents issued by the Commission) and will not have the right to seek court review of the Commission's final order.

The Commission strongly encourages electronic filings of comments, protests and interventions in lieu of paper using the eFiling link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 5 copies of the protest or intervention to the Federal Energy regulatory Commission, 888 First Street NE, Washington, DC 20426.

Comment Date: 5:00 p.m. Eastern Time on May 23, 2018

Dated: May 2, 2018.

Kimberly D. Bose,

Secretary.

[FR Doc. 2018–09713 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

[1] *See Portland Natural Gas Transmission System,* 80 FERC 61,346 (1997); 105 FERC 61,235 (2003); and 161 FERC 61,230 (2017).

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #2

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER11–2154–009.
Applicants: Twin Eagle Resource Management, LLC.
Description: Notice of Change in Status of Twin Eagle Resource Management, LLC.
Filed Date: 4/30/18.
Accession Number: 20180430–5504.
Comments Due: 5 p.m. ET 5/21/18.

Docket Numbers: ER13–102–014.
Applicants: New York Independent System Operator, Inc.
Description: Compliance filing: Amendment Order 1000 compliance—incorrect base tariff document to be effective 4/1/2016.
Filed Date: 5/2/18.
Accession Number: 20180502–5110.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–728–002.
Applicants: California Independent System Operator Corporation.
Description: Compliance filing: 2018–05–02 RAAIM Methodology Modifications Compliance to be effective 5/1/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5094.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–954–001.
Applicants: Appalachian Power Company.
Description: Tariff Amendment: OATT-Attachment K, AEPTX Rate Update—Amendment to be effective 5/2/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5109.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–1505–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 2452R2 KEPCO NITSA NOA to be effective 6/1/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5052.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–1506–000.
Applicants: Southern California Edison Company.
Description: § 205(d) Rate Filing: Third Amended CLGIA Mesa Wind Project SA No. 395 to be effective 7/2/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5065.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–1508–000.
Applicants: Midcontinent Independent System Operator, Inc.
Description: § 205(d) Rate Filing: 2018–05–02_SA 3111 Bayou Bend Solar-ELL GIA (J581) to be effective 4/18/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5073.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–1509–000.
Applicants: ISO New England Inc.
Description: Petition for Waiver of Tariff Provisions of ISO New England Inc.
Filed Date: 5/2/18.
Accession Number: 20180502–5089.
Comments Due: 5 p.m. ET 5/23/18.

Docket Numbers: ER18–1510–000.
Applicants: Appalachian Power Company.
Description: § 205(d) Rate Filing: OATT-Attachment K, AEPTX Rate Update—Amendment to be effective 5/2/2018.
Filed Date: 5/2/18.
Accession Number: 20180502–5098.
Comments Due: 5 p.m. ET 5/23/18.

Take notice that the Commission received the following electric securities filings:

Docket Numbers: ES18–35–000.
Applicants: El Paso Electric Company.
Description: Application for Renewal of Section 204 Authorization of El Paso Electric Company.
Filed Date: 4/30/18.
Accession Number: 20180430–5506.
Comments Due: 5 p.m. ET 5/21/18.

The filings are accessible in the Commission's eLibrary system by clicking on the links or querying the docket number.

Any person desiring to intervene or protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Regulations (18 CFR 385.211 and 385.214) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Dated: May 2, 2018.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2018–09749 Filed 5–7–18; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–9977–70–OA]

Notification of a Public Teleconference of the Science Advisory Board Chemical Assessment Advisory Committee Augmented for the Review of EPA's draft Ethyl Tertiary Butyl Ether (ETBE) and tert-Butyl Alcohol (tert-butanol; tBA) Assessments

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency (EPA) Science Advisory Board (SAB) Staff Office announces a public teleconference of the SAB Chemical Assessment Advisory Committee augmented for the review of two EPA draft assessments; Toxicological Review for Ethyl Tertiary Butyl Ether (ETBE) (*External Review Draft, dated June 2017*); and Toxicological Review of tert-Butyl Alcohol (tert-butanol or tBA) (*External Review Draft, dated June 2017*) (CAAC augmented for ETBE/tBA Panel or Panel). The Panel will meet to discuss its draft peer review report regarding the two EPA draft assessments named above.

DATES: The public teleconference will be held on: Wednesday, June 6, 2018, from 9 a.m. to 1 p.m. (Eastern time).

ADDRESSES: The public teleconference will be held by telephone only.

FOR FURTHER INFORMATION: Any member of the public who wants further information concerning this meeting notice may contact Dr. Shaunta Hill-Hammond, Designated Federal Officer (DFO), via phone at (202) 564–3343, or email at *hill-hammond.shaunta@epa.gov.* General information about the SAB, as well as updates concerning the meeting announced in this notice, may be found on the EPA website at *http://www.epa.gov/sab.*

Technical Contact for EPA's Draft Reports: For information concerning the EPA draft assessments, please contact James Avery, phone (703) 347–8668 or via email at *avery.james@epa.gov.*

SUPPLEMENTARY INFORMATION:

Background: The SAB was established pursuant to the Environmental Research, Development, and Demonstration Authorization Act (ERDDAA), codified at 42 U.S.C. 4365, to provide independent scientific and technical advice to the Administrator on the scientific and technical basis for Agency positions and regulations. The SAB is a Federal Advisory Committee chartered under the Federal Advisory Committee Act (FACA), 5 U.S.C., App.

2. Pursuant to FACA and EPA policy, notice is hereby given that the SAB CAAC augmented for ETBE and tBA Panel will hold a public teleconference to continue discussion its draft report regarding the EPA's draft assessments; *Toxicological Review for Ethyl Tertiary Butyl Ether (ETBE) (External Review Draft, dated June 2017);* and *Toxicological Review of tert-Butyl Alcohol (tert-butanol or tBA)* (*External Review Draft, dated June 2017*). The Panel will provide their advice regarding these two assessments to the Administrator through the chartered SAB.

EPA's Office of Research and Development (ORD) requested that the SAB conduct a peer review of the two EPA draft assessments. The EPA SAB Staff Office augmented the SAB CAAC with subject matter experts, to provide advice to the Administrator through the chartered SAB regarding these assessments. The CAAC augmented for ETBE/tBA Panel convened a public face-to-face meeting on August 15–17, 2017, to develop responses to the peer review charge questions and to hear and consider public comments. The Panel convened a public teleconference on March 22, 2018, and March 27, 2018, to discuss its draft peer review report and to hear public comments. The Panel will meet via a public teleconference to continue discussion on its draft peer review report and hear public comments. The CAAC augmented for ETBE/tBA Panel will comply with the provisions of FACA and all appropriate SAB Staff Office procedural policies.

Availability of Meeting Materials: Prior to the meeting, the Panel's draft report, meeting agenda and other supporting materials (if applicable) will be accessible on the meeting page corresponding to each chemical assessment on the SAB website (*http://www.epa.gov/sab*).

Procedures for Providing Public Input: Public comment for consideration by EPA's federal advisory committees and panels has a different purpose from public comment provided to EPA program offices. Therefore, the process for submitting comments to a federal advisory committee is different from the process used to submit comments to an EPA program office. Federal advisory committees and panels, including scientific advisory committees, provide independent advice to the EPA. Members of the public can submit relevant comments pertaining to the EPA's charge, meeting materials, or the group providing advice. Input from the public to the SAB will have the most impact if it provides specific scientific or technical information or analysis for the SAB to consider or if it relates to the clarity or accuracy of the technical information. Members of the public wishing to provide comment should follow the instructions below to submit comments.

Oral Statements: In general, individuals or groups requesting to make an oral presentation will be limited to three minutes during a public teleconference. Interested parties wishing to provide comments should contact Dr. Hill-Hammond (preferably via email), at the contact information noted above by May 23, 2018, to be placed on the list of public speakers.

Written Statements: Written statements will be accepted throughout the advisory process; however, for timely consideration by SAB members, statements should be supplied to the DFO (preferably via email) at the contact information noted above by May 23, 2018. It is the SAB Staff Office general policy to post written comments on the web page for the advisory meeting or teleconference. Submitters are requested to provide an unsigned version of each document because the SAB Staff Office does not publish documents with signatures on its websites. Members of the public should be aware that their personal contact information, if included in any written comments, may be posted to the SAB website. Copyrighted material will not be posted without explicit permission of the copyright holder.

Accessibility: For information on access or services for individuals with disabilities, please contact Dr. Hill-Hammond at the phone number or email address noted above, preferably at least ten days prior to the meeting, to give the EPA as much time as possible to process your request.

Dated: April 24, 2018.

Khanna Johnston,

Deputy Director, EPA Science Advisory Board Staff Office.

[FR Doc. 2018–09780 Filed 5–7–18; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OLEM–2018–0200, FRL–9977–59–OLEM]

Agency Information Collection Activities; Proposed Collection; Comment Request; Final Authorization for Hazardous Waste Management Programs (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency (EPA) is planning to submit the information collection request (ICR), Final Authorization for Hazardous Waste Management Programs (EPA ICR No. 0969.10, OMB Control No. 2050–0041) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*). Before doing so, the EPA is soliciting public comments on specific aspects of the proposed information collection as described below. This is a proposed extension of the ICR, which is currently approved through September 30, 2018. 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: Comments must be submitted on or before July 9, 2018.

ADDRESSES: Submit your comments, referencing by Docket ID No. EPA–HQ–OLEM–2018–0200, online using *www.regulations.gov* (our preferred method), by email to *rcra-docket@epa.gov,* or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460.

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: Peggy Vyas, (mail code 5303P), Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460; telephone number: 703–308–5477; fax number: 703–308–8433; email address: *vyas.peggy@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.*

Pursuant to section 3506(c)(2)(A) of the PRA, the EPA is soliciting comments and information to enable it to: (i) Evaluate whether the proposed collection of information is necessary for the proper performance of the

functions of the Agency, including whether the information will have practical utility; (ii) evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (iii) enhance the quality, utility, and clarity of the information to be collected; and (iv) minimize the burden of the collection 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. The EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval. At that time, the EPA will issue another **Federal Register** notice to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB.

Abstract: In order for a State to obtain final authorization for a State hazardous waste program or to revise its previously authorized program, it must submit an official application to the EPA Regional office for approval. The purpose of the application is to enable the EPA to properly determine whether the State's program meets the requirements of § 3006 of RCRA. A State with an approved program may voluntarily transfer program responsibilities to EPA by notifying the EPA of the proposed transfer, as required by section 271.23. Further, the EPA may withdraw a State's authorized program under section 271.23.

State program revision may be necessary when the controlling Federal or State statutory or regulatory authority is modified or supplemented. In the event that the State is revising its program by adopting new Federal requirements, the State shall prepare and submit modified revisions of the program description, Attorney General's statement, Memorandum of Agreement, or such other documents as the EPA determines to be necessary. The State shall inform the EPA of any proposed modifications to its basic statutory or regulatory authority in accordance with section 271.21. If a State is proposing to transfer all or any part of any program from the approved State agency to any other agency, it must notify the EPA in accordance with section 271.21 and submit revised organizational charts as required under section 271.6, in accordance with section 271.21. These paperwork requirements are mandatory under § 3006(a). The EPA will use the information submitted by the State in order to determine whether the State's program meets the statutory and regulatory requirements for authorization.

Form numbers: None.

Respondents/affected entities: State/territorial governments.

Respondent's obligation to respond: Mandatory (RCRA § 3006(a)).

Estimated number of respondents: 50.

Frequency of response: Annual.

Total estimated burden: 13,860 hours. Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $499,001 (per year), which includes $499,001 annualized labor and $0 annualized capital or operation & maintenance costs.

Changes in estimates: The burden hours are likely to stay substantially the same.

Dated: April 24, 2018.

Barnes Johnson,

Director, Office of Resource Conservation and Recovery.

[FR Doc. 2018–09770 Filed 5–7–18; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OLEM–2018–0198, FRL–9977–58–OLEM]

Agency Information Collection Activities; Proposed Collection; Comment Request; Land Disposal Restrictions (Renewal)

AGENCY: Environmental Protection Agency.

ACTION: Notice.

SUMMARY: The Environmental Protection Agency (EPA) is planning to submit the information collection request (ICR), Land Disposal Restrictions (EPA ICR No. 1442.23, OMB Control No. 2050–0085) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*). Before doing so, the EPA is soliciting public comments on specific aspects of the proposed information collection as described below. This is a proposed extension of the ICR, which is currently approved through September 30, 2018. 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: Comments must be submitted on or before July 9, 2018.

ADDRESSES: Submit your comments, referencing by Docket ID No. EPA–HQ–OLEM–2018–0198, online using *www.regulations.gov* (our preferred method), by email to *rcra-docket@epa.gov,* or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460.

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: Peggy Vyas, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460; telephone number: 703–308–5477; fax number: 703–308–8433; email address: *vyas.peggy@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.*

Pursuant to section 3506(c)(2)(A) of the PRA, the EPA is soliciting comments and information to enable it to: (i) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility; (ii) evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (iii) enhance the quality, utility, and clarity of the information to be collected; and (iv) minimize the burden of the collection 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. The EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval. At that time, the EPA will issue another **Federal Register** notice to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB.

Abstract: Section 3004 of the Resource Conservation and Recovery Act (RCRA), as amended, requires that EPA develop standards for hazardous waste treatment, storage, and disposal as may be necessary to protect human health and the environment. Subsections 3004(d), (e), and (g) require EPA to promulgate regulations that prohibit the land disposal of hazardous waste unless it meets specified treatment standards described in subsection 3004(m).

The regulations implementing these requirements are codified in the Code of Federal Regulations (CFR) Title 40, Part 268. EPA requires that facilities maintain the data outlined in this ICR so that the Agency can ensure that land disposed waste meets the treatment standards. EPA strongly believes that the recordkeeping requirements are necessary for the agency to fulfill its congressional mandate to protect human health and the environment.

Form numbers: None.

Respondents/affected entities: Private sector and State, Local, or Tribal governments.

Respondent's obligation to respond: Mandatory (40 CFR part 268).

Estimated number of respondents: 90,500.

Frequency of response: On occasion.

Total estimated burden: 646,455 hours Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $86,668,517, which includes $33,928,964 annualized labor costs and $53,739,553 annualized capital or O&M costs.

Changes in estimates: The burden hours are likely to stay substantially the same.

Dated: April 24, 2018.

Barnes Johnson,

Director, Office of Resource Conservation and Recovery.

[FR Doc. 2018–09772 Filed 5–7–18; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OAR–2018–0227; FRL–9977–60–OAR]

RIN 2060–AT31

Notice of EPA Workshop on EPA Fuels Regulatory Streamlining

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of workshop.

SUMMARY: The Environmental Protection Agency (EPA) is announcing a stakeholder workshop to be held in Chicago, Illinois on May 21, 2018, through May 23, 2018, on its anticipated rulemaking on Fuels Regulatory Streamlining. The EPA intends to publish a proposal at a later date in the **Federal Register**.

DATES: The workshop will be held on May 21, 2018, through May 23, 2018, at the location noted below under **ADDRESSES**. On May 21, 2018, the workshop will begin at 12:30 p.m. Central Daylight Time (CDT) and end at 5:00 p.m. CDT. On May 22, 2018, the workshop will begin at 8:00 a.m. CDT and end at 4:00 p.m. CDT. On May 23, 2018, the workshop will begin at 8:30 a.m. CDT and end at 5:00 p.m. CDT. Parties wishing to attend the workshop should notify the contact person listed under **FOR FURTHER INFORMATION CONTACT** by May 14, 2018. Additional information regarding the workshop appears below under **SUPPLEMENTARY INFORMATION**.

ADDRESSES: The workshop will be held at the following location: Palmer House Hilton Hotel, 17 East Monroe Street, Chicago, IL 60603; telephone number: (312) 726–7500. Additional information related to the workshop will be posted on the EPA website at: *https://www.epa.gov/air-pollution-transportation/key-issues-websites-and-programs-epas-office-transportation-and-air.* Interested parties should check the website for any updated information.

FOR FURTHER INFORMATION CONTACT: Nick Parsons, Office of Transportation and Air Quality, Assessment and Standards Division, Environmental Protection Agency, 2000 Traverwood Drive, Ann Arbor, MI 48105; telephone number: (734) 214–4479; email address: *ASD-Registration@epa.gov.*

SUPPLEMENTARY INFORMATION: EPA is exploring opportunities to streamline and modernize its existing fuels regulations under 40 CFR part 80 to update EPA's existing gasoline, diesel, and other fuels regulations to help reduce burden for stakeholders as well as EPA, while improving overall compliance assurance and maintaining environmental performance. EPA intends to achieve this goal in streamlining the existing fuels regulations by: Deleting expired provisions, eliminating redundant compliance provisions (*e.g.,* duplicative registration requirements that are required by every EPA fuels program), and replacing them with a single set of provisions and definitions that would apply across all gasoline, diesel, and other fuels programs currently under 40 CFR part 80.

The workshop will provide the opportunity for EPA to update stakeholders on its progress regarding this streamlining of the existing fuels regulations, and for stakeholders to provide initial feedback as EPA develops its proposed rule.

Dated: April 25, 2018.

Christopher Grundler,

Director, Office of Transportation and Air Quality, Office of Air and Radiation.

[FR Doc. 2018–09783 Filed 5–7–18; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPP–2017–0619; FRL–9973–40]

Agency Information Collection Activities; Proposed Renewal of an Existing Collection; Comment Request

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA), this document announces that EPA is planning to submit an Information Collection Request (ICR) to the Office of Management and Budget (OMB). The ICR, entitled: ''Pesticide Program Public Sector Collections (FIFRA Sections 18 & 24(c))'' and identified by EPA ICR No. 2311.03 and OMB Control No. 2070–0182, represents the renewal of an existing ICR that is scheduled to expire on October 31, 2018. Before submitting the ICR to OMB for review and approval, EPA is soliciting comments on specific aspects of the proposed information collection that is summarized in this document. The ICR and accompanying material are available in the docket for public review and comment.

DATES: Comments must be received on or before April 30, 2018.

ADDRESSES: Submit your comments, identified by docket identification (ID) number EPA–HQ–OPP–2017–0619, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.
- *Mail:* OPP Docket, Environmental Protection Agency Docket Center (EPA/DC), (28221T), 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001.
- *Hand Delivery:* To make special arrangements for hand delivery or

delivery of boxed information, please follow the instructions at *http://www.epa.gov/dockets/contacts.html.*

Additional instructions on commenting or visiting the docket, along with more information about dockets generally, is available at *http://www.epa.gov/dockets.*

FOR FURTHER INFORMATION CONTACT: Connie Hernandez, Field and External Affairs Division (7506P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001; telephone number: (703) 605–5190; email address: *hernandez.connie@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. What information is EPA particularly interested in?

Pursuant to PRA section 3506(c)(2)(A) (44 U.S.C. 3506(c)(2)(A)), EPA specifically solicits comments and information to enable it to:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility.
2. Evaluate the accuracy of the Agency's estimates of the burden of the proposed collection of information, including the validity of the methodology and assumptions used.
3. Enhance the quality, utility, and clarity of the information to be collected.
4. Minimize the burden of the collection 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. In particular, EPA is requesting comments from very small businesses (those that employ less than 25) on examples of specific additional efforts that EPA could make to reduce the paperwork burden for very small businesses affected by this collection.

II. What information collection activity or ICR does this action apply to?

Title: Pesticide Program Public Sector Collections (FIFRA Sections 18 & 24(c)).

ICR number: EPA ICR No. 2311.03.

OMB control number: OMB Control No. 2070–0182.

ICR status: This ICR is currently scheduled to expire on October 31, 2018. 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. The OMB control numbers for EPA's regulations in title 40 of the Code of Federal Regulations (CFR), after appearing in the **Federal Register** when approved, are listed in 40 CFR part 9, are displayed either by publication in the **Federal Register** or by other appropriate means, such as on the related collection instrument or form, if applicable. The display of OMB control numbers for certain EPA regulations is consolidated in 40 CFR part 9.

Abstract: This ICR covers the paperwork burden associated with two types of pesticide registration requests made by states, U.S. Territories, or Federal agencies under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), 7 U.S.C. 136a *et seq.:* (1) Emergency exemption requests, which allow for an unregistered use of a pesticide; and (2) Requests by states to register a pesticide use to meet a special local need (SLN).

FIFRA section 18 allows EPA to grant emergency exemptions to states, U.S. Territories, and Federal agencies to allow an unregistered of a pesticide for a limited time if EPA determines that emergency conditions exists. Section 18 requests include unregistered pesticide use exemptions for specific agricultural, public health and quarantine purposes. FIFRA section 24(c) allows EPA to grant permission to a particular state to register additional uses of a federally registered pesticide for distribution and use within that state to meet a SLN.

Burden statement: The annual public reporting and recordkeeping burden for this combined collection of information is estimated to average 25,753 hours per response. Burden is defined in 5 CFR 1320.3(b).

The ICR, which is available in the docket along with other related materials, provides a detailed explanation of the collection activities and the burden estimate that is only briefly summarized here:

Respondents/affected entities: Entities potentially affected by this ICR are pesticides registrants, which may be identified by North American Classification System (NAICS) codes 325320 (pesticide and other agricultural chemical manufacturing), and 9241 (governments that administer environmental quality programs).

Estimated total number of potential respondents: 669.

Frequency of response: On occasion.

Estimated total average number of responses for each respondent: 1.

Estimated total annual burden hours: 25,753 hours.

Estimated total annual costs: $1,829,103. There are no capital operation & maintenance costs associated with this information collection.

III. Are there changes in the estimates from the last approval?

For Section 18, there is a decrease of 4,158 hours in the total estimated respondent burden compared with that identified in the ICR currently approved by OMB. This decrease corresponds with a decrease in the average number of Section 18s requested per year, from 185 to143. This change is an adjustment.

For Section 24(c), there is a decrease of 4,264 hours in the total estimated respondent burden compared with that identified in the ICR currently approved by OMB. This decrease reflects EPA's significant decrease in the average number of petitions received annually, from about 305 to 223. This change is an adjustment.

IV. What is the next step in the process for this ICR?

EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval pursuant to 5 CFR 1320.12. EPA will issue another **Federal Register** document pursuant to 5 CFR 1320.5(a)(1)(iv) to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB. If you have any questions about this ICR or the approval process, please contact the person listed under **FOR FURTHER INFORMATION CONTACT**.

Authority: 44 U.S.C. 3501 *et seq.*

Dated: April 24, 2018.

Charlotte Bertrand,

Acting Principal Deputy Assistant Administrator, Office of Chemical Safety and Pollution Prevention.

[FR Doc. 2018–09774 Filed 5–7–18; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–9977–17–OLEM]

Thirty-Third Update of the Federal Agency Hazardous Waste Compliance Docket

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: Since 1988, the Environmental Protection Agency (EPA) has maintained a Federal Agency Hazardous Waste Compliance Docket

(''Docket'') under Section 120(c) of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA). Section 120(c) requires EPA to establish a Docket that contains certain information reported to EPA by Federal facilities that manage hazardous waste or from which a reportable quantity of hazardous substances has been released. As explained further below, the Docket is used to identify Federal facilities that should be evaluated to determine if they pose a threat to public health or welfare and the environment and to provide a mechanism to make this information available to the public.

This notice identifies the Federal facilities not previously listed on the Docket and also identifies Federal facilities reported to EPA since the last update on December 8, 2017. In addition to the list of additions to the Docket, this notice includes a section with revisions of the previous Docket list and a section of Federal facilities that are to be deleted from the Docket. Thus, the revisions in this update include 5 additions, 2 deletions, and 1 correction to the Docket since the previous update. At the time of publication of this notice, the new total number of Federal facilities listed on the Docket is 2,352.

DATES: This list is current as of April 10, 2018.

FOR FURTHER INFORMATION CONTACT: Electronic versions of the Docket and more information on its implementation can be obtained at *http://www.epa.gov/fedfac/previous-federal-agency-hazardous-waste-compliance-docket-updates* by clicking on the link for *Cleanups at Federal Facilities* or by contacting Benjamin Simes (*Simes.Benjamin@epa.gov*), Federal Agency Hazardous Waste Compliance Docket Coordinator, Federal Facilities Restoration and Reuse Office (Mail Code 5106R), U.S. Environmental Protection Agency, 1200 Pennsylvania Avenue NW, Washington, DC 20460. Additional information on the Docket and a complete list of Docket sites can be obtained at: *https://www.epa.gov/fedfac/fedfacts.*

SUPPLEMENTARY INFORMATION:

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7.0 Information Contained on Docket Listing

1.0 Introduction

Section 120(c) of CERCLA, 42 United States Code (U.S.C.) 9620(c), as amended by the Superfund Amendments and Reauthorization Act of 1986 (SARA), requires EPA to establish the Federal Agency Hazardous Waste Compliance Docket. The Docket contains information on Federal facilities that manage hazardous waste and such information is submitted by Federal agencies to EPA under Sections 3005, 3010, and 3016 of the Resource Conservation and Recovery Act (RCRA), 42 U.S.C. 6925, 6930, and 6937. Additionally, the Docket contains information on Federal facilities with a reportable quantity of hazardous substances that has been released and such information is submitted by Federal agencies to EPA under Section 103 of CERCLA, 42 U.S.C. 9603. Specifically, RCRA Section 3005 establishes a permitting system for certain hazardous waste treatment, storage, and disposal (TSD) facilities; RCRA Section 3010 requires waste generators, transporters and TSD facilities to notify EPA of their hazardous waste activities; and RCRA Section 3016 requires Federal agencies to submit biennially to EPA an inventory of their Federal hazardous waste facilities. CERCLA Section 103(a) requires the owner or operator of a vessel or onshore or offshore facility to notify the National Response Center (NRC) of any spill or other release of a hazardous substance that equals or exceeds a reportable quantity (RQ), as defined by CERCLA Section 101. Additionally, CERCLA Section 103(c) requires facilities that have ''stored, treated, or disposed of'' hazardous wastes and where there is ''known, suspected, or likely releases'' of hazardous substances to report their activities to EPA.

CERCLA Section 120(d) requires EPA to take steps to assure that a Preliminary Assessment (PA) be completed for those sites identified in the Docket and that the evaluation and listing of sites with a PA be completed within a reasonable time frame. The PA is designed to provide information for EPA to consider when evaluating the site for potential response action or inclusion on the National Priorities List (NPL).

The Docket serves three major purposes: (1) To identify all Federal facilities that must be evaluated to determine whether they pose a threat to human health and the environment sufficient to warrant inclusion on the National Priorities List (NPL); (2) to compile and maintain the information submitted to EPA on such facilities under the provisions listed in Section 120(c) of CERCLA; and (3) to provide a mechanism to make the information available to the public.

The initial list of Federal facilities to be included on the Docket was published in the **Federal Register** on February 12, 1988 (53 FR 4280). Since then, updates to the Docket have been published on November 16, 1988 (53 FR 46364); December 15, 1989 (54 FR 51472); August 22, 1990 (55 FR 34492); September 27, 1991 (56 FR 49328); December 12, 1991 (56 FR 64898); July 17, 1992 (57 FR 31758); February 5, 1993 (58 FR 7298); November 10, 1993 (58 FR 59790); April 11, 1995 (60 FR 18474); June 27, 1997 (62 FR 34779); November 23, 1998 (63 FR 64806); June 12, 2000 (65 FR 36994); December 29, 2000 (65 FR 83222); October 2, 2001 (66 FR 50185); July 1, 2002 (67 FR 44200); January 2, 2003 (68 FR 107); July 11, 2003 (68 FR 41353); December 15, 2003 (68 FR 69685); July 19, 2004 (69 FR 42989); December 20, 2004 (69 FR 75951); October 25, 2005 (70 FR 61616); August 17, 2007 (72 FR 46218); November 25, 2008 (73 FR 71644); October 13, 2010 (75 FR 62810); November 6, 2012 (77 FR 66609); March 18, 2013 (78 FR 16668); January 6, 2014 (79 FR 654), December 31, 2014 (79 FR 78850); August 17, 2015 (80 FR 49223), March 3, 2016 (81 FR 11212), October 24, 2016 (81 FR 73096), June 6, 2017 (82 FR 26092), and December 8, 2017 (82 FR 57976). This notice constitutes the thirty-third update of the Docket.

This notice provides some background information on the Docket. Additional information on the Docket requirements and implementation are found in the Docket Reference Manual, Federal Agency Hazardous Waste Compliance Docket found at *http://www.epa.gov/fedfac/docket-reference-manual-federal-agency-hazardous-waste-compliance-docket-interim-final* or obtained by calling the Regional Docket Coordinators listed below. This notice also provides changes to the list of sites included on the Docket in three areas: (1) Additions, (2) Deletions, and (3) Corrections. Specifically, additions are newly identified Federal facilities that have been reported to EPA since the last update and now are included on the Docket; the deletions section lists Federal facilities that EPA is deleting from the Docket.[1] The information submitted to EPA on each Federal facility is maintained in the Docket repository located in the EPA Regional office of the Region in which the Federal facility is located; for a

[1] See Section 3.2 for the criteria for being deleted from the Docket.

description of the information required under those provisions, *see* 53 FR 4280 (February 12, 1988). Each repository contains the documents submitted to EPA under the reporting provisions and correspondence relevant to the reporting provisions for each Federal facility.

In prior updates, information was also provided regarding No Further Remedial Action Planned (NFRAP) status changes. However, information on NFRAP and NPL status is no longer being provided separately in the Docket update as it is now available at: *http://www.epa.gov/fedfac/fedfacts* or by contacting the EPA HQ Docket Coordinator at the address provided in the **FOR FURTHER INFORMATION CONTACT** section of this notice.

2.0 Regional Docket Coordinators

Contact the following Docket Coordinators for information on Regional Docket repositories:

Martha Bosworth (HBS), US EPA Region 1, 5 Post Office Square, Suite 100, Mail Code: OSRR07–2, Boston, MA 02109–3912, (617) 918–1407.

Cathy Moyik (ERRD), US EPA Region 2, 290 Broadway, New York, NY 10007–1866, (212) 637–4339.

Joseph Vitello (3HS12), US EPA Region 3, 1650 Arch Street, Philadelphia, PA 19107, (215) 814–3354.

Leigh Lattimore (4SF–SRSEB), US EPA Region 4, 61 Forsyth St. SW, Atlanta, GA 30303, 404–562–8768.

David Brauner (SR–6J), US EPA Region 5, 77 W. Jackson Blvd., Chicago, IL 60604, (312) 886–1526.

Philip Ofosu (6SF–RA), US EPA Region 6, 1445 Ross Avenue, Dallas, TX 75202–2733, (214) 665–3178.

Todd H. Davis (SUPRERSP), US EPA Region 7, 11201 Renner Blvd., Lenexa, KS 66219, (913) 551–7749.

Ryan Dunham (EPR–F), US EPA Region 8, 1595 Wynkoop Street, Denver, CO 80202, (303) 312–6627.

Leslie Ramirez (SFD–6–1), US EPA Region 9, 75 Hawthorne Street, San Francisco, CA 94105, (415) 972–3978.

Ken Marcy (ECL, ABU), US EPA Region 10, 1200 Sixth Avenue, Suite 900, ECL–112, Seattle, WA 98101, (206) 890–0591.

3.0 Revisions of the Previous Docket

This section includes a discussion of the additions, deletions, and corrections, to the list of Docket facilities since the previous Docket update.

3.1 Additions

In this notice, 5 Federal facilities are being added to the Docket. Seven of the twenty-one Federal facilities are being added primarily because of new information obtained by EPA (for example, recent reporting of a facility pursuant to RCRA Sections 3005, 3010, or 3016 or CERCLA Section 103). CERCLA Section 120, as amended by the Defense Authorization Act of 1997, specifies that EPA take steps to assure that a Preliminary Assessment (PA) be completed within a reasonable time frame for those Federal facilities that are included on the Docket. Among other things, the PA is designed to provide information for EPA to consider when evaluating the site for potential response action or listing on the NPL.

3.2 Deletions

In this notice, 2 Federal facilities are being deleted from the Docket. There are no statutory or regulatory provisions that address deletion of a facility from the Docket. However, if a facility is incorrectly included on the Docket, it may be deleted from the Docket. The criteria EPA uses in deleting sites from the Docket include: A facility for which there was an incorrect report submitted for hazardous waste activity under RCRA (*e.g.,* 40 CFR 262.44); a facility that was not Federally-owned or operated at the time of the listing; a facility included more than once (*i.e.,* redundant listings); or when multiple facilities are combined under one listing. (*See* Docket Codes (*Categories for Deletion of Facilities*) for a more refined list of the criteria EPA uses for deleting sites from the Docket. Facilities being deleted no longer will be subject to the requirements of CERCLA Section 120(d).

3.3 Corrections

Changes necessary to correct the previous Docket are identified by both EPA and Federal agencies. The corrections section may include changes in addresses or spelling, and corrections of the recorded name and ownership of a Federal facility. In addition, changes in the names of Federal facilities may be made to establish consistency in the Docket or between the Superfund Enterprise Management System (SEMS) and the Docket. For the Federal facility for which a correction is entered, the original entry is as it appeared in previous Docket updates. The corrected update is shown directly below, for easy comparison. This notice includes one correction.

4.0 Process for Compiling the Updated Docket

In compiling the newly reported Federal facilities for the update being published in this notice, EPA extracted the names, addresses, and identification numbers of facilities from four EPA databases—the WebEOC, the Biennial Inventory of Federal Agency Hazardous Waste Activities, the Resource Conservation and Recovery Act Information System (RCRAInfo), and SEMS—that contain information about Federal facilities submitted under the four provisions listed in CERCLA Section 120(c).

EPA assures the quality of the information on the Docket by conducting extensive evaluation of the current Docket list and contacts the other Federal Agency (OFA) with the information obtained from the databases identified above to determine which Federal facilities were, in fact, newly reported and qualified for inclusion on the update. EPA is also striving to correct errors for Federal facilities that were previously reported. For example, state-owned or privately-owned facilities that are not operated by the Federal government may have been included. Such problems are sometimes caused by procedures historically used to report and track Federal facilities data. Representatives of Federal agencies are asked to contact the EPA HQ Docket Coordinator at the address provided in the **FOR FURTHER INFORMATION CONTACT** section of this notice if revisions of this update information are necessary.

5.0 Facilities Not Included

Certain categories of facilities may not be included on the Docket, such as: (1) Federal facilities formerly owned by a Federal agency that at the time of consideration was not Federally-owned or operated; (2) Federal facilities that are small quantity generators (SQGs) that have not, more than once per calendar year, generated more than 1,000 kg of hazardous waste in any single month; (3) Federal facilities that are very small quantity generators (VSQGs) that have never generated more than 100 kg of hazardous waste in any month; (4) Federal facilities that are solely hazardous waste transportation facilities, as reported under RCRA Section 3010; and (5) Federal facilities that have mixed mine or mill site ownership.

An EPA policy issued in June 2003 provided guidance for a site-by-site evaluation as to whether ''mixed ownership'' mine or mill sites, typically created as a result of activities conducted pursuant to the General Mining Law of 1872 and never reported under Section 103(a), should be included on the Docket. For purposes of that policy, mixed ownership mine or mill sites are those located partially on private land and partially on public land. This policy is found at *http://www.epa.gov/fedfac/policy-listing-mixed-ownership-mine-or-mill-sites-created-result-general-mining-law-1872.* The policy of not including these

facilities may change; facilities now omitted may be added at some point if EPA determines that they should be included.

6.0 Facility NPL Status Reporting, Including NFRAP Status

EPA tracks the NPL status of Federal facilities listed on the Docket. An updated list of the NPL status of all Docket facilities, as well as their NFRAP status, is available at *http://www.epa.gov/fedfac/fedfacts* or by contacting the EPA HQ Docket Coordinator at the address provided in the **FOR FURTHER INFORMATION CONTACT** section of this notice. In prior updates, information regarding NFRAP status changes was provided separately.

7.0 Information Contained on Docket Listing

The information is provided in three tables. The first table is a list of additional Federal facilities that are being added to the Docket. The second table is a list of Federal facilities that are being deleted from the Docket. The third table is for corrections.

The Federal facilities listed in each table are organized by the date reported. Under each heading is listed the name and address of the facility, the Federal agency responsible for the facility, the statutory provision(s) under which the facility was reported to EPA, and a code.[2]

The statutory provisions under which a Federal facility is reported are listed in a column titled ''Reporting Mechanism.'' Applicable mechanisms are listed for each Federal facility: For example, Sections 3005, 3010, 3016, 103(c), or Other. ''Other'' has been added as a reporting mechanism to indicate those Federal facilities that otherwise have been identified to have releases or threat of releases of hazardous substances. The National Contingency Plan 40 CFR 300.405 addresses discovery or notification, outlines what constitutes discovery of a hazardous substance release, and states that a release may be discovered in several ways, including: (1) A report submitted in accordance with Section 103(a) of CERCLA, *i.e.,* reportable quantities codified at 40 CFR part 302; (2) a report submitted to EPA in accordance with Section 103(c) of CERCLA; (3) investigation by government authorities conducted in accordance with Section 104(e) of CERCLA or other statutory authority; (4) notification of a release by a Federal or state permit holder when required by its permit; (5) inventory or survey efforts or random or incidental observation reported by government agencies or the public; (6) submission of a citizen petition to EPA or the appropriate Federal facility requesting a preliminary assessment, in accordance with Section 105(d) of CERCLA; (7) a report submitted in accordance with Section 311(b)(5) of the Clean Water Act; and (8) other sources. As a policy matter, EPA generally believes it is appropriate for Federal facilities identified through the CERCLA discovery and notification process to be included on the Docket.

The complete list of Federal facilities that now make up the Docket and the NPL and NFRAP status are available to interested parties and can be obtained at *http://www.epa.gov/fedfac/fedfacts* or by contacting the EPA HQ Docket Coordinator at the address provided in the **FOR FURTHER INFORMATION CONTACT** section of this notice. As of the date of this notice, the total number of Federal facilities that appear on the Docket is 2,352.

Dated: April 17, 2018.

Paul Leonard,

Acting Director, Federal Facilities Restoration and Reuse Office, Office of Land and Emergency Management.

Categories for Deletion of Facilities

(1) Small-Quantity Generator and Very Small Quantity Generator. Show citation box.

(2) Never Federally Owned and/or Operated.

(3) Formerly Federally Owned and/or Operated but not at time of listing.

(4) No Hazardous Waste Generated.

(5) (This code is no longer used.)

(6) Redundant Listing/Site on Facility.

(7) Combining Sites Into One Facility/Entries Combined.

(8) Does Not Fit Facility Definition.

Categories for Addition of Facilities

(15) Small-Quantity Generator with either a RCRA 3016 or CERCLA 103 Reporting Mechanism.

(16) One Entry Being Split Into Two (or more)/Federal Agency Responsibility Being Split. (16A) NPL site that is part of a Facility already listed on the Docket.

(17) New Information Obtained Showing That Facility Should Be Included.

(18) Facility Was a Site on a Facility That Was Disbanded; Now a Separate Facility.

(19) Sites Were Combined Into One Facility.

(19A) New Currently Federally Owned and/or Operated Facility Site.

Categories for Corrections of Information About Facilities

(20) Reporting Provisions Change.

(20A) Typo Correction/Name Change/Address Change.

(21) Changing Responsible Federal Agency. (If applicable, new responsible Federal agency submits proof of previously performed PA, which is subject to approval by EPA.)

(22) Changing Responsible Federal Agency and Facility Name. (If applicable, new responsible Federal Agency submits proof of previously performed PA, which is subject to approval by EPA.)

(24) Reporting Mechanism Determined To Be Not Applicable After Review of Regional Files.

FEDERAL AGENCY HAZARDOUS WASTE COMPLIANCE DOCKET UPDATE #33—ADDITIONS

Facility name	Address	City	State	Zip code	Agency	Reporting mechanism	Code	Date
SEQUOYAH NUCLEAR PLANT.	SEQUOYAH ACCESS ROAD.	SODDY DAISY	TN	37379	TVA	RCRA 3010	17	Update #33.
HIWASSEE HYDRO PLANT.	600 POWERHOUSE ROAD.	MURPHY	NC	28906	TVA	RCRA 3010	17	Update #33.
BLM—ELDER CREEK MINE.	50 BASTIAN RD	BATTLE MOUNTAIN	NV	89820	INTERIOR	RCRA 3010	17	Update #33.
SPRING CREEK PARK SITE.	ATLANTIC OCEAN—SHORE OF JAMAICA BAY—PART OF THE NPS GATEWAY NATIONAL RECREATION AREA.	QUEENS	NY	11414	INTERIOR	CERCLA 103	17	Update #33.

[2] Each Federal facility listed in the update has been assigned a code that indicates a specific reason for the addition or deletion. The code precedes this list.

FEDERAL AGENCY HAZARDOUS WASTE COMPLIANCE DOCKET UPDATE #33—ADDITIONS—Continued

Facility name	Address	City	State	Zip code	Agency	Reporting mechanism	Code	Date
SAN FRANCISCO VA MEDICAL CENTER.	CLEMENT STREET	SAN FRANCISCO	CA	94121	VETERANS AFFAIRS ...	RCRA 3010	17	Update #33.

FEDERAL AGENCY HAZARDOUS WASTE COMPLIANCE DOCKET UPDATE #33—DELETIONS

Facility name	Address	City	State	Zip code	Agency	Reporting mechanism	Code	Date
24 RESEARCH PARKWAY.	24 RESEARCH PARKWAY.	WALLINGFORD	CT	6492	USPS	CERCLA 103	2	12/8/2017
#1 RAVINE UNDER LAKE MONROE.	.....	BLOOMINGTON	IN	47401	CORPS OF ENGINEERS, CIVIL.	CERCLA 103	8	12/8/2017

FEDERAL AGENCY HAZARDOUS WASTE COMPLIANCE DOCKET UPDATE #33—CORRECTIONS

Facility name	Address	City	State	Zip code	Agency	Reporting mechanism	Code	Date
PRESCOTT NF: UPPER LYNX CREEK MINES.	344 SOUTH CORTEZ ...	PRESCOTT	AZ	86303	AGRICULTURE	CERCLA 103	20a	9/27/2991
FS—BLUE JOHN MINE	344 SOUTH CORTEZ ...	PRESCOTT	AZ	86303	AGRICULTURE	CERCLA 103	20a	9/27/2991

[FR Doc. 2018–08971 Filed 5–7–18; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OLEM–2018–0012; FRL–9977–71–OLEM]

Agency Information Collection Activities; Proposed Collection; Comment Request; State Program Adequacy Determination (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency is planning to submit an information collection request (ICR), ''State Program Adequacy Determination: Municipal Solid Waste Landfills (MSWLFs) and Non-Municipal, Non-Hazardous Waste Disposal Units that Receive Conditionally Exempt Small Quantity Generator (CESQG) Hazardous Waste.'' (EPA ICR No. 1608.08, OMB Control No. 2050–0152) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. Before doing so, EPA is soliciting public comments on specific aspects of the proposed information collection as described below. This is a proposed extension of the ICR, which is currently approved through September 30, 2018. 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: Comments must be submitted on or before July 9, 2018.

ADDRESSES: Submit your comments, referencing Docket ID No. EPA–HQ–OLEM–2018–0012, online using *www.regulations.gov* (our preferred method), by email to *rcra-docket@epa.gov* or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460.

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: Craig Dufficy, Materials Recovery and Waste Management Division, Office of Resource Conservation and Recovery, mail code 5304P, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460; telephone number: 703–308–9037; fax number: 703–308–0514; email address: *Dufficy.craig@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.*

Pursuant to section 3506(c)(2)(A) of the PRA, EPA is soliciting comments and information to enable it to: (i) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility; (ii) evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (iii) enhance the quality, utility, and clarity of the information to be collected; and (iv) minimize the burden of the collection 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. EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval. At that time, EPA will issue another **Federal Register** notice to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB.

Abstract: Section 4010(c) of the Resource Conservation and Recovery Act (RCRA) of 1976 requires that EPA revise the landfill criteria promulgated under paragraph (1) of Section 4004(a) and Section 1008(a)(3). Section 4005(c) of RCRA, as amended by the Hazardous Solid Waste Amendments (HSWA) of 1984, requires states to develop and

implement permit programs to ensure that MSWLFs and non-municipal, non-hazardous waste disposal units that receive household hazardous waste or CESQG hazardous waste are in compliance with the revised criteria for the design and operation of non-municipal, non-hazardous waste disposal units under 40 CFR part 257, subpart B and MSWLFs under 40 CFR part 258. (40 CFR part 257, subpart B and 40 CFR part 258 are henceforth referred to as the ''revised federal criteria''.) Section 4005(c) of RCRA further mandates the EPA Administrator to determine the adequacy of state permit programs to ensure owner and/or operator compliance with the revised federal criteria. A state program that is deemed adequate to ensure compliance may afford flexibility to owners or operators in the approaches they use to meet federal requirements, significantly reducing the burden associated with compliance.

In response to the statutory requirement in § 4005(c), EPA developed 40 CFR part 239, commonly referred to as the State Implementation Rule (SIR). The SIR describes the state application and EPA review procedures and defines the elements of an adequate state permit program.

The collection of information from the state during the permit program adequacy determination process allows EPA to evaluate whether a program for which approval is requested is appropriate in structure and authority to ensure owner or operator compliance with the revised federal criteria. The SIR does not require the use of a particular application form. Section 239.3 of the SIR, however, requires that all state applications contain the following five components:

(1) A transmittal letter requesting permit program approval.

(2) A narrative description of the state permit program, including a demonstration that the state's standards for non-municipal, non-hazardous waste disposal units that receive CESQG hazardous waste are technically comparable to the Part 257, Subpart B criteria and/or that its MSWLF standards are technically comparable to the Part 258 criteria.

(3) A legal certification demonstrating that the state has the authority to carry out the program.

(4) Copies of state laws, regulations, and guidance that the state believes demonstrate program adequacy.

(5) Copies of relevant state-tribal agreements if the state has negotiated with a tribe for the implementation of a permit program for non-municipal, non-hazardous waste disposal units that receive CESQG hazardous waste and/or MSWLFs on tribal lands.

The EPA Administrator has delegated the authority to make determinations of adequacy, as contained in the statute, to the EPA Regional Administrator. The appropriate EPA Regional Office, therefore, will use the information provided by each state to determine whether the state's permit program satisfies the statutory test reflected in the requirements of 40 CFR part 239. In all cases, the information will be analyzed to determine the adequacy of the state's permit program for ensuring compliance with the federal revised criteria.

Form numbers: None.

Respondents/affected entities: Entities potentially affected by this section are States.

Respondent's obligation to respond: Mandatory under Section 4005(c) of the Resource Conservation and Recovery Act (RCRA) of 1976.

Estimated number of respondents: 12.

Frequency of response: On occasion.

Total estimated burden: 2,405 hours (per year). Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $135,315 (per year) All costs are labor costs, there are no capital/start-up or O&M costs associated with this ICR.

Changes in estimates: There is no change of 2,405 hours in the total estimated respondent burden compared with the ICR currently approved by OMB. This is a continuation of states revising or updating their state programs.

Dated: April 24, 2018.

Barnes Johnson,

Director, Office of Resource Conservation and Recovery.

[FR Doc. 2018–09771 Filed 5–7–18; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPP–2017–0756; FRL–9977–20]

Pesticide Experimental Use Permit; Receipt of Application; Reopening of Comment Period

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice; reopening of comment period.

SUMMARY: EPA issued a notice in the **Federal Register** of March 9, 2018, concerning receipt of an application, 93167–EUP–R, from Oxitec Ltd. requesting an experimental use permit for the OX513A *Aedes aegypti* mosquitoes expressing tetracycline Trans-Activator Variant protein. This document reopens the comment period for 30 days. The comment period is being reopened because a large interest from the public, including several requests to extend the comment period to provide enough time for stakeholders to provide additional comments.

DATES: Comments, identified by docket identification (ID) number EPA–HQ–OPP–2017–0756, must be received on or before June 7, 2018.

ADDRESSES: Follow the detailed instructions provided under **ADDRESSES** in the **Federal Register** document of March 9, 2018 (83 FR 10475) (FRL–9972–86).

FOR FURTHER INFORMATION CONTACT: Robert McNally, Biopesticides and Pollution Prevention Division (7511P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001; main telephone number: (703) 305–7090; email address: *BPPDFRNotices@epa.gov.*

SUPPLEMENTARY INFORMATION: This document reopens the public comment period established in the **Federal Register** document of March 9, 2018 (83 FR 10475) (FRL–9972–86). EPA is hereby reopening the comment period for 30 days.

To submit comments, or access the docket, please follow the detailed instructions provided under **ADDRESSES** in the **Federal Register** document of March 9, 2018 (83 FR 10475) (FRL–9972–86). If you have questions, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

Authority: 7 U.S.C. 136 *et seq.*

Dated: April 30, 2018.

Robert McNally,

Director, Biopesticides and Pollution Prevention Division, Office of Pesticide Programs.

[FR Doc. 2018–09777 Filed 5–7–18; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL DEPOSIT INSURANCE CORPORATION

Notice of Termination of Receivership

The Federal Deposit Insurance Corporation (FDIC or Receiver), as Receiver for the following insured depository institution, was charged with the duty of winding up the affairs of the former institution and liquidating all related assets. The Receiver has fulfilled its obligations and made all dividend distributions required by law.

NOTICE OF TERMINATION OF RECEIVERSHIP

Fund	Receivership name	City	State	Termination date
10073	The Elizabeth State Bank	Elizabeth	IL	5/1/2018

The Receiver has further irrevocably authorized and appointed FDIC-Corporate as its attorney-in-fact to execute and file any and all documents that may be required to be executed by the Receiver which FDIC-Corporate, in its sole discretion, deems necessary, including but not limited to releases, discharges, satisfactions, endorsements, assignments, and deeds. Effective on the termination date listed above, the Receivership has been terminated, the Receiver has been discharged, and the Receivership has ceased to exist as a legal entity.

Dated at Washington, DC, on May 3, 2018.

Federal Deposit Insurance Corporation.

Robert E. Feldman,

Executive Secretary.

[FR Doc. 2018–09722 Filed 5–7–18; 8:45 am]

BILLING CODE 6714–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of a Bank or Bank Holding Company

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire shares of a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than May 22, 2018.

A. Federal Reserve Bank of Chicago (Colette A. Fried, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690–1414:

1. *Westbury Bank ESOP, West Bend, Wisconsin;* to retain voting shares of Westbury Bancorp, Inc., and thereby indirectly retain shares of Westbury Bank, both of West Bend, Wisconsin.

Board of Governors of the Federal Reserve System, May 3, 2018.

Yao-Chin Chao,

Assistant Secretary of the Board.

[FR Doc. 2018–09757 Filed 5–7–18; 8:45 am]

BILLING CODE 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 June 6, 2018.

A. Federal Reserve Bank of San Francisco (Gerald C. Tsai, Director, Applications and Enforcement) 101 Market Street, San Francisco, California 94105–1579:

1. *Pacific Premier Bancorp, Inc., Irvine, California;* to acquire 100 percent of the voting shares of Grandpoint Capital, Inc., and thereby indirectly acquire Grandpoint Bank, both of Los Angeles, California.

Board of Governors of the Federal Reserve System, May 3, 2018.

Yao-Chin Chao,

Assistant Secretary of the Board.

[FR Doc. 2018–09756 Filed 5–7–18; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Notice of Meetings

AGENCY: Agency for Healthcare Research and Quality (AHRQ), HHS.

ACTION: Notice of five AHRQ subcommittee meetings.

SUMMARY: The subcommittees listed below are part of AHRQ's Health Services Research Initial Review Group Committee. Grant applications are to be reviewed and discussed at these meetings. Each subcommittee meeting will commence in open session before closing to the public for the duration of the meeting.

DATES: See **SUPPLEMENTARY INFORMATION** for specific meeting dates and times.

ADDRESSES: Hilton Rockville & Executive Meeting Center, 1750 Rockville Pike, Rockville, Maryland 20852.

FOR FURTHER INFORMATION CONTACT: (To obtain a roster of members, agenda or minutes of the non-confidential portions of the meetings.) Mrs. Bonnie Campbell, Committee Management Officer, Office of Extramural Research Education and Priority Populations, Agency for Healthcare Research and Quality (AHRQ), 5600 Fishers Lane, Rockville, Maryland 20857, Telephone (301) 427–1554.

SUPPLEMENTARY INFORMATION: These meetings will be closed to the public in accordance with 5 U.S.C. App. 2 section 10(d), 5 U.S.C. 552b(c)(4), and 5 U.S.C. 552b(c)(6). In accordance with section 10(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App. 2), AHRQ announces meetings of the above-listed scientific peer review groups, which are subcommittees of AHRQ's Health Services Research Initial Review Group Committees. Each subcommittee meeting will commence in open session

before closing to the public for the duration of the meeting. The subcommittee meetings will be closed to the public in accordance with the provisions set forth in 5 U.S.C. App. 2 section 10(d), 5 U.S.C. 552b(c)(4), and 5 U.S.C. 552b(c)(6). 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.

Agenda items for these meetings are subject to change as priorities dictate. The meeting dates and times are:

1. *Health Care Research and Training (HCRT)*
   Date: May 24–25, 2018 (Open from 8:00 a.m. to 8:30 a.m. on May 24th and closed for remainder of the meeting)
2. *Health System and Value Research (HSVR)*
   Date: June 6, 2018 (Open from 8:00 a.m. to 8:30 a.m. on June 6th and closed for remainder of the meeting)
3. *Healthcare Effectiveness and Outcomes Research (HEOR)*
   Date: June 6, 2018 (Open from 8:30 a.m. to 9:00 a.m. on June 6th and closed for remainder of the meeting)
4. *Healthcare Safety and Quality Improvement Research (HSQR)*
   Date: June 6–7, 2018 (Open from 7:30 a.m. to 8:00 a.m. on June 6th and closed for remainder of the meeting)
5. *Healthcare Information Technology Research (HITR)*
   Date: June 7–8, 2018 (Open from 8:00 a.m. to 8:30 a.m. on June 7th and closed for remainder of the meeting)

Francis D. Chesley, Jr.,

Acting Deputy Director.

[FR Doc. 2018–09744 Filed 5–7–18; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP)—RFA–CE–18–003; Correction

Notice is hereby given of a change in the meeting of the Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP)—RFA–CE–18–003; May 16–17, 2018, 9:00 a.m.—5:00 p.m., EDT which was published in the **Federal Register** on April 6, 2018 Volume 83, Number 67, page 14854.

The meeting place should read as follows: InterContinental Buckhead Atlanta, 3315 Peachtree Road NE, Atlanta, GA 30326.

FOR FURTHER INFORMATION CONTACT: Dahna Batts, M.D., FACEP, Scientific Review Official, NCIPC, CDC, 4770 Buford Highway NE, Mailstop F–63, Atlanta, GA 30341, Telephone (404) 639–2485; Email: *dbatts@cdc.gov.*

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

Claudette Grant,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2018–09710 Filed 5–7–18; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2018–0002; Internal Agency Docket No. FEMA–B–1821]

Changes in Flood Hazard Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice lists communities where the addition or modification of Base Flood Elevations (BFEs), base flood depths, Special Flood Hazard Area (SFHA) boundaries or zone designations, or the regulatory floodway (hereinafter referred to as flood hazard determinations), as shown on the Flood Insurance Rate Maps (FIRMs), and where applicable, in the supporting Flood Insurance Study (FIS) reports, prepared by the Federal Emergency Management Agency (FEMA) for each community, is appropriate because of new scientific or technical data. The FIRM, and where applicable, portions of the FIS report, have been revised to reflect these flood hazard determinations through issuance of a Letter of Map Revision (LOMR), in accordance with the Code of Federal Regulations. The LOMR will be used by insurance agents and others to calculate appropriate flood insurance premium rates for new buildings and the contents of those buildings. For rating purposes, the currently effective community number is shown in the table below and must be used for all new policies and renewals.

DATES: These flood hazard determinations will be finalized on the dates listed in the table below and revise the FIRM panels and FIS report in effect prior to this determination for the listed communities.

From the date of the second publication of notification of these changes in a newspaper of local circulation, any person has 90 days in which to request through the community that the Deputy Associate Administrator for Insurance and Mitigation reconsider the changes. The flood hazard determination information may be changed during the 90-day period.

ADDRESSES: The affected communities are listed in the table below. Revised flood hazard information for each community is available for inspection at both the online location and the respective community map repository address listed in the table below. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

Submit comments and/or appeals to the Chief Executive Officer of the community as listed in the table below.

FOR FURTHER INFORMATION CONTACT: Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov;* or visit the FEMA Map Information eXchange (FMIX) online at *https://www.floodmaps.fema.gov/fhm/fmx_main.html.*

SUPPLEMENTARY INFORMATION: The specific flood hazard determinations are not described for each community in this notice. However, the online location and local community map repository address where the flood hazard determination information is available for inspection is provided.

Any request for reconsideration of flood hazard determinations must be submitted to the Chief Executive Officer of the community as listed in the table below.

The modifications are made pursuant to section 201 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.,* and with 44 CFR part 65.

The FIRM and FIS report are the basis of the floodplain management measures that the community is required either to adopt or to show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

These flood hazard determinations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities. The flood hazard determinations are in accordance with 44 CFR 65.4.

The affected communities are listed in the following table. Flood hazard determination information for each community is available for inspection at both the online location and the respective community map repository address listed in the table below. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Dated: May 1, 2018.

David I. Maurstad,

Deputy Associate Administrator for Insurance and Mitigation (Acting), Department of Homeland Security, Federal Emergency Management Agency.

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Alabama:						
Lee	City of Auburn (17–04–7132P).	The Honorable Bill Ham, Jr., Mayor, City of Auburn, 144 Tichenor Avenue, Suite 1, Auburn, AL 36830.	City Hall, 144 Tichenor Avenue, Suite 1, Auburn, AL 36830.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 2, 2018	010144
Colorado:						
Boulder	City of Louisville (18–08–0269X).	The Honorable Bob Muckle, Mayor, City of Louisville, 749 Main Street, Louisville, CO 80027.	City Hall, 749 Main Street, Louisville, CO 80027.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 5, 2018	085076
Connecticut:						
New Haven	City of New Haven (18–01–0359P).	The Honorable Toni N. Harp, Mayor, City of New Haven, 165 Church Street, New Haven, CT 06510.	Planning Department, 165 Church Street, New Haven, CT 06510.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 22, 2018	090084
Florida:						
Broward	City of Hollywood (17–04–3432P).	The Honorable Josh Levy, Mayor, City of Hollywood, P.O. Box 229405, Hollywood, FL 33022.	City Hall, 2600 Hollywood Boulevard, Hollywood, FL 33020.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 20, 2018	125113
Charlotte	City of Punta Gorda (18–04–1510P).	The Honorable Rachel Keesling, Mayor, City of Punta Gorda, 326 West Marion Avenue, Punta Gorda, FL 33950.	City Hall, 326 West Marion Avenue, Punta Gorda, FL 33950.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 29, 2018	120062
Collier	Unincorporated areas of Collier County (18–04–1140P).	The Honorable Andy Solis, Chairman, Collier County Board of Commissioners, 3299 Tamiami Trail East, Suite 303, Naples, FL 34112.	Collier County Growth Management Department, 2800 North Horseshoe Drive, Naples, FL 34104.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 5, 2018	120067
Collier	Unincorporated areas of Collier County (18–04–1791P).	The Honorable Andy Solis, Chairman, Collier County Board of Commissioners, 3299 Tamiami Trail East, Suite 303, Naples, FL 34112.	Collier County Growth Management Department, 2800 North Horseshoe Drive, Naples, FL 34104.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 9, 2018	120067
Lee	City of Sanibel (17–04–7625P).	The Honorable Kevin Ruane, Mayor, City of Sanibel, 800 Dunlop Road, Sanibel, FL 33957.	Planning Department, 800 Dunlop Road, Sanibel, FL 33957.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 25, 2018	120402
Miami-Dade	City of Miami (17–04–7381P).	The Honorable Francis Suarez, Mayor, City of Miami, 3500 Pan American Drive, Miami, FL 33133.	Building Department, 444 Southwest 2nd Avenue, Miami, FL 33133.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 20, 2018	120650
Monroe	City of Key West (18–04–1325P).	The Honorable Craig Cates, Mayor, City of Key West, P.O. Box 1409, Key West, FL 33041.	Building Department, 1300 White Street, Key West, FL 33040.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 5, 2018	120168

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Monroe	Unincorporated areas of Monroe County (18–04–0838P).	The Honorable David Rice, Mayor, Monroe County Board of Commissioners, 9400 Overseas Highway, Suite 210, Marathon, FL 33050.	Monroe County Building Department, 9805 Overseas Highway, Suite 300, Marathon, FL 33050.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 15, 2018	125129
Monroe	Village of Islamorada (18–04–1512P).	The Honorable Chris Sante, Mayor, Village of Islamorada, 86800 Overseas Highway, Islamorada, FL 33036.	Planning and Development Department, 86800 Overseas Highway, Islamorada, FL 33036.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 5, 2018	120424
Palm Beach	Village of Tequesta (18–04–1101P).	The Honorable Abby Brennan, Mayor, Village of Tequesta, 345 Tequesta Drive, Tequesta, FL 33469.	Building Department, 345 Tequesta Drive, Tequesta, FL 33469.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 2, 2018	120228
Pinellas	City of Clearwater (18–04–0067P).	The Honorable George N. Cretekos, Mayor, City of Clearwater, P.O. Box 4748, Clearwater, FL 33758.	Engineering Department, 100 South Myrtle Avenue, Suite 220, Clearwater, FL 33758.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 2, 2018	125096
Pinellas	City of Clearwater (18–04–0912P).	The Honorable George N. Cretekos, Mayor, City of Clearwater, P.O. Box 4748, Clearwater, FL 33758.	Engineering Department, 100 South Myrtle Avenue, Suite 220, Clearwater, FL 33758.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 25, 2018	125096
Sarasota	Unincorporated areas of Sarasota County (18–04–1102P).	The Honorable Nancy Detert, Chair, Sarasota County Board of Commissioners, 1660 Ringling Boulevard, Sarasota, FL 34236.	Sarasota County Planning and Development Services Department, 1001 Sarasota Center Boulevard, Sarasota, FL 34240.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 15, 2018	125144
Seminole	City of Oviedo (17–04–2581P).	The Honorable Dominic Persampiere, Mayor, City of Oviedo, 400 Alexandria Boulevard, Oviedo, FL 32765.	Public Works Department, 1655 Evans Street, Oviedo, FL 32765.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 15, 2018	120293
Seminole	Unincorporated areas of Seminole County (17–04–2581P).	The Honorable John Horan, Chairman, Seminole County Board of Commissioners, 1101 East 1st Street, Sanford, FL 32771.	Seminole County Development Review Division, 1101 East 1st Street, Sanford, FL 32771.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 15, 2018	120289
Maryland:						
Prince George's.	Unincorporated areas of Prince George's County (17–03–2338P).	The Honorable Rushern L. Baker, III, Prince George's County Executive, 14741 Governor Oden Bowie Drive, Upper Marlboro, MD 20772.	Prince George's County Department of Stormwater Management, 1801 McCormick Drive, Largo, MD 20774.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 20, 2018	245208
Nevada:						
Clark	Unincorporated areas of Clark County (17–09–2685P).	The Honorable Steve Sisolak, Chairman, Clark County Board of Commissioners, 500 South Grand Central Parkway, Las Vegas, NV 89155.	Clark County Department of Public Works, 500 South Grand Central Parkway, Las Vegas, NV 89155.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 29, 2018	320003
New Hampshire:						
Hillsborough	City of Manchester (17–01–0477P).	The Honorable Theodore L. Gatsas, Mayor, City of Manchester, 1 City Hall Plaza, Manchester, NH 03101.	Planning and Community Development Department, 1 City Hall Plaza, Manchester, NH 03101.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 28, 2018	330169
North Carolina:						
Mitchell	Unincorporated areas of Mitchell County (17–04–0891P).	The Honorable Vern Grindstaff, Chairman, Mitchell County Board of Commissioners 26 Crimson Laurel Circle, Suite 2, Bakersville, NC 28705.	Mitchell County Building Inspections Department, 130 Forest Service Drive, Suite B Bakersville, NC 28705.	*http://www.msc.fema.gov/lomc.*	May 3, 2018	370161
Wake	City of Raleigh (16–04–2597P).	The Honorable Nancy McFarlane, Mayor, City of Raleigh, P.O. Box 590, Raleigh, NC 27602.	Stormwater Management Division, 1 Exchange Plaza, Suite 304, Raleigh, NC 27601.	*http://www.msc.fema.gov/lomc.*	Jun. 27, 2018	370243

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Wake	City of Raleigh (16–04–2710P).	The Honorable Nancy McFarlane, Mayor, City of Raleigh, P.O. Box 590, Raleigh, NC 27602.	Stormwater Management Division, 1 Exchange Plaza, Suite 304, Raleigh, NC 27601.	*http://www.msc.fema.gov/lomc.*	Jun. 27, 2018	370243
Wake	Town of Knightdale (16–04–2597P).	The Honorable James Roberson, Mayor, Town of Knightdale, 950 Steeple Square Court, Knightdale, NC 27545.	Town Hall, 950 Steeple Square Court, Knightdale, NC 27545.	*http://www.msc.fema.gov/lomc.*	Jun. 27, 2018	370241
Pennsylvania:						
Bedford	Borough of Hyndman (17–03–2585P).	The Honorable Newton Huffman, Mayor, Borough of Hyndman, P.O. Box 74, Hyndman, PA 15545.	Borough Hall, 3945 Center Street, Hyndman, PA 15545.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 25, 2018	420121
Bedford	Township of Londonderry (17–03–2585P).	The Honorable Stephen Stouffer, Chairman, Township of Londonderry Board of Supervisors, P.O. Box 215, Hyndman, PA 15545.	Township Hall, 4303 Hyndman Road, Hyndman, PA 15545.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 25, 2018	421345
Dauphin	Township of Derry (17–03–2539P).	The Honorable Marc A. Moyer, Chairman, Township of Derry Board of Supervisors, 600 Clearwater Road, Hershey, PA 17033.	Community Development Department, 600 Clearwater Road, Hershey, PA 17033.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 6, 2018	420376
Lancaster	Township of Manheim (17–03–1486P).	Mr. Sean P. Molchany, Manager-Secretary, Township of Manheim, 1840 Municipal Drive, Lancaster, PA 17601.	Township Hall, 1840 Municipal Drive, Lancaster, PA 17601.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 15, 2018	420556
Lycoming	Township of Loyalsock (18–03–0265P).	Mr. William Burdett, Manager, Township of Loyalsock, 2501 East 3rd Street, Williamsport, PA 17701.	Township Hall, 2501 East 3rd Street, Williamsport, PA 17701.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 19, 2018	421040
Somerset	Borough of Rockwood (18–03–0266P).	The Honorable Melissa Cramer, Mayor, Borough of Rockwood, 669 Somerset Avenue, Rockwood, PA 15557.	Borough Hall, 669 Somerset Avenue, Rockwood, PA 15557.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 20, 2018	422045
South Carolina:						
Berkley	Unincorporated areas of Berkley County (18–04–1462P).	The Honorable William W. Peagler, III, Berkley County Supervisor, P.O. Box 6122, Moncks Corner, SC 29461.	Berkeley County Planning and Zoning Department, 1003 Highway 52, Moncks Corner, SC 29461.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 5, 2018	450029
Charleston	City of Folly Beach (17–04–4686P).	The Honorable Timothy M. Goodwin, Mayor, City of Folly Beach, P.O. Box 48, Folly Beach, SC 29439.	Building Department, 21 Center Street, Folly Beach, SC 29439.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 20, 2018	455415
York	Town of Fort Mill (18–04–0146P).	The Honorable Guynn Savage, Mayor, Town of Fort Mill, P.O. Box 159, Fort Mill, SC 29716.	Town Hall, 200 Tom Hall Street, Fort Mill, SC 29715.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 27, 2018	450195
York	Unincorporated areas of York County (18–04–0146P).	The Honorable Britt Blackwell, Chairman, York County Council, P.O. Box 66, Rock Hill, SC 29745.	York County Planning and Development Department, 1070 Heckle Boulevard, Suite 107, Rock Hill, SC 29732.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 27, 2018	450193
South Dakota:						
Pennington	City of Rapid City (17–08–1343P).	The Honorable Steve Allender, Mayor, City of Rapid City, 300 6th Street, Rapid City, SD 57701.	Public Works Department, Engineering Services Division, 300 6th Street, Rapid City, SD 57701.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 29, 2018	465420
Texas:						
Bexar	City of Balcones Heights (17–06–0549P).	The Honorable Suzanne de Leon, Mayor, City of Balcones Heights, 3300 Hillcrest Drive, Balcones Heights, TX 78201.	Community Development Department, 3300 Hillcrest Drive, Balcones Heights, TX 78201.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 2, 2018	481094

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Bexar	City of Kirby (17–06–3964P).	The Honorable Lisa B. Pierce Mayor, City of Kirby, 112 Bauman Street, Kirby, TX 78219.	City Hall, 112 Bauman Street, Kirby, TX 78219.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 28, 2018	480041
Bexar	City of Leon Valley (17–06–2511P).	The Honorable Chris Riley, Mayor, City of Leon Valley, 6400 El Verde Road, Leon Valley, TX 78238.	Community Development Department, 6400 El Verde Road, Leon Valley, TX 78238.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 2, 2018	480042
Bexar	City of Leon Valley (17–06–2527P).	The Honorable Chris Riley, Mayor, City of Leon Valley, 6400 El Verde Road, Leon Valley, TX 78238.	Community Development Department, 6400 El Verde Road, Leon Valley, TX 78238.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 2, 2018	480042
Bexar	City of San Antonio (17–06–0549P).	The Honorable Ron Nirenberg, Mayor, City of San Antonio, P.O. Box 839966, San Antonio, TX 78283.	Transportation and Capital Improvements Department, Storm Water Division, 1901 South Alamo Street, 2nd Floor, San Antonio, TX 78204.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 2, 2018	480045
Bexar	City of San Antonio (17–06–0568P).	The Honorable Ron Nirenberg, Mayor, City of San Antonio, P.O. Box 839966, San Antonio, TX 78283.	Transportation and Capital Improvements Department, Storm Water Division, 1901 South Alamo Street, 2nd Floor, San Antonio, TX 78204.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 25, 2018	480045
Bexar	City of San Antonio (17–06–2972P).	The Honorable Ron Nirenberg, Mayor, City of San Antonio, P.O. Box 839966, San Antonio, TX 78283.	Transportation and Capital Improvements Department, Storm Water Division, 1901 South Alamo Street, 2nd Floor, San Antonio, TX 78204.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 2, 2018	480045
Brazoria	City of Manvel (17–06–3110P).	The Honorable Debra Davison, Mayor, City of Manvel, 20025 Highway 6, Manvel, TX 77578.	City Hall, 20025 Highway 6, Manvel, TX 77578.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 29, 2018	480076
Brazoria	City of Pearland (17–06–3110P).	Mr. Clay Pearson, Manager, City of Pearland, 3519 Liberty Drive, Pearland, TX 77581.	City Hall, 3519 Liberty Drive, Pearland, TX 77581.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 29, 2018	480077
Brazoria	Unincorporated areas of Brazoria County (17–06–3110P).	The Honorable L.M. "Matt" Sebesta, Jr., Brazoria County Judge, 111 East Locust Street, Suite 102A, Angleton, TX 77515.	Brazoria County West Annex, 451 North Velasco, Suite 210, Angleton, TX 77515.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 29, 2018	485458
Collin	Town of Plano (17–06–3654P).	The Honorable Harry LaRosiliere, Mayor, City of Plano, 1520 K Avenue, Plano, TX 75074.	Engineering Department, 1520 K Avenue, Plano, TX 75074.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 15, 2018	480140
El Paso	City of El Paso (18–06–0747P).	Mr. Tommy Gonzales, Manager, City of El Paso, 300 North Campbell Street, El Paso, TX 79901.	City Hall, 801 Texas Avenue, El Paso, TX 79901.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 18, 2018	480214
Harris	Unincorporated areas of Harris County (17–06–1728P).	The Honorable Edward M. Emmett, Harris County Judge, 1001 Preston Street, Suite 911, Houston, TX 77002.	Harris County Permit Office, 10555 Northwest Freeway, Suite 120, Houston, TX 77002.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 11, 2018	480287
Harris	Unincorporated areas of Harris County (17–06–3887P).	The Honorable Edward M. Emmett, Harris County Judge, 1001 Preston Street, Suite 911, Houston, TX 77002.	Harris County Permit Office, 10555 Northwest Freeway, Suite 120, Houston, TX 77002.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 11, 2018	480287
Harris	Unincorporated areas of Harris County (18–06–0276P).	The Honorable Edward M. Emmett, Harris County Judge, 1001 Preston Street, Suite 911, Houston, TX 77002.	Harris County Permit Office, 10555 Northwest Freeway, Suite 120, Houston, TX 77002.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 18, 2018	480287

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Lamar	City of Paris (17–06–3047P).	The Honorable Steve Clifford, Mayor, City of Paris, P.O. Box 9037, Paris, TX 75460.	Engineering, Planning and Development Department, 150 Southeast 1st Street, Paris, TX 75460.	*https://msc.fema.gov/portal/advanceSearch.*	Jul 3, 2018	480427
Tarrant	City of Arlington (17–06–3146P).	The Honorable W. Jeff Williams, Mayor, City of Arlington, P.O. Box 90231, Arlington, TX 76010.	City Hall, 101 West Abram Street, Arlington, TX 76010.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 29, 2018	485454
Tarrant	City of Fort Worth (17–06–4262P).	The Honorable Betsy Price, Mayor, City of Fort Worth, 200 Texas Street, Fort Worth, TX 76102.	Transportation and Public Works Department, 200 Texas Street, Fort Worth, TX 76102.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 25, 2018	480596
Tarrant	City of Grand Prairie (17–06–3146P).	The Honorable Ron Jensen, Mayor, City of Grand Prairie, P.O. Box 534045, Grand Prairie, TX 75053.	City Hall, 206 West Church Street, Grand Prairie, TX 75050.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 29, 2018	485472
Williamson	City of Taylor (17–06–2515P).	The Honorable Brandt Rydell, Mayor, City of Taylor, 400 Porter Street, Taylor, TX 76574.	Department of Public Works, 400 Porter Street, Taylor, TX 76574.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 29, 2018	480670
Utah:						
Washington	City of Washington (17–08–1258P).	The Honorable Ken Neilson, Mayor, City of Washington, 111 North 100 East, Washington, UT 84780.	Public Works Department, 1305 East Washington Dam Road, Washington, UT 84780.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 9, 2018	490182
Virginia:						
Fairfax	Unincorporated areas of Fairfax County (17–03–2338P).	Mr. Bryan Hill, Fairfax County Executive, 12000 Government Center Parkway, Fairfax, VA 22035.	Fairfax County Government Center, 12000 Government Center Parkway, Suite 449, Fairfax, VA 22035.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 20, 2018	515525
Loudoun	Town of Leesburg (18–03–0635P).	The Honorable Kelly Burk, Mayor, Town of Leesburg, 25 West Market Street, Leesburg, VA 20176.	Department of Plan Review, 25 West Market Street, Leesburg, VA 20176.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 6, 2018	510091
Prince William.	Unincorporated areas of Prince William County (17–03–1826P).	Mr. Christopher E. Martino, Executive, Prince William County, 1 County Complex Court, Prince William, VA 22192.	Prince William County Department of Public Works, 5 County Complex Court, Prince William, VA 22192.	*https://msc.fema.gov/portal/advanceSearch.*	Jun. 28, 2018	510119

[FR Doc. 2018–09699 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2018–0002]

Final Flood Hazard Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final notice.

SUMMARY: Flood hazard determinations, which may include additions or modifications of Base Flood Elevations (BFEs), base flood depths, Special Flood Hazard Area (SFHA) boundaries or zone designations, or regulatory floodways on the Flood Insurance Rate Maps (FIRMs) and where applicable, in the supporting Flood Insurance Study (FIS) reports have been made final for the communities listed in the table below.

The FIRM and FIS report are the basis of the floodplain management measures that a community is required either to adopt or to show evidence of having in effect in order to qualify or remain qualified for participation in the Federal Emergency Management Agency's (FEMA's) National Flood Insurance Program (NFIP). In addition, the FIRM and FIS report are used by insurance agents and others to calculate appropriate flood insurance premium rates for buildings and the contents of those buildings.

DATES: The date of June 20, 2018 has been established for the FIRM and, where applicable, the supporting FIS report showing the new or modified flood hazard information for each community.

ADDRESSES: The FIRM, and if applicable, the FIS report containing the final flood hazard information for each community is available for inspection at the respective Community Map Repository address listed in the tables below and will be available online through the FEMA Map Service Center at *https://msc.fema.gov* by the date indicated above.

FOR FURTHER INFORMATION CONTACT: Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov;* or visit the FEMA Map Information eXchange (FMIX) online at *https://www.floodmaps.fema.gov/fhm/fmx_main.html.*

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) makes the final determinations

listed below for the new or modified flood hazard information for each community listed. Notification of these changes has been published in newspapers of local circulation and 90 days have elapsed since that publication. The Deputy Associate Administrator for Insurance and Mitigation has resolved any appeals resulting from this notification.

This final notice is issued in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR part 67. FEMA has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR part 60.

Interested lessees and owners of real property are encouraged to review the new or revised FIRM and FIS report available at the address cited below for each community or online through the FEMA Map Service Center at *https://msc.fema.gov.* The flood hazard determinations are made final in the watersheds and/or communities listed in the table below.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Date: May 1, 2018.

David I. Maurstad,

Deputy Associate Administrator for Insurance and Mitigation (Acting), Department of Homeland Security, Federal Emergency Management Agency.

Community	Community map repository address
Kent County, Delaware and Incorporated Areas Docket No.: FEMA–B–1701	
Unincorporated Areas of Kent County	Kent County Administrative Complex, Department of Planning Services, 555 Bay Road, Dover, DE 19901.
Sussex County, Delaware and Incorporated Areas Docket No.: FEMA–B–1701	
City of Seaford	City Hall, 414 High Street, Seaford, DE 19973.
Town of Bridgeville	Town Hall, 101 North Main Street, Bridgeville, DE 19933.
Town of Georgetown	Town Hall, 39 The Circle, Georgetown, DE 19947.
Town of Laurel	Code Enforcement Office, 201 Mechanic Street, Laurel, DE 19956.
Town of Millsboro	Town Center, 322 Wilson Highway, Millsboro, DE 19966.
Unincorporated Areas of Sussex County	Sussex County Planning and Zoning Department, 2 The Circle, Georgetown, DE 19947.
Orange County, Florida and Incorporated Areas Docket No.: FEMA–B–1701	
City of Orlando	City Hall, Permitting Services, 400 South Orange Avenue, 1st Floor, Orlando, FL 32801.
Unincorporated Areas of Orange County	Orange County Stormwater Management Division, 4200 South John Young Parkway, Orlando, FL 32839.
Bladen County, North Carolina and Incorporated Areas Docket No.: FEMA–B–1523	
Unincorporated Areas of Bladen County	Bladen County Planning Department, 450 Smith Circle #N8, Elizabethtown, NC 28337.
Cumberland County, North Carolina and Incorporated Areas Docket No.: FEMA–B–1445	
Unincorporated Areas of Cumberland County	Cumberland County Engineering and Infrastructure Department, 130 Gillespie Street, Fayetteville, NC 28301.
Duplin County, North Carolina and Incorporated Areas Docket No.: FEMA–B–1523	
Town of Beulaville	Town Hall, 508 East Main Street, Beulaville, NC 28518.
Town of Wallace	Town Hall, 316 East Murray Street, Wallace, NC 28466.
Town of Warsaw	Town Hall, 121 South Front Street, Warsaw, NC 28398.
Unincorporated Areas of Duplin County	Duplin County Planning Department, 117 Beasley Street, Kenansville, NC 28349.
Johnston County, North Carolina and Incorporated Areas Docket No.: FEMA–B–1445	
Town of Clayton	Town Hall, 111 East 2nd Street, Clayton, NC 27520.
Town of Four Oaks	Town Hall, 304 North Main Street, Four Oaks, NC 27524.
Town of Pine Level	Town Hall, 306 East Brown Street, Pine Level, NC 27568.
Town of Princeton	Town Hall, 503 Doctor Donnie H. Jones, Jr. Boulevard W, Princeton, NC 27569.
Town of Selma	Planning Department, 114 North Raiford Street, Selma, NC 27576.
Town of Smithfield	Town Hall, 350 East Market Street, Smithfield, NC 27577.
Town of Wilson's Mills	Town Hall, 100 Railroad Street, Wilson's Mills, NC 27593.
Unincorporated Areas of Johnston County	Johnston County Planning Department, 309 East Market Street, Smithfield, NC 27577.
Sampson County, North Carolina and Incorporated Areas Docket No.: FEMA–B–1523	
City of Clinton	Clinton-Sampson Planning and Zoning, 227 Lisbon Street, Clinton, NC 28328.
Town of Autryville	Town Hall, 215 North Gray Street, Autryville, NC 28318.
Town of Garland	Town Hall, 190 South Church Street, Garland, NC 28441.
Town of Newton Grove	Town Hall, 304 West Weeksdale Street, Newton Grove, NC 28366.

Community	Community map repository address
Unincorporated Areas of Sampson County	Sampson County Planning and Zoning Department, 227 Lisbon Street, Clinton, NC 28328.
Wayne County, North Carolina and Incorporated Areas Docket No.: FEMA–B–1445	
City of Goldsboro	City Hall, 222 North Center Street, Goldsboro, NC 27530.
Town of Fremont	Town Hall, 120 East Main Street, Fremont, NC 27830.
Town of Mount Olive	Town Hall, 114 East James Street, Mount Olive, NC 28365.
Town of Pikeville	Town Hall, 100 West School Street, Pikeville, NC 27863.
Unincorporated Areas of Wayne County	Wayne County Manager's Office, 224 East Walnut Street, Goldsboro, NC 27533.
Village of Walnut Creek	Walnut Creek Village Hall, 100 Village Drive, Goldsboro, NC 27532.

[FR Doc. 2018–09773 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2018–0002]

Changes in Flood Hazard Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final Notice.

SUMMARY: New or modified Base (1-percent annual chance) Flood Elevations (BFEs), base flood depths, Special Flood Hazard Area (SFHA) boundaries or zone designations, and/or regulatory floodways (hereinafter referred to as flood hazard determinations) as shown on the indicated Letter of Map Revision (LOMR) for each of the communities listed in the table below are finalized. Each LOMR revises the Flood Insurance Rate Maps (FIRMs), and in some cases the Flood Insurance Study (FIS) reports, currently in effect for the listed communities. The flood hazard determinations modified by each LOMR will be used to calculate flood insurance premium rates for new buildings and their contents.

DATES: Each LOMR was finalized as in the table below.

ADDRESSES: Each LOMR is available for inspection at both the respective Community Map Repository address listed in the table below and online through the FEMA Map Service Center at *https://msc.fema.gov.*

FOR FURTHER INFORMATION CONTACT: Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov;* or visit the FEMA Map Information eXchange (FMIX) online at *https://www.floodmaps.fema.gov/fhm/fmx_main.html.*

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) makes the final flood hazard determinations as shown in the LOMRs for each community listed in the table below. Notice of these modified flood hazard determinations has been published in newspapers of local circulation and 90 days have elapsed since that publication. The Deputy Associate Administrator for Insurance and Mitigation has resolved any appeals resulting from this notification.

The modified flood hazard determinations are made pursuant to section 206 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.,* and with 44 CFR part 65.

For rating purposes, the currently effective community number is shown and must be used for all new policies and renewals.

The new or modified flood hazard information is the basis for the floodplain management measures that the community is required either to adopt or to show evidence of being already in effect in order to remain qualified for participation in the National Flood Insurance Program (NFIP).

This new or modified flood hazard information, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities.

This new or modified flood hazard determinations are used to meet the floodplain management requirements of the NFIP and also are used to calculate the appropriate flood insurance premium rates for new buildings, and for the contents in those buildings. The changes in flood hazard determinations are in accordance with 44 CFR 65.4.

Interested lessees and owners of real property are encouraged to review the final flood hazard information available at the address cited below for each community or online through the FEMA Map Service Center at *https://msc.fema.gov.*

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Dated: May 1, 2018.

David I. Maurstad,

Deputy Associate Administrator for Insurance and Mitigation (Acting), Department of Homeland Security, Federal Emergency Management Agency.

State and county	Location and case No.	Chief executive officer of community	Community map repository	Date of modification	Community No.
Arkansas: Benton, (FEMA Docket No.: B–1803).	City of Lowell, (17–06–1806P).	The Honorable Eldon Long, Mayor, City of Lowell, 216 North Lincoln Street, Lowell, AR 72745.	City Hall, 216 North Lincoln Street, Lowell, AR 72745.	Mar. 26, 2018	050342
Colorado: Jefferson, (FEMA Docket No.: B–1803).	City of Westminster, (17–08–0650P).	The Honorable Herb Atchison, Mayor, City of Westminster, 4800 West 92nd Avenue, Westminster, CO 80031.	City Hall, 4800 West 92nd Avenue, Westminster, CO 80031.	Apr. 6, 2018	080008
Florida:					

State and county	Location and case No.	Chief executive officer of community	Community map repository	Date of modification	Community No.
Brevard, (FEMA Docket No.: B–1803).	City of Cocoa Beach, (17–04–7481P).	The Honorable Ben Malik, Mayor, City of Cocoa Beach, P.O. Box 322430, Cocoa Beach, FL 32932.	Development Services Department, 2 South Orlando Avenue, Cocoa Beach, FL 32931.	Apr. 5, 2018	125097
DeSoto, (FEMA Docket No.: B–1803).	Unincorporated areas of DeSoto County, (17–04–5738P).	The Honorable Elton Langford, Chairman, DeSoto County Board of Commissioners, 201 East Oak Street, Suite 201, Arcadia, FL 34266.	DeSoto County Planning and Zoning Department, 201 East Oak Street, Suite 204, Arcadia, FL 34266.	Mar. 23, 2018	120072
Hillsborough, (FEMA Docket No.: B–1803).	Unincorporated areas of Hillsborough County, (17–04–1127P).	The Honorable Stacy White, Chairman, Hillsborough County Board of Commissioners, 601 East Kennedy Boulevard, Tampa, FL 33602.	Hillsborough County Development Services Department, 601 East Kennedy Boulevard, Tampa, FL 33602.	Apr. 4, 2018	120112
Lake, (FEMA Docket No.: B–1803).	Unincorporated areas of Lake County, (17–04–3997P).	The Honorable Timothy I. Sullivan, Chairman, Lake County Board of Commissioners, P.O. Box 7800, Tavares, FL 32778.	Lake County Public Works Department, 437 Ardice Avenue, Eustis, FL 32726.	Mar. 29, 2018	120421
Lee, (FEMA Docket No.: B–1803).	Unincorporated areas of Lee County, (17–04–7100P).	The Honorable Mr. John Manning, Chairman, Lee County Board of Commissioners, P.O. Box 398, Fort Myers, FL 33902.	Lee County Building Department, 1500 Monroe Street, Fort Myers, FL 33901.	Apr. 3, 2018	125124
Georgia:					
Cobb, (FEMA Docket No.: B–1803).	City of Powder Springs, (17–04–7207P).	The Honorable Al Thurman, Mayor, City of Powder Springs, P.O. Box 46, Powder Springs, GA 30127.	Community Development Department, 4488 Pineview Drive, Powder Springs, GA 30127.	Apr. 9, 2018	130056
Cobb, (FEMA Docket No.: B–1803).	Unincorporated areas of Cobb County, (17–04–7207P).	The Honorable Mike Boyce, Chairman, Cobb County Board of Commissioners, 100 Cherokee Street, Marietta, GA 30090.	Cobb County Stormwater Management Division, 680 South Cobb Drive, Marietta, GA 30060.	Apr. 9, 2018	130052
New Mexico: Bernalillo, (FEMA Docket No.: B–1807).	Unincorporated areas of Bernalillo County, (17–06–3952P).	Ms. Julie Morgas Baca, Manager, Bernalillo County, 1 Civic Plaza Northwest, Albuquerque, NM 87102.	Bernalillo County Public Works Division, 2400 Broadway Southeast, Albuquerque, NM 87102.	Apr. 6, 2018	350001
North Carolina:					
Durham, (FEMA Docket No.: B–1816).	Unincorporated areas of Durham County, (17–04–2721P).	The Honorable Wendy Jacobs, Chair, Durham County Board of Commissioners, 200 East Main Street, 2nd Floor, Durham, NC 27701.	Durham County Stormwater Services Department, 101 City Hall Plaza, Durham, NC 27701.	Feb. 21, 2018	370085
Orange, (FEMA Docket No.: B–1803).	Town of Chapel Hill, (17–04–3137P).	The Honorable Pam Hemminger, Mayor, Town of Chapel Hill, 405 Martin Luther King Jr. Boulevard, Chapel Hill, NC 27514.	Stormwater Management Program Department, 208 North Columbia Street, Chapel Hill, NC 27514.	Mar. 13, 2018	370180
Wayne, (FEMA Docket No.: B–1816).	City of Goldsboro, (16–04–6905P).	The Honorable Chuck Allen, Mayor, City of Goldsboro, P.O. Drawer A, Goldsboro, NC 27533.	City Hall, 200 North Center Street, Goldsboro, NC 27530.	Apr. 6, 2018	370255
Wayne, (FEMA Docket No.: B–1816).	Unincorporated areas of Wayne County, (16–04–6905P).	The Honorable Bill Pate, Chairman, Wayne County Board of Commissioners, 224 East Walnut Street, Goldsboro, NC 27530.	Wayne County Planning Department, 134 North John Street, Goldsboro, NC 27530.	Apr. 6, 2018	370254
Oklahoma:					
Tulsa, (FEMA Docket No.: B–1807).	City of Bixby, (17–06–2611P).	The Honorable John Easton, Mayor, City of Bixby, P.O. Box 70, Bixby, OK 74008.	Planning Department, 116 West Needles, Bixby, OK 74008.	Apr. 9, 2018	400207
Tulsa, (FEMA Docket No.: B–1807).	City of Tulsa, (17–06–2611P).	The Honorable G. T. Bynum, Mayor, City of Tulsa, 175 East 2nd Street, 15th Floor, Tulsa, OK 74103.	Planning and Development Department, 175 East 2nd Street, Tulsa, OK 74103.	Apr. 9, 2018	405381
Texas:					
Bexar, (FEMA Docket No.: B–1803).	City of San Antonio, (17–06–2000P).	The Honorable Ron Nirenberg, Mayor, City of San Antonio, P.O. Box 839966, San Antonio, TX 78283.	Transportation and Capital Improvements Department, Storm Water Division, 1901 South Alamo Street, 2nd Floor, San Antonio, TX 78284.	Mar. 30, 2018	480045
Collin, (FEMA Docket No.: B–1803).	City of Frisco, (17–06–3743P).	The Honorable Jeff Cheney, Mayor, City of Frisco, 6101 Frisco Square Boulevard, Frisco, TX 75034.	Engineering Services Department, 11300 Research Road, Frisco, TX 75033.	Apr. 9, 2018	480134
Collin, (FEMA Docket No.: B–1803).	City of McKinney, (17–06–2726P).	The Honorable George Fuller, Mayor, City of McKinney, P.O. Box 517, McKinney, TX 75070.	Engineering Department, 221 North Tennessee Street, McKinney, TX 75069.	Apr. 2, 2018	480135
Collin, (FEMA Docket No.: B–1803).	City of McKinney, (17–06–3589P).	The Honorable George Fuller, Mayor, City of McKinney, P.O. Box 517, McKinney, TX 75070.	Engineering Department, 221 North Tennessee Street, McKinney, TX 75069.	Mar. 26, 2018	480135
Collin, (FEMA Docket No.: B–1810).	City of Murphy, (17–06–1778P).	Mr. Mike Castro, Ph.D., Manager, City of Murphy, 206 North Murphy Road, Murphy, TX 75094.	City Hall, 206 North Murphy Road, Murphy, TX 75094.	Apr. 6, 2018	480137
Dallas, (FEMA Docket No.: B–1810).	City of Dallas, (17–06–2978P).	The Honorable Michael S. Rawlings, Mayor, City of Dallas, 1500 Marilla Street, Suite 5EN, Dallas, TX 75201.	Engineering Department, 320 East Jefferson Boulevard, Room 200, Dallas, TX 75203.	Mar. 26, 2018	480171

State and county	Location and case No.	Chief executive officer of community	Community map repository	Date of modification	Community No.
Denton, (FEMA Docket No.: B–1803).	Town of Prosper, (17–06–2975P).	The Honorable Ray Smith, Mayor, Town of Prosper, P.O. Box 307, Prosper, TX 75078.	Engineering Department, 407 East 1st Street, Prosper, TX 75078.	Mar. 29, 2018	480141
Harris, (FEMA Docket No.: B–1803).	Unincorporated areas of Harris County, (17–06–3082P).	The Honorable Edward M. Emmett, Harris County Judge, 1001 Preston Street, Suite 911, Houston, TX 77002.	Harris County Permit Office, 10555 Northwest Freeway, Suite 120, Houston, TX 77092.	Apr. 2, 2018	480287
Harris and Montgomery, (FEMA Docket No.: B–1810).	City of Houston, (17–06–2680P).	The Honorable Sylvester Turner, Mayor, City of Houston, P.O. Box 1562, Houston, TX 77251.	Department of Public Works and Engineering, 1002 Washington Avenue, 3rd Floor, Houston, TX 77002.	Apr. 9, 2018	480296
Johnson, (FEMA Docket No.: B–1803).	City of Burleson, (17–06–2604P).	The Honorable Ken Shatter, Mayor, City of Burleson, 141 West Renfro Street, Burleson, TX 76028.	Public Works Department, 725 Southeast John Jones Drive, Burleson, TX 76028.	Apr. 6, 2018	485459
Montgomery, (FEMA Docket No.: B–1810).	City of Conroe, (17–06–2100P).	The Honorable Toby Powell, Mayor, City of Conroe, 300 West Davis Street, Conroe, TX 77301.	Engineering Department, 300 West Davis Street, Conroe, TX 77301.	Apr. 9, 2018	480484
Montgomery, (FEMA Docket No.: B–1810).	City of Panorama Village, (17–06–2100P).	The Honorable Lynn Scott, Mayor, City of Panorama Village, 99 Hiwon Drive, Panorama Village, TX 77304.	City Hall, 99 Hiwon Drive, Panorama Village, TX 77304.	Apr. 9, 2018	481263
Montgomery, (FEMA Docket No.: B–1810).	Unincorporated areas of Montgomery County, (17–06–2680P).	The Honorable Craig B. Doyal, Montgomery County Judge, 501 North Thompson Street, Suite 401, Conroe, TX 77301.	Montgomery County, Permit Department, 501 North Thompson Street, Suite 100, Conroe, TX 77301.	Apr. 9, 2018	480483
Tarrant (FEMA Docket No.: B–1807).	City of Fort Worth, (17–06–2262P).	The Honorable Betsy Price, Mayor, City of Fort Worth, 200 Texas Street, Fort Worth, TX 76102.	Transportation and Public Works Department, 200 Texas Street, Fort Worth, TX 76102.	Apr. 9, 2018	480596
Tarrant, (FEMA Docket No.: B–1807).	City of Westworth Village, (17–06–2290P).	The Honorable Michael R. Coleman, Mayor, City of Westworth Village, 311 Burton Hill Road, Westworth Village, TX 76114.	City Hall, 311 Burton Hill Road, Westworth Village, TX 76114.	Apr. 5, 2018	480616
Travis, (FEMA Docket No.: B–1807).	City of Pflugerville, (17–06–3700P).	The Honorable Victor Gonzales, Mayor, City of Pflugerville, P.O. Box 589, Pflugerville, TX 78691.	Development Services Department, 201–B East Pecan Street, Pflugerville, TX 78691.	Apr. 9, 2018	481028
Virginia: Fauquier, (FEMA Docket No.: B–1803).	Unincorporated areas of Fauquier County, (17–03–1541P).	The Honorable Richard R. Gerhardt, Chairman, Fauquier County Board of Supervisors, 10 Hotel Street, Suite 208, Warrenton, VA 20186.	Fauquier County Circuit Court, 29 Ashby Street, 3rd Floor, Warrenton, VA 20186.	Apr. 5, 2018	510055

[FR Doc. 2018–09775 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4360–DR; Docket ID FEMA–2018–0001]

Ohio; 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 Ohio (FEMA–4360–DR), dated April 17, 2018, and related determinations.

DATE: The declaration was issued April 17, 2018.

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 April 17, 2018, 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 Ohio resulting from severe storms, flooding, and landslides during the period of February 14–25, 2018, 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 Ohio.

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 Public Assistance in the designated areas and Hazard Mitigation throughout the State. 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, Steven Johnson, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of Ohio have been designated as adversely affected by this major disaster:

Adams, Athens, Belmont, Brown, Columbiana, Gallia, Hamilton, Jackson, Lawrence, Meigs, Monroe, Muskingum, Noble, Perry, Pike, Scioto, Vinton, and Washington Counties for Public Assistance.

All areas within the State of Ohio are eligible 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.

Brock Long,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2018–09791 Filed 5–7–18; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2018–0002; Internal Agency Docket No. FEMA–B–1827]

Proposed Flood Hazard Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: Comments are requested on proposed flood hazard determinations, which may include additions or modifications of any Base Flood Elevation (BFE), base flood depth, Special Flood Hazard Area (SFHA) boundary or zone designation, or regulatory floodway on the Flood Insurance Rate Maps (FIRMs), and where applicable, in the supporting Flood Insurance Study (FIS) reports for the communities listed in the table below. The purpose of this notice is to seek general information and comment regarding the preliminary FIRM, and where applicable, the FIS report that the Federal Emergency Management Agency (FEMA) has provided to the affected communities. The FIRM and FIS report are the basis of the floodplain management measures that the community is required either to adopt or to show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP). In addition, the FIRM and FIS report, once effective, will be used by insurance agents and others to calculate appropriate flood insurance premium rates for new buildings and the contents of those buildings.

DATES: Comments are to be submitted on or before August 6, 2018.

ADDRESSES: The Preliminary FIRM, and where applicable, the FIS report for each community are available for inspection at both the online location *https://www.fema.gov/preliminaryfloodhazarddata* and the respective Community Map Repository address listed in the tables below. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

You may submit comments, identified by Docket No. FEMA–B–1827, to Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov.*

FOR FURTHER INFORMATION CONTACT: Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov;* or visit the FEMA Map Information eXchange (FMIX) online at *https://www.floodmaps.fema.gov/fhm/fmx_main.html.*

SUPPLEMENTARY INFORMATION: FEMA proposes to make flood hazard determinations for each community listed below, in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed flood hazard determinations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities. These flood hazard determinations are used to meet the floodplain management requirements of the NFIP and also are used to calculate the appropriate flood insurance premium rates for new buildings built after the FIRM and FIS report become effective.

The communities affected by the flood hazard determinations are provided in the tables below. Any request for reconsideration of the revised flood hazard information shown on the Preliminary FIRM and FIS report that satisfies the data requirements outlined in 44 CFR 67.6(b) is considered an appeal. Comments unrelated to the flood hazard determinations also will be considered before the FIRM and FIS report become effective.

Use of a Scientific Resolution Panel (SRP) is available to communities in support of the appeal resolution process. SRPs are independent panels of experts in hydrology, hydraulics, and other pertinent sciences established to review conflicting scientific and technical data and provide recommendations for resolution. Use of the SRP only may be exercised after FEMA and local communities have been engaged in a collaborative consultation process for at least 60 days without a mutually acceptable resolution of an appeal. Additional information regarding the SRP process can be found online at *https://www.floodsrp.org/pdfs/srp_overview.pdf.*

The watersheds and/or communities affected are listed in the tables below. The Preliminary FIRM, and where applicable, FIS report for each community are available for inspection at both the online location *https://www.fema.gov/preliminaryfloodhazarddata* and the respective Community Map Repository address listed in the tables. For communities with multiple ongoing Preliminary studies, the studies can be identified by the unique project number and Preliminary FIRM date listed in the tables. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Dated: May 1, 2018.

David I. Maurstad,

Deputy Associate Administrator for Insurance and Mitigation (Acting), Department of Homeland Security, Federal Emergency Management Agency.

Community	Community map repository address
Galveston County, Texas and Incorporated Areas Project: 06–06–A614S Preliminary Date: September 27, 2012 and February 28, 2018	
City of Hitchcock	City Hall, 7423 Highway 6, Hitchcock, TX 77563.
Unincorporated Areas of Galveston County	Galveston County Courthouse, 722 Moody Avenue, Galveston, TX 77550.
Village of Tiki Island	City Hall, 802 Tiki Drive, Tiki Island, TX 77554.

[FR Doc. 2018–09782 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4302–DR; Docket ID FEMA–2018–0001]

Hoopa Valley Tribe; 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 for the Hoopa Valley Tribe (FEMA–4302–DR), dated February 14, 2017, and related determinations.

DATES: This amendment was issued April 17, 2018.

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 April 17, 2018, the President amended the cost-sharing arrangements regarding Federal funds provided under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), in a letter to Brock Long, Administrator, Federal Emergency Management Agency, Department of Homeland Security, under Executive Order 12148, as follows:

I have determined that the damage to the lands associated with the Hoopa Valley Tribe resulting from a severe winter storm during the period of January 3–5, 2017, is of sufficient severity and magnitude that special cost-sharing arrangements are warranted regarding Federal funds provided under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act'').

Therefore, I amend my declaration of February 14, 2017, to authorize Federal funds for all categories of Public Assistance at 90 percent of total eligible costs.

This adjustment to the cost sharing applies only to Public Assistance costs and direct Federal assistance eligible for such adjustments under the law. The Robert T. Stafford Disaster Relief and Emergency Assistance Act specifically prohibits a similar adjustment for funds provided for the Hazard Mitigation Grant Program (Section 404). These funds will continue to be reimbursed at 75 percent of total eligible costs.

(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.

Brock Long,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2018–09793 Filed 5–7–18; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2018–0002; Internal Agency Docket No. FEMA–B–1822]

Changes in Flood Hazard Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice lists communities where the addition or modification of Base Flood Elevations (BFEs), base flood depths, Special Flood Hazard Area (SFHA) boundaries or zone designations, or the regulatory floodway (hereinafter referred to as flood hazard determinations), as shown on the Flood Insurance Rate Maps (FIRMs), and where applicable, in the supporting Flood Insurance Study (FIS) reports, prepared by the Federal Emergency Management Agency (FEMA) for each community, is appropriate because of new scientific or technical data. The FIRM, and where applicable, portions of the FIS report, have been revised to reflect these flood hazard determinations through issuance of a Letter of Map Revision (LOMR), in accordance with the Code of Federal Regulations. The LOMR will be used by insurance agents and others to calculate appropriate flood insurance premium rates for new buildings and the contents of those buildings. For rating purposes, the currently effective community number is shown in the table below and must be used for all new policies and renewals.

DATES: These flood hazard determinations will be finalized on the dates listed in the table below and revise the FIRM panels and FIS report in effect prior to this determination for the listed communities.

From the date of the second publication of notification of these changes in a newspaper of local circulation, any person has 90 days in which to request through the community that the Deputy Associate Administrator for Insurance and Mitigation reconsider the changes. The flood hazard determination information may be changed during the 90-day period.

ADDRESSES: The affected communities are listed in the table below. Revised flood hazard information for each community is available for inspection at both the online location and the respective community map repository address listed in the table below. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

Submit comments and/or appeals to the Chief Executive Officer of the community as listed in the table below.

FOR FURTHER INFORMATION CONTACT: Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400

C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov;* or visit the FEMA Map Information eXchange (FMIX) online at *https://www.floodmaps.fema.gov/fhm/fmx_main.html.*

SUPPLEMENTARY INFORMATION: The specific flood hazard determinations are not described for each community in this notice. However, the online location and local community map repository address where the flood hazard determination information is available for inspection is provided.

Any request for reconsideration of flood hazard determinations must be submitted to the Chief Executive Officer of the community as listed in the table below.

The modifications are made pursuant to section 201 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.,* and with 44 CFR part 65.

The FIRM and FIS report are the basis of the floodplain management measures that the community is required either to adopt or to show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

These flood hazard determinations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities. The flood hazard determinations are in accordance with 44 CFR 65.4.

The affected communities are listed in the following table. Flood hazard determination information for each community is available for inspection at both the online location and the respective community map repository address listed in the table below. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Dated: May 1, 2018.

David I. Maurstad,

Deputy Associate Administrator for Insurance and Mitigation (Acting), Department of Homeland Security, Federal Emergency Management Agency.

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Arizona:						
Maricopa	City of Glendale (17–09–2397P).	The Honorable Jerry Weiers, Mayor, City of Glendale, 5850 West Glendale Avenue, Glendale, AZ 85301.	City Hall, 5850 West Glendale Avenue, Glendale, AZ 85301.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	040045
Maricopa	City of Phoenix (17–09–2397P).	The Honorable Greg Stanton, Mayor, City of Phoenix, City Hall, 200 West Washington Street, Phoenix, AZ 85003.	Street Transportation Department, 200 West Washington Street, 5th Floor, Phoenix, AZ 85003.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	040051
Maricopa	Unincorporated Areas of Maricopa County (17–09–2397P).	The Honorable Steve Chucri, Chairman, Board of Supervisors, Maricopa County, 301 West Jefferson Street, 10th Floor, Phoenix, AZ 85003.	Flood Control District of Maricopa County, 2801 West Durango Street, Phoenix, AZ 85009.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	040037
Pinal	City of Casa Grande (17–09–0587P).	The Honorable Craig McFarland, Mayor, City of Casa Grande, 510 East Florence Boulevard, Casa Grande, AZ 85122.	Department of Planning and Development, 510 East Florence Boulevard, Casa Grande, AZ 85122.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 13, 2018	040080
Pinal	City of Eloy (17–09–0587P).	The Honorable Joel G. Belloc, Mayor, City of Eloy, City Hall, 628 North Main Street, Eloy, AZ 85131.	Department of Public Works, 1137 West Houser Road, Eloy, AZ 85131.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 13, 2018	040083
Pinal	Unincorporated Areas of Pinal County (17–09–0587P).	The Honorable Todd House, Chairman, Board of Supervisors, Pinal County, P.O. Box 827, Florence, AZ 85132.	Pinal County Public Works Department, 31 North Pinal Street, Building F, Florence, AZ 85132.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 13, 2018	040077
California:						
Monterey	City of Salinas (18–09–0131P).	The Honorable Joe Gunter, Mayor, City of Salinas, 200 Lincoln Avenue, Salinas, CA 93901.	Department of Public Works, 200 Lincoln Avenue, Salinas, CA 93901.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 23, 2018	060202
Orange	City of Lake Forest (17–09–1011P).	The Honorable Scott Voigts, Mayor, City of Lake Forest, 25550 Commercentre Drive, Suite 100, Lake Forest, CA 92630.	City Hall, 25550 Commercentre Drive, Suite 100, Lake Forest, CA 92630.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 16, 2018	060759

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
San Joaquin	City of Lathrop (18–09–0365P).	The Honorable Sonny Dhaliwal, Mayor, City of Lathrop, 390 Town Center Drive, Lathrop, CA 95330.	City Hall, 390 Town Center Drive, Lathrop, CA 95330.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 9, 2018	060738
San Joaquin	City of Stockton (17–09–0527P).	The Honorable Michael D. Tubbs, Mayor, City of Stockton, 425 North El Dorado Street, Stockton, CA 95202.	Community Development Department, 345 North El Dorado Street, Stockton, CA 95202.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 18, 2018	060302
San Joaquin	Unincorporated Areas of San Joaquin County (17–09–0527P).	The Honorable Chuck Winn, Chairman, Board of Supervisors, San Joaquin County, 44 North San Joaquin Street, Suite 627, Stockton, CA 95202.	San Joaquin County, Stockton Courthouse, 180 East Weber Avenue, Stockton, CA 95202.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 18, 2018	060299
Sonoma	City of Rohnert Park (17–09–1348P).	The Honorable Pam Stafford, Mayor, City of Rohnert Park, 130 Avram Avenue, Rohnert Park, CA 94928.	City Hall, 130 Avram Avenue, Rohnert Park, CA 94928.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 16, 2018	060380
Florida:						
Nassau	Unincorporated Areas of Nassau County (18–04–1755P).	The Honorable Pat Edwards, Chairman, Board of Commissioners, Nassau County, 96135 Nassau Place, Suite One, Yulee, FL 32097.	Nassau County Building Department, 96161 Nassau Place, Yulee, FL 32097.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 13, 2018	120170
Minnesota:						
Hennepin	City of Minnetrista (16–05–6914P).	The Honorable Lisa Whalen, Mayor, City of Minnetrista, 7701 County Road, 110 West, Minnetrista, MN 55364.	City Hall, 7701 County Road, 110 West, Minnetrista, MN 55364.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 9, 2018	270175
Hennepin	City of Orono (16–05–6913P).	The Honorable Dennis Walsh, Mayor, City of Orono, P.O. Box 53, Crystal Bay, MN 55323.	City Hall, 2750 Kelley Parkway, Orono, MN 55356.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 9, 2018	270178
Hennepin	City of St. Bonifacius (16–05–6914P).	The Honorable Shawn Ruotsinoja, Mayor, City of St. Bonifacius, 8535 Kennedy Memorial Drive, St. Bonifacius, MN 55375.	City Hall, 8535 Kennedy Memorial Drive, St. Bonifacius, MN 55375.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 9, 2018	270183
Scott	City of Prior Lake (17–05–5335P).	The Honorable Kirt Briggs, Mayor, City of Prior Lake, 4646 Dakota Street Southeast, Prior Lake, MN 55372.	City Hall, 4646 Dakota Street Southeast, Prior Lake, MN 55372.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 9, 2018	270432
Nebraska:						
Washington	City of Blair (17–07–2615P).	The Honorable James Realph, Mayor, City of Blair, 2532 College Drive, Blair, NE 68008.	City Hall, 218 South 16th Street, Blair, NE 68008.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	310228
Nevada:						
Clark	Unincorporated Areas of Clark County (18–09–0452P).	The Honorable Steve Sisolak, Chairman, Board of Supervisors, Clark County, 500 South Grand Central Parkway, 6th Floor, Las Vegas, NV 89106.	Clark County Office of the Director of Public Works, 500 South Grand Central Parkway, Las Vegas, NV 89155.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 10, 2018	320003
Washoe	Unincorporated Areas of Washoe County (17–09–1979P).	The Honorable Marsha Berkbigler, Chair, Board of Commissioners, Washoe County, 1001 East 9th Street, Reno, NV 89512.	Washoe County Administration Building, Department of Public Works, 1001 East 9th Street, Reno, NV 89512.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 6, 2018	320019
Ohio:						
Hamilton	City of Harrison (17–05–5193P).	The Honorable William Neyer, Mayor, City of Harrison, P.O. Box 286, Harrison, OH 45030.	Community Center, 300 George Street, Harrison, OH 45030.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 10, 2018	390220
Wisconsin:						

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Waukesha ..	Unincorporated Areas of Waukesha County (18–05–2348X).	The Honorable Paul L. Decker, Waukesha County Board Chair, County Courthouse, 515 West Moreland Boulevard, Room C170, Waukesha, WI 53188.	Waukesha County Administrator Center, 515 West Moreland Boulevard, Waukesha, WI 53188.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 16, 2018	550476

[FR Doc. 2018–09698 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4359–DR; Docket ID FEMA–2018–0001]

West Virginia; 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 West Virginia (FEMA–4359–DR), dated April 17, 2018, and related determinations.

DATES: The declaration was issued April 17, 2018.

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 April 17, 2018, 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 West Virginia resulting from severe storms, flooding, landslides, and mudslides during the period of February 14–20, 2018, 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 West Virginia.

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 Public Assistance in the designated areas and Hazard Mitigation throughout the State. 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, Steven S. Ward, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of West Virginia have been designated as adversely affected by this major disaster:

Brooke, Cabell, Calhoun, Doddridge, Hancock, Harrison, Lincoln, Logan, Marshall, Mason, Monongalia, Ohio, Pleasants, Preston, Ritchie, Taylor, Tyler, Wayne, Wetzel, Wirt, and Wood Counties(21).

All areas within the State of West Virginia are eligible 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.

Brock Long,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2018–09700 Filed 5–7–18; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2018–0002; Internal Agency Docket No. FEMA–B–1823]

Proposed Flood Hazard Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: Comments are requested on proposed flood hazard determinations, which may include additions or modifications of any Base Flood Elevation (BFE), base flood depth, Special Flood Hazard Area (SFHA) boundary or zone designation, or regulatory floodway on the Flood Insurance Rate Maps (FIRMs), and where applicable, in the supporting Flood Insurance Study (FIS) reports for the communities listed in the table below. The purpose of this notice is to seek general information and comment regarding the preliminary FIRM, and where applicable, the FIS report that the Federal Emergency Management Agency (FEMA) has provided to the affected communities. The FIRM and FIS report are the basis of the floodplain management measures that the community is required either to adopt or to show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP). In addition, the FIRM and FIS report, once effective, will be used by insurance agents and others to calculate appropriate flood insurance premium rates for new buildings and the contents of those buildings.

DATES: Comments are to be submitted on or before August 6, 2018.

ADDRESSES: The Preliminary FIRM, and where applicable, the FIS report for each community are available for inspection at both the online location *https://www.fema.gov/preliminary floodhazarddata* and the respective Community Map Repository address listed in the tables below. Additionally,

the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

You may submit comments, identified by Docket No. FEMA–B–1823, to Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov.*

FOR FURTHER INFORMATION CONTACT: Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov;* or visit the FEMA Map Information eXchange (FMIX) online at *https://www.floodmaps.fema.gov/fhm/fmx_main.html.*

SUPPLEMENTARY INFORMATION: FEMA proposes to make flood hazard determinations for each community listed below, in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed flood hazard determinations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities. These flood hazard determinations are used to meet the floodplain management requirements of the NFIP and also are used to calculate the appropriate flood insurance premium rates for new buildings built after the FIRM and FIS report become effective.

The communities affected by the flood hazard determinations are provided in the tables below. Any request for reconsideration of the revised flood hazard information shown on the Preliminary FIRM and FIS report that satisfies the data requirements outlined in 44 CFR 67.6(b) is considered an appeal. Comments unrelated to the flood hazard determinations also will be considered before the FIRM and FIS report become effective.

Use of a Scientific Resolution Panel (SRP) is available to communities in support of the appeal resolution process. SRPs are independent panels of experts in hydrology, hydraulics, and other pertinent sciences established to review conflicting scientific and technical data and provide recommendations for resolution. Use of the SRP only may be exercised after FEMA and local communities have been engaged in a collaborative consultation process for at least 60 days without a mutually acceptable resolution of an appeal. Additional information regarding the SRP process can be found online at *https://www.floodsrp.org/pdfs/srp_overview.pdf.*

The watersheds and/or communities affected are listed in the tables below. The Preliminary FIRM, and where applicable, FIS report for each community are available for inspection at both the online location *https://www.fema.gov/preliminaryfloodhazard data* and the respective Community Map Repository address listed in the tables. For communities with multiple ongoing Preliminary studies, the studies can be identified by the unique project number and Preliminary FIRM date listed in the tables. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Date: May 1, 2018.

David I. Maurstad,

Deputy Associate Administrator for Insurance and Mitigation (Acting), Department of Homeland Security, Federal Emergency Management Agency.

Community	Community map repository address
Mobile County, Alabama and Incorporated Areas Project: 09–04–8023S Preliminary Date: November 15, 2017	
City of Bayou La Batre	City Hall, 13785 South Wintzell Avenue, Bayou La Batre, AL 36509.
City of Chickasaw	City Hall, 224 North Craft Highway, Chickasaw, AL 36611.
City of Citronelle	City Hall, 19135 South Main Street, Citronelle, AL 36522.
City of Creola	City Hall, 9615 Old Highway 43, Creola, AL 36525.
City of Mobile	City Hall, Engineering Department, 205 Government Street, Mobile, AL 36644.
City of Prichard	City Hall, 216 East Prichard Avenue, Prichard, AL 36610.
City of Saraland	Building Department, 933 Saraland Boulevard South, Saraland, AL 36571.
City of Satsuma	City Hall, 5464 Old Highway 43, Satsuma, AL 36572.
City of Semmes	City Hall, 7875 Moffett Road, Suite F, Semmes, AL 36575.
Town of Dauphin Island	Town Hall, 1011 Bienville Boulevard, Dauphin Island, AL 36528.
Town of Mount Vernon	Town Hall, 1565 Boyles Avenue, Mount Vernon, AL 36560.
Unincorporated Areas of Mobile County	Department of Public Works, Engineering Department, Government Plaza, 205 Government Street, Mobile, AL 36644.
Alachua County, Florida and Incorporated Areas Project: 13–04–3149S Preliminary Date: July 17, 2017	
City of Gainesville	Public Works Department, 405 North West 39th Avenue, Gainesville, FL 32609.
Unincorporated Areas of Alachua County	Alachua County Public Works Department, 5620 North West 120th Lane, Gainesville, FL 32653.
Hendry County, Florida and Incorporated Areas Project: 17–04–4566S Preliminary Date: October 16, 2017	
City of Clewiston	Community Development Department, 121 Central Avenue, Clewiston, FL 33440.

Community	Community map repository address
Unincorporated Areas of Hendry County	Hendry County Administrative Office, 640 South Main Street, LaBelle, FL 33935.
Sumter County, Florida and Incorporated Areas Project: 16–04–6907S Preliminary Date: June 9, 2017	
City of Center Hill	Sumter County Department of Emergency Management, 7375 Powell Road, Wildwood, FL 34785.
City of Webster	Sumter County Department of Emergency Management, 7375 Powell Road, Wildwood, FL 34785.
City of Wildwood	City Hall, 100 North Main Street, Wildwood, FL 34785.
Unincorporated Areas of Sumter County	Sumter County Department of Emergency Management, 7375 Powell Road, Wildwood, FL 34785.
Burke County, Georgia and Incorporated Areas Project: 16–04–5708S Preliminary Date: June 15, 2017	
Unincorporated Areas of Burke County	Burke County Courthouse, 602 North Liberty Street, Waynesboro, GA 30830.
DeKalb County, Georgia and Incorporated Areas Project: 17–04–4538S Preliminary Date: August 14, 2017 and December 20, 2017	
City of Atlanta	Department of Planning and Community Development, 55 Trinity Avenue Southwest, Suite 4700, Atlantic, GA 30303.
City of Brookhaven	City Hall, 4362 Peachtree Road, Brookhaven, GA 30319.
City of Chamblee	City Hall, 5468 Peachtree Road, Chamblee, GA 30341.
City of Clarkston	City Hall—Annex, 1055 Rowland Street, Clarkston, GA 30021.
City of Decatur	Leveritt Public Works Building, 2635 Talley Street, Decatur, GA 30030.
City of Doraville	City Hall, 3725 Park Avenue, Doraville, GA 30340.
City of Dunwoody	City Hall, 4800 Ashford Dunwoody Road, Dunwoody, GA 30338.
City of Tucker	City Hall, 4119 Adrian Street, Tucker, GA 30084.
Unincorporated Areas of DeKalb County	DeKalb County Roads and Drainage Department, 727 Camp Road, Decatur, GA 30032.

[FR Doc. 2018–09786 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2018–0002; Internal Agency Docket No. FEMA–B–1825]

Changes in Flood Hazard Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice lists communities where the addition or modification of Base Flood Elevations (BFEs), base flood depths, Special Flood Hazard Area (SFHA) boundaries or zone designations, or the regulatory floodway (hereinafter referred to as flood hazard determinations), as shown on the Flood Insurance Rate Maps (FIRMs), and where applicable, in the supporting Flood Insurance Study (FIS) reports, prepared by the Federal Emergency Management Agency (FEMA) for each community, is appropriate because of new scientific or technical data. The FIRM, and where applicable, portions of the FIS report, have been revised to reflect these flood hazard determinations through issuance of a Letter of Map Revision (LOMR), in accordance with the Code of Federal Regulations. The LOMR will be used by insurance agents and others to calculate appropriate flood insurance premium rates for new buildings and the contents of those buildings. For rating purposes, the currently effective community number is shown in the table below and must be used for all new policies and renewals.

DATES: These flood hazard determinations will be finalized on the dates listed in the table below and revise the FIRM panels and FIS report in effect prior to this determination for the listed communities.

From the date of the second publication of notification of these changes in a newspaper of local circulation, any person has 90 days in which to request through the community that the Deputy Associate Administrator for Insurance and Mitigation reconsider the changes. The flood hazard determination information may be changed during the 90-day period.

ADDRESSES: The affected communities are listed in the table below. Revised flood hazard information for each community is available for inspection at both the online location and the respective community map repository address listed in the table below. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

Submit comments and/or appeals to the Chief Executive Officer of the community as listed in the table below.

FOR FURTHER INFORMATION CONTACT: Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov;* or visit the FEMA Map Information eXchange (FMIX) online at *https://www.floodmaps.fema.gov/fhm/fmx_main.html.*

SUPPLEMENTARY INFORMATION: The specific flood hazard determinations are not described for each community in this notice. However, the online location and local community map repository address where the flood

hazard determination information is available for inspection is provided.

Any request for reconsideration of flood hazard determinations must be submitted to the Chief Executive Officer of the community as listed in the table below.

The modifications are made pursuant to section 201 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.,* and with 44 CFR part 65.

The FIRM and FIS report are the basis of the floodplain management measures that the community is required either to adopt or to show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

These flood hazard determinations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities. The flood hazard determinations are in accordance with 44 CFR 65.4.

The affected communities are listed in the following table. Flood hazard determination information for each community is available for inspection at both the online location and the respective community map repository address listed in the table below. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Dated: May 1, 2018.

David I. Maurstad,

Deputy Associate Administrator for Insurance and Mitigation (Acting), Department of Homeland Security, Federal Emergency Management Agency.

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Arkansas:						
Benton	City of Centerton (17–06–3374P).	The Honorable Bill Edwards, Mayor, City of Centerton, P.O. Box 208, Centerton, AR 72719.	City Hall, 290 Main Street, Centerton, AR 72719.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 16, 2018	050399
Washington	City of Fayetteville (17–06–3037P).	The Honorable Lioneld Jordan, Mayor, City of Fayetteville, 113 West Mountain Street, Fayetteville, AR 72701.	City Hall, 113 West Mountain Street, Fayetteville, AR 72701.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 10, 2018	050216
Colorado:						
Jefferson	City of Arvada (17–08–0958P).	The Honorable Marc Williams, Mayor, City of Arvada, P.O. Box 8101, Arvada, CO 80001.	Engineering Department, 8101 Ralston Road, Arvada, CO 80001.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 13, 2018	085072
Jefferson	City of Arvada (17–08–1484P).	The Honorable Marc Williams, Mayor, City of Arvada, P.O. Box 8101, Arvada, CO 80001.	Engineering Department, 8101 Ralston Road, Arvada, CO 80001.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 27, 2018	085072
Jefferson	Unincorporated areas of Jefferson County (17–08–0958P).	The Honorable Libby Szabo, Chair, Jefferson County Board of Commissioners, 100 Jefferson County Parkway, Golden, CO 80419.	Jefferson County Department of Planning and Zoning, 100 Jefferson County Parkway, Golden, CO 80419.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 13, 2018	080087
Connecticut:						
Fairfield.	Town of Darien (18–01–0005P).	The Honorable Jayme Stevenson, First Selectwoman, Town of Darien, Board of Selectwomen, 2 Renshaw Road, Darien, CT 06820.	Planning and Zoning Department, 2 Renshaw Road, Darien, CT 06820.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 9, 2018	090005
Florida:						
Alachua	Unincorporated areas of Alachua County (17–04–7240P).	The Honorable Lee Pinkoson, Chairman, Alachua County Board of Commissioners, 12 Southeast 1st Street, Gainesville, FL 32601.	Alachua County Public Works Department, 5620 Northwest 120th Lane, Gainesville, FL 32653.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 23, 2018	120001
Charlotte	Unincorporated areas of Charlotte County (18–04–0611P).	The Honorable Ken Doherty, Chairman, Charlotte County Board of Commissioners, 18500 Murdock Circle, Suite 536, Port Charlotte, FL 33948.	Charlotte County Community Development Department, 18400 Murdock Circle, Port Charlotte, FL 33948.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 12, 2018	120061
Monroe	Unincorporated areas of Monroe County (18–04–1687P).	The Honorable David Rice, Mayor, Monroe County Board of Commissioners, 1100 Simonton Street, Key West, FL 33040.	Monroe County Building Department, 2798 Overseas Highway, Marathon, FL 33050.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 9, 2018	125129

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Monroe	Village of Islamorada (18–04–1511P).	The Honorable Chris Sante, Mayor, Village of Islamorada, 86800 Overseas Highway, Islamorada, FL 33036.	Planning and Development Department, 86800 Overseas Highway, Islamorada, FL 33036.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 11, 2018	120424
Pinellas	City of Indian Rocks Beach (18–04–1507P).	Mr. Brently Gregg Mims, Manager, City of Indian Rocks Beach, 1507 Bay Palm Boulevard, Indian Rocks Beach, FL 33785.	Building Department, 1507 Bay Palm Boulevard, Indian Rocks Beach, FL 33785.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 23, 2018	125117
Volusia	City of Daytona Beach (17–04–3592P).	The Honorable Derrick Henry, Mayor, City of Daytona Beach, 301 South Ridgewood Avenue, Daytona Beach, FL 32114.	Utilities Department, 125 Basin Street, Daytona Beach, FL 32114.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 27, 2018	25099
Volusia	Unincorporated areas of Volusia County (17–04–3592P).	The Honorable Ed Kelley, Chairman, Volusia County Council, 123 West Indiana Avenue, Deland, FL 32720.	Volusia County Building and Zoning Division, 123 West Indiana Avenue, Deland, FL 32720.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 27, 2018	125155
Hawaii: Hawaii	Unincorporated areas of Hawaii County (17–09–1285P).	The Honorable Harry Kim, Mayor, Hawaii County, 25 Aupuni Street, Suite 2603, Hilo, HI 96720.	Hawaii County Department of Public Works, Engineer Division, 101 Pauahi Street, Suite 7, Hilo, HI 96720.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 12, 2018	155166
Mississippi: DeSoto.	City of Olive Branch (17–04–5691P).	The Honorable Scott Phillips, Mayor, City of Olive Branch, 9200 Pigeon Roost Road, Olive Branch, MS 38654.	Development & Planning Department, 9200 Pigeon Roost Road, Olive Branch, MS 38654.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 13, 2018	280286
Montana: Mineral.	Unincorporated areas of Mineral County (17–08–1399P).	The Honorable Roman Zylawy, Chairman, Mineral County Board of Commissioners, P.O. Box 550, Superior, MT 59872.	Mineral County Building, 300 River Street, Superior, MT 59872.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 12, 2018	300159
North Carolina: Stokes.	Unincorporated areas of Stokes County (17–04–7748P).	The Honorable Ronnie Mendenhall, Chairman, Stokes County Board of Commissioners, P.O. Box 20, Danbury, NC 27016.	Stokes County Planning and Inspection Department, 1014 Main Street, Danbury, NC 27016.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	370362
Oklahoma: Washington.	City of Bartlesville (17–06–4218P).	The Honorable Dale Copeland, Mayor, City of Bartlesville, 401 South Johnstone Avenue, Bartlesville, OK 74003.	City Hall, 401 South Johnstone Avenue, Bartlesville, OK 74003.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 12, 2018	400220
Pennsylvania:						
Lancaster	City of Lancaster (17–03–2630P).	The Honorable Danene Sorace, Mayor, City of Lancaster, P.O. Box 1599, Lancaster, PA 17608.	City Hall, 120 North Duke Street, Lancaster, PA 17608.	*https://msc.fema.gov/portal/advanceSearch.*	Aug. 3, 2018	420552
Lancaster	Township of East Lampeter (17–03–2630P).	The Honorable David Buckwalter, Chairman, Township of East Lampeter, Board of Supervisors, 2250 Old Philadelphia Pike, Lancaster, PA 17602.	Township Hall, 2250 Old Philadelphia Pike, Lancaster, PA 17602.	*https://msc.fema.gov/portal/advanceSearch.*	Aug. 3, 2018	421771
Lancaster	Township of Lancaster (17–03–2630P).	Mr. William M. Laudien, Manager, Township of Lancaster, 1240 Maple Avenue, Lancaster, PA 17603.	Municipal Office, 1240 Maple Avenue, Lancaster, PA 17603.	*https://msc.fema.gov/portal/advanceSearch.*	Aug. 3, 2018	420553
Lancaster	Township of Manheim (17–03–2630P).	Mr. Sean P. Molchany, Manager-Secretary, Township of Manheim, 1840 Municipal Drive, Lancaster, PA 17601.	Planning and Zoning Department, 1840 Municipal Drive, Lancaster, PA 17601.	*https://msc.fema.gov/portal/advanceSearch.*	Aug. 3, 2018	420556
Tennessee: Wilson.	Unincorporated areas of Wilson County (18–04–1157P).	The Honorable Randall Hutto, Mayor, Wilson County, 228 East Main Street, Room 104, Lebanon, TN 37087.	Wilson County Courthouse, 228 East Main Street, Room 5, Lebanon, TN 37087.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 11, 2018	470207
Texas:						

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Dallas	City of Rowlett (17–06–2228P).	The Honorable Tammy Dana-Bashian, Mayor, City of Rowlett, 4000 Main Street, Rowlett, TX 75088.	Community Development Building, 3901 Main Street, Rowlett, TX 75088.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	480185
Hays	City of Kyle (17–06–4216P).	The Honorable Travis Mitchell, Mayor, City of Kyle, P.O. Box 40, Kyle, TX 78640.	Stormwater Program and Storm Drainage and Flood Risk Mitigation Utility, 100 West Center Street, Kyle, TX 78640.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 12, 2018	481108
Kaufman	City of Terrell (17–06–3844P).	The Honorable D.J. Ory, Mayor, City of Terrell, P.O. Box 310, Terrell, TX 75160.	Engineering Department, 201 East Nash Street, Terrell, TX 75160.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 13, 2018	480416
Kaufman	Unincorporated areas of Kaufman County (17–06–3844P).	The Honorable Bruce Wood, Kaufman County Judge, 100 West Mulberry Street, Kaufman, TX 75142.	Kaufman County Public Works Department, 3003 South Washington Street, Kaufman, TX 75142.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 13, 2018	480411
Tarrant	City of Fort Worth (17–06–4075P).	The Honorable Betsy Price, Mayor, City of Fort Worth, 200 Texas Street, Fort Worth, TX 76102.	Transportation and Public Works Department, 200 Texas Street, Fort Worth, TX 76102.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 16, 2018	480596
Tarrant	City of Fort Worth (17–06–4082P).	The Honorable Betsy Price, Mayor, City of Fort Worth, 200 Texas Street, Fort Worth, TX 76102.	Transportation and Public Works Department, 200 Texas Street, Fort Worth, TX 76102.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 16, 2018	480596
Williamson	Unincorporated areas of Williamson County (17–06–2076P).	The Honorable Dan A. Gattis, Williamson County Judge, 710 South Main Street, Suite 101, Georgetown, TX 78626.	Williamson County Engineering Department, 3151 South East Inner Loop, Suite B, Georgetown, TX 78626.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 12, 2018	481079
Utah: Grand	Unincorporated areas of Grand County (17–08–1595P).	The Honorable Mary McGann, Chair, Grand County Council, 125 East Center Street, Moab, UT 84532.	Grand County Courthouse, 125 East Center Street, Moab, UT 84532.	*https://msc.fema.gov/portal/advancSearch.*	Jul. 20, 2018	490232
Virginia: Prince William.	Unincorporated areas of Prince William County (17–03–1866P).	Mr. Christopher E. Martino, Prince William County Executive, 1 County Complex Court, Prince William, VA 22192.	Prince William County, Department of Public Works, 5 County Complex Court, Prince William, VA 22192.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 12, 2018	510119

[FR Doc. 2018–09697 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2018–0002; Internal Agency Docket No. FEMA–B–1824]

Proposed Flood Hazard Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: Comments are requested on proposed flood hazard determinations, which may include additions or modifications of any Base Flood Elevation (BFE), base flood depth, Special Flood Hazard Area (SFHA) boundary or zone designation, or regulatory floodway on the Flood Insurance Rate Maps (FIRMs), and where applicable, in the supporting Flood Insurance Study (FIS) reports for the communities listed in the table below. The purpose of this notice is to seek general information and comment regarding the preliminary FIRM, and where applicable, the FIS report that the Federal Emergency Management Agency (FEMA) has provided to the affected communities. The FIRM and FIS report are the basis of the floodplain management measures that the community is required either to adopt or to show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP). In addition, the FIRM and FIS report, once effective, will be used by insurance agents and others to calculate appropriate flood insurance premium rates for new buildings and the contents of those buildings.

DATES: Comments are to be submitted on or before August 6, 2018.

ADDRESSES: The Preliminary FIRM, and where applicable, the FIS report for each community are available for inspection at both the online location *https://www.fema.gov/preliminary floodhazarddata* and the respective Community Map Repository address listed in the tables below. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

You may submit comments, identified by Docket No. FEMA–B–1824, to Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov.*

FOR FURTHER INFORMATION CONTACT: Rick Sacbibit, Chief, Engineering Services

Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov;* or visit the FEMA Map Information eXchange (FMIX) online at *https://www.floodmaps.fema.gov/fhm/fmx_main.html.*

SUPPLEMENTARY INFORMATION: FEMA proposes to make flood hazard determinations for each community listed below, in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed flood hazard determinations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities. These flood hazard determinations are used to meet the floodplain management requirements of the NFIP and also are used to calculate the appropriate flood insurance premium rates for new buildings built after the FIRM and FIS report become effective.

The communities affected by the flood hazard determinations are provided in the tables below. Any request for reconsideration of the revised flood hazard information shown on the Preliminary FIRM and FIS report that satisfies the data requirements outlined in 44 CFR 67.6(b) is considered an appeal. Comments unrelated to the flood hazard determinations also will be considered before the FIRM and FIS report become effective.

Use of a Scientific Resolution Panel (SRP) is available to communities in support of the appeal resolution process. SRPs are independent panels of experts in hydrology, hydraulics, and other pertinent sciences established to review conflicting scientific and technical data and provide recommendations for resolution. Use of the SRP only may be exercised after FEMA and local communities have been engaged in a collaborative consultation process for at least 60 days without a mutually acceptable resolution of an appeal. Additional information regarding the SRP process can be found online at *https://www.floodsrp.org/pdfs/srp_overview.pdf.*

The watersheds and/or communities affected are listed in the tables below. The Preliminary FIRM, and where applicable, FIS report for each community are available for inspection at both the online location *https://www.fema.gov/preliminaryfloodhazard data* and the respective Community Map Repository address listed in the tables. For communities with multiple ongoing Preliminary studies, the studies can be identified by the unique project number and Preliminary FIRM date listed in the tables. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Dated: May 1, 2018.

David I. Maurstad,

Deputy Associate Administrator for Insurance and Mitigation (Acting), Department of Homeland Security, Federal Emergency Management Agency.

Community	Community map repository address
Alameda County, California and Incorporated Areas Project: 17–09–0342S Preliminary Date: September 1, 2017	
City of Fremont	Engineering Department, 39550 Liberty Street, Fremont, CA 94538.
City of Hayward	Public Works Administration, 777 B Street, Hayward, CA 94541.
City of Newark	City Administration Building, 37101 Newark Boulevard, Newark, CA 94560.
City of Union City	City Hall, 34009 Alvarado-Niles Road, Union City, CA 94587.

[FR Doc. 2018–09784 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2018–0002; Internal Agency Docket No. FEMA–B–1826]

Changes in Flood Hazard Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice lists communities where the addition or modification of Base Flood Elevations (BFEs), base flood depths, Special Flood Hazard Area (SFHA) boundaries or zone designations, or the regulatory floodway (hereinafter referred to as flood hazard determinations), as shown on the Flood Insurance Rate Maps (FIRMs), and where applicable, in the supporting Flood Insurance Study (FIS) reports, prepared by the Federal Emergency Management Agency (FEMA) for each community, is appropriate because of new scientific or technical data. The FIRM, and where applicable, portions of the FIS report, have been revised to reflect these flood hazard determinations through issuance of a Letter of Map Revision (LOMR), in accordance with applicable Federal Regulations. The LOMR will be used by insurance agents and others to calculate appropriate flood insurance premium rates for new buildings and the contents of those buildings. For rating purposes, the currently effective community number is shown in the table below and must be used for all new policies and renewals.

DATES: These flood hazard determinations will be finalized on the dates listed in the table below and revise the FIRM panels and FIS report in effect prior to this determination for the listed communities.

From the date of the second publication of notification of these changes in a newspaper of local circulation, any person has 90 days in which to request through the community that the Deputy Associate Administrator for Insurance and Mitigation reconsider the changes. The flood hazard determination information may be changed during the 90-day period.

ADDRESSES: The affected communities are listed in the table below. Revised flood hazard information for each community is available for inspection at both the online location and the respective community map repository address listed in the table below.

Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

Submit comments and/or appeals to the Chief Executive Officer of the community as listed in the table below.

FOR FURTHER INFORMATION CONTACT: Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov;* or visit the FEMA Map Information eXchange (FMIX) online at *https://www.floodmaps.fema.gov/fhm/fmx_main.html.*

SUPPLEMENTARY INFORMATION: The specific flood hazard determinations are not described for each community in this notice. However, the online location and local community map repository address where the flood hazard determination information is available for inspection is provided.

Any request for reconsideration of flood hazard determinations must be submitted to the Chief Executive Officer of the community as listed in the table below.

The modifications are made pursuant to section 201 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.,* and with 44 CFR part 65.

The FIRM and FIS report are the basis of the floodplain management measures that the community is required either to adopt or to show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

These flood hazard determinations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own or pursuant to policies established by other Federal, State, or regional entities. The flood hazard determinations are in accordance with 44 CFR 65.4.

The affected communities are listed in the following table. Flood hazard determination information for each community is available for inspection at both the online location and the respective community map repository address listed in the table below. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Dated: May 1, 2018.

David I. Maurstad,

Deputy Associate Administrator for Insurance and Mitigation (Acting), Department of Homeland Security, Federal Emergency Management Agency.

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Arizona:						
Maricopa	City of Avondale (17–09–2069P).	The Honorable Kenneth N. Weise, Mayor, City of Avondale, 11465 West Civic Center Drive, Avondale, AZ 85323.	Development & Engineering Services Department, 11465 West Civic Center Drive, Avondale, AZ 85323.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 27, 2018	040038
Maricopa	City of Glendale (17–09–2330P).	The Honorable Jerry Weiers, Mayor, City of Glendale, 5850 West Glendale Avenue, Glendale, AZ 85301.	City Hall, 5850 West Glendale Avenue, Glendale, AZ 85301.	*https://msc.fema.gov/portal/advanceSearch.*	Aug. 3, 2018	040045
Maricopa	Unincorporated Areas of Maricopa County (17–09–2069P).	The Honorable Steve Chucri, Chairman, Board of Supervisors, Maricopa County, 301 West Jefferson Street, 10th Floor, Phoenix, AZ 85003.	Flood Control District of Maricopa County, 2801 West Durango Street, Phoenix, AZ 85009.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 27, 2018	040037
Maricopa	Unincorporated Areas of Maricopa County (17–09–2330P).	The Honorable Steve Chucri, Chairman, Board of Supervisors, Maricopa County, 301 West Jefferson Street, 10th Floor, Phoenix, AZ 85003.	Flood Control District of Maricopa County, 2801 West Durango Street, Phoenix, AZ 85009.	*https://msc.fema.gov/portal/advanceSearch.*	Aug. 3, 2018	040037
California:						
Kern	City of Delano (18–09–0302P).	The Honorable Grace Vallejo, Mayor, City of Delano, P.O. Box 3010, Delano, CA 93216.	Community Development, 1015 11th Avenue, Delano, CA 93215.	*https://msc.fema.gov/portal/advanceSearch.*	Aug. 3, 2018	060078
Santa Barbara.	City of Carpinteria (17–09–1980P).	The Honorable Fred Shaw, Mayor, City of Carpinteria, 5775 Carpinteria Avenue, Carpinteria, CA 93013.	Public Works Department, 5775 Carpinteria Avenue, Carpinteria, CA 93013.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	060332
Santa Barbara.	Unincorporated Areas of Santa Barbara County (17–09–1980P).	The Honorable Das Williams, Chairman, Board of Supervisors, Santa Barbara County, 105 East Anapamu Street, 4th Floor, Santa Barbara, CA 93101.	Santa Barbara County Public Works Department, Water Resources Division, 130 East Victoria Street, Santa Barbara, CA 93101.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	060331

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Stanislaus	City of Patterson (17–09–2636P).	The Honorable Deborah M. Novelli, Mayor, City of Patterson, 1 Plaza, 1st Floor, Patterson, CA 95363.	Department of Public Works, 33 South Del Puerto Avenue, Patterson, CA 95363.	*https://msc.fema.gov/portal/advanceSearch.*	Aug. 3, 2018	060390
Illinois:						
Adams	City of Quincy (17–05–6103P).	The Honorable Kyle A. Moore, Mayor, City of Quincy, 730 Maine Street, Quincy, IL 62301.	City Hall, 730 Maine Street, Quincy, IL 62301.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 24, 2018	170003
Adams	Unincorporated Areas of Adams County (17–05–6103P).	The Honorable Les Post, Chairman, Adams County Board, Adams County Courthouse, 101 North 54th Street, Quincy, IL 62305.	Adams County Courthouse, 101 North 54th Street, Quincy, IL 62305.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 24, 2018	170001
Cook	Unincorporated Areas of Cook County (17–05–3265P).	The Honorable Toni Preckwinkle, President, Cook County Board, 118 North Clark Street, Room 537, Chicago, IL 60602.	Cook County Building and Zoning Department, 69 West Washington Street, 21st Floor, Chicago, IL 60602.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	170054
Cook	Village of Northbrook (17–05–3265P).	The Honorable Sandra E. Frum, Village President, Village of Northbrook, 1225 Cedar Lane, Northbrook, IL 60062.	Public Works Department, Engineering Division, 655 Huehl Road, Northbrook, IL 60062.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	170132
Indiana:						
Allen	Unincorporated Areas of Allen County (17–05–6157P).	The Honorable Therese M. Brown, President, Allen County Board of Commissioners, Citizens Square, 200 East Berry Street Suite 410, Fort Wayne, IN 46802.	Allen County Department of Planning Services, 200 East Berry Street, Suite 150, Fort Wayne, IN 46802.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 27, 2018	180302
DeKalb	Unincorporated Areas of DeKalb County (17–05–6157P).	The Honorable Donald D. Grogg, President, DeKalb County Board of County Commissioners, 100 South Main Street Courthouse, Auburn, IN 46706.	DeKalb County Planning Commission, 301 South Union Street, Auburn, IN 46706.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 27, 2018	180044
Nevada:						
Washoe	City of Reno (17–09–2191P).	The Honorable Hillary Schieve, Mayor, City of Reno, P.O. Box 1900, Reno, NV 89501.	City Hall Annex, 450 Sinclair Street, Reno, NV 89501.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 31, 2018	320020
Washoe	Unincorporated Areas of Washoe County (17–09–1858P).	The Honorable Marsha Berkbigler, Chair, Board of Commissioners, Washoe County, 1001 East 9th Street, Reno, NV 89512.	Washoe County Administration Building, Department of Public Works, 1001 East 9th Street, Reno, NV 89512.	*https://msc.fema.gov/portal/advanceSearch.*	Aug. 1, 2018	320019
Washoe	Unincorporated Areas of Washoe County (17–09–2191P).	The Honorable Marsha Berkbigler, Chair, Board of Commissioners, Washoe County, 1001 East 9th Street, Reno, NV 89512.	Washoe County Administration Building, Department of Public Works, 1001 East 9th Street, Reno, NV 89512.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 31, 2018	320019
New Jersey:						
Ocean.	Borough of Point Pleasant Beach (18–02–0563P).	The Honorable Stephen D. Reid, Mayor, Borough of Point Pleasant Beach, 416 New Jersey Avenue, Point Pleasant Beach, NJ 08742.	Municipal Building, 416 New Jersey Avenue, Point Pleasant Beach, NJ 08742.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 27, 2018	340388
Wisconsin:						
Monroe	Unincorporated Areas of Juneau County (17–05–4106P).	The Honorable Alan K. Peterson, Chairman, Juneau County Board of Supervisors, 220 East State Street, Mauston, WI 53948.	Juneau County Courthouse, 220 East State Street, Mauston, WI 53948.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	550580

State and county	Location and case No.	Chief executive officer of community	Community map repository	Online location of letter of map revision	Date of modification	Community No.
Monroe	Unincorporated Areas of Monroe County (17–05–4106P).	The Honorable Cedric Schnitzler, Chair, Monroe County Board Committee, 202 South K Street, Room 1, Sparta, WI 54656.	Monroe County Sanitation and Zoning Office, 14307 County Highway B, Sparta, WI 54656.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	550571
Monroe	Village of Kendall (17–05–4106P).	The Honorable Richard Martin, President, Village of Kendall, P.O. Box 216, Kendall, WI 54638.	Village Hall, 219 West South Railroad Street, Kendall, WI 54638.	*https://msc.fema.gov/portal/advanceSearch.*	Jul. 20, 2018	550287

[FR Doc. 2018–09689 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2018–0002; Internal Agency Docket No. FEMA–B–1813]

Proposed Flood Hazard Determinations

AGENCY: Federal Emergency Management Agency; DHS.

ACTION: Notice; correction.

SUMMARY: On April 5, 2018, FEMA published in the **Federal Register** a proposed flood hazard determination notice that contained an erroneous table. This notice provides corrections to that table, to be used in lieu of the information published at 83 FR 14651–14652. The table provided here represents the proposed flood hazard determinations and communities affected for York County, Nebraska and Incorporated Areas.

DATES: Comments are to be submitted on or before August 6, 2018.

ADDRESSES: The Preliminary Flood Insurance Rate Map (FIRM), and where applicable, the Flood Insurance Study (FIS) report for each community are available for inspection at both the online location and the respective Community Map Repository address listed in the table below. Additionally, the current effective FIRM and FIS report for each community are accessible online through the FEMA Map Service Center at *https://msc.fema.gov* for comparison.

You may submit comments, identified by Docket No. FEMA–B–1813, to Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov.*

FOR FURTHER INFORMATION CONTACT: Rick Sacbibit, Chief, Engineering Services Branch, Federal Insurance and Mitigation Administration, FEMA, 400 C Street SW, Washington, DC 20472, (202) 646–7659, or (email) *patrick.sacbibit@fema.dhs.gov;* or visit the FEMA Map Information eXchange (FMIX) online at *https://www.floodmaps.fema.gov/fhm/fmx_main.html.*

SUPPLEMENTARY INFORMATION: FEMA proposes to make flood hazard determinations for each community listed in the table below, in accordance with Section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed flood hazard determinations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, State, or regional entities. These flood hazard determinations are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after the FIRM and FIS report become effective.

Use of a Scientific Resolution Panel (SRP) is available to communities in support of the appeal resolution process. SRPs are independent panels of experts in hydrology, hydraulics, and other pertinent sciences established to review conflicting scientific and technical data and provide recommendations for resolution. Use of the SRP may only be exercised after FEMA and local communities have been engaged in a collaborative consultation process for at least 60 days without a mutually acceptable resolution of an appeal. Additional information regarding the SRP process can be found online at *https://floodsrp.org/pdfs/srp_fact_sheet.pdf.*

The communities affected by the flood hazard determinations are provided in the table below. Any request for reconsideration of the revised flood hazard determinations shown on the Preliminary FIRM and FIS report that satisfies the data requirements outlined in 44 CFR 67.6(b) is considered an appeal. Comments unrelated to the flood hazard determinations will also be considered before the FIRM and FIS report are made final.

Correction

In the proposed flood hazard determination notice published at 83 FR 14651—14652 in the April 5, 2018, issue of the **Federal Register**, FEMA published a table titled ''York County, Nebraska and Incorporated Areas''. This table contained inaccurate information as to the communities affected by the proposed flood hazard determinations featured in the table.

In this document, FEMA is publishing a table containing the accurate information. The information provided below should be used in lieu of that previously published.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Date: May 1, 2018.

David I. Maurstad,

Deputy Associate Administrator for Insurance and Mitigation (Acting), Department of Homeland Security, Federal Emergency Management Agency.

Community	Community map repository address
York County, Nebraska and Incorporated Areas	
Project: 16–07–0767S Preliminary Dates: July 12, 2017 and December 11, 2017	
City of Henderson	City Hall, 1044 North Main Street, Henderson, NE 68371.
City of York	Municipal Building, 100 East 4th Street, York, NE 68467.
Unincorporated Areas of York County	York County Courthouse, 510 North Lincoln Avenue, York, NE 68467.
Village of Benedict	Village Office, 206 Sherman Street, Benedict, NE 68316.
Village of Bradshaw	Village Office, 455 Lincoln Street, Bradshaw, NE 68319.
Village of Gresham	Village Office, 310 Elm Street, Gresham, NE 68367.
Village of McCool Junction	Village Office, 323 East M Street, McCool Junction, NE 68401.
Village of Thayer	Village of Thayer Clerk's Office, 401 4th Street, Waco, NE 68460.
Village of Waco	Village Office, 403 Midland Street, Waco, NE 68460.

[FR Doc. 2018–09787 Filed 5–7–18; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4312–DR; Docket ID FEMA–2018–0001]

Resighini Rancheria; Amendment No. 2 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 for the Resighini Rancheria (FEMA–4312–DR), dated May 2, 2017, and related determinations.

DATES: This amendment was issued April 19, 2018.

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 April 19, 2018, the President amended the cost-sharing arrangements regarding Federal funds provided under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), in a letter to Brock Long, Administrator, Federal Emergency Management Agency, Department of Homeland Security, under Executive Order 12148, as follows:

I have determined that the damage to the Resighini Rancheria resulting from flooding during the period of February 8–11, 2017, is of sufficient severity and magnitude that special cost-sharing arrangements are warranted regarding Federal funds provided under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act'').

Therefore, I amend my declaration of May 2, 2017, to authorize Federal funds for all categories of Public Assistance at 90 percent of total eligible costs.

This adjustment to the cost sharing applies only to Public Assistance costs and direct Federal assistance eligible for such adjustments under the law. The Robert T. Stafford Disaster Relief and Emergency Assistance Act specifically prohibits a similar adjustment for funds provided for the Hazard Mitigation Grant Program (Section 404). These funds will continue to be reimbursed at 75 percent of total eligible costs.

(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.

Brock Long,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2018–09781 Filed 5–7–18; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

[Docket No. DHS–2018–0013]

Privacy Act of 1974; System of Records

AGENCY: Department of Homeland Security.

ACTION: Notice of Modified System of Records.

SUMMARY: In accordance with the Privacy Act of 1974, the Department of Homeland Security (DHS) proposes to modify, rename, and reissue a current DHS U.S. Immigration and Customs Enforcement (ICE) system of records titled, ''Department of Homeland Security (DHS)/U.S. Immigration and Customs Enforcement (ICE)–007 Alien Criminal Response Information Management (ACRIMe).'' This system of records allows the Department to receive and respond to criminal history and immigration status inquiries made by federal, state, and local law enforcement agencies, and other federal agencies, including the Office of Personnel Management (OPM) and the Department of Health and Human Services (HHS). This system of records notice (SORN) covers records the Department collects and maintains on individuals who are: Arrested; screened as part of a background check to determine suitability for employment, access, or other purposes; screened to verify or ascertain citizenship or immigration status, immigration history, and criminal history to inform an HHS determination regarding sponsorship of an unaccompanied alien child; or otherwise encountered by federal, state, and local law enforcement agencies. DHS may also use information maintained in this system of records for other purposes consistent with its statutory authorities.

As a result of a biennial review of this system, the Department is updating this SORN to: Change the system of records name to Criminal History and Immigration Verification (CHIVe); add one new category of individuals to include individuals seeking approval from HHS to sponsor an unaccompanied alien child and/or other adult members of the potential sponsor's household; add one new category of records to include biometrics for potential sponsors of an unaccompanied alien child and/or other adult members of the potential sponsor's household; expand a category of records to include screening to verify or ascertain citizenship or immigration status, immigration history, and criminal history for sponsorship of unaccompanied alien children; add a

new purpose of the system: To screen individuals to verify or ascertain citizenship or immigration status, immigration history, and criminal history to inform determinations regarding sponsorship of unaccompanied alien children who are in the care and custody of HHS; add a new routine use to describe how the DHS may share information from this system of records with HHS; modify routine use (E) and add routine use (F) to conform to Office of Management and Budget (OMB) Memorandum M–17–12 ''Preparing for and Responding to a Breach of Personally Identifiable Information'' (Jan. 3, 2017); revise the records retention periods so that they align with the records schedule approved by the National Archives and Records Administration (NARA); and clarify that DHS may use information maintained in this system of records for other purposes consistent with its statutory authorities.

Because this system will no longer cover information related to public tips, ICE is also updating the SORN to: Remove two categories of individuals; remove two categories of records; remove one routine use that allows DHS to disclose reports of suspicious activity, tips, potential violations of law, and other relevant information to external law enforcement agencies; and remove four purposes for the collection of information. Additionally, this notice includes non-substantive changes to simplify the formatting and text of the previously published notice. This modified system of records will be included in DHS's inventory of record systems. ICE will issue a new Privacy Act rulemaking, elsewhere in the **Federal Register**.

DATES: Submit comments on or before June 7, 2018. This modified system of records notice will be effective upon publication. New or modified routine uses will be effective June 7, 2018.

ADDRESSES: You may submit comments, identified by docket number DHS–2018–0013 by one of the following methods:

- *Federal e-Rulemaking Portal*: *http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax*: 202–343–4010.
- *Mail*: Philip S. Kaplan, Chief Privacy Officer, Privacy Office, Department of Homeland Security, Washington, DC 20528–0655.

Instructions: All submissions received must include the agency name and docket number for this notice DHS–2018–0013. All comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided.

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: For general questions, please contact: Amber Smith, Privacy Officer, U.S. Immigration and Customs Enforcement, Washington, DC 20536–5600, (202) 732–3300, *ICEPrivacy@ice.dhs.gov.* For privacy questions, please contact: Philip S. Kaplan, *Privacy@hq.dhs.gov,* (202) 343–1717, Chief Privacy Officer, Privacy Office, Department of Homeland Security, Washington, DC 20528–0655.

SUPPLEMENTARY INFORMATION:

I. Background

In accordance with the Privacy Act of 1974, 5 U.S.C. 552a, DHS, U.S. Immigration and Customs Enforcement (ICE) proposes to modify, rename, and reissue a current DHS system of records notice (SORN) titled, ''DHS/ICE–007 Alien Criminal Response Information Management (ACRIMe),'' 78 FR 10623 (Feb. 14, 2013).

The DHS/ICE update to ACRIMe includes several changes. First, the system of records is being renamed ''Criminal History and Immigration Verification (CHIVe)'' to better align with the purpose of the system. This system of records covers records documenting inquiries received from federal, state, and local law enforcement agencies so ICE can check the immigration status and criminal history of individuals who are arrested or otherwise encountered by those agencies; and other federal agencies for screening (including as part of background checks being conducted by those agencies) to inform those agencies' determinations regarding suitability for employment, access, sponsorship of an unaccompanied alien child, or other purposes or otherwise encountered by those agencies.

Second, DHS is adding a purpose of the system, as ICE will now screen individuals seeking approval from HHS to sponsor an unaccompanied alien child, as well as other adult members of the potential sponsor's household, to verify or ascertain citizenship or immigration status, immigration history, and criminal history.

Third, DHS is clarifying that DHS may use information maintained in this system of records for other purposes consistent with its statutory authorities.

Fourth, this update adds a new category of individuals: Those seeking approval from HHS to sponsor an unaccompanied alien child and/or other adult members of the potential sponsor's household.

Fifth, DHS is adding one category of records to include biometrics for potential sponsors and/or other adult members of the potential sponsor's household. DHS has also modified a category of records to include citizenship or immigration status and criminal and immigration history information for sponsorship of unaccompanied alien children.

Sixth, DHS is adding one new routine use that would allow ICE to share from this system of records the results of screening of potential sponsors and adult members of their households with HHS to inform HHS's determination whether to grant sponsor applications. Below is a summary of the new routine use and its corresponding letter:

(HH) To HHS, the citizenship or immigration status, immigration history, criminal history information, and other biographic information of potential sponsors for unaccompanied alien children and other adult members of the potential sponsors' households to inform an HHS determination regarding sponsorship of an unaccompanied alien child.

DHS is also modifying routine use (E) and adding routine use (F) to conform to Office of Management and Budget (OMB) Memorandum M–17–12 ''Preparing for and Responding to a Breach of Personally Identifiable Information'' (Jan. 3, 2017). All following routine uses are being renumbered to account for the additional routine use.

Seventh, DHS is revising the records retention periods so that they align with the records retention schedule approved by the National Archives and Records Administration (NARA).

Finally, DHS is modifying this SORN since this system will no longer store information pertaining to the collection, processing, and response to public tip information concerning customs and immigration violations, suspicious activity, or other law enforcement matters. ICE will continue to collect information about individuals reporting tips, the subjects of such tips, and any information ICE collects in following up on a tip in the DHS/ICE–016 FALCON Search and Analysis System of Records, 82 FR 20905 (May 4, 2017).

As a result, the following changes are being made: (1) Two categories of individuals are being removed from the system—individuals who report tips and individuals about whom those reports are made; (2) two categories of records are being removed from the system—those public tip records, which consist of information contained in tips

received from the public or other sources regarding customs and immigration violations, other actual or potential violations of law, and suspicious activities; and also records created pertaining to ICE's follow-up activities regarding a tip; (3) one routine use is being removed from the system that allows DHS to disclose reports of suspicious activity, tips, potential violations of law, and other relevant information to external law enforcement agencies; and (4) four purposes for the collection of information are being removed from the system. Purpose (4) in the prior iteration of this SORN has been removed as it pertains to public tip records. Purposes (5), (6), and (7) have been removed since these purposes are more focused on ICE's Law Enforcement Support Center (LESC) rather than the system as a whole.

Information stored in the DHS/ICE–007 Criminal History and Immigration Verification (CHIVe) System of Records may be shared with other DHS components that have a need to know the information to carry out their national security, law enforcement, immigration, intelligence, or other homeland security functions. In addition, ICE may share information with appropriate federal, state, local, tribal, territorial, foreign, or international government agencies consistent with the routine uses set forth in this SORN. This modified system of records will be included in DHS's inventory of record systems. Further, ICE will issue a new rule covering exemptions for this modified SORN elsewhere in the **Federal Register**.

II. Privacy Act

The Privacy Act embodies fair information practice principles in a statutory framework governing the means by which Federal Government agencies collect, maintain, use, and disseminate individuals' records. The Privacy Act applies to information that is maintained in a ''system of records.'' A ''system of records'' is a group of any records under the control of an agency from which information is retrieved by the name of an individual or by some identifying number, symbol, or other identifying particular assigned to the individual. In the Privacy Act, an individual is defined to encompass U.S. citizens and lawful permanent residents. Additionally, the Judicial Redress Act (JRA) provides covered persons with a statutory right to make requests for access and amendment to covered records, as defined by the JRA, along with judicial review for denials of such requests. In addition, the JRA prohibits disclosures of covered records, except as otherwise permitted by the Privacy Act.

Below is the description of the DHS/ICE–007 Criminal History and Immigration Verification (CHIVe) System of Records.

In accordance with 5 U.S.C. 552a(r), DHS has provided a report of this system of records to the Office of Management and Budget and to Congress.

SYSTEM NAME AND NUMBER:

Department of Homeland Security (DHS)/U.S. Immigration and Customs Enforcement (ICE)–007 Criminal History and Immigration Verification (CHIVe) System of Records.

SECURITY CLASSIFICATION:

Unclassified.

SYSTEM LOCATION:

Records are maintained at the ICE Headquarters in Washington, DC and ICE field offices. Records are also maintained in the ACRIMe information technology system, and the DHS Data Centers in Washington, DC.

SYSTEM MANAGER(S):

Unit Chief, Law Enforcement Support Center, U.S. Immigration and Customs Enforcement, 188 Harvest Lane, Williston, VT 05495; Unit Chief, Juvenile and Family Residential Management Unit, U.S. Immigration and Customs Enforcement, 500 12th Street SW, Washington, DC 20536.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

8 U.S.C. secs. 1103, 1226, 1227, 1228, 1231, 1232, 1357, 1360; 19 U.S.C. 1589a; and the Brady Handgun Violence Protection Act of 1993 (Pub. L. 103–159).

PURPOSE(S) OF THE SYSTEM:

The purposes of this system are: (1) To assist in identifying and arresting individuals in the United States who may be subject to removal under the Immigration and Nationality Act, as amended; (2) To respond to inquiries from criminal justice agencies that seek to determine the immigration status of an individual in the context of a criminal justice matter for the purpose of identifying and arresting those who may be subject to removal; (3) To screen individuals to verify or ascertain citizenship or immigration status, immigration history, and criminal history to inform determinations regarding sponsorship of unaccompanied alien children who are in the care and custody of HHS and to identify and arrest those who may be subject to removal; and (4) To inform criminal justice agencies and agencies conducting background checks whether an individual is under investigation and/or wanted by ICE or other criminal justice agencies.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Categories of individuals covered in this system include:

(1) Individuals who are the subjects of immigration status inquiries submitted to ICE or immigration checks conducted by ICE, including:

A. Individuals who are encountered by, arrested by, under the investigation of, or in the custody of a criminal justice agency.

B. Individuals convicted of sexual offenses required to register as a sexual offender.

C. Individuals subject to background checks or investigations by or under the authority of a federal, state, local, tribal, or territorial agency to determine eligibility or suitability for employment, access, or other purposes.

D. Individuals applying to obtain/purchase a firearm in the United States and whose information has been submitted to ICE for the purpose of conducting an immigration status check in support of background checks required by the Brady Handgun Violence Protection Act (Brady Act) or other applicable laws.

(2) Individuals who are the subjects of criminal arrest warrants and immigration lookouts that ICE has entered into the Federal Bureau of Investigation's (FBI) National Crime Information Center (NCIC) System.

(3) Individuals seeking approval from HHS to sponsor an unaccompanied alien child, and/or other adult members of the potential sponsor's household.

(4) Law enforcement officers or other personnel working for criminal justice agencies who contact ICE for reasons relating to the purposes of this system of records, or for other law enforcement assistance.

CATEGORIES OF RECORDS IN THE SYSTEM:

Categories of records in this system include:

- Biographic identifiers, other identifiers, and contact information (*e.g.,* name, aliases, date and place of birth, address, telephone number, Social Security number (SSN), Alien Registration Number (A-Number), driver's license number, other personal identification numbers, fingerprint identification number, passport number);
- Visa, border, immigration and citizenship information (*e.g.,* citizenship and/or immigration status, application

for benefit information, visa and travel history);

• Criminal history information (*e.g.,* FBI number, booking number, current charge[s], custodial status, past offenses and convictions);

• NCIC hit confirmation records, which consist of information supporting the entry of criminal warrants or immigration lookouts into the NCIC system, such as criminal arrest warrant information, fingerprints and photographs, other information identifying the individual, and records reflecting the purpose/basis for the warrant or lookout. Records of inquiries received from criminal justice agencies regarding potential matches against ICE-created NCIC records, and records pertaining to ICE's research, resolution, and response to those inquiries;

• Background investigation records, which consist of identifying and other information received from agencies requesting an immigration status check and/or criminal history check on individuals as part of a background check for employment, gun ownership, or other reasons; research conducted by ICE during the conduct of the immigration status check; and ICE's research, resolution, and response to those inquiries;

• Sponsor screening records, which consist of identifying and other information received from HHS regarding potential sponsors of unaccompanied alien children and other adult members of the potential sponsor's household; research conducted by ICE during such screening; and ICE's response to those inquiries.

• Biometric identifiers (potential sponsors for unaccompanied alien children and other adult members of the potential sponsors' household only);

• Criminal justice immigration status check records, which consist of identifying and other information received from criminal justice agencies requesting an immigration status check on individuals in the context of a criminal justice matter; prioritization of requests; research conducted by ICE during the conduct of the immigration status check; and ICE's research, resolution, and response to those inquiries;

• Information received pursuant to the activities supported by this system of records, including leads for ICE investigations and referrals to other agencies; and

• Identification and authentication information for law enforcement officers or other criminal justice personnel who contact ICE.

RECORD SOURCE CATEGORIES:

Records are obtained from ICE, other federal, state, local, tribal, foreign, and international criminal justice entities (*e.g.,* law enforcement agencies, investigators, prosecutors, correctional institutions, police departments, and parole boards), and other Federal Government agencies.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND PURPOSES OF SUCH USES:

In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, all or a portion of the records or information contained in this system may be disclosed outside DHS as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows:

A. To the Department of Justice (DOJ), including the U.S. Attorneys Offices, or other federal agency conducting litigation or proceedings before any court, adjudicative, or administrative body, when it is relevant or necessary to the litigation and one of the following is a party to the litigation or has an interest in such litigation:

1. DHS or any component thereof;

2. Any employee or former employee of DHS in his/her official capacity;

3. Any employee or former employee of DHS in his/her individual capacity, only when DOJ or DHS has agreed to represent the employee; or

4. The United States or any agency thereof.

B. To a congressional office from the record of an individual in response to an inquiry from that congressional office made at the request of the individual to whom the record pertains.

C. To the National Archives and Records Administration (NARA) or General Services Administration pursuant to records management inspections being conducted under the authority of 44 U.S.C. 2904 and 2906.

D. To an agency or organization for the purpose of performing audit or oversight operations as authorized by law, but only such information as is necessary and relevant to such audit or oversight function.

E. To appropriate agencies, entities, and persons when (1) DHS suspects or has confirmed that there has been a breach of the system of records; (2) DHS has determined that as a result of the suspected or confirmed breach there is a risk of harm to individuals, DHS (including its information systems, programs, and operations), the Federal Government, or national security; and (3) the disclosure made to such agencies, entities, and persons is reasonably necessary to assist in connection with DHS's efforts to respond to the suspected or confirmed breach or to prevent, minimize, or remedy such harm.

F. To another Federal agency or Federal entity, when DHS determines that information from this system of records is reasonably necessary to assist the recipient agency or entity in (1) responding to a suspected or confirmed breach or (2) preventing, minimizing, or remedying the risk of harm to individuals, the recipient agency or entity (including its information systems, programs, and operations), the Federal Government, or national security, resulting from a suspected or confirmed breach.

G. To contractors and their agents, grantees, experts, consultants, and others performing or working on a contract, service, grant, cooperative agreement, or other assignment for DHS, when necessary to accomplish an agency function related to this system of records. Individuals provided information under this routine use are subject to the same Privacy Act requirements and limitations on disclosure as are applicable to DHS officers and employees.

H. To an appropriate federal, state, tribal, local, international, or foreign law enforcement agency or other appropriate authority charged with investigating or prosecuting a violation or enforcing or implementing a law, rule, regulation, or order, when a record, either on its face or in conjunction with other information, indicates a violation or potential violation of law, which includes criminal, civil, or regulatory violations and such disclosure is proper and consistent with the official duties of the person making the disclosure.

I. To federal, state, local, tribal, territorial, foreign, or international agencies, if the information is relevant and necessary to a requesting agency's decision concerning individuals who are being screened with respect to their participation in, attendance at, or other relation to a national or special security event.

J. To domestic governmental agencies seeking to determine the immigration status of persons who have applied to purchase/obtain a firearm in the United States, pursuant to checks conducted on such persons under the Brady Handgun Violence Prevention Act or other applicable laws.

K. To federal, state, local, tribal, territorial, or international agencies seeking to verify or ascertain the citizenship or immigration status of any individual within the jurisdiction of the agency for any purpose authorized by law.

L. To courts, magistrates, administrative tribunals, opposing counsel, parties, and witnesses, in the course of immigration, civil, or criminal proceedings (including discovery, presentation of evidence, and settlement negotiations) and when DHS determines that use of such records is relevant and necessary to the litigation before a court or adjudicative body when any of the following is a party to or have an interest in the litigation:

1. DHS or any component thereof;

2. Any employee of DHS in his/her official capacity;

3. Any employee of DHS in his/her individual capacity when the Government has agreed to represent the employee; or

4. The United States, when DHS determines that litigation is likely to affect DHS or any of its components.

M. To the DOJ, Federal Bureau of Prisons (BOP), and other federal, state, local, territorial, tribal, and foreign law enforcement or custodial agencies for the purpose of placing an immigration detainer on an individual in that agency's custody, or to facilitate the transfer of custody of an individual to DHS from the other agency.

N. To a former employee of DHS for purposes of responding to an official inquiry by federal, state, local, tribal, territorial government agencies, or professional licensing authorities; or facilitating communications with a former employee that may be relevant and necessary for personnel-related or other official purposes when DHS requires information or consultation assistance from the former employee regarding a matter within that person's former area of responsibility.

O. To federal, state, local, tribal, territorial, or foreign government agencies, as well as to other individuals and organizations during the course of an investigation by DHS or the processing of a matter under DHS's jurisdiction, or during a proceeding within the purview of the immigration and nationality laws, when DHS deems that such disclosure is necessary to carry out its functions and statutory mandates or to elicit information required by DHS to carry out its functions and statutory mandates.

P. To international, foreign, intergovernmental, and multinational government agencies, authorities, and organizations in accordance with law and formal or informal international arrangements.

Q. To OMB in connection with the review of private relief legislation as set forth in OMB Circular No. A–19 at any stage of the legislative coordination and clearance process as set forth in the Circular.

R. To the U.S. Senate Committee on the Judiciary or the U.S. House of Representatives Committee on the Judiciary when necessary to inform members of Congress about an alien who is being considered for private immigration relief.

S. To the Department of State when it requires information to consider and/or provide an informed response to a request for information from a foreign, international, or intergovernmental agency, authority, or organization about an alien or an enforcement operation with transnational implications.

T. To federal, state, local, territorial, tribal, international, or foreign criminal, civil, or regulatory law enforcement authorities when the information is necessary for collaboration, coordination, and de-confliction of investigative matters, prosecutions, and/or other law enforcement actions to avoid duplicative or disruptive efforts and to ensure the safety of law enforcement officers who may be working on related law enforcement matters.

U. To federal, state, local, tribal, territorial, or foreign government agencies or entities or multinational government agencies, with the approval of the Chief Privacy Officer, when DHS desires to exchange relevant data for the purpose of developing, testing, or implementing new software or technology whose purpose is related to this system of records.

V. To prospective claimants and their attorneys for the purpose of negotiating the settlement of an actual or prospective claim against DHS or its current or former employees, in advance of the initiation of formal litigation or proceedings.

W. To federal and foreign government intelligence or counterterrorism agencies or components when DHS becomes aware of an indication of a threat or potential threat to national or international security, or when such disclosure is to support the conduct of national intelligence and security investigations or to assist in anti-terrorism efforts.

X. To the DOJ, Federal Bureau of Investigation (FBI) in order to facilitate responses to fingerprint-based immigration status queries that are sent to ICE, including queries that the FBI sends on behalf of another agency.

Y. To federal, state, local, tribal, territorial, international, or foreign government agencies or entities for the purpose of consulting with that agency or entity:

1. To assist in making a determination regarding redress for an individual in connection with the operations of a DHS component or program;

2. To verify the identity of an individual seeking redress in connection with the operations of a DHS component or program; or

3. To verify the accuracy of information submitted by an individual who has requested such redress on behalf of another individual.

Z. To federal, state, local, tribal, territorial, foreign, or international agencies, if the information is relevant and necessary to a requesting agency's decision concerning the hiring or retention of an individual, or the issuance, grant, renewal, suspension, or revocation of a security clearance, license, contract, grant, or other benefit; or to the extent necessary to obtain information relevant and necessary to a DHS decision concerning the hiring or retention of an employee, the issuance of a security clearance, the reporting of an investigation of an employee, the letting of a contract, or the issuance of a license, grant or other benefit.

AA. To federal, state, local, tribal, territorial, foreign, or international agencies, if DHS determines (1) the information is relevant and necessary to the agency's decision concerning the hiring or retention of an individual, or the issuance of a security clearance, license, contract, grant, or other benefit, and (2) failure to disclose the information is likely to create a risk to government facilities, equipment, or personnel; sensitive information; critical infrastructure; or the public safety.

BB. To federal, state, local, tribal, territorial, foreign, or international agencies seeking information on the subjects of wants, warrants, or lookouts, or any other subject of interest, for purposes related to administering or enforcing the law, national security, immigration, or intelligence, when consistent with a DHS mission-related function.

CC. To federal, state, local, tribal, territorial, or foreign government agencies or organizations, or international organizations, lawfully engaged in collecting law enforcement intelligence, whether civil or criminal, to enable these entities to carry out their law enforcement responsibilities, including the collection of law enforcement intelligence.

DD. To foreign governments in order to notify them concerning an alien who is incapacitated, an unaccompanied minor, or deceased.

EE. To federal, state, local, tribal, and territorial courts or government agencies involved in criminal investigation or

prosecution, pretrial services, sentencing, parole, probation, bail bonds, child welfare services, or any other aspect of the criminal justice process, and to counsel representing an individual in a criminal, civil, or child welfare proceeding, in order to ensure the integrity of the justice system by informing these recipients of the existence of an immigration detainer on that individual or that individual's status in removal proceedings, including removal, voluntary departure, or custodial status/location. Disclosure of that individual's Alien Registration Number (A-Number) and country of birth is also authorized to facilitate use of the ICE Online Detainee Locator System by the aforementioned individuals and agencies. This routine use does not authorize disclosure to bail bond companies or agents.

FF. To appropriate federal, state, local, tribal, foreign or international criminal justice agencies, or other authorized users of NCIC, to respond to inquiries regarding a person who is or may be the subject of an ICE-generated NCIC criminal arrest warrant or immigration lookout record.

GG. To the U.S. Department of Health and Human Services (HHS), the citizenship or immigration status, immigration history, criminal history information, and other biographic information of potential sponsors for unaccompanied alien children and other adult members of the potential sponsors' households to inform an HHS determination regarding sponsorship of an unaccompanied alien child.

HH. To the news media and the public, with the approval of the Chief Privacy Officer in consultation with counsel, when there exists a legitimate public interest in the disclosure of the information, when disclosure is necessary to preserve confidence in the integrity of DHS, or when disclosure is necessary to demonstrate the accountability of DHS's officers, employees, or individuals covered by the system, except to the extent the Chief Privacy Officer determines that release of the specific information in the context of a particular case would constitute a clearly unwarranted invasion of personal privacy.

POLICIES AND PRACTICES FOR STORAGE OF RECORDS:

DHS/ICE stores records in this system electronically or on paper in secure facilities in a locked drawer behind a locked door. The records may be stored on magnetic disc, tape, and digital media.

POLICIES AND PRACTICES FOR RETRIEVAL OF RECORDS:

DHS/ICE retrieves records by personal, biographic, or biometric identifiers such as name, date of birth, place of birth, address, A-Number(s), FBI criminal history number(s), Social Security number, Fingerprint Identification Number, and passport number.

POLICIES AND PRACTICES FOR RETENTION AND DISPOSAL OF RECORDS:

In accordance with Records Control Schedule DAA–0567–2017–0002, ICE retains the Immigration Alien Query (IAQ) and Immigration Alien Response (IAR) records pertaining to traditional law enforcement checks, non-criminal biographical and biometric investigations; and ICE-generated FBI NCIC records for seventy-five (75) years. Records collected pursuant to the Brady Act, special security events, and OPM checks will be kept for five (5) years from the date an immigration status determination is made and an IAR returned, after which the records will be deleted from the ACRIMe information technology system. Furthermore, ICE is proposing to NARA to maintain records pertaining to the sponsorship of unaccompanied alien children for five (5) years. Until these records are officially scheduled, they will be treated as permanent and cannot be deleted.

ADMINISTRATIVE, TECHNICAL, AND PHYSICAL SAFEGUARDS:

DHS/ICE safeguards records in this system according to applicable rules and policies, including all applicable DHS automated systems security and access policies. ICE has imposed strict controls to minimize the risk of compromising the information that is being stored. Access to the computer system containing the records in this system is limited to those individuals who have a need to know the information for the performance of their official duties and who have appropriate clearances or permissions.

RECORD ACCESS PROCEDURES:

The Secretary of Homeland Security has exempted this system from the notification, access, and amendment procedures of the Privacy Act, and the JRA if applicable, because it is a law enforcement system. However, DHS/ICE will consider individual requests to determine whether or not information may be released. Thus, individuals seeking access to and notification of any record contained in this system of records, or seeking to contest its content, may submit a request in writing to the ICE Freedom of Information Act (FOIA) Officer, whose contact information can be found at *http://www.dhs.gov/foia* under ''Contact Information.'' If an individual believes more than one component maintains Privacy Act records concerning him or her, the individual may submit the request to the Chief Privacy Officer and Chief Freedom of Information Act Officer, Department of Homeland Security, Washington, DC 20528–0655. Even if neither the Privacy Act nor the JRA provides a right of access, certain records about the individual may be available under FOIA.

When an individual is seeking records about himself or herself from this system of records or any other Departmental system of records, the individual's request must conform with the Privacy Act regulations set forth in 6 CFR part 5. The individual must first verify his or her identity, meaning that the individual must provide his or her full name, current address, and date and place of birth. The individual must sign the request, and the individual's signature must either be notarized or submitted under 28 U.S.C. 1746, a law that permits statements to be made under penalty of perjury as a substitute for notarization. While no specific form is required, an individual may obtain forms for this purpose from the Chief Privacy Officer and Chief FOIA Officer, *http://www.dhs.gov/foia* or 1–866–431–0486. In addition, the individual should:

- Explain why he or she believe the Department would have information being requested;
- Identify which component(s) of the Department the individual believes may have the information about him or her;
- Specify when the individual believes the records would have been created; and
- Provide any other information that will help the FOIA staff determine which DHS component agency may have responsive records;

If an individual's request is seeking records pertaining to another living individual, the first individual must include a statement from the second individual certifying his/her agreement for the first individual to access his or her records.

Without the above information, the component(s) may not be able to conduct an effective search, and the individual's request may be denied due to lack of specificity or lack of compliance with applicable regulations.

CONTESTING RECORD PROCEDURES:

Individuals who wish to contest the accuracy of records in this system of records should submit these requests to

the ICE Office of Information Governance and Privacy—Privacy Division. Requests must comply with verification of identity requirements set forth in DHS Privacy Act regulations at 6 CFR 5.21(d). Please specify the nature of the complaint and provide any supporting documentation. By mail (please note substantial delivery delays exist): ICE Office of Information Governance and Privacy—Privacy Division, 500 12th Street SW, Mail Stop 5004, Washington, DC 20536. By email: *ICEPrivacy@ice.dhs.gov.* Please contact the Privacy Division with any questions about submitting a request or complaint at 202–732–3300 or *ICEPrivacy@ice.dhs.gov.*

NOTIFICATION PROCEDURES:

See ''Record Access Procedures.''

EXEMPTIONS PROMULGATED FOR THE SYSTEM:

The Secretary of Homeland Security, pursuant to 5 U.S.C. 552a(j)(2), has exempted this system from the following provisions of the Privacy Act: 5 U.S.C. 552a(c)(3), (c)(4); (d); (e)(1), (e)(2), (e)(3), (e)(4)(G), (e)(4)(H), (e)(4)(I), (e)(5), and (e)(8); (f); and (g). Additionally, the Secretary of Homeland Security, pursuant to 5 U.S.C. 552a(k)(2), has exempted this system from the following provisions of the Privacy Act: 5 U.S.C. 552a(c)(3), (d), and (e)(1), (e)(4)(G), (e)(4)(H), and (f). Rules have been promulgated in accordance with the requirements of 5 U.S.C. 553(b), (c), and (e) and have been published in the **Federal Register** as additions to Title 28, Code of Federal Regulations (28 CFR 16.99). In addition, to the extent a record contains information from other exempt systems of records, ICE will rely on the exemptions claimed for those systems.

HISTORY:

78 FR 10623 (Feb. 14, 2013); 75 FR 8377 (Feb. 24, 2010); 74 FR 45079 (Aug. 31, 2009); 73 FR 74739 (Dec. 9, 2008).

Philip S. Kaplan,

Chief Privacy Officer, Department of Homeland Security.

[FR Doc. 2018–09902 Filed 5–7–18; 8:45 am]

BILLING CODE 9111–28–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–7000–N–01]

60 Day Notice of Proposed Information Collection; Production of Material or Provision of Testimony by HUD in Response to Demands in Legal Proceedings Among Private Litigants

AGENCY: Office of the General Counsel, HUD.

ACTION: Notice.

SUMMARY: HUD is seeking approval from the Office of Management and Budget (OMB) for the information collection described below. In accordance with the Paperwork Reduction Act, HUD is requesting comment from all interested parties on the proposed collection of information. The purpose of this notice is to allow for 60 days of public comment.

DATES: *Comments Due Date:* July 9, 2018.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Colette Pollard, Reports Management Officer, QDAM, Department of Housing and Urban Development, 451 7th Street SW, Room 4176, Washington, DC 20410–5000; telephone 202–402–3400 (this is not a toll-free number) or email at *Colette.Pollard@hud.gov* for a copy of the proposed forms or other available information. Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at (800) 877–8339.

FOR FURTHER INFORMATION CONTACT: Allen Villafuerte, Managing Attorney, Office of Litigation, Office of General Counsel, Department of Housing and Urban Development, 451 7th Street SW, Room 10258, Washington, DC 20410–0500, telephone (202 708–0300) (this is not a toll-free number).

SUPPLEMENTARY INFORMATION: This notice informs the public that HUD is seeking approval from OMB for the information collection described in Section A.

A. Overview of Information Collection

Title of Information Collection: Production of Material or Provision of Testimony in Response to Demands in Legal Proceedings Among Private Litigants.

OMB Approval Number: 2510–0014.

Type of Request: Reinstatement of collection.

Form Number: None. Please see 24 CFR 15.203.

Description of the need for the information and proposed use:

Section 15.203 of HUD's regulations in 24 CFR specify the manner in which demands for documents and testimony from the Department should be made. Providing the information specified in 24 CFR 15.203 allows the Department to more promptly identify documents and testimony which a requestor may be seeking and determine whether the Department should produce such documents and testimony.

Members of affected public: All types of entities, private and non-profit organizations, individuals and households.

Estimation of the total numbers of hours needed to prepare the information collection including number of respondents, frequency of response, and hours of response:

Number of respondents	Frequency of response	Hours per response	Total burden hours
106	1	1.5	159

B. Solicitation of Public Comment

This notice is soliciting comments from members of the public and affected parties concerning the collection of information described in Section A on the following:

(1) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) The accuracy of the agency's estimate of the burden of the proposed collection of information;

(3) Ways to enhance the quality, utility, and clarity of the information to be collected; and

(4) Ways to minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

HUD encourages interested parties to submit comment in response to these questions.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. Chapter 35.

Dated: May 1, 2018.

Ariel Pereira,

Associate General Counsel for Legislation and Regulations.

[FR Doc. 2018–09778 Filed 5–7–18; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–7001–N–20]

30-Day Notice of Proposed Information Collection: Self-Help Homeownership Opportunity Program (SHOP)

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: HUD is seeking approval from the Office of Management and Budget (OMB) for the information collection described below. In accordance with the Paperwork Reduction Act, HUD is requesting comment from all interested parties on the proposed collection of information. The purpose of this notice is to allow for 30 days of public comment.

DATES: *Comments Due Date:* June 7, 2018.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: HUD Desk Officer, Office of Management and Budget, New Executive Office Building, Washington, DC 20503; fax: 202–395–5806, Email: *OIRA Submission@omb.eop.gov*.

FOR FURTHER INFORMATION CONTACT: Anna P. Guido, Reports Management Officer, QMAC, Department of Housing and Urban Development, 451 7th Street SW, Washington, DC 20410; email Anna P. Guido at *Anna.P.Guido@hud.gov* or telephone 202–402–5535. This is not a toll-free number. Person with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at (800) 877–8339. Copies of available documents submitted to OMB may be obtained from Ms. Guido.

SUPPLEMENTARY INFORMATION: This notice informs the public that HUD is seeking approval from OMB for the information collection described in Section A. The **Federal Register** notice that solicited public comment on the information collection for a period of 60 days was corrected and re-published a on March 6, 2018 at 83 FR 9532.

A. Overview of Information Collection

Title of Information Collection: Self-Help Homeownership Opportunity Program (SHOP).

OMB Approval Number: 2506–0157.

Type of Request: Extension of currently approved collection.

Form Number: HUD–424CB, HUD–2880, HUD–2993, HUD–2995, HUD–96011.

Description of the need for the information and proposed use: This is a proposed information collection for submission requirements under the SHOP Notice of Funding Availability (NOFA). HUD requires information in order to ensure the eligibility of SHOP applicants and the compliance of SHOP proposals, to rate and rank SHOP applications, and to select applicants for grant awards. Information is collected on an annual basis from each applicant that responds to the SHOP NOFA. The SHOP NOFA requires applicants to submit specific forms and narrative responses.

Estimated Number of Respondents/ Estimated Number of Responses:

Information collection	Number of respondents	Frequency of response	Responses per annual	Burden hour per response	Annual burden hours	Hourly cost per response	Annual cost
SF–424	10.00	0.00	0.00	0.00	00.00	0.00	$0.00
HUD–424CB	10.00	1.00	10.00	10.00	100.00	60.00	6,000.00
HUD–424CBW	10.00	1.00	10.00	30.00	300.00	60.00	18,000.00
SF–LLL	10.00	0.00	0.00	0.00	0.00	0.00	0.00
HUD–2880	10.00	1.00	10.00	.50	5.00	60.00	300.00
HUD–2993	10.00	1.00	10.00	.50	5.00	60.00	300.00
HUD–2995	10.00	1.00	10.00	.50	5.00	60.00	300.00
HUD–96011	10.00	1.00	10.00	.50	5.00	60.00	300.00
Applicant Eligibility	10.00	1.00	10.00	10.00	100.00	60.00	6,000.00
SHOP Program Design and Scope of Work	10.00	1.00	10.00	30.00	300.00	60.00	18,000.00
Rating Factor 1	10.00	1.00	10.00	25.00	250.00	60.00	15,000.00
Rating Factor 2	10.00	1.00	10.00	25.00	250.00	60.00	15,000.00
Rating Factor 3	10.00	1.00	10.00	55.00	550.00	60.00	33,000.00
Rating Factor 4	10.00	1.00	10.00	30.00	300.00	60.00	18,000.00
Rating Factor 5	10.00	1.00	10.00	25.00	250.00	60.00	15,000.00
Total Annual Hour Burden					2,420.00		145,200.00

B. Solicitation of Public Comment

This notice is soliciting comments from members of the public and affected parties concerning the collection of information described in Section A on the following:

(1) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) The accuracy of the agency's estimate of the burden of the proposed collection of information;

(3) Ways to enhance the quality, utility, and clarity of the information to be collected; and

(4) Ways to minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

HUD encourages interested parties to submit comment in response to these questions.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. Chapter 35.

Dated: April 24, 2018.

Anna P. Guido,

Department Reports Management Officer, Office of the Chief Information Officer.

[FR Doc. 2018–09776 Filed 5–7–18; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

[189A2100DD/AAKC001030/ A0A501010.999900253G]

Indian Gaming; Tribal-State Class III Gaming Compact Taking Effect in the State of Arizona

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: The notice announces that the Tribal-State Class III Gaming Compact entered into between the Hopi Tribe of Arizona and State of Arizona is taking effect.

DATES: This compact take effect on May 8, 2018.

FOR FURTHER INFORMATION CONTACT: Ms. Paula L. Hart, Director, Office of Indian Gaming, Office of the Deputy Assistant Secretary—Policy and Economic Development, Washington, DC 20240, (202) 219–4066.

SUPPLEMENTARY INFORMATION: Under section 11 of the Indian Gaming Regulatory Act (IGRA) Public Law 100–497, 25 U.S.C. 2701 *et seq.,* the Secretary of the Interior shall publish in the **Federal Register** notice of approved Tribal-State compacts for the purpose of engaging in Class III gaming activities on Indian lands. As required by IGRA and 25 CFR 293.4, all compacts are subject to review and approval by the Secretary. The Secretary took no action on the compact between the Hopi Tribe of Arizona and the State of Arizona within 45 days of its submission. Therefore, the Compact is considered to have been approved, but only to the extent the Compact is consistent with IGRA. *See* 25 U.S.C. 2710(d)(8)(C).

Dated: April 20, 2018.

John Tahsuda,

Principal Deputy Assistant Secretary—Indian Affairs, Exercising the Authority of the Acting Assistant Secretary—Indian Affairs.

[FR Doc. 2018–09800 Filed 5–7–18; 8:45 am]

BILLING CODE 4337–15–P

DEPARTMENT OF THE INTERIOR

Office of the Secretary

[18XD4523WS DS62200000 DWSN00000.000000 DP.62206; OMB Control Number 1090–0009]

Agency Information Collection Activities; Donor Certification Form

AGENCY: Office of the Secretary, Office of Financial Management, Interior.

ACTION: Notice of Information Collection; request for comment.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, we, the Office of Financial Management are proposing to renew an information collection.

DATES: Interested persons are invited to submit comments on or before July 9, 2018.

ADDRESSES: Send your comments on this information collection request (ICR) by mail to Paul Batlan, Office of Financial Management, 1849 C St. NW, MS 2557 MIB, Washington, DC 20240, or email him at *Paul_Batlan@ios.doi.gov.* Please reference OMB Control Number 1090–0009 in the subject line of your comments.

FOR FURTHER INFORMATION CONTACT: To request additional information about this ICR, contact Paul Batlan by email at *Paul_Batlan@ios.doi.gov.*

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act of 1995, we provide the general public and other Federal agencies with an opportunity to comment on new, proposed, revised, and continuing collections of information. This helps us assess the impact of our information collection requirements and minimize the public's reporting burden. It also helps the public understand our information collection requirements and provide the requested data in the desired format.

We are soliciting comments on the proposed ICR that is described below. We are especially interested in public comment addressing the following issues: (1) Is the collection necessary to the proper functions of the Office of Financial Management; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Office of Financial Management enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Office of Financial Management minimize the burden of this collection on the respondents, including through the use of information technology.

Comments that you submit in response to this notice are a matter of public record. We will include or summarize each comment in our request to OMB to approve this ICR. Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Abstract: This notice identifies an information collection activity that the Office of Financial Management has submitted to OMB for approval for the Department and its bureaus to continue to collect information from proposed donors relative to their relationship(s) with the Department. The Department and its individual bureaus have gift acceptance authorities. In support of the variety of donation authorities in the Department and increasing numbers of donations, it is the policy of the Department to ask those proposing to donate gifts valued at $25,000 or more to provide information regarding their relationship with the Department. The purpose of this policy is to ensure that the acceptance of a gift does not create legal or ethical issues for the Department, its bureaus, or potential donors. The information will be gathered through the use of a form that collects information relevant to the acceptability of the proposed donation in conformance with the Department's donations policy. The form is completed and certified by the prospective donor then submitted to the Department or its bureau for review. Having the donor certify his or her interactions with the Department gives the staff vetting the proposed donation basic information to be verified, resulting in a more efficient and timely donation review process. The information collected is as follows:

Information collected	Reason for collection
Name, and indication whether executing in individual capacity, or on behalf of an organization.	To identify the donor, and whether the donor is acting individually or on behalf of an organization.

Information collected	Reason for collection
Declaration whether the donor is involved with litigation or controversy with the Department.	To assist the Department in determining whether there are any issues associated with the proffer of the gift that need to be more closely examined.
Declaration whether the donor is engaged in any financial or business relationship with the Department.	To assist the Department in determining whether there are any issues associated with the proffer of the gift that need to be more closely examined.
Declaration whether the donor has been debarred, excluded or disqualified from the non-procurement common rule, or otherwise declared ineligible from doing business with any Federal agency.	To assist the Department in determining whether there are any issues associated with the proffer of the gift that need to be more closely examined.
Declaration as to whether the donation is expected to be involved with marketing or advertising.	To assist the Department in determining whether there are any issues associated with the proffer of the gift that need to be more closely examined.
Declaration whether the donor is seeking to attach conditions to the donation.	To assist the Department in determining whether there are any issues associated with the proffer of the gift that need to be more closely examined.
Declaration whether this proposed donation is or is not part of a series of donations to the Department.	To assist the Department in determining the scope and context of the donation, and to assist in determining whether there are any issues associated with the proffer of the gift that need to be more closely examined.
Signature, Printed Name, Date, Organization, Email address, City, State, Zip, and daytime or work phone number.	To establish the contact information of the potential donor, and have the certifier sign the certification form.

Title of Collection: Donor Certification Form.

OMB Control Number: 1090–0009.

Form Number: DI–3680.

Type of Review: Extension of a currently approved collection.

Respondents/Affected Public: Individuals or households, Businesses, Not-for-profit institutions, Tribal governments.

Total Estimated Number of Annual Respondents: 100.

Total Estimated Number of Annual Responses: 100.

Estimated Completion Time per Response: 20 Minutes.

Total Estimated Number of Annual Burden Hours: 33 Hours.

Respondent's Obligation: Voluntary.

Frequency of Collection: Once per prospective donor per fiscal year.

Total Estimated Annual Nonhour Burden Cost: None.

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.

The authority for this action is the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq*).

Douglas A. Glenn,

Deputy Chief Financial Officer and Director, Office of Financial Management.

[FR Doc. 2018–09745 Filed 5–7–18; 8:45 am]

BILLING CODE 4334–63–P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

William R. Montiel, M.D.; Decision and Order

On August 10, 2017, the Acting Assistant Administrator, Diversion Control Division, Drug Enforcement Administration, issued an Order to Show Cause to William R. Montiel, M.D. (hereinafter, Registrant), of Prattville, Alabama. GX 2. The Show Cause Order proposed the revocation of Registrant's authority under his DEA Certificate of Registration to dispense schedule II controlled substances, and the denial of ''any applications for renewal or modification of such [s]chedule II authority and any applications for any other DEA registrations with [s]chedule II authority pursuant to 21 U.S.C. 824(a)(3), because [he has] no state authority to handle controlled substances.'' *Id.* at 1.

With respect to the Agency's jurisdiction, the Show Cause Order alleged that Registrant is registered as a practitioner with authority to dispense controlled substances in schedules II through V under Certificate of Registration No. FM0822812, at the location of 554C McQueen Smith Road, Prattville, Alabama. *Id.* The Order further alleged that this registration does not expire until January 31, 2020. *Id.*

As the substantive ground for the proceeding, the Show Cause Order alleged that ''[o]n March 7, 2017, the Medical Licensure Commission of Alabama issued an Order restricting [Registrant's] license to practice medicine in . . . Alabama such that [he] 'shall not prescribe any substance listed in [s]chedule II of the Alabama Controlled Substance Act . . . or any substance listed on the [DEA's] listing of [s]hedule II controlled substances.''' *Id.* at 1–2. The Show Cause Order thus alleged that as a result of the Commission's action, Registrant is ''currently without authority to handle [s]chedule II controlled substances in . . . Alabama, the [S]tate in which [he is] registered with'' DEA, and that as a consequence, his schedule II authority is subject to revocation. *Id.* at 1–2.

The Show Cause Order notified Registrant of his right to a hearing or to submit a written statement while waiving his right to a hearing, the procedure for electing either option, and the consequence of failing either option. *Id.* at 2 (citing 21 CFR 1301.43(a) & (c)). The Order also notified Registrant of his right to submit a corrective action plan. *Id.* at 2–3.

On October 25, 2017, the Government submitted a Request for Final Agency Action (RFAA I). GX 5, at 4. Therein, the Government represented that ''[o]n August 10, 2017, personnel from DEA's Office of Chief Counsel, Diversion and Regulatory Section, mailed a copy of the Order to Registrant's registered address via first-class United States mail'' and that the letter was not returned ''as undeliverable.'' *Id.* The Government further represented that Registrant had neither requested a hearing, nor submitted a written statement while waiving his right to a hearing, within the 30-day time period following service for electing either option. *Id.* The Government thus maintained that Registrant had waived his right to either a hearing or to submit a written statement and sought a final order.

On review, I held that the Government's effort at service was ''a

departure from the Agency traditional practice.'' GX 6 (Administrator's Order, Feb. 6, 2016). I also noted that ''the Government cite[d] no authority establishing that a sole effort of mailing by first class mail (with no evidence of delivery to the address) is sufficient to provide constitutionally adequate service for initiating a proceeding under the Due Process Clause.'' *Id.* I therefore ordered the Government ''to either address why its effort was consistent with the Due Process Clause or to engage in additional reasonable efforts to serve Registrant.'' *Id.*

On March 20, 2018, the Government submitted a Second Request for Final Agency Action. RFAA II, at 5. Therein, the Government represents that on August 15, 2017, the case agent travelled to Registrant's registered address to personally serve the Show Cause Order on Registrant. *Id.* at 2. The Government further represents that the case agent met with Registrant and upon informing Registrant that he was there to serve the Show Cause Order, Registrant stated that he had received the Order in the mail the previous day and showed the Order to the case agent who confirmed that it was identical to the Order he planned to serve on Registrant. *Id.* As support for these representations, the Government provided a declaration by the case agent. GX 7.

Based on the case agent's declaration, I now find that Registrant was served with the Show Cause Order on August 14, 2017. In its Second Request, the Government again represents that ''Registrant has not requested a hearing and has not otherwise corresponded or communicated with DEA regarding the'' Show Cause Order, to ''include[e] the filing of [a] written statement in lieu of a hearing.'' RFAA II, at 2–3. Because more than 30 days have now passed since the date of service of the Show Cause Order, and Registrant has neither requested a hearing nor submitted a written statement while waiving his right to a hearing, I find that Registrant has waived his right to a hearing or to submit a written statement. 21 CFR 1301.43(d). I therefore issue this Decision and Order based on the evidentiary record submitted by the Government. *Id.* § 1301.43(e). I make the following factual findings.

FINDINGS

Registrant is the holder of DEA Certificate of Registration No. FM0822812, pursuant to which he is authorized to dispense controlled substances in schedules II through V as a practitioner, at the registered address of 554C McQueen Smith Road, Prattville, Alabama. GX 1, at 1. This registration does not expire until January 31, 2020. *Id.*

Registrant is also the holder of a medical license issued by the Medical Licensure Commission of Alabama. GX 3, at 2. Following a hearing, on March 7, 2017, the Commission issued an Order which found that Registrant's ''treatment of chronic pain patients is not in compliance with the Board of Medical Examiners' guidelines for pain management and the standards for the utilization of controlled substances set out'' in various provisions of the Alabama Administrative Code, ''in violation of § 34–24–360(23) of the Alabama Code.'' GX 3, at 2–3. The Commission also found that Registrant's ''continued prescribing of'' schedule II controlled substances ''presents a risk of harm to his patients.'' *Id.* at 3. The Commission thus restricted Registrant's medical license to prohibit him from prescribing any schedule II controlled substance. *Id.* The Commission's Order became effective at midnight on June 23, 2017. *Id.* at 4 (Commission's Order, May 24, 2017). According to the online records of the Commission of which I take official notice, this restriction remains in effect as of the date of this Order. *See http://www.albme.org* (visited April 30, 2018).

DISCUSSION

Under the Controlled Substances Act (CSA), a practitioner's registration grants authority to dispense a controlled substance, which by definition ''means to deliver a controlled substance to an ultimate user . . . by, or *pursuant to the lawful order of, a practitioner.*'' 21 U.S.C. 802(10) (emphasis added). Likewise, the CSA defines the ''[t]he term 'practitioner' [to] mean[] a physician . . . licensed, registered, or otherwise permitted, by . . . the jurisdiction in which he practices . . . to distribute, dispense, [or] administer . . . a controlled substance in the course of professional practice.'' *Id.* § 802(21). Finally, under the CSA's registration provision applicable to a practitioner, ''[t]he Attorney General shall register practitioners . . . if the applicant is authorized to dispense . . . controlled substances under the laws of the State in which he practices.'' *Id.* § 823(f). These provisions thus make clear that a practitioner's possession of federal authority to dispense controlled substances is generally premised on his possession of authority under state law to do so. *See also see also id.* § 824(a)(3) (authorizing the suspension or revocation of registration issued under section 823 of the CSA, ''upon a finding that the registrant . . . has had . . . [her] State License or registration suspended [or] revoked by competent State authority and is no longer authorized by State law to engage in the . . . dispensing of controlled substances'').

As the Supreme Court recognized in *United States* v. *Moore,* 423 U.S. 122, 140–41 (1975), ''[i]n the case of a physician this scheme contemplates that he is authorized by the State to practice medicine and to dispense drugs in connection with his professional practice. The federal registration . . . extends no further.''

Thus, to the extent a practitioner is not authorized under state law to dispense certain categories or schedules of controlled substances, he can no longer lawfully dispense them under federal law. *See Kenneth Harold Bull,* 78 FR 62666, 62672, 62676 (2013) (restricting practitioner's registration to authorize the dispensing of only those controlled substances authorized to dispense under his state license). Accordingly, where a state board takes such action, at a minimum, a practitioner's CSA registration must be restricted to authorize the dispensing of only those controlled substances which he can lawfully dispense under state law. *See id.; see also* 21 U.S.C. 824(a)(3).

Based on the Commission's Order, I find that Registrant is currently without authority to prescribe schedule II controlled substance under his Alabama Medical License. Because his authority under his DEA registration (in Alabama) can only extend as far as his state authority, I will order that his authority to prescribe schedule II controlled substances be revoked and that his registration be restricted to prohibit him from prescribing schedule II controlled substances.[1]

ORDER

Pursuant to the authority vested in me by 28 CFR 0.100(b) and 21 U.S.C. 824(a)(3), I order that the authority of William R. Montiel, M.D., to prescribe schedule II controlled substances under

[1] While the Government argues that ''Registrant's [s]chedule II authority should be revoked . . . because Registrant has no state authority to handle [s]chedule II controlled substances in Alabama,'' RFAA II, at 4, the various state Orders submitted by the Government address only his authority to prescribe and not to engage in other activities which fall within the definition of dispense, such as administering or direct dispensing, whether under the CSA or Alabama law. *See* Ala. Code § 20–2–2 (defining the term ''dispense'' to mean ''[t]o deliver a controlled substance to an ultimate user . . . by or pursuant to the lawful order of a practitioner, including the prescribing, [or] administering'' of a controlled substance). While it may have been the intent of the Commission to entirely limit Registrant's schedule II authority, that is not apparent on the face of its Orders.

Certificate of Registration No. FM0822812 be, and it hereby is, revoked. I further order that any application of William R. Montiel, M.D., to renew or modify his registration, or for any other registration in the State of Alabama, be, and it hereby is denied, to the extent it seeks authority to prescribe schedule II controlled substances in the State of Alabama. This ORDER is effective immediately.[2]

Dated: April 30, 2018.

Robert W. Patterson,

Acting Administrator.

[FR Doc. 2018–09738 Filed 5–7–18; 8:45 am]

BILLING CODE 4410–09–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: (18–046)]

Earth Science Advisory Committee; Meeting

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, as amended, the National Aeronautics and Space Administration (NASA) announces a meeting of the Earth Science Advisory Committee (ESAC). This Committee functions in an advisory capacity to the Director, Earth Science Division, in the NASA Science Mission Directorate. The meeting will be held for the purpose of soliciting, from the Earth science community and other persons, scientific and technical information relevant to program planning.

DATES: Tuesday, May 29, 2018, 1:00 p.m.–2:00 p.m., Eastern Time.

ADDRESSES: This meeting will take place telephonically. Any interested person must use a touch-tone phone to participate in this meeting. Any interested person may call the USA toll free number 1–888–955–8964, passcode 3820950.

FOR FURTHER INFORMATION CONTACT: KarShelia Henderson, Science Mission Directorate, NASA Headquarters, Washington, DC 20546, (202) 358–2355, fax (202) 358–2779, or *khenderson@nasa.gov.*

The agenda for the meeting includes the following topic:

—Earth Science Program High Impact Research

It is imperative that the meeting be held on this date to accommodate the scheduling priorities of the key participants.

Deborah F. Bloxon,

Federal Liaison Officer.

[FR Doc. 2018–09803 Filed 5–7–18; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[18–041]

Notice of Information Collection

AGENCY: National Aeronautics and Space Administration (NASA).

ACTION: Notice of information collection.

SUMMARY: The National Aeronautics and Space Administration, 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.

DATES: All comments should be submitted within June 7, 2018.

ADDRESSES: All comments should be addressed to Lori Parker, National Aeronautics and Space Administration, 300 E Street SW, Washington, DC 20546–0001.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Lori Parker, NASA Clearance Officer, NASA Headquarters, 300 E Street SW, JF0000, Washington, DC 20546, (202) 358–1351.

SUPPLEMENTARY INFORMATION:

I. Abstract

Supersonic flight over land is currently restricted in the U.S. and many countries because sonic boom noise disturbs people on the ground and can potentially damage private property. NASA is researching the public acceptability of quiet commercial supersonic flight. As sufficient research is assembled, there is potential for a change in federal and international regulations.

The 2018 Quiet Supersonic Flight Community Response Test will correlate human annoyance response with low level supersonic exposure in a community setting. The supersonic exposure will be generated with an F–18 research aircraft performing a specialized maneuver. This effort is designed to evaluate remote aircraft basing and operations, community engagement, sonic boom measurements, and community annoyance surveys. The effort will improve research methods for future community-scale response testing using a purpose-built, low boom flight demonstration aircraft (LBFD).

NASA supported a prior risk reduction field test to evaluate data collection methods for low boom community response at Edwards Air Force Base (EAFB) in November 2011. The annoyance response findings from the study are not readily generalizable to a larger population, as the residents at EAFB are accustomed to hearing full level sonic booms on a routine basis.

II. Methods of Collection

Web-Based/Electronic.

III. Data

Title: 2018 Quiet Supersonic Flight Community Response Test.

OMB Number: 2700–xxxx.

Type of review: New Clearance.

Affected Public: Individuals and Households, Businesses and Organizations, State, Local, or Tribal Government.

Average Expected Annual Number of activities: Four questionnaires administered with varying frequency over 10 days.

Average number of Respondents per Activity: 500 respondents (maximum).

Annual Responses: 112 responses (maximum) per respondent.

Frequency of Responses: 10 responses (maximum) per day.

Average minutes Per Response: Typical response time is 2 minutes

Burden Hours: Not to exceed 2,000 hours.

IV. Request for Comments

Comments are invited on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of NASA, including whether the information collected has practical utility; (2) the accuracy of NASA's estimate of the burden (including hours and cost) of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including automated collection techniques or the use of other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the request for OMB approval of this information collection.

[2] I further order that Registrant's Certificate of Registration be modified to reflect this restriction on his authority. Based on the findings of the Commission, I find that the public interest necessitates that the revocation of his schedule II prescribing authority be effective immediately. 21 CFR 1316.67.

They will also become a matter of public record.

Lori Parker,

NASA PRA Clearance Officer.

[FR Doc. 2018–09676 Filed 5–7–18; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: (18–044)]

Earth Science Advisory Committee; Meeting

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, the National Aeronautics and Space Administration (NASA) announces a meeting of the Earth Science Advisory Committee (ESAC). This Committee functions in an advisory capacity to the Director, Earth Science Division, in the NASA Science Mission Directorate. The meeting will be held for the purpose of soliciting, from the Earth science community and other persons, scientific and technical information relevant to program planning.

DATES: Tuesday, May 29, 2018, 1:00 p.m.–2:00 p.m., Eastern Time.

ADDRESSES: This meeting will take place telephonically. Any interested person must use a touch-tone phone to participate in this meeting. Any interested person may call the USA toll free number 1–888–955–8964, passcode 3820950.

FOR FURTHER INFORMATION CONTACT: KarShelia Henderson, Science Mission Directorate, NASA Headquarters, Washington, DC 20546, (202) 358–2355, fax (202) 358–2779, or *khenderson@nasa.gov.*

The agenda for the meeting includes the following topic:

—Earth Science Program High Impact Research

It is imperative that the meeting be held on this date to accommodate the scheduling priorities of the key participants.

Patricia Rausch,

Advisory Committee Management Officer, National Aeronautics and Space Administration.

[FR Doc. 2018–09769 Filed 5–7–18; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: (18–042)]

Notice of Information Collection

AGENCY: National Aeronautics and Space Administration (NASA).

ACTION: Notice of information collection.

SUMMARY: The National Aeronautics and Space Administration, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public to take this opportunity to comment on the ''Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery'' for approval under the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 et. seq.). This collection was developed as part of a Federal Government-wide effort to streamline the process for seeking feedback from the public on service delivery. This notice announces our intent to submit this collection to OMB for approval and solicits comments on specific aspects for the proposed information collection,

DATES: All comments should be submitted within 60 calendar days from the date of this publication.

ADDRESSES: All comments should be addressed to Lori Parker, National Aeronautics and Space Administration, 300 E Street SW, Washington, DC 20546–0001.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Lori Parker, NASA Clearance Officer, NASA Headquarters, 300 E Street SW, JF0000, Washington, DC 20546, (202) 358–1351.

SUPPLEMENTARY INFORMATION:

I. Abstract

The proposed information collection activity provides a means to garner qualitative customer and stakeholder feedback in an efficient, timely manner, in accordance with the Administration's commitment to improving 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. 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. These collections will allow for ongoing, collaborative and actionable communications between the Agency and its customers and stakeholders. It will also allow feedback to contribute directly to the improvement of program management.

The solicitation of feedback will target areas such as: Timeliness, appropriateness, accuracy of information, courtesy, efficiency of service delivery, and resolution of issues with service delivery. Responses will be assessed to plan and inform efforts to improve or maintain the quality of service offered to the public. If this information is not collected, vital feedback from customers and stakeholders on the Agency's services will be unavailable.

II. Methods of Collection

The Agency will only submit a collection for approval under this generic clearance if it meets the following conditions:

The collections are voluntary;

The collections are low-burden for respondents (based on considerations of total burden hours, total number of respondents, or burden-hours per respondent) and are low-cost for both the respondents and the Federal Government;

The collections are non-controversial and do not raise issues of concern to other Federal agencies;

Any collection is targeted to the solicitation of opinions from respondents who have experience with the program or may have experience with the program in the near future;

Information gathered will be used only internally for general service improvement and program management purposes and is not intended for release outside of the agency;

Information gathered will not be used for the purpose of substantially informing influential policy decisions; and

Information gathered will yield qualitative information; the collections will not be designed or expected to yield statistically reliable results or used as though the results are generalizable to the population of study.

Feedback collected under this generic clearance provides useful information, but it does not yield data that can be generalized to the overall population. This type of generic clearance for qualitative information will not be used for quantitative information collections that are designed to yield reliably actionable results, such as monitoring trends over time or documenting program performance. Such data uses require more rigorous designs that address: The target population to which

generalizations will be made, the sampling frame, the sample design (including stratification and clustering), the precision requirements or power calculations that justify the proposed sample size, the expected response rate, methods for assessing potential non-response bias, the protocols for data collection, and any testing procedures that were or will be undertaken prior to fielding the study. Depending on the degree of influence the results are likely to have, such collections may still be eligible for submission for other generic mechanisms that are designed to yield quantitative results.

As a general matter, information collections will not result in any new system of records containing privacy information and will not ask questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

III. Data

Title: Extension of the Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery.

OMB Number: 2700–0153

Type of Review: Extension of approval for a collection of information.

Affected Public: Individuals and Households, Businesses and Organizations, State, Local, or Tribal Government.

Average Expected Annual Number of Activities: 60.

Average Number of Respondents per Activity: 300.

Annual Responses: 18,000.

Frequency of Responses: Once per request.

Average minutes per Response: 5.

Burden Hours: 1,500.

IV. Request for Comments

Comments are invited on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of NASA, including whether the information collected has practical utility; (2) the accuracy of NASA's estimate of the burden (including hours and cost) of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including automated collection techniques or the use of other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the request for OMB approval of this information collection. They will also become a matter of public record.

Deborah F. Bloxon,

NASA Federal Liaison Officer.

[FR Doc. 2018–09684 Filed 5–7–18; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: (18–043)]

Notice of Information Collection

AGENCY: National Aeronautics and Space Administration (NASA).

ACTION: Notice of information collection.

SUMMARY: The National Aeronautics and Space Administration, 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.

DATES: All comments should be submitted within 30 calendar days from the date of this publication.

ADDRESSES: All comments should be addressed to Lori Parker, National Aeronautics and Space Administration, 300 E Street SW, Washington, DC 20546–0001.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Lori Parker, NASA Clearance Officer, NASA Headquarters, 300 E Street SW, JF0000, Washington, DC 20546, (202) 358–1351.

SUPPLEMENTARY INFORMATION:

I. Abstract

Supersonic flight over land is currently restricted in the U.S. and many countries because sonic boom noise disturbs people on the ground and can potentially damage private property. NASA is researching the public acceptability of quiet commercial supersonic flight. As sufficient research is assembled, there is potential for a change in federal and international regulations.

The 2018 Quiet Supersonic Flight Community Response Test will correlate human annoyance response with low level supersonic exposure in a community setting. The supersonic exposure will be generated with an F–18 research aircraft performing a specialized maneuver. This effort is designed to evaluate remote aircraft basing and operations, community engagement, sonic boom measurements, and community annoyance surveys. The effort will improve research methods for future community-scale response testing using a purpose-built, low boom flight demonstration aircraft (LBFD).

NASA supported a prior risk reduction field test to evaluate data collection methods for low boom community response at Edwards Air Force Base (EAFB) in November 2011. The annoyance response findings from the study are not readily generalizable to a larger population, as the residents at EAFB are accustomed to hearing full level sonic booms on a routine basis.

II. Methods of Collection

Web-Based/Electronic.

III. Data

Title: 2018 Quiet Supersonic Flight Community Response Test.

OMB Number: 2700-xxxx.

Type of review: New Clearance.

Affected Public: Individuals and Households, Businesses and Organizations, State, Local, or Tribal Government.

Average Expected Annual Number of Activities: Four questionnaires administered with varying frequency over 10 days.

Average Number of Respondents per Activity: 500 respondents (maximum).

Annual Responses: 112 responses (maximum) per respondent.

Frequency of Responses: 10 responses (maximum) per day.

Average minutes per Response: Typical response time is 2 minutes.

Burden Hours: Not to exceed 2,000 hours.

IV. Request for Comments

Comments are invited on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of NASA, including whether the information collected has practical utility; (2) the accuracy of NASA's estimate of the burden (including hours and cost) of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including automated collection techniques or the use of other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the request for OMB approval of this information collection.

They will also become a matter of public record.

Deborah F. Bloxon,

NASA Federal Liaison Officer.

[FR Doc. 2018–09685 Filed 5–7–18; 8:45 am]

BILLING CODE 7510–13–P

NUCLEAR REGULATORY COMMISSION

[NRC–2018–0091]

Relocation of Regulatory Issue Summary Notices in the Federal Register

AGENCY: Nuclear Regulatory Commission.

ACTION: Categorization of notice.

SUMMARY: The Nuclear Regulatory Commission (NRC) is notifying the public that documents regarding draft and final Regulatory Issue Summaries that historically have published in the ''Notices'' section of the **Federal Register** will now be published in the ''Proposed Rules'' and ''Rules and Regulations'' sections of the **Federal Register**. The Office of the Federal Register (OFR) recently informed the NRC that under OFR guidelines, these documents fall into the ''Proposed Rules'' and ''Rules and Regulations'' categories and requested that NRC reclassify these notices.

ADDRESSES: Please refer to Docket ID NRC–2018–0091 when contacting the NRC about the availability of information regarding this document. You may obtain publicly-available information related to this document using any of the following methods:

- *Federal Rulemaking Website:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2018–0091. Address questions about NRC dockets to Jennifer Borges; telephone: 301–287–9127; email: *Jennifer.Borges@nrc.gov.* For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly-available documents online in the ADAMS Public Documents collection 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.*
- *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.

FOR FURTHER INFORMATION CONTACT: Anthony de Jesus, Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–287–9219, email: *Anthony.deJesus@nrc.gov.*

SUPPLEMENTARY INFORMATION: The NRC issues Regulatory Issue Summaries to communicate with stakeholders on a broad range of matters. This may include clarification of existing requirements and regulations. This may also include communicating and clarifying the NRC's technical or policy positions on regulatory matters that have not been communicated to, or are not broadly understood by, the nuclear industry. Documents regarding Regulatory Issue Summaries historically have been published in the ''Notices'' section of the **Federal Register**.

Under the Federal Register Act (44 U.S.C. chapter 15), the Administrative Committee of the Federal Register issues regulations regarding publishing documents in the **Federal Register** (see chapter I of title 1 of the *Code of Federal Regulations* (1 CFR)). Based on these governing regulations, the OFR classifies agency documents published in the **Federal Register** in one of three categories: Rules and regulations, proposed rules, and notices. The regulation establishing document types is available in 1 CFR 5.9.

In accordance with the OFR's request that the NRC reclassify Regulatory Issue Summaries, these documents will be published in the ''Proposed Rules'' or ''Rules and Regulations'' section of the **Federal Register**. This change is effective immediately.

Dated at Rockville, Maryland, this 2nd day of May 2018.

For the Nuclear Regulatory Commission.

Cindy K. Bladey,

Federal Register Liaison Officer, Division of Rulemaking, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 2018–09687 Filed 5–7–18; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2018–0085]

Biweekly Notice; Applications and Amendments to Facility Operating Licenses and Combined Licenses Involving No Significant Hazards Considerations

AGENCY: Nuclear Regulatory Commission.

ACTION: Biweekly notice.

SUMMARY: Pursuant to Section 189a.(2) of the Atomic Energy Act of 1954, as amended (the Act), the U.S. Nuclear Regulatory Commission (NRC) is publishing this regular biweekly notice. The Act requires the Commission to publish notice of any amendments issued, or proposed to be issued, and grants the Commission the authority to issue and make immediately effective any amendment to an operating license or combined license, as applicable, upon a determination by the Commission that such amendment involves no significant hazards consideration, notwithstanding the pendency before the Commission of a request for a hearing from any person.

This biweekly notice includes all notices of amendments issued, or proposed to be issued, from April 10, 2018, to April 23, 2018. The last biweekly notice was published on April 24, 2018.

DATES: Comments must be filed by June 7, 2018. A request for a hearing must be filed by July 9, 2018.

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 Website:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2018–0085. Address questions about NRC dockets to Jennifer Borges; telephone: 301–287–9127; email: *Jennifer.Borges@nrc.gov.* For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *Mail comments to:* May Ma, Office of Administration, Mail Stop: TWFN–7–A60M, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

For additional direction on obtaining information and submitting comments, see ''Obtaining Information and Submitting Comments'' in the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT: Shirley Rohrer, U.S. Nuclear Regulatory

Commission, Washington DC 20555–0001; telephone: 301–415–5411, email: *Shirley.Rohrer@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Obtaining Information and Submitting Comments

A. Obtaining Information

Please refer to Docket ID NRC–2018–0085, facility name, unit number(s), plant docket number, application date, and subject when contacting the NRC about the availability of information for this action. You may obtain publicly-available information related to this action by any of the following methods:

- *Federal Rulemaking Website:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2018–0085.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly-available documents online in the ADAMS Public Documents collection 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 (if it is available in ADAMS) is provided the first time that it is mentioned in this document
- *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–2018–0085, facility name, unit number(s), plant docket number, application date, and subject in your comment submission.

The NRC cautions you not to include identifying or contact information that you do not want to be publicly disclosed in your 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 into ADAMS.

II. Notice of Consideration of Issuance of Amendments to Facility Operating Licenses and Combined Licenses and Proposed No Significant Hazards Consideration Determination

The Commission has made a proposed determination that the following amendment requests involve no significant hazards consideration. Under the Commission's regulations in § 50.92 of title 10 of the *Code of Federal Regulations* (10 CFR), this means that operation of the facility in accordance with the proposed amendment would not: (1) Involve a significant increase in the probability or consequences of an accident previously evaluated; or (2) create the possibility of a new or different kind of accident from any accident previously evaluated; or (3) involve a significant reduction in a margin of safety. The basis for this proposed determination for each amendment request is shown below.

The Commission is seeking public comments on this proposed determination. Any comments received within 30 days after the date of publication of this notice will be considered in making any final determination.

Normally, the Commission will not issue the amendment until the expiration of 60 days after the date of publication of this notice. The Commission may issue the license amendment before expiration of the 60-day period provided that its final determination is that the amendment involves no significant hazards consideration. In addition, the Commission may issue the amendment prior to the expiration of the 30-day comment period if circumstances change during the 30-day comment period such that failure to act in a timely way would result, for example in derating or shutdown of the facility. If the Commission takes action prior to the expiration of either the comment period or the notice period, it will publish in the **Federal Register** a notice of issuance. If the Commission makes a final no significant hazards consideration determination, any hearing will take place after issuance. The Commission expects that the need to take this action will occur very infrequently.

A. Opportunity To Request a Hearing and Petition for Leave To Intervene

Within 60 days after the date of publication of this notice, any persons (petitioner) whose interest may be affected by this action may file a request for a hearing and petition for leave to intervene (petition) with respect to the action. Petitions shall be filed in accordance with the Commission's ''Agency Rules of Practice and Procedure'' in 10 CFR part 2. Interested persons should consult a current copy of 10 CFR 2.309. The NRC's regulations are accessible electronically from the NRC Library on the NRC's website at *http://www.nrc.gov/reading-rm/doc-collections/cfr/.* Alternatively, a copy of the regulations is available at the NRC's Public Document Room, located at One White Flint North, Room O1–F21, 11555 Rockville Pike (first floor), Rockville, Maryland 20852. If a petition is filed, the Commission or a presiding officer will rule on the petition and, if appropriate, a notice of a hearing will be issued.

As required by 10 CFR 2.309(d) the petition should specifically explain the reasons why intervention should be permitted with particular reference to the following general requirements for standing: (1) The name, address, and telephone number of the petitioner; (2) the nature of the petitioner's right under the Act to be made a party to the proceeding; (3) the nature and extent of the petitioner's property, financial, or other interest in the proceeding; and (4) the possible effect of any decision or order which may be entered in the proceeding on the petitioner's interest.

In accordance with 10 CFR 2.309(f), the petition must also set forth the specific contentions which the petitioner seeks to have litigated in the proceeding. Each contention must consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the petitioner must provide a brief explanation of the bases for the contention and a concise statement of the alleged facts or expert opinion which support the contention and on which the petitioner intends to rely in proving the contention at the hearing. The petitioner must also provide references to the specific sources and documents on which the petitioner intends to rely to support its position on the issue. The petition must include sufficient information to show that a genuine dispute exists with the applicant or licensee on a material issue of law or fact. Contentions must be limited to matters within the scope of the proceeding. The contention must be one which, if proven, would entitle the

petitioner to relief. A petitioner who fails to satisfy the requirements at 10 CFR 2.309(f) with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene. Parties have the opportunity to participate fully in the conduct of the hearing with respect to resolution of that party's admitted contentions, including the opportunity to present evidence, consistent with the NRC's regulations, policies, and procedures.

Petitions must be filed no later than 60 days from the date of publication of this notice. Petitions and motions for leave to file new or amended contentions that are filed after the deadline will not be entertained absent a determination by the presiding officer that the filing demonstrates good cause by satisfying the three factors in 10 CFR 2.309(c)(1)(i) through (iii). The petition must be filed in accordance with the filing instructions in the ''Electronic Submissions (E-Filing)'' section of this document.

If a hearing is requested, and the Commission has not made a final determination on the issue of no significant hazards consideration, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to establish when the hearing is held. If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it immediately effective, notwithstanding the request for a hearing. Any hearing would take place after issuance of the amendment. If the final determination is that the amendment request involves a significant hazards consideration, then any hearing held would take place before the issuance of the amendment unless the Commission finds an imminent danger to the health or safety of the public, in which case it will issue an appropriate order or rule under 10 CFR part 2.

A State, local governmental body, Federally-recognized Indian Tribe, or agency thereof, may submit a petition to the Commission to participate as a party under 10 CFR 2.309(h)(1). The petition should state the nature and extent of the petitioner's interest in the proceeding. The petition should be submitted to the Commission no later than 60 days from the date of publication of this notice. The petition must be filed in accordance with the filing instructions in the ''Electronic Submissions (E-Filing)'' section of this document, and should meet the requirements for petitions set forth in this section, except that under 10 CFR 2.309(h)(2) a State, local governmental body, or Federally-recognized Indian Tribe, or agency thereof does not need to address the standing requirements in 10 CFR 2.309(d) if the facility is located within its boundaries. Alternatively, a State, local governmental body, Federally-recognized Indian Tribe, or agency thereof may participate as a non-party under 10 CFR 2.315(c). If a hearing is granted, any person who is not a party to the proceeding and is not affiliated with or represented by a party may, at the discretion of the presiding officer, be permitted to make a limited appearance pursuant to the provisions of 10 CFR 2.315(a). A person making a limited appearance may make an oral or written statement of his or her position on the issues but may not otherwise participate in the proceeding. A limited appearance may be made at any session of the hearing or at any prehearing conference, subject to the limits and conditions as may be imposed by the presiding officer. Details regarding the opportunity to make a limited appearance will be provided by the presiding officer if such sessions are scheduled.

B. Electronic Submissions (E-Filing)

All documents filed in NRC adjudicatory proceedings, including a request for hearing and petition for leave to intervene (petition), 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 that request to participate under 10 CFR 2.315(c), must be filed in accordance with the NRC's E-Filing rule (72 FR 49139; August 28, 2007, as amended at 77 FR 46562; August 3, 2012). 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. Detailed guidance on making electronic submissions may be found in the Guidance for Electronic Submissions to the NRC and on the NRC website at *http://www.nrc.gov/site-help/e-submittals.html.* 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 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 (1) request a digital identification (ID) certificate, which allows the participant (or its counsel or representative) to digitally sign submissions and access the E-Filing system for any proceeding in which it is participating; and (2) advise the Secretary that the participant will be submitting a petition or other adjudicatory document (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 website at *http://www.nrc.gov/site-help/e-submittals/getting-started.html.* Once a participant has obtained a digital ID certificate and a docket has been created, the participant can then submit adjudicatory documents. Submissions must be in Portable Document Format (PDF). Additional guidance on PDF submissions is available on the NRC's public website at *http://www.nrc.gov/site-help/electronic-sub-ref-mat.html.* A filing is considered complete at the time the document is 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 document on those participants separately. Therefore, applicants and other participants (or their counsel or representative) must apply for and receive a digital ID certificate before adjudicatory documents are filed so that they can obtain access to the documents via the E-Filing system.

A person filing electronically using the NRC's adjudicatory E-Filing system may seek assistance by contacting the NRC's Electronic Filing Help Desk through the ''Contact Us'' link located on the NRC's public website at *http://www.nrc.gov/site-help/e-submittals.html,* by email to *MSHD.Resource@nrc.gov,* or by a toll-free call at 1–866–672–7640. The NRC

Electronic Filing Help Desk is available between 9 a.m. and 6 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 paper filing stating why there is good cause for not filing electronically and requesting authorization to continue to submit documents in paper format. 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: Rulemaking and Adjudications Staff; or (2) courier, express mail, or expedited delivery service to the Office of the Secretary, 11555 Rockville Pike, Rockville, Maryland 20852, Attention: Rulemaking and Adjudications Staff. Participants filing adjudicatory documents 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 *https://adams.nrc.gov/ehd,* unless excluded pursuant to an order of the Commission or the presiding officer. If you do not have an NRC-issued digital ID certificate as described above, click cancel when the link requests certificates and you will be automatically directed to the NRC's electronic hearing dockets where you will be able to access any publicly available documents in a particular hearing docket. Participants are requested not to include personal privacy information, such as social security numbers, home addresses, or personal phone numbers in their filings, unless an NRC regulation or other law requires submission of such information. For example, in some instances, individuals provide home addresses in order to demonstrate proximity to a facility or site. 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.

For further details with respect to these license amendment applications, see the application for amendment which is available for public inspection in ADAMS and at the NRC's PDR. For additional direction on accessing information related to this document, see the ''Obtaining Information and Submitting Comments'' section of this document.

Exelon Generation Company, LLC, Docket Nos. 50–317 and 50–318, Calvert Cliffs Nuclear Power Plant (CCNPP), Unit Nos. 1 and 2, Calvert County, Maryland

Exelon Generation Company, LLC, Docket Nos. 50–220 and 50–410, Nine Mile Point Nuclear Station (NMP), Unit Nos. 1 and 2, Oswego County, New York

Exelon Generation Company, LLC, Docket No. 50–244, R.E. Ginna Nuclear Power Plant (Ginna), Wayne County, New York

Date of amendment request: March 26, 2018. A publicly-available version is in ADAMS under Accession No. ML18086A138.

Description of amendment request: The amendments would revise the licenses to eliminate the Nuclear Advisory Committee.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed amendment involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed amendment deletes license conditions associated with the establishment of the Nuclear Advisory Committee (NAC) as provided in the orders approving the corporate merger between Exelon Corporation and Constellation Energy Group, Inc., and the resultant transfer of the renewed facility operating licenses for CCNPP, Units 1 and 2; NMP, Units 1 and 2; and Ginna on February 15, 2012.

The NAC's oversight function helps to ensure that Constellation Energy Nuclear Group (CENG) remains in compliance with laws and regulations regarding foreign domination and control of nuclear operations, and that a decision of a foreign government could not adversely affect or interfere with the reliable and safe operation of any nuclear assets of CENG or its affiliates.

The NAC is an advisory committee and does not function in a decision-making role. If the NAC becomes aware of a Foreign Ownership, Control, or Domination (FOCD) event or issue, it will bring it to the attention of CENG management and/or the CENG Board of Directors. The NAC advises the CENG Board of Directors and provides its recommendations regarding the regulatory or safety significance of the issue, and recommended actions to address the issue.

Eliminating the NAC will not impact compliance with FOCD requirements, nor will it impair the ability to identify and resolve any FOCD issues that could impact the safe or reliable operation of the nuclear units. Multiple avenues exist to resolve any concerns regarding FOCD issues. These include the ability of personnel to report an FOCD concern to their supervisor, enter a potential FOCD concern into the corrective action program, or raise the concern with the Employee Concerns Program. In addition, personnel are always free to report any concern directly to the NRC.

This proposed administrative change enables the elimination of the NAC and does not alter: 1) The extent of the ownership of the reactors, 2) the authority to operate the reactors, 3) the directors or officers and details concerning the relevant companies, 4) access to restricted data, or; 5) details concerning ownership of the foreign parent company. This change does not alter compliance with the Atomic Energy Act, 10 CFR 50.38, ''Ineligibility of Certain Applicants,'' or the guidance provided in the Standard Review Plan (SRP), Final Standard Review Plan on Foreign Ownership, Control, or Domination. Additionally, this administrative change will not impact reactor operations or safety analyses.

Therefore, the proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

This proposed administrative change enables the elimination of the NAC and does not alter: 1) The extent of the ownership of the reactors, 2) the authority to operate the reactors, 3) the directors or officers and details concerning the relevant companies, 4) access to restricted data, or; 5) details concerning ownership of the foreign parent company. This change does not alter compliance with the Atomic Energy Act, 10 CFR 50.38, ''Ineligibility of Certain Applicants,'' or the guidance provided in the Standard Review Plan (SRP), Final Standard Review Plan on Foreign Ownership, Control, or Domination.

Eliminating the NAC will not impact compliance with FOCD requirements, nor will it impair the ability to identify and resolve any FOCD issues that could impact the safe or reliable operation of the nuclear units. FOCD issues will be addressed via current processes (employees reporting to their supervisor, entering an issue into the corrective action program, raising the concern to the Employee Concerns Program, or reporting directly to the NRC).

This is an administrative change, and no new operating configuration is being imposed that would create a new failure

scenario. In addition, no new failure modes are being created for any plant equipment. This change does not result in any new or different accident scenarios.

Therefore, the proposed change does not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

This is an administrative change. No safety analyses are being changed or modified as a result of this proposed change. This proposed administrative change does not alter the manner in which safety limits, limiting safety system settings, or limiting conditions for operation are determined. Margins associated with the current safety analyses acceptance criteria are unaffected. The safety systems credited in the safety analyses will continue to be available to perform their mitigation functions.

Therefore, the proposed change does not result in a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the requested amendments involve no significant hazards consideration.

Attorney for licensee: Tamra Domeyer, Associate General Counsel, Exelon Generation Company, LLC, 4300 Winfield Road, Warrenville, IL 60555.

NRC Branch Chief: David J. Wrona.

Indiana Michigan Power Company, Docket No. 50–315, Donald C. Cook Nuclear Plant (CNP), Unit No. 1, Berrien County, Michigan

Date of amendment request: March 7, 2018. A publicly-available version is in ADAMS under Accession No. ML18072A012.

Description of amendment request: The proposed change would allow for the application of leak-before-break (LBB) methodology to piping for the accumulator, residual heat removal, and safety injection systems at the CNP, Unit No. 1. In addition, the proposed change would modify technical specification (TS) 3.4.13, ''RCS [Reactor Coolant System] Operational LEAKAGE.''

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed amendment involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

Overall protection system performance will remain within the bounds of the previously performed accident analyses. The design of the protection systems will be unaffected. The reactor protection system and engineered safety feature actuation system will continue to function in a manner consistent with the plant design basis. All design, material and construction standards that were applicable prior to the request are maintained.

For CNP, Unit 1, the bounding accident for pipe breaks is a Large Break Loss of Coolant Accident (LBLOCA). Since the application of the LBB analysis verifies the integrity of the piping attached to the reactor coolant system, the probability of a previously evaluated accident is not increased. The consequences of a LBLOCA have been previously evaluated and found to be acceptable. The application of the LBB analysis will cause no change in the dose analysis associated with a LBLOCA, and therefore, does not affect the consequences of an accident.

The proposed amendment will not alter any assumptions or change any mitigation actions in the radiological consequence evaluations in the Updated Final Safety Analysis Report (UFSAR).

Therefore, the proposed changes do not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any previously evaluated?

Response: No.

No new accident scenarios, failure mechanisms, or single failures are introduced as a result of the proposed change. All systems, structures, and components previously required for the mitigation of an event remain capable of fulfilling their intended design function. The proposed change has no adverse effects on any safety related systems or components and does not challenge the performance or integrity of any safety related system. Further, there are no changes in the method by which any safety-related plant system performs its safety function. This amendment will not affect the normal method of power operation or change any operating parameters.

Therefore, the proposed changes do not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

Margin of safety is related to the ability of the fission product barriers to perform their design functions during and following accident conditions. These barriers include the fuel cladding, the reactor coolant system, and the containment. The proposed amendment request does not involve a change to any of these barriers.

The proposed change does not involve a significant reduction in a margin of safety because the proposed changes do not reduce the margin of safety that exists in the present CNP Unit 1 TS or UFSAR. The operability requirements of the TS are consistent with the initial condition assumptions of the safety analyses.

This proposed amendment uses LBB technology combined with leakage monitoring to show that it is acceptable to exclude the dynamic effects associated with postulated pipe ruptures from the licensing basis for the systems evaluated that are attached to the RCS. The enclosed analysis demonstrates that the LBB margins discussed in NUREG–1061, Volume 3 are satisfied.

Therefore, the proposed changes do not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Robert B. Haemer, Senior Nuclear Counsel, One Cook Place, Bridgman, MI 49106.

NRC Branch Chief: David J. Wrona.

Tennessee Valley Authority (TVA), Docket No. 50–259, Browns Ferry Nuclear Plant (BFN), Unit 1, Limestone County, Alabama

Date of amendment request: March 16, 2018, as supplemented by letter dated April 19, 2018. Publicly-available versions are in ADAMS under Accession Nos. ML18080A171 and ML18109A573.

Description of amendment request: The amendment would revise License Condition 2.C(18)(a)3 for Unit 1 that requires the submittal of a revised Unit 1 replacement steam dryer (RSD) analysis utilizing the Unit 3 on-dryer strain gauge based end-to-end bias and uncertainties at extended power conditions ''at least 90 days prior to the start of the BFN Unit 1 EPU [extended power uprate] outage.'' TVA is unable to submit the revised Unit 1 RSD analysis 90 days prior to the start of the Unit 1 EPU outage, because of delays in Unit 3 power ascension. In its supplement dated April 19, 2018, TVA proposed to revise Unit 1 analysis submittal from 90 days before the outage to 60 days prior to exceeding 3458 megawatt thermal (MWt) after the outage. The license amendment request was originally noticed in the **Federal Register** on April 10, 2018 (83 FR 15418). The renotice replaces and supersedes the original notice in its entirety.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below.

1. Does the proposed amendment involve a significant increase in the probability or consequence of an accident previously evaluated?

Response: No.

The proposed license amendment reduces the length of time, from 90 days prior to the outage to 60 days prior to exceeding 3458 MWt after the outage, by which a revised analysis of the Browns Ferry Nuclear Plant (BFN) Unit 1 replacement steam dryer (RSD), performed using an NRC-approved methodology benchmarked on the BFN Unit 3 RSD, must be submitted to the NRC for information. There is no required review or approval of the revised analysis needed to satisfy the license condition. The proposed change is an administrative change to the period before the outage and does not impact any system, structure or component in such a way as to affect the probability or consequences of an accident previously evaluated. The proposed amendment is purely administrative and has no technical or safety aspects. Therefore, the proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed license amendment reduces the length of time, from 90 days prior to the outage to 60 days prior to exceeding 3458 MWt after the outage, by which a revised analysis of the BFN Unit 1 RSD must be submitted to the NRC for information. The proposed amendment is purely administrative and has no technical or safety aspects. Therefore, the proposed change does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

The proposed license amendment reduces the length of time, from 90 days prior to the outage to 60 days prior to exceeding 3458 MWt after the outage, by which a revised analysis of the BFN Unit 1 RSD must be submitted to the NRC for information. The proposed amendment is purely administrative and has no technical or safety aspects. Therefore, the proposed change does not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: General Counsel, Tennessee Valley Authority, 400 West Summit Hill Drive, 6A West Tower, Knoxville, TN 37902.

NRC Acting Branch Chief: Brian W. Tindell.

United States Maritime Administration (MARAD), Docket No. 50–238, Nuclear Ship Savannah (NSS), Baltimore, Maryland

Date of amendment request: March 30, 2018. A publicly-available version is in ADAMS under Accession No. ML18093A377.

Description of amendment request: The proposed amendment would amend the Technical Specifications to establish controls for all accesses to the Containment Vessel (CV) in support of two structural modifications. One modification will construct a horizontal access portal to the CV that will be secured by a new D Deck CV Door. The other modification will restore the original forward access between the Cold Chemistry Laboratory (CCL) at D Deck and the Reactor Compartment (RC) Lower Level.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed amendment involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed changes will modify the Technical Specifications (TSs) to include all CV accesses into TS 3.7.1.1 and add two additional accesses into TS 3.7.1.5. The proposed changes are required by two modifications to plant equipment. The completed modification improved personnel access to the RC Lower Level by restoring access between the CCL at D Deck and the RC Lower Level and the proposed modification will improve personnel access to the CV by constructing a horizontal access portal that will be secured by the D Deck CV Door. Neither the proposed changes to the TSs nor the modifications that require those changes affect basic plant operation of a permanently shutdown and defueled facility.

The completed modification restored the original forward access between the CCL at D Deck and the RC Lower Level to improve normal personnel access to the RC Lower Level. It also improved the ability to remove an injured person from the RC Lower Level.

Prior to completing the modification, the only access to the RC Lower Level was via a 12 in. radius access trunk down an approximately 36 ft. ladder from B Deck of the RC to the RC Lower Level at the Tank Top. Emergency personnel egress from the RC Lower Level will be available through either the D Deck opening or the 12 in. radius access trunk down an approximately 36 ft. ladder from B Deck of the RC to the RC Lower Level at the Tank Top.

This modification effectively expanded the boundary of the RC to include the CCL and therefore, requires the proposed change to TS 3.7.1.5 to include the C Deck entrance to the CCL.

The proposed modification—to construct a horizontal access portal that will be secured by the D Deck CV Door—is an improvement in personnel safety. Emergency personnel egress from the CV, in addition to that provided by existing ladders, will be available through the open D Deck CV Door.

The proposed modification will add an access to the CV that has not previously existed and therefore, requires the proposed change to TS 3.7.1.5 to include the D Deck CV Door. Note that this door will open into a passageway similar to the B Beck RC door that is currently the only door listed in TS 3.7.1.5. However, since the proposed D Deck CV Door will provide a direct access to the CV, a change is also proposed to TS 3.7.1.1 to include all CV entrances into its scope.

If any event requires shutting any door to the CV or RC, the limiting closure time is the time it would take for the door guard to simply swing the door shut and secure it with installed dogs or quick closure operators. The worst case time to secure any door is the time to secure the D Deck CV Door, a watertight double door. The time to secure it is estimated to be approximately 120 seconds after the CV and RC have been checked to be free of personnel. Administrative controls will be put in place to ensure that (1) the swing path of the door is not blocked, (2) the door shall not be fouled and (3) trained personnel will be in the immediate vicinity of the door and available to close it in a timely manner following any event where closing the door is appropriate.

The NSS's reactor is not operational and the level of radioactivity in the NSS has significantly decreased from the levels that existed when the 1976 Possession-only License was issued. No aspect of any of the proposed changes is an initiator of any accident previously evaluated. Consequently, the probability of an accident previously evaluated is not significantly increased.

Therefore, the proposed changes do not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed changes will modify the Technical Specifications (TSs) to include all CV accesses into TS 3.7.1.1 and add two additional accesses into TS 3.7.1.5. The proposed changes are required by two modifications to plant equipment. The completed modification improved personnel access to the RC Lower Level by restoring access between the CCL at D Deck and the RC Lower Level and the proposed modification will improve personnel access to the CV by constructing a horizontal access portal that will be secured by the D Deck CV Door. Neither the proposed changes to the TSs nor the modifications that require those changes affect basic plant operation of a permanently shutdown and defueled facility.

In both cases, the physical alteration of plant equipment is similar to that which was previously allowed by Technical Specifications. Specifically, since November

1995, the C Deck Door to the Cold Chemistry Laboratory has been locked from the outside and fitted with an intrusion alarm that alerts a security monitoring station. When opened, the door has been manned and protected. Likewise, the D Deck CV Door shall be locked from the outside and fitted with an intrusion alarm that alerts a security monitoring station; when opened the D Deck CV Door shall be manned and protected.

Neither of the proposed changes to TS 3.7.1.1 and TS 3.7.1.5 will change the method by which any safety-related system performs its function. As such, no new or different types of equipment will be installed, and the basic operation of installed equipment is unchanged. The methods governing plant operation and testing remain consistent with current safety analysis assumptions.

Therefore, the proposed changes do not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the change involve a significant reduction in a margin of safety?

Response: No.

The proposed changes will modify the Technical Specifications (TSs) to include all CV accesses into TS 3.7.1.1 and add two additional accesses into TS 3.7.1.5. The proposed changes are required by two modifications to plant equipment. The completed modification improved personnel access to the RC Lower Level by restoring access between the CCL at D Deck and the RC Lower Level and the proposed modification will improve personnel access to the CV by constructing a horizontal access portal that will be secured by the D Deck CV Door. Neither the proposed changes to the TSs nor the modifications that require those changes affect any margins of safety that are relevant to the ship's defueled and partially dismantled reactor.

The completed modification improved personnel access to the RC Lower Level by restoring access between the CCL at D Deck and the RC Lower Level. The proposed modification will improve personnel access to the CV by constructing a horizontal access portal that will be secured by the D Deck CV Door.

As such, there are no changes being made to safety analysis assumptions, safety limits or safety system settings that would adversely affect plant safety or are relevant to the ship's defueled and partially dismantled reactor as a result of the proposed changes.

Additionally, when any door to the CV or RC door is open, administrative controls will be put in place to ensure that (1) the swing path of the door is not blocked, (2) the door shall not be fouled and (3) trained personnel will be in the immediate vicinity of the door and available to close it in a timely manner following any event where closing the door is appropriate.

Therefore, the proposed changes do not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Advisor for licensee: Erhard W. Koehler, U.S. Department of Transportation, Maritime Administration, 1200 New Jersey Ave. SE, Washington, DC 20590.

NRC Branch Chief: Bruce Watson.

III. Notice of Issuance of Amendments to Facility Operating Licenses and Combined Licenses

During the period since publication of the last biweekly notice, the Commission has issued the following amendments. The Commission has determined for each of these amendments that the application complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations. The Commission has made appropriate findings as required by the Act and the Commission's rules and regulations in 10 CFR chapter I, which are set forth in the license amendment.

A notice of consideration of issuance of amendment to facility operating license or combined license, as applicable, proposed no significant hazards consideration determination, and opportunity for a hearing in connection with these actions, was published in the **Federal Register** as indicated.

Unless otherwise indicated, the Commission has determined that these amendments satisfy the criteria for categorical exclusion in accordance with 10 CFR 51.22. Therefore, pursuant to 10 CFR 51.22(b), no environmental impact statement or environmental assessment need be prepared for these amendments. If the Commission has prepared an environmental assessment under the special circumstances provision in 10 CFR 51.22(b) and has made a determination based on that assessment, it is so indicated.

For further details with respect to the action see (1) the applications for amendment, (2) the amendment, and (3) the Commission's related letter, Safety Evaluation, and/or Environmental Assessment, as indicated. All of these items can be accessed as described in the ''Obtaining Information and Submitting Comments'' section of this document.

Duke Energy Carolinas, LLC, Docket Nos. 50–269, 50–270, and 50–287, Oconee Nuclear Station, Unit Nos. 1, 2, and 3, Oconee County, South Carolina

Date of amendment request: March 30, 2017, as supplemented by letters dated May 11 and October 16, 2017, and April 4, 2018.

Brief description of amendments: The amendments revised the Technical Specifications in accordance with the NRC-approved Technical Specifications Task Force (TSTF) Standard Technical Specifications Change Traveler TSTF–448, Revision 3, ''Control Room Habitability,'' with variations from TSTF–448 because of the plant's design and licensing basis.

Date of issuance: April 12, 2018.

Effective date: As of the date of issuance and shall be implemented within 180 days of issuance.

Amendment Nos.: 408, 410, and 409. A publicly-available version is in ADAMS under Accession No. ML18040A194; documents related to these amendments are listed in the Safety Evaluation enclosed with the amendments.

Facility Operating License Nos. DPR–38, DPR–47 and DPR–55: Amendments revised the Facility Operating Licenses and Technical Specifications.

Date of initial notice in ***Federal Register:*** July 18, 2017 (82 FR 32879). The supplemental letters dated October 16, 2017, and April 4, 2018, provided additional information that clarified the application, did not expand the scope of the application as originally noticed, and did not change the NRC staff's original proposed no significant hazards consideration determination as published in the **Federal Register**.

The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated April 12, 2018.

No significant hazards consideration comments received: No.

Duke Energy Progress Inc., Docket No. 50–261, H.B. Robinson Steam Electric Plant, Unit No. 2 (Robinson), Darlington County, South Carolina

Duke Energy Progress, LLC, Docket No. 50–400, Shearon Harris Nuclear Power Plant, Unit 1 (Harris), Wake and Chatham Counties, North Carolina

Date of amendment request: November 19, 2015, as superseded by application dated October 3, 2016, and as supplemented by letters dated November 10, 2016, and October 9, October 30, and December 19, 2017.

Brief description of amendments: The amendments revised the Robinson Technical Specification (TS) 5.6.5.b and the Harris TS 6.9.1.6.2 to adopt the methodology reports DPC–NE–3008–P, Revision 0, ''Thermal-Hydraulic Models for Transient Analysis,'' and DPC–NE–3009–P, Revision 0, ''FSAR/UFSAR Chapter 15 Transient Analysis Methodology,'' for application specific to Robinson and Harris.

Date of issuance: April 10, 2018.

Effective date: As of the date of issuance and shall be implemented within 120 days of issuance.

Amendment Nos.: 164 (Robinson) and 257 (Harris). A publicly-available version is in ADAMS under Accession No. ML18060A401; documents related to these amendments are listed in the Safety Evaluation enclosed with the amendments.

Renewed Facility Operating License Nos. DPR–23 and NPF–63: Amendments revised the Facility Operating Licenses and TSs.

*Date of initial notice in **Federal Register:*** April 5, 2016 (81 FR 19645). The supplemental letter dated October 3, 2016, provided additional information that expanded the scope of the application as originally noticed, and changed the NRC staff's original proposed no significant hazards consideration determination as published in the **Federal Register**. Accordingly, the NRC published a second proposed no significant hazards consideration determination in the **Federal Register** on May 2, 2017 (82 FR 20496). This notice superseded the original notice in its entirety. The supplemental letters dated November 10, 2016, and October 9, October 30, and December 19, 2017, provided additional information that clarified the application, did not expand the scope beyond the second notice, and did not change the NRC staff's proposed no significant hazards consideration determination as published in the **Federal Register**.

The Commission's related evaluations of the amendments are contained in the Safety Evaluation dated April 10, 2018.

No significant hazards consideration comments received: No.

Duke Energy Progress, LLC, Docket Nos. 50–325 and 50–324, Brunswick Steam Electric Plant, Unit Nos. 1 and 2 (Brunswick), Brunswick County, North Carolina

Date of amendment request: June 29, 2017, as supplemented by letters dated January 4 and January 23, 2018.

Brief description of amendments: The amendments adopted Technical Specifications Task Force (TSTF) Traveler TSTF–542, Revision 2, ''Reactor Pressure Vessel Water Inventory Control [RPVWIC].'' The amendments replaced existing technical specification (TS) requirements associated with ''operations with the potential for draining the reactor vessel,'' with revised TSs providing alternative requirements for RPVWIC. These alternative requirements protect Safety Limit 2.1.1.3, which states, ''Reactor vessel water level shall be greater than the top of active irradiated fuel.''

Date of issuance: April 13, 2018.

Effective date: As of the date of issuance and shall be implemented: (1) For Unit 1, within 180 days of issuance and (2) for Unit 2, prior to its 2019 refueling outage.

Amendment Nos.: 283 (Unit No. 1) and 311 (Unit No. 2). A publicly-available version is in ADAMS under Accession No. ML18039A444; documents related to these amendments are listed in the Safety Evaluation enclosed with the amendments.

Renewed Facility Operating License Nos. DPR–71 and DPR–62: Amendments revised the Renewed Facility Operating Licenses and TSs.

*Date of initial notice in **Federal Register:*** September 12, 2017 (82 FR 42846). The supplemental letters dated January 4 and January 23, 2018, provided additional information that clarified the application, did not expand the scope of the application as originally noticed, and did not change the NRC staff's original proposed no significant hazards consideration determination as published in the **Federal Register**.

The Commission's related evaluation of the amendments is contained in a Safety Evaluation dated April 13, 2018.

No significant hazards consideration comments received: No.

Energy Northwest, Docket No. 50–397, Columbia Generating Station, Benton County, Washington

Date of amendment request: August 30, 2016, as supplemented by letter dated November 20, 2017.

Brief description of amendment: The amendment revised the Columbia Generating Station Final Safety Analysis Report to reclassify reactor water cleanup piping, valves, pumps, and mechanical modules located outside of the primary and secondary containment in the radwaste building from Quality Group C to Quality Group D.

Date of issuance: April 17, 2018.

Effective date: As of its date of issuance and shall be implemented within 120 days from the date of issuance.

Amendment No.: 248. A publicly-available version is in ADAMS under Accession No. ML18075A351; documents related to this amendment are listed in the Safety Evaluation enclosed with the amendment.

Renewed Facility Operating License No. NPF–21: The amendment revised the Final Safety Analysis Report.

*Date of initial notice in **Federal Register:*** December 6, 2016 (81 FR 87968). The supplemental letter dated November 20, 2017, provided additional information that clarified the application, did not expand the scope of the application as originally noticed, and did not change the NRC staff's original proposed no significant hazards consideration determination as published in the **Federal Register**.

The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated April 17, 2018.

No significant hazards consideration comments received: No.

PSEG Nuclear LLC and Exelon Generation Company, LLC, Docket Nos. 50–272 and 50–311, Salem Nuclear Generating Station, Unit Nos. 1 and 2, Salem County, New Jersey

Date of amendment request: September 27, 2017.

Brief description of amendments: The amendments relocated the Reactor Coolant System Pressure Isolation Valve Table from the Technical Specifications to the Technical Requirements Manual. The amendments also removed references to the table and moved all notes and leakage acceptance criteria from the table to the Technical Specification surveillance requirements.

Date of issuance: April 18, 2018.

Effective date: As of the date of issuance and shall be implemented within 60 days of issuance.

Amendment Nos.: 323 (Unit No. 1) and 304 (Unit No. 2). A publicly-available version is in ADAMS under Accession No. ML18040A778; documents related to these amendments are listed in the Safety Evaluation enclosed with the amendments.

Renewed Facility Operating License Nos. DPR–70 and DPR–75: The amendments revised the Renewed Facility Operating Licenses and Technical Specifications.

*Date of initial notice in **Federal Register:*** November 21, 2017 (82 FR 55408).

The Commission's related evaluation of the amendments is contained in a Safety Evaluation dated April 18, 2018.

No significant hazards consideration comments received: No.

PSEG Nuclear LLC and Exelon Generation Company, LLC, Docket Nos. 50–272 and 50–311, Salem Nuclear Generating Station, Unit Nos. 1 and 2, Salem County, New Jersey

Date of amendment request: February 8, 2018.

Brief description of amendments: The amendments modified the Salem Nuclear Generating Station, Unit Nos. 1 and 2, Technical Specification (TS)-allowed outage time for more than one inoperable analog rod position indicator

from 1 hour to 24 hours and changed the basis for entry into the TS actions for inoperable rod position indicators from ''per bank'' to ''per group.'' The amendments also separated existing TS 3.1.3.2.1, Action a.1, into two separate actions and removed the duplicative Action b (Unit No. 1 only).

Date of issuance: April 18, 2018.

Effective date: As of the date of issuance and shall be implemented within 30 days from the date of issuance.

Amendment Nos.: 324 (Unit No. 1) and 305 (Unit No. 2). A publicly-available version is in ADAMS under Accession No. ML18085B198; documents related to these amendments are listed in the Safety Evaluation enclosed with the amendments.

Renewed Facility Operating License Nos. DPR–70 and DPR–75: The amendments revised the Renewed Facility Operating Licenses and TSs.

*Date of initial notice in **Federal Register:*** March 1, 2018 (83 FR 8904).

The Commission's related evaluation of the amendments is contained in a Safety Evaluation dated April 18, 2018.

No significant hazards consideration comments received: No.

PSEG Nuclear LLC, Docket No. 50–354, Hope Creek Generating Station (HCGS), Salem County, New Jersey

Date of amendment request: November 9, 2017, as supplemented by letter dated January 22, 2018.

Brief description of amendment: The amendment revised the HCGS Technical Specifications. Specifically, the amendment revised the safety limit minimum critical power ratio for two recirculation loop operation and single recirculation loop operation based on the HCGS Cycle 22 specific analysis.

Date of issuance: April 11, 2018.

Effective date: As of the date of issuance and shall be implemented prior to startup following the spring 2018 refueling outage.

Amendment No.: 211. A publicly-available version is in ADAMS under Accession No. ML18081A044; documents related to this amendment are listed in the Safety Evaluation enclosed with the amendment.

Renewed Facility Operating License No. NPF–57: The amendment revised the renewed facility operating license and technical specifications.

*Date of initial notice in **Federal Register***: February 6, 2018 (83 FR 5281). The supplemental letter dated January 22, 2018, provided additional information that clarified the application, did not expand the scope of the application as originally noticed, and did not change the NRC staff's original proposed no significant hazards consideration determination as published in the **Federal Register**.

The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated April 11, 2018.

No significant hazards consideration comments received: No.

Southern Nuclear Operating Company, Docket Nos. 52–025 and 52–026, Vogtle Electric Generating Plant (VEGP), Unit Nos. 3 and 4, Burke County, Georgia

Date of amendment request: September 13, 2017.

Description of amendment: The amendments authorized changes to the VEGP, Unit Nos. 3 and 4, Updated Final Safety Analysis Report in the form of departures from the plant-specific Design Control Document Tier 2 information and involved related changes to the VEGP, Units 3 and 4, Combined License (COL) Appendix A, Technical Specifications.

The amendments authorized changes to the mass of trisodium phosphate required inside containment to provide adjustment of the pH of the water in the containment following an accident in which the containment floods. These changes are reflected in COL Appendix A.

Date of issuance: February 27, 2018.

Effective date: As of the date of issuance and shall be implemented within 30 days of issuance.

Amendment Nos.: 110 (Unit No. 3) and 109 (Unit No. 4). A publicly-available version is in ADAMS under Package Accession No. ML18030A612; documents related to these amendments are listed in the Safety Evaluation enclosed with the amendments.

Facility Combined Licenses Nos. NPF–91 and NPF–92: Amendments revised the facility COL.

*Date of initial notice in **Federal Register:*** November 21, 2017 (82 FR 55401).

The Commission's related evaluation of the amendments is contained in a Safety Evaluation dated February 27, 2018.

No significant hazards consideration comments received: No.

Dated at Rockville, Maryland, this 26th day of April 2018.

For the Nuclear Regulatory Commission.

Tara Inverso,

Acting Deputy Director, Division of Operating Reactor Licensing, Office of Nuclear Reactor Regulation.

[FR Doc. 2018–09244 Filed 5–7–18; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 52–025 and 52–026; NRC–2018–0071]

Applications and Amendments to Facility Operating Licenses and Combined Licenses Involving Proposed No Significant Hazards Considerations and Containing Sensitive Unclassified Non-Safeguards Information and Order Imposing Procedures for Access to Sensitive Unclassified Non-Safeguards Information

AGENCY: Nuclear Regulatory Commission.

ACTION: License amendment request; notice of opportunity to comment, request a hearing, and petition for leave to intervene; order imposing procedures.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) received and is considering approval of one amendment request for Vogtle Electric Generating Plant, Units 3 and 4. The NRC proposes to determine that the amendment request involves no significant hazards consideration. Because the amendment request contains sensitive unclassified non-safeguards information (SUNSI), an order imposes procedures to obtain access to SUNSI for contention preparation.

DATES: Comments must be filed by June 7, 2018. A request for a hearing must be filed by July 9, 2018. Any potential party, as defined in § 2.4 of title 10 of the *Code of Federal Regulations* (10 CFR), who believes access to SUNSI is necessary to respond to this notice must request document access by May 18, 2018.

ADDRESSES: You may submit comments by any of the following methods:

- *Federal Rulemaking Website:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2018–0071. Address questions about NRC dockets to Jennifer Borges; telephone: 301–287–9127; email: *Jennifer.Borges@nrc.gov.* For technical questions, contact the individual listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *Mail comments to:* May Ma, Office of Administration, Mail Stop: TWFN–7–A60, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

For additional direction on obtaining information and submitting comments, see ''Obtaining Information and Submitting Comments'' in the

SUPPLEMENTARY INFORMATION section of this document.

FOR FURTHER INFORMATION CONTACT: Kay Goldstein, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–1506, email: *Kay.Goldstein@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Obtaining Information and Submitting Comments

A. Obtaining Information

Please refer to Docket ID NRC–2018–0071, facility name, unit number(s), plant docket number, application date, and subject when contacting the NRC about the availability of information for this action. You may obtain publicly-available information related to this action by any of the following methods:

- *Federal Rulemaking Website:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2018–0071.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly-available documents online in the ADAMS Public Documents collection 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 (if it is available in ADAMS) is provided the first time that it is mentioned in this document.
- *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–2018–0071, facility name, unit number(s), plant docket number, application date, and subject in your comment submission.

The NRC cautions you not to include identifying or contact information that you do not want to be publicly disclosed in your 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 into ADAMS.

II. Background

Pursuant to Section 189.a.(2) of the Atomic Energy Act of 1954, as amended (the Act), the NRC is publishing this notice. The Act requires the Commission to publish notice of any amendments issued, or proposed to be issued and grants the Commission the authority to issue and make immediately effective any amendment to an operating license or combined license, as applicable, upon a determination by the Commission that such amendment involves no significant hazards consideration, notwithstanding the pendency before the Commission of a request for a hearing from any person.

This notice includes notices of amendments containing SUNSI.

III. Notice of Consideration of Issuance of Amendments to Facility Operating Licenses or Combined Licenses, Proposed No Significant Hazards Consideration Determination, and Opportunity for a Hearing

The Commission has made a proposed determination that the following amendment request involves no significant hazards consideration. Under the Commission's regulations in 10 CFR 50.92, this means that operation of the facility in accordance with the proposed amendment would not (1) involve a significant increase in the probability or consequences of an accident previously evaluated, or (2) create the possibility of a new or different kind of accident from any accident previously evaluated, or (3) involve a significant reduction in a margin of safety. The basis for this proposed determination for the amendment request is shown below.

The Commission is seeking public comments on this proposed determination. Any comments received within 30 days after the date of publication of this notice will be considered in making any final determination.

Normally, the Commission will not issue the amendment until the expiration of 60 days after the date of publication of this notice. The Commission may issue the license amendment before expiration of the 60-day period provided that its final determination is that the amendment involves no significant hazards consideration. In addition, the Commission may issue the amendment prior to the expiration of the 30-day comment period if circumstances change during the 30-day comment period such that failure to act in a timely way would result, for example, in derating or shutdown of the facility. If the Commission takes action prior to the expiration of either the comment period or the notice period, it will publish a notice of issuance in the **Federal Register**. If the Commission makes a final no significant hazards consideration determination, any hearing will take place after issuance. The Commission expects that the need to take this action will occur very infrequently.

A. Opportunity To Request a Hearing and Petition for Leave To Intervene

Within 60 days after the date of publication of this notice, any person (petitioner) whose interest may be affected by this action may file a request for a hearing and petition for leave to intervene (petition) with respect to the action. Petitions shall be filed in accordance with the Commission's ''Agency Rules of Practice and Procedure'' in 10 CFR part 2. Interested persons should consult a current copy of 10 CFR 2.309. The NRC's regulations are accessible electronically from the NRC Library on the NRC's website at *http://www.nrc.gov/reading-rm/doc-collections/cfr/.* Alternatively, a copy of the regulations is available at the NRC's Public Document Room, located at One White Flint North, Room O1–F21, 11555 Rockville Pike (First Floor), Rockville, Maryland 20852. If a petition is filed, the Commission or a presiding officer will rule on the petition and, if appropriate, a notice of a hearing will be issued.

As required by 10 CFR 2.309(d) the petition should specifically explain the reasons why intervention should be permitted with particular reference to the following general requirements for standing: (1) The name, address, and telephone number of the petitioner; (2) the nature of the petitioner's right under the Act to be made a party to the proceeding; (3) the nature and extent of the petitioner's property, financial, or other interest in the proceeding; and (4) the possible effect of any decision or order which may be entered in the proceeding on the petitioner's interest.

In accordance with 10 CFR 2.309(f), the petition must also set forth the specific contentions which the petitioner seeks to have litigated in the proceeding. Each contention must

consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the petitioner must provide a brief explanation of the bases for the contention and a concise statement of the alleged facts or expert opinion which support the contention and on which the petitioner intends to rely in proving the contention at the hearing. The petitioner must also provide references to the specific sources and documents on which the petitioner intends to rely to support its position on the issue. The petition must include sufficient information to show that a genuine dispute exists with the applicant or licensee on a material issue of law or fact. Contentions must be limited to matters within the scope of the proceeding. The contention must be one which, if proven, would entitle the petitioner to relief. A petitioner who fails to satisfy the requirements at 10 CFR 2.309(f) with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene. Parties have the opportunity to participate fully in the conduct of the hearing with respect to resolution of that party's admitted contentions, including the opportunity to present evidence, consistent with the NRC's regulations, policies, and procedures.

Petitions must be filed no later than 60 days from the date of publication of this notice. Petitions and motions for leave to file new or amended contentions that are filed after the deadline will not be entertained absent a determination by the presiding officer that the filing demonstrates good cause by satisfying the three factors in 10 CFR 2.309(c)(1)(i) through (iii). The petition must be filed in accordance with the filing instructions in the ''Electronic Submissions (E-Filing)'' section of this document.

If a hearing is requested, and the Commission has not made a final determination on the issue of no significant hazards consideration, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to establish when the hearing is held. If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it immediately effective, notwithstanding the request for a hearing. Any hearing would take place after issuance of the amendment. If the final determination is that the amendment request involves a significant hazards consideration, then any hearing held would take place before the issuance of the amendment unless the Commission finds an imminent danger to the health or safety of the public, in which case it will issue an appropriate order or rule under 10 CFR part 2.

A State, local governmental body, Federally-recognized Indian Tribe, or agency thereof, may submit a petition to the Commission to participate as a party under 10 CFR 2.309(h)(1). The petition should state the nature and extent of the petitioner's interest in the proceeding. The petition should be submitted to the Commission no later than 60 days from the date of publication of this notice. The petition must be filed in accordance with the filing instructions in the ''Electronic Submissions (E-Filing)'' section of this document, and should meet the requirements for petitions set forth in this section, except that under 10 CFR 2.309(h)(2) a State, local governmental body, or Federally-recognized Indian Tribe, or agency thereof does not need to address the standing requirements in 10 CFR 2.309(d) if the facility is located within its boundaries. Alternatively, a State, local governmental body, Federally-recognized Indian Tribe, or agency thereof may participate as a non-party under 10 CFR 2.315(c).

If a hearing is granted, any person who is not a party to the proceeding and is not affiliated with or represented by a party may, at the discretion of the presiding officer, be permitted to make a limited appearance pursuant to the provisions of 10 CFR 2.315(a). A person making a limited appearance may make an oral or written statement of his or her position on the issues but may not otherwise participate in the proceeding. A limited appearance may be made at any session of the hearing or at any prehearing conference, subject to the limits and conditions as may be imposed by the presiding officer. Details regarding the opportunity to make a limited appearance will be provided by the presiding officer if such sessions are scheduled.

B. Electronic Submissions (E-Filing)

All documents filed in NRC adjudicatory proceedings, including a request for hearing and petition for leave to intervene (petition), 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 that request to participate under 10 CFR 2.315(c), must be filed in accordance with the NRC's E-Filing rule (72 FR 49139; August 28, 2007, as amended at 77 FR 46562; August 3, 2012). 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. Detailed guidance on making electronic submissions may be found in the Guidance for Electronic Submissions to the NRC and on the NRC website at *http://www.nrc.gov/site-help/e-submittals.html.* 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 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 (1) request a digital identification (ID) certificate, which allows the participant (or its counsel or representative) to digitally sign submissions and access the E-Filing system for any proceeding in which it is participating; and (2) advise the Secretary that the participant will be submitting a petition or other adjudicatory document (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 website at *http://www.nrc.gov/site-help/e-submittals/getting-started.html.* Once a participant has obtained a digital ID certificate and a docket has been created, the participant can then submit adjudicatory documents. Submissions must be in Portable Document Format (PDF). Additional guidance on PDF submissions is available on the NRC's public website at *http://www.nrc.gov/site-help/electronic-sub-ref-mat.html.* A filing is considered complete at the time the document is 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 document on those participants separately. Therefore, applicants and other participants (or their counsel or representative) must apply for and receive a digital ID certificate before adjudicatory documents are filed so that they can obtain access to the documents via the E-Filing system.

A person filing electronically using the NRC's adjudicatory E-Filing system may seek assistance by contacting the NRC's Electronic Filing Help Desk through the ''Contact Us'' link located on the NRC's public website at *http://www.nrc.gov/site-help/e-submittals.html,* by email to *MSHD.Resource@nrc.gov,* or by a toll-free call at 1–866–672–7640. The NRC Electronic Filing Help Desk is available between 9 a.m. and 6 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 paper filing stating why there is good cause for not filing electronically and requesting authorization to continue to submit documents in paper format. 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: Rulemaking and Adjudications Staff; or (2) courier, express mail, or expedited delivery service to the Office of the Secretary, 11555 Rockville Pike, Rockville, Maryland 20852, Attention: Rulemaking and Adjudications Staff. Participants filing adjudicatory documents 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 *https://adams.nrc.gov/ehd,* unless excluded pursuant to an order of the Commission or the presiding officer. If you do not have an NRC-issued digital ID certificate as described above, click cancel when the link requests certificates and you will be automatically directed to the NRC's electronic hearing dockets where you will be able to access any publicly available documents in a particular hearing docket. Participants are requested not to include personal privacy information, such as social security numbers, home addresses, or personal phone numbers in their filings, unless an NRC regulation or other law requires submission of such information. For example, in some instances, individuals provide home addresses in order to demonstrate proximity to a facility or site. 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.

Southern Nuclear Operating Company, Inc., Docket Nos. 52–025 and 52–026, Vogtle Electric Generating Plant, Units 3 and 4, Burke County, Georgia

Date of amendment request: December 21, 2017. A publicly-available version is in ADAMS under Accession No. ML18029A243.

Description of amendment request: This amendment request contains sensitive unclassified non-safeguards information (SUNSI). The amendment request proposes changes to the Updated Final Safety Analysis Report (UFSAR) in the form of departures from the incorporated plant-specific Design Control Document (DCD) Tier 2* and Tier 2 information and related changes to the Vogtle Electric Generating Plant, Units 3 and 4, Combined License (COL) Appendix A and COL Appendix C (and corresponding plant-specific DCD Tier 1) information. An exemption request relating to the proposed changes to the AP1000 DCD Tier 1 is included with the request. Specifically, the amendment request states that design changes within containment have necessitated recalculation of geometry input to the WGOTHIC evaluation model (EM) used for containment integrity analyses. Heat sinks, control volumes, and flow paths have been recalculated, and are in turn modeled in the WGOTHIC EM. Mass and energy (M&E) releases for Loss of Coolant Accident (LOCA) and Main Steam Line Break (MSLB) events are also recalculated. Various methodology changes are also made to the WGOTHIC methodology for the AP1000 design. These updates culminate in the recalculation of the containment integrity analyses. Additionally, changes are proposed to Inspections, Tests, Analyses, and Acceptance Criteria (ITAAC) related to flow rate testing of the passive containment cooling system (PCS) in order to capture lessons learned from preoperational testing performed at China's AP1000 nuclear power station, Sanmen Unit 1.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below with NRC staff edits in square brackets:

1. Does the proposed amendment involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

This change proposes updates to the plant-specific containment integrity analyses. Heat sinks, control volumes, and flow paths have been recalculated, and are in turn modeled in the WGOTHIC EM. Various methodology changes are also made to the WGOTHIC methodology for the AP1000 plant design. M&E releases for LOCA and MSLB are also recalculated. These updates culminate in the recalculation of the containment integrity calculations. Additionally, changes are proposed to ITAAC acceptance criteria related to flow rate testing of the PCS in order to capture lessons learned from testing at [China's AP1000] Sanmen Unit 1.

The proposed changes do not adversely affect the operation of any systems or equipment that initiate an analyzed accident or alter any structures, systems, and components (SSC) accident initiator or initiating sequence of events. The proposed changes do not adversely affect the physical design and operation of the PCS including as-installed inspections, testing, and maintenance requirements, as described in the UFSAR. Therefore, the operation of the PCS is not adversely affected. A LOCA and a MSLB are considered and identified as the limiting events for the AP1000 design with respect to containment peak pressure and temperature. However, the proposed changes do not adversely affect the probability of either a LOCA or MSLB from occurring. Therefore, the probabilities of the accidents previously evaluated in the UFSAR are not affected.

The proposed changes do not adversely affect the ability of the PCS to perform its design functions. The design of the PCS continues to meet the same regulatory acceptance criteria, codes, and standards as required by the UFSAR. In addition, the proposed changes maintain the capabilities of the PCS to mitigate the consequences of an accident and to meet the applicable regulatory acceptance criteria. The proposed changes do not adversely affect the prevention and mitigation of other abnormal events, *e.g.,* anticipated operational occurrences, earthquakes, floods and turbine missiles, or their safety or design analyses. Therefore, the consequences of accidents evaluated in the UFSAR are not affected.

Therefore, the proposed amendment does not involve a significant increase in the

consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

This change proposes updates to the plant-specific containment integrity analyses. Heat sinks, control volumes, and flow paths have been recalculated, and are in turn modeled in the WGOTHIC EM. Various methodology changes are also made to the WGOTHIC methodology for the AP1000 plant design. M&E releases for LOCA and MSLB are also recalculated. These updates culminate in the recalculation of the containment integrity calculations. Additionally, changes are proposed to ITAAC acceptance criteria related to flow rate testing of the passive containment cooling system PCS in order to capture lessons learned from testing at [China's AP1000] Sanmen Unit 1.

The proposed changes would not introduce a new failure mode, fault, or sequence of events that could result in a radioactive material release. The proposed changes do not alter the design, configuration, or method of operation of the plant beyond standard functional capabilities of the equipment. Therefore, this activity does not allow for a new fission product release path, result in a new fission product barrier failure mode, or create a new sequence of events which results in significant fuel cladding failures.

Therefore, the proposed changes do not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

This change proposes updates to the plant-specific containment integrity analyses. Heat sinks, control volumes, and flow paths have been recalculated, and are in turn modeled in the WGOTHIC EM. Various methodology changes are also made to the WGOTHIC methodology for the AP1000 plant design. M&E releases for LOCA and MSLB are also recalculated. These updates culminate in the recalculation of the containment integrity calculations. Additionally, changes are proposed to ITAAC acceptance criteria related to flow rate testing of the passive containment cooling system (PCS) in order to capture lessons learned from testing at [China's AP1000] Sanmen Unit 1.

Safety margins are applied at many levels to the design and licensing basis functions and to the controlling values of parameters to account for various uncertainties and to avoid exceeding regulatory or licensing limits. The proposed changes maintain existing safety margins, and in some cases, provide additional margin. The proposed changes maintain the capabilities of the PCS to perform its design functions. Therefore, the proposed changes satisfy the same design functions in accordance with the same codes and standards as stated in the UFSAR. These changes do not adversely affect any design code, function, safety analysis, safety analysis input or results, or design/safety margin. No safety analysis or design basis acceptance limit/criterion is challenged or exceeded by the proposed changes, and no margin of safety is reduced.

Therefore, the proposed amendment does not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Kathryn M. Sutton, Morgan, Lewis & Bockius LLC, 1111 Pennsylvania Avenue NW, Washington, DC 20004–2514.

NRC Branch Chief: Jennifer Dixon-Herrity.

Order Imposing Procedures for Access to Sensitive Unclassified Non-Safeguards Information for Contention Preparation

Southern Nuclear Operating Company, Inc., Docket Nos. 52–025 and 52–026, Vogtle Electric Generating Plant, Units 3 and 4, Burke County, Georgia

A. This Order contains instructions regarding how potential parties to this proceeding may request access to documents containing Sensitive Unclassified Non-Safeguards Information (SUNSI).

B. Within 10 days after publication of this notice of hearing and opportunity to petition for leave to intervene, any potential party who believes access to SUNSI is necessary to respond to this notice may request access to SUNSI. A ''potential party'' is any person who intends to participate as a party by demonstrating standing and filing an admissible contention under 10 CFR 2.309. Requests for access to SUNSI submitted later than 10 days after publication of this notice will not be considered absent a showing of good cause for the late filing, addressing why the request could not have been filed earlier.

C. The requester shall submit a letter requesting permission to access SUNSI to the Office of the Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Rulemakings and Adjudications Staff, and provide a copy to the Associate General Counsel for Hearings, Enforcement and Administration, Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. The expedited delivery or courier mail address for both offices is: U.S. Nuclear Regulatory Commission, 11555 Rockville Pike, Rockville, Maryland 20852. The email addresses for the Office of the Secretary and the Office of the General Counsel are *Hearing.Docket@nrc.gov* and *OGCmailcenter@nrc.gov,* respectively.[1] The request must include the following information:

(1) A description of the licensing action with a citation to this **Federal Register** notice;

(2) The name and address of the potential party and a description of the potential party's particularized interest that could be harmed by the action identified in C.(1); and

(3) The identity of the individual or entity requesting access to SUNSI and the requester's basis for the need for the information in order to meaningfully participate in this adjudicatory proceeding. In particular, the request must explain why publicly available versions of the information requested would not be sufficient to provide the basis and specificity for a proffered contention.

D. Based on an evaluation of the information submitted under paragraph C.(3), the NRC staff will determine within 10 days of receipt of the request whether:

(1) There is a reasonable basis to believe the petitioner is likely to establish standing to participate in this NRC proceeding; and

(2) The requestor has established a legitimate need for access to SUNSI.

E. If the NRC staff determines that the requestor satisfies both D.(1) and D.(2) above, the NRC staff will notify the requestor in writing that access to SUNSI has been granted. The written notification will contain instructions on how the requestor may obtain copies of the requested documents, and any other conditions that may apply to access to those documents. These conditions may include, but are not limited to, the signing of a Non-Disclosure Agreement or Affidavit, or Protective Order[2] setting forth terms and conditions to prevent the unauthorized or inadvertent disclosure of SUNSI by each individual who will be granted access to SUNSI.

F. Filing of Contentions. Any contentions in these proceedings that are based upon the information received as a result of the request made for SUNSI must be filed by the requestor no later than 25 days after receipt of (or

[1] While a request for hearing or petition to intervene in this proceeding must comply with the filing requirements of the NRC's ''E-Filing Rule,'' the initial request to access SUNSI under these procedures should be submitted as described in this paragraph.

[2] Any motion for Protective Order or draft Non-Disclosure Affidavit or Agreement for SUNSI must be filed with the presiding officer or the Chief Administrative Judge if the presiding officer has not yet been designated, within 30 days of the deadline for the receipt of the written access request.

access to) that information. However, if more than 25 days remain between the petitioner's receipt of (or access to) the information and the deadline for filing all other contentions (as established in the notice of hearing or opportunity for hearing), the petitioner may file its SUNSI contentions by that later deadline.

G. Review of Denials of Access.

(1) If the request for access to SUNSI is denied by the NRC staff after a determination on standing and requisite need, the NRC staff shall immediately notify the requestor in writing, briefly stating the reason or reasons for the denial.

(2) The requester may challenge the NRC staff's adverse determination by filing a challenge within 5 days of receipt of that determination with: (a) The presiding officer designated in this proceeding; (b) if no presiding officer has been appointed, the Chief Administrative Judge, or if he or she is unavailable, another administrative judge, or an Administrative Law Judge with jurisdiction pursuant to 10 CFR 2.318(a); or (c) if another officer has been designated to rule on information access issues, with that officer.

(3) Further appeals of decisions under this paragraph must be made pursuant to 10 CFR 2.311.

H. Review of Grants of Access. A party other than the requester may challenge an NRC staff determination granting access to SUNSI whose release would harm that party's interest independent of the proceeding. Such a challenge must be filed within 5 days of the notification by the NRC staff of its grant of access and must be filed with: (a) The presiding officer designated in this proceeding; (b) if no presiding officer has been appointed, the Chief Administrative Judge, or if he or she is unavailable, another administrative judge, or an Administrative Law Judge with jurisdiction pursuant to 10 CFR 2.318(a); or (c) if another officer has been designated to rule on information access issues, with that officer.

If challenges to the NRC staff determinations are filed, these procedures give way to the normal process for litigating disputes concerning access to information. The availability of interlocutory review by the Commission of orders ruling on such NRC staff determinations (whether granting or denying access) is governed by 10 CFR 2.311.[3]

I. The Commission expects that the NRC staff and presiding officers (and any other reviewing officers) will consider and resolve requests for access to SUNSI, and motions for protective orders, in a timely fashion in order to minimize any unnecessary delays in identifying those petitioners who have standing and who have propounded contentions meeting the specificity and basis requirements in 10 CFR part 2. The attachment to this Order summarizes the general target schedule for processing and resolving requests under these procedures.

It is so ordered.

Dated at Rockville, Maryland, this 9th of April 2018.

For the Nuclear Regulatory Commission.

Annette L. Vietti-Cook,

Secretary of the Commission.

ATTACHMENT 1—GENERAL TARGET SCHEDULE FOR PROCESSING AND RESOLVING REQUESTS FOR ACCESS TO SENSITIVE UNCLASSIFIED NON-SAFEGUARDS INFORMATION IN THIS PROCEEDING

Day	Event/activity
0	Publication of **Federal Register** notice of hearing and opportunity to petition for leave to intervene, including order with instructions for access requests.
10	Deadline for submitting requests for access to Sensitive Unclassified Non-Safeguards Information (SUNSI) with information: Supporting the standing of a potential party identified by name and address; describing the need for the information in order for the potential party to participate meaningfully in an adjudicatory proceeding.
60	Deadline for submitting petition for intervention containing: (i) Demonstration of standing; and (ii) all contentions whose formulation does not require access to SUNSI (+25 Answers to petition for intervention; +7 petitioner/requestor reply).
20	U.S. Nuclear Regulatory Commission (NRC) staff informs the requester of the staff's determination whether the request for access provides a reasonable basis to believe standing can be established and shows need for SUNSI. (NRC staff also informs any party to the proceeding whose interest independent of the proceeding would be harmed by the release of the information.) If NRC staff makes the finding of need for SUNSI and likelihood of standing, NRC staff begins document processing (preparation of redactions or review of redacted documents).
25	If NRC staff finds no "need" or no likelihood of standing, the deadline for petitioner/requester to file a motion seeking a ruling to reverse the NRC staff's denial of access; NRC staff files copy of access determination with the presiding officer (or Chief Administrative Judge or other designated officer, as appropriate). If NRC staff finds "need" for SUNSI, the deadline for any party to the proceeding whose interest independent of the proceeding would be harmed by the release of the information to file a motion seeking a ruling to reverse the NRC staff's grant of access.
30	Deadline for NRC staff reply to motions to reverse NRC staff determination(s).
40	(Receipt +30) If NRC staff finds standing and need for SUNSI, deadline for NRC staff to complete information processing and file motion for Protective Order and draft Non-Disclosure Affidavit. Deadline for applicant/licensee to file Non-Disclosure Agreement for SUNSI.
A	If access granted: Issuance of presiding officer or other designated officer decision on motion for protective order for access to sensitive information (including schedule for providing access and submission of contentions) or decision reversing a final adverse determination by the NRC staff.
A + 3	Deadline for filing executed Non-Disclosure Affidavits. Access provided to SUNSI consistent with decision issuing the protective order.
A + 28	Deadline for submission of contentions whose development depends upon access to SUNSI. However, if more than 25 days remain between the petitioner's receipt of (or access to) the information and the deadline for filing all other contentions (as established in the notice of opportunity to request a hearing and petition for leave to intervene), the petitioner may file its SUNSI contentions by that later deadline.
A + 53	(Contention receipt +25) Answers to contentions whose development depends upon access to SUNSI.
A + 60	(Answer receipt +7) Petitioner/Intervenor reply to answers.
>A + 60	Decision on contention admission.

[3] Requesters should note that the filing requirements of the NRC's E-Filing Rule (72 FR 49139; August 28, 2007, as amended at 77 FR 46562; August 3, 2012) apply to appeals of NRC staff determinations (because they must be served on a presiding officer or the Commission, as applicable), but not to the initial SUNSI request submitted to the NRC staff under these procedures.

[FR Doc. 2018–07705 Filed 5–7–18; 8:45 am]

BILLING CODE 7590–01–P

POSTAL SERVICE

Temporary Emergency Committee of the Board of Governors; Sunshine Act Meeting

TIME AND DATE: Wednesday, May 9, 2018, at 10:30 a.m.

PLACE: Washington, DC, and via Teleconference.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Wednesday, May 9, 2018, at 10:30 a.m.

1. Strategic Items.
2. Financial Matters.
3. Executive Session—Discussion of prior agenda items and Temporary Emergency Committee governance.

General Counsel Certification: The General Counsel of the United States Postal Service has certified that the meeting may be closed under the Government in the Sunshine Act.

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. 2018–09905 Filed 5–4–18; 4:15 pm]

BILLING CODE 7710–12–P

RAILROAD RETIREMENT BOARD

Agency Forms Submitted for OMB Review, Request for Comments

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35), the Railroad Retirement Board (RRB) is forwarding an Information Collection Request (ICR) to the Office of Information and Regulatory Affairs (OIRA), Office of Management and Budget (OMB). Our ICR describes the information we seek to collect from the public. Review and approval by OIRA ensures that we impose appropriate paperwork burdens.

The RRB invites comments on the proposed collections of information to determine (1) the practical utility of the collections; (2) the accuracy of the estimated burden of the collections; (3) ways to enhance the quality, utility, and clarity of the information that is the subject of collection; and (4) ways to minimize the burden of collections on respondents, including the use of automated collection techniques or other forms of information technology. Comments to the RRB or OIRA must contain the OMB control number of the ICR. For proper consideration of your comments, it is best if the RRB and OIRA receive them within 30 days of the publication date.

1. Title and purpose of information collection: Appeal Under the Railroad Retirement and Railroad Unemployment Insurance Act; OMB 3220–0007.

Under Section 7(b)(3) of the Railroad Retirement Act (RRA), and Section 5(c) of the Railroad Unemployment Insurance Act (RUIA) any person aggrieved by a decision made by an office of the RRB on his or her application for an annuity or benefit under those Acts has the right to appeal to the RRB. This right is prescribed in 20 CFR 260 and 20 CFR 320. The notification letter, which is provided at the time of filing the original application, informs the applicant of such right. When an applicant protests a decision, the concerned RRB office reviews the entire file and any additional evidence submitted and sends the applicant a letter explaining the basis of the determination. The applicant is then notified that to protest further, they can appeal to the RRB's Bureau of Hearings and Appeals. The appeal process is prescribed in 20 CFR 260.5 and 260.9 and 20 CFR 320.12 and 320.38.

To file a request for an appeal the applicant must complete Form HA–1, *Appeal Under the Railroad Retirement Act or Railroad Unemployment Insurance Act.* The form asks the applicant to explain the basis for their request for an appeal and, if necessary, to describe any additional evidence they wish to submit in support of the appeal. Completion is voluntary, however, if the information is not provided the RRB cannot process the appeal.

Previous Requests for Comments: The RRB has already published the initial 60-day notice (83 FR 7511 on February 21, 2018) required by 44 U.S.C. 3506(c)(2). That request elicited no comments.

Information Collection Request (ICR)

Title: Appeal Under the Railroad Retirement and Railroad Unemployment Insurance Act.

OMB Control Number: 3220–0007.

Form(s) submitted: HA–1.

Type of request: Extension without change of a currently approved collection.

Affected public: Individuals or Households.

Abstract: Under Section 7(b)(3) of the Railroad Retirement Act and Section 5(c) of the Railroad Unemployment Insurance Act, a person aggrieved by a decision on his or her application for an annuity or other benefit has the right to appeal to the RRB. The collection provides the means for the appeal action.

Changes proposed: The RRB proposes no changes to Form HA–1.

The burden estimate for the ICR is as follows:

Form No.	Annual responses	Time (minutes)	Burden (hours)
HA–1	550	20	185

2. Title and Purpose of information collection: Annual Earnings Questionnaire; OMB 3220–0179.

Under section 2(e)(3) of the Railroad Retirement Act (RRA), an annuity is not payable for any month in which a beneficiary works for a railroad. In addition, an annuity is reduced for any month in which the beneficiary works for an employer other than a railroad employer and earns more than a prescribed amount. Under the 1988 amendments to the RRA, the Tier II portion of the regular annuity and any supplemental annuity must be reduced by one dollar for each two dollars of Last Pre-Retirement Non-Railroad Employment (LPE) earnings for each month of such service. However, the reduction cannot exceed 50 percent of the Tier II and supplemental annuity amount for the month to which such deductions apply. The LPE generally refers to an annuitant's last employment with a non-railroad person, company, or institution prior to retirement, which was performed at the same time as railroad employment or after the annuitant stopped railroad employment. The collection obtains earnings information needed by the RRB to determine if possible reductions in annuities are in order due to LPE.

The RRB utilizes Form G–19L, *Annual Earnings Questionnaire,* to obtain LPE earnings information from

annuitants. One response is requested of each respondent. Completion is required to retain a benefit.

Previous Requests for Comments: The RRB has already published the initial 60-day notice (83 FR 7511 on February 21, 2018) required by 44 U.S.C. 3506(c)(2). That request elicited no comments.

Information Collection Request (ICR)

Title: Annual Earnings Questionnaire for Annuitants in Last Pre-Retirement Non-Railroad Employment.

OMB Control Number: 3220–0179.

Form submitted: G–19L.

Type of request: Extension without change of a currently approved collection.

Affected public: Individuals or Households.

Abstract: Under Section 2(e)(3) of the Railroad Retirement Act, an annuity is not payable or is reduced for any month in which the beneficiary works for a railroad or earns more than the prescribed amounts. The collection obtains earnings information needed by the Railroad Retirement Board to determine possible reductions in annuities because of earnings.

Changes proposed: The RRB proposes no changes to Form G–19L.

The burden estimate for the ICR is as follows:

Form No.	Annual responses	Time (minutes)	Burden (hours)
G–19L	300	15	75

Additional Information or Comments: Copies of the forms and supporting documents can be obtained from Dana Hickman at (312) 751–4981 or *Dana.Hickman@RRB.GOV.*

Comments regarding the information collection should be addressed to Brian Foster, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611–1275 or *Brian.Foster@rrb.gov* and to the OMB Desk Officer for the RRB, Fax: 202–395–6974, Email address: *OIRA_Submission@omb.eop.gov.*

Brian Foster,

Clearance Officer.

[FR Doc. 2018–09702 Filed 5–7–18; 8:45 am]

BILLING CODE 7905–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–83158; File No. SR–NYSE–2018–18]

Self-Regulatory Organizations; New York Stock Exchange LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend the Certificate of Incorporation of Its Parent Company NYSE Group, Inc.

May 3, 2018.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (the ''Act''),[2] and Rule 19b–4 thereunder,[3] notice is hereby given that on April 25, 2018, New York Stock Exchange LLC (''NYSE'' or the ''Exchange'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the self-regulatory organization. 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 Article X of the certificate of incorporation of its parent company NYSE Group, Inc. (''NYSE Group'') and make certain technical and conforming changes. The proposed rule change is available on the Exchange's website at *www.nyse.com,* at the principal office of the Exchange, 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 self-regulatory organization 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 those 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 parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend Article X (Confidential Amendment) of the Sixth Amended and Restated Certificate of Incorporation of NYSE Group (''NYSE Group Certificate'') and make certain technical and conforming changes.

NYSE Group owns all of the equity interest in the Exchange and its national securities exchange affiliates, NYSE Arca, Inc. (''NYSE Arca''), NYSE American LLC (''NYSE American'') and NYSE National, Inc. (''NYSE National''). In turn, NYSE Group is a wholly-owned subsidiary of NYSE Holdings LLC (''NYSE Holdings''), which is wholly owned by Intercontinental Exchange Holdings, Inc. (''ICE Holdings''). ICE Holdings is wholly owned by Intercontinental Exchange Inc. (''ICE'').[4]

In 2017, the Exchange amended the certificates of incorporation, bylaws, and operating agreements, as applicable, of ICE, ICE Holdings, NYSE Holdings and NYSE Group (collectively, the ''Governing Documents'').[5] The changes to the Governing Documents included, among other things, amendments streamlining references to ICE subsidiaries that either are or control national securities exchanges, deleting references to other ICE subsidiaries, and amending provisions relating to confidential information.[6] As a result of

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] ICE is a publicly traded company listed on the NYSE.

[5] The Governing Documents are the Fourth Amended and Restated Certificate of Incorporation of Intercontinental Exchange, Inc. (''ICE Certificate''); Eighth Amended and Restated Bylaws of Intercontinental Exchange, Inc. (''ICE Bylaws''); Ninth Amended and Restated Certificate of Incorporation of Intercontinental Exchange Holdings, Inc. (''ICE Holdings Certificate''); Sixth Amended and Restated Bylaws of Intercontinental Exchange Holdings, Inc. (''ICE Holdings Bylaws''); Ninth Amended and Restated Limited Liability Company Agreement of NYSE Holdings LLC (''NYSE Holdings Operating Agreement''); Fourth Amended and Restated Bylaws of NYSE Group, Inc. (''NYSE Group Bylaws''); and the NYSE Group Certificate.

[6] *See* Securities Exchange Act Release Nos. 82081 (November 15, 2017), 82 FR 55474 (November 21, 2017) (SR–NYSE–2017–57) (notice of filing and immediate effectiveness of proposed rule change to amend the governing documents of the Exchange's intermediate parent companies) (''Holding Companies Release''); and 80752 (May 24, 2017), 82 FR 25018 (May 31, 2017) (SR– NYSE–2017–13; SR–NYSEArca–2017–29; SR– NYSEMKT–2017–17; SR–

Continued

the changes, ''Exchange'' is defined in each Governing Document as a national securities exchange registered under Section 6 of the Exchange Act [7] that is directly or indirectly controlled by the relevant entity.[8]

In making such changes, lists of specific entities were replaced with ''Exchange'' or ''Exchanges,'' as applicable.[9] For example, in Article XII, clause (b) of the NYSE Group Certificate, ''the boards of directors of New York Stock Exchange, NYSE Arca, NYSE Arca Equities, NYSE MKT and NYSE National or the boards of directors of their successors'' was amended to ''the boards of directors of each Exchange.'' [10]

However, the NYSE Group Certificate retains one list of specific entities, which it proposes to amend now. Specifically, in the first sentence of Article X of the NYSE Group Certificate, the Exchange proposes to replace ''New York Stock Exchange, NYSE Arca, NYSE Arca Equities, NYSE MKT and NYSE National'' with ''any Exchange, in each case to the extent that such entities continue to be controlled, directly or indirectly, by the Corporation''.[11]

The proposed change would not have a substantive effect on what entities the provision covers. As national securities exchanges registered under Section 6 of the Exchange Act [12] that are directly controlled by NYSE Group, each of the NYSE, NYSE Arca, NYSE MKT (now NYSE American LLC) [13] and NYSE National are ''Exchanges'' within the scope of the definition. The reference to NYSE Arca Equities is obsolete, as it has been merged out of existence.[14] As a result, the change is non-substantive.

The Exchange notes that the proposed amendment would make the first sentence of Article X of the NYSE Group Certificate more consistent with the use of ''Exchange'' throughout the Governing Documents, particularly in the confidential information provisions of the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement, all of which have the text ''any Exchange, in each case to the extent that such entities continue to be controlled, directly or indirectly, by the'' Corporation or Company, as applicable.[15]

In addition, technical and conforming changes would be made to the title, recitals, effective time, date and signature line of the NYSE Group Certificate.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Exchange Act [16] in general, and with Section 6(b)(1) [17] in particular, in that it enables the Exchange to be so organized as to have the capacity to be able to carry out the purposes of the Exchange Act and to comply, and to enforce compliance by its exchange members and persons associated with its exchange members, with the provisions of the Exchange Act, the rules and regulations thereunder, and the rules of the Exchange.

The Exchange believes that the proposed rule change would enable the Exchange to continue to be so organized as to have the capacity to carry out the purposes of the Exchange Act and comply and enforce compliance with the provisions of the Exchange Act by its members and persons associated with its members, because the proposed change would add further clarity and transparency to the Exchange's rules without having a substantive effect on which entities the provision would cover. As national securities exchanges registered under Section 6 of the Exchange Act [18] that are directly controlled by NYSE Group, each of the NYSE, NYSE Arca, NYSE American and NYSE National fall within the scope of the definition of ''Exchange.'' In addition, removing the obsolete reference to NYSE Arca Equities would contribute to the orderly operation of the Exchange by adding clarity and transparency to the Exchange's rules. The Exchange believes that the proposed technical and conforming changes to the title, recitals, effective time, date and signature line of the NYSE Group Certificate would contribute to the orderly operation of the Exchange by adding clarity and transparency to its rules.

Further, the Exchange notes that the Exchange Act definition of ''exchange'' states that ''exchange'' ''includes the market place and the market facilities maintained by such exchange.'' [19] Accordingly, any market places and market facilities maintained by the Exchange would fall within the definition of ''Exchange'' and therefore would fall within the scope of Article X of the NYSE Group Certificate.

For similar reasons, the Exchange also believes that the proposed rule change is consistent with Section 6(b)(5) of the Act,[20] in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system and, in general, to protect investors and the public interest.

The Exchange believes that the proposed rule change would remove impediments to and perfect the mechanism of a free and open market and a national market system by simplifying and streamlining the Exchange's rules and removing an obsolete reference, thereby ensuring that market participants can more easily navigate, understand and comply with its rules. In this manner, the proposed change would ensure that persons subject to the Exchange's jurisdiction, regulators, and the investing public can more easily navigate and understand the NYSE Group Certificate.

In addition, the Exchange believes that the proposed rule change would remove impediments to and perfect the mechanism of a free and open market and a national market system, because the proposed change would conform the text of Article X with the use of ''Exchange'' throughout the Governing Documents, generally, and with the confidential information provisions of the ICE Bylaws, the ICE Holdings

NYSENAT–2017–01) (order approving proposed rule changes to amend the certificate and bylaws of the exchange's ultimate parent company) (''Parent Company Release'').

[7] 15 U.S.C. 78f.

[8] *See* Holding Companies Release, *supra* note 6, at 55475; ICE Certificate, Article V, Section A(3)(a); ICE Bylaws, Article III, Section 3.15; ICE Holdings Certificate, Article V, Section A(1); ICE Holdings Bylaws, Article III, Section 3.15; NYSE Holdings Operating Agreement, Article 1, Section 1.1; NYSE Group Bylaws, Article VII, Article 7.9(b); and NYSE Group Certificate, Article IV, Section 4(b)(1)(A).

[9] *See* Holding Companies Release, *supra* note 6, at 55475, and Parent Company Release, *supra* note 6, at 25019. Similarly, the terms ''U.S. Regulated Subsidiary,'' ''U.S. Regulated Subsidiaries,'' ''Regulated Subsidiary,'' and ''Regulated Subsidiaries'' were replaced with ''Exchange'' or ''Exchanges,'' as applicable.

[10] *See* Holding Companies Release, *supra* note 6, note 12.

[11] The Exchange's affiliates NYSE American, NYSE Arca, and NYSE National have each submitted substantially the same proposed rule change to propose the changes described herein. *See* SR–NYSEAmer–2018–16, SR–NYSEArca–2018–26, and SR–NYSENAT–2018–05.

[12] 15 U.S.C. 78f.

[13] ''NYSE MKT LLC'' changed its name to ''NYSE American LLC'' in 2017. *See* Securities Exchange Act Release Nos. 80283 (March 21, 2017), 82 FR 15244 (March 27, 2017) (SR–NYSEMKT–2017–14).

[14] *See* Securities Exchange Act Release No. 81419 (August 17, 2017), 82 FR 40044 (August 23, 2017) (SR–NYSEArca–2017–40).

[15] *See* ICE Bylaws, Article VIII, Section 8.1; ICE Holdings Bylaws, Article VIII, Section 8.1; and NYSE Holdings Operating Agreement, Article XII, Section 12.1. *See also* Holding Companies Release, *supra* note 6, at 55477–55478.

[16] 15 U.S.C. 78f(b).

[17] 15 U.S.C. 78f(b)(1).

[18] 15 U.S.C. 78f.

[19] 15 U.S.C. 78c(a)(1).

[20] 15 U.S.C. 78f(b)(5).

Bylaws, and the NYSE Holdings Operating Agreement, more specifically. As a result, the Governing Documents would be more consistent and persons subject to the Exchange's jurisdiction, regulators, and the investing public could more easily navigate and understand the NYSE Group Certificate and the other Governing Documents.

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 Exchange Act. The proposed rule change is not designed to address any competitive issue but rather is meant to update and streamline the NYSE Group Certificate to make it more consistent with the use of ''Exchange'' throughout the Governing Documents and the confidential information provisions in the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement. The Exchange believes that the proposed rule change will serve to promote clarity and consistency, thereby reducing burdens on the marketplace and facilitating investor protection. The proposed rule change would result in no concentration or other changes of ownership of exchanges.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to 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 Section 19(b)(3)(A) of the Act and Rule 19b–4(f)(6) thereunder.[21]

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–NYSE–2018–18 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSE–2018–18. 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 website (*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 website 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. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSE–2018–18, and should be submitted on or before May 29,2018.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[22]

Eduardo A. Aleman,

Assistant Secretary.

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[21] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[22] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–83156; File No. SR–ISE–2018–39]

Self-Regulatory Organizations; Nasdaq ISE, LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend ISE Rules 412, Position Limits, and 414, Exercise Limits

May 2, 2018.

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 April 20, 2018, Nasdaq ISE, LLC (''ISE'' or ''Exchange'') filed with the Securities and Exchange Commission (''SEC'' or ''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 amend ISE Rules 412, Position Limits, and 414, Exercise Limits, to increase the position and exercise limits for options on the following exchange traded funds (''ETFs''): iShares China Large-Cap ETF (''FXI''), iShares MSCI EAFE ETF (''EFA''), iShares MSCI Emerging Markets ETF (''EEM''), iShares Russell 2000 ETF (''IWM''), iShares MSCI Brazil Capped ETF (''EWZ''), iShares 20+ Year Treasury Bond Fund ETF (''TLT''), PowerShares QQQ Trust (''QQQQ''), and iShares MSCI Japan Index (''EWJ'').

The text of the proposed rule change is available on the Exchange's website at *http://ise.cchwallstreet.com/,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

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

Position Limit Increase

Position limits for options on ETFs such as those subject to this proposal are determined pursuant to Exchange Rule 412, and, with certain exceptions, vary by tier according to the number of outstanding shares and the trading volume of the underlying security. Options in the highest tier—*i.e.,* options that overlie securities with the largest numbers of outstanding shares and trading volumes—have a standard option position limit of 250,000 contracts (with adjustments for splits, re-capitalizations, etc.) on the same side of the market. In addition, Rule 412 currently sets forth separate position limits for options on certain ETFs, including 500,000 contracts for options on EEM and IWM, and 900,000 contracts for options on QQQQ.

The Exchange proposes to revise Rule 412 to increase the position limits for options on certain ETFs, as described more fully below.[3] The Exchange believes that increasing the position limits for these options will lead to a more liquid and competitive market environment for these options that will benefit customers interested in these products.

First, the Exchange proposes to increase the position limits for options on FXI, EFA, EWZ, TLT, and EWJ, each of which fall into the highest standard tier set forth in Exchange Rule 412(d)(5). Rule 412, Supplementary Material .01, would be amended to increase the current position limit of 250,000 contracts for options on these securities to 500,000 contracts.

Second, the Exchange proposes to increase the position limits for options on EEM and IWM from 500,000 contracts to 1,000,000 contracts.[4]

Finally, the Exchange proposes to increase the position limits on options on QQQQ from 900,000 contracts to 1,800,000 contracts.

In support of this proposal, the Exchange represents that the above listed ETFs qualify for either: (i) The initial listing criteria set forth in Exchange Rule 502(h) for ETFs holding non-U.S. component securities; or (ii) for ETFs listed pursuant to generic listing standards for series of portfolio depository receipts and index fund shares based on international or global indexes under which a comprehensive surveillance agreement (''CSA'') is not required.[5] FXI tracks the performance of the FTSE China 50 Index, which is composed of the 50 largest Chinese stocks.[6] EEM tracks the performance of the MSCI Emerging Markets Index, which is composed of approximately 800 component securities.[7] The MSCI Emerging Markets Index consists of the following 21 emerging market country indices: Brazil, Chile, China, Colombia, Czech Republic, Egypt, Hungary, India, Indonesia, Korea, Malaysia, Mexico, Morocco, Peru, Philippines, Poland, Russia, South Africa, Taiwan, Thailand, and Turkey.[8] IWM tracks the performance of the Russell 2000 Index, which is composed of 2,000 small-cap domestic stocks.[9] EFA tracks the performance of MSCI EAFE Index, which has over 900 component securities.[10] The MSCI EAFE Index is designed to represent the performance of large and mid-cap securities across 21 developed markets, including countries in Europe, Australasia and the Far East, excluding the U.S. and Canada.[11] EWZ tracks the performance of the MSCI Brazil 25/50 Index, which is composed of shares of large and mid-size companies in Brazil.[12] TLT tracks the performance of ICE U.S. Treasury 20+ Year Bond Index, which is composed of long-term U.S. Treasury bonds.[13] QQQQ tracks the performance of the Nasdaq-100 Index, which is composed of 100 of the largest domestic and international nonfinancial companies listed on the Nasdaq Stock Market LLC (''Nasdaq'').[14] EWJ tracks the MSCI Japan Index, which tracks the performance of large and mid-sized companies in Japan.[15]

The Exchange represents that more than 50% of the weight of the securities held by the options subject to this proposal are also subject to a CSA.[16] Additionally, the component securities of the MSCI Emerging Markets Index on which EEM is based for which the primary market is in any one country that is not subject to a CSA do not represent 20% or more of the weight of the MSCI Emerging Markets Index.[17] Finally, the component securities of the MSCI Emerging Markets Index on which EEM is based, for which the primary market is in any two countries that are not subject to CSAs do not represent 33% or more of the weight of the MSCI Emerging Markets Index.[18]

Market participants have increased their demand for options on FXI, EFA, EWZ, TLT, and EWJ for hedging and trading purposes and the Exchange believes the current position limits are too low and may be a deterrent to successful trading of options on these securities.

The CBOE Analysis

The Commission has recently approved a proposed rule change of the Chicago Board Options Exchange (''CBOE'') to increase position limits for these same options.[19] The discussion that follows is based upon the CBOE's analysis presented in that proposal.

In its proposal, CBOE stated that it had collected the following trading statistics on the ETFs that are subject to this proposal:

[3] ISE Rule 414 establishes exercise limits for the corresponding options at the same levels as the corresponding security's position limits. Rule 414 would be amended such that the exercise limits for each of these options would be increased to the level of the new position limits.

[4] The Exchange is also amending Rules 412 and 414 to update and correct the names of IWM and EEM, which are currently referred to in that rule as the iShares® Russell 2000® Index Fund and iShares MSCI Emerging Markets Index Fund, respectively.

[5] The Exchange notes that the initial listing criteria for options on ETFs that hold non-U.S. component securities are more stringent than the maintenance listing criteria for those same ETF options. *See* Exchange Rule 503(h).

[6] *See https://www.ishares.com/us/products/239536/ishares-china-largecap-etf.*

[7] *See http://us.ishares.com/product_info/fund/overview/EEM.htm.*

[8] *See http://www.msci.com/products/indices/tools/index.html#EM.*

[9] *See https://www.ishares.com/us/products/239710/ishares-russell-2000-etf.*

[10] *See https://www.ishares.com/us/products/239623/.*

[11] *See https://www.msci.com/eafe.*

[12] *See https://www.ishares.com/us/products/239612/ishares-msci-brazil-capped-etf.*

[13] *See https://www.ishares.com/us/products/239454/.*

[14] *See https://www.invesco.com/portal/site/us/financial-professional/etfs/productdetail?productId=QQQ&ticker=QQQ&title=powershares-qqq.*

[15] *See https://www.ishares.com/us/products/239665/EWJ.*

[16] *See* Exchange Rule 502(h)(b)(2).

[17] *See* Exchange Rule 502(h)(b)(3).

[18] *See* Exchange Rule 502(h)(b)(4).

[19] *See* Securities Exchange Act Release No. 82770 (February 23, 2018) (approving SR–CBOE–2017–057).

ETF	2017 ADV (Mil. shares)	2017 ADV (option contracts)	Shares outstanding (Mil.)	Fund market cap ($Mil.)
FXI	15.08	71,944	78.6	3,343.6
EEM	52.12	287,357	797.4	34,926.1
IWM	27.46	490,070	253.1	35,809.1
EFA	19.42	98,844	1178.4	78,870.3
EWZ	17.08	95,152	159.4	6,023.4
TLT	8.53	80,476	60.0	7,442
QQQQ	26.25	579,404	351.6	50,359.7
EWJ	6.06	4,715	303.6	16,625.1
SPY	64.63	2,575,153	976.23	240,540.0

In support of its proposal to increase the position limits for QQQQ to 1,800,000 contracts, CBOE compared the trading characteristics of QQQQ to that of the SPDR S&P 500 ETF (''SPY''), which has no position limits. As shown in the above table, the average daily trading volume through August 14, 2017 for QQQQ was 26.25 million shares compared to 64.63 million shares for SPY. The total shares outstanding for QQQQ are 351.6 million compared to 976.23 million for SPY. The fund market cap for QQQQ is $50,359.7 million compared to $240,540 million for SPY. SPY is one of the most actively trading ETFs and is, therefore, subject to no position limits. QQQQ is also very actively traded, and while not to the level of SPY, should be subject to the proposed higher position limits based on its trading characteristics when compared to SPY. The proposed position limit coupled with QQQQ's trading behavior would continue to address potential manipulative schemes and adverse market impact surrounding the use of options and trading in its underlying the options.

In support of its proposal to increase the position limits for EEM and IWM from 500,000 contracts to 1,000,000 contracts, CBOE also compared the trading characteristics of EEM and IWM to that of QQQQ, which currently has a position limit of 900,000 contracts. As shown in the above table, the average daily trading volume through July 31, 2017 for EEM was 52.12 million shares and IWM was 27.46 million shares compared to 26.25 million shares for QQQQ. The total shares outstanding for EEM are 797.4 million and for IWM are 253.1 million compared to 351.6 million for QQQQ. The fund market cap for EEM is $34,926.1 million and IWM is $35,809 million compared to $50,359.7 million for QQQQ. EEM, IWM and QQQQ have similar trading characteristics and subjecting EEM and IWM to the proposed higher position limit would continue be designed to address potential manipulate schemes that may arise from trading in the options and their underlying securities. These above trading characteristics for QQQQ when compared to EEM and IWM also justify increasing the position limit for QQQQ. QQQQ has a higher options ADV than EEM and IWM, a higher numbers of shares outstanding than IWM and a much higher market cap than EEM and IWM which justify doubling the position limit for QQQQ. CBOE concluded that, based on these statistics, and as stated above, the proposed position limit coupled with QQQQ's trading behavior would continue to address potential manipulative schemes and adverse market impact surrounding the use of options and trading in the securities underlying the options.

In support of its proposal to increase the position limits for FXI, EFA, EWZ, TLT, and EWJ from 250,000 contracts to 500,000 contracts, CBOE compared the trading characteristics of FXI, EFA, EWZ, TLT, and EWJ to that of EEM and IWM, both of which currently have a position limit of 500,000 contracts. As shown in the above table, the average daily trading volume through July 31, 2017 for FXI is 15.08 million shares, EFA is 19.42 million shares, EWZ is 17.08 million shares, TLT is 8.53 million shares, and EWJ is 6.06 million shares compared to 52.12 million shares for EEM and 27.46 million shares for IWM. The total shares outstanding for FXI is 78.6 million, EFA is 1178.4 million, EWZ is 159.4 million, TLT is 60 million, and EWJ is 303.6 million compared to 797.4 million for EEM and 253.1 million for IWM. The fund market cap for FXI is $3,343.6 million, EFA is $78,870.3 million, EWZ is $6,023.4 million, TLT is $7,442.4 million, and EWJ is $16,625.1 million compared to $34,926.1 million for EEM and $35,809.1 million for IWM.

In Partial Amendment No. 1 to its proposed rule change, CBOE provided additional analysis and support for its proposed rule change.[20] According to CBOE, market participants' trading activity has been adversely impacted by the current position limits as such limits have caused options trading in the symbols subject to the proposed rule change to move from exchanges to the over-the-counter market. CBOE stated it had submitted the proposed rule change at the request of market participants whose on-exchange activity has been hindered by the existing position limits causing them to be unable to provide additional liquidity not just on CBOE, but also on other options exchanges on which they participate.

CBOE stated it understood that certain market participants wishing to make trades involving a large number of options contracts in the symbols subject to the proposed rule change are opting to execute those trades in the over-the-counter market, that the over-the counter transactions occur via bilateral agreements the terms of which are not publicly disclosed to other market participants, and that therefore, these large trades do not contribute to the price discovery process performed on a lit market. It stated that position limits are designed to address potential manipulative schemes and adverse market impact surrounding the use of options, such as disrupting the market in the security underlying the options, and that the potential manipulative schemes and adverse market impact are balanced against the potential of setting the limits so low as to discourage participation in the options market. It stated that the level of those position limits must be balanced between curtailing potential manipulation and the cost of preventing potential hedging activity that could be used for legitimate economic purposes.

CBOE observed that the ETFs that underlie options subject to the proposed rule change are highly liquid, and are based on a broad set of highly liquid securities and other reference assets,

[20] *See* SR–CBOE–2017–057, Partial Amendment No. 1 (November 22, 2017).

and noted that the Commission has generally looked through to the liquidity of securities comprising an index in establishing position limits for cash-settled index options. It further noted that options on certain broad-based security indexes have no position limits. CBOE observed that the Commission has recognized the liquidity of the securities comprising the underlying interest of the SPDR S&P 500 ETF (''SPY'') in permitting no position limits on SPY options since 2012,[21] and expanded position limits for options on EEM, IWM and QQQQ.

CBOE stated that the creation and redemption process for these ETFs also lessen the potential for manipulative activity, explaining that when an ETF company wants to create more ETF shares, it looks to an Authorized Participant, which is a market maker or other large financial institution, to acquire the securities the ETF is to hold. For instance, IWM is designed to track the performance of the Russell 2000 Index, the Authorized Participant will purchase all the Russell 2000 constituent securities in the exact same weight as the index, then deliver those shares to the ETF provider. In exchange, the ETF provider gives the Authorized Participant a block of equally valued ETF shares, on a one-for-one fair value basis. The price is based on the net asset value, not the market value at which the ETF is trading. The creation of new ETF units can be conducted all trading day and is not subject to position limits. This process can also work in reverse where the ETF company seeks to decrease the number of shares that are available to trade. The creation and redemption process, therefore, creates a direct link to the underlying components of the ETF, and serves to mitigate potential price impact of the ETF shares that might otherwise result from increased position limits. The ETF creation and redemption seeks to keep ETF share prices trading in line with the ETF's underlying net asset value. Because an ETF trades like a stock, its price will fluctuate during the trading day, due to simple supply and demand. If demand to buy an ETF is high, for instance, the ETF's share price might rise above the value of its underlying securities. When this happens, the Authorized Participant believes the ETF may now be overpriced, and can buy the underlying shares that compose the ETF and then sell ETF shares on the open market. This should help drive the ETF's share price back toward fair value. Likewise, if the ETF starts trading at a discount to the securities it holds, the Authorized Participant can buy shares of the ETF and redeem them for the underlying securities. Buying undervalued ETF shares should drive the price of the ETF back toward fair value. This arbitrage process helps to keep an ETF's price in line with the value of its underlying portfolio.

CBOE stated that in proposing the increased position limits, the Exchange considered the availability of economically equivalent products and their respective position limits. For instance, some of the ETFs underlying options subject to the proposed rule change are based on broad-based indices that underlie cash settled options that are economically equivalent to the ETF options that are the subject of the proposed rule change and have no position limits. Other ETFs are based on broad-based indexes that underlie cash-settled options with position limits reflecting notional values that are larger than the current position limits for ETF analogues (EEM, EFA). Where there was no approved index analogue, CBOE stated its belief, based on the liquidity, breadth and depth of the underlying market, that the index referenced by the ETF would be considered a broad-based index.[22] CBOE argued that if certain position limits are appropriate for the options overlying the same index or is an analogue to the basket of securities that the ETF tracks, then those same economically equivalent position limits should be appropriate for the option overlying the ETF. In addition, CBOE observed, the market capitalization of the underlying index or reference asset is large enough to absorb any price movements that may be caused by an oversized trade. Also, the Authorized Participant or issuer may look to the stocks comprising the analogous underlying index or reference asset when seeking to create additional ETF shares are part of the creation/redemption process to address supply and demand or to mitigate the price movement the price of the ETF. CBOE offered the following specific examples to illustrate:

QQQQ

For example, the PowerShares QQQ Trust or QQQQ is an ETF that tracks the Nasdaq 100 Index or NDX, which is an index composed of 100 of the largest non-financial securities listed on Nasdaq. Options on NDX are currently subject to no position limits but share similar trading characteristics as QQQQ. Based on QQQQ's share price of $154.54[23] and NDX's index level of 6,339.14, approximately 40 contracts of QQQQ equals one contract of NDX. Assume that NDX was subject to the standard position limit of 25,000 contracts for broad-based index options. Based on the above comparison of notional values, this would result in a positon limit equivalent to 1,000,000 contracts for QQQQ as NDX's analogue. However, NDX is not subject to position limits and has an average daily trading volume of 15,300 contracts. QQQQ is currently subject to a position limit of 900,000 contracts but has a much higher average daily trading volume of 579,404 contracts. Furthermore, NDX currently has a market capitalization of $17.2 trillion and QQQQ has a market capitalization of $50,359.7 million, and the component securities of NDX, in aggregate, have traded an average of 440 million shares per day in 2017, both large enough to absorb any price movement cause by a large trade in the QQQQ. The Commission has also approved no position limit for NDX, although it has a much lower average daily trading volume than its analogue, the QQQQ. Therefore, CBOE concluded and the Exchange agrees it was reasonable to increase the positon limit for options on the QQQQ from 900,000 to 1,800,000 contracts.

IWM

The iShares Russell 2000 ETF or IWM, is an ETF that also tracks the Russell 2000 Index or RUT, which is an index that is composed of 2,000 small-cap domestic companies in the Russell 3000 index. Options on RUT are currently subject to no position limits but share similar trading characteristics as IWM. Based on IWM's share price of $144.77 and RUT's index level of 1,486.88, approximately 10 contracts of IWM equals one contract of RUT. Assume that RUT was subject to the standard position limit of 25,000 contracts for broad-based index options under Exchange Rule 24.4(a). Based on the above comparison of notional values, this would result in a positon limit equivalent to 250,000 contracts for IWM as RUT's analogue. However, RUT is not subject to position limits and has an average daily trading volume of 66,200 contracts. IWM is currently subject to a position limit of 500,000 contracts but has a much higher average daily trading volume of 490,070

[21] *See* Securities Exchange Act Release No. 67937 (September 27, 2012), 77 FR 60489 (October 3, 2012) (SR–CBOE–2012–091).

[22] CBOE Rule 24.4 and Exchange Rule 2004 set forth the CBOE and the ISE position limits for broad-based index options.

[23] CBOE stated that all share prices used in its analysis were based on the closing price of the security on November 16, 2017 and cited Yahoo Finance as the source.

contracts. The Commission has approved no position limit for RUT, although it has a much lower average daily trading volume than its analogue, the IWM. Furthermore, RUT currently has a market capitalization of $2.4 trillion and IWM has a market capitalization of $35,809.1 million, and the component securities of RUT, in aggregate, have traded an average of 270 million shares per day in 2017, both large enough to absorb any price movement cause by a large trade in the IWM. Therefore, CBOE concluded and the Exchange agrees it is reasonable to increase the positon limit for options on the IWM from 500,000 to 1,000,000 contracts.

EEM

EEM tracks the performance of the MSCI Emerging Markets Index or MXEF, which is composed of approximately 800 component securities following 21 emerging market country indices: Brazil, Chile, China, Colombia, Czech Republic, Egypt, Hungary, India, Indonesia, Korea, Malaysia, Mexico, Morocco, Peru, Philippines, Poland, Russia, South Africa, Taiwan, Thailand, and Turkey. Based on EEM's share price of $47.06 and MXEF's index level of 1,136.45, approximately 24 contracts of EEM equals one contract of MXEF. MXEF is currently subject to the standard position limit of 25,000 contracts for broad-based index options. Based on the above comparison of notional values, this would result in a position limit economically equivalent to 604,000 contracts for EEM as MXEF's analogue. However, MXEF has an average daily trading volume of 180 contracts. EEM is currently subject to a position limit of 500,000 contracts but has a much higher average daily trading volume of 287,357 contracts. Furthermore, MXEF currently has a market capitalization of $5.18 trillion and EEM has a market capitalization of $34,926.1 million, and the component securities of MXEF, in aggregate, have traded an average of 33.6 billion shares per day in 2017, both large enough to absorb any price movement cause by a large trade in the EEM. Therefore, based on the comparison of average daily trading volume, CBOE believed and the Exchange agrees that it is reasonable to increase the positon limit for options on the IWM from 500,000 to 1,000,000 contracts.

EFA

EFA tracks the performance of MSCI EAFE Index or MXEA, which has over 900 component securities designed to represent the performance of large and mid-cap securities across 21 developed markets, including countries in Europe, Australasia and the Far East, excluding the U.S. and Canada. Based on EFA's share price of $69.16 and MXEA's index level of 1,986.15, approximately 29 contracts of EFA equals one contract of MXEA. MXEA is currently subject to the standard position limit of 25,000 contracts for broad-based index options. Based on the above comparison of notional values, this would result in a positon limit economically equivalent to 721,000 contracts for EFA as MXEA's analogue. Furthermore, MXEA currently has a market capitalization of $18.7 trillion and EFA has a market capitalization of $78,870.3 million, and the component securities of MXEA, in aggregate, have traded an average of 4.6 billion shares per day in 2017, both large enough to absorb any price movement cause by a large trade in the EEM. However, MXEA has an average daily trading volume of 270 contracts. EFA is currently subject to a position limit of 250,000 contracts but has a much higher average daily trading volume of 98,844 contracts. Based on the above comparisons, CBOE believed and the Exchange agrees that it is reasonable to increase the positon limit for options on the EFA from 250,000 to 500,000 contracts.

FXI

FXI tracks the performance of the FTSE China 50 Index, which is composed of the 50 largest Chinese stocks. There is currently no index analogue for FXI approved for options trading. However, the FTSE China 50 Index currently has a market capitalization of $1.7 trillion and FXI has a market capitalization of $2,623.18 million, both large enough to absorb any price movement cause by a large trade in FXI. The components of the FTSE China 50 Index, in aggregate, have an average daily trading volume of 2.3 billion shares. FXI is currently subject to a position limit of 250,000 contracts but has a much higher average daily trading volume of 15.08 million shares. Based on the above comparisons, CBOE believed, and that Exchange agrees, that it is reasonable to increase the positon limit for options on the FXI from 250,000 to 500,000 contracts.

EWZ

EWZ tracks the performance of the MSCI Brazil 25/50 Index, which is composed of shares of large and mid-size companies in Brazil. There is currently no index analogue for EWZ approved for options trading. However, the MSCI Brazil 25/50 Index currently has a market capitalization of $700 billion and EWZ has a market capitalization of $6,023.4 million, both large enough to absorb any price movement cause by a large trade in EWZ. The components of the MSCI Brazil 25/50 Index, in aggregate, have an average daily trading volume of 285 million shares. EWZ is currently subject to a position limit of 250,000 contracts but has a much higher average daily trading volume of 17.08 million shares. Based on the above comparisons, CBOE believed and the Exchange agrees that it is reasonable to increase the positon limit for options on the EWZ from 250,000 to 500,000 contracts.

TLT

TLT tracks the performance of ICE U.S. Treasury 20+ Year Bond Index, which is composed of long-term U.S. Treasury bonds. There is currently no index analogue for TLT approved for options trading. However, the U.S. Treasury market is one of the largest and most liquid markets in the world, with over $14 trillion outstanding and turnover of approximately $500 billion per day. TLT currently has a market capitalization of $7,442.4 million, both large enough to absorb any price movement cause by a large trade in TLT. Therefore, the potential for manipulation will not increase solely due the increase in position limits as set forth in the proposed rule change. Based on the above comparisons, CBOE believed and the Exchange agrees it is reasonable to increase the positon limit for options on the TLT from 250,000 to 500,000 contracts.

EWJ

EWJ tracks the MSCI Japan Index, which tracks the performance of large and mid-sized companies in Japan. There is currently no index analogue for EWJ approved for options trading. However, the MSCI Japan Index has a market capitalization of $3.5 trillion and EWJ has a market capitalization of $16,625.1 million, and the component securities of the MSCI Japan Index, in aggregate, have traded an average of 1.1 billion shares per day in 2017, both large enough to absorb any price movement cause by a large trade in EWJ. EWJ is currently subject to a position limit of 250,000 contracts and has an average daily trading volume of 6.6 million shares. Based on the above comparisons, CBOE believed and the Exchange agrees that it is reasonable to increase the positon limit for options on EWJ from 250,000 to 500,000 contracts.

ISE Analysis and Conclusions

ISE has reviewed the CBOE analysis set forth above. On the basis of that analysis ISE believes that market

participants' trading activity could be adversely impacted by the current position limits for FXI, EFA, EWZ, TLT and EWJ and such limits may cause options trading in these symbols to move from exchanges to the over-the-counter market. The above trading characteristics of FXI, EFA, EWZ, TLT and EWJ are either similar to those of EEM and IWM or sufficiently active so that the proposed limit would continue to address potential manipulation that may arise. Specifically, EFA has far more shares outstanding and a larger fund market cap than EEM, IWM, and QQQQ. EWJ has more shares outstanding than IWM and only slightly fewer shares outstanding than QQQQ.

On the other hand, while FXI, EWZ and TLT do not exceed EEM, IWM or QQQQ in any of the specified areas, they are all actively trading so that market participants' trading activity has been impacted by them being restricted by the current position limits. The Exchange believes that the trading activity and these securities being based on a broad basket of underlying securities alleviates concerns as to any potential manipulative activity that may arise. In addition, as discussed in more detail below, the Exchange's existing surveillance procedures and reporting requirements at the Exchange, at other options exchanges, and at the several clearing firms are capable of properly identifying unusual and/or illegal trading activity.

On the basis of CBOE's analysis ISE also believes that market participants' trading activity could be adversely impacted by the current position limits for EEM, IWM and QQQQ. As discussed above, EEM, IWM and QQQQ have similar trading characteristics. Subjecting EEM and IWM to the proposed higher position limit would continue be designed to address potential manipulate schemes that may arise from trading in the options and their underlying securities. The trading characteristics for QQQQ described above, when compared to EEM and IWM, also justify increasing the position limit for QQQQ. QQQQ has a higher options ADV than EEM and IWM, a higher numbers of shares outstanding than IWM and a much higher market cap than EEM and IWM which justify doubling the positon limit for QQQQ. Based on these statistics, the proposed position limit coupled with QQQQ's trading behavior would continue to address potential manipulative schemes and adverse market impact surrounding the use of options and trading in its underlying the options.

The Exchange believes that increasing the position limits for the options subject to this proposal would lead to a more liquid and competitive market environment for these options, which will benefit customers interested in this product. Under the proposal, the reporting requirement for the above options would be unchanged. Thus, the Exchange would still require that each Member file with the Exchange the name, address and social security or tax identification number of any customer, as well as any Member, any general or special partner of the Member, any officer or director of the Member or any participant, as such, in any joint, group or syndicate account with the Member or with any partner, officer or director thereof, who, on the previous business day held aggregate long or short positions of 200 or more options contracts of any single class of options traded on the Exchange. The report is also required to indicate for each such class of options contracts the number of options contracts comprising each such position and, in case of short positions, whether covered or uncovered. Additionally, Electronic Access Members that maintain an end of day position in excess of 10,000 non-FLEX equity options contracts on the same side of the market on behalf of its own account or for the account of a customer, are required to report whether such position is hedged and provide documentation as to how such position is hedged. This report is required at the time the subject account exceeds the 10,000 contract threshold and thereafter, for customer accounts, when the position increases by 2,500 contracts and for proprietary accounts when the position increases by 5,000 contracts. Finally, Members are also required to report promptly to the Exchange any instance in which the Member has reason to believe that a person included in Rule 415(a), acting alone or in concert with others, has exceeded or is attempting to exceed the position limits established pursuant to Rule 412.[24]

The Exchange believes that the existing surveillance procedures and reporting requirements at the Exchange, other options exchanges, and at the several clearing firms are capable of properly identifying unusual and/or illegal trading activity. In addition, routine oversight inspections of the Exchange's regulatory programs by the Commission have not uncovered any material inconsistencies or shortcomings in the manner in which the Exchange's market surveillance is conducted. These procedures utilize daily monitoring of market movements via automated surveillance techniques to identify unusual activity in both options and underlying stocks.[25]

Furthermore, large stock holdings must be disclosed to the Commission by way of Schedules 13D or 13G.[26] The positions for options subject to this proposal are part of any reportable positions and, thus, cannot be legally hidden. Moreover, the Exchange's requirement that Members file reports with the Exchange for any customer who held aggregate large long or short positions of any single class for the previous day will continue to serve as an important part of the Exchange's surveillance efforts.

The Exchange believes that the current financial requirements imposed by the Exchange and by the Commission adequately address concerns that a member organization or its customer may try to maintain an inordinately large un-hedged position in the options subject to this proposal. Current margin and risk-based haircut methodologies serve to limit the size of positions maintained by any one account by increasing the margin and/or capital that a member organization must maintain for a large position held by itself or by its customer.[27] In addition, Rule 15c3–1 [28] imposes a capital charge on member organizations to the extent of any margin deficiency resulting from the higher margin requirement.

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act,[29] in general, and furthers the objectives of Section 6(b)(5) of the Act,[30] in particular, in that it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general to protect investors and the public interest. As noted above, the Commission has recently approved increasing position limits to the levels proposed herein on the same ETF options on the CBOE. The Exchange believes that the proposed position limits would continue to address potential manipulative activity while allowing for potential hedging

[24] *See* Exchange Rule 415 for reporting requirements.

[25] These procedures have been effective for the surveillance of trading the options subject to this proposal and will continue to be employed.

[26] 17 CFR 240.13d–1.

[27] *See* Exchange Rule 1202(a), which provides that a Member must elect to be bound by the initial and maintenance margin requirements of either the CBOE or the New York Stock Exchange as the same may be in effect from time to time.

[28] 17 CFR 240.15c3–1.

[29] 15 U.S.C. 78f(b).

[30] 15 U.S.C. 78f(b)(5).

activity for appropriate economic purposes.

The current position limits for the options subject to this proposal have inhibited the ability of market makers to make markets on the Exchange. Specifically, the proposal is designed to encourage market makers to shift liquidity from over the counter markets onto the Exchange, which will enhance the process of price discovery conducted on the Exchange through increased order flow. The proposal will also benefit institutional investors as well as retail traders, and public customers, by providing them with a more effective trading and hedging vehicle. In addition, the Exchange believes that the structure of the ETFs subject to this proposal and the considerable liquidity of the market for options on those ETFs diminishes the opportunity to manipulate this product and disrupt the underlying market that a lower position limit may protect against.

Increased position limits for select actively traded options, such as that proposed herein, is not novel and has been previously approved by the Commission. For example, the Commission has previously approved, on a pilot basis, eliminating position limits for certain options.[31] Additionally, the Commission has approved similar proposed rule changes to increase position limits for options on highly liquid, actively-traded ETFs,[32] including a proposal to permanently eliminate the position and exercise limits for options overlaying the S&P 500 Index, S&P 100 Index, Dow Jones Industrial Average, Nasdaq 100 Index, and the Russell 2000(R) Index (''RUT'').[33] In approving the permanent elimination of position and exercise limits for these index options, the Commission relied heavily upon the Exchange's surveillance capabilities, and the Commission expressed trust in the enhanced surveillance and reporting safeguards that the Exchange took in order to detect and deter possible manipulative behavior which might arise from eliminating position and exercise limits.[34] Furthermore, as described more fully above, options on other ETFs have the position limits proposed herein and those ETFs have trading characteristics and trading volumes that are similar to those of the ETFs subject to this proposed rule change.

Last, the Commission has expressed the belief that removing position and exercise limits may bring additional depth and liquidity without increasing concerns regarding intermarket manipulation or disruption of the options or the underlying securities.[35] The Exchange's enhanced surveillance and reporting safeguards continue to be designed to deter and detect possible manipulative behavior which might arise from eliminating position and exercise limits.

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 not necessary or appropriate in furtherance of the purposes of the Act. On the contrary, the Exchange believes that the proposed rule change will result in additional opportunities to achieve the investment and trading objectives of market participants seeking efficient trading and hedging vehicles, to the benefit of investors, market participants, and the marketplace in general.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

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 Section 19(b)(3)(A)(iii) of the Act[36] and subparagraph (f)(6) of Rule 19b–4 thereunder.[37]

A proposed rule change filed under Rule 19b–4(f)(6)[38] normally does not become operative prior to 30 days after the date of the filing. However, Rule 19b–4(f)(6)(iii)[39] permits the Commission to 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 proposed rule change may become effective and operative immediately upon filing. The Exchange states that waiver of the operative delay would permit the Exchange to immediately implement the proposed rule change to increase the position limits as proposed herein and thereby seamlessly continue to offer traders and the investing public the ability to use these products as effective hedging and trading vehicles. The Exchange further states that waiver would allow the Exchange to remain competitive with other exchanges. The Commission believes that waiver of the 30-day operative delay is consistent with the protection of investors and the public interest. Therefore, the Commission hereby waives the 30-day operative delay and designates the proposed rule change as operative upon filing.[40]

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: (i) Necessary or appropriate in the public interest; (ii) for the protection of investors; or (iii) otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings to determine whether the proposed rule should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing,

[31] *See* Securities Exchange Act Release Nos. 67672 (August 15, 2012), 77 FR 50750 (August 22, 2012) (SR–NYSEAmex–2012–29); 67937 (September 27, 2012), 77 FR 60489 (October 3, 2012) (SR–CBOE–2012–091).

[32] *See* Securities Exchange Act Release Nos. 68086 (October 23, 2012), 77 FR 65600 (October 29, 2012) (SR–CBOE–2012–066); 64928 (July 20, 2011), 76 FR 44633 (July 26,2011) (SR–CBOE–2011–065); 64695 (June 17, 2011), 76 FR 36942 (June 23, 2011) (SR–PHLX–2011–58); and 55176 (January 25, 2007), 72 FR 4741 (February 1, 2017) (SR–CBOE–2007–008.).

[33] *See* Securities Exchange Act Release Nos. 44994 (October 26, 2001), 66 FR 55722 (November 2, 2001) (SR–CBOE–2001–22) (elimination of position and exercise limits on SPX, OEX, and DJX options) (''SPX, OEX, and DJX Position Limit Elimination Approval Order''); 52650 (October 21, 2005), 70 FR 62147 (October 28, 2005) (SR–CBOE–2005–41) (elimination of position and exercise limits on NDX options) (''NDX Position Limit Elimination Approval Order''); 56651 (October 12, 2007), 72 FR 59130 (October 18, 2007) (SR–Phlx–2007–71) (''RUT Position Limit Elimination Approval Order'').

[34] *Id.*

[35] *Id.*

[36] 15 U.S.C. 78s(b)(3)(A)(iii).

[37] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6)(iii) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[38] 17 CFR 240.19b–4(f)(6).

[39] 17 CFR 240.19b–4(f)(6)(iii).

[40] For purposes only of waiving the 30-day operative delay, the Commission has also considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

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–ISE–2018–39 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–ISE–2018–39. 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 website (*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 website 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. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–ISE–2018–39 and should be submitted on or before May 29, 2018.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[41]

Eduardo A. Aleman,

Assistant Secretary.

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[41] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–83153; File No. SR–FICC–2018–003]

Self-Regulatory Organizations; Fixed Income Clearing Corporation; Notice of Filing of Proposed Rule Change To Amend the Fee Structure of the Government Securities Division Rulebook

May 2, 2018.

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 April 27, 2018, Fixed Income Clearing Corporation (''FICC'') 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 by the clearing agency. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Clearing Agency's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change would amend the Fee Structure of the FICC Government Securities Division (''GSD'') Rulebook (''GSD Rules'')[3] with respect to the fees associated with the delivery-versus-payment (''DVP'') service as well as make other changes, as described in greater detail below.

II. Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the clearing agency 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 clearing agency has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such 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 amend the Fee Structure of the GSD Rules with respect to the fees associated with the DVP service and make other changes[4] in order to reduce complexity and to better align pricing with the costs of services provided by GSD. The proposed rule change would also make conforming, clarifying, and technical changes. Taken collectively, the proposed rule changes are designed to be revenue neutral for GSD and may eliminate perceived pricing barriers to entry, as described below.

(i) Background

GSD provides clearance and settlement services for trades executed by its Members in the U.S. government securities market. GSD supports and facilitates these services through transaction processing and position management.

Transaction processing for the DVP service includes the recording and comparison of transactions submitted to GSD for clearance and settlement through GSD's comparison system, the Real-Time Trade Matching system.

Position management for the DVP service includes trade netting, trade settlement, and the management of credit risks, market risks, and liquidity risks associated with transactions submitted to GSD for clearance and settlement.

(ii) Current Fees

Members are assessed fees in accordance with the GSD Fee Structure. The current GSD Fee Structure covers a multitude of fees that are assessed on Members based upon their activities and the services utilized. The number of fees and the methods by which they are calculated makes the current GSD Fee Structure unnecessarily complex. In addition, due to changes in technology and regulatory environment, certain fees in the current GSD Fee Structure have become misaligned with the costs of services provided by GSD.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Capitalized terms not defined herein are defined in the GSD Rules, *available at http://www.dtcc.com/~/media/Files/Downloads/legal/rules/ficc_gov_rules.pdf.*

[4] FICC is not proposing changes to fees specifically associated with either the GCF Repo® Service or the CCIT Service at this time because those fees are more aligned with the costs of providing such services. However, as further discussed below in Item II.(A)1.(iii) (entitled ''PROPOSED FEE CHANGES''), FICC is proposing a change to the minimum monthly fee. The minimum monthly fee is not specific to any service and would apply to each account of either a Comparison-Only Member or a Netting Member; such account of a Netting Member could include GCF Repo and/or CCIT activity. The minimum monthly fee for an account would not apply if the total monthly fees incurred by the account pursuant to proposed Sections I, II, and IV of the GSD Fee Structure exceed $2,500. CCIT Members are not subject to the minimum monthly fee.

For additional information on the GCF Repo Service and the CCIT Service, please refer to GSD Rule 20 and GSD Rule 3B, respectively. *See* GSD Rule 20 and GSD Rule 3B. GSD Rules, *id.*

A. Pricing Overly Complex

The current GSD Fee Structure (as it relates to the DVP service) consists of trade submission fees, trade netting fees, Repo Transaction [5] processing fees, and settlement fees.[6]

Trade submission fees are based on a seven-tiered structure where the fees are charged based on the number of sides of buy/sell transactions and Repo Transactions submitted and matched in a given month. There are two (2) tiered structures for the trade submission fees, one for the Dealer Accounts and the other one for the Broker Accounts.

Trade netting fees consist of ''into the net'' fees and ''out of the net'' fees. The ''into the net'' fees are different for Broker Accounts and Dealer Accounts and are based on the number of sides of buy/sell transactions and Repo Transactions that are being netted (a seven-tiered structure based on the monthly number of sides of buy/sell transactions and Repo Transactions), and the par value of those sides.[7] The ''out of the net'' fee is a par value-based fee for each Deliver Obligation and Receive Obligation created as a result of the netting process.[8]

Repo Transaction processing fees are comprised of (1) two gross Repo Transaction processing fees, one for Broker Accounts and one for Dealer Accounts, and (2) a net Repo Transaction processing fee.[9]

With a combination of the tiered structure for trade submission fees and trade netting fees, an ''into the net'' par value-based fee, an ''out of the net'' par value-based fee, and gross and net Repo Transaction processing fees, the current GSD Fee Structure can be difficult for Members to understand and reconcile. In fact, Members and market participants have often indicated to FICC that the current GSD Fee Structure is too complex and difficult to understand. The complexity of the GSD Fee Structure is also noted in the U.S. Department of the Treasury October 2017 report to President Donald Trump on U.S. capital markets (''Treasury Report'').[10]

B. Pricing Alignment With Costs of Services Provided by GSD

With respect to the fees associated with the DVP service, a portion of the current GSD Fee Structure is based on transaction processing, with a number of fees charged to Members being driven by the number of transactions that the Members submit to GSD for clearance and settlement (tiered structure for trade submission fees and tiered structure for trade netting fees, as described in Item II.(A)1.(ii)A. above). As a result, under the current GSD Fee Structure, fees are higher for a Member that submitted a larger number of transactions to GSD than a Member that submitted a smaller number of transactions, even when the total par value of the trades that each such Member submitted to GSD is the same.

With technological advancements, GSD's systems have become more scalable and efficient with respect to transaction processing, which has resulted in a reduction in GSD's costs associated with transaction processing. In contrast, GSD faces continued increasing risk management costs, such as costs of account monitoring, intraday margining, and end of day risk management. Therefore, GSD has had to shift its resource allocation so that a sizable portion of its resources is now dedicated to the management of Members' positions. Consequently, certain fees in the current GSD Fee Structure have become misaligned with the costs of services provided by GSD.

As an example, the costs for GSD to manage a single $50 million 30-day Term Repo Transaction [11] for Member A and twenty (20) [12] $50 million overnight Repo Transactions [13] for Member B are similar because the resulting daily positions are the same over the 30-day period, and similar resources are utilized to ensure the safety and soundness of the clearing agency to these transaction types. However, even though these transactions require similar costs and resources to manage, under the current GSD Fee Structure, Member B will be assessed a fee [14] that is approximately 3.3 times the fee assessed on Member A. This is because under the current GSD Fee Structure, fees associated with Member B's overnight Repo Transactions are higher (*e.g.,* on each Business Day, Member B will be assessed $0.17 per side of trade going into the net, $0.016 per million par value going into the net, and $0.175 per million par value out of the net) than fees associated with Member A's Term Repo Transaction (*e.g.,* Member A will be assessed each of the following fees once: $0.17 per side of trade going into the net, $0.016 per million par value going into the net, and $0.175 per million par value out of the net; in addition, on each calendar day, Member A will be assessed a 0.04 basis point charge applied to the gross dollar amount of its Term Repo Transaction and a 0.08 basis point charge applied to the net dollar amount of its Term Repo Transaction).

[5] The term ''Repo Transaction'' means: (1) An agreement of a party to transfer Eligible Securities to another party in exchange for the receipt of cash, and the simultaneous agreement of the former party to later take back the same Eligible Securities (or any subsequently substituted Eligible Securities) from the latter party in exchange for the payment of cash, or (2) an agreement of a party to take in Eligible Securities from another party in exchange for the payment of cash, and the simultaneous agreement of the former party to later transfer back the same Eligible Securities (or any subsequently substituted Eligible Securities) to the latter party in exchange for the receipt of cash, as the context may indicate, the data on which have been submitted to FICC pursuant to the GSD Rules. A ''Repo Transaction'' includes a GCF Repo Transaction, unless the context indicates otherwise. *See* GSD Rule 1. GSD Rules, *supra* note 3. For the purposes of describing the proposed rule changes, the term ''Repo Transaction'' will exclude GCF Repo Transactions.

[6] Settlement fees consist of obligation fees and pass-through fees for clearing bank services. These fees are not being changed under this proposal.

[7] With respect to the DVP service, the ''into the net'' par value-based fee is currently $0.015 per one million of par value for Broker Accounts and $0.016 per one million of par value for Dealer Accounts for each Compared Trade, Start Leg of a Repo Transaction, Close Leg of a Repo Transaction, Fail Deliver Obligation, and Fail Receive Obligation. *See* current Section III.A.1(ii) of the GSD Fee Structure. GSD Rules, *supra* note 3.

[8] With respect to the DVP service, the ''out of the net'' par value-based fee is currently $0.175 per one million of par value for each Deliver Obligation and Receive Obligation created as a result of the netting process. *See* current Section III.A.2 of the GSD Fee Structure. GSD Rules, *supra* note 3.

[9] The gross Repo Transaction processing fees are currently a 0.0175 basis point charge and a 0.04 basis point charge applied to the gross dollar amount of each Term Repo Transaction for Broker Accounts and Dealer Accounts, respectively, that has been compared and netted but not yet settled. The net Repo Transaction processing fee is currently a 0.08 basis point charge applied to the net dollar amount of a Netting Member's Term Repo Transactions within a CUSIP that has been compared and netted but not yet settled. *See* current Section III.E. of the GSD Fee Structure. GSD Rules, *supra* note 3.

[10] *See* U.S. Department of the Treasury, A Financial System That Creates Economic Opportunities: Capital Markets (October 2017), at 81, *available at https://www.treasury.gov/press-center/press-releases/Documents/A-Financial-System-Capital-Markets-FINAL-FINAL.pdf.*

[11] The term ''Term Repo Transaction'' means, on any particular Business Day, a Repo Transaction for which settlement of the Close Leg is scheduled to occur two or more Business Days after the scheduled settlement of the Start Leg. *See* GSD Rule 1, Definitions. GSD Rules, *supra* note 3.

[12] The example assumes there are twenty (20) Business Days in a month. Twenty (20) overnight Repo Transactions would span the same number of calendar days, *i.e.,* 30 calendar days, as a single 30-day Term Repo Transaction. This is because each overnight Repo Transaction that starts on a Friday will settle on the following Monday.

[13] Overnight Repo Transactions are Repo Transactions for which settlement of the Close Leg is scheduled to occur one Business Day after the scheduled settlement of the Start Leg.

[14] In addition, Member A and Member B would be assessed other fees, such as trade submission fees and clearance charges; however, these fees are excluded for the purposes of this example because they are not relevant to position management.

C. Review of Current Fees and Rationale for Proposed Fee Amounts

Over the past two years, GSD performed an extensive review of the current GSD Fee Structure with the goals of reducing pricing complexity and aligning pricing with costs, while on an overall basis maintaining GSD's revenue at the current level.

GSD believes it is reasonable and appropriate to assess Members fees that are commensurate with the costs of services provided to Members. Accordingly, based on a review of the costs associated with position management vis-à-vis the overall cost structure as well as the current fees, GSD estimates that the transaction processing fees and the position management fees associated with the DVP service should account for approximately thirty percent (30%) and seventy percent (70%), respectively, of GSD's projected revenue associated with the DVP service. In particular, the position management fees would be comprised of an intraday position management fee and an end of day position management fee, each aimed to reflect the respective costs of services required in managing intraday positions and end of day positions. The proposed fee changes would better align GSD's revenue with the 30/70 split between transaction processing and position management costs. FICC expects GSD's net revenue to remain relatively unchanged as a result of this proposal.

(iii) Proposed Fee Changes

Based upon feedback from Members and market participants as well as a review of current fees conducted by FICC as described above, FICC is proposing to modify the GSD Fee Structure to (i) reduce pricing complexity and (ii) better align pricing with costs of services provided by GSD.

In that respect, the proposed GSD Fee Structure would establish four (4) new fees, modify three (3) existing fees, and eliminate twelve (12) fees, each as further described below.

FICC is proposing to add the following fees—

- Transaction processing fee for Broker Accounts
- Transaction processing fee for Dealer Accounts
- Intraday position fee
- End of day position fee

FICC is proposing to modify the following fees—

- Minimum monthly fee
- Auction takedown fee
- Locked-in trade data fee

FICC is proposing to eliminate the following fees—

- Surcharge for submission method
- Seven-tiered transaction based DVP trade submission fee for Broker Accounts
- Seven-tiered transaction based DVP trade submission fee for Dealer Accounts
- Seven-tiered transaction based DVP netting fee for Broker Accounts
- Seven-tiered transaction based DVP netting fee for Dealer Accounts
- DVP par value based into the net fee for Broker Accounts
- DVP par value based into the net fee for Dealer Accounts
- DVP par value based obligation fee (the ''out of the net'' fee)
- Gross Repo Transaction processing fee for Broker Accounts for DVP transactions
- Gross Repo Transaction processing fee for Dealer Accounts for DVP transactions
- Net Repo Transaction processing fee for DVP transactions
- Fees applicable to additional accounts

The foregoing proposed fee changes would address pricing complexity, pricing alignment to costs, or both, as further described in the section-by-section discussion below. FICC believes the proposed fee changes that address pricing complexity would enhance pricing transparency, making it easier for Members (and prospective members) to understand the GSD Fee Structure. FICC also believes shifting the GSD Fee Structure regarding the DVP service away from a volume-driven approach may result in making central clearing more accessible to additional market participants. Taken collectively, the proposed rule changes are designed to be revenue neutral for GSD and may eliminate perceived pricing barriers to entry.

Section I of GSD Fee Structure

In order to address the complexity of the GSD Fee Structure, FICC is proposing to replace the seven-tiered trade submission fees for both Dealer Accounts and Broker Accounts with a single transaction processing fee that would be charged to Members upon the comparison of a side of a buy/sell transaction or a Repo Transaction in the DVP service. As proposed, Dealer Accounts would be charged a fee of $0.04 per million par value for transaction processing, and Broker Accounts would be charged a fee of $0.02 per million par value for transaction processing.[15] This proposed change would also enable GSD to better align pricing with costs by assessing a fee that is more reflective of the costs that GSD is currently incurring for transaction processing, as described above in Item II.(A)1.(ii)C.

In order to further reduce the complexity of the current GSD Fee Structure, FICC is proposing to delete fees in Section I of the GSD Fee Structure that are no longer applicable. Specifically, FICC is proposing to delete Section I.B. of the GSD Fee Structure, which imposes surcharges on a Member based on the submission method used by the Member. Current Section I.B. of the GSD Fee Structure imposes certain surcharges on Members submitting trade data to GSD using submission methods other than the Interactive Submission Method, *e.g.,* the Multiple Batch Submission Method or the Single Batch Submission Method. These surcharges are no longer required because all Members currently submit trade data to GSD using the Interactive Submission Method, and FICC does not expect that to change in the future because of technological advancements in real-time trade submission capability across the financial industry. This proposed change would necessitate the re-lettering of the subsequent provisions in Section I of the GSD Fee Structure.

Section II of GSD Fee Structure

In order to better align pricing with the costs of services provided by GSD, FICC is proposing to add two position management fees applicable to the DVP service in proposed Section II of the GSD Fee Structure. The first position management fee would be the intraday position fee of $0.04 per million par value that would be calculated for a Member each Business Day based on the largest gross position of the Member (including positions of any Non-Member that the Member is clearing for) that Business Day. FICC proposes to determine the gross position of a Member in 15-minute intervals between 9 a.m. and 4 p.m. each Business Day by netting the par value of all compared buy/sell transactions, Repo Transactions, and unsettled obligations of the Member (including any such activity submitted by the Member for a Non-Member that the Member is clearing for) by CUSIP Number and taking the sum of the absolute par value of each such CUSIP Number.

The second position management fee would be the end of day position fee of $0.115 per million par value that would be calculated for a Member each Business Day based on the end of day gross position of the Member (including positions of any Non-Member that the

[15] Broker Accounts submit two sides per transaction. As such, a Broker Account would be charged a total of $0.04 per million par value (*i.e.,* $0.02 per million par value times two) for each transaction.

Member is clearing for) that Business Day. FICC proposes to determine the end of day gross position of a Member by netting the par value of all compared buy/sell transactions, Repo Transactions, and unsettled obligations of the Member (including any such activity submitted by the Member for a Non-Member that the Member is clearing for) at the end of the Business Day by CUSIP Number and taking the sum of the absolute par value of each such CUSIP Number.

The two proposed position management fees would better align pricing with costs of services provided by GSD because they would be driven by position management and, as stated above, GSD's costs associated with position management have increased. The proposed intraday position fee of $0.04 per million par value is aimed to reflect the costs associated with monitoring and management of Members' intraday DVP positions. The proposed end of day position fee of $0.115 per million par value is aimed to reflect the costs associated with end of day processing, overnight position management, and various risk and operational activities required to assure the ability of FICC to continue to provide a dependable, stable and efficient clearing and settlement service for Members.

Section IV of GSD Fee Structure

In order to reduce pricing complexity further, FICC is proposing to eliminate all netting fees provided in renumbered Section IV of the GSD Fee Structure, *i.e.,* (1) the two seven-tiered netting fees for both Broker Accounts and Dealer Accounts, (2) the ''into the net'' fees of $0.015 per one million of par value for Broker Accounts and $0.016 per one million of par value for Dealer Accounts for each Compared Trade, Start Leg of a Repo Transaction, Close Leg of a Repo Transaction, Fail Deliver Obligation, and Fail Receive Obligation, and (3) the ''out of the net'' fees of $0.175 per one million of par value for each Deliver Obligation and Receive Obligation created as a result of the netting process. This would reduce pricing complexity and thereby enhance pricing transparency because the proposal would eliminate the necessity for Members to reconcile their fees to the multiple-tiered netting fees, the ''into the net'' fees, and the ''out of the net'' fees.

In addition, FICC is proposing to delete from renumbered Section IV.C. of the GSD Fee Structure the Repo Transaction processing fees and related language for Term Repo Transactions in the DVP service that have been compared and netted but not yet settled. This would reduce pricing complexity and thereby enhance pricing transparency because there would no longer be separate Repo Transaction processing fees for Term Repo Transactions. As proposed, Term Repo Transactions would be assessed the proposed position management fees, just like overnight Repo Transactions and buy/sell transactions.

Section V of GSD Fee Structure

In order to reduce pricing complexity, FICC is proposing to eliminate fees applicable to additional accounts from current Section V of the GSD Fee Structure. FICC believes this proposed change would reduce pricing complexity and thereby enhance pricing transparency because Members would no longer need to differentiate and keep track of their main accounts versus their additional accounts. As proposed, each account of every Comparison-Only Member and Netting Member would now be subject to the same fee, *i.e.,* the minimum monthly fee.

In order to better align pricing with the costs of services provided by GSD, FICC is proposing changes to fees associated with accounts of Comparison-Only Members and Netting Members. Specifically, FICC is proposing to modify the minimum monthly fee in proposed Section V of the GSD Fee Structure. As proposed, the minimum monthly fee would be increased from $1,000 to $2,500 per account and would apply to all accounts of every Comparison-Only Member and Netting Member instead of just their sole or primary account.[16] FICC is proposing to increase the minimum monthly fee to $2,500 per account because FICC believes this change would better reflect GSD's costs of account monitoring, which have increased as described above in Item II.(A)1.(ii)B.

(iv) Expected Member Impact

In general, FICC anticipates that the proposal would result in fee increases for Members that currently have large directional term repurchase agreement positions. This is because under the current GSD Fee Structure, Members with Term Repo Transactions are charged less than Members with overnight Repo Transactions. In contrast, under the proposal the Members would be assessed the same position management fees for both their Term Repo Transactions as well as their overnight Repo Transactions.

Using the same example from Item II.(A)1.(ii)B (entitled ''CURRENT FEES—Pricing Alignment with Costs of Services Provided by GSD''), under the proposal, both Member A and Member B would be assessed the same fee for position management of their respective Repo Transactions because the proposal would harmonize how fees are assessed for the management of positions related to overnight Repo Transactions and Term Repo Transactions.[17]

Meanwhile, FICC anticipates that Members with high volumes of buy/sell transactions that maintain minimal positions would see a decrease in their fees because the position management fee associated with their activities would be minimal.

FICC anticipates that the proposal would have a lesser impact on fees for Members with diversified portfolios of varying transaction types/terms.

(v) Alternatives Considered

During development of this proposal, FICC considered a range of alternatives to the proposal, including:

(i) A tiered, fixed monthly membership fee based on Members' historical activity level, which would provide certainty to Members regarding their monthly fee amounts. However, establishing an equitable baseline for such a fixed membership fee would be difficult because Members' volumes and positions vary (materially in some cases) over time due to market events, trading strategies or corporate outlook, and, as such, Members' utilization of GSD services would change accordingly;

(ii) A single fee based on Members' end of day positions; however, under this alternative, Members with end of day positions would disproportionally subsidize intraday position holders who do not carry end of day positions as well as Members with large transaction volumes but minimal end of day positions;

(iii) A combination of two fees based on Members' end of day and intraday positions, respectively; however, under this alternative, Members with end of day and/or intraday positions would disproportionally subsidize Members with large transaction volumes but minimal intraday and/or end of day positions; and

(iv) A combination of two fees based on Members' end of day positions and

[16] As proposed, the minimum monthly fee would apply to all accounts of a Netting Member, including any account the Netting Member may have as a Sponsoring Member.

[17] When comparing with fees under the current GSD Fee Structure, excluding transaction processing fees and clearance charges, as proposed, Member A would see a fee increase of approximately 2.6 times and Member B would see a decrease of approximately twenty percent (20%).

transaction processing, respectively; however, under this alternative, Members with end of day positions would disproportionately subsidize intraday position holders with minimal end of day positions.

Given the shortcomings noted above, FICC did not choose the foregoing alternatives.

(vi) Conforming, Clarifying, and Technical Changes

FICC is proposing a number of conforming, clarifying, and technical changes. The proposed rule changes to make conforming, clarifying, and technical changes are set forth in proposed Sections I, III, IV, V, VI, VII, VIII, and XII of the GSD Fee Structure, as further described below.

Section I of GSD Fee Structure

FICC is proposing to rename the heading of Section I of the GSD Fee Structure from ''Trade Comparison Fees'' to ''Transaction Fees'' to better reflect the proposed changes to that section, as described above.

FICC is proposing to rename the heading of Section I.A. of the GSD Fee Structure from ''Trade Submission'' to ''Transaction Processing.'' In addition, FICC is proposing changes throughout Section I.A. of the GSD Fee Structure to clarify that references to a ''trade'' means a ''buy/sell transaction.'' FICC is also proposing a number of conforming changes in Section I.A. of the GSD Fee Structure. Specifically, FICC is proposing to delete a reference to ''submission fee'' and replace it with ''processing fee.'' FICC is also proposing to update the reference to ''subsection D'' to reflect the proposed re-lettering of that subsection.

Additionally, FICC is proposing to update the format of (i) the $.50 rejection fee to $0.50 in Section I.A. of the GSD Fee Structure, (ii) the 15 cents yield-to-price conversion charge to $0.15 in the proposed Section I.B. of the GSD Fee Structure, (iii) the 25 cents and 5 cents modification/cancellation fees to $0.25 and $0.05, respectively, in the proposed Section I.C. of the GSD Fee Structure, (iv) the 25 cents coupon pass-through fee to $0.25 in the proposed Section I.D. of the GSD Fee Structure, (v) the $.75 repurchase agreement collateral substitution fee to $0.75 in the proposed Section I.E. of the GSD Fee Structure, (vi) the $.07 and $.025 recording fees to $0.07 and $0.025 in the proposed Section I.G. of the GSD Fee Structure, and (vii) the $.07 recording fee to $0.07 in the proposed Section I.H. of the GSD Fee Restructure, in order to be consistent with the format of the other fees in the GSD Fee Structure.

For better organization of the GSD Fee Structure, FICC is proposing to relocate current Sections III.B. (Auction Takedown Process), III.F. (Coupon Pass-Through Fee), and III.G. (Repo Collateral Substitution Fees), which cover fees associated with the Auction Takedown Service, pass-through of coupon payments, and the processing of repurchase agreement collateral substitution requests, to proposed Sections I.F., I.D., and I.E., respectively, of the GSD Fee Structure because each of these fees is a type of transaction fee.

In addition, FICC is proposing to revise the section on Auction Takedown Process (proposed Section I.D. of the GSD Fee Structure) by replacing the words ''locked-in trades'' with ''buy/sell transactions'' because all trades associated with the Auction Takedown Service are locked-in. FICC is also proposing to change this section to reflect that, instead of the ''Trade Submission'' fees, fees for trades associated with the Auction Takedown Service would include the proposed ''Transaction Processing'' fees in Section I.A. of the GSD Fee Structure and the proposed ''Position Management Fees'' in Section II of the GSD Fee Structure.

FICC is proposing a conforming change in the proposed Section I.G. of the GSD Fee Structure by deleting the reference to ''Trade Submission'' fee schedule and replacing it with ''Transaction Processing'' fees.

Section III of GSD Fee Structure

FICC is proposing the renumbering of this section from current Section II of the GSD Fee Structure to proposed Section III of the GSD Fee Structure.

Section IV of GSD Fee Structure

FICC is proposing to rename the heading of renumbered Section IV of the GSD Fee Structure from ''Netting Fee and Charges (in addition to the comparison fee)'' to ''Other Charges (in addition to the transaction fees)'' to better reflect the proposed changes to this section, as described above.

As described above, for better organization of the GSD Fee Structure, FICC is also proposing to relocate current Sections III.B. (Auction Takedown Process), III.F. (Coupon Pass-Through Fee), and III.G. (Repo Collateral Substitution Fees) to proposed Sections I.F., I.D., and I.E., respectively, of the GSD Fee Structure. These proposed changes would necessitate a re-lettering of all subsequent provisions in renumbered Section IV of the GSD Fee Structure.

In addition, FICC is proposing to rename the heading of renumbered Section IV.C. of the GSD Fee Structure from ''Repo Transaction Processing Fee'' to ''GCF Repo Transaction and CCIT Transaction Processing Fee'' to better reflect the proposed changes to this section. FICC is also proposing two conforming changes: (i) Relocate and update the reference to ''Repo Broker'' definition to appear right after the first usage of ''Repo Broker'' in this section and (ii) reflect the remaining fee in renumbered Section IV.C. of the GSD Fee Structure in a singular form.

In addition, FICC is proposing a conforming change in renumbered Section IV.D. of the GSD Fee Structure to reflect the proposed renumbering of sections in the GSD Fee Structure by changing a reference from ''Section III'' to ''Section IV.''

Section V of GSD Fee Structure

Currently, the minimum monthly fee does not apply if the total monthly fees incurred by the sole or primary account of a Comparison-Only Member or a Netting Member pursuant to existing Sections I and III of the GSD Fee Structure exceed the minimum monthly fee; however, this is not expressly stated in the current GSD Fee Structure. FICC is proposing to add a sentence to proposed Section V of the GSD Fee Structure that would make it clear to Members that the minimum monthly fee would not apply to an account if the total monthly fees incurred by the account pursuant to Sections I, II (a proposed new section), and IV (renumbered from III) of the GSD Fee Structure exceed $2,500.

Section VI of GSD Fee Structure

FICC is proposing changes in Section VI of the GSD Fee Structure to clarify that references to ''trades'' means ''buy/sell transactions and Repo Transactions.''

Section VII of GSD Fee Structure

FICC is proposing two changes to Section VII of the GSD Fee Structure. The first change is being proposed in order to conform to the deletion of the fee for additional accounts in proposed Section V of the GSD Fee Structure, as described above in Item II.(A)1.(iii) (entitled ''PROPOSED FEE CHANGES''). Specifically, FICC is proposing to delete the reference to the fee for additional accounts, which is being eliminated under the proposal.

The second change is being proposed in order to make it clear that a Sponsoring Member would be subject to the minimum monthly fee set forth in proposed Section V of the GSD Fee Structure, as described above in Item II.(A)1.(iii) (entitled ''PROPOSED FEE

CHANGES''). This is a clarifying change because, pursuant to the GSD Rules, Sponsoring Members are by definition also Netting Members,[18] and, as proposed, each account of every Netting Member would be subject to the minimum monthly fee, which would include any account the Netting Member may have as a Sponsoring Member. This proposed change would make it clear to a Sponsoring Member that its Sponsoring Member Omnibus Account would be subject to the minimum monthly fee.

Section VIII of GSD Fee Structure

In current Section VIII of the GSD Fee Structure, FICC is proposing (i) a technical change to reflect the reference to the GSD Fee Structure as ''Fee Structure'' instead of ''fee structure'' and (ii) changes to clarify that references to a ''trade'' means a ''buy/sell transaction.'' In addition, FICC is proposing a change to clarify that a CCIT Transaction, like a Term GCF Repo Transaction, would be considered to have one Start Leg and one Close Leg during its term. This clarification is being proposed because a CCIT Transaction is similar to a GCF Repo Transaction, and FICC believes this would be a helpful clarification for Members.

Section XII of GSD Fee Structure

FICC is proposing a conforming change in current Section XII of the GSD Fee Structure by deleting the reference to ''comparison and netting fees'' and replacing it with ''transaction fees.'' In addition, FICC is proposing a technical change by deleting the outdated reference to ''Operations and Planning Committee'' and replacing it with Board, which is defined in GSD Rule 1 (Definitions) as ''the Board of Directors of Fixed Income Clearing Corporation or a committee thereof acting under delegated authority.'' [19]

(vii) Member Outreach

Beginning in December 2017, FICC conducted outreach to each Member in order to provide them with notice of the proposed changes and the anticipated impact for the Member. As of the date of this filing, no written comments relating to the proposed changes have been received in response to this outreach. The Commission will be notified of any written comments received.

(viii) Implementation Timeframe

Pending Commission approval, FICC expects to implement this proposal on July 2, 2018. As proposed, a legend would be added to the GSD Fee Structure stating that there are changes that have been approved by the Commission but have not yet been implemented. The proposed legend also would include a date on which such changes would be implemented and the file number of this proposal, and state that, once this proposal is implemented, the legend would automatically be removed from the GSD Fee Structure.

2. Statutory Basis

FICC believes this proposal is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a registered clearing agency. Specifically, FICC believes this proposal is consistent with Sections 17A(b)(3)(D) [20] and 17A(b)(3)(F) [21] of the Act and Rule 17Ad–22(e)(23)(ii),[22] as promulgated under the Act, for the reasons described below.

Section 17A(b)(3)(D) of the Act requires that the GSD Rules provide for the equitable allocation of reasonable dues, fees, and other charges among its participants.[23] FICC believes the proposed rule changes to the GSD Fee Structure, described in detail in Item II.(A)1.(iii) (entitled ''PROPOSED FEE CHANGES''), to better align pricing with costs of GSD services would provide for the equitable allocation of reasonable fees. As described above in Item II.(A)1.(ii)B (entitled ''CURRENT FEES—Pricing Alignment with Costs of Services Provided by GSD''), GSD's costs have increased due to the continued increasing risk management costs and are no longer aligned with the current GSD Fee Structure. This proposal would better align GSD's pricing (*e.g.,* fees associated with the DVP service as well as the minimum monthly fee) with costs attributed to GSD's management of Members' DVP positions and costs of account monitoring, respectively. With respect to proposed fees associated with the DVP service, a Member whose DVP positions result in higher position management costs to GSD would be charged a relatively higher fee as that would be reflective of the higher costs to GSD in managing those positions of the Member. On the other hand, a Member whose DVP positions require less management by GSD would be charged a lower fee that is reflective of the lower costs to GSD in managing those positions of the Member. Accordingly, FICC believes the proposed fees would be equitably allocated because Members with similar DVP positions would be treated alike under the proposal. With respect to proposed changes to the minimum monthly fee, each account of every Comparison-Only Member and Netting Member would be subject to a minimum monthly fee threshold that reflects the costs of account monitoring. To the extent applicable monthly fees for such an account fall below the proposed minimum monthly fee threshold, then the Comparison-Only Member or the Netting Member, as applicable, would be assessed the minimum monthly fee for that account. FICC believes the proposed changes to the minimum monthly fee would allow FICC to equitably allocate fees that are reflective of the costs of account monitoring among the accounts that are being monitored. FICC believes the proposed rule changes discussed in this paragraph would be reasonable because the proposed fees would be commensurate with the costs of resources allocated by GSD to manage Members' DVP positions and monitor accounts of Comparison-Only Members and Netting Members. In addition, taken collectively, the proposed fee changes are designed to maintain GSD's existing revenue derived from fees associated with the DVP service and the minimum monthly fee, in accordance with the current GSD Fee Structure, which fees have been in effect since January 1, 2016 [24] and July 3, 2000,[25] respectively. Therefore, FICC believes the proposed rule changes to the GSD Fee Structure described in detail in Item II.(A)1.(iii) (entitled ''PROPOSED FEE CHANGES'') to better align pricing with costs of GSD services are consistent with Section 17A(b)(3)(D) of the Act.

Section 17A(b)(3)(F) of the Act requires, in part, that the GSD Rules be designed to promote the prompt and accurate clearance and settlement of securities transactions.[26] The proposed rule changes to make conforming, clarifying, and technical changes, as described in Item II.(A)1.(vi) (entitled ''CONFORMING, CLARIFYING, AND TECHNICAL CHANGES''), would help ensure that the GSD Rules, including the GSD Fee Structure, remain accurate

[18] The term ''Sponsoring Member'' means a Netting Member whose application to become a Sponsoring Member has been approved by the Board pursuant to GSD Rule 3A. *See* GSD Rule 1, Definitions. GSD Rules, *supra* note 3.

[19] *See* GSD Rule 1. GSD Rules, *supra* note 3.

[20] 15 U.S.C. 78q–1(b)(3)(D).

[21] 15 U.S.C. 78q–1(b)(3)(F).

[22] 17 CFR 240.17Ad–22(e)(23)(ii).

[23] 15 U.S.C. 78q–1(b)(3)(D).

[24] *See* Securities Exchange Act Release No. 76840 (January 6, 2016), 81 FR 1450 (January 12, 2016) (FR–FICC–2015–005).

[25] *See* Securities Exchange Act Release No. 43026 (July 12, 2000), 65 FR 44555 (July 18, 2000) (SR–GSCC–00–07).

[26] 15 U.S.C. 78q–1(b)(3)(F).

and clear to Members. Having accurate and clear GSD Rules would help Members to better understand their rights and obligations regarding GSD's clearance and settlement services. When Members better understand their rights and obligations regarding GSD's clearance and settlement services, they can act in accordance with the GSD Rules, which FICC believes would promote the prompt and accurate clearance and settlement of securities transactions by GSD. As such, FICC believes the proposed rule changes to make conforming, clarifying, and technical changes are consistent with Section 17A(b)(3)(F) of the Act.

Rule 17Ad–22(e)(23)(ii) under the Act requires FICC to establish, implement, maintain and enforce written policies and procedures reasonably designed to provide sufficient information to enable participants to identify and evaluate the risks, fees, and other material costs they incur by participating in the covered clearing agency.[27] The proposed rule changes to reduce the complexity of the GSD Fee Structure, as described in Item II.(A)1.(iii) (entitled ''PROPOSED FEE CHANGES''), and to make conforming, clarifying, and technical changes, as described in Item II.(A)1.(vi) (entitled ''CONFORMING, CLARIFYING, AND TECHNICAL CHANGES'') would help ensure that the GSD Fee Structure is transparent and clear to Members. Having a transparent and clear GSD Fee Structure would help Members to better understand GSD's fees and help provide Members with increased predictability and certainty regarding the fees they incur in participating in GSD. As such, FICC believes the proposed rule changes to reduce the complexity of the GSD Fee Structure and to make conforming, clarifying, and technical changes are consistent with Rule 17Ad–22(e)(23)(ii) under the Act.

(B) Clearing Agency's Statement on Burden on Competition

FICC believes the proposed rule changes to fees associated with the DVP service to better align GSD's pricing with its costs of services could have an impact on competition because these changes would likely either increase or decrease Members' fees when compared to their fees under the current GSD Fee Structure. FICC believes these proposed rule changes could both burden competition and promote competition by altering Members' fees. When fees are decreased because of these proposed rule changes, the proposal could promote competition by positively impacting Members' operating costs. Conversely, when the proposed rule changes result in fee increases for Members, the proposal could burden competition by negatively affecting Members' operating costs. While some Members may experience large increases in their fees when compared to their fees under the current GSD Fee Structure, FICC does not believe such change in fees would in and of itself mean that the burden on competition is significant. This is because even though the amount of the fee increase may be significant, FICC believes the increase in fees would similarly affect all Members that tend to maintain large directional term repurchase agreement positions[28] and therefore the burden on competition would not be significant. Regardless of whether the burden on competition is deemed significant, FICC believes any burden on competition that is created by the proposed rule changes to fees associated with the DVP service would be necessary and appropriate in furtherance of the purposes of the Act, as permitted by Section 17A(b)(3)(I) of the Act.[29]

FICC believes the proposed rule changes to the minimum monthly fee to better align GSD's pricing with its costs of services could have an impact on competition but only to the extent that the minimum monthly fee applies to a Comparison-Only Member's or Netting Member's account(s) (because the minimum monthly fee only applies if the threshold amount is not reached as described above). There would be no impact on competition, however, if an account incurs applicable fees that exceed the proposed minimum monthly fee threshold because the minimum monthly fee would not apply to the account. When the minimum monthly fee would apply, FICC believes the proposed rule changes to the minimum monthly fee could burden competition by increasing Members' fees and thereby negatively affecting such Members' operating costs. FICC does not believe such burden on competition would be significant because the proposed minimum monthly fee would apply equally to all Comparison-Only Members and Netting Members that have minimal activity in their accounts. Regardless of whether the burden on competition is deemed significant, FICC believes any burden on competition that is created by the proposed rule changes to the minimum monthly fee would be necessary and appropriate in furtherance of the purposes of the Act, as permitted by Section 17A(b)(3)(I) of the Act.[30]

The proposed rule changes to better align GSD's pricing (*e.g.,* fees associated with the DVP service as well as the minimum monthly fee) with the costs of services would be necessary in furtherance of the purposes of the Act because the GSD Rules must provide for the equitable allocation of reasonable dues, fees, and other charges among its participants.[31] As described above, the proposed rule changes would result in fees that are equitably allocated (by better aligning pricing with costs so that (i) a Member whose positions result in higher costs to GSD for maintaining such positions would be charged a relatively higher fee, and a Member whose positions require less maintenance by GSD would be charged a lower fee and (ii) fees that are reflective of the costs of account monitoring would be allocated among the accounts that are being monitored) and would result in reasonable fees (by being designed to be revenue neutral and commensurate with costs). As such, FICC believes the proposed rule changes to better align GSD's pricing with the costs of services would be necessary in furtherance of the purposes of the Act, as permitted by Section 17A(b)(3)(I) of the Act.[32]

FICC believes any burden on competition that is created by the proposed rule changes to better align GSD's pricing (*e.g.,* fees associated with the DVP service as well as the minimum monthly fee) with the costs of services would also be appropriate in furtherance of the purposes of the Act. The proposed rule changes would provide GSD with the ability to assess fees that are not only reflective of the services utilized by Members but are also commensurate with FICC's increased risk management costs, such as costs of account monitoring, intraday margining, and end of day risk management. Having the ability to assess fees that are reflective of the services provided by GSD and that are commensurate with GSD's costs of providing such services would help GSD to continue providing dependable and stable clearance and settlement services to its Members. As such, FICC believes the proposed rule changes to better align GSD's pricing with the costs of services would be appropriate in furtherance of the purposes of the Act,

[27] 17 CFR 240.17Ad–22(e)(23)(ii).

[28] Though admittedly a fee increase would be more impactful for Members that are smaller than for Members that are larger, FICC believes such difference in impact is due to the relative market positions of the respective Members and not as a result of these proposed rule changes.

[29] 15 U.S.C. 78q–1(b)(3)(I).

[30] *Id.*

[31] 15 U.S.C. 78q–1(b)(3)(D).

[32] 15 U.S.C. 78q–1(b)(3)(I).

as permitted by Section 17A(b)(3)(I) of the Act.[33]

FICC does not believe the proposed rule changes to reduce the complexity of the GSD Fee Structure and to make conforming, clarifying, and technical changes, as discussed above in Items II.(A)1.(iii) and (vi), respectively, would impact competition.[34] The proposed rule changes to address the complexity of the GSD Fee Structure would allow Members to better understand the GSD Fee Structure and allow them more ease in reconciling to it. Making conforming, clarifying, and technical changes to ensure the GSD Fee Structure remains clear and accurate would facilitate Members' understanding of the GSD Fee Structure and their obligations thereunder. Having transparent, accessible, clear, and accurate provisions in the GSD Fee Structure would improve the readability and clarity of the GSD Rules regarding the fees that Members would incur by participating in GSD. These changes would apply equally to all Members and would not affect Members' rights and obligations. As such, FICC believes the proposed rule changes to reduce the complexity of the GSD Fee Structure and to make conforming, clarifying, and technical changes would not have any impact on competition.

(C) Clearing Agency's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments relating to this proposed rule change have not been solicited or received. FICC will notify the Commission of any written comments received by FICC.

III. Date of Effectiveness of the Proposed Rule Change, and Timing for Commission Action

Within 45 days of the date of publication of this notice in the **Federal Register** or within such longer period up to 90 days (i) as the Commission may designate if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve or disapprove such proposed rule change, or

(B) institute proceedings to determine whether the proposed rule change should be 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–FICC–2018–003 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549.

All submissions should refer to File Number SR–FICC–2018–003. 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 website (*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 website 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 FICC and on DTCC's website (*http://dtcc.com/legal/sec-rule-filings.aspx*). All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–FICC–2018–003 and should be submitted on or before May 29, 2018.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[35]

Eduardo A. Aleman,

Assistant Secretary.

[FR Doc. 2018–09693 Filed 5–7–18; 8:45 am]

BILLING CODE 8011–01–P

[33] *Id.*

[34] *Id.*

[35] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–83155; File No. SR–FINRA–2018–017]

Self-Regulatory Organizations; Financial Industry Regulatory Authority, Inc.; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Extend the Implementation Date of Certain Amendments to FINRA Rule 4210 Approved Pursuant to SR–FINRA–2015–036

May 2, 2018.

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 April 20, 2018, Financial Industry Regulatory Authority, Inc. (''FINRA'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by FINRA. FINRA has designated the proposed rule change as constituting a ''non-controversial'' rule change under paragraph (f)(6) of Rule 19b–4 under the Act,[3] which renders the proposal effective upon receipt of this filing by the Commission. 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

FINRA is proposing to extend, to March 25, 2019, the implementation date of the amendments to FINRA Rule 4210 (Margin Requirements) pursuant to SR–FINRA–2015–036, other than the amendments pursuant to SR–FINRA–2015–036 that were implemented on December 15, 2016. The proposed rule change would not make any changes to FINRA rules.

The text of the proposed rule change is available on FINRA's website at *http://www.finra.org,* at the principal office of FINRA and at the Commission's Public Reference Room.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 17 CFR 240.19b–4(f)(6).

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, FINRA 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. FINRA 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

On October 6, 2015, FINRA filed with the Commission proposed rule change SR–FINRA–2015–036, which proposed to amend FINRA Rule 4210 to establish margin requirements for (1) To Be Announced (''TBA'') transactions, inclusive of adjustable rate mortgage (''ARM'') transactions; (2) Specified Pool Transactions; and (3) transactions in Collateralized Mortgage Obligations (''CMOs''), issued in conformity with a program of an agency or Government-Sponsored Enterprise (''GSE''), with forward settlement dates, as defined more fully in the filing (collectively, ''Covered Agency Transactions''). The Commission approved SR–FINRA–2015–036 on June 15, 2016 (the ''Approval Date'').[4]

Pursuant to Partial Amendment No. 3 to SR–FINRA–2015–036, FINRA announced in *Regulatory Notice* 16–31 that the rule change would be become effective on December 15, 2017, 18 months from the Approval Date, except that the risk limit determination requirements as set forth in paragraphs (e)(2)(F), (e)(2)(G) and (e)(2)(H) of Rule 4210 and in new Supplementary Material .05, each as respectively amended or established by SR–FINRA–2015–036 (collectively, the ''risk limit determination requirements''), would become effective on December 15, 2016, six months from the Approval Date.[5]

Industry participants sought clarification regarding the implementation of the requirements pursuant to SR–FINRA–2015–036. Industry participants also requested additional time to make system changes necessary to comply with the requirements, including time to test the system changes, and requested additional time to update or amend margining agreements and related documentation. In response, FINRA made available a set of Frequently Asked Questions & Guidance[6] and, pursuant to SR–FINRA–2017–029,[7] extended the implementation date of the requirements of SR–FINRA–2015–036 to June 25, 2018 (the ''June 25, 2018 implementation date''), except for the risk limit determination requirements, which, as announced in *Regulatory Notice* 16–31, became effective on December 15, 2016.

Industry participants have requested that FINRA reconsider the potential impact of certain requirements pursuant to SR–FINRA–2015–036 on smaller and medium-sized firms. Industry participants have also requested that FINRA extend the June 25, 2018 implementation date pending such reconsideration to reduce potential uncertainty in the Covered Agency Transaction market. FINRA stated in Partial Amendment No. 3 to SR–FINRA–2015–036 that FINRA would monitor the impact of the requirements pursuant to that rulemaking and, if the requirements prove overly onerous or otherwise are shown to negatively impact the market, FINRA would consider revisiting such requirements as may be necessary to mitigate the rule's impact.[8] FINRA believes, in the interest of avoiding unnecessary disruption to the Covered Agency Transaction market, that it is appropriate to consider potential revisions to the requirements pursuant to SR–FINRA–2015–036 and is proposing to extend the June 25, 2018 implementation date to March 25, 2019 while FINRA considers, in consultation with industry participants and other regulators, whether any revisions are appropriate. FINRA notes that the risk limit determination requirements pursuant to SR–FINRA–2015–036 became effective on December 15, 2016 and, as such, the implementation of such requirements is not affected by the proposed rule change.

FINRA has filed the proposed rule change for immediate effectiveness and has requested that the Commission waive the requirement that the proposed rule change not become operative for 30 days after the date of the filing. The operative date will be the date of filing of the proposed rule change.

2. Statutory Basis

FINRA believes that the proposed rule change is consistent with the provisions of Section 15A(b)(6) of the Act,[9] which requires, among other things, that FINRA rules must be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and, in general, to protect investors and the public interest. FINRA believes that the proposed rule change provides FINRA additional time to consider whether any revisions to the requirements pursuant to SR–FINRA–2015–036 are appropriate and helps to reduce potential uncertainty in the Covered Agency Transaction market while FINRA considers such revisions. FINRA believes that providing additional time is consistent with the Act because this provides FINRA, in consultation with industry participants and other regulators, additional opportunity to consider whether revisions to the requirements would improve their effectiveness and thereby protect investors and the public interest by helping to promote stability in the Covered Agency Transaction market.

B. Self-Regulatory Organization's Statement on Burden on Competition

FINRA does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. FINRA believes that extending the June 25, 2018 implementation date to March 25, 2019, so as to provide additional time for FINRA to consider, in consultation with industry participants and other regulators, whether any revisions to the requirements pursuant to SR–FINRA–2015–036 are appropriate will benefit all parties.

[4] *See* Securities Exchange Act Release No. 78081 (June 15, 2016), 81 FR 40364 (June 21, 2016) (Notice of Filing of Amendment No. 3 and Order Granting Accelerated Approval to a Proposed Rule Change to Amend FINRA Rule 4210 (Margin Requirements) to Establish Margin Requirements for the TBA Market, as Modified by Amendment Nos. 1, 2, and 3; File No. SR–FINRA–2015–036).

[5] *See* Partial Amendment No. 3 to SR–FINRA–2015–036 and *Regulatory Notice* 16–31 (August 2016), both available at: *www.finra.org.*

[6] Available at: *www.finra.org/industry/guidance.* Further, staff of the SEC's Division of Trading and Markets made available a set of Frequently Asked Questions regarding Exchange Act Rule 15c3–1 and Rule 15c3–3 in connection with Covered Agency Transactions under FINRA Rule 4210, also available at: *www.finra.org/industry/guidance.*

[7] *See* Securities Exchange Act Release No. 81722 (September 26, 2017), 82 FR 45915 (October 2, 2017) (Notice of Filing and Immediate Effectiveness of a Proposed Rule Change to Delay the Implementation Date of Certain Amendments to FINRA Rule 4210 Approved Pursuant to SR–FINRA–2015–036; File No. SR–FINRA–2017–029); *see also Regulatory Notice* 17–28 (September 29, 2017).

[8] *See* Partial Amendment No. 3 to SR–FINRA–2015–036, available at: *www.finra.org.*

[9] 15 U.S.C. 78*o*–3(b)(6).

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

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 Section 19(b)(3)(A) of the Act [10] and Rule 19b–4(f)(6) thereunder.[11]

A proposed rule change filed under Rule 19b–4(f)(6) [12] normally does not become operative for 30 days after the date of 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. FINRA has asked the Commission to waive the 30-day operative delay so that the proposal may become operative upon filing. FINRA has stated that the purpose of the proposed rule change is to allow FINRA additional time to consider potential revisions to the requirements pursuant to SR–FINRA–2015–036 and to consult with industry participants and other regulators whether any revisions are appropriate, in the interest of avoiding unnecessary disruption to the Covered Agency Transaction market. The Commission believes that waiving the 30-day operative delay is consistent with the protection of investors and the public interest because the proposal to extend the implementation date of certain amendments to FINRA Rule 4210 does not raise any new or novel issues and will help to facilitate the implementation of the margin requirements for Covered Agency Transactions. Furthermore, the Commission understands that market participants have expressed support for the extension of the implementation date in order to give FINRA time to determine, in consultation with market participants and other interested parties, whether changes to the amendments are appropriate, and if so, what those changes should be.[14] Therefore, the Commission hereby waives the 30-day operative delay requirement and designates the proposed rule change as operative upon filing.[15]

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 shall institute proceedings to determine whether the proposed rule 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–FINRA–2018–017 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–FINRA–2018–017. 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 website (*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 website 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 office of FINRA. All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–FINRA–2018–017 and should be submitted on or before May 29, 2018.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[16]

Eduardo A. Aleman,

Assistant Secretary.

[FR Doc. 2018–09695 Filed 5–7–18; 8:45 am]

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[10] 15 U.S.C. 78s(b)(3)(A).

[11] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6)(iii) requires FINRA to give the Commission written notice of FINRA's intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the filing of the proposed rule change, or such shorter time as designated by the Commission. FINRA has satisfied this requirement.

[12] 17 CFR 240.19b–4(f)(6).

[13] 17 CFR 240.19b–4(f)(6)(iii).

[14] *See, e.g.,* Letter from Chris Killian, Managing Director, SIFMA (March 7, 2018), available at: *www.sec.gov.*

[15] For purposes only of waiving the 30-day operative delay, the Commission has also considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[16] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of FOIA Services, 100 F Street NE, Washington, DC 20549–2736

Extension:

Regulation AC; SEC File No. 270–517, OMB Control No. 3235–0575

Notice is hereby given that pursuant to the Paperwork Reduction Act of 1995 (''PRA'') (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission (''Commission'') is soliciting comments on the existing collection of information provided for in Regulation Analyst Certification (''Regulation AC'') (17 CFR 242.500–505, under the Securities Exchange Act of 1934 (15 U.S.C. 78a *et seq.*). The Commission plans to submit this existing collection of information to the Office of Management and Budget (''OMB'') for extension and approval.

Regulation AC requires that research reports published, circulated, or provided by a broker or dealer or covered person contain a statement attesting that the views expressed in each research report accurately reflect

the analyst's personal views and whether or not the research analyst received or will receive any compensation in connection with the views or recommendations expressed in the research report. Regulation AC also requires broker-dealers to, on a quarterly basis, make, keep, and maintain records of research analyst statements regarding whether the views expressed in public appearances accurately reflected the analyst's personal views, and whether any part of the analyst's compensation is related to the specific recommendations or views expressed in the public appearance. Regulation AC also requires that research prepared by foreign persons be presented to U.S. persons pursuant to Securities Exchange Act Rule 15a–6 and that broker-dealers notify associated persons if they would be covered by the regulation. Regulation AC excludes the news media from its coverage.

The Commission estimates that Regulation AC imposes an aggregate annual time burden of approximately 25,844 hours on 5,186 respondents, or approximately 5 hours per respondent. The Commission estimates that the total annual internal cost of compliance for the 25,844 hours is approximately $12,452,349, or approximately $2,401 per respondent, annually.

Written comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's estimates of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information 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. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information under the PRA unless it displays a currently valid OMB control number.

Please direct your written comments to: Pamela Dyson, Director/Chief Information Officer, Securities and Exchange Commission, c/o Remi Pavlik-Simon, 100 F Street NE, Washington, DC 20549, or send an email to: *PRA_Mailbox@sec.gov.*

Dated: May 1, 2018.

Eduardo A. Aleman,

Assistant Secretary.

[FR Doc. 2018–09691 Filed 5–7–18; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–83152; File No. SR–CboeBZX–2018–018]

Self-Regulatory Organizations; Cboe BZX Exchange, Inc.; Notice of Filing of a Proposed Rule Change To List and Trade Shares of the Principal Morley Short Duration Index ETF Under Rule 14.11(c)(4)

May 2, 2018.

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 April 23, 2018, Cboe BZX Exchange, Inc. (''Exchange'' or ''BZX'') 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 filed a proposal to list and trade under BZX Rule 14.11(c)(4) the shares of the Principal Morley Short Duration Index ETF (the ''Fund'') of Principal Exchange-Traded Funds (the ''Trust'').

The text of the proposed rule change is available at the Exchange's website at *www.markets.cboe.com,* at the principal office of the Exchange, 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 parts of such statements.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to list and trade shares of the Fund (''Shares'') under BZX Rule 14.11(c)(4),[3] which governs the listing and trading of index fund shares based on fixed income securities indexes.[4] The Shares will be offered by the Trust, which was established as a Delaware statutory trust on March 05, 2013. The Trust is registered with the Commission as an open-end investment company and has filed a registration statement on behalf of the Fund on Form N–1A (''Registration Statement'') with the Commission.[5] All statements and

[3] The Commission approved BZX Rule 14.11(c) in Securities Exchange Act Release No. 65225 (August 30, 2011), 76 FR 55148 (September 6, 2011) (SR–BATS–2011–018).

[4] The Commission previously has approved proposed rule changes relating to listing and trading of funds based on municipal bond indexes. *See* Securities Exchange Act Release Nos. 78329 (July 14, 2016), 81 FR 47217 (July 20, 2016) (SR–BatsBZX–2016–01) (order approving the listing and trading of the following series of VanEck Vectors ETF Trust: VanEck Vectors AMT-Free 6–8 Year Municipal Index ETF; VanEck Vectors AMT-Free 8–12 Year Municipal Index ETF; and VanEck Vectors AMT-Free 12–17 Year Municipal Index ETF); 67985 (October 4, 2012), 77 FR 61804 (October 11, 2012) (SR–NYSEArca–2012–92) (order approving proposed rule change relating to the listing and trading of iShares 2018 S&P AMT-Free Municipal Series and iShares 2019 S&P AMT-Free Municipal Series under NYSE Arca, Inc. (''NYSE Arca'') Rule 5.2(j)(3), Commentary .02); 72523 (July 2, 2014), 79 FR 39016 (July 9, 2014) (SR–NYSEArca–2014–37) (order approving proposed rule change relating to the listing and trading of iShares 2020 S&P AMT-Free Municipal Series under NYSE Arca Rule 5.2(j)(3), Commentary .02); and 75468 (July 16, 2015), 80 FR 43500 (July 22, 2015) (SR–NYSEArca–2015–25) (order approving proposed rule change relating to the listing and trading of the iShares iBonds Dec 2021 AMT-Free Muni Bond ETF and iShares iBonds Dec 2022 AMT-Free Muni Bond ETF under NYSE Arca Rule 5.2(j)(3), Commentary .02). The Commission also has issued a notice of filing and immediate effectiveness of a proposed rule change relating to listing and trading on NYSE Arca of the iShares Taxable Municipal Bond Fund. *See* Securities Exchange Act Release No. 63176 (October 25, 2010), 75 FR 66815 (October 29, 2010) (SR–NYSEArca–2010–94). The Commission has approved two actively managed funds of the PIMCO ETF Trust that hold municipal bonds. *See* Securities Exchange Act Release No. 60981 (November 10, 2009), 74 FR 59594 (November 18, 2009) (SR–NYSEArca–2009–79) (order approving listing and trading of PIMCO ShortTerm Municipal Bond Strategy Fund and PIMCO Intermediate Municipal Bond Strategy Fund, among others). The Commission also has approved listing and trading of the SPDR Nuveen S&P High Yield Municipal Bond Fund. *See* Securities Exchange Act Release No.63881 (February 9, 2011), 76 FR 9065 (February 16, 2011) (SR–NYSEArca–2010–120).

[5] *See* Registration Statement on Form N–1A for the Trust, dated September 1, 2017 (File Nos. 333–201935 and 811–23029). The descriptions of the Fund and the Shares contained herein are based, in part, on information in the Registration Statement.

representations made in this filing regarding the index composition, the description of the portfolio or reference assets, limitations on portfolio holdings or reference assets, dissemination and availability of index, reference asset, and intraday indicative values, and the applicability of Exchange rules specified in this filing shall constitute continued listing requirements for the Fund.

Description of the Shares and the Fund

Principal Global Investors, LLC will be the investment adviser (the ''Adviser'') to the Fund and Morley Capital Management will be the sub-adviser (the ''Sub-Adviser'') to the Fund.[6] The Adviser will serve as the administrator for the Fund (the ''Administrator''). The State Street Bank and Trust Company will serve as the custodian (''Custodian''), transfer agent (''Transfer Agent'') and sub-administrator (''Sub-Administrator) for the Fund. ALPS Distributors, Inc. (the ''Distributor'') will be the distributor of the Shares. Neither the Adviser nor the Sub-Adviser is registered as a broker-dealer, but they are affiliated with broker-dealers, [sic] Both the Advisor and Sub-Advisor has [sic] implemented and will maintain a fire wall with respect to such broker-dealer affiliates regarding access to information concerning the composition and/or changes to the portfolio, and will be subject to procedures designed to prevent the use and dissemination of material non-public information regarding such portfolio. Adviser and Sub-Adviser personnel who make decisions regarding the Fund's portfolio are subject to procedures designed to prevent the use and dissemination of material nonpublic information regarding the Fund's portfolio. In the event that (a) the Adviser or Sub-Adviser becomes registered as a broker-dealer or newly affiliated with a broker-dealer; or (b) any new adviser or sub-adviser is a registered broker-dealer or becomes affiliated with a broker-dealer; the Adviser and Sub-Adviser will implement a fire wall with respect to relevant personnel or such broker-dealer affiliate, as applicable, regarding access to information concerning the composition and/or changes to the portfolio, and will be subject to procedures designed to prevent the use and dissemination of material non-public information regarding such portfolio.

The ICE BofA Merrill Lynch Low Duration U.S. ABS & CMBS Equal Par Index

The Fund seeks to provide investment results that seek to replicate, before expenses, to [sic] the performance of The ICE BofA Merrill Lynch Low Duration U.S. ABS & CMBS Equal Par Index (the ''Index''). The Index is designed to provide exposure to investment-grade securitized products issued in the U.S., including ABS[7] and CMBS.[8] To qualify for inclusion in the Index, eligible securities must be a component of the The ICE BofA Merrill Lynch US ABS & CMBS Index (the ''Feeder Index''). Such securities are then selected and weighted based upon the Index methodology discussed below.

Feeder Index

In order to be included in the Feeder Index, a security (whether ABS or CMBS) must meet the following criteria (the ''Basic Criteria''):

- be rated investment-grade (based on an average of Moody's, S&P Global, and Fitch);
- have a term of at least one year remaining until final stated maturity; and have at least one month to the last expected cash flow; and
- inverse floating rate, interest only, and principal only securities are excluded.

In addition to the Basic Criteria, an ABS must meet the following criteria:

- must issue a fixed or floating rate coupon;
- must have an original deal size for the collateral group[9] of at least $250 million;
- must have a current outstanding deal size for the collateral group greater than or equal to 10% of the original deal size; and
- a minimum current outstanding tranche size of $50 million for senior tranches and $10 million current amount outstanding for mezzanine and subordinated tranches.

In addition to the Basic Criteria, a CMBS (which may include U.S. agency CMBS) must also meet the following criteria:

- must issue a fixed coupon schedule;
- must have an original deal size for the collateral group of at least $250 million;
- must have a current outstanding deal size for the collateral group that is greater than or equal to 10% of the original deal size; and
- must have a minimum outstanding tranche size of $50 million for senior tranches and $10 million for mezzanine and subordinated tranches.

Index Methodology

All securities in the Feeder Index are screened for inclusion/exclusion in the Index based on the following criteria:

- ABS related to home equity and manufactured housing are excluded;
- CMBS securities that are rated less than AAA credit quality (based on an average of Moody's, S&P Global and Fitch) are excluded;
- CMBS securities that are issued prior to December 31, 2010 are excluded;
- Securities must have a modified duration to worst that is less than or equal to 5 years for intial [sic] inclusion in the Index, although once included, the security remains in the Index provided the remaining criteria are met.

The qualifying securities are assigned equal par amounts with a 70% allocation given to ABS securities and a 30% allocation given to CMBS securities. The Index rebalances on a monthly basis.

The Exchange is submitting this proposed rule change because the Index for the Fund does not meet all of the ''generic'' listing requirements of Rule 14.11(c)(4) applicable to the listing of index fund shares based on fixed

The Commission has issued an order granting certain exemptive relief to the Trust under the Investment Company Act of 1940 (15 U.S.C. 80a–1) (''1940 Act'') (the ''Exemptive Order''). *See* Investment Company Act Release No. 31872 (October 19, 2015) (File No. 812–14509).

[6] An investment adviser to an open-end fund is required to be registered under the Investment Advisers Act of 1940 (the ''Advisers Act''). As a result, the Adviser and its related personnel are subject to the provisions of Rule 204A–1 under the Advisers Act relating to codes of ethics. This Rule requires investment advisers to adopt a code of ethics that reflects the fiduciary nature of the relationship to clients as well as compliance with all applicable securities laws. Accordingly, procedures designed to prevent the communication and misuse of non-public information by an investment adviser must be consistent with Rule 204A–1 under the Advisers Act. In addition, Rule 206(4)–7 under the Advisers Act makes it unlawful for an investment adviser to provide investment advice to clients unless such investment adviser has (i) adopted and implemented written policies and procedures reasonably designed to prevent violation, by the investment adviser and its supervised persons, of the Advisers Act and the Commission rules adopted thereunder; (ii) implemented, at a minimum, an annual review regarding the adequacy of the policies and procedures established pursuant to subparagraph (i) above and the effectiveness of their implementation; and (iii) designated an individual (who is a supervised person) responsible for administering the policies and procedures adopted under subparagraph (i) above.

[7] For purposes of this filing, the term ''ABS'' shall mean fixed and floating rate debt securities secured by non-mortgage assets.

[8] For purposes of this filing, the term ''CMBS'' shall mean fixed rate debt securities secured by first mortgages on commercial real estate.

[9] A collateral group describes the assets (receivables) that are held by the special purpose vehicle (''SPV'') issuing the ABS securities. The collateral group provides the source of payment for the SPV's liabilities (*i.e.* ABS securities). Typically, an SPV will include assets greater than its liabilities as a form of credit enhancement.

income securities indexes. The Index meets all such requirements except for those set forth in Rule 14.11(c)(4)(B)(i)(b) [10] and 14.11(c)(4)(B)(i)(f).[11] Specifically, as of February 22, 2018, 57.9% of the weight of the Index components have a minimum original principal amount outstanding of $100 million or more and 68.0% of the weight of the Index components met the requirements of Rule 14.11(c)(4)(B)(i)(f).

As of February 22, 2018, there were 2,693 constituents in the Index.

Principal Morley Short Duration Index ETF

According to the Registration Statement, the Fund will seek to provide investment results that closely correspond, before expenses, to the performance of the Index. Under Normal Market Conditions,[12] the Fund will invest at least 80% of its net assets, plus any borrowings for investment purposes, in ABS and CMBS that compose the Index at the time of purchase.

Other Portfolio Holdings

While the Fund normally will invest at least 80% of its net assets, plus any borrowings for investment purposes, in ABS and CMBS that compose the Index, as described above, the Fund may invest its remaining assets in securities not included in the Index including only the following instruments: ABS and CMBS not included in the Index; cash and cash equivalents; [13] Treasury Securities with a maturity of three months or greater; centrally cleared, index-based credit default swaps; [14] and, to the extent permitted by the 1940 Act, other exchange-traded funds (''ETFs'').[15]

Discussion

The Exchange is submitting this proposed rule change because the Index for the Fund does not meet all of the ''generic'' listing requirements of Rule 14.11(c)(4) applicable to the listing of index fund shares based on fixed income securities indexes. The Index meets all such requirements except for those set forth in Rule 14.11(c)(4)(B)(i)(b) [16] and 14.11(c)(4)(B)(i)(f).[17] Specifically, as of February 22, 2018, 57.9% of the weight of the Index components have a minimum original principal amount outstanding of $100 million or more and 68.0% of the weight of the Index components met the requirements of Rule 14.11(c)(4)(B)(i)(f). The Exchange notes that at least 90% of the weight of the Index will be comprised of securities that have a minimum par amount of $10 million and were a constituent of an offering where the original deal size was at least $250 million.

While the Index will not meet certain provisions of Rule 14.11(c)(4), as described above, the Exchange believes that the policy issues which such provisions are intended to address are otherwise mitigated. Specifically, the concerns around the size and manipulability of the underlying Fixed Income Securities that Rule 14.11(c)(4)(B)(i)(b) is intended to address are mitigated by the fact that at least 90% of the weight of the Index will be comprised of securities that have a minimum par amount of $10 million and were a constituent of an offering where the original deal size was at least $250 million. Similar standards have been applied for other comparably situated funds and the Exchange believes that there is no reason that this standard should not be applied for the Fund.[18]

Further, the concerns around the availability of information that Rule 14.11(c)(4)(B)(i)(f) is intended to address are also mitigated as it relates to the ABS and CMBS that populate the Index. While only 68.0% of the weight of the portfolio meets the requirements of Rule 14.11(c)(4)(B)(i)(f), the Index's inability to meet the 90% threshold is largely based on a technicality in the rule text. Part (1) of the Rule includes in the calculation of percentage ''issuers that are *required* [emphasis added] to file reports pursuant to Sections 13 and 15(d) of the Act.'' The technicality is that, while only certain registered issuances of ABS and CMBS are required to file reports pursuant to Sections 13 or 15(d) of the Act, many ABS and CMBS issuances include in the bond indenture a requirement that the issuer make a public disclosure of a Statement to Noteholders. To this point, the Fund will only hold ABS and CMBS

[10] Rule 14.11(c)(4)(B)(i)(b) provides that components that in the aggregate account for at least 75% of the weight of the index or portfolio each shall have a minimum original principal amount outstanding of $100 million or more.

[11] Rule 14.11(c)(4)(B)(i)(f) provides that component securities that in aggregate account for at least 90% of the Fixed Income Securities portion of the weight of the index or portfolio must be either: (1) from issuers that are required to file reports pursuant to Sections 13 and 15(d) of the Act; (2) from issuers that have a worldwide market value of its outstanding common equity held by non-affiliates of $700 million or more; (3) from issuers that have outstanding securities that are notes, bonds, debentures, or evidence of indebtedness having a total remaining principal amount of at least $1 billion; (4) exempted securities as defined in section 3(a)(12) of the Act; or (5) from issuers that are a government of a foreign country or a political subdivision of a foreign country.

[12] The term ''Normal Market Conditions'' includes, but is not limited to, the absence of trading halts in the applicable financial markets generally; operational issues causing dissemination of inaccurate market information or system failures; or force majeure type events such as natural or man-made disaster, act of God, armed conflict, act of terrorism, riot or labor disruption, or any similar intervening circumstance.

[13] For purposes of this filing, cash equivalents are short-term instruments with maturities of less than three months, including: (i) U.S. Government securities, including bills, notes, and bonds differing as to maturity and rates of interest, which are either issued or guaranteed by the U.S. Treasury or by U.S. Government agencies or instrumentalities; (ii) certificates of deposit issued against funds deposited in a bank or savings and loan association; (iii) bankers acceptances, which are short-term credit instruments used to finance commercial transactions; (iv) repurchase agreements and reverse repurchase agreements; (v) bank time deposits, which are monies kept on deposit with banks or savings and loan associations for a stated period of time at a fixed rate of interest; (vi) commercial paper, which are short-term unsecured promissory notes; and (vii) money market funds.

[14] Centrally cleared swaps are cleared through a central clearinghouse and, as such, the counterparty risk traditionally associated with over-the-counter swaps is eliminated.

[15] For purposes of this filing, ETFs include Index Fund Shares (as described in Rule 14.11(c)); Portfolio Depositary Receipts (as described in Rule 14.11(b)); and Managed Fund Shares (as described in Rule 14.11(i)). The ETFs all will be listed and traded in the U.S. on registered exchanges. The Fund may invest in the securities of ETFs registered under the 1940 Act consistent with the requirements of Section 12(d)(1) of the 1940 Act, or any rule, regulation or order of the Commission or interpretation thereof. The Fund will not invest in leveraged or inverse leveraged (*e.g.,* 2X, –2X, 3X or –3X) ETFs.

[16] Rule 14.11(c)(4)(B)(i)(b) provides that components that in the aggregate account for at least 75% of the weight of the index or portfolio each shall have a minimum original principal amount outstanding of $100 million or more.

[17] Rule 14.11(c)(4)(B)(i)(f) provides that component securities that in aggregate account for at least 90% of the Fixed Income Securities portion of the weight of the index or portfolio must be either: (1) From issuers that are required to file reports pursuant to Sections 13 and 15(d) of the Act; (2) from issuers that have a worldwide market value of its outstanding common equity held by non-affiliates of $700 million or more; (3) from issuers that have outstanding securities that are notes, bonds, debentures, or evidence of indebtedness having a total remaining principal amount of at least $1 billion; (4) exempted securities as defined in section 3(a)(12) of the Act; or (5) from issuers that are a government of a foreign country or a political subdivision of a foreign country.

[18] The Commission has previously approved a proposed rule change relating to the listing and trading of twelve series of Index Fund Shares based on municipal bond indexes that did not satisfy the requirement that component fixed income securities that, in the aggregate, account for at least 75% of the weight of the index or portfolio have a minimum principal amount outstanding of $100 million or more, provided that such municipal bond index contained at least 500 component securities on a continuous basis. See Securities Exchange Act Release No. 82295 (December 12, 2017), 82 FR 60056 (December 18, 2017) (SR–NYSEArca–2017–56).

for which the bond indenture requires the public disclosure of a Statement to Noteholders on a no less frequent than quarterly basis.[19] As such, while the Fund will not technically meet the requirements of Rule 14.11(c)(4)(B)(i)(f)(1), the policy concerns related to the transparency and availability of information regarding the Fixed Income Securities held by a fund that the Rule is intended to address are otherwise mitigated.

Further, the Index is broad-based and currently includes 2,693 component securities. Whereas the generic listing rules permit a single component security to represent up to 30% of the weight of an index and the top five component securities to, in aggregate, represent up to 65% of the weight of an index, the largest component security in the Underyling Index only constitutes 0.044% of the weight of the Index and the largest five component securities represent 0.22% of the weight of the Index. The Exchange believes that this significant diversification and the lack of concentration among constituent securities provides a strong degree of protection against index manipulation. On a continuous basis, the Index will (i) contain at least 500 component securities and (ii) comply with the index methodology description provided above.

Additional Information

The Index value, calculated and disseminated at least once daily, as well as the components of the Index and their percentage weighting, will be available from major market data vendors. In addition, the portfolio of securities held by the Fund will be disclosed on the Fund's website at *www.PrincipalETFs.com*.

The Exchange represents that: (1) Except as described above, the Index currently satisfies and will continue to satisfy all of the generic listing standards under Rule 14.11(c)(4); (2) the continued listing standards under BZX Rule 14.11(c) applicable to index fund shares shall apply to the Shares of the Fund; and (3) the Trust is required to comply with Rule 10A–3 [20] under the Act for the initial and continued listing of the Shares of the Fund. In addition, the Exchange represents that the Shares of the Fund will comply with all other requirements applicable to index fund shares including, but not limited to, requirements relating to the dissemination of key information such as the value of the Index and the Intraday Indicative Value (''IIV''), rules governing the trading of equity securities, trading hours, trading halts, surveillance, and the information circular, as set forth in Exchange rules applicable to index fund shares and the orders approving such rules.

Availability of Information

The Fund's website, which will be publicly available prior to the public offering of Shares, will include a form of the prospectus for the Fund that may be downloaded. The website will include additional quantitative information updated on a daily basis, including, for the Fund: (1) The prior business day's reported NAV, daily trading volume, and a calculation of the premium and discount of the Bid/Ask Price against the NAV; and (2) data in chart format displaying the frequency distribution of discounts and premiums of the daily Bid/Ask Price against the NAV, within appropriate ranges, for each of the four previous calendar quarters. Daily trading volume information for the Fund will also be available in the financial section of newspapers, through subscription services such as Bloomberg, Thomson Reuters, and International Data Corporation, which can be accessed by authorized participants and other investors, as well as through other electronic services, including major public websites. On each business day, before commencement of trading in Shares during Regular Trading Hours [21] on the Exchange, the Fund will disclose on its website the identities and quantities of the portfolio of securities and other assets in the portfolio held by the Fund that will form the basis for the Fund's calculation of NAV at the end of the business day. The portfolio description will include, as applicable: The ticker symbol; CUSIP number or other identifier, if any; a description of the holding (including the type of holding, such as the type of swap); the identity of the security, index or other asset or instrument underlying the holding, if any; for options, the option strike price; quantity held (as measured by, for example, par value, notional value or number of shares, contracts, or units); maturity date, if any; coupon rate, if any; effective date, if any; market value of the holding; and the percentage weighting of the holding in the Fund's portfolio. The website and information will be publicly available at no charge. The value, components, and percentage weightings of the Index will be calculated and disseminated at least once daily and will be available from major market data vendors. Rules governing the Index are available on the Index Provider's website and in the Fund's prospectus.

In addition, an estimated value, defined in BZX Rule 14.11(c)(6)(A) as the ''Intraday Indicative Value,'' that reflects an estimated intraday value of the Fund's portfolio, will be disseminated. Moreover, the Intraday Indicative Value will be based upon the current value for the components of the daily disclosed portfolio and will be updated and widely disseminated by one or more major market data vendors at least every 15 seconds during the Exchange's Regular Trading Hours.[22] In addition, the quotations of certain of the Fund's holdings may not be updated during U.S. trading hours if updated prices cannot be ascertained.

The dissemination of the Intraday Indicative Value, together with the daily disclosed portfolio, will allow investors to determine the value of the underlying portfolio of the Fund on a daily basis and provide a close estimate of that value throughout the trading day.

Quotation and last sale information for the Shares of the Fund will be

[19] A Statement to Noteholders generally includes the same pieces of information about an issuer and issuance of ABS or CMBS that would be included in Form 10D. All ABS and CMBS held by the Fund will issue Statements to Noteholders that will include, at a minimum, a remittance report that will show monthly or quarterly cash flows of the assets and liabilities for the issuance. Statements to Noteholders also typically include the following types of information: (1) The amount of the distribution(s) allocable to interest on the notes; (2) the amount of the distribution(s) allocable to principal of the notes; (3) the note balance, after taking into account all payments to be made on such distribution date; (4) the servicing fee paid and/or due but unpaid as of such distribution date; (5) the pool balance and required overcollateralization amount as of the close of business on the last day of the related collection period; (6) the reserve fund amount, the reserve fund required amount and the reserve fund draw amount; (7) the amount of the aggregate realized losses on the loans, if any, for the preceding collection period and the cumulative default ratio; (8) whether an amortization event will exist as of such distribution date; (9) the aggregate repurchase prices for loans, if any, that were repurchased by the seller during the related collection period; (10) the amount of fees payable to all parties pursuant to the indenture; (11) any and all other fees, expenses, indemnities or taxes payable by the issuer or the grantor trust (including reserved amounts for payments required to be made before the next distribution date); (12) the payments to the certificate holders; and (13) during a pre-funding period, the amount on deposit in the pre-funding account as of the close of business on the last day of the related collection period, and the pool balance of subsequent loans purchased during the related collection period, and following the pre-funding period, the amount of principal payments made on each class of notes from amounts on deposit in the pre-funding account.

[20] *See* 17 CFR 240.10A–3.

[21] Regular Trading Hours are 9:30 a.m. to 4:00 p.m. Eastern Time.

[22] Currently, it is the Exchange's understanding that several major market data vendors display and/or make widely available Intraday Indicative Values published via the Consolidated Tape Association (''CTA'') or other data feeds.

available via the CTA high speed line. Price information regarding ABS, CMBS, and other non-exchange traded assets, including the types of swaps held by the Fund, cash and cash equivalents, and other Treasury Securities, is available from third party pricing services and major market data vendors. For exchange-traded assets, including ETFs, such intraday information is available directly from the applicable listing exchange.

Initial and Continued Listing

The Shares of the Fund will conform to the initial and continued listing criteria under BZX Rule 14.11(c)(4), except as described above. The Exchange represents that, for initial and/or continued listing, the Fund and the Trust must be in compliance with Rule 10A–3 under the Act.[23] A minimum of 100,000 Shares of the Fund will be outstanding at the commencement of trading on the Exchange. The Exchange will obtain a representation from the issuer of the Shares that the NAV per Share for the Fund will be calculated daily and will be made available to all market participants at the same time.

Trading Halts

With respect to trading halts, the Exchange may consider all relevant factors in exercising its discretion to halt or suspend trading in the Shares of the Fund. The Exchange will halt trading in the Shares under the conditions specified in BZX Rule 11.18. Trading may be halted because of market conditions or for reasons that, in the view of the Exchange, make trading in the Shares inadvisable. These may include: (1) The extent to which trading is not occurring in the securities and/or the financial instruments composing the daily disclosed portfolio of the Fund; or (2) whether other unusual conditions or circumstances detrimental to the maintenance of a fair and orderly market are present. Trading in the Shares also will be subject to Rule 14.11(c)(1)(B)(iv), which sets forth circumstances under which Shares of the Fund may be halted.

Trading Rules

The Exchange deems the Shares to be equity securities, thus rendering trading in the Shares subject to the Exchange's existing rules governing the trading of equity securities. The Exchange will allow trading in the Shares from 8:00 a.m. until 5:00 p.m. Eastern Time and has the appropriate rules to facilitate transactions in the Shares during all trading sessions. As provided in BZX Rule 11.11(a), the minimum price variation for quoting and entry of orders in securities traded on the Exchange is $0.01, with the exception of securities that are priced less than $1.00, for which the minimum price variation for order entry is $0.0001.

Surveillance

The Exchange believes that its surveillance procedures are adequate to properly monitor the trading of the Shares on the Exchange during all trading sessions and to deter and detect violations of Exchange rules and the applicable federal securities laws. Trading of the Shares through the Exchange will be subject to the Exchange's surveillance procedures for derivative products, including Index Fund Shares. The issuer has represented to the Exchange that it will advise the Exchange of any failure by the Fund to comply with the continued listing requirements, and, pursuant to its obligations under Section 19(g)(1) of the Exchange Act, the Exchange will surveil for compliance with the continued listing requirements. FINRA conducts certain cross-market surveillances on behalf of the Exchange pursuant to a regulatory services agreement. The Exchange is responsible for FINRA's performance under this regulatory services agreement. If the Fund is not in compliance with the applicable listing requirements, the Exchange will commence delisting procedures under Exchange Rule 14.12. The Exchange, or FINRA on behalf of the Exchange, may obtain information regarding trading in the Shares and the underlying shares in exchange traded equity securities, including ETFs, via the ISG, from other exchanges that are members or affiliates of the ISG, and the Exchange may obtain such information from markets with which the Exchange has entered into a comprehensive surveillance sharing agreement.[24] In addition, the Exchange, or FINRA on behalf of the Exchange, is able to access, as needed, trade information for certain fixed income instruments reported to FINRA's Trade Reporting and Compliance Engine (''TRACE''). The Exchange prohibits the distribution of material non-public information by its employees.

2. Statutory Basis

The Exchange believes that the proposal is consistent with Section 6(b) of the Act[25] in general and Section 6(b)(5) of the Act[26] in particular in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system and, in general, to protect investors and the public interest.

The Exchange believes that the proposed rule change is designed to prevent fraudulent and manipulative acts and practices in that the shares of the Fund will be listed and traded on the Exchange pursuant to the initial and continued listing criteria for Index Fund Shares based on a fixed income index in Rule 14.11(c)(4), except for the requirements of Rule 14.11(c)(4)(B)(i)(b) and Rule 14.11(c)(4)(B)(i)(f). The Exchange represents that trading in the shares of the Fund will be subject to the existing trading surveillances administered by the Exchange as well as cross-market surveillances administered by the FINRA on behalf of the Exchange, which are designed to detect violations of Exchange rules and federal securities laws applicable to trading on the Exchange. The Exchange represents that these procedures are adequate to properly monitor Exchange trading of the shares of the Fund in all trading sessions and to deter and detect violations of Exchange rules and federal securities laws applicable to trading on the Exchange. The Exchange or FINRA, on behalf of the Exchange, or both, will communicate as needed regarding trading in the shares of the Fund with other markets that are members of the ISG. In addition, the Exchange will communicate as needed regarding trading in the shares of the Fund with other markets that are members of the ISG or with which the Exchange has in place a comprehensive surveillance sharing agreement. FINRA, on behalf of the Exchange, is able to access, as needed, trade information for certain fixed income securities held by the Fund reported to TRACE.

Further, the Index is broad-based and currently includes 2,693 component securities. Whereas the generic listing rules permit a single component security to represent up to 30% of the weight of an index and the top five component securities to, in aggregate, represent up to 65% of the weight of an index, the largest component security in the Underyling Index only constitutes

[23] *See* 17 CFR 240.10A–3.

[24] For a list of the current members of ISG, *see www.isgportal.org.* The Exchange notes that not all components of the portfolio for the Fund may trade on markets that are members of ISG or with which the Exchange has in place a comprehensive surveillance sharing agreement.

[25] 15 U.S.C. 78f.

[26] 15 U.S.C. 78f(b)(5).

0.044% of the weight of the Index and the largest five component securities represent 0.22% of the weight of the Index. The Exchange believes that this significant diversification and the lack of concentration among constituent securities provides a strong degree of protection against index manipulation. On a continuous basis, the Index will (i) contain at least 500 component securities and (ii) comply with the index methodology description provided above.

As of February 22, 2018, 57.9% of the weight of the Index components have a minimum original principal amount outstanding of $100 million or more and 68.0% of the weight of the Index components met the requirements of Rule 14.11(c)(4)(B)(i)(f). The Exchange notes that at least 90% of the weight of the Index will be comprised of securities that have a minimum par amount of $25 million and were a constituent of an offering where the original deal size was at least $250 million.

While the Index will not meet certain provisions of Rule 14.11(c)(4), as described above, the Exchange believes that the policy issues which such provisions are intended to address are otherwise mitigated. Specifically, the concerns around the size and manipulability of the underlying Fixed Income Securities that Rule 14.11(c)(4)(B)(i)(b) is intended to address are mitigated by the fact that at least 90% of the weight of the Index will be comprised of securities that have a minimum par amount of $25 million and were a constituent of an offering where the original deal size was at least $250 million. Similar standards have been applied for other comparably situated funds and the Exchange believes that there is no reason that this standard should not be applied for the Fund.[27]

Further, the concerns around the availability of information that Rule 14.11(c)(4)(B)(i)(f) is intended to address are also mitigated as it relates to the ABS and CMBS that populate the Index. While only 68.0% of the weight of the portfolio meets the requirements of Rule 14.11(c)(4)(B)(i)(f), the Index's inability to meet the 90% threshold is largely based on a technicality in the rule text. Part (1) of the Rule includes in the calculation of percentage ''issuers that are *required* [emphasis added] to file reports pursuant to Sections 13 and 15(d) of the Act.'' The technicality is that, while only certain registered issuances of ABS and CMBS are required to file reports pursuant to Sections 13 or 15(d) of the Act, many ABS and CMBS issuances include in the bond indenture a requirement that the issuer make a public disclosure of a Statement to Noteholders.[28] To this point, the Fund will only hold ABS and CMBS for which the bond indenture requires the public disclosure of a Statement to Noteholders on a no less frequent than quarterly basis. As such, while the Fund will not technically meet the requirements of Rule 14.11(c)(4)(B)(i)(f)(1), the policy concerns related to the transparency and availability of information regarding the Fixed Income Securities held by a fund that the Rule is intended to address are otherwise mitigated.

The proposed rule change is designed to promote just and equitable principles of trade and to protect investors and the public interest in that a large amount of information is publicly available regarding the Funds, thereby promoting market transparency. The Fund's portfolio holdings will be disclosed on the Fund's website daily after the close of trading on the Exchange and prior to the opening of trading on the Exchange the following day. Moreover, the IIV for shares of the Fund will be widely disseminated by one or more major market data vendors at least every 15 seconds during the Exchange's Regular Trading Hours. The current value of the Index will be disseminated by one or more major market data vendors at least once per day. Information regarding market price and trading volume of the shares of the Fund will be continually available on a real-time basis throughout the day on brokers' computer screens and other electronic services, and quotation and last sale information will be available via the CTA high-speed line. The website for the Fund will include the prospectus for the Fund and additional data relating to NAV and other applicable quantitative information.

If the Exchange becomes aware that the Fund's NAV is not being disseminated to all market participants at the same time, it will halt trading in the shares of the Fund until such time as the NAV is available to all market participants. With respect to trading halts, the Exchange may consider all relevant factors in exercising its discretion to halt or suspend trading in the shares of the Fund. Trading also may be halted because of market conditions or for reasons that, in the view of the Exchange, make trading in the shares the Fund inadvisable. If the IIV and index value are not being disseminated for the Fund as required, the Exchange may halt trading during the day in which the interruption to the dissemination of the IIV or index value occurs. If the interruption to the dissemination of an IIV or index value persists past the trading day in which it occurred, the Exchange will halt trading. The Exchange may consider all relevant factors in exercising its discretion to halt or suspend trading in the Shares of the Fund. The Exchange will halt trading in the Shares under the conditions specified in BZX Rule 11.18. Trading may be halted because of market conditions or for reasons that, in the view of the Exchange, make trading in the Shares inadvisable. These may include: (1) The extent to which trading is not occurring in the securities and/or the financial instruments composing the daily disclosed portfolio of the Funds; or (2) whether other unusual conditions or circumstances detrimental to the

[27] The Commission has previously approved a proposed rule change relating to the listing and trading of twelve series of Index Fund Shares based on municipal bond indexes that did not satisfy the requirement that component fixed income securities that, in the aggregate, account for at least 75% of the weight of the index or portfolio have a minimum principal amount outstanding of $100 million or more, provided that such municipal bond index contained at least 500 component securities on a continuous basis. See Securities Exchange Act Release No. 82295 (December 12, 2017), 82 FR 60056 (December 18, 2017) (SR–NYSEArca–2017–56).

[28] A Statement to Noteholders generally includes the same pieces of information about an issuer and issuance of ABS or CMBS that would be included in Form 10D. All Statements to Noteholders issued by ABS and CMBS held by the Fund will include, at a minimum, a remittance report that will show monthly or quarterly cash flows of the assets and liabilities for the issuance. Statements to Noteholders also typically include the following types of information: (1) The amount of the distribution(s) allocable to interest on the notes; (2) the amount of the distribution(s) allocable to principal of the notes; (3) the note balance, after taking into account all payments to be made on such distribution date; (4) the servicing fee paid and/or due but unpaid as of such distribution date; (5) the pool balance and required overcollateralization amount as of the close of business on the last day of the related collection period; (6) the reserve fund amount, the reserve fund required amount and the reserve fund draw amount; (7) the amount of the aggregate realized losses on the loans, if any, for the preceding collection period and the cumulative default ratio; (8) whether an amortization event will exist as of such distribution date; (9) the aggregate repurchase prices for loans, if any, that were repurchased by the seller during the related collection period; (10) the amount of fees payable to all parties pursuant to the indenture; (11) any and all other fees, expenses, indemnities or taxes payable by the issuer or the grantor trust (including reserved amounts for payments required to be made before the next distribution date); (12) the payments to the certificate holders; and (13) during a pre-funding period, the amount on deposit in the pre-funding account as of the close of business on the last day of the related collection period, and the pool balance of subsequent loans purchased during the related collection period, and following the pre-funding period, the amount of principal payments made on each class of notes from amounts on deposit in the pre-funding account.

maintenance of a fair and orderly market are present. Trading in the Shares also will be subject to Rule 14.11(c)(1)(B)(iv), which sets forth circumstances under which Shares of a Fund may be halted. In addition, investors will have ready access to information regarding the applicable IIV, and quotation and last sale information for the shares of the Fund.

All statements and representations made in this filing regarding the index composition, the description of the portfolio or reference assets, limitations on portfolio holdings or reference assets, dissemination and availability of index, reference asset, and intraday indicative values (as applicable), or the applicability of Exchange listing rules shall constitute continued listing requirements for listing the Shares on the Exchange. The issuer is required to advise the Exchange of any failure by the Fund to comply with the continued listing requirements, and, pursuant to its obligations under Section 19(g)(1) of the Act, the Exchange will monitor for compliance with the continued listing requirements. If the Fund is not in compliance with the applicable listing requirements, the Exchange will commence delisting procedures under Rule 14.12.

The proposed rule change is designed to perfect the mechanism of a free and open market and, in general, to protect investors and the public interest in that it will facilitate the listing and trading of an exchange-traded product that principally holds ABS and CMBS and that will enhance competition among market participants, to the benefit of investors and the marketplace. The Exchange has in place surveillance procedures relating to trading in the shares of the Fund and may obtain information via ISG from other exchanges that are members of ISG or with which the Exchange has entered into a comprehensive surveillance sharing agreement. In addition, investors will have ready access to information regarding the IIV and quotation and last sale information for the shares of the Fund.

For the above reasons, the Exchange believes that the proposed rule change is consistent with the requirements of Section 6(b)(5) of the Act.

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 purpose of the Act. The Exchange notes that the proposed rule change will facilitate the listing and trading of an additional exchange-traded product that will enhance competition among market participants, to the benefit of investors and the marketplace.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

The Exchange has neither solicited nor received written comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 45 days of the date of publication of this notice in the **Federal Register** or up to 90 days (i) as the Commission may designate if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve or disapprove the proposed rule change, or

(B) institute proceedings to determine whether the proposed rule change should be 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–CboeBZX–2018–018 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–CboeBZX–2018–018. 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 website (*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 website 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. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–CboeBZX–2018–018 and should be submitted on or before May 29, 2018.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[29]

Eduardo A. Aleman,

Assistant Secretary.

[FR Doc. 2018–09692 Filed 5–7–18; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of FOIA Services, 100 F Street NE, Washington, DC 20549–2736.

Extension:

Rule 17a–6; SEC File No. 270–433, OMB Control No. 3235–0489.

Notice is hereby given that pursuant to the Paperwork Reduction Act of 1995 (''PRA'') (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission (''Commission'') is soliciting comments on the collection of information provided for in Rule 17a–6 (17 CFR 240.17a–6) under the Securities Exchange Act of 1934 (15 U.S.C. 78a *et seq.*). The Commission plans to submit this existing collection of information to the Office of Management and Budget (''OMB'') for extension and approval.

Rule 17a–6 permits national securities exchanges, national securities associations, registered clearing agencies, and the Municipal Securities Rulemaking Board (''MSRB'') (collectively, ''SROs'') to destroy or

[29] 17 CFR 200.30–3(a)(12).

convert to microfilm or other recording media records maintained under Rule 17a–1, if they have filed a record destruction plan with the Commission and the Commission has declared the plan effective.

There are currently 32 SROs: 21 national securities exchanges, 1 national securities association, the MSRB, and 9 registered clearing agencies. Of the 32 SROs, only 2 SRO respondents have filed a record destruction plan with the Commission. The staff calculates that the preparation and filing of a new record destruction plan should take 160 hours. Further, any existing SRO record destruction plans may require revision, over time, in response to, for example, changes in document retention technology, which the Commission estimates will take much less than the 160 hours estimated for a new plan. The Commission estimates that each SRO that has filed a destruction plan will spend approximately 30 hours per year making required revisions. Thus, the total annual compliance burden is estimated to be 60 hours per year based on two respondents. The approximate compliance cost per hour is $422, resulting in a total internal cost of compliance for these respondents of $25,320 per year (60 hours @ $422 per hour).

Written comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission'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; 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. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information under the PRA unless it displays a currently valid OMB control number.

Please direct your written comments to: Pamela Dyson, Director/Chief Information Officer, Securities and Exchange Commission, c/o Remi Pavlik-Simon, 100 F Street NE Washington, DC 20549, or send an email to: *PRA_Mailbox@sec.gov.*

Dated: May 1, 2018.

Eduardo A. Aleman,

Assistant Secretary.

[FR Doc. 2018–09690 Filed 5–7–18; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–83160; File No. SR–NYSEArca-2018–26]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend the Certificate of Incorporation of Its Parent Company NYSE Group, Inc.

May 3, 2018.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (the ''Act''),[2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on April 25, 2018, NYSE Arca, Inc. (the ''Exchange'' or ''NYSE Arca'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the self-regulatory organization. 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 Article X of the certificate of incorporation of its parent company NYSE Group, Inc. (''NYSE Group'') and make certain technical and conforming changes. The proposed rule change is available on the Exchange's website at *www.nyse.com,* at the principal office of the Exchange, 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 self-regulatory organization 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 those 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 parts of such statements.

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend Article X (Confidential Amendment) of the Sixth Amended and Restated Certificate of Incorporation of NYSE Group (''NYSE Group Certificate'') and make certain technical and conforming changes.

NYSE Group owns all of the equity interest in the Exchange and its national securities exchange affiliates, the New York Stock Exchange LLC (''NYSE LLC''), NYSE American LLC (''NYSE American'') and NYSE National, Inc. (''NYSE National''). In turn, NYSE Group is a wholly-owned subsidiary of NYSE Holdings LLC (''NYSE Holdings''), which is wholly owned by Intercontinental Exchange Holdings, Inc. (''ICE Holdings''). ICE Holdings is wholly owned by Intercontinental Exchange Inc. (''ICE'').[4]

In 2017, the Exchange amended the certificates of incorporation, bylaws, and operating agreements, as applicable, of ICE, ICE Holdings, NYSE Holdings and NYSE Group (collectively, the ''Governing Documents'').[5] The changes to the Governing Documents included, among other things, amendments streamlining references to ICE subsidiaries that either are or control national securities exchanges, deleting references to other ICE subsidiaries, and amending provisions relating to confidential information.[6] As a result of the changes, ''Exchange'' is defined in each Governing Document as a national

[4] ICE is a publicly traded company listed on the NYSE.

[5] The Governing Documents are the Fourth Amended and Restated Certificate of Incorporation of Intercontinental Exchange, Inc. (''ICE Certificate''); Eighth Amended and Restated Bylaws of Intercontinental Exchange, Inc. (''ICE Bylaws''); Ninth Amended and Restated Certificate of Incorporation of Intercontinental Exchange Holdings, Inc. (''ICE Holdings Certificate''); Sixth Amended and Restated Bylaws of Intercontinental Exchange Holdings, Inc. (''ICE Holdings Bylaws''); Ninth Amended and Restated Limited Liability Company Agreement of NYSE Holdings LLC (''NYSE Holdings Operating Agreement''); Fourth Amended and Restated Bylaws of NYSE Group, Inc. (''NYSE Group Bylaws''); and the NYSE Group Certificate.

[6] *See* Securities Exchange Act Release Nos. 82083 (November 15, 2017), 82 FR 55453 (November 21, 2017) (SR–NYSEArca–2017–125) (notice of filing and immediate effectiveness of proposed rule change to amend the governing documents of the Exchange's intermediate parent companies) (''Holding Companies Release''); and 80752 (May 24, 2017), 82 FR 25018 (May 31, 2017) (SR– NYSE–2017–13; SR–NYSEArca–2017–29; SR– NYSEMKT–2017–17; SR–NYSENAT–2017–01) (order approving proposed rule changes to amend the certificate and bylaws of the exchange's ultimate parent company) (''Parent Company Release'').

securities exchange registered under Section 6 of the Exchange Act [7] that is directly or indirectly controlled by the relevant entity.[8]

In making such changes, lists of specific entities were replaced with ''Exchange'' or ''Exchanges,'' as applicable.[9] For example, in Article XII, clause (b) of the NYSE Group Certificate, ''the boards of directors of New York Stock Exchange, NYSE Arca, NYSE Arca Equities, NYSE MKT and NYSE National or the boards of directors of their successors'' was amended to ''the boards of directors of each Exchange.'' [10]

However, the NYSE Group Certificate retains one list of specific entities, which it proposes to amend now. Specifically, in the first sentence of Article X of the NYSE Group Certificate, the Exchange proposes to replace ''New York Stock Exchange, NYSE Arca, NYSE Arca Equities, NYSE MKT and NYSE National'' with ''any Exchange, in each case to the extent that such entities continue to be controlled, directly or indirectly, by the Corporation''.[11]

The proposed change would not have a substantive effect on what entities the provision covers. As national securities exchanges registered under Section 6 of the Exchange Act[12] that are directly controlled by NYSE Group, each of the NYSE, NYSE Arca, NYSE MKT (now NYSE American LLC) [13] and NYSE National are ''Exchanges'' within the scope of the definition. The reference to NYSE Arca Equities is obsolete, as it has been merged out of existence.[14] As a result, the change is non-substantive.

The Exchange notes that the proposed amendment would make the first sentence of Article X of the NYSE Group Certificate more consistent with the use of ''Exchange'' throughout the Governing Documents, particularly in the confidential information provisions of the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement, all of which have the text ''any Exchange, in each case to the extent that such entities continue to be controlled, directly or indirectly, by the'' Corporation or Company, as applicable.[15]

In addition, technical and conforming changes would be made to the title, recitals, effective time, date and signature line of the NYSE Group Certificate.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Exchange Act [16] in general, and with Section 6(b)(1) [17] in particular, in that it enables the Exchange to be so organized as to have the capacity to be able to carry out the purposes of the Exchange Act and to comply, and to enforce compliance by its exchange members and persons associated with its exchange members, with the provisions of the Exchange Act, the rules and regulations thereunder, and the rules of the Exchange.

The Exchange believes that the proposed rule change would enable the Exchange to continue to be so organized as to have the capacity to carry out the purposes of the Exchange Act and comply and enforce compliance with the provisions of the Exchange Act by its members and persons associated with its members, because the proposed change would add further clarity and transparency to the Exchange's rules without having a substantive effect on which entities the provision would cover. As national securities exchanges registered under Section 6 of the Exchange Act [18] that are directly controlled by NYSE Group, each of the NYSE LLC, NYSE Arca, NYSE American and NYSE National fall within the scope of the definition of ''Exchange.'' In addition, removing the obsolete reference to NYSE Arca Equities would contribute to the orderly operation of the Exchange by adding clarity and transparency to the Exchange's rules.

The Exchange believes that the proposed technical and conforming changes to the title, recitals, effective time, date and signature line of the NYSE Group Certificate would contribute to the orderly operation of the Exchange by adding clarity and transparency to its rules.

Further, the Exchange notes that the Exchange Act definition of ''exchange'' states that ''exchange'' ''includes the market place and the market facilities maintained by such exchange.'' [19] Accordingly, any market places and market facilities maintained by the Exchange would fall within the definition of ''Exchange'' and therefore would fall within the scope of Article X of the NYSE Group Certificate.

For similar reasons, the Exchange also believes that the proposed rule change is consistent with Section 6(b)(5) of the Act,[20] in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system and, in general, to protect investors and the public interest.

The Exchange believes that the proposed rule change would remove impediments to and perfect the mechanism of a free and open market and a national market system by simplifying and streamlining the Exchange's rules and removing an obsolete reference, thereby ensuring that market participants can more easily navigate, understand and comply with its rules. In this manner, the proposed change would ensure that persons subject to the Exchange's jurisdiction, regulators, and the investing public can more easily navigate and understand the NYSE Group Certificate.

In addition, the Exchange believes that the proposed rule change would remove impediments to and perfect the mechanism of a free and open market and a national market system, because the proposed change would conform the text of Article X with the use of ''Exchange'' throughout the Governing Documents, generally, and with the confidential information provisions of the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement, more specifically. As a result, the Governing Documents would be more consistent and persons subject to the Exchange's jurisdiction, regulators, and the investing public

[7] 15 U.S.C. 78f.

[8] *See* Holding Companies Release, *supra* note 6, at 55454; ICE Certificate, Article V, Section A(3)(a); ICE Bylaws, Article III, Section 3.15; ICE Holdings Certificate, Article V, Section A(1); ICE Holdings Bylaws, Article III, Section 3.15; NYSE Holdings Operating Agreement, Article 1, Section 1.1; NYSE Group Bylaws, Article VII, Article 7.9(b); and NYSE Group Certificate, Article IV, Section 4(b)(1)(A).

[9] *See* Holding Companies Release, *supra* note 6, at 55455, and Parent Company Release, *supra* note 6, at 25019. Similarly, the terms ''U.S. Regulated Subsidiary,'' ''U.S. Regulated Subsidiaries,'' ''Regulated Subsidiary,'' and ''Regulated Subsidiaries'' were replaced with ''Exchange'' or ''Exchanges,'' as applicable.

[10] *See* Holding Companies Release, *supra* note 6, note 12.

[11] The Exchange's affiliates the NYSE LLC, NYSE American, and NYSE National have each submitted substantially the same proposed rule change to propose the changes described herein. *See* SR–NYSE–2018–18, SR–NYSEAmer–2018–16, and SR–NYSENAT–2018–05.

[12] 15 U.S.C. 78f.

[13] ''NYSE MKT LLC'' changed its name to ''NYSE American LLC'' in 2017. *See* Securities Exchange Act Release Nos. 80283 (March 21, 2017), 82 FR 15244 (March 27, 2017) (SR–NYSEMKT–2017–14).

[14] *See* Securities Exchange Act Release No. 81419 (August 17, 2017), 82 FR 40044 (August 23, 2017) (SR–NYSEArca–2017–40).

[15] *See* ICE Bylaws, Article VIII, Section 8.1; ICE Holdings Bylaws, Article VIII, Section 8.1; and NYSE Holdings Operating Agreement, Article XII, Section 12.1. *See also* Holding Companies Release, *supra* note 6, at 55457.

[16] 15 U.S.C. 78f(b).

[17] 15 U.S.C. 78f(b)(1).

[18] 15 U.S.C. 78f.

[19] 15 U.S.C. 78c(a)(1).

[20] 15 U.S.C. 78f(b)(5).

could more easily navigate and understand the NYSE Group Certificate and the other Governing Documents.

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 Exchange Act. The proposed rule change is not designed to address any competitive issue but rather is meant to update and streamline the NYSE Group Certificate to make it more consistent with the use of ''Exchange'' throughout the Governing Documents and the confidential information provisions in the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement. The Exchange believes that the proposed rule change will serve to promote clarity and consistency, thereby reducing burdens on the marketplace and facilitating investor protection. The proposed rule change would result in no concentration or other changes of ownership of exchanges.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received from Members, Participants, or Others

No written comments were solicited or received with respect to 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 Section 19(b)(3)(A) of the Act and Rule 19b–4(f)(6) thereunder.[21]

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–NYSEArca–2018–26 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEArca–2018–26. 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 website (*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 website 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. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEArca–2018–26, and should be submitted on or before May 29, 2018.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[22]

Eduardo A. Aleman,

Assistant Secretary.

[FR Doc. 2018–09764 Filed 5–7–18; 8:45 am]

BILLING CODE 8011–01–P

[21] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[22] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–83161; File No. SR–NYSENAT–2018–05]

Self-Regulatory Organizations; NYSE National, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend the Certificate of Incorporation of Its Parent Company NYSE Group, Inc.

May 3, 2018.

Pursuant to Section 19(b)(1)[1] of the Securities Exchange Act of 1934 (the ''Act''),[2] and Rule 19b–4 thereunder,[3] notice is hereby given that on April 25, 2018, NYSE National, Inc. (the ''Exchange'' or ''NYSE National'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the self-regulatory organization. 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 Article X of the certificate of incorporation of its parent company NYSE Group, Inc. (''NYSE Group'') and make certain technical and conforming changes. The proposed rule change is available on the Exchange's website at *www.nyse.com,* at the principal office of the Exchange, 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 self-regulatory organization 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 those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries,

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend Article X (Confidential Amendment) of the Sixth Amended and Restated Certificate of Incorporation of NYSE Group (''NYSE Group Certificate'') and make certain technical and conforming changes.

NYSE Group owns all of the equity interest in the Exchange and its national securities exchange affiliates, the New York Stock Exchange LLC (''NYSE LLC''), NYSE Arca, Inc. (''NYSE Arca''), and NYSE American LLC (''NYSE American''). In turn, NYSE Group is a wholly-owned subsidiary of NYSE Holdings LLC (''NYSE Holdings''), which is wholly owned by Intercontinental Exchange Holdings, Inc. (''ICE Holdings''). ICE Holdings is wholly owned by Intercontinental Exchange Inc. (''ICE'').[4]

In 2017, the Exchange amended the certificates of incorporation, bylaws, and operating agreements, as applicable, of ICE, ICE Holdings, NYSE Holdings and NYSE Group (collectively, the ''Governing Documents'').[5] The changes to the Governing Documents included, among other things, amendments streamlining references to ICE subsidiaries that either are or control national securities exchanges, deleting references to other ICE subsidiaries, and amending provisions relating to confidential information.[6] As a result of the changes, ''Exchange'' is defined in each Governing Document as a national securities exchange registered under Section 6 of the Exchange Act[7] that is directly or indirectly controlled by the relevant entity.[8]

In making such changes, lists of specific entities were replaced with ''Exchange'' or ''Exchanges,'' as applicable.[9] For example, in Article XII, clause (b) of the NYSE Group Certificate, ''the boards of directors of New York Stock Exchange, NYSE Arca, NYSE Arca Equities, NYSE MKT and NYSE National or the boards of directors of their successors'' was amended to ''the boards of directors of each Exchange.''[10]

However, the NYSE Group Certificate retains one list of specific entities, which it proposes to amend now. Specifically, in the first sentence of Article X of the NYSE Group Certificate, the Exchange proposes to replace ''New York Stock Exchange, NYSE Arca, NYSE Arca Equities, NYSE MKT and NYSE National'' with ''any Exchange, in each case to the extent that such entities continue to be controlled, directly or indirectly, by the Corporation''.[11]

The proposed change would not have a substantive effect on what entities the provision covers. As national securities exchanges registered under Section 6 of the Exchange Act[12] that are directly controlled by NYSE Group, each of the NYSE, NYSE Arca, NYSE MKT (now NYSE American LLC)[13] and NYSE National are ''Exchanges'' within the scope of the definition. The reference to NYSE Arca Equities is obsolete, as it has been merged out of existence.[14] As a result, the change is non-substantive.

The Exchange notes that the proposed amendment would make the first sentence of Article X of the NYSE Group Certificate more consistent with the use of ''Exchange'' throughout the Governing Documents, particularly in the confidential information provisions of the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement, all of which have the text ''any Exchange, in each case to the extent that such entities continue to be controlled, directly or indirectly, by the'' Corporation or Company, as applicable.[15]

In addition, technical and conforming changes would be made to the title, recitals, effective time, date and signature line of the NYSE Group Certificate.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Exchange Act[16] in general, and with Section 6(b)(1)[17] in particular, in that it enables the Exchange to be so organized as to have the capacity to be able to carry out the purposes of the Exchange Act and to comply, and to enforce compliance by its exchange members and persons associated with its exchange members, with the provisions of the Exchange Act, the rules and regulations thereunder, and the rules of the Exchange.

The Exchange believes that the proposed rule change would enable the Exchange to continue to be so organized as to have the capacity to carry out the purposes of the Exchange Act and comply and enforce compliance with the provisions of the Exchange Act by its members and persons associated with its members, because the proposed change would add further clarity and transparency to the Exchange's rules without having a substantive effect on which entities the provision would cover. As national securities exchanges registered under Section 6 of the Exchange Act[18] that are directly controlled by NYSE Group, each of the NYSE LLC, NYSE Arca, NYSE American and NYSE National fall within the scope of the definition of ''Exchange.'' In

[4] ICE is a publicly traded company listed on the NYSE.

[5] The Governing Documents are the Fourth Amended and Restated Certificate of Incorporation of Intercontinental Exchange, Inc. (''ICE Certificate''); Eighth Amended and Restated Bylaws of Intercontinental Exchange, Inc. (''ICE Bylaws''); Ninth Amended and Restated Certificate of Incorporation of Intercontinental Exchange Holdings, Inc. (''ICE Holdings Certificate''); Sixth Amended and Restated Bylaws of Intercontinental Exchange Holdings, Inc. (''ICE Holdings Bylaws''); Ninth Amended and Restated Limited Liability Company Agreement of NYSE Holdings LLC (''NYSE Holdings Operating Agreement''); Fourth Amended and Restated Bylaws of NYSE Group, Inc. (''NYSE Group Bylaws''); and the NYSE Group Certificate.

[6] *See* Securities Exchange Act Release Nos. 82084 (November 15, 2017), 82 FR 55460 (November 21, 2017) (SR–NYSENAT–2017–05) (notice of filing and immediate effectiveness of proposed rule change to amend the governing documents of the Exchange's intermediate parent companies) (''Holding Companies Release''); and 80752 (May 24, 2017), 82 FR 25018 (May 31, 2017) (SR–NYSE–2017–13; SR–NYSEArca–2017–29; SR–NYSEMKT–2017–17; SR–NYSENAT–2017–01) (order approving proposed rule changes to amend the certificate and bylaws of the exchange's ultimate parent company) (''Parent Company Release'').

[7] 15 U.S.C. 78f.

[8] *See* Holding Companies Release, *supra* note 6, at 55461; ICE Certificate, Article V, Section A(3)(a); ICE Bylaws, Article III, Section 3.15; ICE Holdings Certificate, Article V, Section A(1); ICE Holdings Bylaws, Article III, Section 3.15; NYSE Holdings Operating Agreement, Article 1, Section 1.1; NYSE Group Bylaws, Article VII, Article 7.9(b); and NYSE Group Certificate, Article IV, Section 4(b)(1)(A).

[9] *See* Holding Companies Release, *supra* note 6, at 55461, and Parent Company Release, *supra* note 6, at 25019. Similarly, the terms ''U.S. Regulated Subsidiary,'' ''U.S. Regulated Subsidiaries,'' ''Regulated Subsidiary,'' and ''Regulated Subsidiaries'' were replaced with ''Exchange'' or ''Exchanges,'' as applicable.

[10] *See* Holding Companies Release, *supra* note 6, note 12.

[11] The Exchange's affiliates NYSE LLC, NYSE American, and NYSE Arca have each submitted substantially the same proposed rule change to propose the changes described herein. *See* SR–NYSE–2018–18, SR–NYSEAmer–2018–16, and SR–NYSEArca–2018–26.

[12] 15 U.S.C. 78f.

[13] ''NYSE MKT LLC'' changed its name to ''NYSE American LLC'' in 2017. *See* Securities Exchange Act Release Nos. 80283 (March 21, 2017), 82 FR 15244 (March 27, 2017) (SR–NYSEMKT–2017–14).

[14] *See* Securities Exchange Act Release No. 81419 (August 17, 2017), 82 FR 40044 (August 23, 2017) (SR–NYSEArca–2017–40).

[15] *See* ICE Bylaws, Article VIII, Section 8.1; ICE Holdings Bylaws, Article VIII, Section 8.1; and NYSE Holdings Operating Agreement, Article XII, Section 12.1. *See also* Holding Companies Release, *supra* note 6, at 55463–55464.

[16] 15 U.S.C. 78f(b).

[17] 15 U.S.C. 78f(b)(1).

[18] 15 U.S.C. 78f.

addition, removing the obsolete reference to NYSE Arca Equities would contribute to the orderly operation of the Exchange by adding clarity and transparency to the Exchange's rules. The Exchange believes that the proposed technical and conforming changes to the title, recitals, effective time, date and signature line of the NYSE Group Certificate would contribute to the orderly operation of the Exchange by adding clarity and transparency to its rules.

Further, the Exchange notes that the Exchange Act definition of ''exchange'' states that ''exchange'' ''includes the market place and the market facilities maintained by such exchange.'' [19] Accordingly, any market places and market facilities maintained by the Exchange would fall within the definition of ''Exchange'' and therefore would fall within the scope of Article X of the NYSE Group Certificate.

For similar reasons, the Exchange also believes that the proposed rule change is consistent with Section 6(b)(5) of the Act,[20] in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system and, in general, to protect investors and the public interest.

The Exchange believes that the proposed rule change would remove impediments to and perfect the mechanism of a free and open market and a national market system by simplifying and streamlining the Exchange's rules and removing an obsolete reference, thereby ensuring that market participants can more easily navigate, understand and comply with its rules. In this manner, the proposed change would ensure that persons subject to the Exchange's jurisdiction, regulators, and the investing public can more easily navigate and understand the NYSE Group Certificate.

In addition, the Exchange believes that the proposed rule change would remove impediments to and perfect the mechanism of a free and open market and a national market system, because the proposed change would conform the text of Article X with the use of ''Exchange'' throughout the Governing Documents, generally, and with the confidential information provisions of the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement, more specifically. As a result, the Governing Documents would be more consistent and persons subject to the Exchange's jurisdiction, regulators, and the investing public could more easily navigate and understand the NYSE Group Certificate and the other Governing Documents.

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 Exchange Act. The proposed rule change is not designed to address any competitive issue but rather is meant to update and streamline the NYSE Group Certificate to make it more consistent with the use of ''Exchange'' throughout the Governing Documents and the confidential information provisions in the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement. The Exchange believes that the proposed rule change will serve to promote clarity and consistency, thereby reducing burdens on the marketplace and facilitating investor protection. The proposed rule change would result in no concentration or other changes of ownership of exchanges.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to 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 Section 19(b)(3)(A) of the Act and Rule 19b–4(f)(6) thereunder.[21]

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–NYSENAT–2018–05 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSENAT–2018–05. 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 website (*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 website 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. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSENAT–2018–05, and

[19] 15 U.S.C. 78c(a)(1).

[20] 15 U.S.C. 78f(b)(5).

[21] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

should be submitted on or before May 29, 2018.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[22]

Eduardo A. Aleman,

Assistant Secretary.

[FR Doc. 2018–09765 Filed 5–7–18; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–83159; File No. SR–NYSEAMER–2018–16]

Self-Regulatory Organizations; NYSE American LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Amend the Certificate of Incorporation of Its Parent Company NYSE Group, Inc.

May 3, 2018.

Pursuant to Section 19(b)(1)[1] of the Securities Exchange Act of 1934 (the ''Act''),[2] and Rule 19b-4 thereunder,[3] notice is hereby given that on April 25, 2018, NYSE American LLC (the ''Exchange'' or ''NYSE American'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the self-regulatory organization. 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 Article X of the certificate of incorporation of its parent company NYSE Group, Inc. (''NYSE Group'') and make certain technical and conforming changes. The proposed rule change is available on the Exchange's website at *www.nyse.com,* at the principal office of the Exchange, 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 self-regulatory organization 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 those 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 parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend Article X (Confidential Amendment) of the Sixth Amended and Restated Certificate of Incorporation of NYSE Group (''NYSE Group Certificate'') and make certain technical and conforming changes.

NYSE Group owns all of the equity interest in the Exchange and its national securities exchange affiliates, the New York Stock Exchange LLC (''NYSE LLC''), NYSE Arca, Inc. (''NYSE Arca''), and NYSE National, Inc. (''NYSE National''). In turn, NYSE Group is a wholly-owned subsidiary of NYSE Holdings LLC (''NYSE Holdings''), which is wholly owned by Intercontinental Exchange Holdings, Inc. (''ICE Holdings''). ICE Holdings is wholly owned by Intercontinental Exchange Inc. (''ICE'').[4]

In 2017, the Exchange amended the certificates of incorporation, bylaws, and operating agreements, as applicable, of ICE, ICE Holdings, NYSE Holdings and NYSE Group (collectively, the ''Governing Documents'').[5] The changes to the Governing Documents included, among other things, amendments streamlining references to ICE subsidiaries that either are or control national securities exchanges, deleting references to other ICE subsidiaries, and amending provisions relating to confidential information.[6] As a result of the changes, ''Exchange'' is defined in each Governing Document as a national securities exchange registered under Section 6 of the Exchange Act[7] that is directly or indirectly controlled by the relevant entity.[8]

In making such changes, lists of specific entities were replaced with ''Exchange'' or ''Exchanges,'' as applicable.[9] For example, in Article XII, clause (b) of the NYSE Group Certificate, ''the boards of directors of New York Stock Exchange, NYSE Arca, NYSE Arca Equities, NYSE MKT and NYSE National or the boards of directors of their successors'' was amended to ''the boards of directors of each Exchange.''[10]

However, the NYSE Group Certificate retains one list of specific entities, which it proposes to amend now. Specifically, in the first sentence of Article X of the NYSE Group Certificate, the Exchange proposes to replace ''New York Stock Exchange, NYSE Arca, NYSE Arca Equities, NYSE MKT and NYSE National'' with ''any Exchange, in each case to the extent that such entities continue to be controlled, directly or indirectly, by the Corporation''.[11]

The proposed change would not have a substantive effect on what entities the provision covers. As national securities exchanges registered under Section 6 of the Exchange Act[12] that are directly controlled by NYSE Group, each of the NYSE, NYSE Arca, NYSE MKT (now NYSE American LLC)[13] and NYSE National are ''Exchanges'' within the

[22] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] ICE is a publicly traded company listed on the NYSE.

[5] The Governing Documents are the Fourth Amended and Restated Certificate of Incorporation of Intercontinental Exchange, Inc. (''ICE Certificate''); Eighth Amended and Restated Bylaws of Intercontinental Exchange, Inc. (''ICE Bylaws''); Ninth Amended and Restated Certificate of Incorporation of Intercontinental Exchange Holdings, Inc. (''ICE Holdings Certificate''); Sixth Amended and Restated Bylaws of Intercontinental Exchange Holdings, Inc. (''ICE Holdings Bylaws''); Ninth Amended and Restated Limited Liability Company Agreement of NYSE Holdings LLC (''NYSE Holdings Operating Agreement''); Fourth Amended and Restated Bylaws of NYSE Group, Inc. (''NYSE Group Bylaws''); and the NYSE Group Certificate.

[6] *See* Securities Exchange Act Release Nos. 82082 (November 15, 2017), 82 FR 55466 (November 21, 2017) (SR–NYSEAmer–2017–29) (notice of filing and immediate effectiveness of proposed rule change to amend the governing documents of the Exchange's intermediate parent companies) (''Holding Companies Release''); and 80752 (May 24, 2017), 82 FR 25018 (May 31, 2017) (SR– NYSE–2017–13; SR–NYSEArca–2017–29; SR– NYSEMKT–2017–17; SR–NYSENAT–2017–01) (order approving proposed rule changes to amend the certificate and bylaws of the exchange's ultimate parent company) (''Parent Company Release'').

[7] 15 U.S.C. 78f.

[8] *See* Holding Companies Release, *supra* note 6, at 55467; ICE Certificate, Article V, Section A(3)(a); ICE Bylaws, Article III, Section 3.15; ICE Holdings Certificate, Article V, Section A(1); ICE Holdings Bylaws, Article III, Section 3.15; NYSE Holdings Operating Agreement, Article 1, Section 1.1; NYSE Group Bylaws, Article VII, Article 7.9(b); and NYSE Group Certificate, Article IV, Section 4(b)(1)(A).

[9] *See* Holding Companies Release, *supra* note 6, at 55467, and Parent Company Release, *supra* note 6, at 25019. Similarly, the terms ''U.S. Regulated Subsidiary,'' ''U.S. Regulated Subsidiaries,'' ''Regulated Subsidiary,'' and ''Regulated Subsidiaries'' were replaced with ''Exchange'' or ''Exchanges,'' as applicable.

[10] *See* Holding Companies Release, *supra* note 6, note 12.

[11] The Exchange's affiliates NYSE LLC, NYSE Arca, and NYSE National have each submitted substantially the same proposed rule change to propose the changes described herein. *See* SR–NYSE–2018–18, SR–NYSEArca–2018–26, and SR–NYSENAT–2018–05.

[12] 15 U.S.C. 78f.

[13] ''NYSE MKT LLC'' changed its name to ''NYSE American LLC'' in 2017. *See* Securities Exchange Act Release Nos. 80283 (March 21, 2017), 82 FR 15244 (March 27, 2017) (SR–NYSEMKT–2017–14).

scope of the definition. The reference to NYSE Arca Equities is obsolete, as it has been merged out of existence.[14] As a result, the change is non-substantive.

The Exchange notes that the proposed amendment would make the first sentence of Article X of the NYSE Group Certificate more consistent with the use of ''Exchange'' throughout the Governing Documents, particularly in the confidential information provisions of the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement, all of which have the text ''any Exchange, in each case to the extent that such entities continue to be controlled, directly or indirectly, by the'' Corporation or Company, as applicable.[15]

In addition, technical and conforming changes would be made to the title, recitals, effective time, date and signature line of the NYSE Group Certificate.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Exchange Act [16] in general, and with Section 6(b)(1) [17] in particular, in that it enables the Exchange to be so organized as to have the capacity to be able to carry out the purposes of the Exchange Act and to comply, and to enforce compliance by its exchange members and persons associated with its exchange members, with the provisions of the Exchange Act, the rules and regulations thereunder, and the rules of the Exchange.

The Exchange believes that the proposed rule change would enable the Exchange to continue to be so organized as to have the capacity to carry out the purposes of the Exchange Act and comply and enforce compliance with the provisions of the Exchange Act by its members and persons associated with its members, because the proposed change would add further clarity and transparency to the Exchange's rules without having a substantive effect on which entities the provision would cover. As national securities exchanges registered under Section 6 of the Exchange Act [18] that are directly controlled by NYSE Group, each of the NYSE LLC, NYSE Arca, NYSE American and NYSE National fall within the scope of the definition of ''Exchange.'' In addition, removing the obsolete reference to NYSE Arca Equities would contribute to the orderly operation of the Exchange by adding clarity and transparency to the Exchange's rules. The Exchange believes that the proposed technical and conforming changes to the title, recitals, effective time, date and signature line of the NYSE Group Certificate would contribute to the orderly operation of the Exchange by adding clarity and transparency to its rules.

Further, the Exchange notes that the Exchange Act definition of ''exchange'' states that ''exchange'' ''includes the market place and the market facilities maintained by such exchange.'' [19] Accordingly, any market places and market facilities maintained by the Exchange would fall within the definition of ''Exchange'' and therefore would fall within the scope of Article X of the NYSE Group Certificate.

For similar reasons, the Exchange also believes that the proposed rule change is consistent with Section 6(b)(5) of the Act,[20] in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system and, in general, to protect investors and the public interest.

The Exchange believes that the proposed rule change would remove impediments to and perfect the mechanism of a free and open market and a national market system by simplifying and streamlining the Exchange's rules and removing an obsolete reference, thereby ensuring that market participants can more easily navigate, understand and comply with its rules. In this manner, the proposed change would ensure that persons subject to the Exchange's jurisdiction, regulators, and the investing public can more easily navigate and understand the NYSE Group Certificate.

In addition, the Exchange believes that the proposed rule change would remove impediments to and perfect the mechanism of a free and open market and a national market system, because the proposed change would conform the text of Article X with the use of ''Exchange'' throughout the Governing Documents, generally, and with the confidential information provisions of the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement, more specifically. As a result, the Governing Documents would be more consistent and persons subject to the Exchange's jurisdiction, regulators, and the investing public could more easily navigate and understand the NYSE Group Certificate and the other Governing Documents.

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 Exchange Act. The proposed rule change is not designed to address any competitive issue but rather is meant to update and streamline the NYSE Group Certificate to make it more consistent with the use of ''Exchange'' throughout the Governing Documents and the confidential information provisions in the ICE Bylaws, the ICE Holdings Bylaws, and the NYSE Holdings Operating Agreement. The Exchange believes that the proposed rule change will serve to promote clarity and consistency, thereby reducing burdens on the marketplace and facilitating investor protection. The proposed rule change would result in no concentration or other changes of ownership of exchanges.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to 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 Section 19(b)(3)(A) of the Act and Rule 19b-4(f)(6) thereunder.[21]

[14] *See* Securities Exchange Act Release No. 81419 (August 17, 2017), 82 FR 40044 (August 23, 2017) (SR–NYSEArca–2017–40).

[15] *See* ICE Bylaws, Article VIII, Section 8.1; ICE Holdings Bylaws, Article VIII, Section 8.1; and NYSE Holdings Operating Agreement, Article XII, Section 12.1. *See also* Holding Companies Release, *supra* note 6, at 55469.

[16] 15 U.S.C. 78f(b).

[17] 15 U.S.C. 78f(b)(1).

[18] 15 U.S.C. 78f.

[19] 15 U.S.C. 78c(a)(1).

[20] 15 U.S.C. 78f(b)(5).

[21] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time

Continued

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–NYSEAmer–2018–16 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEAmer–2018–16. 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 website (*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 website 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. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEAmer–2018–16, and should be submitted on or before May 29, 2018.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[22]

Eduardo A. Aleman,

Assistant Secretary.

[FR Doc. 2018–09763 Filed 5–7–18; 8:45 am]

BILLING CODE 8011–01–P

as designated by the Commission. The Exchange has satisfied this requirement.

[22] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–83154; File No. SR–FINRA–2018–016]

Self-Regulatory Organizations; Financial Industry Regulatory Authority, Inc.; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change Relating to FINRA Rule 3310 to Conform FINRA Rule 3310 to FinCEN's Final Rule on Customer Due Diligence Requirements for Financial Institutions

May 2, 2018.

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 April 20, 2018, Financial Industry Regulatory Authority, Inc. (''FINRA'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by FINRA. FINRA has designated the proposed rule change as constituting a ''non-controversial'' rule change under paragraph (f)(6) of Rule 19b–4 under the Act,[3] which renders the proposal effective upon receipt of this filing by the Commission. 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

FINRA is proposing to amend FINRA Rule 3310 (Anti-Money Laundering Compliance Program) to reflect the Financial Crimes Enforcement Network's (''FinCEN'') adoption of a final rule on Customer Due Diligence Requirements for Financial Institutions (''CDD Rule''). Specifically, the proposed amendments would conform FINRA Rule 3310 to the CDD Rule's amendments to the minimum regulatory requirements for member firms' anti-money laundering (''AML'') compliance programs by requiring such programs to include risk-based procedures for conducting ongoing customer due diligence. This ongoing customer due diligence element for AML programs includes: (1) Understanding the nature and purpose of customer relationships for the purpose of developing a customer risk profile; and (2) conducting ongoing monitoring to identify and report suspicious transactions and, on a risk basis, to maintain and update customer information.

The text of the proposed rule change is available on FINRA's website at *http://www.finra.org,* at the principal office of FINRA 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, FINRA 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. FINRA 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. Background

The Bank Secrecy Act[4] (''BSA''), among other things, requires financial institutions,[5] including broker-dealers, to develop and implement AML programs that, at a minimum, meet the statutorily enumerated ''four pillars.''[6] These four pillars currently require broker-dealers to have written AML programs that include, at a minimum:

- The establishment and implementation of policies, procedures and internal controls reasonably designed to achieve compliance with the applicable provisions of the BSA and implementing regulations;

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 17 CFR 240.19b–4(f)(6).

[4] 31 U.S.C. 5311, *et seq.*

[5] *See* 31 U.S.C. 5312(a)(2) (defining ''financial institution'').

[6] 31 U.S.C. 5318(h)(1).

• independent testing for compliance by broker-dealer personnel or a qualified outside party;

• designation of an individual or individuals responsible for implementing and monitoring the operations and internal controls of the AML program; and

• ongoing training for appropriate persons.[7]

In addition to meeting the BSA's requirements with respect to AML programs, broker-dealers must also comply with FINRA Rule 3310, which incorporates the BSA's four pillars, as well as requiring broker-dealers' AML programs to establish and implement policies and procedures that can be reasonably expected to detect and cause the reporting of suspicious transactions.

On May 11, 2016, FinCEN, the bureau of the Department of the Treasury responsible for administering the BSA and its implementing regulations, issued the CDD Rule[8] to clarify and strengthen customer due diligence for covered financial institutions,[9] including broker-dealers. In its CDD Rule, FinCEN identifies four components of customer due diligence: (1) Customer identification and verification; (2) beneficial ownership identification and verification; (3) understanding the nature and purpose of customer relationships; and (4) ongoing monitoring for reporting suspicious transactions and, on a risk basis, maintaining and updating customer information.[10] As the first component is already required to be part of a broker-dealer's AML program under the BSA, the CDD Rule focuses on the other three components.

Specifically, the CDD Rule focuses particularly on the second component by adding a new requirement that covered financial institutions identify and verify the identity of the beneficial owners of all legal entity customers at the time a new account is opened, subject to certain exclusions and exemptions.[11] The CDD Rule also addresses the third and fourth components, which FinCEN states ''are already implicitly required for covered financial institutions to comply with their suspicious activity reporting requirements,'' by amending the existing AML program rules for covered financial institutions to explicitly require these components to be included in AML programs as a new ''fifth pillar.'' As a result of the CDD Rule, member firms should ensure that their AML programs are updated, as necessary, to comply with the CDD Rule by May 11, 2018.

On November 21, 2017, FINRA published *Regulatory Notice* 17–40 to provide guidance to member firms regarding their obligations under FINRA Rule 3310 in light of the adoption of FinCEN's CDD Rule. In addition, the *Notice* summarized the CDD Rule's impact on member firms, including the addition of the new fifth pillar required for member firms' AML programs. This proposed rule change amends FINRA Rule 3310 to incorporate the fifth pillar.

b. FINRA Rule 3310 and Amendment to Minimum Requirements for Member Firms' AML Programs

Section 352 of the USA PATRIOT Act of 2001[12] amended the BSA to require broker-dealers to develop and implement AML programs that include the four pillars mentioned above. Consistent with Section 352 of the PATRIOT Act, and incorporating the four pillars, FINRA Rule 3310 requires each member firm to develop and implement a written AML program reasonably designed to achieve and monitor the member firm's compliance with the BSA and implementing regulations. Among other requirements, FINRA Rule 3310 requires that each member firm, at a minimum: (1) Establish and implement policies and procedures that can be reasonably expected to detect and cause the reporting of suspicious transactions; (2) establish and implement policies, procedures, and internal controls reasonably designed to achieve compliance with the BSA and implementing regulations; (3) provide for annual (on a calendar-year basis) independent testing for compliance to be conducted by member firm personnel or a qualified outside party;[13] (4) designate and identify to FINRA an individual or individuals (*i.e.,* AML compliance person(s)) who will be responsible for implementing and monitoring the day-to-day operations and internal controls of the AML program and provide prompt notification to FINRA of any changes to the designation; and (5) provide ongoing training for appropriate persons.

FinCEN's CDD Rule does not change the requirements of FINRA Rule 3310 and member firms must continue to comply with its requirements.[14] However, FinCEN's CDD Rule amends the minimum regulatory requirements for member firms' AML programs by explicitly requiring such programs to include risk-based procedures for conducting ongoing customer due diligence.[15] Accordingly, FINRA is proposing to amend FINRA Rule 3310 to incorporate into the Rule this ongoing customer due diligence element, or ''fifth pillar'' required for AML programs. Thus, proposed Rule 3310(f) would provide that the AML programs required by this Rule shall, at a minimum include appropriate risk-based procedures for conducting ongoing customer due diligence, to include, but not be limited to: (1) Understanding the nature and purpose of customer relationships for the purpose of developing a customer risk profile; and (2) Conducting ongoing monitoring to identify and report suspicious transactions and, on a risk basis, to maintain and update customer information.

As stated in the CDD Rule, these provisions are not new and merely codify existing expectations for firms to adequately identify and report suspicious transactions as required under the BSA and encapsulate practices generally already undertaken by securities firms to know and understand their customers.[16] The proposed rule change simply incorporates into FINRA Rule 3310 the ongoing customer due diligence

[7] 31 CFR 1023.210(b).

[8] FinCEN Customer Due Diligence Requirements for Financial Institutions; CDD Rule, 81 FR 29397 (May 11, 2016) (CDD Rule Release); 82 FR 45182 (September 28, 2017) (making technical correcting amendments to the final CDD Rule published on May 11, 2016). FinCEN is authorized to impose AML program requirements on financial institutions and to require financial institutions to maintain procedures to ensure compliance with the BSA and associated regulations. 31 U.S.C. 5318(h)(2) and (a)(2). The CDD Rule is the result of the rulemaking process FinCEN initiated in March 2012. *See* 77 FR 13046 (March 5, 2012) (Advance Notice of Proposed Rulemaking) and 79 FR 45151 (Aug. 4, 2014) (Notice of Proposed Rulemaking).

[9] *See* 31 CFR 1010.230(f) (defining ''covered financial institution'').

[10] *See* CDD Rule Release at 29398.

[11] *See* 31 CFR 1010.230(d) (defining ''beneficial owner'') and 31 CFR 1010.230(e) (defining ''legal entity customer'').

[12] Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001, Public Law 107–56, 115 Stat. 272 (2001).

[13] If a member firm does not execute transactions for customers or otherwise hold customer accounts or act as an introducing broker with respect to customer accounts (*e.g.,* engages solely in proprietary trading or conducts business only with other broker-dealers), then ''independent testing'' is required every two years. *See* FINRA Rule 3310(c). However, a member should conduct more frequent testing than required if circumstances warrant. *See* Supplementary Material .01(a).

[14] In fact, FinCEN notes that broker-dealers must continue to comply with FINRA Rules, notwithstanding differences between the CDD Rule and FINRA Rule 3310. *See* CDD Rule Release 29421, n. 85.

[15] *See* CDD Rule Release at 29420; 31 CFR 1023.210.

[16] *See id.* at 29419.

element, or ''fifth pillar,'' required for AML programs by the CDD Rule to aid member firms in complying with the CDD Rule's requirements. However, to the extent that these elements, which are briefly summarized below, are not already included in member firms' AML programs, the CDD Rule requires member firms to update their AML programs to explicitly incorporate them.

c. Summary of Fifth Pillar's Requirements

Understanding the Nature and Purpose of Customer Relationships

FinCEN states in the CDD Rule that firms must necessarily have an understanding of the nature and purpose of the customer relationship in order to determine whether a transaction is potentially suspicious and, in turn, to fulfill their SAR obligations.[17] To that end, the CDD Rule requires that firms understand the nature and purpose of the customer relationship in order to develop a customer risk profile. The customer risk profile refers to information gathered about a customer to form the baseline against which customer activity is assessed for suspicious transaction reporting.[18] Information relevant to understanding the nature and purpose of the customer relationship may be self-evident and, depending on the facts and circumstances, may include such information as the type of customer, account or service offered, and the customer's income, net worth, domicile, or principal occupation or business, as well as, in the case of existing customers, the customer's history of activity.[19] The CDD Rule also does not prescribe a particular form of the customer risk profile.[20] Instead, the CDD Rule states that depending on the firm and the nature of its business, a customer risk profile may consist of individualized risk scoring, placement of customers into risk categories or another means of assessing customer risk that allows firms to understand the risk posed by the customer and to demonstrate that understanding.[21]

The CDD Rule also addresses the interplay of understanding the nature and purpose of customer relationships with the ongoing monitoring obligation discussed below. The CDD Rule explains that firms are not necessarily required or expected to integrate customer information or the customer risk profile into existing transaction monitoring systems (for example, to serve as the baseline for identifying and assessing suspicious transactions on a contemporaneous basis).[22] Rather, FinCEN expects firms to use the customer information and customer risk profile as appropriate during the course of complying with their obligations under the BSA in order to determine whether a particular flagged transaction is suspicious.[23]

Conducting Ongoing Monitoring

As with the requirement to understand the nature and purpose of the customer relationship, the requirement to conduct ongoing monitoring to identify and report suspicious transactions and, on a risk basis, to maintain and update customer information, merely adopts existing supervisory and regulatory expectations as explicit minimum standards of customer due diligence required for firms' AML programs.[24] If, in the course of its normal monitoring for suspicious activity, the member firm detects information that is relevant to assessing the customer's risk profile, the member firm must update the customer information, including the information regarding the beneficial owners of legal entity customers.[25] However, there is no expectation that the member firm update customer information, including beneficial ownership information, on an ongoing or continuous basis.[26]

FINRA has filed the proposed rule change for immediate effectiveness. The implementation date for the proposed changes will be May 11, 2018 to coincide with the compliance date under the CDD Rule.

2. Statutory Basis

FINRA believes that the proposed rule change is consistent with the provisions of Section 15A(b)(6) of the Act,[27] which requires, among other things, that FINRA rules must be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and, in general, to protect investors and the public interest. FINRA believes the proposed rule change will aid member firms in complying with the CDD Rule's requirement that member firms' AML programs include risk-based procedures for conducting ongoing customer due diligence by also incorporating the requirement into FINRA Rule 3310.

B. Self-Regulatory Organization's Statement on Burden on Competition

FINRA does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. The proposed rule change simply incorporates into FINRA Rule 3310 the ongoing customer due diligence element, or ''fifth pillar,'' required for AML programs by the CDD Rule. Regardless of the proposed rule change, to the extent that the elements of the fifth pillar are not already included in member firms' AML programs, the CDD Rule requires member firms to update their AML programs to explicitly incorporate them by May 11, 2018. In addition, as stated in the CDD Rule, these elements are already implicitly required for covered financial institutions to comply with their suspicious activity reporting requirements. FINRA is not imposing any additional direct or indirect burdens on member firms or their clients through this proposal, and as such the proposal imposes no new burdens on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

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 Section 19(b)(3)(A) of the Act[28] and Rule 19b–4(f)(6) thereunder.[29]

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 shall institute proceedings

[17] *See id.* at 29421.

[18] *See id.* at 29422.

[19] *See id.*

[20] *See id.*

[21] *See id.*

[22] *See id.*

[23] *See id.*

[24] *See id.* at 29402.

[25] *See id.* at 29420–21. *See also Regulatory Notice* 17–40 (discussing identifying and verifying the identity of beneficial owners of legal entity customers).

[26] *See id.*

[27] 15 U.S.C. 78*o*–3(b)(6).

[28] 15 U.S.C. 78s(b)(3)(A).

[29] 17 CFR 240.19b–4(f)(6).

to determine whether the proposed rule 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–FINRA 2018–016 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–FINRA–2018–016. 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 website (*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 website 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 office of FINRA. All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–FINRA–2018–016 and should be submitted on or before May 29, 2018.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[30]

Eduardo A. Aleman,

Assistant Secretary.

[FR Doc. 2018–09694 Filed 5–7–18; 8:45 am]

BILLING CODE 8011–01–P

[30] 17 CFR 200.30–3(a)(12).

TENNESSEE VALLEY AUTHORITY

Sunshine Act Meeting Notice

Meeting No. 18–02

The TVA Board of Directors will hold a public meeting on May 10, 2018, at the Shoals Marriott and Conference Center, 10 Hightower Place, Florence, Alabama. The public may comment on any agenda item or subject at a *public listening session* which begins at 9:30 a.m. (CT). Following the end of the public listening session, the meeting will be called to order to consider the agenda items listed below. On-site registration will be available until 15 minutes before the public listening session begins at 9:30 a.m. (CT). TVA management will answer questions from the news media following the Board meeting.

STATUS: Open.

Agenda

Chair's Welcome

Old Business

Approval of minutes of the February 16, 2018, Board Meeting

New Business

1. Report From President and CEO
2. Governance Item
   A. Assistant Corporate Secretaries
3. Report of the Audit, Risk, and Regulation Committee
4. Report of the People and Performance Committee
5. Report of the Finance, Rates, and Portfolio Committee
   A. Rate Change
   B. Optional Electric Vehicle Rate Pilot
   C. Tennessee Gas Pipeline Agreements and Delegation
   D. Texas Gas Transmission Agreements
6. Report of the External Relations Committee
   A. Modified Land and Equipment Conveyance Delegations
7. Report of the Nuclear Oversight Committee

FOR MORE INFORMATION: Please call TVA Media Relations at (865) 632–6000, Knoxville, Tennessee. People who plan to attend the meeting and have special needs should call (865) 632–6000. Anyone who wishes to comment on any of the agenda in writing may send their comments to: TVA Board of Directors, Board Agenda Comments, 400 West Summit Hill Drive, Knoxville, Tennessee 37902.

Dated: May 3, 2018.

Sherry A. Quirk,

General Counsel.

[FR Doc. 2018–09845 Filed 5–4–18; 11:15 am]

BILLING CODE 8120–08–P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

Notice of Final Federal Agency Actions on Interstate 95 in the City of Fredericksburg and the Counties of Spotsylvania, Stafford, Prince William, and Fairfax, Virginia

AGENCY: Federal Highway Administration (FHWA), DOT

ACTION: Notice of Limitation on Claims for Judicial Review of Actions by FHWA.

SUMMARY: This notice announces actions taken by the FHWA that are final. The actions relate to roadway improvements to enhance Express Lane access at the I–95/Russell Road Interchange (Exit 148), as well as expand the Express Lanes approximately ten miles from near the I–95/VA 610 Interchange at Garrisonville Road (Exit 143) to near the I–95/US 17 Interchange at Warrenton Road (Exit 133), in the City of Fredericksburg and the Counties of Spotsylvania, Stafford, Prince William, and Fairfax.

DATES: By this notice, the FHWA is advising the public of final agency actions subject to 23 U.S.C. 139(*l*)(1). A claim seeking judicial review of the Federal agency actions on the project will be barred unless the claim is filed on or before October 5, 2018. Notwithstanding any other provision of law, a claim arising under Federal law seeking judicial review of a permit, license, or approval issued by a Federal agency for a highway or public transportation capital project shall be barred unless it is filed within 150 days after publication of a notice in the **Federal Register** announcing that the permit, license, or approval is final pursuant to the law under which the agency action is taken, unless a shorter time is specified in the Federal law pursuant to which judicial review is allowed.

FOR FURTHER INFORMATION CONTACT: For FHWA: Mr. Mack Frost, Planning and Environmental Specialist, Federal Highway Administration, 400 North 8th

Street, Richmond, Virginia 23219; telephone: (804) 775–3352; email: *Mack.frost@dot.gov.* The FHWA Virginia Division Office's normal business hours are 7:00 a.m. to 5:00 p.m. (Eastern Time). For the Virginia Department of Transportation (VDOT): Mr. Scott Smizik, 1401 East Broad Street, Richmond, Virginia 23219; email: *Scott.Smizik@vdot.virginia.gov;* telephone: (804) 371–4082.

SUPPLEMENTARY INFORMATION: Notice is hereby given that FHWA has taken final agency actions subject to 23 U.S.C. 139(*l*)(1) by issuing licenses, permits, and approvals for the following project in the State of Virginia: roadway improvements to enhance Express Lane access at the I–95/Russell Road Interchange (Exit 148), as well as expand the Express Lanes approximately ten miles from near the I–95/VA 610 Interchange at Garrisonville Road (Exit 143) to near the I–95/US 17 Interchange at Warrenton Road (Exit 133), in the City of Fredericksburg and the Counties of Spotsylvania, Stafford, Prince William, and Fairfax. The actions taken by FHWA, and the laws under which such actions were taken, are described in the Revised Environmental Assessment, the Request for the Finding of No Significant Impact (FONSI), and the FONSI. The Revised EA was signed on October 31, 2017. The FONSI was issued on March 19, 2018. The Revised EA, Request for the FONSI, and FONSI can be viewed on the project's internet site at *http://www.virginiadot.org/projects/fredericksburg/i-95_express_lanes_fredericksburg_extension.asp.* These documents and other project records are also available by contacting FHWA or the Virginia Department of Transportation at the phone numbers and addresses provided above.

This notice applies to all Federal agency decisions as of the issuance date of this notice and all laws under which such actions were taken, including but not limited to:

1. *General:* National Environmental Policy Act (NEPA) [42 U.S.C. 4321–4351]; Federal-Aid Highway Act (FAHA) [23 U.S.C. 109 and 23 U.S.C. 128].
2. *Air:* Clean Air Act [42 U.S.C. 7401–7671(q)].
3. *Land:* Section 4(f) of the Department of Transportation Act of 1966 [23 U.S.C. 138 and 49 U.S.C. 303].
4. *Historic and Cultural Resources:* Section 106 of the National Historic Preservation Act of 1966, as amended [54 U.S.C. 300101 *et seq.*].
5. *Social and Economic:* Farmland Protection Policy Act [7 U.S.C. 4201–4209].
6. *Executive Orders:* E.O. 12898, Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations.

(Catalog of Federal Domestic Assistance Program Number 20.205, Highway Planning and Construction. The regulations implementing Executive Order 12372 regarding intergovernmental consultation on Federal programs and activities apply to this program.)

Authority: 23 U.S.C 139(*l*)(1)

Issued on: May 1, 2018.

John Simkins

Planning and Environment Team Leader, Richmond, VA.

[FR Doc. 2018–09810 Filed 5–7–18; 8:45 am]

BILLING CODE 4910–RY–P

DEPARTMENT OF TRANSPORTATION

Federal Transit Administration

[FTA Docket No. FTA 2018–0003]

Agency Information Collection Activity under OMB Review

AGENCY: Federal Transit Administration, DOT.

ACTION: Notice of request for comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, this notice announces that the Information Collection Requirements (ICRs) abstracted below have been forwarded to the Office of Management and Budget (OMB) for review and comment. The ICR describe the nature of the information collection and their expected burdens. The **Federal Register** notice with a 60-day comment period soliciting comments on the following collections of information was published on January 22, 2018.

DATES: Comments must be submitted on or before June 7, 2018.

ADDRESSES: All written comments must refer to the docket number that appears at the top of this document and be submitted to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725—17th Street NW, Washington, DC 20503, Attention: FTA Desk Officer. Alternatively, comments may be sent via email to the Office of Information and Regulatory Affairs (OIRA), Office of Management and Budget, at the following address: *oira_submissions@omb.eop.gov*

Comments are Invited On: Whether the proposed collection of information is necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; the accuracy of the Department's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology. A comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication of this notice in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Tia Swain, Office of Administration, Management Planning Division, 1200 New Jersey Avenue SE, Mail Stop TAD–10, Washington, DC 20590 (202) 366–0354 or *tia.swain@dot.gov.*

SUPPLEMENTARY INFORMATION: The Paperwork Reduction Act of 1995 (PRA), Public Law 104–13, Section 2, 109 Stat. 163 (1995) (codified as revised at 44 U.S.C. 3501–3520), and its implementing regulations, 5 CFR part 1320, require Federal agencies to issue two notices seeking public comment on information collection activities before OMB may approve paperwork packages. 44 U.S.C. 3506, 3507; 5 CFR 1320.5, 1320.8(d)(1), 1320.12. On January 22, 2018, FTA published a 60-day notice (83 FR 3050) in the **Federal Register** soliciting comments on the ICR that the agency was seeking OMB approval. FTA received (1) comment after issuing this 60-day notice. However, that comment was posted three days after the comment period expired and the comment was outside the scope of the Paperwork Reduction Act and made no reference to the grant program or any FTA related programs. Accordingly, DOT announces that these information collection activities have been re-evaluated and certified under 5 CFR 1320.5(a) and forwarded to OMB for review and approval pursuant to 5 CFR 1320.12(c).

Before OMB decides whether to approve these proposed collections of information, it must provide 30 days for public comment. 44 U.S.C. 3507(b); 5 CFR 1320.12(d). Federal law requires OMB to approve or disapprove paperwork packages between 30 and 60 days after the 30-day notice is published. 44 U.S.C. 3507 (b)–(c); 5 CFR 1320.12(d); *see also* 60 FR 44978, 44983, Aug. 29, 1995. OMB believes that the 30-day notice informs the regulated community to file relevant comments and affords the agency adequate time to digest public comments before it renders a decision; *see also* 60 FR 44983, Aug. 29, 1995. Therefore, respondents should submit their

respective comments to OMB within 30 days of publication to best ensure having their full effect. 5 CFR 1320.12(c); *see also* 60 FR 44983, Aug. 29, 1995.

The summaries below describe the nature of the information collection requirements (ICRs) and the expected burden. The requirements are being submitted for clearance by OMB as required by the PRA.

Title: 49 U.S.C. Section 5320 Paul S. Sarbanes Transit in Parks.

OMB Control Number: 2132–0574.

Type of Request: Extension of a currently approved information collection.

Abstract: Section 3021 of the Safe, Accountable, Flexible, Efficient Transportation Equity Act—A Legacy for Users (SAFETEA–LU), as amended, established the Paul S. Sarbanes Transit in Parks Program (Transit in Parks Program—49 U.S.C. 5320). The program was administered by FTA in partnership with the Department of the Interior (DOI) and the U.S. Department of Agriculture's Forest Service. The program provided grants to Federal land management agencies that manage an eligible area, including but not limited to the National Park Service, the Fish and Wildlife Service, the Bureau of Land Management, the Forest Service, the Bureau of Reclamation; and State, tribal and local governments with jurisdiction over land in the vicinity of an eligible area, acting with the consent of a Federal land management agency, alone or in partnership with a Federal land management agency or other governmental or non-governmental participant. The purpose of the program was to provide for the planning and capital costs of alternative transportation systems that will enhance the protection of national parks and Federal lands; increase the enjoyment of visitors' experience by conserving natural, historical, and cultural resources; reduce congestion and pollution; improve visitor mobility and accessibility; enhance visitor experience; and ensure access to all, including persons with disabilities. The Paul S. Sarbanes Transit in the Parks program was repealed under the Moving Ahead for Progress in the 21st Century Act (MAP–21). However, funds previously authorized for programs repealed by MAP–21 remain available for their originally authorized purposes until the period of availability expires, the funds are fully expended, the funds are rescinded by Congress, or the funds are otherwise reallocated.

Annual Estimated Total Burden Hours: 50 hours.

William Hyre,

Deputy Associate Administrator for Administration.

[FR Doc. 2018–09723 Filed 5–7–18; 8:45 am]

BILLING CODE P

DEPARTMENT OF THE TREASURY

Office of the Comptroller of the Currency

Agency Information Collection Activities: Information Collection Renewal; Submission for OMB Review; Registration of Mortgage Loan Originators

AGENCY: Office of the Comptroller of the Currency (OCC), Treasury.

ACTION: ACTION: Notice and request for comment.

SUMMARY: The OCC, 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 a continuing information collection as required by the Paperwork Reduction Act of 1995 (PRA).

In accordance with the requirements of the PRA, the OCC may not conduct or sponsor, and respondents are not required to respond to, an information collection unless it displays a currently valid Office of Management and Budget (OMB) control number.

The OCC is soliciting comment concerning the renewal of its information collection titled ''Registration of Mortgage Loan Originators.'' The OCC also is giving notice that it has sent the collection to OMB for review.

DATES: You should submit written comments by: June 7, 2018.

ADDRESSES: Commenters are encouraged to submit comments by email, if possible. You may submit comments by any of the following methods:

- *Email: prainfo@occ.treas.gov.*
- *Mail:* Legislative and Regulatory Activities Division, Office of the Comptroller of the Currency, Attention: 1557–0243, 400 7th Street SW, Suite 3E–218, Washington, DC 20219.
- *Hand Delivery/Courier:* 400 7th Street SW, Suite 3E–218, Washington, DC 20219.
- *Fax:* (571) 465–4326.

Instructions: You must include ''OCC'' as the agency name and ''1557–0243'' in your comment. In general, the OCC will publish them on *www.reginfo.gov* without change, including any business or personal information that you provide, such as name and address information, email addresses, or phone numbers. Comments received, including attachments and other supporting materials, are part of the public record and subject to public disclosure. Do not include any information in your comment or supporting materials that you consider confidential or inappropriate for public disclosure.

Additionally, please send a copy of your comments by mail to: OCC Desk Officer, 1557–0243, U.S. Office of Management and Budget, 725 17th Street NW, #10235, Washington, DC 20503 or by email to *oira_submission@omb.eop.gov.*

You may review comments and other related materials that pertain to this information collection [1] following the close of the 30-Day comment period for this notice by any of the following methods:

- Viewing Comments Electronically: Go to *www.reginfo.gov.* Click on the ''Information Collection Review'' tab. Underneath the ''Currently under Review'' section heading, from the drop-down menu, select ''Department of Treasury'' and then click ''submit.'' This information collection can be located by searching by OMB control number ''1557–0243'' or ''Registration of Mortgage Loan Originators.'' Upon finding the appropriate information collection, click on the related ''ICR Reference Number.'' On the next screen, select ''View Supporting Statement and Other Documents'' and then click on the link to any comment listed at the bottom of the screen.
- For assistance in navigating *www.reginfo.gov,* please contact the Regulatory Information Service Center at (202) 482–7340.
- Viewing Comments Personally: You may personally inspect comments at the OCC, 400 7th Street SW, Washington, DC. For security reasons, the OCC requires that visitors make an appointment to inspect comments. You may do so by calling (202) 649–6700 or, for persons who are deaf or hearing impaired, TTY, (202) 649–5597. Upon arrival, visitors will be required to present valid government-issued photo identification and submit to security screening in order to inspect comments.

FOR FURTHER INFORMATION CONTACT: Shaquita Merritt, OCC Clearance Officer, (202) 649–5490 or, for persons

[1] On February 6, 2018, the OCC published a 60-Day notice for this information collection. The comments can be viewed on *www.reginfo.gov.* Please follow the instructions listed in this notice to view them.

who are deaf or hearing impaired, TTY, (202) 649–5597, Legislative and Regulatory Activities Division, Office of the Comptroller of the Currency, 400 7th Street SW, Suite 3E–218, Washington, DC 20219.

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3520), federal agencies must obtain approval from the OMB for each collection of information that they conduct or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) to include agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. The OCC is requesting that OMB extend its approval of the following collection.

Title: Registration of Mortgage Loan Originators.

OMB Number: 1557–0243.

Description: The Secure and Fair Enforcement for Mortgage Licensing Act (the S.A.F.E. Act) [2] requires an employee of a bank, savings association, or credit union and their subsidiaries regulated by a federal banking agency or an employee of an institution regulated by the Farm Credit Administration (FCA) (collectively, institutions) who engages in the business of a residential mortgage loan originator (MLO) to register with the Nationwide Mortgage Licensing System and Registry (Registry) and obtain a unique identifier. Institutions must require their employees who act as residential MLOs to comply with the Act's requirements to register and obtain a unique identifier and also adopt and follow written policies and procedures to assure compliance with these requirements.

Among other things, the Registry is intended to aggregate and improve the flow of information to and between regulators; provide increased accountability and tracking of mortgage loan originators; enhance consumer protections; reduce fraud in the residential mortgage loan origination process; and provide consumers with easily accessible information at no charge regarding the employment history of, and the publicly adjudicated disciplinary and enforcement actions against, mortgage loan originators.

Along with the Board of Governors of the Federal Reserve System, the Federal Deposit Insurance Corporation, the National Credit Union Administration, and the Farm Credit Administration, the OCC issued a final rule implementing the SAFE Act.[3] The Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), Public Law 111–203, later transferred this rule to the Consumer Financial Protection Bureau (CFPB) and the CFPB republished this rule as 12 CFR part 1007.[4] However, the OCC retains enforcement authority for this rule for national banks, federal savings associations and federal branches and agencies of foreign banks with total assets of $10 billion or less.[5]

MLO Reporting Requirements

Except in situations where the de minimis exception applies, 12 CFR 1007.103 requires an employee of an institution who is engaged in the business of a MLO to register with the Registry, maintain and update such registration, and obtain a unique identifier. This section also requires an institution to require its MLO employees to comply with these requirements. Section 1007.103(d) sets forth the categories of information that an institution must require its employees to submit to the Registry or to submit on the employee's behalf. This section also requires the employee to submit to the Registry an attestation as to the correctness of the information submitted and an authorization for the Registry to obtain further information.

MLO Disclosure Requirement

Section 1007.105(b) requires the MLO to provide the unique identifier to a consumer upon request, before acting as a mortgage loan originator, and through the originator's initial written communication with a consumer, if any, whether on paper or electronically.

Financial Institution Reporting Requirements

Section 1007.103(e) specifies the institution and employee information that an institution must submit to the Registry in connection with the registration of one or more MLOs and annually thereafter. The institution also must update this information within 30 days of it becoming inaccurate. Employees of the institution who submit information to the Registry on behalf of the institution also must verify their identity and attest to the accuracy of the information submitted.

Financial Institution Disclosure Requirements

Section 1007.105(a) requires the institution to make the unique identifier of MLO employees available to consumers in a manner and method practicable to the institution.

Financial Institution Recordkeeping Requirements

Section 1007.104 requires that an institution that employs MLOs to adopt and follow written policies and procedures, at a minimum addressing certain specified areas, but otherwise appropriate to the nature, size and complexity of their mortgage lending activities.

Type of Review: Regular.

Affected Public: Individuals; Businesses or other for-profit.

Estimated Number of Respondents: 85,353.

Estimated Total Annual Burden: 51,384 hours.

The OCC issued a notice for 60 days of comment regarding this collection on February 6, 2018, 83 FR 5293. No comments were received. Comments continue to be invited on:

(a) Whether the collection of information is necessary for the proper performance of the functions of the OCC, including whether the information has practical utility;

(b) The accuracy of the OCC'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 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.

Dated: May 2, 2018.

Karen Solomon,

Acting Senior Deputy Comptroller and Chief Counsel.

[FR Doc. 2018–09779 Filed 5–7–18; 8:45 am]

BILLING CODE 4810–33–P

[2] The S.A.F.E. Act was enacted as part of the Housing and Economic Recovery Act of 2008, Public Law 110–289, Division A, Title V, sections 1501–1517, 122 Stat. 2654, 2810–2824 (July 30, 2008), *codified at* 12 U.S.C. 5101–5116.

[3] 75 FR 44656 (July 28, 2010), as corrected in 75 FR 51623 (Aug. 23, 2010).

[4] 76 FR 78487 (Dec. 19, 2011).

[5] *See* section 1025 of the Dodd-Frank Act, codified at 12 U.S.C. 5515.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Open Meeting of the Taxpayer Advocacy Panel Toll-Free Phone Line Project Committee

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of meeting.

SUMMARY: An open meeting of the Taxpayer Advocacy Panel Toll-Free Phone Line Project Committee will be

conducted. The Taxpayer Advocacy Panel is soliciting public comments, ideas, and suggestions on improving customer service at the Internal Revenue Service.

DATES: The meeting will be held Tuesday, June 12, 2018.

FOR FURTHER INFORMATION CONTACT: Rosalind Matherne at 1–888–912–1227 or 202–317–4115.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to Section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. App. (1988) that an open meeting of the Taxpayer Advocacy Panel Toll-Free Phone Line Project Committee will be held Tuesday, June 12, 2018, at 3:00 p.m. Eastern Time via teleconference. The public is invited to make oral comments or submit written statements for consideration. Due to limited conference lines, notification of intent to participate must be made with Rosalind Matherne. For more information please contact Rosalind Matherne at 1–888–912–1227 or 202–317–4115, or write TAP Office, 1111 Constitution Ave. NW, Room 1509, Washington, DC 20224 or contact us at the website: *http://www.improveirs.org.* The agenda will include various IRS issues.

The committee will be discussing Toll-free issues and public input is welcomed.

Dated: May 1, 2018.

Kevin Brown,

Acting Director, Taxpayer Advocacy Panel.

[FR Doc. 2018–09701 Filed 5–7–18; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Open Meeting of the Taxpayer Advocacy Panel Joint Committee

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of meeting.

SUMMARY: An open meeting of the Taxpayer Advocacy Panel Joint Committee will be conducted. The Taxpayer Advocacy Panel is soliciting public comments, ideas, and suggestions on improving customer service at the Internal Revenue Service.

DATES: The meeting will be held Wednesday, June 27, 2018.

FOR FURTHER INFORMATION CONTACT: Lisa Billups at 1–888–912–1227 or (214) 413–6523.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to Section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. App. (1988) that an open meeting of the Taxpayer Advocacy Panel Joint Committee will be held Wednesday, June 27, 2018, at 1:00 p.m. Eastern Time via teleconference. The public is invited to make oral comments or submit written statements for consideration. For more information please contact Lisa Billups at 1–888–912–1227 or (214) 413–6523, or write TAP Office 1114 Commerce Street, Dallas, TX 75242–1021, or post comments to the website: *http://www.improveirs.org.*

The agenda will include various committee issues for submission to the IRS and other TAP related topics. Public input is welcomed.

Dated: May 1, 2018.

Kevin Brown,

Acting Director, Taxpayer Advocacy Panel.

[FR Doc. 2018–09708 Filed 5–7–18; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Open Meeting of the Taxpayer Advocacy Panel Joint Committee

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of meeting.

SUMMARY: An open meeting of the Taxpayer Advocacy Panel Joint Committee will be conducted. The Taxpayer Advocacy Panel is soliciting public comments, ideas, and suggestions on improving customer service at the Internal Revenue Service.

DATES: The meeting will be held Wednesday, June 27, 2018.

FOR FURTHER INFORMATION CONTACT: Lisa Billups at 1–888–912–1227 or (214) 413–6523.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to Section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. App. (1988) that an open meeting of the Taxpayer Advocacy Panel Joint Committee will be held Wednesday, June 27, 2018, at 1:00 p.m. Eastern Time via teleconference. The public is invited to make oral comments or submit written statements for consideration. For more information please contact Lisa Billups at 1–888–912–1227 or (214) 413–6523, or write TAP Office 1114 Commerce Street, Dallas, TX 75242–1021, or post comments to the website: *http://www.improveirs.org.*

The agenda will include various committee issues for submission to the IRS and other TAP related topics. Public input is welcomed.

Dated: May 1, 2018.

Kevin Brown,

Acting Director, Taxpayer Advocacy Panel.

[FR Doc. 2018–09706 Filed 5–7–18; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Open Meeting of the Taxpayer Advocacy Panel Taxpayer Assistance Center Improvements Project Committee

AGENCY: Internal Revenue Service (IRS) Treasury.

ACTION: Notice of meeting.

SUMMARY: The Taxpayer Advocacy Panel Taxpayer Assistance Center Improvements Project Committee will conduct an open meeting and will solicit public comments, ideas, and suggestions on improving customer service at the Internal Revenue Service.

DATES: The meeting will be held Tuesday, June 19, 2018.

FOR FURTHER INFORMATION CONTACT: Gilbert Martinez at 1–888–912–1227 or (737) 800–4060.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to Section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. App. (1988) that a meeting of the Taxpayer Advocacy Panel Taxpayer Assistance Center Improvements Project Committee will be held Tuesday, June 19, 2018, at 4:00 p.m. Eastern Time. The public is invited to make oral comments or submit written statements for consideration. Due to limited conference lines, notification of intent to participate must be made with Gilbert Martinez. For more information please contact Gilbert Martinez at 1–888–912–1227 or 214–413–6523, or write TAP Office 3651 S. IH–35, STOP 1005 AUSC, Austin, TX 78741, or post comments to the website: *http://www.improveirs.org.*

The committee will be discussing various issues related to the Taxpayer Assistance Centers and public input is welcomed.

Dated: May 1, 2018.

Kevin Brown,

Acting Director, Taxpayer Advocacy Panel.

[FR Doc. 2018–09705 Filed 5–7–18; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Open Meeting of the Taxpayer Advocacy Panel Joint Committee

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of meeting.

SUMMARY: An open meeting of the Taxpayer Advocacy Panel Joint Committee will be conducted. The Taxpayer Advocacy Panel is soliciting public comments, ideas, and suggestions on improving customer service at the Internal Revenue Service.

DATES: The meeting will be held Wednesday, June 27, 2018.

FOR FURTHER INFORMATION CONTACT: Lisa Billups at 1–888–912–1227 or (214) 413–6523.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to Section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. App. (1988) that an open meeting of the Taxpayer Advocacy Panel Joint Committee will be held Wednesday, June 27, 2018, at 1:00 p.m. Eastern Time via teleconference. The public is invited to make oral comments or submit written statements for consideration. For more information please contact Lisa Billups at 1–888–912–1227 or (214) 413–6523, or write TAP Office 1114 Commerce Street, Dallas, TX 75242–1021, or post comments to the website: *http://www.improveirs.org.*

The agenda will include various committee issues for submission to the IRS and other TAP related topics. Public input is welcomed.

Dated: May 1, 2018.

Kevin Brown,

Acting Director, Taxpayer Advocacy Panel.

[FR Doc. 2018–09707 Filed 5–7–18; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Open Meeting of the Taxpayer Advocacy Panel Special Projects Committee

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of meeting.

SUMMARY: An open meeting of the Taxpayer Advocacy Panel Special Projects Committee will be conducted. The Taxpayer Advocacy Panel is soliciting public comments, ideas, and suggestions on improving customer service at the Internal Revenue Service.

DATES: The meeting will be held Wednesday, June 20, 2018.

FOR FURTHER INFORMATION CONTACT: Matthew O'Sullivan at 1–888–912–1227 or (510) 907–5274.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to Section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. App. (1988) that a meeting of the Taxpayer Advocacy Panel Special Projects Committee will be held Wednesday, June 20, 2018, at 2:00 p.m. Eastern Time via teleconference. The public is invited to make oral comments or submit written statements for consideration. Due to limited conference lines, notification of intent to participate must be made with Matthew O'Sullivan. For more information please contact Matthew O'Sullivan at 1–888–912–1227 or (510) 907–5274, or write TAP Office, 1301 Clay Street, Oakland, CA 94612–5217 or contact us at the website: *http://www.improveirs.org.* The agenda will include various IRS issues.

The agenda will include a discussion on various special topics with IRS processes.

Dated: May 1, 2018.

Kevin Brown,

Acting Director, Taxpayer Advocacy Panel.

[FR Doc. 2018–09704 Filed 5–7–18; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Quarterly Publication of Individuals, Who Have Chosen To Expatriate, as Required by Section 6039G

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice.

SUMMARY: This notice is provided in accordance with IRC section 6039G of the Health Insurance Portability and Accountability Act (HIPPA) of 1996, as amended. This listing contains the name of each individual losing United States citizenship (within the meaning of section 877(a) or 877A) with respect to whom the Secretary received information during the quarter ending March 31, 2018. For purposes of this listing, long-term residents, as defined in section 877(e)(2), are treated as if they were citizens of the United States who lost citizenship.

Last name	First name	Middle name/initials
ABOULKHEIR	YEHIA	S.
ACKER	EDWARD	AMBROSE
ACKERMAN	CHARLES	JOUDREY
AHAMED	AZEEM	AZIZDIN
AHN	KIRI	
AKINER	ALP	AVNI
AKITOMI	KIMITAKA	
AL MUHAIRI	HAMDAN	MUBARAK
ALBANI	DAVIDE	ROBERTO
ALBERTS	MARGARET	THERESE
ALBURY	CHRISTOPHER	BRIAN
ALEXANDER	JOAN	PRUDENCE
ALFADLI	ILHAM	
ALFORD	WILLIAM	DAVID
ALLEGRETTI	JOHN	MICHAEL
ALLEMANN	FRANZISKA	RUTH
ALLEN	PAMELA	CLAIRE
ALMOALLIM	MOHAMED	MAZIN
AL-NOWAISER	ROWAIDH	ESSA ABDULLAH
AL-QURASHI	MUHAMMAD	HEMAID
ALSTON	JENNY	GWYN
ALTHAUS	STEFANIE	IRENE
AMBJORN	POLV	HENRI
AMIS	CATHERINE	LAURA

Last name	First name	Middle name/initials
ANDEREGG	CHRISTOPHER	FRANCIS
ANDERSEN	NIELS	ERIC
ANG	JOSHUA	JO-HUA
ANSELIN	JUSTINE	MARIE
ARES	SOPHIE	MARIE ROLLANDE
ARIEL	DAKEN	
ARINAMI	PETER	KOJI
ARIS	ANGELA	KATHRYN
ASCHBERGER	YELENA	
ASHORN	PER	ALLAN ILMARI
ASHURST	DAVID	ALLEN
ASHWORTH	DIANE	GAY
ATHER	MOHAMMED	AYYAN
AVRAMOFF	VIVIENNE	
BAER	YUVAL	RAHAMIN
BAILEY	CHASE	ELL
BAKER	RAYMOND	N.
BAKER	ROBERT	KYLE
BAKERMAN	LEE	EVAN
BAL	PARVESH	KAUR
BALDINI	VERA	VANNA
BALDWIN	BARROW	WINDLEY
BALDWIN	JULIA	ANNE
BALLU	SOLANGE	ANNE DONOHUE
BANAI	NIMROD	
BANTOURAKIS	YIANNA	LILIANE
BARANDUN	ROMINA	
BARTLE	GREGORY	KWAKU
BASCHUNG DANDLIKER	ANITA	CHRISTINE
BASSANINI	KRIZIA	VALERIE
BATA	CHARLOTTE	ISABELLE CLAIRE
BATA	THOMAS	ARCHER
BAUMANN	MARCEL	
BAXTER	JONATHON	MARK
BEAUCHEMIN	EDWARD	JOHN
BEAUMAN	MARY	ELIZABETH
BECKER-VON HAUSEGGER	SALLY	DAWSON
BEER	DANIEL	JAMES
BEHKI	RAMA	RANI
BEISSEL VON GYMNICH	JEANNETTE	GRAEFIN
BEIVERS	BENJAMIN	
BELCHER	TIMOTHY	JAMES
BELLISSIMO	RADKA	
BENAN	MATTI	ELHANAN
BENGTSSON	MAX	
BERENDZEN	KENNETH	WAYNE
BERRINGER	JAY	DAVID
BERTI	ADRIANA	
BEZEMER	HENK	
BIRCH	NIGEL	TARO
BIRD	DAVID	WALTER
BIRD	TANYAMAS	C.
BISHOP	DOROTHY	ANN
BLACK	DONALD	CAMERON
BODIN	MOREL	
BOL-GROOTENHUIS	ALEXANDRA	
BOLLIGER	LAURA	MARY
BONFORTE	SIOUX	
BOOIJ	JENNIFER	JIYOUNG
BORRELLI	MARY	ANNA
BOSS	DORIS	URSULA
BOURJAILY	DALE	ANN CATHERINE
BOYD	JAMES	ALEXANDER
BOYES	PATTIE	ALETHA
BOYLAN	CARRIE	LYNN
BRACH	ZACHARY	ALEXANDER
BRADLEY	BENJAMIN	DAVID JAMES
BRANDLEY	MELANIE	
BRAS	JESSICA	VIEIRA
BRENNAN-MCBRIDE	VANESSA	MARIE
BRENTA	ROBERTO	GIACOMO
BRERETON	SIMON	
BRIN	SHIRLEY	DIANA
BRINKERHOFF	CHARLES	RICHARD

Last name	First name	Middle name/initials
BRINTRUP	JON	ENRIQUE
BROCCO	NAAMAH	LEAH
BRODBECK	THOMAS	DANIEL
BRONNIMANN	AMANDA	GABRIELA
BROOKS	SHADRIN	MCKENNA
BROWN	DAVID	ANDREW
BROWN	DOUGLAS	JOHN AIRLIE
BROWN	KATHERINE	MARION
BRUECKNER	GABRIELE	
BRUMFIELD	STEVEN	JOSEF
BUCKNALL	KRISTEN	STEPHANIE
BULT	THOMAS	JOHN
BURNHAM	OLYMPIA	
BUSCHMANN	MARINUS	JOSEPH ELISABETH
CAINE	CHRISTIAAN	EDWARD
CAINE	TESSA	JANNEKE
CALSY	ADRIANNE	MARGARET
CAMPBELL	JANIS	PAULA
CAMPBELL	LOUISE	ADELLA
CAMPBELL	ROWYN	GRACE
CANNON	RANN	ROBERT
CAREY	ELOISE	ALICE VENETIA
CARILLE	TARA	NOELLE
CARLE	CHRISTOPHE	PHILIPPE
CARRINGTON	VANESSA	FAITH
CARROLL	MARSHALL	TODD
CARRUTHERS	SUSAN	L.
CATANZARITI	BETTY	CLAIRE
CAUDET-ROCA	LUCIA	INES
CAVIEZEL	SUSAN	URSULA
CHABERT	MICKAEL	
CHADWICK	TOMAS	IRARRAZAVAL
CHAN	BRENDON	JAMES
CHAN	BRIAN	JOHN
CHAN	JANET	SUE-AN
CHAN	LILY	
CHAN	TAK	FUN
CHANG	LOUISE	CHIA-LIN
CHANG	REI-YUN	
CHANG	TIFFANY	T.N.
CHANRAI	VEENA	
CHAO	ROYAL	
CHAPUISAT	PETER	GILLIAT
CHEN	AMY	
CHENEY	NANCY	KIYONO
CHENG	JONATHAN	TSUN HUNG
CHENG	YU	
CHESTERMAN	KATHLEEN	GRISWOLD
CHIN	ARTHUR	KA-MING
CHING	TUAN	YEOW
CHIPCHASE	JEFFREY	JOHN
CHOI	ESTHER	
CHOI	JASON	
CHOI	JASON	CHEI SUNG
CHOI	WAYNE	CHUNG
CHOWDHURY	SANJOY	
CHRISTIAN	GLENFORD	
CHRISTIAN	MARVA	ELIZABETH
CHRISTOPH	GISELA	
CHRISTOPH	SONJA	R.
CHU	VINCENT	KAM CHIU
CHUA	LUKE	
CHUNG	KAREN	JUI FEN
CITRON	BETTINA	
CLARK	DEBBIE	
CLEEMPUT	RAF	
COHEN	CHANA	ESTER
COHEN	HAVIVA	TZIONA
COHEN	MALKA	PEARL
COHEN	NACHSHON	TZVI
COHEN	YEHEZKEL	SHRAGA
CONNER	GORDON	FRANCIS
CONNER	JOSSELYN	ELLEN
CONTANT	SUSAN	METIA

Last name	First name	Middle name/initials
CONTI-RAMSDEN	FRANCES	INEZ
CONTRERAS	CARMEN	ADELA
COOPER	JENNIFER	ANNE
COOPER SUTTON	ZOE	Q.
CORRIVEAU	STEVEN	REJEAN
COTTICA	LORENZO	CARLO
COVEY	ELIZABETH	ANN
COWLING	SARAH	ALICE
COWLISHAW	MARK	CARY
CRACCO	ROLAND	FRANCOIS
CROAN	SUSAN	CLAYTON
CROTTY	JEFFREY	PATRICK
CUESTA	INES	MARIA CREEL
CUILLE	GILLES	EMILE JEAN-JACQUES
CUTTELOD	THERESE	CELINE
DALSNES	NILS	KRISTIAN
DALTON	ABIGAIL	MARY
DANIELS	DAYNA	BETH
DAUGHERTY	DUANE	WILLIAM
DAVIDOW	JOSHUA	MAX
DAVIES	MARTIN	CHRISTOPHER
DAVIS	MARC	STEVEN
DAVIS	MARY	ANN
DAVIS	STEVEN	
DAY	GEORGIA	ANN
DAY	SUSAN	LAURIE
DE CHENE	BRENT	EUGENE
DE GRAAF	JULIA	CORRINNE
DE GROOT	SEBASTIAN	MARK
DE JESUS	JAMES	GERARD OSMENA
DE JONG	NICOLE	ALICE
DE JONGHE D'ARDOYE	BEATRICE	
DE LEON	LISA	HARVEY
DE MAN	JAN-FELIX	MATTHIAS
DE MESMAY	PASCALINE	MARIE-EMILIE
DE MONTMARIN	THOMAS	MARIE HUBERT DE MARIN
DE MONTULE	CAROLINE	DU BOIS
DE ROOY	YOLANDA	JULIA
DEL BASSO	MANON	ELEN
DELACRETAZ	STEPHANIE	ELIZABETH
DELACRETAZ-JAUNICH	RACHEL	MARGUERITE
DELSHAD	AMIT	
DEMEL	MILAN	
DENIS	MAURICE	EDWIN
DENNING	DAVID	WEMYSS
DERADO	NADYA	ANITA
DESBAILLETS HAKIMI	ISABELLE	JANE
DEVENPORT	CHANTAL	
DEVORE	MICHELLE	MARINA
DI GIULIO	DEBORAH	HELEN
DIGBY	KATRINA	JACLYN
DILL	NANCY	ELIZABETH
DOBER	ALOIS	JOSEF
DOING	MAREN	KATHLEEN
DONATO	DOMINIQUE	MARIA
DONOHUE	CHANTAL	CLAIRE
DOUGLAS	AMANDA	KIRSTEN
DOUGLAS	KRISTIN	MICHELLE
DOWSETT	SUZANNE	NAOMI
DRAUT	DANIELA	KRISTIN
DRUMMOND	SHELLEY	DENISON
DU BOIS	DEIDRE	MICHELLE
DUGAL	ERIC	PAUL
DUNSER	MARKUS	KARL
DUSINBERRE	MARTIN	WILLIAM
DWYER	DEIRDRE	ANNE TREACY
DYCE	GORDON	RONALD
DYER	CANDACE	CLAIRE
DZIUBA JR	PETER	
EADES	JONATHON	NOEL
EASLEY	ARNOLD	THOMAS
EBNER	BRIGITTE	CLAIRE J.
EDELMAN	GARY	MARK
EDERER	JOERG	PETER

Last name	First name	Middle name/initials
EDLER-GUETTAF	YVONNE	
EDMONDS	DAVID	SHEPHERD
EDRICH	JOCHEN	
EHRISMANN	SEBASTIAN	GREGOR
EL GAMAL	RASHA	ASHRAF
ELLENSON	BARBARA	ELIZABETH
ELLIFF	EDWARD	WILLIAM
ELSASSER	MARCENE	ANN
EMPSON	TANYA	LYNN
ENGLE	LILLI	ANNA
ENGUIX	CARMEN	
EPPLE	PETER	KONRAD
ERBA	DANIELE	
ERBAR	MARCUS	
ERICKSON	VICKI	CARPENTER
ERNST	TALITHA	ANNE
ETCHEBERRY	NICOLAS	SOLARI
ETHIER	RONALD	GILBERT
EVANS	MARK	DOUGLAS
EVENHOUSE	KRISTER	HENRY
FABRIS	DENIS	MIRKO
FABRO	THEODORE	JOSEPH
FAID	REMINGTON	ROBERT
FAKHOURY	LAITH	GHANDI
FALK	BARBARA	ANN
FANTOZZI	ROBERTO	FRANCESCO ANGELO
FATH	MICHEL	WOZIWODZKI
FAULKNER	JENNIFER	JANE
FAWE	JEAN	SIMON ARTHUR JULIEN
FEDAK	MICHAEL	JON
FEINERMAN	SARAH	NORMANDY
FEIST	SEBASTIAN	MICHAEL
FELLING	CHRISTOPHER	JAMES STEWART
FENG	ISAAC	JONATHON
FERNANDEZ-LIEBANA	RAPHAEL	OLIVIER
FERRI	ARNOLD	ALPHONSE
FERRIS	LINDA	RUTH
FICHTNER	BENJAMIN	ANDREAS
FINN	ALICE	LOUISE
FIRESTONE	MICHAL	
FIRLEY	NICOLE	
FISS	ERIC	ALAN
FITZGERALD	MICHELLE	ANN
FITZGERALD	RICHARD	
FLECK	BARBARA	
FLEMING	JOHN	DOUGLAS
FLYNN	PENNY	JEAN
FOKKER	EMILIE	AVELINE
FONG	MAY	WAH
FORTIN	DIANE	MARIE
FORZANI	MICHAEL	JOHN
FOURACRES	PRISCILLA	JEAN
FREEDHOFF	STEPHEN	HART
FREEDMAN	MATTHEW	LEO
FREEMAN	CLICIA	MARIE LUTTI
FRINTS	MARK	WILLEM
FROST	IAN	R.
FROST	JANICE	S.
FRYE	INGE	WILHELMINE
FUNG	MICHELLE	A.
FURNARI	STEVEN	MICHAEL
FURUKAWA	MASARU	
FURUKAWA	YUKIKO	
FUTTERMAN	ELAINE	JUDY
FUYAMA	EDYTHE	CHIE
GAASTRA-BEAUCHEMIN	GWEN	HENRIETTE
GABLER	MELISSA	JANE
GAIER	MARTIN	
GAILY	BRUCE	DONALD
GALARDI	MICHAEL	JAMES
GAMMETER	CHRISTOPH	PETER
GARTNER	HERMAN	
GAVIOLI	MATTEO	
GENE	ANJANETTE	DENISE

Last name	First name	Middle name/initials
GERBAUD	AUGUSTO	
GERBER	SOFIA	MARINA
GHANAYEM	WAEL	ADNAN
GIBSON	ALISON	
GIBSON	SHIRLEY	JEAN
GIERAERTS	CHRISTOPHER	LUCIEN JOSEPH
GIESBRECHT	CONNIE	GAIL
GILBERT	PETER	JAY
GILIBERTO	MARISA	LYNN
GILLES	BRIEUC	GABRIEL TRISTAN
GIN	ROSEMARY	
GJERSTAD	KEVIN	BLAINE
GLIDAI	SYRIL	CINDY
GLOVER	MARY	CATHERINE
GODFREY	THELMA	JOYCE
GOGNIAT	CHANTAL	JANE
GOH	DONNA	MAE
GOLDMUND	MELANIE	JANE
GOODENDAY	MATTHEW	ROGER DAVID
GORMAN	BRIAN	DAVID
GORMAN	CHRISTOPHER	LEE
GOSSIAUX	PAUL	
GRABARKEWITZ-STEIN	MERRIDEE	KAY
GREEN	CHARLES	S.
GREEN	SUMMER	
GREGOIRE	LISA	JANE
GRUDZIEN	KAREN	FELICIA
GULLESTRUP	PETER	
GUMMER	MEGAN	STEPHANIE
GUTERMANN	NATALIA	ELISABETH ANJA
GYGAX-HERSCHKOWITZ	JESSICA	CLAIRE
HAAB	LEONIE	CLAUDINE
HAAN	BARBARA	LOUISE
HAARMANS	ERIC	HENDRIK BERNARD
HABER	ARIEL	
HAIM	DAVID	MARC PEHA
HALDER	SARAH	LEANNE
HALDOUPIS	ANDREAS	JOHN
HALDOUPIS	JONAS	
HALDOUPIS	NIKOLAS	
HALL	DAVID	RICHARD
HALL	HAMILTON	
HALPRIN	NURIT	MAXINE
HAMBUSCH	GERHARD	
HAMILTON	KATHERINE	SANDS FRASER
HAMILTON	WENDY	ELIZABETH
HAN	RACHELLE	HOJUNG
HANNUM	NANCY	OSGOOD
HANSEN	MARK	SILVIN
HARMON	BEN	
HARPER	DOROTHY	EDNA
HARPER	PENNI	JO ANN
HARRINGTON	RACHEL	ANN
HARRIS	PAULA	
HART-BANKS	LOUIS	CHRISTIAN
HARVEY	JOSHUA	MENACHEM
HARVEY	ZACHARY	DOV BER
HASHEM	LINA	ESAM
HASLETT	SCOTT	MITCHELL
HAUPT	MICHAEL	JIMMIE
HAYES	EDWARD	NEAL
HEATON	DON	MICHAEL
HEATON	JENNIFER	MARY
HEDBYS	ANNA	KRISTINA
HEIMDAHL	KENDALL	HEATHER
HELLERSMITH	ROBERT	HENDRIK
HELLSTROM	FRIDA	
HENDERSON	ANDREW	JAMES
HENDRICK	SHONA	TRUDY
HENDRY	JOHN	
HERRING	ANTHONY	MICHAEL
HESS	CHARLES	JEFFERSON
HESTENES	BRITT	MARIE
HILLIS	WENDY	ELLEN

Last name	First name	Middle name/initials
HILLS	BARRETT	DAVIS
HINNEBERG	HARI	HANS
HO	JEFFREY	CHUN WAI
HOERLER	IVAN	ALOIS
HOEVENAARS	ADRIANUS	MARIA GERARDUS M.F.
HOFFMAN	STEVEN	JUSTIN
HOGAN	JEREMY	CHARLES KINGSMILL
HOLENDER	MARNIE	ELLYSE
HOLLSTEIN	MONICA	CARRINGTON
HOLMEN	MARY	JESSICA
HOLMSTROM	NIKLAS	ERIC
HOLZWARTH	JAMES	ANTHONY
HOOKS	MARTIN	ROBERT
HOOPER	SHERRY	MARIE
HORIE	KENJI	
HORWITZ	MICHAEL	
HOSHIZAKI	LISA	MARIE
HOSPER	PEGGY	ERNESTINE
HOUMPHAN	ANDREW	BENJAMIN
HOUMPHAN	PHILENE	
HSIAO	OLIVIA	CHING-CHU
HSU	ERIC	
HUBER	HANS	JUERG DIETRICH
HUBERMAN	JEFFREY	NORMAN
HUGHES	JULIE	ANN
HULICK	MARY	ANN MICHELLE
HYLTON	TRACY	ANN
IGARASHI	KAORI	
ILLI	LINDSAY	ELAINE
ILLI	NICOLA	LOUISE
IRWIN	BENJAMIN	GEORGE
ISSA	GABRIEL	NAOUM
ISSA	NASSER	GEORGES
IVANICK	RAND	ANTUN
IVKOVIC	HEIDI	LISA
IZZO	LUIGI	
JABANOSKI	JEAN	ALICE
JACOBS	GIDEON	
JACOBSON	GREG	
JAEGER	THERESIA	MONIKA
JAFFER	YASMIN	ADIL
JAMES	KEITH	EDWARD
JAMMER	JOSEPH	HERMAN
JANDRISITS	ROSANNE	
JENNINGS	LAWRENCE	CHARLES
JEON	RUELLA	
JETTER	SUSANNE	THERESE
JEWETT	CAROLYN	ANN
JOHANNESSEN	JOAN	BOOTH
JOHNSON	DANIEL	PAUL
JOHNSON	TAMARA	KATHLEEN
JOHNSTON	RAPHAEL	
JONES	JEAN	CONARD
JONES	JILL	VICTORIA
JONES	JULIE	JOANNE MANSER
JONES	KEIANA	OMEICA
JOOS	CHRISTOPHER	MICHEL
JUN	ALEX	SEIMIN
JUN	JIN	
JUON	ERIN	
KAHANA	DORON	
KAISERSHOT	HEIDI	BETTINA
KALLEN	PAUL	WILLEM
KAMBHAM	PRASADA	REDDY
KAMP	ANTON	JAN
KANE	EDWARD	ELIEZER
KANE	JAMES	ARTHUR
KANEKO	MARI	
KANEKO	SETSUKO	
KANG	CHI	HYONG
KATZ	AARON	
KATZ	ESTHER	
KATZMAN	JOYCE	KAREN
KEELER	DOUGLAS	MARK

Last name	First name	Middle name/initials
KEIGHLEY	MATTHEW	JOHN
KEIJZERS	MAARTEN	BRYAN
KELLY	DAVID	ARTHUR
KELLY	SHEELAGH	ANNE
KEMPNER	THERESE	BENEDICTE
KERR	GRAEME	ROBERT
KEYZOR	ALISON	JANE
KHANNA	ANISSA	ADVANI
KHOURY	KHALIL	NABIH
KIFT	NATHAN	P.
KIGHT	PAUL	RICHARD
KILBOURN	BARBARA	CROOKS
KILBOURN	BRENT	SCOTT
KIM	ANDREW	HWAN
KIM	GA-YEON	
KIM	KAY	
KIM	MINGEE	CHRISTINE
KING	BRYAN	DALY
KIRK	SONDRA	POWERS
KIRK	TYLER	VAUGHAN
KIRSCHBAUM	ANNE	B.
KIRSCHNER	ELENA	TERESA
KISSOON	JANICE	GWEN
KISTLER	JOSHUA	JEREMY
KLEIMAN	SIMCHA	JOSEPH
KLIEMS	UTE	BEATE
KNAPSTEIN	URSULA	ANN BRIGITTE
KO	JOHN	SHIH KWONG
KO	SOEN	CHYI
KOBAYASHI	YU	
KOELEWYN	PEARL	ZALTZMAN
KOGITZ	STEPHAN	
KOK	HAICO	VICTOR
KOMOROWSKI	COLEEN	KATHRYN DORIS
KOONMEN	JOHN	MICHAEL
KOUTOULAKIS MERCHADOU	KALLIOPI	
KOYKKA	MIKKO	JUHO MATIAS
KRAMER	JOANNE	LOUISE
KRAMER	JULIE	CHRISTINE
KREINER	ANDREAS	FRIEDRICH
KREMPL	RALPH	DIETER
KRIDLE	TEKLA	JOAN
KRIDLE	WILLIAM	LEO
KROIS	GEORGE	WILLIAM
KRUPS	JULIA	
KUEPPERS	KIRSTEN	
KUIKEN	DONALD	LEE
KUIPERS	STEPHEN	JOHN
KUMMROW	MICHELE	ANNE
KUMPIS	RICHARD	JAMES
KUO	SHARON	
KURMANN	ALEXA	LAUREN
KUTRZEBA	MARCUS	F.
KWAN	MELISSA	RACHEL KA-LING
KWAN	PHOEBE	ONGMAN
LA BELLA	JENNIFER	MCDOWELL
LAFON	BRENDA	
LAI	FRANCES	CHI WING
LAM	CLARENCE	CHAD
LAMMOGLIA	JULIEN	JEAN
LAMONTAGNE	MARC	DENIS
LANCLUME	NATHALIE	FRANCOISE
LANDAU	RIKKI	ERIN
LANDTWING	VANESSA	SONJA
LARBES	MAX	ALI
LARSEN	WILLIAM	ANDRE
LARSON	REBECCA	SUSANNE
LARSON	STEPHEN	MARK
LAU	SAMSON	SIN SAM
LAURIE	SHERRY	LEE
LAVIN	HELEN	MARIE
LAWSON	ROBERT	DIRK
LAWTON	AIMEE	ROZE
LAX	GLORIA	M.

Last name	First name	Middle name/initials
LAZARO-JOUBERT	MICHELLE	MARIE A.
LEE	JASON	TYLER
LEE	JENNIFER	ANN
LEE	KELLY	
LEE	KERN	TZEN
LEE	RAYMOND	
LEEK	JONATHON	NIGEL
LEGER	TIFFANY	THAISA
LESLAU	JONAH	ETHAN
LESTER	MARGARET	HELEN
LEU	KATJA	MARIA
LEVY	ROBERT	ALEXANDER
LI	FAYE	TSUI
LI	JONATHAN	HO MING
LI	XIAODAN	
LIANG	NICOLE	JEANNIE
LIAO	FLORA	VALERIE
LICARI	GABRIELLA	SABRINA
LIEW	FONG	TING
LILJEDAHL	ULLA	MONIKA
LIM	CAROL	MARIE
LIM	MING-EN	JOSHUA
LIN	CHIN	CHUCH
LIN	JEFFREY	
LIN	LAWRENCE	
LIN	ROBERT	
LINDHOLM-VENTOLA	JONNA	KATARIINA
LIU	WILLIAM	
LIU	YUCHANG	
LIUKSIALA	HENRI	KRISTIAN
LOEFS MOS	JOHANNA	GEERTRUIDA HENDRIKA
LOGAN	LISA	MICHELLE
LOH	SAMMY	KHIN YEE
LOIRE	BERNADETTE	MICHELLE
LONG	GINA	MARIA
LOPERT	MICHELLE	DIANE
LORAN	CAROL-LEAH	CECELIA
LORCH	AMNON	
LOWELL	ALEXANDER	
LUANGAROONLERD	WEERACHAI	
LUNDSTROM	DENISE	JO
LYNCH	CATHAL	
LYNCH	MARY	MARTHA
LYON	KEITH	ANDERSON
MACGREGOR WILLIAMSON	ALEXANDER	JAMES
MACKENZIE	JOANNA	ELIZABETH
MACKENZIE-THOMPSON	ANNE	MARIE
MACKEY	JESSICA	ELLEN
MADON	SAVAK	
MAERCKER	MATTHIAS	
MAGEE	JAMES	BRUCE
MAGUIRE	AIVEEN	MARY TREACY
MAHONEY	KEVIN	GENE
MALVANKAR	SANJAY	
MANELIA	LOUISE	ANN
MANGUM	DEAN	SCOTT
MANNING	HARVEY	PAUL
MARANTZ	VALERIE	
MARGOLIS	REBECCA	SUE HELLER
MARK	GRAHAM	DAVID
MARKOSKY	WENDY	LYNN
MAROZEAU	JEREMY	PAUL
MARTIN	ARABELLA	PRESCOTT
MARTIN	CHARLES	WILLIAM
MARTIN	MARGARET	MACLEAN
MARTINEZ	DESIREE	B.
MARTINS	KYENTA	MEAGEN
MASTAI	ANDREAS	MICHAEL
MATHYS	FLORIAN	EMANUEL
MAUSBERG	STEVEN	JASON
MAUTNER MARKHOF	ANNA	MARIE
MAY	CATHERINE	ANNE
MAYR	MARIE	LOUISE
MC CALL	DEBORAH	SUSANNE

Last name	First name	Middle name/initials
MC CLARAN	JACQUELINE	COX
MC CORMACK	KIERAN	GERARD
MC DERMOTT	SEBASTIAN	CHARLES AUGUSTE
MC LANDRESS	CHARLES	WALLACE
MC LEAN	DEBRA	LUCILE
MC NAMARA	MIALL	PATRICK
MC SORLEY	PATRICK	LYNE
MCDOUGALL	TRACIE	DIANE
MCGUINNESS	AUDREY	JANE
MCGUIRE VISSER	CHRISTENE	
MCNEICE	LAURA	JANINE
MCNEICE	SHANNON	MARIE
MCRAE	THALIA	MURRAY
MEANS	GARY	LEE
MEHROTRA	SATYAVRAT	
MEIJBOOM	BARTJE	INGRID
MELLIARD-MOREL	ELIZABETH	FERNANDE
MELVILLE	GAILE	ANNE
METZGER	BENYAMIN	YEDIDIA
MEUWESE	MARK	THEO
MEYER	ILAN	SAUL
MICHAUD	ISABELLE	
MICHAUD	NATHALIE	
MILLER	AVRUM	JONATHON
MILLS	NATALIE	MARIE-JOANNA
MILLS	SUSAN	PATRICIA
MINDEN	ANDREA	LYN
MINDEN	DEWI	KATHRYN SUZANNE
MISSELBROOK	LINDA	BLOCK
MITCHELL	RORY	LYLE CAMPBELL
MITSUI	MASAE	
MIZOKAMI	TSUBASA	DAVID
MO	FREDERICK	YIU-SING
MOCHIDA	MASAYUKI	
MOCHIZUKI	KATSURA	
MOCHKIN	PERETZ	SHLOMO
MOK	ADRIANA	YUEN YING
MOLSTER	FIEKE	HELLEEN
MOLYNEUX KNISPEL	ANNE	BETH
MONTGOMERY	MARGARET	ELIZABETH
MOORE	ELIZABETH	JANE
MOORE	MADYSON	ERICA
MOREAU	KYLE	ARTHUR
MORIKAWA	TOMOKO	
MORRIS	THOMAS	RICHARD
MORRISON	GILLIAN	KER
MORRISON	REBECCA	SUSAN
MORRISON	RICHARD	JAY
MOSER	MICHELLE	SARA BAGGI
MOSS	MITCHELL	LYLE
MOTAKIS	IAKOVOS	
MOTTAHED	BAYAN	
MUENGER	CAROL	BARBARA AMERKI
MUHR	OLIVER	
MUKATY	ZAIN	ASHRAF
MULARONI	CONRAD	P.
MULARONI	MARGARET	
MUMENTHALER	FRANZISKA	JENNIFER
MUNCH-HANSEN	LISE	
MURPHY	MARGARET	REGINA
MUSSON	DONALD	ROBERTSON
MYER	LESLIE	DARLENE
MYHRE	SALLY	LAVONNE
NAEGELI	PAMELA	
NAGAYASU	EIJI	
NAGL	KRISTOF	ODO
NAKAJIMA	ALBERT	AKIRA
NAKAMURA	YUKI	
NAROD	SAUL	BRIAN BARRY
NARUSE	JUNKO	
NARUSE	YASUO	
NASH	CATHY	ANN
NAUMANN	DAVID	NATHANIEL
NEARY	SARAH	ELIZABETH VON FELBAU

Last name	First name	Middle name/initials
NEFSKY	BARI	NICOLE BUDD
NESTIBO	BRENDA	SUE
NEUHAUS	RALPH	
NG	ROSE	KAI CHING
NIELSEN	CHARLES	EMIL FINN
NIEUWENHUIS	MAARTJE	JOANNA
NIGGEBRUEGGE	JENS	
NILAND	ADAM	CHARLES
NILERT	HENRY	TORE
NIMJI	ZARINE	
NIZAMI	FARIDA	YASMIN
NORDBERG	REBECCA	CECILIA
NORRIS-NICHOLAS	DAVID	GRAHAM
NOTERDAEME	OLIVIER	A.P.J.J.
OBERMEIER	KIMBERLY	ANNE BEARD
O'BRIEN	CAREY	MARIE
O'CONNOR	JOSEPH	ANTHONY
OECHSLIN	NOEMIE	TARA
OEFELI	ROBERT	MARKUS
OEHRI	EVELYNE	SARAH
OFFENBACKER	STEPHEN	PHILLIP
OFIR	LEORA	
OGAWA	YUJI	
OGRADY	JILLIAN	MORGAN
OKI	MICHIE	
OKI	TSUYOSHI	
OKUBO	SATOSHI	
OLSON	CAROL	LOUISE
OLSON	JOSHUA	PAUL
O'NEILL	SIOBHAN	AGNES TREACY
ONO	RANKO	FLORA
OPPEN	EVAN	FREDERICK
ORPAZ	LEIGH	
OTA	TSUYOSHI	THOMAS
OVAERT	LAURENT	
OVASKA	SAMI-SEPPO	CHRISTOPHER
OWEN	TRISTAN	LLEWELLYN
OWENS	ERIC	OLINDER LYTLE
OXLAND	EMILY	CHRISTINE
PAAUWE	FREDERIK	CAREL
PACKER	FREDRICK	JOHN
PALMER	MEGAN	ELIZABETH
PALMETTO	ERIK	THOMAS
PANG	SIOK	CHOO NICHOLETTE
PARKES	JORDAN	RICHARD
PASCAL	MARIA	MAGDALENA
PAULSEN	KRISTINE	FREDINE
PEIRCE	JULIA	NORTON
PENTAREDDY	SANDHYA	RANI
PERETTI	PABLO	MIGUEL
PERRY	MICHELE	ANDREE
PETER	VIRGINIE	GISELE
PETERSON	AUBREY	LYNN
PETERSON	DONALD	JAY
PETERSON	NANCY	ANN
PETERSON	PAUL	ARTHUR
PETITPAS	CATHY-ANN	EVELYN
PETTY	RUTH	TIFFANY
PFENNINGER	JACQUELINE	DORA
PIAGET	CLAUDINE	COLETTE
PIEPLOW	MONICA	
PIERARD	AGNES	MARIE
PIETSCH	ERICA	ABBEY
PINCUS	DANIEL	JAMES
PITKANEN	TUULIKKI	TELLERVO
PLAATSMAN	PAUL	JACOB
PLANCHADELL MARTI	LAURA	
PLESS	PATRICIA	REGINA
PLOTKIN	JULIE	SARAH
PLOTKIN	RACHEL	JILL
POLLAK	KAREN	JOY
PONSTEIN	ELISE	
POO	MUMING	
POPOVE	MYRNA	ILENE

Last name	First name	Middle name/initials
PORTER	MELISSA	JANE
POSSEK	VERONIKA	YURIEVNA
POUPARD	CLARISSE	ALINE MARIE
POWERS	RICHARD	LEE
PREIS	JEANETTE	
PUCHIR	LINDA	ELAINE
PUNIA	KULJIY	SINGH
PUNTENEY	RONALD	DEAN
PUNTENEY	SOPHIA	RACHEL
QUAIL	JACQUELINE	MARY
QUANGTAKOUNE	ANNIE	
QUICK	JEREMY	ANDRE
QUINTER	REMY	ANDREW
QUINTILIO	LAURA	EILEEN
RABINOWICZ	MICHAEL	SETH
RAETZKE	CHRISTIAN	PETER
RAMANATHAN	S.	
RANCOURT	HILARY	MEREDITH SCHWEISSING
RATNER	JOSHUA	NATHANIEL
RAY	COLIN	SHAWN
READ	JUDITH	ANN
REED	DEMIAN	
REHNER	ALAN	LOWELL
RENOLD	MARC-ANDRE	JEAN
RETEZATU	ILIE	
REVEL	SAMUEL	TSEVI
REVILLON	OLIVIER	PAUL
REY-CUILLE	MARIE-ANNE	
RIDDELL	REBECCA	MARIA
RIEDER	MARTIN	BRUNO
RINEHART	APRIL	CHER
ROBBINS	SENIA	LIAN-LU
ROBERTS	JAMES	HAWKINS
ROBERTSON	DALE	
ROBERTSON	DIANE	MARRI
ROBINSON	BOYD	C.
ROETERINK	CASPER	ALLARD
ROMBAUT	BENOIT	PIERRE
ROSANOVE	HELENE	ANDREA
ROSELAND	MARK	LESTER
ROSENFELD	ADAM	LEE
ROSMAN	ETIENNE	FRANCOIS
ROSS	HEATHER	CHRISTINE
ROSSIGNOL	VICTOIRE	MARIE
ROTHKOFF	ZEV	MOSHE
ROUNIS	ANNA	LOUISE
ROWE	BRONWEN	MARGARET
ROY	FRANCE	LINDA
ROY	NOEL	MICHEL
ROZEBOOM	CYNTHIA	LOUISE
RUEBSAMEN	MATTHIAS	HEINZ
RUEGG	KASPAR	RICHARD
RUETSCHI	MATHILDE	JOSEPHINE
RUETSCHI	YANN	JOE
RUFFO	EDOARDO	GUGLIELMO
RUSHWORTH	LINDA	MAE
RUSZ	ALAN	
RYAN	KATHLEEN	NESHKA
RYAN	MARY	ANNE
RYAN	SHINOBU	
SAARINEN	MARIA	KAROLIINA
SAARNI	RUNA	CHRISTINA
SABOROWSKI	ANGELA	MARIE
SACHS	MAXIMILIAN	STEFFEN HANS
SAHLSTEDT	JORMA	
SAHLSTEDT	LEILA	
SAINATHAN	PREMSAI	
SAITO	YUSUKE	
SAKAI	RYOSUKE	EDWARD
SALDEN	GEORGE	STEFFEN
SALMANOWITZ	RICHARD	SAMUEL
SALSKY	MARNIE	ELLEN
SALVESEN	EMILIE	MARIA
SALZBERG	CHRISTOPHER	PIETER

Last name	First name	Middle name/initials
SANDBERG	FREDRIK	
SANDMAN	HANOCH	ELIEZER
SANT	CLAIRE	ELEANOR
SANTI	KATHY	DEBBY
SARKARIA	GAGANDEEP	SINGH
SARR	PATRICIA	ACKERMAN
SASAHIRA	TOSHIHIKO	
SATO	ATSUSHI	
SATO	YOSUKE	
SAWADA	HISAE	
SCHACHTER	GABRIEL	ANGEL MISHA
SCHAER	JULIE	CHARLOTTE
SCHAFFNER	CHRISTINA	EVA
SCHELLER	PETER	CHRISTIAN
SCHELLER	PHILIP	ALAN
SCHERF	MICHELE	C.
SCHMID	MARTIN	CHRISTIAN
SCHMIDT	NINA	LOUISE
SCHNEEWEISS	WOLFRAM	KARL SIEGFRIED
SCHNEIDER	MARK	ANDREAS
SCHOBERG	MERRY	CAROL HERRICK
SCHOEBEL	GUILLAUME	PAUL-MARIE
SCHOERNER	WOLFGANG	HENRY
SEAY	JILL	PRINCE
SEAY JR	WILLIAM	MICHAEL
SEBENS	SABRINA	HEIDE
SERRA	TANIA	EUNICE
SGUAZZINI	MARINA	MARGHERITA
SHAH	AMI	SUKETU
SHARMA	ROBYN	SHEELA
SHEA	DIANE	ELIZABETH
SHEARING	PHILIP	A.
SHEARING	RACHEL	G.
SHEARING	RUBY	G.
SHELY	GIL	
SHERWOOD	JOHN	EVAN
SHIBAHARA	BARBARA	
SHIELDS	HENRIETTA	OLIVIA
SHIFF	ALLAN	ALEXANDER
SHIINO	EMI	LISA
SHIMIZU	HARUKI	
SHINOHARA	MINORU	
SIDDALL	CAROLINE	EMILIE
SILVERMAN	NOAH	ERIC
SIMAN-TOV	YORAM	
SIMARD	REBECCA	ANN
SIMMONDS	IAN	PAUL
SIMPSON	ANNE	TURNER
SINK	JOHN	ALLEN
SKIDMORE	LOUISE	MARGARET
SKIFFINGTON	JANICE	CATHERINE
SMART	DARLENE	JOY
SMITH	BEVERLY	NAN
SMITH	HANNAH	JOSEPHINE
SMITH	NICOLE	KATHLEEN
SMITH	SUSAN	ELIZABETH
SNIPES-HOYT	CAROLYN	MARIE
SODERLING	MICHAEL	TOIVO JOHAN
SOELBERG	CARL	FREDERIK
SOH	ROMAINE	RUI-MIN
SONG	WILLIAM	TZYY-WEI
SONG	XIAOBING	
SONIDO	F.	JOSEPH
SONNEVILLE	FRANCOIS	PIERRE
SONO	JANET	JENSEN
SOO	DONALD	YEAW TECK
SOO	RONNY	ARTHUR
SOUTHWELL	DIANA	MARY
SPAULDING	GABRIELE	
SPENCE	ALEXANDER	J.
SPENCE	DIANE	GEORGE
SPENCE	JOHN	BRIAN
SPENCER	ERIK	WILLIAM
SPITZNAGEL	TINA	CLARA

Last name	First name	Middle name/initials
ST DENIS	DIANE	LENETTA
ST ONGE	SUSAN	MARIE
STAUFFER	JUERG	MICHAEL
STEIN	ERIC	SAMUEL GEORGE
STEINER	BETTINA	GOY
STEUERWALD	STEFAN	MANFRED
STEWART	CAMMY	JEAN
STEWART	SHANE	ARTHUR
STONE	BRIAN	GORDON
STREET	MARGERY	MORE
STROOSNYDER	PAULINA	MARIA
STUDER	ANDREA	LEE
STUTLER	IZUMI	ALISSA
STUTLER	JOSIAH	THOMAS
SUEHIRO	KANJI	
SUMMERMATTER	JEAN	MARY
SUMOMOGI	NORIKO	
SUMOMOGI	NORIO	
SUNDARARAJU	SINDUJA	
SUNG	ERIC	
SUTTER	BRANDON	CHASE
SYNCHYSHYN	RACHEL	ELIZABETH
SZUBERWOOD	BRIAN	CHRISTOPHER
TABBARA	MARYA	
TABBARA	RAMSEY	
TAHIR	AASIYA	
TAKAHASHI	MOTOKI	
TAN	LYNETTE	CHIU KUAN
TAN	ZHENGPING	
TANG	GENIE	KA-LING
TANG	JASON	CHIA-HUNG
TANG	PAUL	MINGZHENG
TANI	MASAYUKI	RICHARD
TANISHIMA	MITSURU	
TANISHIMA	YUKO	
TANZER PETERS	BARBARA	FREDERIEKE
TAO	BEN	NIEN
TAUB	RACHEL	
TENG	JACK	
TEUTBERG	TILMAN	FRIEDRICH KARL
THALER	LEN	DAVID VALENTIN
THALIN	MARSHA	BETH
THALMANN	GUYSLAINE	AIMEE
THEE	AARON	ZVI
THOMAN	MARINA	ANGELA
THOMPSON	MEREDITH	JANE
THRASHER	ALAN	ROBERT
THURNER	CARSTEN	JOACHIM
TOBLER	PETER	RUDOLF
TOLLENAAR	ELTJE	FREDERIKA
TOM	ALLISON	READ
TONG	THOMAS	
TOPFER	EVELYNE	
TORABI	SOHRAB	
TOWSLEY	KAREN	GODFREY
TOYODA	MITSUHIRO	
TROTTER	KAREN	KWEI-AI
TROTTIER	THOMAS	EUGENE
TRUTMANN	OLIVER	ALBET TIARE-URA
TSATURYAN	SEVAK	
TSERETOPOULOS	DENISIA	KATHERINE
TSURUGA	KANAE	
TUCHSCHMID	GILLES	GRAVES
TURANEC	ESTHER	FURRER
TURANEC	IVAN	
TURCOTTE	MIREILLE	
TURKI	SULTAN	MOHAMED
UDLAND	NORMAN	
UJAIMI	HATTAN	KHALED
UMARI	ABDUL-WAHAB	
UTSUGISAWA	MAY	
VAGGE	SYLVIA	DARIA SCHIELE
VALENCA	CAROLINA	FALCAO
VAN DE GRIENDT	MONIQUE	PATRICIA

Last name	First name	Middle name/initials
VAN DER BENT	ELISABETH	ANNE
VAN DER VEEN	JORRIT	FRISCO
VAN DER VEEN	PETRONELLA	ADRIANA
VAN DER VORST	DIEDERIK	LOUIS
VAN EE	NIKKI	
VAN GENT	PETER	GEORGE
VAN HOF	RALPH	EDWARD
VAN KOOTEN-VAN DER MEULEN	IRENE	HELEN
VAN RIEMSDIJK	FRANCOISE	MICHELINE
VAN WERT	ROBERT	SELKIRK
VANCE	DENNIS	EDWARD
VANDELOO	JULIE	
VEIT, JR	WILBERT	GEORGE
VER	ROGER	KEITH
VER	ROGER	KEITH
VERMEER	DERK	JAN BRIAN
VIDA	ARIEL	
VIKTORSSON	GREGORY	SCOTT
VILJANEN	MARKUS	JUHANI
VILLEGAS	JOSE	A.
VINCENT	JOANNE	MARIE
VIRSUNEN	GERALDINE	LOVE
VISSER BLOMBERG	RITA	HENDRINA
VON GYMNICH	MAX-DOMINIC	GRAF BEISSEL
VON LERCHENFELD	ALICE	ISABEL FREIFRAU
VON MALAPERT-NEUFVILLE	STEPHEN	JOHANNES FREIHERR
VOOGT	DARSHAM	EVA
VRANA	MICHEL	PETER
VRIESMAN	ADRIAN	CORNELIUS VAN BREDA
WAHL	STANLEY	CLAUDE
WAKS	KATHARINE	LAUREN
WALDRAM	SALLY	CANDISS
WALLER	PAUL	MICHAEL
WALLMAN	STEPHEN	JAY
WALSH	CLAIRE	ANNE
WALTER	PHILIP	GEORGE
WALTI	CHARLOTTE	SOPHIA
WARREN	JONATHON	PHILLIP
WASHIO	TAKASHI	ROBERT
WATTERS	GREGOR	ANTON RANDALL HARTL
WAYGOOD	KAZUMI	
WEBER	BRUCE	HOWARD
WEEDON	CAROLINE	J.
WEENINK	LOUISE	MARTINA
WEI	HANG	
WEIL	PETER	ALAN
WEISEL	CHARLENE	ANN
WEISSMAN	IRA	BROOKOFF.
WENTZ	JED	ALAN
WESTERMARK	ULF	ROLAND
WHEELER-CARLSSON	TRACY	KRISTINE
WHELAN	TERRENCE	JOSEPH
WHITE	STEPHANIE	FRANCES
WHITMORE	CHRISTOPHER	CLAY
WIEBE	PATRICIA	ANN
WILLEMS	ANNAMARIE	
WILLIS	SAMUEL	WILLIAM WYTHES
WILSON	RICHARD	LESLIE
WINE	DEVAH	IRENE
WINEHOUSE	JANIS	HOLLY
WINKLER	JENS	STEFFEN
WINTELER	MICHAEL	CURT
WINTELER	SANDRA	
WITZEL	THOMAS	JOSEF
WONG	CHRISTINA	MARIA MEI LIN
WONG	DANIEL	CHIU
WONG	ERICK	
WONG	JASON	CHI SING
WONG	RACHEL	JING YI
WONG	SONGKAI	GIDEON
WOO	REBECCA	HENG YUN
WOOD	EUAN	D.
WOOD	JEAN	MARIE
WOODWARD	DUSTIN	

Last name	First name	Middle name/initials
WOOLDRIDGE	REBECCA	MARY
WRAY	KENNETH	
WU	KRISTY	AIHSUAN
WU	YAN	
WYNER	HAL	OWEN
YAMAGUCHI	MASAHIKO	JUN
YAMANAKA	SHUNICHI	BRYAN
YAN	DAPENG	
YANG	ERICA	CHUEH-YU
YANG	SHUN	MEI
YANIR	TOMER	
YAP	JONATHAN	MARC
YASUNO	ATSUKO	
YASUNO	SHIRO	
YEKIMENKOV	SERGEY	ALEKSANDROVICH
YEKIMENKOVA	IRINA	ALEKSANDROVNA
YEN	STEPHEN	PO-HSUAN
YEO	KRISTIN	ALANNA KOERNER
YEUNG	CHUN	MAN DAVID
YI	RUSSELL	
YIN	ELAINE	
YIN	HAIQING	
YIP	MICHELLE	SHI YUN
YLAGAN	CARLO	ANTONIO
YOSHIDA	MICHIKO	
YU	CARY	KA-MEI
YUM	EDWARD	LIANG
ZACK	LAWRENCE	MARK
ZAMPIER HENDERSON	LISA	MARIE
ZANOTTO	VIKKI-ANNE	
ZEE	ADRIAN	DAR HENG
ZEITMAN	LUKAS	RAPHAEL
ZHANG	BARBARA	PEI WEN
ZHANG	JASON	YANG
ZHENG	LING	
ZIADEH	MARIANA	BASSEM
ZIMMERMAN	JOANNE	
ZOGG	DAVID	ALEXANDER
ZUIDHOF	JANET	MARGUERITE

Dated: April 26, 2018.

Diane Costello,

Manager Classification Team 82413, Examinations Operations—Philadelphia Compliance Services.

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

Open Meeting of the Taxpayer Advocacy Panel Notices and Correspondence Project Committee

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of meeting.

SUMMARY: An open meeting of the Taxpayer Advocacy Panel Notices and Correspondence Project Committee will be conducted. The Taxpayer Advocacy Panel is soliciting public comments, ideas, and suggestions on improving customer service at the Internal Revenue Service.

DATES: The meeting will be held Thursday, June 14, 2018.

FOR FURTHER INFORMATION CONTACT: Otis Simpson at 1–888–912–1227 or 202–317–3332.

SUPPLEMENTARY INFORMATION: Notice is hereby given pursuant to Section 10(a)(2) of the Federal Advisory Committee Act, 5 U.S.C. App. (1988) that a meeting of the Taxpayer Advocacy Panel Notices and Correspondence Project Committee will be held Thursday, June 14, 2018, at 1:00 p.m. Eastern Time via teleconference. The public is invited to make oral comments or submit written statements for consideration. Due to limited conference lines, notification of intent to participate must be made with Otis Simpson. For more information please contact Otis Simpson at 1–888–912–1227 or 202–317–3332, or write TAP Office, 1111 Constitution Ave. NW, Room 1509, Washington, DC 20224 or contact us at the website: *http://www.improveirs.org.* The agenda will include various IRS issues. Otis Simpson. For more information please contact Otis Simpson at 1–888–912–1227 or 202–317–3332, or write TAP Office, 1111 Constitution Ave. NW, Room 1509, Washington, DC 20224 or contact us at the website: *http://www.improveirs.org.* The agenda will include various IRS issues.

The agenda will include a discussion on various letters, and other issues related to written communications from the IRS.

Dated: May 1, 2018.

Kevin Brown,

Acting Director, Taxpayer Advocacy Panel.

[FR Doc. 2018–09703 Filed 5–7–18; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF VETERANS AFFAIRS

National Research Advisory Council (NRAC); Notice of Meeting

The Department of Veterans Affairs (VA) gives notice under the Federal Advisory Committee Act that the NRAC will hold a meeting on Wednesday, June 6, 2018, in Conference Room 730, at 810

Vermont Ave. NW, Washington, DC 20420. The meeting will convene at 9:00 a.m. and end at 3:30 p.m. This meeting is open to the public.

The agenda will include VA modernization and the Secretary's priorities, a communication update, status of NRAC recommendations to VA, diversity and inclusion efforts, and the Office of Research and Development (ORD) priorities. No time will be allocated at this meeting for receiving oral presentations from the public. Members of the public wanting to attend may contact Ms. Melissa Cooper, Designated Federal Officer, ORD (10P9), Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, at (202) 461–6044, or by email at *Melissa.Cooper@va.gov* no later than close of business on May 25, 2018. Because the meeting is being held in a government building, a photo I.D. must be presented at the Guard's Desk as a part of the clearance process. Due to security protocols, and in order to prevent delays in clearance processing, you should allow an additional 30 minutes before the meeting begins. Any member of the public seeking additional information should contact Ms. Cooper at the phone number or email address noted above.

Dated: May 2, 2018.

LaTonya L. Small,

Advisory Committee Management Officer.

[FR Doc. 2018–09760 Filed 5–7–18; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

Joint Biomedical Laboratory Research and Development and Clinical Science Research and Development Services Scientific Merit Review Board Notice of Meetings Amended

The Department of Veterans Affairs (VA) gives notice under Federal Advisory Committee Act that the subcommittees of the Joint Biomedical Laboratory Research and Development and Clinical Science Research and Development Services Scientific Merit Review Board (JBL/CS SMRB) will meet from 8 a.m. to 5 p.m. on the dates indicated below (unless otherwise listed):

Subcommittee	Date	Location
Oncology-C	May 16–17, 2018	20 F Conference Center.
Nephrology	May 17, 2018	Phoenix Park Hotel.
Hematology	May 18, 2018	20 F Conference Center.
Oncology-A/D	May 18, 2018	20 F Conference Center.
Cellular & Molecular Medicine	May 21, 2018	20 F Conference Center.
Endocrinology-B	May 21, 2018	* VA Central Office.
Oncology-B	May 21, 2018	20 F Conference Center.
Neurobiology-C	May 22, 2018	20 F Conference Center.
Infectious Diseases-B	May 23, 2018	Training Development Center.
Surgery	May 23, 2018	20 F Conference Center.
Cardiovascular Studies-A	May 24, 2018	20 F Conference Center.
Infectious Diseases-A	May 24, 2018	* VA Central Office.
Immunology & Dermatology-A	May 30, 2018	20 F Conference Center.
Neurobiology-B	May 30, 2018	20 F Conference Center.
Oncology-E	May 30, 2018	* VA Central Office.
Gulf War Research	May 31, 2018	* VA Central Office.
Pulmonary Medicine	May 31, 2018	20 F Conference Center.
Endocrinology-A	June 1, 2018	20 F Conference Center.
Neurobiology-A	June 1, 2018	20 F Conference Center.
Neurobiology-E	June 1, 2018	20 F Conference Center.
Special Emphasis Panel on Million Veteran Prog Proj	June 5, 2018	* VA Central Office.
Gastroenterology	June 6, 2018	20 F Conference Center.
Mental Health & Behavioral Sciences-A	June 6, 2018	* VA Central Office.
Neurobiology-F	June 6, 2018	* VA Central Office.
Cardiovascular Studies-B	June 7, 2018	20 F Conference Center.
Epidemiology	June 7, 2018	* VA Central Office.
Mental Health & Behavioral Sciences-B	June 7, 2018	20 F Conference Center.
Neurobiology-D	June 8, 2018	20 F Conference Center.
Eligibility	July 16, 2018	20 F Conference Center.

* Teleconference.

The addresses of the meeting sites are:

20 F Conference Center, 20 F Street NW, Washington, DC

Phoenix Park Hotel, 520 North Capital Street NW, Washington, DC

Training Development Center, 400 Maryland Avenue SW, Washington, DC

VA Central Office, 1100 First Street NE, Suite 600, Washington, DC

The purpose of the subcommittees is to provide advice on the scientific quality, budget, safety and mission relevance of investigator-initiated research proposals submitted for VA merit review evaluation. Proposals submitted for review include various medical specialties within the general areas of biomedical, behavioral and clinical science research.

These subcommittee meetings will be closed to the public for the review, discussion, and evaluation of initial and renewal research proposals, which involve reference to staff and consultant critiques of research proposals. Discussions will deal with scientific merit of each proposal and qualifications of personnel conducting the studies, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy. Additionally, premature disclosure of research information could significantly obstruct implementation of proposed agency action regarding the research proposals. As provided by subsection 10(d) of Public Law 92–463, as amended by Public Law 94–409, closing the subcommittee meetings is in accordance with Title 5 U.S.C. 552b(c)(6) and (9)(B).

Those who would like to obtain a copy of the minutes from the closed subcommittee meetings and rosters of the subcommittee members should contact Holly Krull, Ph.D., Manager, Merit Review Program (10P9B), Department of Veterans Affairs, 810

Vermont Avenue NW, Washington, DC 20420, at (202) 632–8522 or email at *holly.krull@va.gov.*

Dated: May 3, 2018.

LaTonya L. Small,

Federal Advisory Committee Management Officer.

[FR Doc. 2018–09724 Filed 5–7–18; 8:45 am]

BILLING CODE 8320–01–P

FEDERAL REGISTER

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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 418

Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1692–P]

RIN 0938–AT26

Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2019. The rule also proposes to make conforming regulations text changes to recognize physician assistants as designated hospice attending physicians effective January 1, 2019. Finally, the rule proposes changes to the Hospice Quality Reporting Program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 26, 2018.

ADDRESSES: In commenting, please refer to file code CMS–1692–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1692–P, P.O. Box 8010, Baltimore, MD 21244–1850.

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–1692–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT:

Debra Dean-Whittaker, (410) 786–0848 for questions regarding the CAHPS® Hospice Survey.

Cindy Massuda, (410) 786–0652 for questions regarding the hospice quality reporting program.

For general questions about hospice payment policy, please send your inquiry via email to: *hospicepolicy@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

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

Wage index addenda will be available only through the internet on our website at: (*http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.*)

I. Executive Summary

A. Purpose

This rule proposes updates to the hospice payment rates for fiscal year (FY) 2019, as required under section 1814(i) of the Social Security Act (the Act). This rule also proposes conforming regulations text changes as a result of section 51006 of the Bipartisan Budget Act of 2018, which amended section 1861(dd)(3)(B) of the Act such that, effective January 1, 2019, physician assistants (PAs) will be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners. Finally, this rule proposes changes to the hospice quality reporting program (HQRP), consistent with the requirements of section 1814(i)(5) of the Act. In accordance with section 1814(i)(5)(A) of the Act, hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to their payments.

B. Summary of the Major Provisions

Section III.A of this proposed rule describes monitoring activities intended to identify potential impacts related to the hospice reform policies finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule and analyzes current trends in hospice utilization and expenditures.

Section III.B.1 of this proposed rule proposes updates to the hospice wage index with updated wage data and makes the application of the updated wage data budget neutral for all four levels of hospice care. In section III.B.2 of this proposed rule, we discuss the FY 2019 hospice payment update percentage of 1.8 percent. Sections III.B.3 and III.B.4 of this proposed rule update the hospice payment rates and hospice cap amount for FY 2019 by the hospice payment update percentage discussed in section III.B.2 of this proposed rule. We also propose regulations text changes in section III.C and section III.D pertaining to the definition of ''attending physician'' and ''cap period.''

Finally, in section III.E of this proposed rule, we propose updates to the HQRP, including: Data review and correction timeframes for data submitted using the HIS; extension of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey participation requirements, exemption criteria and public reporting policies to future years; procedures to announce quality measure readiness for public reporting and public reporting timelines; removal of routine public reporting of the 7 HIS measures; and public display of public use file data on the Hospice Compare website.

C. Summary of Impacts

The overall economic impact of this proposed rule is estimated to be $340 million in increased payments to hospices during FY 2019.

D. Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

Regulatory reform and reducing regulatory burden are high priorities for CMS. To reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care, in October 2017, we launched the Meaningful Measures Initiative.[1] This initiative is one component of our agency-wide Patients Over Paperwork Initiative,[2] which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. The Meaningful

[1] Meaningful Measures web page: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.*

[2] See Remarks by Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit, as prepared for delivery on October 30, 2017 *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html.*

Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes. The Meaningful Measures Initiative represents a new approach to quality measures that fosters operational efficiencies, and will reduce the costs including, collection and reporting burden while producing quality measurement that is more focused on meaningful outcomes.

The Meaningful Measures Framework has the following objectives:

- Address high-impact measure areas that safeguard public health;
- Patient-centered and meaningful to patients;
- Outcome-based where possible;
- Fulfill each program's statutory requirements;
- Minimize the level of burden for health care providers (for example, through a preference for EHR-based measures where possible, such as electronic clinical quality measures [3]);
- Significant opportunity for improvement;
- Address measure needs for population based payment through alternative payment models; and
- Align across programs and/or with other payers.

In order to achieve these objectives, we have identified 19 Meaningful Measures areas and mapped them to six overarching quality priorities as shown in the Table 1 below.

TABLE 1—MEANINGFUL MEASURES

Quality priority	Meaningful measure area
Making Care Safer by Reducing Harm Caused in the Delivery of Care	Healthcare-Associated Infections.
	Preventable Healthcare Harm.
Strengthen Person and Family Engagement as Partners in Their Care	Care is Personalized and Aligned with Patient's Goals.
	End of Life Care according to Preferences.
	Patient's Experience of Care.
	Patient Reported Functional Outcomes.
Promote Effective Communication and Coordination of Care	Medication Management.
	Admissions and Readmissions to Hospitals.
	Transfer of Health Information and Interoperability.
Promote Effective Prevention and Treatment of Chronic Disease	Preventive Care.
	Management of Chronic Conditions.
	Prevention, Treatment, and Management of Mental Health.
	Prevention and Treatment of Opioid and Substance Use Disorders.
	Risk Adjusted Mortality.
Work with Communities to Promote Best Practices of Healthy Living	Equity of Care.
	Community Engagement.
Make Care Affordable	Appropriate Use of Healthcare.
	Patient-focused Episode of Care.
	Risk Adjusted Total Cost of Care.

By including Meaningful Measures in our programs, we believe that we can also address the following cross-cutting measure criteria:

- Eliminating disparities;
- Tracking measurable outcomes and impact;
- Safeguarding public health;
- Achieving cost savings;
- Improving access for rural communities; and
- Reducing burden.

We believe that the Meaningful Measures Initiative will improve outcomes for patients, their families, and health care providers while reducing burden and costs for clinicians and providers as well as promoting operational efficiencies.

E. Advancing Health Information Exchange

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care. The Office of the National Coordinator for Health Information Technology (ONC) and CMS work collaboratively to advance interoperability across settings of care.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113 185) (IMPACT Act) requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers. To further progress toward the goal of interoperability, we are developing a Data Element Library to serve as a publically available centralized, authoritative resource for standardized data elements and their associated mappings to health IT standards. These interoperable data elements can reduce provider burden by allowing the use and reuse of healthcare data, support provider exchange of electronic health information for care coordination, person-centered care, and support real-time, data driven, clinical decision making. Once available, standards in the Data Element Library can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA).

The 2018 Interoperability Standards Advisory (ISA) is available at: *https://www.healthit.gov/standards-advisory.*

Most recently, the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, requires HHS to take new steps to enable the electronic sharing of health information ensuring interoperability for providers and settings across the care continuum. Specifically, the Congress directed ONC to ''develop or support a trusted exchange framework, including a common agreement among health information networks nationally.'' This framework (*https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement*) outlines a common set of principles for trusted exchange and minimum terms and conditions for trusted exchange in order to enable interoperability across disparate health information networks. In another

[3] See section VIII.A.8.c. of the preamble of this proposed rule where we seek comment on the potential future development and adoption of eCQMs.

important provision, the Congress established new authority for HHS to discourage ''information blocking'', defined as practices likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information. We invite providers to learn more about these important developments and how they are likely to affect hospices.

II. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that recognizes that the impending death of an individual, upon his or her choice, warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define ''palliative care'' as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (42 CFR 418.3). Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit.

The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. Hospice is compassionate beneficiary and family/caregiver-centered care for those who are terminally ill.

As referenced in our regulations at § 418.22(b)(1), to be eligible for Medicare hospice services, the patient's attending physician (if any) and the hospice medical director must certify that the individual is ''terminally ill,'' as defined in section 1861(dd)(3)(A) of the Act and our regulations at § 418.3; that is, the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. The regulations at § 418.22(b)(3) require that the certification and recertification forms include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

Under the Medicare hospice benefit, the election of hospice care is one a patient choice and once a terminally ill patient elects to receive hospice care, a hospice interdisciplinary group is essential in the seamless provision of services. These hospice services are provided primarily in the individual's home. The hospice interdisciplinary group works with the beneficiary, family, and caregivers to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families about changes in their condition. The beneficiary's care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

While the goal of hospice care is to allow the beneficiary to remain in his or her home, circumstances during the end of life may necessitate short-term inpatient admission to a hospital, skilled nursing facility (SNF), or hospice facility for necessary pain control or acute or chronic symptom management that cannot be managed in any other setting. These acute hospice care services ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to his or her home. Limited, short-term, intermittent, inpatient respite care (IRC) is also available because of the absence or need for relief of the family or other caregivers. Additionally, an individual can receive continuous home care (CHC) during a period of crisis in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. Continuous home care may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with our regulations at § 418.204. A minimum of 8 hours of nursing care, or nursing and aide care, must be furnished on a particular day to qualify for the continuous home care rate (§ 418.302(e)(4)).

Hospices are expected to comply with all civil rights laws, including the provision of auxiliary aids and services to ensure effective communication with patients and patient care representatives with disabilities consistent with section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act. Additionally, they must provide language access for such persons who are limited in English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information about these requirements may be found at *http://www.hhs.gov/ocr/civilrights.*

B. Services Covered by the Medicare Hospice Benefit

Coverage under the Medicare Hospice benefit requires that hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. Section 1861(dd)(1) of the Act establishes the services that are to be rendered by a Medicare-certified hospice program. These covered services include: Nursing care; physical therapy; occupational therapy; speech-language pathology therapy; medical social services; home health aide services (now called hospice aide services); physician services; homemaker services; medical supplies (including drugs and biologicals); medical appliances; counseling services (including dietary counseling); short-term inpatient care in a hospital, nursing facility, or hospice inpatient facility (including both respite care and procedures necessary for pain control and acute or chronic symptom management); continuous home care during periods of crisis, and only as necessary to maintain the terminally ill individual at home; and any other item or service which is specified in the plan of care and for which payment may otherwise be made under Medicare, in accordance with Title XVIII of the Act.

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary who is a hospice patient be established before care is provided by, or under arrangements made by, that hospice program and that the written plan be periodically reviewed by the beneficiary's attending physician (if any), the hospice medical director, and an interdisciplinary group (described in section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available to beneficiaries as needed, 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act).

Upon the implementation of the hospice benefit, the Congress also expected hospices to continue to use volunteer services, though these services are not reimbursed by Medicare (see section 1861(dd)(2)(E) of the Act). As stated in the FY 1983 Hospice Wage Index and Rate Update proposed rule (48 FR 38149), the hospice interdisciplinary group should comprise paid hospice employees as well as hospice volunteers, and that ''the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the voluntary

spirit of hospices.'' This expectation supports the hospice philosophy of community based, holistic, comprehensive, and compassionate end-of-life care.

C. Medicare Payment for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, and our regulations in part 418, establish eligibility requirements, payment standards and procedures; define covered services; and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G, provides for a per diem payment in one of four prospectively-determined rate categories of hospice care (routine home care (RHC), CHC, IRC, and general inpatient care (GIP)), based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected). This per diem payment is to include all of the hospice services and items needed to manage the beneficiary's care, as required by section 1861(dd)(1) of the Act. There has been little change in the hospice payment structure since the benefit's inception. The per diem rate based on level of care was established in 1983, and this payment structure remains today with some adjustments, as noted below.

1. Omnibus Budget Reconciliation Act of 1989

Section 6005(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) amended section 1814(i)(1)(C) of the Act and provided changes in the methodology concerning updating the daily payment rates based on the hospital market basket percentage increase applied to the payment rates in effect during the previous federal fiscal year.

2. Balanced Budget Act of 1997

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) established that updates to the hospice payment rates beginning FY 2002 and subsequent FYs be the hospital market basket percentage increase for the FY.

3. FY 1998 Hospice Wage Index Final Rule

The FY 1998 Hospice Wage Index final rule (62 FR 42860), implemented a new methodology for calculating the hospice wage index and instituted an annual Budget Neutrality Adjustment Factor (BNAF) so aggregate Medicare payments to hospices would remain budget neutral to payments calculated using the 1983 wage index.

4. FY 2010 Hospice Wage Index Final Rule

The FY 2010 Hospice Wage Index and Rate Update final rule (74 FR 39384) instituted an incremental 7-year phase-out of the BNAF beginning in FY 2010 through FY 2016. The BNAF phase-out reduced the amount of the BNAF increase applied to the hospice wage index value, but was not a reduction in the hospice wage index value itself or in the hospice payment rates.

5. The Affordable Care Act

Starting with FY 2013 (and in subsequent FYs), the market basket percentage update under the hospice payment system referenced in sections 1814(i)(1)(C)(ii)(VII) and 1814(i)(1)(C)(iii) of the Act is subject to annual reductions related to changes in economy-wide productivity, as specified in section 1814(i)(1)(C)(iv) of the Act. In FY 2013 through FY 2019, the market basket percentage update under the hospice payment system will be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act).

In addition, sections 1814(i)(5)(A) through (C) of the Act, as added by section 3132(a) of the Affordable Care Act, require hospices to begin submitting quality data, based on measures to be specified by the Secretary of the Department of Health and Human Services (the Secretary), for FY 2014 and subsequent FYs. Beginning in FY 2014, hospices that fail to report quality data will have their market basket percentage increase reduced by 2 percentage points.

Section 1814(a)(7)(D)(i) of the Act, as added by section 3132(b)(2) of the Affordable Care Act, requires, effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary's hospice care prior to the 180th-day recertification and each subsequent recertification, and to attest that such visit took place. When implementing this provision, we finalized in the FY 2011 Hospice Wage Index final rule (75 FR 70435) that the 180th-day recertification and subsequent recertifications would correspond to the beneficiary's third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as added by section 3132(a)(1)(B) of the Affordable Care Act, authorizes the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The types of data and information suggested in the Affordable Care Act could capture accurate resource utilization, which could be collected on claims, cost reports, and possibly other mechanisms, as the Secretary determined to be appropriate. The data collected could be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care, no earlier than October 1, 2013, as described in section 1814(i)(6)(D) of the Act. In addition, we were required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

6. FY 2012 Hospice Wage Index Final Rule

In the FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314) we announced that beginning in 2012, the hospice aggregate cap would be calculated using the patient-by-patient proportional methodology, within certain limits. We allowed existing hospices the option of having their cap calculated via the original streamlined methodology, also within certain limits. As of FY 2012, new hospices have their cap determinations calculated using the patient-by-patient proportional methodology. If a hospice's total Medicare payments for the cap year exceed the hospice aggregate cap, then the hospice must repay the excess back to Medicare.

7. FY 2015 Hospice Wage Index and Payment Rate Update Final Rule

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50452) finalized a requirement that requires the Notice of Election (NOE) be filed within 5 calendar days after the effective date of hospice election. If the NOE is filed beyond this 5-day period, hospice providers are liable for the services furnished during the days from the effective date of hospice election to the date of NOE filing (79 FR 50474). Similar to the NOE, the claims processing system must be notified of a beneficiary's discharge from hospice or hospice benefit revocation within 5 calendar days after the effective date of the discharge/revocation (unless the hospice has already filed a final claim) through the submission of a final claim or a Notice of Termination or Revocation (NOTR).

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50479) also finalized a requirement that the

election form include the beneficiary's choice of attending physician and that the beneficiary provide the hospice with a signed document when he or she chooses to change attending physicians.

Hospice providers are required to begin using a Hospice Experience of Care Survey for informal caregivers of hospice patients as of 2015. The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50496) provided background, eligibility criteria, survey respondents, and implementation of the Hospice Experience of Care Survey for informal caregivers, that hospices are required to use as of 2015.

Finally, the FY 2015 Hospice Wage Index and Rate Update final rule required providers to complete their aggregate cap determination not sooner than 3 months after the end of the cap year, and not later than 5 months after, and remit any overpayments. Those hospices that fail to timely submit their aggregate cap determinations will have their payments suspended until the determination is completed and received by the Medicare contractor (79 FR 50503).

8. IMPACT Act of 2014

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113–185) became law on October 6, 2014. Section 3(a) of the IMPACT Act mandated that all Medicare certified hospices be surveyed every 3 years beginning April 6, 2015 and ending September 30, 2025. In addition, section 3(c) of the IMPACT Act requires medical review of hospice cases involving beneficiaries receiving more than 180 days care in select hospices that show a preponderance of such patients; section 3(d) of the IMPACT Act contains a new provision mandating that the cap amount for accounting years that end after September 30, 2016, and before October 1, 2025 be updated by the hospice payment update rather than using the consumer price index for urban consumers (CPI–U) for medical care expenditures.

9. FY 2016 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we created two different payment rates for RHC that resulted in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for subsequent days of hospice care. We also created a Service Intensity Add-on (SIA) payment payable for services during the last 7 days of the beneficiary's life, equal to the CHC hourly payment rate multiplied by the amount of direct patient care provided by a registered nurse (RN) or social worker that occurs during the last 7 days (80 FR 47177).

In addition to the hospice payment reform changes discussed, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47186) implemented changes mandated by the IMPACT Act, in which the cap amount for accounting years that end after September 30, 2016 and before October 1, 2025 is updated by the hospice payment update percentage rather than using the CPI–U. This was applied to the 2016 cap year, starting on November 1, 2015 and ending on October 31, 2016. In addition, we finalized a provision to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the fiscal year for FY 2017 and thereafter. Finally, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47144) clarified that hospices must report all diagnoses of the beneficiary on the hospice claim as a part of the ongoing data collection efforts for possible future hospice payment refinements.

10. FY 2017 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52160), we finalized several new policies and requirements related to the HQRP. First, we codified our policy that if the National Quality Forum (NQF) makes non-substantive changes to specifications for HQRP measures as part of the NQF's re-endorsement process, we will continue to utilize the measure in its new endorsed status, without going through new notice-and-comment rulemaking. We will continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures we have adopted for the HQRP; determinations about what constitutes a substantive versus non-substantive change will be made on a measure-by-measure basis. Second, we finalized two new quality measures for the HQRP for the FY 2019 payment determination and subsequent years: Hospice Visits when Death is Imminent Measure Pair and Hospice and Palliative Care Composite Process Measure-Comprehensive Assessment at Admission (81 FR 52173). The data collection mechanism for both of these measures is the HIS, and the measures are effective April 1, 2017. Regarding the CAHPS® Hospice Survey, we finalized a policy that hospices that receive their CMS Certification Number (CCN) after January 1, 2017 for the FY 2019 Annual Payment Update (APU) and January 1, 2018 for the FY 2020 APU will be exempted from the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) requirements due to newness (81 FR 52182). The exemption is determined by CMS and is for 1 year only.

D. Trends in Medicare Hospice Utilization

Since the implementation of the hospice benefit in 1983, and especially within the last decade, there has been substantial growth in hospice benefit utilization. The number of Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to nearly 1.5 million in FY 2017. Similarly, Medicare hospice expenditures have risen from $2.8 billion in FY 2000 to approximately $17.5 billion in FY 2017. Our Office of the Actuary (OACT) projects that hospice expenditures are expected to continue to increase, by approximately 8 percent annually, reflecting an increase in the number of Medicare beneficiaries, more beneficiary awareness of the Medicare hospice benefit for end-of-life care, and a growing preference for care provided in home and community-based settings.

There have also been changes in the diagnosis patterns among Medicare hospice enrollees. While in 2002, lung cancer was the top principal diagnosis, neurologically based diagnoses have topped the list for the past 5 years. Additionally, in FY 2013, ''debility'' and ''adult failure to thrive'' were the first and sixth most common hospice claims-reported diagnoses, respectively, accounting for approximately 14 percent of all diagnoses; however, effective October 1, 2014, these diagnoses are no longer permitted as principal diagnosis codes on hospice claims. As a result of this, the most common hospice claims-reported diagnoses have changed from primarily cancer diagnoses to neurological and organ-based failure diagnoses. The top 20 most frequently hospice claims-reported diagnoses for FY 2017 are in Table 2 below.

TABLE 2—THE TOP TWENTY PRINCIPAL HOSPICE DIAGNOSES, FY 2017

Rank	ICD–10/reported principal diagnosis	Count	Percentage
1	G30.9 Alzheimer's disease, unspecified	155,066	10
2	J44.9 Chronic obstructive pulmonary disease	77,758	5
3	I50.9 Heart failure, unspecified	69,216	4
4	G31.1 Senile degeneration of brain, not elsewhere classified	66,309	4
5	C34.90 Malignant Neoplasm Of Unsp Part Of Unsp Bronchus Or Lung	53,137	3
6	G20 Parkinson's disease	40,186	3
7	G30.1 Alzheimer's disease with late onset	38,710	2
8	I25.10 Atherosclerotic heart disease of native coronary art without angina pectoris	34,761	2
9	J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation	33,547	2
10	I67.2 Cerebral atherosclerosis	30,146	2
11	C61 Malignant neoplasm of prostate	25,215	2
12	I63.9 Cerebral infarction, unspecified	22,825	1
13	N18.6 End stage renal disease	21,549	1
14	C18.9 Malignant neoplasm of colon, unspecified	21,543	1
15	C25.9 Malignant neoplasm of pancreas, unspecified	20,851	1
16	I51.9 Heart disease, unspecified	18,794	1
17	I11.0 Hypertensive heart disease with heart failure	18,345	1
18	I67.9 Cerebrovascular disease, unspecified	18,234	1
19	I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease.	15,632	1
20	A41.9 Sepsis, unspecified organism	14,012	1

Note(s): The frequencies shown represent beneficiaries that had a least one claim with the specific ICD–10 code reported as the principal diagnosis. Beneficiaries could be represented multiple times in the results if they have multiple claims during that time period with different principal diagnoses.

Source: FY 2017 hospice claims data from the CCW, accessed and merged with ICD–10 codes on January 10, 2018.

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47201), we clarified that hospices will report *all* diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual, effective October 1, 2015. Analysis of FY 2017 hospice claims show that 100 percent of hospices reported more than one diagnosis, 89 percent submitted at least two diagnoses, and 81 percent included at least three diagnoses.

III. Provisions of the Proposed Rule

A. Monitoring for Potential Impacts—Affordable Care Act Hospice Reform

1. Hospice Payment Reform: Research and Analyses

This section of the proposed rule describes current trends in hospice utilization and provider behavior, such as lengths of stay, live discharge rates, skilled visits during the last days of life, and non-hospice spending. Utilization data on these metrics were examined to determine the potential impacts related to the hospice reform policies finalized in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), if any. Moreover, in response to Office of Inspector General (OIG) report ''Hospice Inappropriately Billed Medicare Over $250 Million for General Inpatient Care'' (OEI–02–10–00491) released in March 2016, which identified the drugs paid for by Part D and provided to beneficiaries during GIP stays, we have also continued to monitor non-hospice spending during a hospice election as described in this section. Additionally, we have included information on the costs of hospice care using data from the new hospice Medicare cost report, effective for cost reporting periods that began on or after October 1, 2014 (FY 2015). Section 1814(i)(6) of the Act, as amended by section 3132(a)(1)(B) of the Affordable Care Act, authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes, including such data sources as the Medicare cost reports. These preliminary analyses may inform future work that could include such refinements to hospice payment rates.

a. Length of Stay and Live Discharges

Hospice Length of Stay

Eligibility under the Medicare hospice benefit is predicated on the individual being certified as terminally ill. Medicare regulations at § 418.3 define ''terminally ill'' to mean that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. However, we have recognized in previous rules that prognostication is not an exact science (79 FR 50470), and thus, a beneficiary may be under a hospice election longer than 6 months, as long as there remains a reasonable expectation that the individual has a life expectancy of 6 months or less.

The number of days that a hospice beneficiary receives care under a hospice election is referred to as the hospice length of stay. Hospice length of stay can be influenced by a number of factors including disease course, timing of referral, decision to resume curative treatment, and/or stabilization or improvement where the individual is no longer certified as terminally ill. Longer lengths of stay in hospice may reflect admission to hospice earlier in the disease trajectory or miscalculation of prognosis, among other situations. Shorter lengths of stay in hospice may reflect hospice election late in the disease trajectory or a rapidly progressing acute condition. This also may be due to individual reluctance to accept that his or her condition is terminal and choose the hospice benefit; inadequate knowledge regarding the breadth of services available under hospice care; cultural, ethnic, and/or religious backgrounds inhibiting or even precluding the use of hospice services; and other reasons.[4] As such, hospice lengths of stay are variable.

We examined length of stay, meaning the number of hospice days during a single hospice election at the date of live discharge or death. We also examined total *lifetime* length of stay, which would include the sum of all days of hospice care across all hospice elections. This would mean if a beneficiary had one hospice election,

[4] Vig, E., Starks, H., Taylor, J., Hopley, E., Fryer-Edwards, K. (2010). ''Why Don't Patients Enroll in Hospice? Can We Do Anything About It?'' Journal of General Internal Medicine. 25(10): 1009–19. Doi: 10.1007/s11606–010–1423–9.

was discharged alive, and then re-elected the benefit at a later date, the sum of both elections would count towards their lifetime length of stay. In FY 2017, the average length of stay in hospice was 79.7 days and the average *lifetime* length of stay in hospice was 96.2 days. The average length of stay was 78.1 days in FY 2015, 79.2 days in FY 2016, and 79.7 days in FY 2017. The average lifetime length of stay similarly remained virtually the same between FY 2016 and FY 2017, 96.1 and 96.2 days, respectively.

The median (50th percentile) length of stay in FY 2017 was 18 days. This means that half of hospice beneficiaries received care for fewer than 18 days and half received care for more than 18 days. While the median length of stay has remained relatively constant over the past several years, the average length of stay has increased from year to year.

The Medicare hospice benefit provides four levels of care: Routine home care, general inpatient care, continuous home care, and inpatient respite care. The majority of hospice patient care is provided at the RHC level of care and can be provided wherever the patient calls ''home,'' including nursing homes and assisted living facilities. As indicated in Table 3 below, most hospice care (98 percent) provided is RHC. Approximately 56 percent of all hospice days are provided at the RHC level of care in the patient's residence whereas 41 percent is provided at the RHC level of care to patients that reside in a nursing home or assisted living facility.

TABLE 3—SHARE OF HOSPICE DAYS BY LEVEL OF CARE AND SITE OF SERVICE, FOR BENEFICIARIES DISCHARGED ALIVE OR DECEASED IN FY 2017

Level of care	Site of service	Number of hospice days	% of all hospice days
RHC	Home + Hospice Residential Facility	66,320,796	55.75
	SNF/NF	28,656,850	24.09
	Assisted Living Facility	20,299,401	17.06
	Other	1,351,575	1.14
	Total	116,628,622	98.04
GIP	Inpatient Hospital	409,123	0.34
	Inpatient Hospice Facility	1,158,985	0.97
	Skilled Nursing Facility	64,349	0.05
	Other	5,571	0.01
	Total	1,638,028	1.38
CHC	Home + Hospice Residential Facility	199,595	0.17
	SNF/NF	47,098	0.04
	Assisted Living Facility	78,927	0.07
	Other	3,758	0.00
	Total	329,378	0.28
IRC	Inpatient Hospital	32,397	0.03
	Inpatient Hospice Facility	121,597	0.10
	SNF/NF	206,983	0.17
	Other	1,558	0.00
	Total	362,535	0.30
Total		118,958,563	100

Source: Common Working File (CWF) All hospice claims from 2006 to 2017 were included, for beneficiaries whose final claim in FY 2017, according to through date, for a hospice discharge (excluded status code ''30'', indicating a continuing patient). Hospice days with invalid or missing site of service HCPCS code are excluded.

In addition to analyzing the hospice average and average lifetime lengths of stay, we examined the average lifetime lengths of stay associated with hospice principal diagnoses by site of service at admission in FY 2017 (see Table 4 below). We limited our analysis to those beneficiaries that were receiving RHC at admission. As noted in Table 3 above, RHC was the level of care for 98 percent of all hospice days. We found that beneficiaries with chronic, progressive neurological diseases such as Alzheimer's disease and related dementias, and Parkinson's disease had the longest average lifetime lengths of stay at 177 days in FY 2017. Beneficiaries with Chronic Kidney Disease and cancer had shorter average lifetime lengths of stay, 56.8 and 63 days, respectively. For all diagnoses, the average lifetime length of stay was 113.5 days in FY 2017 when level of care at admission is RHC.

TABLE 4—AVERAGE LIFETIME LENGTH OF STAY BY DIAGNOSIS AND SITE OF SERVICE ON THE DAY OF ADMISSION IN FY 2017, WHEN LEVEL OF CARE AT ADMISSION IS RHC

Primary hospice diagnosis at admission	Home + hospice residential facility		Assisted living facility		SNF + LTC or non-skilled nursing facility		Other*		All sites of service	
	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay
All Diagnoses	582,280	110.59	115,742	162.60	219,063	102.87	47,700	79.33	964,785	113.53
Alzheimer's, Dementia, and Parkinson's	75,915	191.29	39,288	204.24	60,895	143.63	6,741	173.29	182,839	177.00
CVA/Stroke	18,514	176.77	9,013	200.25	14,364	142.65	1,730	141.33	43,621	169.19
Cancers	223,000	63.21	12,408	97.53	30,219	62.22	17,916	40.23	283,543	62.92
Chronic Kidney Disease	12,319	60.69	1,436	81.71	5,537	45.09	952	38.90	20,244	56.84
Heart (CHF and Other Heart Disease)	101,059	130.39	22,138	144.68	36,694	87.61	7,596	94.51	167,487	120.96
Lung (COPD and Pneumonias)	57,733	142.60	7,309	152.88	16,286	88.89	3,863	72.27	85,191	131.23
All Other Diagnoses	93,740	110.34	24,150	138.44	55,068	89.83	8,902	67.27	181,860	106.43

Source: Common Working File (CWF) All hospice claims from 2006 to 2017 were included, for beneficiaries whose final claim in FY 2017, according to through date, for a hospice discharge (excluded status code "30", indicating a continuing patient). Diagnosis code and site of service were determined by the first hospice claim for a beneficiary. Diagnosis categories are consistent with those outlined in Abt's 2015 technical report (*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/December-2015-Technical-Report.pdf*).

Note: "Other" category includes inpatient hospital, inpatient hospice facility, LTCH, IPF, and places not otherwise specified. Although dementia was no longer a valid primary diagnosis for the hospice benefit, our study time period examines primary diagnoses dating back to 2006.

As we indicated above, the average lifetime length of stay across all levels of care at admission was 96.2 days in FY 2017. However, the average lifetime length of stay was 113.5 days in FY 2017 when the level of care was RHC at admission (see Table 5 below). This suggests that beneficiaries not receiving RHC level of care at admission had shorter lifetime lengths of stay compared to the beneficiaries whose level of care was RHC at admission. In particular, those beneficiaries who are admitted to hospice at the GIP level of care typically are more acute and often die without transitioning to RHC and thus, have overall shorter lengths of stay. Therefore, the shorter lengths of stay for those admitted at the GIP level of care affect the overall average lifetime length of stay across all levels of care.

TABLE 5—AVERAGE LIFETIME LENGTH OF STAY LEVEL OF CARE TO RHC AT ADMISSION, FY 2016–FY 2017

	FY 2016		FY 2017	
	Number of benes	Average lifetime length of stay	Number of benes	Average lifetime length of stay
Any Level of Care at Admission	1,117,643	96.14	1,176,946	96.17
RHC at Admission	909,961	114.02	964,785	113.53

Source: Common Working File (CWF) All hospice claims were included, for beneficiaries whose final claim in FY 2017, according to through date, for a hospice discharge (excluded status code "30", indicating a continuing patient).

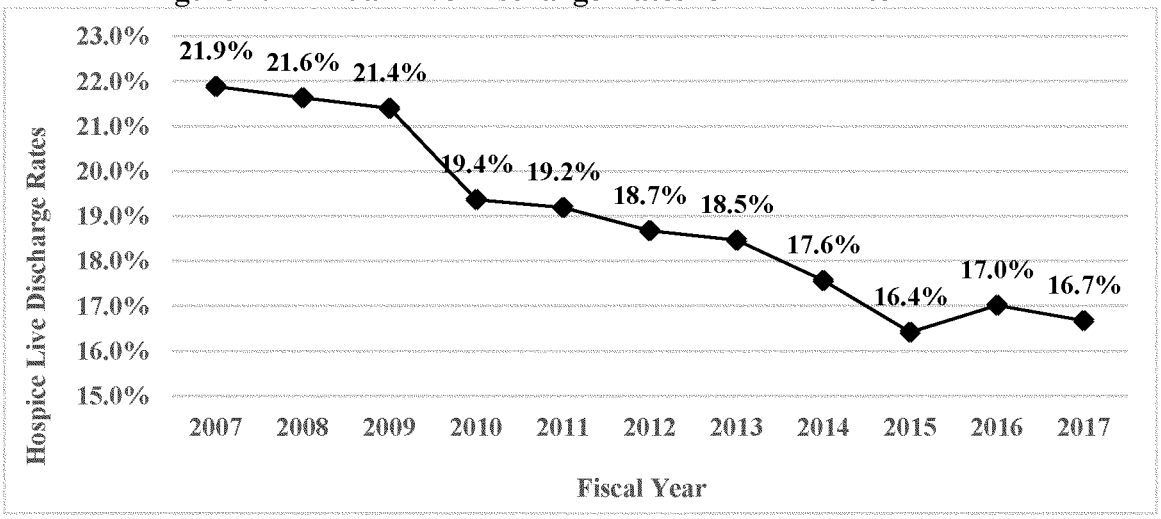
Live Discharges

A beneficiary who has elected hospice may revoke his or her hospice election at any time and for any reason. The regulations state that if the hospice beneficiary (or his or her representative) revokes the hospice election, the beneficiary may, at any time, re-elect to receive hospice coverage for any other hospice election period that he or she is eligible to receive (§§ 418.24(e) and 418.28(c)(3)). Immediately upon hospice revocation, Medicare coverage resumes for those Medicare benefits previously waived with the hospice election. A revocation can only be made by the beneficiary, in writing, and must specify the effective date of the revocation. A hospice cannot "revoke" a beneficiary's hospice election, nor is it appropriate for hospices to encourage, request, or demand that the beneficiary or his or her representative revoke his or her hospice election. Like the hospice election, a hospice revocation is to be an informed choice based on the beneficiary's goals, values and preferences for the services the person wishes to receive through Medicare.

Federal regulations limit the circumstances in which a Medicare hospice provider may discharge a patient from its care. In accordance with § 418.26, discharge from hospice care is permissible when the patient moves out of the provider's service area, is determined to be no longer terminally ill, or for cause. Hospices may not discharge the patient at their discretion, even if the care may be costly or inconvenient for the hospice program. As we indicated in the FY 2015 Hospice Wage Index and Payment Rate Update proposed and final rules, we understand that the rate of live discharges should not be zero, given the uncertainties of prognostication and the ability of beneficiaries and their families to revoke the hospice election at any time (79 FR 26549 and 79 FR 50463). On July 1, 2012, we began collecting discharge information on the claim to capture the reason for all types of discharges which includes, death, revocation, transfer to another hospice, moving out of the hospice's service area, discharge for cause, or due to the beneficiary no longer being considered terminally ill (that is, no longer qualifying for hospice services). In FY 2017, approximately 16.7 percent of hospice beneficiaries were discharged alive (see Figure 1 below). Beneficiary revocations represented 44 percent of all live discharges whereas 45 percent of live discharges were instances where the beneficiary was discharged because the beneficiary was considered no longer terminally ill, and 9 percent of live discharges were instances where beneficiaries transferred to other hospices. In analyzing hospice live discharge rates over time, Figure 1 demonstrates an incremental decrease in average annual rates of live discharge rates from FY 2007 to FY 2015, but an increase in the live discharge rate

between FY 2015 and FY 2016, and a slight decrease between FY 2016 and FY 2017. Between FY 2007 and FY 2017, there has been a reduction in the live discharge rate of 23.7 percent over this time period.

Figure 1: Annual Live Discharge Rates for FY 2007 to FY 2017



Source: FY 2007 through FY 2017 hospice claims data from Common Working File (CWF). All hospice claims were examined that list a discharge status code (meaning claims were excluded if they listed status code 30, indicating a continuing patient). Live discharges were defined as hospice claims with a status code of "01".

As part of our ongoing monitoring efforts, we analyzed the distribution of live discharge rates among hospices with 50 or more discharges (discharged alive or deceased). Table 6 shows that there is significant variation in the rate of live discharge between the 10th and 90th percentiles. Most notably, hospices at the 95th percentile discharged 47.6 percent of their patients alive in FY 2017.

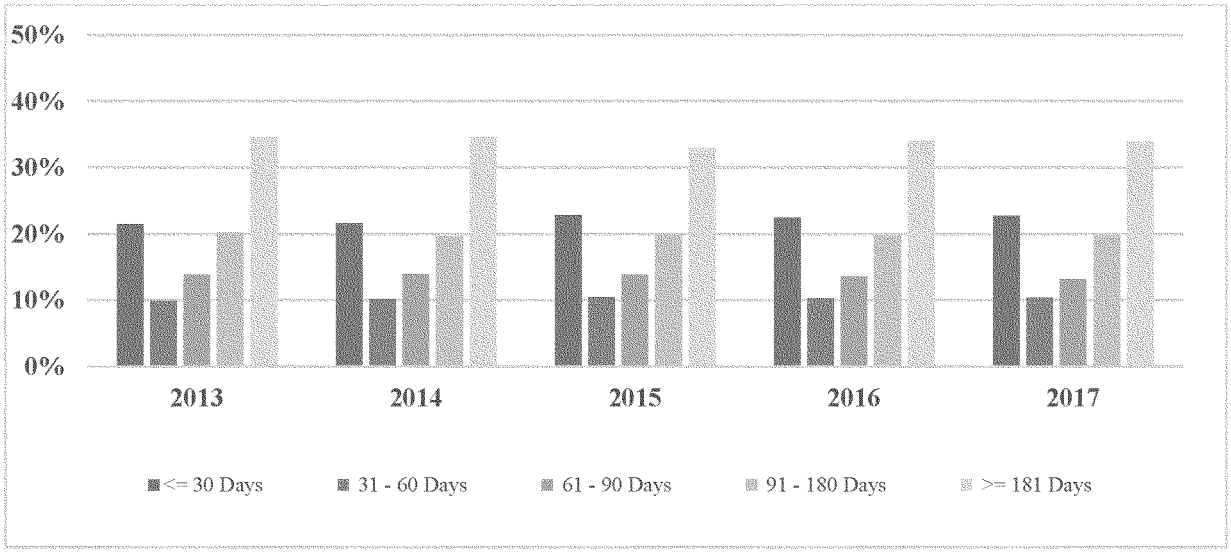
TABLE 6—DISTRIBUTION OF LIVE DISCHARGE RATES FOR HOSPICES WITH 50 OR MORE LIVE DISCHARGES, FY 2015 TO FY 2017

Statistics	Live discharge rate (%)		
	FY 2015	FY 2016	FY 2017
5th Percentile	6.9%	7.0%	6.9%
10th Percentile	8.5%	8.5%	8.4%
25th Percentile	11.6%	11.8%	11.7%
Median	16.8%	17.1%	17.3%
75th Percentile	24.7%	25.6%	25.4%
90th Percentile	35.9%	37.8%	37.3%
95th Percentile	45.6%	49.2%	47.6%
# Providers	3,215	3,268	3,312

Source: FY 2015, FY 2016, and FY 2017 hospice claims data from Common Working File (CWF) that list a discharge status code (meaning claims were excluded if they listed status code 30, indicating a continuing patient). Live discharges were defined as hospice claims with a status code of "01".

Finally, we looked at the distribution of live discharges by length of stay intervals. In looking at the length of stay intervals, 22 percent of the live discharges occurred within 30 days of the start of hospice care, 10 percent between 31 to 60 days, 14 percent between 61 to 90 days, 20 percent between 91 to 180 days, and 35 percent of live discharges occurred after a length of stay over 180 days of hospice care (see Figure 2 below). The proportion of live discharges occurring between the length of stay intervals was relatively constant from FY 2013 to FY 2017. However, we will continue to monitor the data available so as to identify any concerning behavior in response to recent payment policy reforms.

Figure 2. Length of Stay Intervals Distribution for Live Discharges, FY 2013 to FY 2017



Source: FY 2013 – FY 2017 final hospice claims from Common Working File (CWF).

b. Skilled Visits in the Last Days of Life

As we noted in both the FY 2016 and FY 2017 Hospice Wage Index and Rate Update final rules (80 FR 47164 and 81 FR 52143, respectively), we are concerned that many hospice beneficiaries may not be receiving skilled visits during the last days of life. In the period of time immediately preceding death, patient needs typically surge and more intensive services are warranted, so we expect that the provision of care would proportionately escalate in order to meet the increased clinical, emotional, and other needs of the hospice beneficiary and his or her family and caregiver(s). The last week of life is typically the period within the terminal illness trajectory that is associated with the highest symptom burden, typically marked by impactful physical and emotional symptoms, necessitating attentive care and engagement from the integrated hospice team. In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47164 through 47177), the SIA payment policy was finalized with an implementation date of January 1, 2016. This payment was developed in part with the objective of encouraging visits during the last days of life. Additionally, in the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52143), we finalized two new hospice HQRP measures effective April 1, 2017: (1) Hospice Visits When Death is Imminent, assessing hospice staff visits to patients and caregivers in the last week of life; and (2) Hospice and Palliative Care Composite Process Measure, assessing the percentage of hospice patients who received care processes consistent with existing guidelines. These efforts represent meaningful advances in encouraging visits to hospice beneficiaries during the time period preceding death.

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47164), commenters expressed concern regarding potential impacts of the new payment policies. Some noted that the new payment structures could potentially impact patient access to hospice care and articulated concerns around beneficiary discharges, specifically around the 60-day mark of a hospice stay. In response to these concerns, we pledged to monitor real-time hospice data, evaluating for any shifts in utilization or provision of services to Medicare beneficiaries.

As part of our monitoring efforts, we assessed the delivery of hospice care during the period of time preceding death. Analysis of FY 2017 claims data, which encompasses hospice claims from October 1, 2016 through September 30, 2017, shows that on any given day during the last 7 days of a hospice election, nearly 42 percent of the time the patient has not received a skilled visit (skilled nursing or social worker visit) (see Table 7 below). This figure represents an incremental improvement when compared to the figures presented in our FY 2018 Hospice Wage Index and Rate Update proposed rule (82 FR 20762), where FY 2016 claims showed approximately 44 percent for this metric. Additionally, Table 7 shows that approximately 20 percent of beneficiaries did not receive a skilled visit (skilled nursing or social work visit) on the day of death in FY 2017. This value also indicates an improvement compared to the FY 2016 claims data, in which nearly 21 percent of hospice beneficiaries did not receive a skilled visit on the day of death (82 FR 20762).

TABLE 7—FREQUENCY AND LENGTH OF SKILLED NURSING AND SOCIAL WORK VISITS (COMBINED) DURING THE LAST 7 DAYS OF A HOSPICE ELECTION ENDING IN DEATH, FY 2017

Visit length	Days before death							All 7 days combined
	0 Days (day of death) (%)	1 Day (%)	2 Days (%)	3 Days (%)	4 Days (%)	5 Days (%)	6 Days (%)	
No Visit	19.9	34.6	42.3	47.7	51.7	55.0	57.4	42.3
15 Minutes to 1 Hour	26.3	31.1	29.0	27.4	26.0	25.0	24.2	27.2
1 Hour, 15 Minutes to 2 Hours	27.3	20.7	18.3	16.4	15.0	13.6	12.8	18.4
2 Hours, 15 Minutes to 3 Hours	13.9	7.4	6.0	5.1	4.4	3.9	3.5	6.8
3 Hours, 15 Minutes to 3 Hours, 45 Minutes	4.9	2.3	1.8	1.4	1.2	1.0	0.9	2.1
4 or More Hours	7.7	3.9	2.6	2.0	1.6	1.3	1.2	3.2

Source: FY 2017 hospice claims data from Common Working File (CWF) (as of January 1, 2018).

While Table 7 above shows the frequency and length of skilled nursing and social work visits combined during the last 7 days of a hospice election in FY 2017, Tables 8 and 9 below show the frequency and length of visits for skilled nursing and social work separately. Analysis of FY 2017 claims data shows that on any given day during the last 7 days of a hospice election, almost 45 percent of the time the patient had not received a visit by a skilled nurse, and 89 percent of the time the patient had not received a visit by a social worker (see Tables 8 and 9, respectively). We believe it is important to ensure that beneficiaries and their families and caregivers are, in fact, receiving the level of care necessary during critical periods such as the very end of life.

TABLE 8—FREQUENCY AND LENGTH OF SKILLED NURSING VISITS DURING THE LAST 7 DAYS OF A HOSPICE ELECTION ENDING IN DEATH, FY 2017

Visit length	Days before death							All 7 days combined
	0 Days (day of death) (%)	1 Day (%)	2 Days (%)	3 Days (%)	4 Days (%)	5 Days (%)	6 Days (%)	
No Visit	21.3	37.3	45.3	50.9	55.0	58.3	60.8	45.1
15 Minutes to 1 Hour	27.3	33.3	30.3	28.1	26.2	24.9	23.9	28.1
1 Hour, 15 Minutes to 2 Hours	27.9	19.6	17.1	15.2	13.8	12.5	11.6	17.6
2 Hours, 15 Minutes to 3 Hours	13.3	5.5	4.3	3.6	3.1	2.7	2.4	5.4
3 Hours, 15 Minutes to 3 Hours, 45 Minutes	4.2	1.6	1.1	0.9	0.8	0.6	0.6	1.5
4 or More Hours	6.1	2.8	1.8	1.4	1.1	0.9	0.8	2.4

Source: FY 2017 hospice claims data from Common Working File (CWF) (as of January 1, 2018).

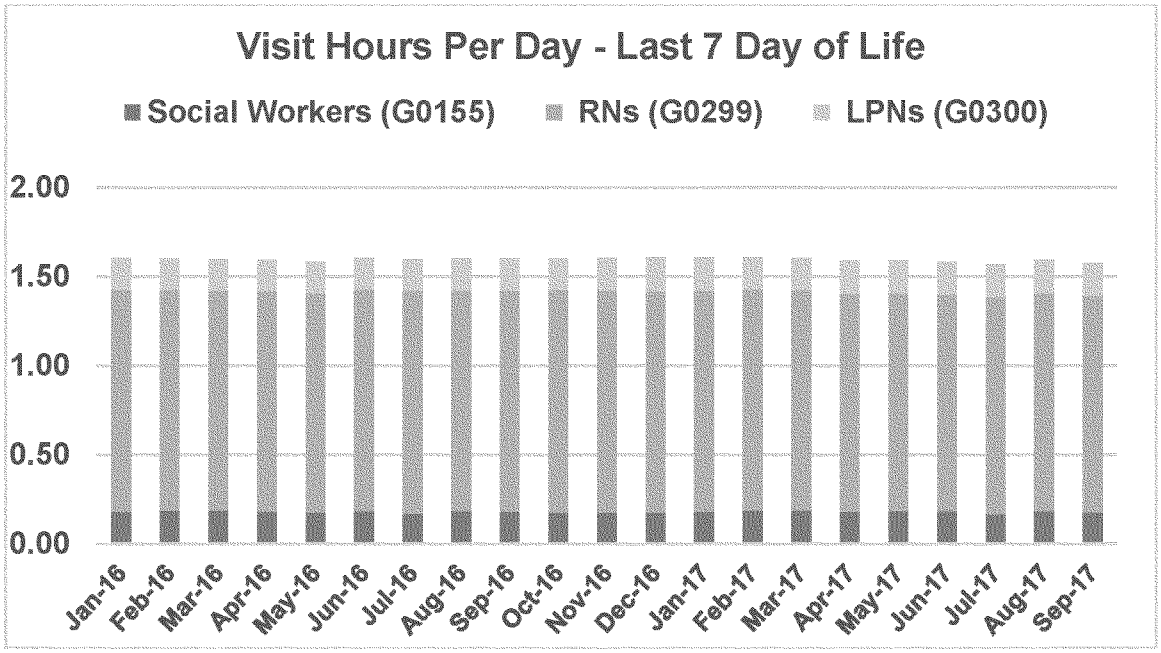
TABLE 9—FREQUENCY AND LENGTH OF SOCIAL WORK VISITS DURING THE LAST 7 DAYS OF A HOSPICE ELECTION ENDING IN DEATH, FY 2017

Visit length	Days before death							All 7 days combined
	0 Days (day of death) (%)	1 Day (%)	2 Days (%)	3 Days (%)	4 Days (%)	5 Days (%)	6 Days (%)	
No Visit	89.5	86.5	88.2	89.5	90.2	90.9	91.3	89.3
15 Minutes to 1 Hour	6.6	9.3	8.2	7.4	7.0	6.5	6.2	7.4
1 Hour, 15 Minutes to 2 Hours	2.8	3.5	3.0	2.7	2.5	2.2	2.1	2.8
2 Hours, 15 Minutes to 3 Hours	0.7	0.5	0.4	0.3	0.3	0.3	0.2	0.4
3 Hours, 15 Minutes to 3 Hours, 45 Minutes	0.2	0.1	0.1	0.0	0.0	0.0	0.0	0.1
4 or More Hours	0.2	0.1	0.1	0.0	0.0	0.0	0.0	0.1

Source: FY 2017 hospice claims data from Common Working File (CWF) (as of January 1, 2018).

Additionally, we have analyzed the overall levels of nursing and medical social services provided during the 7 days prior to death. In an assessment of FY 2015 claims, we estimate that the total number of hours of skilled services, including skilled nursing (as reported with code G0154) and medical social services visits, provided to Medicare hospice beneficiaries in the RHC level of care in the 7 days preceding death was approximately 1.6 hours per day. As depicted in Figure 3 below, from our analysis of FY 2016 and 2017 hospice claims data that begins January 1, 2016 and spans through September 30, 2017, a relatively consistent level of nursing and medical social services visits are being provided among RHC days in the 7 days prior to death, averaging around 1.6 hours per day. For the period spanning January 1, 2016 through September 30, 2017, our analysis shows that approximately 1.24 hours of services were provided by RNs, 0.18 hours were provided by Licensed Practical Nurses (LPNs), and 0.18 hours were provided by social workers per day. We note that for purposes of the SIA payment, only those hours of service provided by an RN, which became separately categorized as G0299 beginning January 1, 2016, and medical social worker count toward the calculation of the SIA payment. Additionally, we note that G0154 was retired as of January 1, 2016; however, this code was still reported by some providers in the months of January and February 2016, and thus was included in Figure 3.

Figure 3: Visit Hours per Day in the Last Seven Days of Life, January 2016 to September 2017



Source: Medicare hospice claims, January 1, 2016 through September 30, 2017; RHC days only; claims extracted on January 5, 2018 from Common Working File (CWF).

Given this evaluation of this more comprehensive dataset, which encompasses the payment policy changes that began on January 1, 2016, we are concerned at the lack of increase in visits to hospice patients at the end of life. Beneficiaries appear to be receiving similar levels of care when compared to time periods prior to the implementation of the payment policy reforms, which may indicate that hospices are not providing additional resources to patients during a time of increased need. We expect that hospices would be increasing visit frequency at the end of life, as the SIA payment serves to compensate providers for the cost of providing additional, more intensive care at the end of life, in addition to the payment already made for those RHC level of care days that qualify for the SIA.

Moreover, as described in the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52173), our quality reporting program started data collection effective April 1, 2017 for the quality measure pair, Hospice Visits When Death is Imminent, via the implementation of the new Hospice Item Set (HIS) V2.00. This measure pair assesses hospice staff visits to patients at the end of life. Measure 1 assesses the percentage of patients receiving at least one visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last 3 days of life while Measure 2 measures the percentage of patients receiving at least two visits from medical social workers, chaplains or spiritual counselors, LPNs, or hospice aides in the last 7 days of life. Data collected on these measures for the time period of 2017 will be applied to the Hospice Quality Reporting Program's Annual Payment Update (APU) in FY 2019, impacting provider payment based on quality of hospice care provided to Medicare beneficiaries. We will continue to monitor the provision of hospice services at end-of-life and impacts of the SIA payment and other policies.

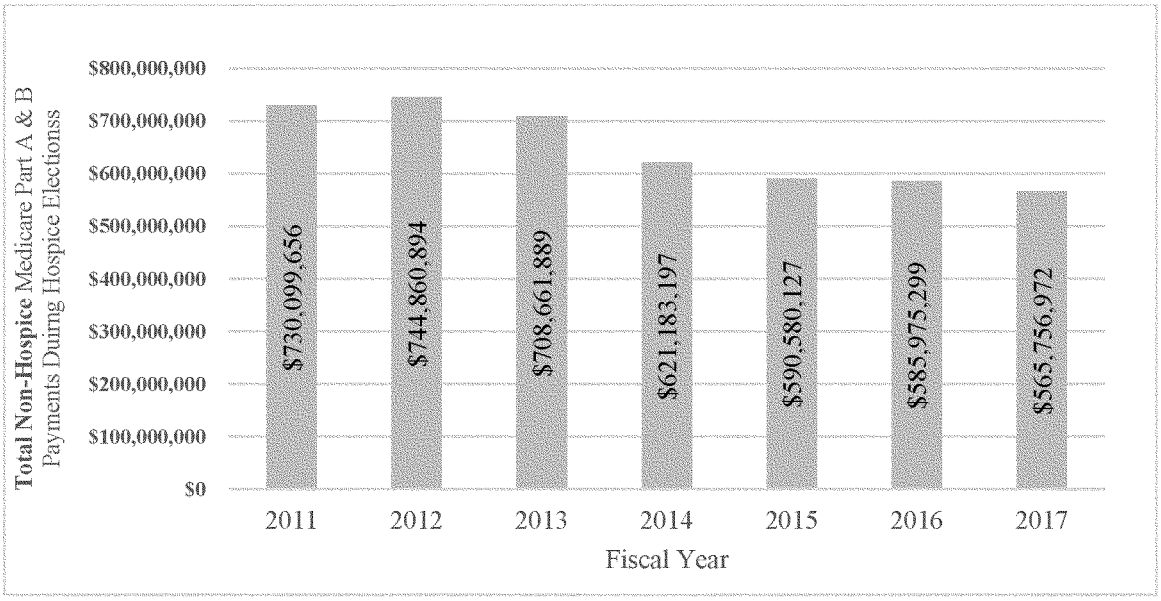
c. Non-Hospice Spending

When a beneficiary elects the Medicare hospice benefit, he or she waives the right to Medicare payment for services related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made, except for services

provided by the designated hospice and the attending physician. Hospice services are comprehensive and we have reiterated since 1983 that ''virtually all'' care needed by the terminally ill individual would be provided by hospice. We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life. However, we continue to conduct ongoing analysis of non-hospice spending during a hospice election and the results of our analysis seems to suggest the unbundling of items and services that perhaps should have been provided and covered under the Medicare hospice benefit.

We first reported findings on 2012 non-hospice spending during a hospice election in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452). This proposed rule updates our analysis of non-hospice spending during a hospice election using FY 2017 data. We found that in FY 2017, Medicare paid over $900 million for items and services under Parts A, B, and D for beneficiaries during a hospice election. Medicare payments for non-hospice Part A and Part B items and services received by hospice beneficiaries during hospice election were $730 million in FY 2011, $745 million in FY 2012, $709 million in FY 2013, $621 million in FY 2014, $591 million in FY 2015, $586 million in FY 2016, and $566 million in FY 2017 (see Figure 4 below). The beneficiary cost sharing amount in FY 2017 was $138 million. Non-hospice spending for Part A and Part B items and services has decreased each year since we began reporting these findings. Overall, from FY 2011 to FY 2017 non-hospice Medicare spending for Parts A and B during hospice election declined 23 percent. However, there continues to be a non-trivial amount of non-hospice Parts A and B spending on beneficiaries under a hospice election, and we will continue to monitor data regarding this issue.

Figure 4: Medicare Payments for Non-Hospice Medicare Part A and Part B items and services during Hospice Elections, FY 2011 – FY 2017

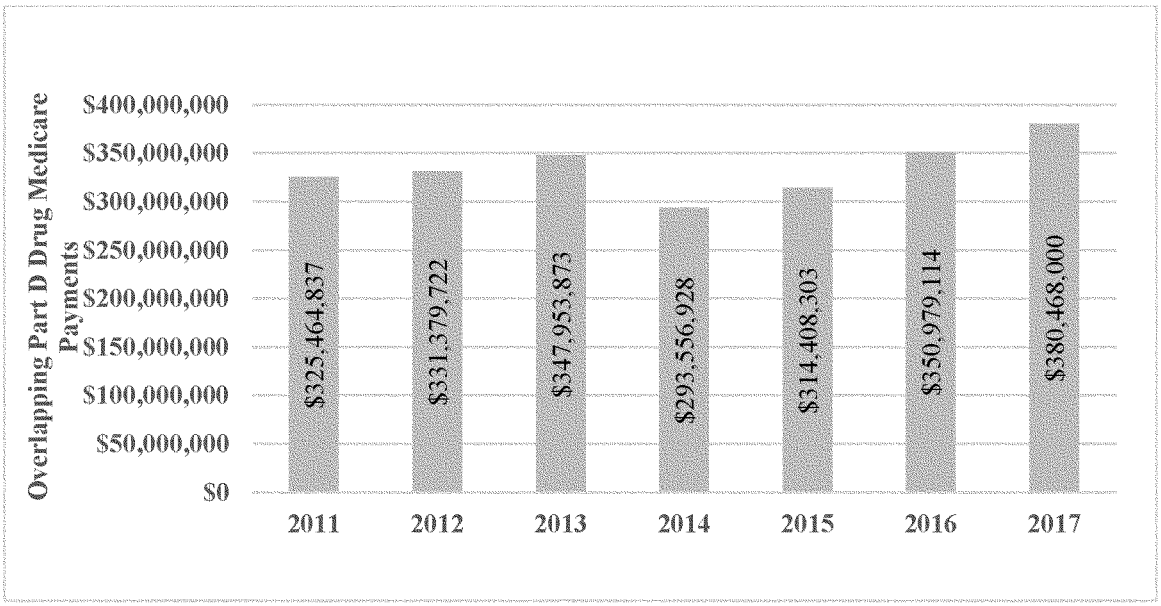


Source: Analysis of 100 percent Medicare Part A and Part B claims data from Common Working File (CWF) (final action claims), FY 2011 through FY 2017, excluding utilization on hospice admission or live discharge days.

We also examined Part D spending from FY 2011 to FY 2017 for those beneficiaries under a hospice election. The data shows Medicare payments for non-hospice Part D drugs received by hospice beneficiaries during a hospice election were $325 million in FY 2011, $331 million in FY 2012, $348 million in FY 2013, $294 million in FY 2014, $314 million in FY 2015, $351 million in FY 2016, and $380 million in FY 2017 (see Figure 5). In contrast to non-hospice spending during a hospice election for Medicare Parts A and B items and services, non-hospice spending for Part D drugs increased in FY 2017 compared to FY 2011.

Recent analyses of Part D prescription drug event (PDE) data suggest that the current prior authorization (PA) has reduced Part D program payments for drugs in four targeted categories (analgesics, anti-nauseants, anti-anxiety, and laxatives). However, under Medicare Part D there has been an increase in hospice beneficiaries filling prescriptions for a separate category of drugs we refer to as maintenance drugs, as recently analyzed by CMS (*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf*). Currently, maintenance drugs for beneficiaries under a hospice election are not subject to the Part D PA process. After a hospice election, many maintenance drugs as well as drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, there are maintenance drugs that are appropriate to continue as they may offer symptom relief for the palliation and management of the terminal illness and related conditions, and therefore should be covered under the hospice benefit, not Part D. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes. These categories include beta blockers, calcium channel blockers, corticosteroids, and insulin.

Figure 5: Medicare Payments for Non-Hospice Medicare Part D Prescription Drugs during Hospice Elections, FY 2011 - FY 2017



Source: Analysis of 100% FY 2012 through FY 2015 Part D TAP data listing a drug for a valid Generic Product Identifier (GPI).

Table 10 below details the various components of Part D spending for patients receiving hospice care for FY 2017. The portion of the $474.2 million total Part D spending that was paid by Medicare is the sum of the Low Income Cost-Sharing Subsidy (row 2 in Table 10) and the Covered Drug Plan Paid Amount (row 5), or approximately $380.5 million. The beneficiary cost sharing amount was approximately $68.6 million, including patient pay amount (row 1), other true out-of-pocket amount (row 3), and patient liability reduction due to other payer amount (row 4).

TABLE 10—DRUG COST SOURCES FOR HOSPICE BENEFICIARIES' FY 2017 DRUGS RECEIVED THROUGH PART D

Component	FY 2017 expenditures
Patient Pay Amount	$50,903,365
Low Income Cost-Sharing Subsidy	111,159,483
Other True Out-of-Pocket Amount	1,555,456
Patient Liability Reduction due to Other Payer Amount	16,153,569
Covered Drug Plan Paid Amount	269,308,517
Non-Covered Plan Paid Amount	8,664,146
Six Payment Amount Totals	457,744,535
Unknown/Unreconciled	16,425,792

TABLE 10—DRUG COST SOURCES FOR HOSPICE BENEFICIARIES' FY 2017 DRUGS RECEIVED THROUGH PART D—Continued

Component	FY 2017 expenditures
Gross Total Drug Costs, Reported	474,170,328

Source: Analysis of 100% FY 2017 Medicare Claim Files. For more information on the components above and on Part D data, go to the Research Data Assistance Center's (ResDAC's) website at: *http://www.resdac.org/*.

Hospices are responsible for covering drugs and biologicals related to the palliation and management of the terminal illness and related conditions while the patient is under hospice care. For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment unrelated to the terminal illness or related conditions. As noted above, after a hospice election, many maintenance drugs or drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, those same drugs may be appropriate to continue as they may offer symptom relief for the palliation and management of the terminal prognosis.[5] In our ongoing analysis of non-hospice spending, we remain concerned that common palliative and other disease-specific drugs for hospice beneficiaries that are covered under the Part A Medicare hospice benefit are instead being covered and paid for through Part D. Based on our own analysis as demonstrated in the data provided above and similar analyses conducted by the OIG regarding Part D drug expenditures for Medicare hospice beneficiaries, we believe that Medicare could be paying twice for drugs that are already covered under the hospice per diem payment by also paying for them under Part D.[6]

We continue to expect that hospices should be providing virtually all of the care needed by terminally ill individuals, including related prescription drugs. The comprehensive nature of the services covered under the Medicare hospice benefit is structured such that hospice beneficiaries should not have to routinely seek items, services, and/or medications beyond those provided by hospice. The hospice medical director, the attending physician (if any), and the hospice interdisciplinary group (IDG) determine, on a case-by-case basis, what items and services are related and unrelated to the palliation and management of the terminal illness and related conditions during the admission process, the initial and comprehensive assessments, and in

[5] *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf.*

[6] *https://oig.hhs.gov/oas/reports/region6/61000059.asp,* ''Medicare Could Be Paying Twice for Prescriptions for Beneficiaries in Hospice.''

the development of the hospice plan of care (§§ 418.25, 418.54, and 418.56).

To the extent that individuals receive services outside of the Medicare hospice benefit, Medicare coverage is determined by whether or not the services are for the treatment of a condition completely unrelated to the individual's terminal illness and related conditions (48 FR 38148). However, we have presented hospice monitoring data from the past several years, as seen above, that continue to show a non-trivial amount of items, services, and medications being furnished outside of the Medicare hospice benefit to beneficiaries under a hospice election. We encourage hospices to educate beneficiaries regarding the comprehensive nature of the hospice benefit. Although it should be rare, if any conditions are identified by the hospice as unrelated to the terminal illness and related conditions, we further encourage hospices to inform the beneficiary (or representative) at or near the time of election and provide the clinical rationale for such determinations. The regulations at § 476.78 state that providers must inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to Quality Improvement Organization (QIO) review. If a beneficiary disagrees with the hospice determination of what conditions are unrelated to the terminal illness and related conditions (and thus arguably not provided as part of the hospice benefit), we strongly encourage hospices to work to resolve the disagreement with the beneficiary (or representative), taking into consideration his or her wishes, treatment preferences and goals. If a resolution cannot be reached, the beneficiary and the hospice can agree to participate in a flexible, dialogue-based resolution process, called immediate advocacy, which is coordinated by the QIO. We will continue to monitor non-hospice spending during a hospice election and consider ways to address this issue through future regulatory and/or program integrity efforts, if needed.

2. Initial Analysis of Revised Hospice Cost Report Data

a. Background

As mentioned in section II.B of this proposed rule, the Medicare hospice per diem payment amounts were developed to cover all services needed for the palliation and management of the terminal illness and related conditions, as described in section 1861(dd)(1) of the Act. Services provided under a written plan of care could include: Nursing care provided by or under the supervision of a registered professional nurse; physical therapy, occupational therapy, speech-language pathology services; counseling (including dietary counseling); medical social services under the direction of a physician; services of a home health aide; homemaker services; medical supplies (including drugs and biologicals) and the use of durable medical equipment; physician services; short-term inpatient care (including both respite care and care necessary for pain control and acute and chronic symptom management) in a qualified inpatient facility; or any other item or service which has been specified in the plan of care for which payment may be made under Medicare. Under the current payment system, hospices are paid for each day that a beneficiary is enrolled in hospice care, regardless of whether services are rendered on any given day.

As described in the FY 2016 Hospice Wage Index and Rate Update final rule, we finalized changes to the hospice cost report form in order to broaden the scope and detail of data we collect regarding the costs of providing hospice care (80 FR 47150).[7] We believed that changes were needed to the hospice cost report in order to collect data on the costs of services provided at each level of care, rather than by costs per day, regardless of the level of care. The revisions to the cost report form for freestanding hospices became effective for cost reporting periods beginning on or after October 1, 2014. The instructions for completing the revised freestanding hospice cost report form are found in the Medicare Provider Reimbursement Manual-Part 2, chapter 43.[8] Medicare-certified institutional providers are required to submit an annual cost report to a Medicare contractor. The cost report contains provider information such as facility characteristics, utilization data, costs by cost center (for all payers as well as Medicare), Medicare settlement data, and financial statement data.

b. Methodology

Section 1814(i)(6) of the Act, as amended by section 3132(a)(1)(B) of the Affordable Care Act, authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The data collected may be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care. Effective October 1, 2014, we finalized changes to the hospice cost report to improve data collection on the costs of providing hospice care. We conducted an updated analysis of the revised cost report data (CMS Form 1984–14) for freestanding hospices with cost reporting periods in FY 2016, which totaled 2,867 reports. Using this data we calculated preliminary estimates of total costs per day by level of care. It is important to note that the values we computed for cost per day include all payer sources, both Medicare and non-Medicare; however, we believe that the total cost figures represent a reasonable proxy for estimating costs related to the provision of care for Medicare beneficiaries. In order to compute total Medicare-related costs by level of care, we multiplied the computed cost per day by level of care (as reported on Worksheet C) for each hospice by the number of Medicare days by level of care. We then calculated total payments by level of care for each hospice by multiplying the FY 2016 Medicare hospice payments by level of care by the number of Medicare days by level of care. Total costs, payments, and days by level of care were summed for each unique hospice. In order to more accurately account for the hourly CHC cost per day, we used data from Medicare claims in order to quantify the hours of CHC provided by summing the values reported in revenue center 0652, which tallies the units of CHC care. We then divided the CHC costs by the number of CHC hours as reported in revenue center 0652 to calculate a CHC per-hour value. Additionally, we obtained hospice provider characteristics from the Provider of Services (POS) file from December 2016; from that dataset, 4,367 unique providers were identified.

In order to evaluate the cost report data for implausible cost reports or cost reports that included unexpected data values, we applied three distinct trimming methodologies. The first trim applied a simple truncation at the statistical ends of the data. For each calculated outcome (for example, total RHC costs per day), we excluded those values that are above the 99th percentile and those values that are below the 1st percentile. For the purposes of this discussion, we refer to this trim as the ''1% Trim.''

The second trim is a more robust trim meant to remove unexpected results from the cost report data. For the

[7] CMS Transmittal 2864. ''Additional Data Reporting Requirements for Hospice Claims'', Available at: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf.*

[8] *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1P243.pdf.*

purposes of this discussion, we refer to this trim as the ''CMS Trim.'' The following list shows the exclusion criteria used for this trimming approach. For each element we have listed the number of hospices impacted by each exclusion criteria with the notation ''n=XX''. Additionally, we note that an individual hospice's cost report may have been impacted by multiple exclusion criteria.

1. We exclude cost reports less than 10 months or more than 14 months in length (n=130).

2. We excluded hospices with missing payment (n=2) or cost information (n=0).

3. We excluded hospices with negative payment (n=0) or cost information (n=21).

4. We exclude hospices that are in the 1st or 99th percentile of cost per day (n=60). Cost is determined from Worksheet F–2—Row 41—Colum 2 (Total operating expenses). Days are determined from Worksheet S–1—Row 34—Column 4 (Total unduplicated days). Note that these values compute cost per day including all payer sources.

5. We exclude hospices that are in the top and bottom 5 percent of hospices in terms of margins (n=290). Margins were computed including all payer sources. Cost is determined from Worksheet F–2—Row 41—Colum 2 (Total operating expenses). Payments come from worksheet F–2—Row 26—Column 4 (Total Revenues).

6. We exclude hospices that have extreme payment or cost values (n=108). This trimming criterion included agencies where the log of the ratio of payment to cost exceeded the 90th percentile of its distribution plus 1.5 times the interdecile range or if it was less than the 10th percentile minus 1.5 times its interdecile range.

In order to improve the quality of data submitted on the cost report, industry representatives suggested various edits, which, for the purposes of this discussion will be labeled ''Level 1 Edits'' as they would cause the hospice cost report to be revised before being accepted by the Medicare Administrative Contractors (MACs). These types of edits could force adherence to certain cost reporting principles and could lead to the reporting of higher-quality hospice cost data. The suggested edits would cause Worksheet A to generate a Level 1 Edit and reject a cost report if no costs were included in the following recommended Cost Centers:

Line 3—Employee Benefits
Line 4—Administrative and General
Line 5—Plant Operations and Maintenance
Line 13—Volunteer Services Coordination
Line 14—Pharmacy
Line 28—Registered Nurse
Line 37—Hospice Aide and Homemaker Services
Line 38—Durable Medical Equipment/Oxygen
Line 41—Labs and Diagnostics
Line 1—Capital Related Costs—Building and Fixtures and
Line 33—Medical Social Services

In order to estimate the potential impact of the application of these possible edits, we analyzed the 2016 hospice cost report data and applied the edits to the cost centers highlighted by industry representatives and removed cost reports where data was not submitted for the lines of interest. For each of the cost centers identified, we excluded those cost reports that provided no cost data on the line items. In total, almost 66 percent of the cost reports submitted by hospices for 2016 were missing data on one of the reporting lines identified as essential.

TABLE 11—NUMBER AND PERCENTAGE OF FREESTANDING HOSPICE COST REPORTS WITH MISSING INFORMATION IN WORKSHEET A—COLUMN 7—''LEVEL 1 EDITS''

Part of the cost report	Line	% missing	N that are missing
Employee Benefits	3	13.80	385
Administrative & General	4	0.29	8
Plant Operations and Maintenance	5	45.16	1,260
Volunteer Services Coordination	13	37.71	1,052
Pharmacy	14	12.47	348
Registered Nurse	28	1.22	34
Hospice Aide and Homemaker Services	37	2.69	75
Durable Medical Equipment/Oxygen	38	11.65	325
Labs Diagnostics	41	22.83	637
Capital Related Costs—Building and Fixtures	1	17.13	478
Medical Social Services	33	4.37	122
Missing Any of the Above		65.59	1,830

Source: Medicare hospice cost report data for FY 2016.

Given the high volume of cost reports that show zero costs on lines that are expected to be populated, it is evident that hospices may not be providing thorough and representative cost data currently. If we were to implement the industry-requested Level 1 edits to the 2016 cost reports, nearly two thirds of the reports would be rejected based on missing cost data. Given that these edits are for consideration only and have not yet been proposed, we plan to continue collaborating with the provider community to identify ways in which we may foster the submission of high quality hospice cost data. We reiterate that this ''Potential Level 1 Edit'' approach is for discussion purposes only and may be considered for potential future use.

c. Overall Payments and Costs and Costs by Level of Care

For the purposes of evaluating calculated costs per day by level of care compared to Medicare payment amounts, we compared the reported costs on the Medicare cost report to the FY 2016 per diem payment rates by level of care. In order to estimate the potential impact of the application of the three different trim methodologies mentioned above, we analyzed the 2016 hospice cost report data and applied the three sets of edits. Table 12 below shows the distribution of the calculated Average Cost Per Day by Level of Care, using data from Worksheet C—Rows 3, 8, 13, 18—Column 3.

TABLE 12—TOTAL COST PER DIEM BY LEVEL OF CARE APPLYING THREE TRIM METHODOLOGIES

Level of care	Number of cost reports	Mean	Weighted mean	Minimum value	25th percentile	Median	75th percentile	Maximum value	FY 2016 per diem payment amounts
CHC:									
1% Trim	1,171	78	51	2	19	51	90	1,576	* $944.79
CMS Trim	1,111	135	52	0	18	51	91	19,864	
Level 1 Edits	425	129	53	0	23	52	86	19,864	
RHC:									
1% Trim	2,715	133	125	64	107	127	151	315	161.89
CMS Trim	2,465	148	124	6	106	126	149	19,372	
Level 1 Edits	967	139	123	1	105	125	145	3,487	
IRC:									
1% Trim	1,987	498	397	52	215	313	483	6,678	167.45
CMS Trim	1,828	629	448	2	214	311	489	67,766	
Level 1 Edits	800	602	415	2	215	299	492	25,817	
GIP:									
1% Trim	1,794	1,040	841	75	586	856	1,187	10,370	720.11
CMS Trim	1,664	1,353	834	2	590	858	1,192	149,422	
Level 1 Edits	737	1,287	880	19	596	835	1,094	60,779	

* $39.37/hr.
Source: Medicare hospice cost report & claims data for FY 2016.
Note: Weighted means are computed based on the number of days by level of care.

As described above, the cost report data analyzed were trimmed to minimize the effect of statistical anomalies. Nevertheless, there is substantial variation in the reported cost per day by hospices under each of the three trimming methodologies. The results displayed in Table 12 indicate that applying the 1% Trim leads to the exclusion of the least number of cost reports, while applying Level 1 Edits leads to the exclusion of the largest number of cost reports. For instance, when total RHC costs per day are trimmed based on the 1% Trim, 2,715 cost reports are retained. Applying the CMS Trim slightly reduces the number of cost reports to 2,465, while applying Level 1 Edits reduces the sample to 967 reports. However, we note that reductions in sample size do not necessarily lead to the exclusion of the largest outliers. For instance, the maximum value for total RHC costs per day is $315 after the 1% Trim, the analogous value after the CMS Trim is $19,372, and the analogous value after Level 1 Edits is $3,487. For mean values, we calculated both unweighted means as well as the means that are weighted by the number of days by level of care. Weighted means are closer to the medians than unweighted means, suggesting that extreme values come from smaller hospices with fewer hospices days. The estimated median cost values are lower than the base payment rate for RHC, but not for CHC, IRC, or GIP.

Total cost per day values in the four levels of care span from a minimum of $1 to maximum values in the tens of thousands. Because of this wide range of values in the distribution, we used the median as well as the mean values weighted by the number of days by level of care as reference points in these preliminary analyses. When compared with the FY 2016 per diem payment rates, the calculated median and weighted mean costs associated with providing RHC are lower than the base payment rates. As noted in section III.A of this proposed rule, the RHC level of care accounts for over 98 percent of all hospice days based on our analysis of claims for FY 2017. The median and weighted mean costs for the provision of RHC under all three trim methodologies cluster around an estimated $126 and $124 respectively, with both figures presenting lower values than the single RHC FY 2016 per diem payment rate of $161.89, a difference of approximately $38 and $38 respectively.

Conversely, for CHC the estimated median and weighted mean costs per day under each of the three trim methodologies hover around $51 and 52 per hour, respectively. The FY 2016 payment rate for CHC was $39.37 per hour. The CHC level of care accounts for approximately 0.28 percent of all hospice days in FY 2017, as noted in section III.A of this proposed rule. Similarly, the median and weighted mean costs per day associated with the provision of GIP care under all three trim methodologies is estimated in the mid-$800 range, while the FY 2016 per diem payment amount for GIP was $720.11. As noted in section III.A of this proposed rule, the GIP level of care accounts for approximately 1.38 percent of all hospice days based on our analysis of FY 2017 claims. Likewise, costs per day associated with the IRC level of care are estimated at around $300 for median values and in a range of $397 to nearly $450 under the three trimming methodologies for weighted mean values. We note that the per diem payment amount for the IRC level of care for FY 2015 was $167.45, showing a gap between the estimated costs and current payment rate. We estimate that IRC days represent approximately 0.30 percent of all hospice days in FY 2017 claims as described in section III.A of this proposed rule.

As we continue to gather more cost report data, we plan to conduct more thorough analyses of the cost report data and fully assess Medicare-related hospice costs as compared with Medicare hospice payments by level of care. We encourage hospices to continue to submit the most accurate data possible on Medicare cost reports and invite feedback regarding potential edits and other strategies for improving the data for hospice providers.

B. Proposed FY 2019 Hospice Wage Index and Rate Update

1. Proposed FY 2019 Hospice Wage Index

The hospice wage index is used to adjust payment rates for hospice agencies under the Medicare program to reflect local differences in area wage levels, based on the location where services are furnished. The hospice wage index utilizes the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. Our regulations at § 418.306(c) require each

labor market to be established using the most current hospital wage data available, including any changes made by Office of Management and Budget (OMB) to the Metropolitan Statistical Areas (MSAs) definitions.

We use the previous FY's hospital wage index data to calculate the hospice wage index values. For FY 2019, the hospice wage index will be based on the FY 2018 hospital pre-floor, pre-reclassified wage index. This means that the hospital wage data used for the hospice wage index are not adjusted to take into account any geographic reclassification of hospitals including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all of the Core-Based Statistical Areas (CBSAs) within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2019, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia.

There exist some geographic areas where there were no hospitals, and thus, no hospital wage data on which to base the calculation of the hospice wage index. In the FY 2008 Hospice Wage Index final rule (72 FR 50217 through 50218), we implemented a methodology to update the hospice wage index for rural areas without hospital wage data. In cases where there was a rural area without rural hospital wage data, we use the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs, to represent a reasonable proxy for the rural area. The term ''contiguous'' means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, for rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For FY 2019, we propose to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

As described in the August 8, 1997 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. Pre-floor, pre-reclassified hospital wage index values below 0.8 are adjusted by a 15 percent increase subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8, then County A's hospice wage index would be 0.4593. In another example, if County B has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15 which equals 0.8556. Because 0.8556 is greater than 0.8, County B's hospice wage index would be 0.8.

On February 28, 2013, OMB issued OMB Bulletin No. 13–01, announcing revisions to the delineation of MSAs, Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineation in these areas. In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47178), we adopted the OMB's new area delineations using a 1-year transition. In that final rule, we also stated that beginning October 1, 2016, the wage index for all hospice payments would be fully based on the new OMB delineations.

On August 15, 2017, OMB issued bulletin No. 17–01, which is available at *https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/bulletins/2017/b-17–01.pdf.* In this bulletin, OMB announced that one Micropolitan Statistical Area, Twin Falls, Idaho, now qualifies as a Metropolitan Statistical Area. The new CBSA (46300) comprises the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho. The FY 2019 hospice wage index value for CBSA 46300, Twin Falls, Idaho, will be 0.8000.

The proposed hospice wage index applicable for FY 2019 (October 1, 2018 through September 30, 2019) is available on our website at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.*

2. Proposed FY 2019 Hospice Payment Update Percentage

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the inpatient hospital market basket percentage increase set out under section 1886(b)(3)(B)(iii) of the Act, minus 1 percentage point. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient market basket percentage increase for that FY. The Act historically required us to use the inpatient hospital market basket as the basis for the hospice payment rate update.

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage would be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP). In addition to the MFP adjustment, section 3401(g) of the Affordable Care Act also mandated that in FY 2013 through FY 2019, the hospice payment update percentage would be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act).

The proposed hospice payment update percentage for FY 2019 is based on the estimated inpatient hospital market basket update of 2.9 percent (based on IHS Global Inc.'s first quarter 2018 forecast with historical data through the fourth quarter 2017). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the estimated inpatient hospital market basket update for FY 2019 of 2.9 percent must be reduced by a MFP adjustment as mandated by Affordable Care Act (currently estimated to be 0.8 percentage point for FY 2019). The estimated inpatient hospital market basket update for FY 2019 is reduced

further by 0.3 percentage point, as mandated by the Affordable Care Act. In effect, the proposed hospice payment update percentage for FY 2019 is 1.8 percent.

Currently, the labor portion of the hospice payment rates is as follows: For RHC, 68.71 percent; for CHC, 68.71 percent; for General Inpatient Care, 64.01 percent; and for Respite Care, 54.13 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. Therefore, the non-labor portion of the payment rates is as follows: For RHC, 31.29 percent; for CHC, 31.29 percent; for General Inpatient Care, 35.99 percent; and for Respite Care, 45.87 percent. Beginning with cost reporting periods starting on or after October 1, 2014, freestanding hospice providers are required to submit cost data using CMS Form 1984–14 (*https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Hospice-2014.html*). We are currently analyzing this data for possible use in updating the labor portion of the hospice payment rates. Any changes to the labor portions would be proposed in future rulemaking and would be subject to public comments.

3. Proposed FY 2019 Hospice Payment Rates

There are four payment categories that are distinguished by the location and intensity of the services provided. The base payments are adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index. A hospice is paid the RHC rate for each day the beneficiary is enrolled in hospice, unless the hospice provides CHC, IRC, or GIP. CHC is provided during a period of patient crisis to maintain the patient at home; IRC is short-term care to allow the usual caregiver to rest and be relieved from caregiving; and GIP is to treat symptoms that cannot be managed in another setting.

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we implemented two different RHC payment rates, one RHC rate for the first 60 days and a second RHC rate for days 61 and beyond. In addition, in that final rule, we implemented a Service Intensity Add-on (SIA) payment for RHC when direct patient care is provided by a RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to 4 hours total) that occurred on the day of service, if certain criteria are met. In order to maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the new RHC rates were adjusted by a SIA budget neutrality factor.

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47177), we will continue to make the SIA payments budget neutral through an annual determination of the SIA budget neutrality factor (SBNF), which will then be applied to the RHC payment rates. The SBNF will be calculated for each FY using the most current and complete utilization data available at the time of rulemaking. For FY 2018, we calculated the SBNF using FY 2017 utilization data. For FY 2019, the SBNF that would apply to days 1 through 60 is calculated to be 0.9991. The SBNF that would apply to days 61 and beyond is calculated to be 0.9998.

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. In order to calculate the wage index standardization factor, we simulate total payments using the FY 2019 hospice wage index and compare it to our simulation of total payments using the FY 2018 hospice wage index. By dividing payments for each level of care using the FY 2019 wage index by payments for each level of care using the FY 2018 wage index, we obtain a wage index standardization factor for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP). The wage index standardization factors for each level of care are shown in the tables below.

The proposed FY 2019 RHC rates are shown in Table 13. The proposed FY 2019 payment rates for CHC, IRC, and GIP are shown in Table 14.

TABLE 13—PROPOSED FY 2019 HOSPICE RHC PAYMENT RATES

Code	Description	FY 2018 payment rates	SIA budget neutrality factor	Wage index standardization factor	Proposed FY 2019 hospice payment update	Proposed FY 2019 payment rates
651	Routine Home Care (days 1–60)	$192.78	× 0.9991	× 1.0009	× 1.018	$196.25
651	Routine Home Care (days 61+)	151.41	× 0.9998	× 1.0007	× 1.018	154.21

TABLE 14—PROPOSED FY 2019 HOSPICE CHC, IRC, AND GIP PAYMENT RATES

Code	Description	FY 2018 payment rates	Wage index standardization factor	Proposed FY 2019 hospice payment update	Proposed FY 2019 payment rates
652	Continuous Home Care Full Rate = 24 hours of care $41.62 = hourly rate	$976.42	× 1.0048	× 1.018	$998.77
655	Inpatient Respite Care	172.78	× 1.0007	× 1.018	176.01
656	General Inpatient Care	743.55	× 1.0015	× 1.018	758.07

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index final rule (76 FR 47320 through 47324), we

implemented a Hospice Quality Reporting Program (HQRP) as required by section 3004 of the Affordable Care Act. Hospices were required to begin collecting quality data in October 2012, and submit that quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. The proposed FY 2019 rates for hospices that do not submit the required quality data would be updated by the proposed FY 2019 hospice payment update percentage of 1.8 percent minus 2 percentage points. These rates are shown in Tables 15 and 16.

TABLE 15—PROPOSED FY 2019 HOSPICE RHC PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2018 payment rates	SIA budget neutrality factor	Wage index standardization factor	Proposed FY 2019 hospice payment update of 1.8% minus 2 percentage points = −0.2%	Proposed FY 2019 payment rates
651	Routine Home Care (days 1–60)	$192.78	× 0.9991	× 1.0009	× 0.998	$192.39
651	Routine Home Care (days 61+)	151.41	× 0.9998	× 1.0007	× 0.998	151.18

TABLE 16—PROPOSED FY 2019 HOSPICE CHC, IRC, AND GIP PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2018 payment rates	Wage index standardization factor	Proposed FY 2019 hospice payment update of 1.8% minus 2 percentage points = −0.2%	Proposed FY 2019 payment rates
652	Continuous Home Care Full Rate= 24 hours of care $40.80 = hourly rate	$976.42	× 1.0048	× 0.998	$979.14
655	Inpatient Respite Care	172.78	× 1.0007	× 0.998	172.56
656	General Inpatient Care	743.55	× 1.0015	× 0.998	743.18

4. Proposed Hospice Cap Amount for FY 2019

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014 (P. L. 113–185). Specifically, for accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. The proposed hospice cap amount for the 2019 cap year will be $29,205.44, which is equal to the 2018 cap amount ($28,689.04) updated by the proposed FY 2019 hospice payment update percentage of 1.8 percent.

C. Request for Information Update—Comments Related to Hospice Claims Processing

In the FY 2018 Hospice Wage Index and Rate Update proposed rule (82 FR 20789), we invited public comments to start a national conversation about improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families. We specifically stated that we would not respond to the comment submissions in the final rule. Instead, we would review the submitted request for information comments and actively consider them as we develop future regulatory proposals or future sub-regulatory policy guidance.

After reviewing all submitted requests for information, we believe one recommendation in particular warranted a revision to our current policy. Commenters suggested that CMS remove the requirement to report detailed drug data on the hospice claim as a way to reduce burden for hospices. We initially began asking for this information via Hospice Change Request 8358 in support of hospice payment reform [*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Transmittals-Items/Hospice-CR8358–R2747CP.html*]. After determining that this information is not currently used for quality, payment, or program integrity purposes, we are removing this requirement effective October 1, 2018. We also believe this could result in a significant reduction of burden to Medicare hospices, potentially reducing the number of line items on hospice claims by approximately 21.5 million, in aggregate. We will allow hospices two options for reporting hospice drug information. Providers will have the option to continue to report infusion pumps and drugs, with corresponding NDC information, on the hospice claim as separate line items. This submission option will no longer be mandatory. Alternatively, hospices can submit total, aggregate DME and drug charges on the claim. We believe that removing the requirement for the separate submission of detailed drug information on hospice claim lines and offering the alternative option to submit aggregate, total charge amounts provides flexibility for hospices as well as potentially reducing burden. In order to effectuate this change, we will issue a detailed sub-

regulatory change request, effective October 1, 2018.

Another suggestion which we would like to highlight was for CMS to remove the sequential billing requirement, which requires that claims are submitted in chronological order. While we are always evaluating ways to make operational improvements, sequential billing for hospice claims is required because of how hospice benefit periods are constructed in statute. Specifically, section 1812(a)(4) of the Social Security Act creates a sequence of benefit periods, defining coverage for periods of ''hospice care with respect to the individual during up to two benefit periods of 90 days each and an unlimited number of *subsequent* periods of 60 days each . . .'' Sequential billing ensures that Medicare systems create and exhaust each period before creating a later period, maintaining the statutorily-required sequence. In addition, as finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142), payment for routine home care now varies depending on length of stay (a higher rate for days 1–60 and a lower rate for days 61+) making the sequential billing of hospice claims necessary to accurately pay claims and ensure the system applies benefit periods. Sequential billing ensures correct payments are made and to providers, minimizes the need to resubmit claims or face claims denials, and ultimately reduces burden. As a result, we are not able to eliminate the sequential billing requirement for hospice claims.

While we are not proposing changes to either the hospice billing procedures or payment regulations in this proposed rule, we will consider whether future regulatory or sub-regulatory changes are warranted to reduce unnecessary burden. We thank the commenters for taking the time to convey their thoughts and suggestions on this initiative.

D. Proposed Regulations Text Changes in Recognition of Physician Assistants as Designated Attending Physicians

When electing the Medicare hospice benefit, the beneficiary agrees to forgo the right to have Medicare payment made for services related to the beneficiary's terminal illness and related conditions, except when such services are provided by the designated hospice and the beneficiary's designed attending physician as outlined in section 1812(d)(2)(A) of the Act. The designated attending physician plays an important role in the care of a Medicare hospice beneficiary. If a beneficiary designates an attending physician, the beneficiary or his or her representative acknowledges that the identified attending physician was his or her choice and that the attending physician identified by the beneficiary, at the time he or she elects to receive hospice care, has the most significant role in the determination and delivery of the individual's medical care. The designated attending physician is required to certify that the beneficiary is terminally ill and participates as a member of the hospice IDG that establishes and/or or updates the individual's plan of care, ensuring that the Medicare beneficiary receives high quality hospice care.

Under the current hospice regulations at 42 CFR 418.3, the attending physician is defined as a doctor of medicine or osteopathy who is legally authorized to practice medicine or surgery by the state in which he or she performs that function, or a nurse practitioner, and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care. A nurse practitioner is defined as a registered nurse who performs such services as legally authorized to perform (in the state in which the services are performed) in accordance with state law (or state regulatory mechanism provided by state law) and who meets training, education, and experience requirements described in 42 CFR 410.75.

Section 51006 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) amended section 1861(dd)(3)(B) of the Social Security Act such that, effective January 1, 2019, physician assistants (PAs) will be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners. We define the PA as a professional who has graduated from an accredited physician assistant educational program who performs such services as he or she is legally authorized to perform (in the state in which the services are performed) in accordance with state law (or state regulatory mechanism provided by state law) and who meets the training, education, and experience requirements as the Secretary may prescribe. The PA qualifications for eligibility for furnishing services under the Medicare program can be found in the regulations at 42 CFR 410.74(c). We note section 1861(s)(2)(K)(i) of the Act states that PAs are authorized to furnish physician services under their State scope of practice, under the general supervision of a physician; therefore the regulations at 42 CFR 410.150(a)(15) require that payment for PA services may be made to the employer or contractor of a PA.

Effective January 1, 2019, Medicare will pay for medically reasonable and necessary services provided by PAs to Medicare beneficiaries who have elected the hospice benefit and who have selected a PA as their attending physician. PAs are paid 85 percent of the fee schedule amount for their services as designated attending physicians. Attending physician services provided by PAs may be separately billed to Medicare only if the PA is the beneficiary's designated attending physician, services are medically reasonable and necessary, services would normally be performed by a physician in the absence of the PA, whether or not the PA is directly employed by the hospice, and services are not related to the certification of terminal illness.

Since PAs are not physicians, as defined in 1861(r)(1) of the Act, they may not act as medical directors or physicians of the hospice or certify the beneficiary's terminal illness and hospices may not contract with a PA for their attending physician services as described in section 1861(dd)(2)(B)(i)(III) of the Act, which outlines the requirements of the interdisciplinary group as including at least one physician, employed by or under contract with the agency or organization. All of these provisions apply to PAs without regard to whether they are hospice employees.

Finally, we note that the Bipartisan Budget Act of 2018 did not make changes to which practitioners can certify terminal illness for a Medicare beneficiary nor who may perform the face-to-face encounter. Section 1814(a)(7)(A)(i)(I) of the Act was amended by section 51006 of the Bipartisan Budget Act of 2018 to specify that certification of terminal illness for hospice benefits shall be based on the clinical judgment of the hospice medical director or physician member of the IDG and the individual's attending physician, if he or she has one (except for the purposes of certifying terminal illness the individual's attending physician does not include a nurse practitioner *or a physician assistant* [emphasis added]), regarding the normal course of the individual's illness. No one other than a medical doctor or doctor of osteopathy can certify or re-certify terminal illness. PAs were not authorized by section 51006 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) to perform the required hospice face-to-face encounter for recertifications. The hospice face-to-face encounter is required per section 1814(a)(7)(D)(i) of the Act, which continues to state that only a hospice

physician or a hospice nurse practitioner can perform the encounter. The regulations at 42 CFR 418.22 will continue to state that the hospice face-to-face encounter must be performed by a hospice physician or hospice nurse practitioner.

In summary, we propose to make statutorily-required updates to § 418.3 in the Hospice Care regulations to expand the definition of attending physician to include physician assistants (PA). We also propose to amend 42 CFR 418.304 (Payment for physician and nurse practitioner services) in the Hospice Care regulations to include the details outlined above regarding Medicare payment for designated hospice attending physician services provided by physician assistants. We are soliciting comments on these proposed changed to the regulations at §§ 418.3 and 418.304.

E. Proposed Technical Correction Regarding Hospice Cap Period Definition

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), we finalized aligning the cap period, for both the inpatient cap and the hospice aggregate cap, with the federal FY for FY 2017 and later. Therefore, the cap year now begins October 1 and ends on September 30 (80 FR 47186). We propose to make a technical correction in § 418.3 to reflect the revised timeframes for hospice cap periods. Specifically, we propose that 42 CFR 418.3 would specify that the cap period means the twelve-month period ending September 30 used in the application of the cap on overall hospice reimbursement specified in § 418.309. We are soliciting comments on this technical change to our regulations at § 418.3.

F. Updates to the Hospice Quality Reporting Program (HQRP)

1. Background and Statutory Authority

The Hospice Quality Reporting Program includes HIS and CAHPS. Section 3004(c) of the Affordable Care Act amended section 1814(i)(5) of the Act to authorize a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. Depending on the amount of the annual update for a particular year, a reduction of 2 percentage points could result in the annual market basket update being less than 0 percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the particular year involved. Any such reduction would not be cumulative nor be taken into account in computing the payment amount for subsequent FYs. Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form, manner, and at a time specified by the Secretary.

2. General Considerations Used for Selection of Quality Measures for the Hospice QRP

a. Background

The ''Meaningful Measures'' initiative is intended to provide a framework for quality measurement and improvement work at CMS. While this framework serves to focus on those core issues that are most vital to providing high-quality care and improving patient outcomes, it also takes into account opportunities to reduce paperwork and reporting burden on providers associated with quality measurement. To that end, we have begun assessing our programs' quality measures in accordance with the Meaningful Measures framework. We refer readers to the Executive Summary, for more information on the ''Meaningful Measures'' initiative.

b. Accounting for Social Risk Factors in the Hospice QRP

In the FY 2018 Hospice Wage Index final rule (82 FR 36652 through 36654), we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex patients, as well as those with social risk factors, receive excellent care. We discussed how studies show that social risk factors, such as being near or below the poverty level, as set out annually in HHS guidelines, *https://www.federalregister.gov/documents/2018/01/18/2018-00814/annual-update-of-the-hhs-poverty-guidelines,* belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes and how some of this disparity is related to the quality of health care.[9] Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex patients as well as those with social risk factors receive excellent care. Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in CMS value-based purchasing programs.[10] As we noted in the FY 2018 Hospice Wage Index final rule (82 FR 36652 through 36654), ASPE's report to Congress, which was required by section 2(d) of the IMPACT Act, found that, in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that they examined and tested. ASPE is continuing to examine this issue in its second report required by the IMPACT Act, which is due to Congress in the fall of 2019. In addition, as we noted in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38428), the National Quality Forum (NQF) undertook a 2-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate for these measures.[11] The trial period ended in April 2017 and a final report is available at: *http://www.qualityforum.org/SES_Trial_Period.aspx.* The trial concluded that ''measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship'' between social risk factors and the outcomes measured. This discrepancy may be explained in part by the ''methods used for adjustment and the limited availability of robust data on social risk factors''. NQF has extended the socioeconomic status (SES) trial,[12] allowing further examination of social risk factors in outcome measures.

In the FY 2018/CY 2018 proposed rules for our quality reporting and

[9] See, for example United States Department of Health and Human Services. ''Healthy People 2020: Disparities. 2014.'' Available at: *http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities;* or National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: National Academies of Sciences, Engineering, and Medicine 2016.

[10] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), ''Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs.'' December 2016. Available at: *https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.*

[11] Available at: *http://www.qualityforum.org/SES_Trial_Period.aspx.*

[12] Available at: *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86357.*

value-based purchasing programs, we solicited feedback on which social risk factors provide the most valuable information to stakeholders and the methodology for illuminating differences in outcomes rates among patient groups within provider that would also allow for a comparison of those differences, or disparities, across providers. Feedback we received across our quality reporting programs included encouraging CMS to explore whether factors that could be used to stratify or risk adjust the measures (beyond dual eligibility); considering the full range of differences in patient backgrounds that might affect outcomes; exploring risk adjustment approaches; and offering careful consideration of what type of information display would be most useful to the public.

We also sought public comment on confidential reporting and future public reporting of some of our measures stratified by patient dual-eligibility. In general, commenters noted that stratified measures could serve as tools for hospitals to identify gaps in outcomes for different groups of patients, improve the quality of health care for all patients, and empower consumers to make informed decisions about health care. Commenters encouraged us to stratify measures by other social risk factors such as age, income, and educational attainment. With regard to value-based purchasing programs, commenters also cautioned CMS to balance fair and equitable payment while avoiding payment penalties that mask health disparities or discouraging the provision of care to more medically complex patients. Commenters also noted that value-based payment program measure selection, domain weighting, performance scoring, and payment methodology must account for social risk.

As a next step, we are considering options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities as shown by quality measures. We also are considering how this work applies to other CMS quality programs in the future. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38403 through 38409) for more details, where we discuss the potential stratification of certain Hospital Inpatient Quality Reporting Program outcome measures. Furthermore, we continue to consider options to address equity and disparities in our value-based purchasing programs.

We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.

c. New Measure Removal Factor

In the FY 2016 Hospice Final Rule (80 FR 47186), we adopted seven factors for measure removal. We are adopting an eighth factor to consider when evaluating measures for removal from the HQRP measure set: The costs associated with a measure outweighs the benefit of its continued use in the program.

As we discussed in the Executive Summary, we are engaging in efforts to ensure that the HQRP measure set continues to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program. We believe these costs are multi-faceted and includes not only the burden associated with reporting, but also the costs associated with complying with the program. We have identified several different types of costs, including, but not limited to: (1) Provider and clinician information collection burden and burden associated with the submitting/reporting of quality measures to CMS; (2) the provider and clinician cost associated with complying with other Hospital IQR programmatic requirements; (3) the provider and clinician cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs; (4) the cost to CMS associated with the program oversight of the measure including measure maintenance and public display; and/or (5) the provider and clinician cost associated with compliance to other federal and/or state regulations (depending upon the measure). For example, it may be needlessly costly and/or of limited benefit to retain or maintain a measure for which our analyses show no longer meaningfully supports program objectives (for example, informing beneficiary choice or payment scoring). It may also be costly for health care providers to track the confidential feedback and preview reports, as well as publicly reported information on a measure we use in more than one program. We may also have to expend unnecessary resources to maintain the specifications for the measure, including the tools we need to collect, validate, analyze, and publicly report the measure data. Furthermore, beneficiaries may find it confusing to see public reporting on the same measure in different programs. There also may be other burdens associated with a measure that arise on a case-by-case basis.

When these costs outweigh the evidence supporting the continued use of a measure in the HQRP, we believe it may be appropriate to remove the measure from the program. Although we recognize that one of the main goals of the HQRP is to improve beneficiary outcomes by incentivizing health care providers to focus on specific care issues and making public data related to those issues, we also recognize that those goals can have limited utility where, for example, the publicly reported data is of limited use because it cannot be easily interpreted by beneficiaries and used to influence their choice of providers. In these cases, removing the measure from the HQRP may better accommodate the costs of program administration and compliance without sacrificing improved health outcomes and beneficiary choice.

We are proposing that we would remove measures based on this factor on a case-by-case basis. We might, for example, decide to retain a measure that is burdensome for health care providers to report if we conclude that the benefit to beneficiaries justifies the reporting burden. Our goal is to move the program forward in the least burdensome manner possible, while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients.

We are inviting public comment on our proposal to adopt an additional measure removal factor, ''the costs associated with a measure outweighs the benefit of its continued use in the program,'' beginning with the FY 2019 Hospice Wage Index final rule.

3. Previously Adopted Quality Measures for FY 2019 Payment Determination and Future Years

In the FY 2014 Hospice Wage Index final rule (78 FR 48257), and in compliance with section 1814(i)(5)(C) of the Act, we finalized the specific collection of data items that support the following 7 National Quality Forum (NQF)-endorsed measures for hospice:

- NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen,
- NQF #1634 Pain Screening,
- NQF #1637 Pain Assessment,
- NQF #1638 Dyspnea Treatment,
- NQF #1639 Dyspnea Screening,
- NQF #1641 Treatment Preferences,
- NQF #1647 Beliefs/Values Addressed (if desired by the patient)

We finalized the following 2 additional measures in the FY 2017 Hospice Wage Index final rule, effective

April 1, 2017. Data collected will, if not reported, affect payments for FY 2019 and subsequent years. (81 FR 52163 through 52173):

- Hospice Visits when Death is Imminent
- Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

The Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission measure (hereafter referred to as ''the Hospice Comprehensive Assessment Measure'') underwent an off-cycle review by the NQF Palliative and End-of-Life Standing Committee and successfully received NQF endorsement in July 2017.

Data for the Hospice Visits when Death is Imminent measure pair is being collected using new items added to the HIS V2.00.0, effective April 1, 2017. We will need at least 4 quarters of reliable data to conduct the necessary analyses to support submission to NQF. We will also need to assess the quality of data submitted in the first quarter of item implementation to determine whether they can be used in the analyses. We have begun analysis of the data, and, pending analysis, we will submit the Hospice Visits when Death is Imminent measure pair to NQF for endorsement review in accordance with NQF project timelines and call for measures. We will use a similar process to analyze and submit new quality measures to NQF for endorsement in future years. Providers will be notified of measure endorsement and the public reporting through sub-regulatory channels.

In the FY 2015 Hospice Wage Index final rule (79 FR 50491 through 50496), we also finalized the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey to support quality measures based on patient and family experience of care. We refer readers to section III.D.5 of the FY 2019 Proposed Rule for details regarding the CAHPS® Hospice Survey, including public reporting of selected survey measures.

TABLE 17—PREVIOUSLY FINALIZED QUALITY MEASURES AFFECTING THE FY 2019 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

NQF No.	Hospice item set quality measure	Year the measure was first adopted for use in APU determination
1641	Treatment Preferences	FY 2016.
1647	Beliefs/Values Addressed (if desired by the patient)	FY 2016.
1634	Pain Screening	FY 2016.
1637	Pain Assessment	FY 2016.
1639	Dyspnea Screening	FY 2016.
1638	Dyspnea Treatment	FY 2016.
1617	Patients Treated with an Opioid Who are Given a Bowel Regimen	FY 2016.
3235	The Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission.	FY 2019.
TBD	Hospice Visits when Death is Imminent	FY 2019.

4. Form, Manner, and Timing of Quality Data Submission

a. Background

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. Such data must be submitted in a form and manner, and at a time specified by the Secretary. Section 1814(i)(5)(A)(i) of the Act requires that beginning with the FY 2014 and for each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

b. Revised Data Review and Correction Timeframes for Data Submitted Using the HIS

In the FY 2015 Hospice Wage Index final rule (79 FR 50486), we finalized our policy requiring that hospices complete and submit HIS records for all patient admissions to hospice on or after July 1, 2014. For each HQRP reporting year, we require that hospices submit data in accordance with the reporting requirements specified in the FY 2015 Hospice final rule (79 FR 50486) for the designated reporting period. Electronic submission is required for all HIS records. For more information about HIS data collection and submission policies and procedures, we refer readers to the FY 2018 Hospice Wage Index final rule (82 FR 36663) and the CMS HQRP website: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html.* For more information about CAHPS® Hospice Survey data submission policies and timelines, we refer readers to section III.D.5 of the FY 2019 proposed rule.

Hospices currently have 36 months to modify HIS records. However, only data modified before the public reporting ''freeze date'' are reflected in the corresponding CMS Hospice Compare website refresh. For more information about the HIS ''freeze date'', please see the Public Reporting: Key Dates for Providers page on the CMS HQRP website: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Key-Dates-for-Providers.html.*

To ensure that the data reported on Hospice Compare is accurate, we propose that hospices be provided a distinct period of time to review and correct the data that is to be publically reported. This approach would allow hospices a time frame in which they may analyze their data and make corrections (up until 11:59:59 p.m. PST of the quarterly deadline) prior to receiving their preview reports. Once the preview reports are received, it is infeasible to make corrections to the data underlying the quality measure scores that are to be made public. Therefore, we are proposing that for data reported using the HIS that there be a specified time period for data review and a correlating data correction deadline for public reporting at which point the data is frozen for the associated quarter. Similar to the policies outlined in the FY 2016 SNF final rule (81 FR 24271) and the FY 2016 IPPS/LTCH final rule (80 FR 49754), at this deadline for public reporting, we propose that data from HIS records with target dates within the correlating quarter become a frozen ''snapshot'' of data for public reporting purposes. Any record-level data correction after the date on which the data are frozen will not be incorporated into measure calculation for the

purposes of public reporting on the CMS Hospice Compare website. For each calendar quarter of data submitted using the HIS, approximately 4.5 months after the end of each CY quarter we are proposing a deadline, or freeze date for the submissions of corrections to records. We note that this newly proposed data correction deadline for HIS records is separate and apart from the established 30-day data submission deadline. More information about the data submission deadline can be found at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/*.

Specifically, each deadline would occur on the 15th of the CY month that is approximately 4.5 months after the end of each CY quarter, and that hospices would have up until 11:59:59 p.m. PST on that date to submit corrections or requests for inactivation of their data for the quarter involved. For example, for data reported in CY Q1, the freeze date would be August 15th, for CY Q2 the freeze date would be November 15th and so on. Under this policy, any modification to or inactivation of records that occur after the proposed correction deadline would not be reflected in publicly reported data on the CMS Hospice Compare website. For example, for the data collected during the 1st quarter, that is January 1st through March 31st of a given year, the hospice will have until 11:59:59 p.m. PST on August 15th of that year to ensure all of their data is correct. Any modifications to first quarter data that are submitted to us after August 15th would not be reflected during any subsequent Hospice Compare refresh. We believe that this is a reasonable amount of time to allow providers to make any necessary corrections to submitted data prior to public reporting. This revised policy aligns HQRP with the policies and procedures that exist in our other quality reporting programs including the post-acute care programs, which also enables providers to review their data and make necessary corrections within the specified time frame of approximately 4.5 months following the end of a given CY quarter and prior to the public reporting of such data.

We propose that beginning January 1, 2019, HIS records with target dates on or after January 1, 2019 will have a data correction deadline for public reporting of approximately 4.5 months after the end of each CY quarter in which the target date falls, and that hospices will have until 11:59:59 p.m. PST on the deadline to submit corrections.

We also propose that for the purposes of public reporting, the first quarterly freeze date for CY 2019 data corrections will be August 15, 2019. To accommodate those HIS records with target dates prior to January 1, 2019 and still within a target period for public reporting, we also propose to extend to hospices the opportunity to review their data and submit corrections up until the CY 19 Q1 deadline of 11:59:59 p.m. PST on August 15, 2019. Table 18 presents the proposed data correction deadlines for public reporting beginning in CY 2019.

TABLE 18—DATA CORRECTION DEADLINES FOR PUBLIC REPORTING BEGINNING CY 2019

Data reporting period *	Data correction deadline for public reporting *
Prior to January 1, 2019.	August 15, 2019.
January 1, 2019–March 31, 2019.	August 15, 2019.
April 1, 2019–June 30, 2019.	November 15, 2019.
July 1, 2019–September 30, 2019.	February 15, 2020.
October 1, 2019–December 31, 2019.	May 15, 2020.

* This CY time period involved is intended to inform both CY 2019 data and to serve as an illustration for the review and correction deadlines that are associated with each calendar year of data reporting quarter.

We are soliciting public comments on these proposals.

5. CAHPS® Hospice Survey Participation Requirements for the FY 2023 APU and Subsequent Years

The CAHPS® Hospice Survey of CMS' HQRP is used to collect data on the experiences of hospice patients and the primary caregivers listed in their hospice records. Readers who want more information are referred to our extensive discussion of the Hospice Experience of Care prior to our proposal for the public reporting of measures may refer to 79 FR 50452 and 78 FR 48261.

a. Background and Description of the CAHPS® Hospice Survey

The CAHPS® Hospice Survey is the first standardized national survey available to collect information on patients' and informal caregivers' experience of hospice care. Patient-centered experience measures are a key component of the CMS Quality Strategy, emphasizing patient-centered care by rating experience as a means to empower patients and their caregivers and improving the quality of their care. In addition, the survey introduces standard survey administration protocols that allow for fair comparisons across hospices.

Although the development of the CAHPS® Hospice Survey predates the Meaningful Measures initiative, it used many of the Meaningful Measure principles in its development. The overarching quality priority of ''Strengthen Person and Family Engagement as Partners in Their Care'' includes Meaningful Measure areas such as ''Care is personalized and Aligned with Patient's Goals,'' ''End of Life Care According to Preferences'' and ''Patients Experience of Care.'' The survey questions were developed with input from caregivers of patients who died under hospice care. The survey focuses on topics that are meaningful to caregivers/patients and supports CMS's efforts to put the patient and their family members first.

Details regarding CAHPS® Hospice Survey national implementation, survey administration, participation requirements, exemptions from the survey's requirements, hospice patient and caregiver eligibility criteria, fielding schedules, sampling requirements, survey instruments, and the languages that are available for the survey, are all available on the official CAHPS® Hospice Survey website: *https://www.HospiceCAHPSsurvey.org,* and in the CAHPS® Hospice Survey Quality Assurance Guidelines (QAG), which are posted on the website.

b. Overview of the CAHPS® Hospice Survey Measures

The CAHPS® Hospice Survey is administered after the patient is deceased and queries the decedent's primary, informal caregiver (usually a family member) regarding the patient and family experience of care, unlike the Hospital CAHPS® Survey deployed in 2006 (71 FR 48037 through 48039) and other subsequent CAHPS® surveys. National implementation of the CAHPS® Hospice Survey commenced January 1, 2015 as stated in the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452).

The survey consists of 47 questions and is available (using the mailed version) in English, Spanish, Chinese, Russian, Portuguese, Vietnamese, Polish, and Korean. It covers topics such as access to care, communications, getting help for symptoms, and interactions with hospice staff. The survey also contains 2 global rating questions and asks for self-reported demographic information (race/ethnicity, educational attainment level, languages spoken at home, among others). The CAHPS® Hospice Survey

measures received NQF endorsement on October 26th, 2016 (NQF #2651). Measures derived from the CAHPS® Hospice Survey include 6 multi-item (composite) measures and 2 global ratings measures. They received NQF endorsement on October 26, 2016 (NQF #2651). We adopted these 8 survey-based measures for the CY 2018 data collection period and for subsequent years. These 8 measures are reported on Hospice Compare.

c. Data Sources

As discussed in the CAHPS® Hospice Survey QAG V4.0 (*http://www.hospice CAHPSsurvey.org/en/quality-assurance-guidelines/*), the survey has three administration methods: mail only, telephone only, and mixed mode (mail with telephone follow-up of non-respondents). We previously finalized the participation requirements for the FY 2020, FY 2021, and FY 2022 APUs (82 FR 36673). We propose to extend the same participation requirements to all future years, for example, the FY 2023, FY 2024 and FY 2025 Annual Payment and subsequent updates. To summarize, to meet the CAHPS® Hospice Survey requirements for the HQRP, we propose that hospice facilities must contract with a CMS-approved vendor to collect survey data for eligible patients on a monthly basis and report that data to CMS on the hospice's behalf by the quarterly deadlines established for each data collection period. The list of approved vendors is available at: *http://www.hospiceCAHPSsurvey.org/en/approved-vendor-list.*

Hospices are required to provide lists of the patients who died under their care, along with the associated primary caregiver information, to their respective survey vendors to form the samples for the CAHPS® Hospice Survey. We emphasize the importance of hospices providing complete and accurate information to their respective survey vendors in a timely manner.

Hospices must contract with an approved CAHPS® Hospice Survey vendor to conduct the survey on their behalf. Hospices are responsible for making sure their respective survey vendors meet all data submission deadlines. Vendor failures to submit data on time are the responsibility of the hospices. We invite public comment on this proposal.

d. Public Reporting of CAHPS® Hospice Survey Results

We began public reporting of the results of the CAHPS® Hospice Survey on Hospice Compare as of February 2018. The first report of CAHPS® data covered survey results from deaths occurring between Quarter 2, 2015 and Quarter 1, 2017. We report the most recent 8 quarters of data on the basis of a rolling average with the most recent quarter of data being added and the oldest quarter of data removed from the averages for each data refresh. We detailed the calculation of these measures in 82 FR 36674. We refresh the data 4 times a year in the months of February, May, August, and November. We will not publish CAHPS® data for any hospice that has fewer than 30 completed surveys due to concerns about statistical reliability. We propose to use the same public reporting policies in future years. We are soliciting comments on this proposal.

e. Volume-Based Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements

We previously finalized a volume-based exemption for CAHPS® Hospice Survey Data Collection and Reporting requirements in the FY 2017 final rule (82 FR 36671). We propose to continue our policy for a volume-based exemption for CAHPS® Hospice Survey Data Collection for FY 2023 and every year thereafter. For example, for the FY 2023 APU, hospices that have fewer than 50 survey eligible decedents/caregivers in the period from January 1, 2020 through December 31, 2020 (reference year) are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements (corresponds to the CY 2021 data collection period). To qualify, hospices must submit an exemption request form for the FY 2023 APU. The exemption request form is available on the official CAHPS® Hospice Survey website: *http://www.hospice CAHPSsurvey.org.*

Hospices that intend to claim the size exemption are required to submit to CMS their total unique patient count for the period of January 1, 2020 through December 31, 2020 (reference year). The due date for submitting the exemption request form for the FY 2023 APU is December 31, 2021. Exemptions for size are active for 1 year only. If a hospice continues to meet the eligibility requirements for this exemption in future FY APU periods, the organization needs to request the exemption annually for every applicable FY APU period.

For FY 2024 APU, hospices that have fewer than 50 survey eligible decedents/caregivers in the period from January 1, 2021 through December 31, 2021 (reference year) are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements. Hospices that intend to claim the size exemption are required to submit to CMS their total unique patient count for the period of January 1, 2021 through December 31, 2021. The due date for submitting the exemption request form for the FY 2024 APU is December 31, 2022. Exemptions for size are active for 1 year only. If a hospice continues to meet the eligibility requirements for this exemption in future FY APU periods, the organization must request the exemption annually for every applicable FY APU period.

For the FY 2025 APU, hospices that have fewer than 50 survey eligible decedents/caregivers in the period from January 1, 2022 through December 31, 2022 (reference year) are eligible to apply for an exemption from CAHPS® Hospice Survey data collection and reporting requirements for the FY 2025 payment determination. Hospices that intend to claim the size exemption are required to submit to CMS their total unique patient count for the period of January 1, 2022 through December 31, 2022. The due date for submitting the exemption request form for the FY 2025 APU is December 31, 2023. If a hospice continues to meet the eligibility requirements for this exemption in future FY APU periods, the organization must request the exemption annually for every applicable FY APU period.

TABLE 19—SIZE EXEMPTION KEY DATES FY 2023, FY 2024 AND FY 2025

Fiscal year	Data collection year	Reference year (count total number of unique patients in this year)	Size exemption form submission deadline
FY 2023	2021	2020	December 31, 2021.
FY 2024	2022	2021	December 31, 2022.
FY 2025	2023	2022	December 31, 2023.

f. Newness Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements

We previously finalized a one-time newness exemption for hospices that meet the criteria (81 FR 52181). We propose to continue the newness exemption for FY 2023, FY 2024, FY 2025, and all future years.

Specifically, hospices that are notified about their Medicare CCN after January 1, 2021 are exempted from the FY 2023 APU CAHPS® Hospice Survey requirements due to newness. Likewise, hospices notified about their Medicare CCN after January 1, 2022 are exempted from the FY 2024 APU CAHPS® Hospice Survey requirements due to newness. Hospices notified about their Medicare CCN after January 1, 2023 are exempted from the FY 2025 APU CAHPS® Hospice Survey requirements due to newness. No action is required on the part of the hospice to receive this exemption. The newness exemption is a one-time exemption from the survey. We encourage hospices to keep the letter they receive providing them with their CCN. The letter can be used to show when you received your number.

We propose that this newness exemption to the CAHPS® Hospice Survey will apply to all future years. We invite public comment on this proposal.

g. Requirements for the FY 2023 APU

To meet participation requirements for the FY 2023 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2021 through December 2021 (all 12 months) to receive their full payment for the FY 2023 APU. All data submission deadlines for the FY 2023 APU are in Table 20. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 20 for all APU periods listed in the table and moving forward. There are no late submissions permitted after the deadlines, except for extraordinary circumstances beyond the control of the provider as discussed above.

TABLE 20—CAHPS® HOSPICE SURVEY DATA SUBMISSION DATES FOR THE APU IN FY 2023, FY 2024, AND FY 2025

Sample months [1] (month of death)	CAHPS Quarterly data submission deadlines [2]
FY 2023 APU	
CY January–March 2021 (Quarter 1).	August 11, 2021.
CY April–June 2021 (Q2).	November 10, 2021.
CY July–September 2021 (Q3).	February 9, 2022.
CY October–December 2021 (Q4).	May 11, 2022.
FY 2024 APU	
CY January–March 2022 (Q1).	August 10, 2022.
CY April–June 2022 (Q2).	November 9, 2022.
CY July–September 2022 (Q3).	February 8, 2023.
CY October–December 2022 (Q4).	May 10, 2023.
FY 2025 APU	
CY January–March 2023 (Q1).	August 9, 2023.
CY April–June 2023 (Q2).	November 8, 2023.
CY July–September 2023 (Q3).	February 14, 2024.
CY October–December 2023 (Q4).	May 8, 2024.

[1] Data collection for each sample month initiates 2 months following the month of patient death (for example, in April for deaths occurring in January).

[2] Data submission deadlines are the second Wednesday of the submission months, which are the months August, November, February, and May.

h. Requirements for the FY 2024 APU

To meet participation requirements for the FY 2024 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2022 through December 2022 (all 12 months) to receive their full payment for the FY 2024 APU. All data submission deadlines for the FY 2024 APU are in Table 20. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 20 for all APU periods listed in the table and moving forward. There are no late submissions permitted after the deadlines, except for extraordinary circumstances beyond the control of the provider as discussed above.

i. Requirements for the FY 2025 APU

To meet participation requirements for the FY 2025 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2023 through December 2023 (all 12 months) to receive their full payment for the FY 2025 APU. All data submission deadlines for the FY 2025 APU are in Table 20. CAHPS® Hospice Survey vendors must submit data by the deadlines listed in Table 20 for all APU periods listed in the table and moving forward. There are no late submissions permitted after the deadlines, except for extraordinary circumstances beyond the control of the provider as discussed above.

j. For Further Information About the CAHPS® Hospice Survey

We encourage hospices and other entities to learn more about the survey on: *https://www.hospiceCAHPSsurvey.org.* For direct questions, please contact the CAHPS® Hospice Survey Team at *hospiceCAHPSsurvey@HCQIS.org* or telephone 1–844–472–4621.

6. Public Display of Quality Measures and Other Hospice Data for the HQRP

Under section 1814(i)(5)(E) of the Act, the Secretary is required to establish procedures for making any quality data submitted by hospices available to the public. These procedures shall ensure that a hospice has the opportunity to review the data that is to be made public prior to such data being made public; the data will be available on our public website.

To meet the Affordable Care Act's requirement for making quality measure data public, we launched the Hospice Compare website in August 2017. This website allows consumers, providers, and other stakeholders to search for all Medicare-certified hospice providers and view their information and quality measure scores. Since its release, the CMS Hospice Compare website has reported 7 HIS Measures (NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, and NQF #1617). In February 2018, CAHPS® Hospice Survey measures (NQF #2651) were added to the website.

a. Adding Quality Measures to Publically Available Websites—Procedures To Determine Quality Measure Readiness for Public Reporting

Quality measures are added to Hospice Compare once they meet readiness standards for public reporting, which is determined through the following processes.

First, we assess the reliability and validity of each quality measure to determine the scientific acceptability of each measure. This acceptability analysis is the first step in determining a measure's readiness for public reporting. We evaluate the quality

measures using the NQF Measure Evaluation Criteria found on the NQF website here: *http://www.qualityforum.org/Measuring_Performance/Submitting_Standards/Measure_Evaluation_Criteria.aspx#scientific.* Analyses to assess scientific acceptability of new measures are important to determine if the measure produces reliable and credible results when implemented. Reliability testing demonstrates that a measure is correctly specified by ensuring that ''measure data elements are repeatable, producing the same results a high proportion of time when assessed in the same population in the same time period and/or that the measure score is precise.'' Validity testing demonstrates that measure specifications are consistent with the focus of the measure and that the measure score can accurately distinguish between quality of care provided by providers. Reliability and validity are tested at both the data item and quality measure levels. For example, at the item-level, we examine the missing data rate and cross validate the data elements between the assessment data and Medicare claims to ensure validity of the data elements. At the quality measure level, we conduct split-half analysis, consistency analysis across time, stability analysis, and signal-to-noise analysis to demonstrate the reliability of the measures. We examine the relationships between different quality measures assessing similar quality areas to demonstrate the validity of the quality measures.

To establish reliability and validity of the quality measures, at least 4 quarters of data are analyzed. The first quarter of data after new adoption of, or changes to, standardized data collection tools may reflect the learning curve of the hospices; we first analyze these data separately to determine the appropriateness to use them to establish reliability and validity of quality measures.

To further inform which of the measures are eligible for public reporting, we then examine the distribution of hospice-level denominator size for each quality measure to assess whether the denominator size is large enough to generate the statistically reliable scores necessary for public reporting. This goal of this analysis is to establish the minimum denominator size for public reporting, which is referred to as reportability analysis. Reportability analysis is necessary because, if a hospice QM score is generated from a denominator that is too small, the observed measure score may be a biased assessment of the provider's performance, yielding scores that are statistically unreliable. Thus, we have set a minimum denominator size for public reporting, as well as the data selection period necessary to generate the minimum denominator size for the CMS Hospice Compare website.

This approach to testing reliability, validity, and reportability of quality measures (QMs) is consistent with the approach taken in other CMS quality reporting programs. Further, CMS provides hospices the opportunity to review their measures through their Certification and Survey Provider Enhanced Reports (CASPER) and additionally publishes the methodology related to the calculation of each quality measure in the Hospice Quality Measure User's Manual, which is updated with the addition of each quality measure to the Hospice QRP. Since December 2016, two provider feedback reports have been available to providers: The Hospice-Level Quality Measure Report and the Patient Stay-Level Quality Measure Report. These confidential feedback reports are available to each hospice using the CASPER system, and are part of the class of CASPER reports known as QM Reports. These reports are for the purposes of internal provider quality improvement and are available to hospices on-demand. We encourage providers to use the CASPER QM Reports to review their HIS quality measures regularly to ensure submitted quality measure data is correct. For more information on the CASPER QM Reports, we refer readers to the CASPER QM Factsheet on the HQRP website at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.html.*

Because we follow the above outlined processes in determining the readiness for a quality measure to be publicly reported, and perform the necessary analysis to determine and demonstrate that our measures meet the NQF standards for reliability, validity, and reportability, prior to publicly reporting provider performance on these quality metrics, we are proposing to announce to providers, any future intent to publicly report a quality measure on Hospice Compare, including timing, through sub-regulatory means.

Conducting these analyses and announcing measures timeline and readiness for public reporting through sub-regulatory channels will allow us to implement measures for public reporting in a more expeditious, yet still transparent manner, benefitting the public by providing QM data as soon as it is determined to meet the minimum standards for public reporting. We will continue to provide updates about public reporting of QMs through the normal CMS HQRP communication channels, including postings and announcements on the CMS HQRP website, MLN eNews communications, national provider association calls, and announcements on Open Door Forums. We are soliciting comments on this proposal.

b. Quality Measures To Be Displayed on Hospice Compare in FY 2019

We anticipate that we will begin public reporting of the HIS-based Hospice Comprehensive Assessment Measure (NQF #3235), a composite measure of the 7 original HIS Measures (NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, and NQF #1617), on the CMS Hospice Compare website in Fall 2019. For more information on how this measure is calculated, please see the HQRP QM User's Manual v2.00 in the ''Downloads'' section of the Current Measures page on the CMS HQRP website: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html.* The reporting period for which the measure will be displayed on the CMS Hospice Compare website will align with the currently established procedures for the 7 HIS measures. For more information about reporting periods, please see the Public Reporting: Key Dates for Providers page on the CMS HQRP website: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Key-Dates-for-Providers.html.* We used the analytic approach described above to determine reliability, validity, and reportability of the HIS-based Hospice Comprehensive Assessment Measure (NQF #3235). Reliability and validity testing found that the Hospice Comprehensive Assessment Measure had high reliability and validity. For more information about the reliability and validity of this measure, please see the NQF Palliative and End-of-Life Care Off-Cycle Measure Review 2017 Publication available for download here: *https://www.qualityforum.org/Publications/2017/09/Palliative_and_End-of-Life_Care_Off-Cycle_Measure_Review_2017.aspx.* Per the approach described above, we then conducted reportability analysis. Based on reportability analysis results, we determined this measure, calculated based on a 12-rolling month data selection period, to be eligible for

public reporting with a minimum denominator size of 20 patient stays. A majority of hospices, using rolling 4 quarters of data, have at least 20 patient stays eligible for the calculation and public reporting of the Hospice Comprehensive Assessment Measure. We plan to begin public reporting of the Hospice Comprehensive Assessment Measure with a minimum denominator size of 20.

We also anticipate that we will begin public reporting of the HIS-based Hospice Visits when Death is Imminent Measure Pair in FY 2019. This same analytic approach described above will be applied to determine the reliability, validity, and reportability of the Hospice Visits when Death is Imminent Measure Pair. This measure pair assesses hospice staff visits to patients at the end of life. Specifications for the Hospice Visits when Death is Imminent measure pair were finalized in the FY 2017 Hospice Final Rule (81 FR 52162). Pending the finalization of our proposal to announce future intentions to publicly display hospice quality measures via sub-regulatory means, the exact timeline for public reporting of this measure pair will be announced through regular sub-regulatory channels once necessary analyses and measure specifications are finalized.

c. Updates to the Public Display of HIS Measures

As discussed previously, we strive to put patients first, ensuring they are empowered to make decisions about their own healthcare, along with their clinicians, using data-driven information that are increasingly aligned with a parsimonious set of meaningful quality measures that drive quality improvement. We recognize that the HQRP represents a key component in bringing quality measurement, transparency, and improvement to the hospice care setting. To that end, we have begun analyzing our programs' measures in accordance with the Meaningful Measures framework to ensure high quality care and that empowers patients to make decisions about their own healthcare, using consumable, data-driven information.

With this framework in mind, we evaluated our measure set and specifically the measure Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission (NQF #3235) which we intend to publicly display on the Hospice Compare website in FY 2019. Through feedback received, we have learned that while the 7 original HIS measures (NQF #1641, NQF #1647, NQF #1634, NQF #1637, NQF #1639, NQF #1638, and NQF #1617) that represent the individual care processes captured in this composite measure are important, the composite measure provides for consumers a more accessible measure for evaluating the quality of a hospice.

The composite measure is more illustrative than the individual, high performing measures based on analyses. The hospice performance scores on the 7 component measures that comprise the composite measure are high (a score of 90 percent or higher on most component measures); however, analyses also show that, on average, a much lower percentage of patient stays received all seven desirable care processes at admission. Thus, by assessing hospices' performance of a comprehensive assessment via an all-or-none calculation methodology, the composite measure sets a higher standard of care for hospices and reveals a larger performance gap. Meaning, the composite measure holds hospices to a higher standard by requiring them to perform all seven care processes for a given patient admission. The performance gap identified by the composite measure creates opportunities for quality improvement and may motivate providers to conduct a greater number of high priority care processes for as many patients as possible upon admission to hospice.

The table below shows the mean measure score across all hospices for Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment Measure at Admission and the 7 component measures that would no longer be routinely individually displayed on Hospice Compare once the composite measure would be displayed.

TABLE 21—MEAN MEASURE SCORE OF THE HOSPICE AND PALLIATIVE CARE COMPOSITE PROCESS MEASURE—COMPREHENSIVE ASSESSMENT MEASURE AT ADMISSION AND 7 ORIGINAL HIS COMPONENT MEASURES

Measure title	Measure score (%)
Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission (NQF #3235)	71.3
Component Measure: Treatment Preferences (NQF #1641)	98.8
Component Measure: Beliefs/Values (NQF #1647)	95.9
Component Measure: Pain Screening (NQF #1634)	93.2
Component Measure: Pain Assessment (NQF #1637)	72.5
Component Measure: Dyspnea Screening (NQF #1639)	98.5
Component Measure: Dyspnea Treatment (NQF #1638)	92.8
Component Measure: Bowl Regimen (NQF #1617)	97.5

Further, we believe the reporting of these 7 component measures alongside the composite measure may be redundant and may result in confusion and burden for users as they attempt to interpret data displayed on the Hospice Compare website. However, we also recognize that the component measures may be useful to some individuals using Hospice Compare. Therefore, while we intend to no longer directly display the 7 component measures as individual measures on Hospice Compare, once the composite measure is displayed, we would still provide the public the ability to view these component measures in a manner that avoids confusion on Hospice Compare. We plan to achieve this by reformatting the display of the component measures so that they are only viewable in an expandable/collapsible format under the composite measure itself, thus allowing users the opportunity to view the component measure scores that were used to calculate the main composite measure score.

This proposal would change only the display of data on Hospice Compare for the HIS-based measure(s). This proposal would not change any current HIS data collection procedures outlined in the FY 2018 Hospice final rule (82 FR 36663 through 36664). Providers would still collect all HIS items in the current version of the HIS (HIS V2.00.0), including the 7 aforementioned component measures. Providers would continue to follow the coding guidelines and policies outlined in the HIS Manual V2.00, which can be found under the Downloads section of the HIS page of the HQRP website *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html.* Therefore, this proposal would not impact data collection.

Additionally, because the composite measure is composed of the 7 aforementioned component measures, these component measures would still be reported on CASPER QM reports and HIS provider preview reports for providers' internal quality purposes.

We invite public comment on our proposal to remove from Hospice Compare the direct display of the 7 original HIS measures, allowing for the reformatting of the display of these measures under the composite measure, once the Hospice Comprehensive Assessment Measure is displayed.

d. Display of Public Use File Data and/or Other Publicly Available CMS Data on the Hospice Compare Website

In the FY 2016 Hospice Wage Index final rule (80 FR 47199), we announced that we would make available hospice data in a public data set, the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File (PUF), as part of our ongoing efforts to make healthcare more transparent, affordable, and accountable. Hospice data has been available at the provider-level in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier PUF since 2016 and is located at: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Hospice.html.* The primary data source for the Hospice PUF is the CMS Chronic Condition Data Warehouse (CCW), a database with 100 percent of Medicare enrollment and fee-for-service adjudicated claims data.

These Hospice PUFs serve as a resource for the healthcare community by providing information on services provided to Medicare beneficiaries by hospice providers. The Hospice PUF contains information on utilization, payment (Medicare payment and standard payment), submitted charges, primary diagnoses, sites of service, and hospice beneficiary demographics organized by CMS Certification Number (6-digit provider identification number) and state. While these files are extensively downloaded by the public and especially researchers, currently the files are not in a format that would be considered user-friendly for many of the consumers who would look for hospice information to support provider selection.

As part of our ongoing efforts to make the Hospice Compare website more informative to our beneficiaries, loved ones, and their families, we propose to post information from these PUF and/or other publicly available CMS data to the Hospice Compare website in a user-friendly way. We propose to use information available in these public files to develop a new section of the Hospice Compare website that would provide additional information along with the HIS and CAHPS® quality measures and demographic information already displayed. Other Compare websites, such as the Nursing Home Compare and the End Stage Renal Disease Compare websites, have an information section similar to what we anticipate posting.

Information on the Hospice Compare website for each hospice includes data from the PUF and/or other publicly available CMS data displayed in a consumer-friendly format. This means that we may display the data as shown from the PUF or present the data after additional calculations. For example, the data could be averaged over multiple years, displayed as a percentage rather than the raw number so it has meaning to end-users, or other calculations in a given year or over multiple years. Any calculation will be performed on data exclusively from the source file like the PUF or other publicly available CMS data. The data may be displayed with supporting narrative when needed to make the data more understandable.

Examples, provided for illustration of how CMS could use the PUF or other publicly available CMS data, include:

- Percent of days a hospice provided routine home care (RHC) to patients, averaged over multiple years,
- Percent of primary diagnosis of patients served by the hospice (cancer, dementia, circulatory/heart disease, stroke, respiratory disease) which would be a calculation of the total number of patients by diagnosis and dividing by the total number of patients that the hospice served, and
- Site of service (long term care or non-skilled nursing facility, skilled nursing facility, inpatient hospital) with a notation of yes, based on whether the hospice serves patients in that facility type.

While these types of information are not quality measures, they capture information that many consumers seek during the provider selection process and, therefore, will help them to make an informed decision. For example, information about conditions treated by the hospice could show a patient with dementia if a hospice specializes or is experienced in caring for patients with this condition. Additionally, if a patient has a specific need, like receiving hospice care in a nursing home, information from the PUF could help this patient or their loved ones determine if a provider in their service area has provided care in this setting. Analyses of the PUF data show variation between hospice providers in the data points outlined above, indicating that these data points could be meaningful to consumers in comparing services provided by hospices based on the factors most important to them. PUF data can serve as one more piece of information, along with quality of care metrics from the HIS and CAHPS® Hospice Survey, to help consumers effectively and efficiently compare hospice providers and make an informed decision about their care in a stressful time.

By averaging or trending data over multiple years, we make it fairer so that the data applies to hospices broadly regardless of size or location or other factors. We anticipate that over time and as appropriate, we may add other items from the PUF or other publicly available CMS data to the Hospice Compare website via sub-regulatory processes and would plan to inform the public via regular HQRP communication strategies, such as Open Door Forums, Medicare Learning Network, Spotlight announcements and other opportunities. We invite public comment on these proposals.

IV. Request for Information on Possible Establishment of CMS Patient Health and Safety Requirements for Hospitals and Other Medicare-Participating Providers and Suppliers for Electronic Transfer of Health Information

Currently, Medicare- and Medicaid-participating providers and suppliers are at varying stages of adoption of health information technology (health IT). Many hospitals have adopted electronic health records (EHRs), and the Centers for Medicare & Medicaid Services (CMS) has provided incentive payments to eligible hospitals, critical access hospitals (CAHs), and eligible professionals who have demonstrated meaningful use of certified EHR technology under the Medicare EHR Incentive Program. As of 2015, 96 percent of Medicare-participating non-federal acute care hospitals had adopted certified EHRs with the capability to electronically export a summary of clinical care.[13] While both adoption of EHRs and electronic exchange of information have grown substantially among hospitals, significant obstacles to exchanging electronic health information across the continuum of care persist. Routine electronic transfer of information post-discharge has not

[13] These statistics can be accessed at *https://dashboard.healthit.gov/quickstats/pages/FIG-Hospital-EHR-Adoption.php.*

been achieved by providers and suppliers in many localities and regions throughout the nation.

We are firmly committed to the use of certified health IT and interoperable EHR systems for electronic healthcare information exchange to effectively help hospitals and other Medicare-participating providers and suppliers improve internal care delivery practices, support the exchange of important information across care team members during transitions of care, and enable reporting of specified electronically clinical quality measures (eCQMs). The Office of the National Coordinator for Health Information Technology (ONC) acts as the principal federal entity charged with coordination of nationwide efforts to implement and use health IT and the electronic exchange of health information on behalf of the Department of Health and Human Services (HHS).

In 2015, ONC finalized the 2015 Edition health IT certification criteria (2015 Edition), the most recent criteria for health IT to be certified under the ONC Health IT Certification Program. The 2015 Edition facilitates greater interoperability for several clinical health information purposes and enables health information exchange through new and enhanced certification criteria, standards, and implementation specifications. CMS requires eligible hospitals and CAHs in the Medicare and Medicaid EHR Incentive Programs and eligible clinicians in the Quality Payment Program to use EHR technology certified to the 2015 Edition beginning in CY 2019.

In addition, several important initiatives will be implemented over the next several years to provide hospitals and other participating providers and suppliers with access to robust infrastructure that will enable routine electronic exchange of health information. Section 4003 of the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, and amended section 3000 of the Public Health Service Act (42 U.S.C. 300jj), requires HHS to take steps to advance the electronic exchange of health information and interoperability for participating providers and suppliers in various settings across the care continuum. Specifically, the Congress directed that ONC ''. . . for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally.'' In January 2018, ONC released a draft version of its proposal for the Trusted Exchange Framework and Common Agreement,[14] which outlines principles and minimum terms and conditions for trusted exchange to enable interoperability across disparate health information networks (HINs). The Trusted Exchange Framework (TEF) is focused on achieving the following four important outcomes in the long-term:

- Professional care providers, who deliver care across the continuum, can access health information about their patients, regardless of where the patient received care.
- Patients can find all of their health information from across the care continuum, even if they don't remember the name of the professional care provider they saw.
- Professional care providers and health systems, as well as public and private health care organizations and public and private payer organizations accountable for managing benefits and the health of populations, can receive necessary and appropriate information on groups of individuals without having to access one record at a time, allowing them to analyze population health trends, outcomes, and costs; identify at-risk populations; and track progress on quality improvement initiatives.
- The health IT community has open and accessible application programming interfaces (APIs) to encourage entrepreneurial, user-focused innovation that will make health information more accessible and improve EHR usability.

ONC will revise the draft TEF based on public comment and ultimately release a final version of the TEF that will subsequently be available for adoption by HINs and their participants seeking to participate in nationwide health information exchange. The goal for stakeholders that participate in, or serve as, a HIN is to ensure that participants will have the ability to seamlessly share and receive a core set of data from other network participants in accordance with a set of permitted purposes and applicable privacy and security requirements. Broad adoption of this framework and its associated exchange standards is intended to both achieve the outcomes described above while creating an environment more conducive to innovation.

In light of the widespread adoption of EHRs along with the increasing availability of health information exchange infrastructure predominantly among hospitals, we are interested in hearing from stakeholders on how we could use the CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs (that is, the Conditions of Participation (CoPs) and Conditions for Coverage (CfCs)) to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers. Specifically, CMS might consider revisions to the current CMS CoPs for hospitals such as: Requiring that hospitals transferring medically necessary information to another facility upon a patient transfer or discharge do so electronically; requiring that hospitals electronically send required discharge information to a community provider through electronic means if possible and if a community provider can be identified; and requiring that hospitals make certain information available to patients or a specified third-party application (for example, required discharge instructions) through electronic means if requested.

On November 3, 2015, we published a proposed rule (80 FR 68126) to implement the provisions of the IMPACT Act and to revise the discharge planning CoP requirements that hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Hospitals (IRFs), Inpatient Psychiatric Hospitals (IPFs), Children's Hospitals, and Cancer Hospitals), critical access hospitals (CAHs), and home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. However, several of the proposed requirements directly address the issue of communication between providers and between providers and patients, as well as the issue of interoperability:

- Hospitals and CAHs would be required to transfer certain necessary medical information and a copy of the discharge instructions and discharge summary to the patient's practitioner, if the practitioner is known and has been clearly identified;
- Hospitals and CAHs would be required to send certain necessary medical information to the receiving facility/post-acute care providers, at the time of discharge; and
- Hospitals, CAHs and HHAs, would need to comply with the IMPACT Act requirements that would require hospitals, CAHs, and certain post-acute care providers to use data on quality

[14] The draft version of the trusted Exchange Framework may be accessed at *https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement*).

measures and data on resource use measures to assist patients during the discharge planning process, while taking into account the patient's goals of care and treatment preferences.

We also published another proposed rule (81 FR 39448), on June 16, 2016, that updated a number of CoP requirements that hospitals and CAHs must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. One of the proposed hospital CoP revisions in this rule directly addresses the issues of communication between providers and patients, patient access to their medical records, and interoperability. We proposed that patients have the right to access their medical records, upon an oral or written request, in the form and format requested by such patients, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, including current medical records, within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

Additionally, we specifically invite stakeholder feedback on the following questions regarding possible new or revised CoPs/CfCs for interoperability and electronic exchange of health information:

- If CMS were to propose a new CoP/CfC standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?
- Should CMS propose new CoPs/CfCs for hospitals and other participating providers and suppliers to ensure a patient's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient access as well as interoperability?
- Are new or revised CMS CoPs/CfCs for interoperability and electronic exchange of health information necessary to ensure patients and other treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, Health Insurance Portability and Accountability Act of 1996 (HIPAA), and implementation of relevant policies in the 21st Century Cures Act?
- What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?
- Do stakeholders believe that new or revised CMS CoPs/CfCs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient care and safety?
- Under new or revised CoPs/CfCs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient discharge/transfer summaries shared directly with the patient or with the receiving provider or supplier, either directly transferred with the patient or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient cannot receive the information electronically?
- Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs if they are proposed and finalized in the future?
- What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs if they are proposed and finalized in the future? Should exceptions under the Quality Payment Program including Certified Electronic Health Record Technology hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

We would also like to directly address the issue of communication between hospitals (as well as the other providers and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records. Privacy and security of patient data will be at the center of all our efforts in this area. CMS must protect the confidentiality of patient data, and CMS is completely aligned with the Veterans Affairs, the National Institutes of Health, ONC, and the rest of the federal government, on this objective. While some Medicare beneficiaries have had, for quite some time, the ability to download their Medicare claims information, in pdf or Excel formats, through the CMS Blue Button platform, the information was provided without any context or other information that would help beneficiaries understand what the data was really telling them. For beneficiaries, their claims information is useless if it is either too hard to obtain or, as was the case with the information provided through previous versions of Blue Button, hard to understand. In an effort to fully contribute to the federal government's MyHealthEData initiative, CMS developed and launched the new Blue Button 2.0, which represents a major step toward giving patients meaningful control of their health information in an easy-to-access and understandable way. Blue Button 2.0 is a developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to secure applications, services, and research programs they trust. The possibilities for better care through Blue Button 2.0 data are exciting, and might include enabling the creation of health dashboards for Medicare beneficiaries to view their health information in a single portal, or allowing beneficiaries to share complete medication lists with their doctors to prevent dangerous drug interactions.

To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, we invite members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to

access and control their medical records. We also welcome the public's ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs or CfCs for hospitals and other participating providers and suppliers. We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.

Please note, this is a Request for Information only. Respondents are encouraged to provide complete but concise and organized responses, including any relevant data and specific examples. However, respondents are not required to address every issue or respond to every question discussed in this Request for Information to have their responses considered. In accordance with the implementing regulations of the Paperwork Reduction Act at 5 CFR 1320.3(h)(4), all responses will be considered provided they contain information we can use to identify and contact the commenter, if needed.

This Request for Information is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This Request for Information does not commit the United States (U.S.) Government to contract for any supplies or services or make a grant award. Further, we are not seeking proposals through this Request for Information and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this Request for Information; all costs associated with responding to this Request for Information will be solely at the interested party's expense.

We note that not responding to this Request for Information does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this Request for Information announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this Request for Information. We will not respond to comment submissions in response to this Request for Information in the FY 2019 IPPS/LTCH PPS final rule. Rather, we will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. We may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this Request for Information. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this Request for Information may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential.

This Request for Information should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. We may publically post the public comments received, or a summary of those public comments.

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.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements.

A. ICRs Regarding Hospice Item Set

In the FY 2014 Hospice Wage Index final rule (78 FR 48257), and in compliance with section 1814(i)(5)(C) of the Act, we finalized the specific collection of data items that support the following 7 NQF endorsed measures for hospice:

- NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen,
- NQF #1634 Pain Screening,
- NQF #1637 Pain Assessment,
- NQF #1638 Dyspnea Treatment,
- NQF #1639 Dyspnea Screening,
- NQF #1641 Treatment Preferences,
- NQF #1647 Beliefs/Values Addressed (if desired by the patient).

We finalized the following two additional measures in the FY 2017 Hospice Wage Index final rule affecting FY 2019 payment determinations (81 FR 52163 through 52173):

- Hospice Visits when Death is Imminent
- Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

In section III.E of this proposed rule, we propose removal of the 7 original HIS measures from public reporting display on Hospice Compare. This proposal would not change any current HIS data collection procedures outlined in the FY 2018 Hospice final rule (82 FR 36663 through 36664). The HIS V2.00.0 was approved by the OMB on April 17, 2017 under control number 0938–1153 for 1 year. The information collection request (ICR) is currently pending OMB approval for 3 years. We are not proposing any new updates or additional collections of information in this proposed rule in regards to the HIS.

B. ICRs Regarding CAHPS® Hospice Survey Information Collection Requirements

National Implementation of the Hospice Experience of Care Survey (CAHPs Hospice Survey) data measures (82 FR 36672) would not impose any new or revised reporting, recordkeeping, or third-party disclosure requirements 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.*). The information collection requirements and burden have been approved by OMB through December 31, 2020 under OMB control number 0938–1257.

C. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of

the rule's information collection and recordkeeping requirements. The requirements are not effective until they have been approved by OMB.

We invite public comments on these information collection requirements. If you wish to comment, please identify the rule (CMS–1692–P) and, where applicable, the ICR's CFR citation, CMS ID number, and OMB control number.

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

1. Access our website address at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html.*

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov.*

3. Call the Reports Clearance Office at (410) 786–1326. See this rule's **DATES** and **ADDRESSES** sections for the comment due date and for additional instructions.

VI. 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.

VII. Regulatory Impact Analysis

A. Statement of Need

This proposed rule meets the requirements of our regulations at § 418.306(c), which requires annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of Core-Based Statistical Areas (CBSAs), or previously used Metropolitan Statistical Areas (MSAs). This proposed rule would also update payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2018 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. In addition, the payment rate updates may be reduced by an additional 0.3 percentage point (although for FY 2014 to FY 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions specified in section 1814(i)(1)(C)(v) of the Act). Lastly, section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices and this rule discusses changes in the requirements for the hospice quality reporting program in accordance with section 1814(i)(5) of the Act.

B. Overall Impacts

We estimate that the aggregate impact of the payment provisions in this proposed rule would result in an increase of $340 million in payments to hospices, resulting from the hospice payment update percentage of 1.8 percent. The impact analysis of this proposed rule represents the projected effects of the changes in hospice payments from FY 2018 to FY 2019. Using the most recent data available at the time of rulemaking, in this case FY 2017 hospice claims data, we apply the current FY 2018 wage index and labor-related share values to the level of care per diem payments and SIA payments for each day of hospice care to simulate FY 2018 payments. Then, using the same FY 2017 data, we apply the FY 2019 wage index and labor-related share values to simulate FY 2019 payments. Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. 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 hospices.

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) (Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a RIA that, to the best of our ability presents the costs and benefits of the rulemaking.

C. Anticipated Effects

The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than $7.5 million to $38.5 million in any 1 year), or being nonprofit organizations. For purposes of the RFA, we consider all hospices as small entities as that term is used in the RFA. 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. The effect of the FY 2018 hospice payment update percentage results in an overall increase in estimated hospice payments of 1.8 percent, or $340 million. Therefore, the Secretary has determined that this proposed rule would not create a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This proposed rule would only affect hospices. Therefore, the Secretary has determined that this proposed rule 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. The 2018 UMRA threshold is $150 million. This proposed rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of $150 million or more.

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. We have reviewed this proposed rule under these criteria of Executive Order 13132, and have determined that it would not impose substantial direct costs on state or local governments.

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

Using the wage information from the Bureau of Labor Statistics (BLS) for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $107.38 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately one hour for the staff to review half of this proposed rule which consists of approximately 30,000 words. For each hospice that reviews the rule, the estimated cost is $107.38 (1 hour × $107.38). Therefore, we estimate that the total cost of reviewing this regulation is $9,664.20 ($107.38 × 90 reviewers).

As we noted in section III.C of this proposed rule, we are making optional the requirement to submit specific, detailed data regarding drugs on hospice claims, which could result in a significant reduction of burden to Medicare hospices. We estimate that the total number of lines on hospice claims could be reduced by 21.5 million in the aggregate, which corresponds to an average reduction in the total number of lines on hospices claims by 5,000 per hospice.

D. Detailed Economic Analysis

The FY 2019 hospice payment impacts appear in Table 22. We tabulate the resulting payments according to the classifications in Table 22 (for example, facility type, geographic region, facility ownership), and compare the difference between current and future payments to determine the overall impact.

The first column shows the breakdown of all hospices by urban or rural status, census region, hospital-based or freestanding status, size, and type of ownership, and hospice base. The second column shows the number of hospices in each of the categories in the first column.

The third column shows the effect of the annual update to the wage index. This represents the effect of using the FY 2019 hospice wage index. The aggregate impact of this change is zero percent, due to the hospice wage index standardization factor. However, there are distributional effects of the FY 2019 hospice wage index.

The fourth column shows the effect of the hospice payment update percentage for FY 2019. The proposed FY 2019 hospice payment update percentage of 1.8 percent is mandated by section 1814(i)(1)(C) of the Act, and is constant for all providers.

The fifth column shows the effect of all the proposed changes on FY 2019 hospice payments. It is projected that aggregate payments would increase by 1.8 percent, assuming hospices do not change their service and billing practices.

As illustrated in Table 22, the combined effects of all the proposals vary by specific types of providers and by location.

TABLE 22—PROJECTED IMPACT TO HOSPICES FOR FY 2019

(1)	Number of providers (2)	Updated wage data (%) (3)	FY 2019 hospice payment update (%) (4)	FY 2019 total change (%) (5)
All Hospices	4,408	0.0	1.8	1.8
Urban Hospices	3,523	0.0	1.8	1.8
Rural Hospices	885	0.1	1.8	1.9
Urban Hospices—New England	124	−0.1	1.8	1.7
Urban Hospices—Middle Atlantic	249	0.1	1.8	1.9
Urban Hospices—South Atlantic	443	−0.2	1.8	1.6
Urban Hospices—East North Central	397	−0.1	1.8	1.7
Urban Hospices—East South Central	149	0.0	1.8	1.8
Urban Hospices—West North Central	241	0.2	1.8	2.0
Urban Hospices—West South Central	691	0.4	1.8	2.2
Urban Hospices—Mountain	354	−0.3	1.8	1.5
Urban Hospices—Pacific	835	0.2	1.8	2.0

TABLE 22—PROJECTED IMPACT TO HOSPICES FOR FY 2019—Continued

(1)	Number of providers (2)	Updated wage data (%) (3)	FY 2019 hospice payment update (%) (4)	FY 2019 total change (%) (5)
Urban Hospices—Outlying	40	0.4	1.8	2.2
Rural Hospices—New England	27	1.5	1.8	3.3
Rural Hospices—Middle Atlantic	35	0.0	1.8	1.8
Rural Hospices—South Atlantic	108	0.0	1.8	1.8
Rural Hospices—East North Central	137	0.0	1.8	1.8
Rural Hospices—East South Central	111	0.0	1.8	1.8
Rural Hospices—West North Central	167	0.3	1.8	2.1
Rural Hospices—West South Central	160	0.2	1.8	2.0
Rural Hospices—Mountain	92	−0.4	1.8	1.4
Rural Hospices—Pacific	42	0.1	1.8	1.9
Rural Hospices—Outlying	6	−0.3	1.8	1.5
0–3,499 RHC Days (Small)	975	0.3	1.8	2.1
3,500–19,999 RHC Days (Medium)	2,036	0.1	1.8	1.9
20,000+ RHC Days (Large)	1,397	0.0	1.8	1.8
Non-Profit Ownership	1,026	0.0	1.8	1.8
For Profit Ownership	2,830	0.0	1.8	1.8
Government Ownership	141	0.2	1.8	2.0
Other Ownership	411	0.0	1.8	1.8
Freestanding Facility Type	3,608	0.0	1.8	1.8
HHA/Facility-Based Facility Type	800	−0.1	1.8	1.7

Source: FY 2017 hospice claims from the Chronic Conditions Data Warehouse (CCW) Research Identifiable Files (RIFs) as of February 2, 2018.

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. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 23, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 23 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this proposed rule. This estimate is based on the data for 4,408 hospices in our impact analysis file, which was constructed using FY 2017 claims available in February 2018. All expenditures are classified as transfers to hospices.

TABLE 23—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS AND COSTS, FROM FY 2018 TO FY 2019

Category	Transfers
Annualized Monetized Transfers.	$ 340 million.*

TABLE 23—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS AND COSTS, FROM FY 2018 TO FY 2019—Continued

Category	Transfers
From Whom to Whom?.	Federal Government to Medicare Hospices.

*The net increase of $340 million in transfer payments is a result of the 1.8 percent hospice payment update compared to payments in FY 2018.

F. Regulatory Reform Analysis Under E.O. 13771

Executive Order 13771, entitled ''Reducing Regulation and Controlling Regulatory Costs,'' was issued on January 30, 2017 (82 FR 9339, February 3, 2017) and requires that the costs associated with significant new regulations ''shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' It has been determined that this proposed rule is an action that primarily results in transfers and does not impose more than de minimis costs as described above and thus is not a regulatory or deregulatory action for the purposes of Executive Order 13771.

G. Conclusion

We estimate that aggregate payments to hospices in FY 2019 will increase by $340 million, or 1.8 percent, compared to payments in FY 2018. We estimate that in FY 2019, hospices in urban and rural areas will experience, on average, 1.8 percent and 1.9 percent increases, respectively, in estimated payments compared to FY 2018. Hospices providing services in the urban West South Central and Outlying regions and the rural New England region would experience the largest estimated increases in payments of 2.2 percent and 3.3 percent, respectively. Hospices serving patients in rural areas in the Mountain region would experience, on average, the lowest estimated increase of 1.4 percent in FY 2019 payments.

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

List of Subjects in 42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 418—HOSPICE CARE

■ 1. The authority citation for part 418 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 418.3 is amended by revising paragraph (1) of the definition of ''Attending physician'' and revising the definition of ''Cap period'' to read as follows:

§ 418.3 Definitions.

* * * * *

Attending physician * * *

(1)(i) Doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action; or

(ii) Nurse practitioner who meets the training, education, and experience requirements as described in § 410.75 (b) of this chapter; or

(iii) Physician assistant who meets the requirements of § 410.74 (c) of this chapter.

* * * * *

Cap period means the twelve-month period ending September 30 used in the application of the cap on overall hospice reimbursement specified in § 418.309.

* * * * *

■ 3. Section 418.304 is amended by revising the section heading and adding paragraph (f) to read as follows:

§ 418.304 Payment for physician, and nurse practitioner, and physician assistant services.

* * * * *

(f)(1) Effective January 1, 2019, Medicare pays for attending physician services provided by physician assistants to Medicare beneficiaries who have elected the hospice benefit and who have selected a physician assistant as their attending physician. This applies to physician assistants without regard to whether they are hospice employees.

(2) The employer or a contractor of a physician assistant must bill and receive payment for physician assistant services only if the—

(i) Physician assistant is the beneficiary's attending physician as defined in § 418.3;

(ii) Services are medically reasonable and necessary;

(iii) Services are performed by a physician in the absence of the physician assistant and, the physician assistant services are furnished under the general supervision of a physician; and

(iv) Services are not related to the certification of terminal illness specified in § 418.22.

(3) The payment amount for physician assistant services when serving as the attending physician for hospice patients is 85 percent of what a physician is paid under the Medicare physician fee schedule.

Dated: April 16, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 17, 2018.

Alex M. Azar II,

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 412

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1688–P]

RIN 0938–AT25

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2019. As required by the Social Security Act (the Act), this proposed rule includes the classification and weighting factors for the IRF prospective payment system's (PPS) case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2019. We are also proposing to alleviate administrative burden for IRFs by removing the Functional Independence Measure (FIM™) instrument and associated Function Modifiers from the IRF Patient Assessment Instrument (IRF–PAI) and revising certain IRF coverage requirements to reduce the amount of required paperwork in the IRF setting. In addition, we are soliciting comments on removing the face-to-face requirement for rehabilitation physician visits and expanding the use of non-physician practitioners (that is, nurse practitioners and physician assistants) in meeting the IRF coverage requirements. For the IRF Quality Reporting Program (QRP), we are proposing to adopt a new measure removal factor, remove two measures from the IRF QRP measure set, and codify in our regulations a number of requirements.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, not later than 5 p.m. on June 26, 2018.

ADDRESSES: In commenting, please refer to file code CMS–1688–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1688–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–1688–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT:

Gwendolyn Johnson, (410) 786–6954, for general information.

Catie Kraemer, (410) 786–0179, for information about the proposed payment policies and payment rates.

Kadie Derby, (410) 786–0468, for information about the IRF coverage policies.

Christine Grose, (410) 786–1362, for information about the quality reporting program.

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 as soon as possible after they have been received at *http://www.regulations.gov.* Follow the search instructions on that website to view public comments.

The IRF PPS Addenda along with other supporting documents and tables referenced in this proposed rule are available through the internet on the CMS website at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/.*

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

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Executive Summary

A. Purpose

This proposed rule would update the prospective payment rates for IRFs for FY 2019 (that is, for discharges occurring on or after October 1, 2018, and on or before September 30, 2019) as required under section 1886(j)(3)(C) of the Act. As required by section 1886(j)(5) of the Act, this rule includes the classification and weighting factors for the IRF PPS's case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2019. In addition, this proposed rule would reduce the regulatory burden for IRFs by removing data items from the IRF–PAI and revising certain IRF coverage and paperwork requirements. In addition, this proposed rule solicits comments regarding removing the face-to-face requirement for rehabilitation physician visits and expanding the use of non-physician practitioners (that is, nurse practitioners and physician assistants) in meeting the IRF coverage requirements. We are also proposing to update the requirements for the IRF QRP, including adding a new quality measure removal factor, removing two measures from the measure set, and codifying in our regulations a number of requirements.

B. Summary of Major Provisions

In this proposed rule, we use the methods described in the FY 2018 IRF PPS final rule (82 FR 36238) to update the prospective payment rates for FY 2019 using updated FY 2017 IRF claims and the most recent available IRF cost report data, which is FY 2016 IRF cost report data. (*Note:* In the interest of brevity, the rates previously referred to as the ''Federal prospective payment rates'' are now referred to as the ''prospective payment rates''. No change in meaning is intended.) We are also proposing to alleviate administrative burden for IRFs by removing the FIM$_{TM}$ instrument and associated Function Modifiers from the IRF–PAI and revising certain IRF coverage requirements to reduce the amount of required paperwork in the IRF setting. In addition, we are soliciting comments on removing the face-to-face requirement for rehabilitation physician visits and expanding the use of non-physician practitioners (that is, nurse practitioners and physician assistants) in meeting the IRF coverage requirements. We are also proposing to update requirements for the IRF QRP.

C. Summary of Impacts

Provision description	Transfers
FY 2019 IRF PPS payment rate update	The overall economic impact of this proposed rule is an estimated $75 million in increased payments from the Federal government to IRFs during FY 2019.
Provision description	**Costs**
Removal of FIM™ Items from IRF–PAI	The total reduction in costs in FY 2020 for IRFs as a result of the removal of the FIM™ instrument and associated Function Modifiers from the IRF–PAI is estimated to be $10.2 million.
Removal of certain IRF coverage requirements	The total reduction in costs in FY 2019 for IRFs as a result of the removal of certain IRF coverage requirements is estimated to be $40.5 million.
New IRF QRP requirements	The total reduction in costs in FY 2019 for IRFs as a result of the new quality reporting requirements is estimated to be $2.4 million.

D. Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

Regulatory reform and reducing regulatory burden are high priorities for CMS. To reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care, in October 2017, we launched the Meaningful Measures Initiative.[1] This initiative is one component of our agency-wide Patients Over Paperwork Initiative,[2] which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes. The Meaningful Measures Initiative represents a new approach to quality measures that fosters operational efficiencies, and will reduce costs, including collection and reporting burden while producing quality measurement that is more focused on meaningful outcomes.

The Meaningful Measures Framework has the following objectives:

- Address high-impact measure areas that safeguard public health;
- Patient-centered and meaningful to patients;
- Outcome-based where possible;
- Fulfill each program's statutory requirements;
- Minimize the level of burden for health care providers (for example,

[1] Meaningful Measures web page: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.*

[2] See Remarks by Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit, as prepared for delivery on October 30, 2017 *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html.*

through a preference for EHR-based measures where possible, such as electronic clinical quality measures);

- Significant opportunity for improvement;
- Address measure needs for population based payment through alternative payment models; and
- Align across programs and/or with other payers.

In order to achieve these objectives, we have identified 19 Meaningful Measures areas and mapped them to six overarching quality priorities as shown in the Table 1:

TABLE 1—MEANINGFUL MEASURES FRAMEWORK DOMAINS AND MEASURE AREAS

Quality priority	Meaningful measure area
Making Care Safer by Reducing Harm Caused in the Delivery of Care	Healthcare-Associated Infections. Preventable Healthcare Harm.
Strengthen Person and Family Engagement as Partners in Their Care	Care is Personalized and Aligned with Patient's Goals. End of Life Care according to Preferences. Patient's Experience of Care. Patient Reported Functional Outcomes.
Promote Effective Communication and Coordination of Care	Medication Management. Admissions and Readmissions to Hospitals. Transfer of Health Information and Interoperability.
Promote Effective Prevention and Treatment of Chronic Disease	Preventive Care. Management of Chronic Conditions. Prevention, Treatment, and Management of Mental Health. Prevention and Treatment of Opioid and Substance Use Disorders. Risk Adjusted Mortality.
Work with Communities to Promote Best Practices of Healthy Living	Equity of Care. Community Engagement.
Make Care Affordable	Appropriate Use of Healthcare. Patient-focused Episode of Care. Risk Adjusted Total Cost of Care.

By including Meaningful Measures in our programs, we believe that we can also address the following cross-cutting measure criteria:

- Eliminating disparities;
- Tracking measurable outcomes and impact;
- Safeguarding public health;
- Achieving cost savings;
- Improving access for rural communities; and
- Reducing burden.

We believe that the Meaningful Measures Initiative will improve outcomes for patients, their families, and health care providers while reducing burden and costs for clinicians and providers as well as promoting operational efficiencies.

I. Background

A. Historical Overview of the IRF PPS

Section 1886(j) of the Act provides for the implementation of a per-discharge prospective payment system (PPS) for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (collectively, hereinafter referred to as IRFs). Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs), but not direct graduate medical education costs, costs of approved nursing and allied health education activities, bad debts, and other services or items outside the scope of the IRF PPS. Although a complete discussion of the IRF PPS provisions appears in the original FY 2002 IRF PPS final rule (66 FR 41316) and the FY 2006 IRF PPS final rule (70 FR 47880), we are providing a general description of the IRF PPS for FYs 2002 through 2018.

Under the IRF PPS from FY 2002 through FY 2005, the prospective payment rates were computed across 100 distinct case-mix groups (CMGs), as described in the FY 2002 IRF PPS final rule (66 FR 41316). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed five special CMGs to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors accounted for the relative difference in resource use across all CMGs. Within each CMG, we created tiers based on the estimated effects that certain comorbidities would have on resource use.

We established the federal PPS rates using a standardized payment conversion factor (formerly referred to as the budget-neutral conversion factor). For a detailed discussion of the budget-neutral conversion factor, please refer to our FY 2004 IRF PPS final rule (68 FR 45684 through 45685). In the FY 2006 IRF PPS final rule (70 FR 47880), we discussed in detail the methodology for determining the standard payment conversion factor.

We applied the relative weighting factors to the standard payment conversion factor to compute the unadjusted prospective payment rates under the IRF PPS from FYs 2002 through 2005. Within the structure of the payment system, we then made adjustments to account for interrupted stays, transfers, short stays, and deaths. Finally, we applied the applicable adjustments to account for geographic variations in wages (wage index), the percentage of low-income patients, location in a rural area (if applicable), and outlier payments (if applicable) to the IRFs' unadjusted prospective payment rates.

For cost reporting periods that began on or after January 1, 2002, and before October 1, 2002, we determined the final prospective payment amounts using the transition methodology prescribed in section 1886(j)(1) of the Act. Under this provision, IRFs transitioning into the PPS were paid a blend of the federal IRF PPS rate and the payment that the IRFs would have received had the IRF PPS not been implemented. This provision also allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs

now consist of 100 percent of the federal IRF PPS rate.

We established a CMS website as a primary information resource for the IRF PPS which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html.* The website may be accessed to download or view publications, software, data specifications, educational materials, and other information pertinent to the IRF PPS.

Section 1886(j) of the Act confers broad statutory authority upon the Secretary to propose refinements to the IRF PPS. In the FY 2006 IRF PPS final rule (70 FR 47880) and in correcting amendments to the FY 2006 IRF PPS final rule (70 FR 57166) that we published on September 30, 2005, we finalized a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. These refinements included the adoption of the Office of Management and Budget's (OMB) Core-Based Statistical Area (CBSA) market definitions, modifications to the CMGs, tier comorbidities, and CMG relative weights, implementation of a new teaching status adjustment for IRFs, revision and rebasing of the market basket index used to update IRF payments, and updates to the rural, low-income percentage (LIP), and high-cost outlier adjustments. Beginning with the FY 2006 IRF PPS final rule (70 FR 47908 through 47917), the market basket index used to update IRF payments was a market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding inpatient psychiatric facilities (IPFs), and long-term care hospitals (LTCHs) (hereinafter referred to as the rehabilitation, psychiatric, and long-term care (RPL) market basket). Any reference to the FY 2006 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments. For a detailed discussion of the final key policy changes for FY 2006, please refer to the FY 2006 IRF PPS final rule (70 FR 47880 and 70 FR 57166).

In the FY 2007 IRF PPS final rule (71 FR 48354), we further refined the IRF PPS case-mix classification system (the CMG relative weights) and the case-level adjustments, to ensure that IRF PPS payments would continue to reflect as accurately as possible the costs of care. For a detailed discussion of the FY 2007 policy revisions, please refer to the FY 2007 IRF PPS final rule (71 FR 48354).

In the FY 2008 IRF PPS final rule (72 FR 44284), we updated the prospective payment rates and the outlier threshold, revised the IRF wage index policy, and clarified how we determine high-cost outlier payments for transfer cases. For more information on the policy changes implemented for FY 2008, please refer to the FY 2008 IRF PPS final rule (72 FR 44284), in which we published the final FY 2008 IRF prospective payment rates.

After publication of the FY 2008 IRF PPS final rule (72 FR 44284), section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173, enacted on December 29, 2007) (MMSEA) amended section 1886(j)(3)(C) of the Act to apply a zero percent increase factor for FYs 2008 and 2009, effective for IRF discharges occurring on or after April 1, 2008. Section 1886(j)(3)(C) of the Act required the Secretary to develop an increase factor to update the IRF prospective payment rates for each FY. Based on the legislative change to the increase factor, we revised the FY 2008 prospective payment rates for IRF discharges occurring on or after April 1, 2008. Thus, the final FY 2008 IRF prospective payment rates that were published in the FY 2008 IRF PPS final rule (72 FR 44284) were effective for discharges occurring on or after October 1, 2007, and on or before March 31, 2008, and the revised FY 2008 IRF prospective payment rates were effective for discharges occurring on or after April 1, 2008, and on or before September 30, 2008. The revised FY 2008 prospective payment rates are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.*

In the FY 2009 IRF PPS final rule (73 FR 46370), we updated the CMG relative weights, the average length of stay values, and the outlier threshold; clarified IRF wage index policies regarding the treatment of ''New England deemed'' counties and multi-campus hospitals; and revised the regulation text in response to section 115 of the MMSEA to set the IRF compliance percentage at 60 percent (the ''60 percent rule'') and continue the practice of including comorbidities in the calculation of compliance percentages. We also applied a zero percent market basket increase factor for FY 2009 in accordance with section 115 of the MMSEA. For more information on the policy changes implemented for FY 2009, please refer to the FY 2009 IRF PPS final rule (73 FR 46370), in which we published the final FY 2009 IRF prospective payment rates.

In the FY 2010 IRF PPS final rule (74 FR 39762) and in correcting amendments to the FY 2010 IRF PPS final rule (74 FR 50712) that we published on October 1, 2009, we updated the prospective payment rates, the CMG relative weights, the average length of stay values, the rural, LIP, teaching status adjustment factors, and the outlier threshold; implemented new IRF coverage requirements for determining whether an IRF claim is reasonable and necessary; and revised the regulation text to require IRFs to submit patient assessments on Medicare Advantage (MA) (formerly called Medicare Part C) patients for use in the 60 percent rule calculations. Any reference to the FY 2010 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments. For more information on the policy changes implemented for FY 2010, please refer to the FY 2010 IRF PPS final rule (74 FR 39762 and 74 FR 50712), in which we published the final FY 2010 IRF prospective payment rates.

After publication of the FY 2010 IRF PPS final rule (74 FR 39762), section 3401(d) of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), as amended by section 10319 of the same Act and by section 1105 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010) (collectively, hereinafter referred to as ''PPACA''), amended section 1886(j)(3)(C) of the Act and added section 1886(j)(3)(D) of the Act. Section 1886(j)(3)(C) of the Act requires the Secretary to estimate a multifactor productivity (MFP) adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010 to 2019.

Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(i) of the Act defined the adjustments that were to be applied to the market basket increase factors in FYs 2010 and 2011. Under these provisions, the Secretary was required to reduce the market basket increase factor in FY 2010 by a 0.25 percentage point adjustment. Notwithstanding this provision, in accordance with section 3401(p) of the PPACA, the adjusted FY 2010 rate was only to be applied to discharges occurring on or after April 1, 2010. Based on the self-implementing legislative changes to section 1886(j)(3) of the Act, we adjusted the FY 2010 federal prospective payment rates as required, and applied these rates to IRF discharges occurring on or after April 1, 2010, and on or before September 30,

2010. Thus, the final FY 2010 IRF prospective payment rates that were published in the FY 2010 IRF PPS final rule (74 FR 39762) were used for discharges occurring on or after October 1, 2009, and on or before March 31, 2010, and the adjusted FY 2010 IRF prospective payment rates applied to discharges occurring on or after April 1, 2010, and on or before September 30, 2010. The adjusted FY 2010 prospective payment rates are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.*

In addition, sections 1886(j)(3)(C) and (D) of the Act also affected the FY 2010 IRF outlier threshold amount because they required an adjustment to the FY 2010 RPL market basket increase factor, which changed the standard payment conversion factor for FY 2010. Specifically, the original FY 2010 IRF outlier threshold amount was determined based on the original estimated FY 2010 RPL market basket increase factor of 2.5 percent and the standard payment conversion factor of $13,661. However, as adjusted, the IRF prospective payments are based on the adjusted RPL market basket increase factor of 2.25 percent and the revised standard payment conversion factor of $13,627. To maintain estimated outlier payments for FY 2010 equal to the established standard of 3 percent of total estimated IRF PPS payments for FY 2010, we revised the IRF outlier threshold amount for FY 2010 for discharges occurring on or after April 1, 2010, and on or before September 30, 2010. The revised IRF outlier threshold amount for FY 2010 was $10,721.

Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(i) of the Act also required the Secretary to reduce the market basket increase factor in FY 2011 by a 0.25 percentage point adjustment. The FY 2011 IRF PPS notice (75 FR 42836) and the correcting amendments to the FY 2011 IRF PPS notice (75 FR 70013) described the required adjustments to the FY 2010 and FY 2011 IRF PPS prospective payment rates and outlier threshold amount for IRF discharges occurring on or after April 1, 2010, and on or before September 30, 2011. It also updated the FY 2011 prospective payment rates, the CMG relative weights, and the average length of stay values. Any reference to the FY 2011 IRF PPS notice in this proposed rule also includes the provisions effective in the correcting amendments. For more information on the FY 2010 and FY 2011 adjustments or the updates for FY 2011, please refer to the FY 2011 IRF PPS notice (75 FR 42836 and 75 FR 70013).

In the FY 2012 IRF PPS final rule (76 FR 47836), we updated the IRF prospective payment rates, rebased and revised the RPL market basket, and established a new quality reporting program (QRP) for IRFs in accordance with section 1886(j)(7) of the Act. We also consolidated, clarified, and revised existing policies regarding IRF hospitals and IRF units of hospitals to eliminate unnecessary confusion and enhance consistency. For more information on the policy changes implemented for FY 2012, please refer to the FY 2012 IRF PPS final rule (76 FR 47836), in which we published the final FY 2012 IRF prospective payment rates.

The FY 2013 IRF PPS notice (77 FR 44618) described the required adjustments to the FY 2013 prospective payment rates and outlier threshold amount for IRF discharges occurring on or after October 1, 2012, and on or before September 30, 2013. It also updated the FY 2013 prospective payment rates, the CMG relative weights, and the average length of stay values. For more information on the updates for FY 2013, please refer to the FY 2013 IRF PPS notice (77 FR 44618).

In the FY 2014 IRF PPS final rule (78 FR 47860), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also updated the facility-level adjustment factors using an enhanced estimation methodology, revised the list of diagnosis codes that count toward an IRF's 60 percent rule compliance calculation to determine ''presumptive compliance,'' revised sections of the inpatient rehabilitation facility patient assessment instrument (IRF–PAI), revised requirements for acute care hospitals that have IRF units, clarified the IRF regulation text regarding limitation of review, updated references to previously changed sections in the regulations text, and updated requirements for the IRF QRP. For more information on the policy changes implemented for FY 2014, please refer to the FY 2014 IRF PPS final rule (78 FR 47860), in which we published the final FY 2014 IRF prospective payment rates.

In the FY 2015 IRF PPS final rule (79 FR 45872), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also revised the list of diagnosis codes that count toward an IRF's 60 percent rule compliance calculation to determine ''presumptive compliance,'' revised sections of the IRF–PAI, and updated requirements for the IRF QRP. For more information on the policy changes implemented for FY 2015, please refer to the FY 2015 IRF PPS final rule (79 FR 45872) and the FY 2015 IRF PPS correction notice (79 FR 59121).

In the FY 2016 IRF PPS final rule (80 FR 47036), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also adopted an IRF-specific market basket that reflects the cost structures of only IRF providers, a blended 1-year transition wage index based on the adoption of new OMB area delineations, a 3-year phase-out of the rural adjustment for certain IRFs due to the new OMB area delineations, and updates for the IRF QRP. For more information on the policy changes implemented for FY 2016, please refer to the FY 2016 IRF PPS final rule (80 FR 47036).

In the FY 2017 IRF PPS final rule (81 FR 52056), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also updated requirements for the IRF QRP. For more information on the policy changes implemented for FY 2017, please refer to the FY 2017 IRF PPS final rule (81 FR 52056) and the FY 2017 IRF PPS correction notice (81 FR 59901).

In the FY 2018 IRF PPS final rule (82 FR 36238), we updated the prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also revised the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) diagnosis codes that are used to determine presumptive compliance under the ''60 percent rule,'' removed the 25 percent payment penalty for IRF–PAI late transmissions, removed the voluntary swallowing status item (Item 27) from the IRF–PAI, summarized comments regarding the criteria used to classify facilities for payment under the IRF PPS, provided for a subregulatory process for certain annual updates to the presumptive methodology diagnosis code lists, adopted the use of height/weight items on the IRF–PAI to determine patient body mass index (BMI) greater than 50 for cases of single-joint replacement under the presumptive methodology, and updated requirements for the IRF QRP. For more information on the policy changes implemented for FY 2018, please refer to the FY 2018 IRF PPS final rule (82 FR 36238).

B. Provisions of the PPACA Affecting the IRF PPS in FY 2012 and Beyond

The PPACA included several provisions that affect the IRF PPS in FYs 2012 and beyond. In addition to what

was previously discussed, section 3401(d) of the PPACA also added section 1886(j)(3)(C)(ii)(I) of the Act (providing for a ''productivity adjustment'' for fiscal year 2012 and each subsequent fiscal year). The productivity adjustment for FY 2019 is discussed in section V.B. of this proposed rule. Section 3401(d) of the PPACA requires an additional 0.75 percentage point adjustment to the IRF increase factor for each of FYs 2017, 2018, and 2019. The applicable adjustment for FY 2019 is discussed in section V.B. of this proposed rule. Section 1886(j)(3)(C)(ii)(II) of the Act provides that the application of these adjustments to the market basket update may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year.

Sections 3004(b) of the PPACA and section 411(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114–10, enacted on April 16, 2015) (MACRA) also addressed the IRF PPS. Section 3004(b) of PPACA reassigned the previously designated section 1886(j)(7) of the Act to section 1886(j)(8) and inserted a new section 1886(j)(7), which contains requirements for the Secretary to establish a QRP for IRFs. Under that program, data must be submitted in a form and manner and at a time specified by the Secretary. Section 411(b) of MACRA amended section 1886(j)(3)(C) of the Act by adding clause (iii), which required us to apply for FY 2018, after the application of section 1886(j)(3)(C)(ii) of the Act, an increase factor of 1.0 percent to update the IRF prospective payment rates. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Act requires the application of a 2 percentage point reduction to the market basket increase factor otherwise applicable to an IRF (after application of subparagraphs (C)(iii) and (D) of section 1886(j)(3) of the Act) for a fiscal year if the IRF does not comply with the requirements of the IRF QRP for that fiscal year. Application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Reporting-based reductions to the market basket increase factor are not cumulative; they only apply for the FY involved.

C. Operational Overview of the Current IRF PPS

As described in the FY 2002 IRF PPS final rule (66 FR 41316), upon the admission and discharge of a Medicare Part A Fee-for-Service (FFS) patient, the IRF is required to complete the appropriate sections of a patient assessment instrument (PAI), designated as the IRF–PAI. In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each Medicare Advantage (MA) patient, as described in the FY 2010 IRF PPS final rule (74 FR 39762 and 74 FR 50712). All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the Grouper software. The Grouper software uses specific IRF–PAI data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The Grouper software produces a five-character CMG number. The first character is an alphabetic character that indicates the comorbidity tier. The last four characters are numeric characters that represent the distinct CMG number. Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the Grouper software, are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html.*

Once a Medicare Part A FFS patient is discharged, the IRF submits a Medicare claim as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, enacted on August 21, 1996) (HIPAA) compliant electronic claim or, if the Administrative Simplification Compliance Act of 2002 (Pub. L. 107–105, enacted on December 27, 2002) (ASCA) permits, a paper claim (a UB–04 or a CMS–1450 as appropriate) using the five-character CMG number and sends it to the appropriate Medicare Administrative Contractor (MAC). In addition, once a MA patient is discharged, in accordance with the Medicare Claims Processing Manual, chapter 3, section 20.3 (Pub. L. 100–04), hospitals (including IRFs) must submit an informational-only bill (Type of Bill (TOB) 111), which includes Condition Code 04 to their MAC. This will ensure that the MA days are included in the hospital's Supplemental Security Income (SSI) ratio (used in calculating the IRF LIP adjustment) for fiscal year 2007 and beyond. Claims submitted to Medicare must comply with both ASCA and HIPAA.

Section 3 of the ASCA amended section 1862(a) of the Act by adding paragraph (22), which requires the Medicare program, subject to section 1862(h) of the Act, to deny payment under Part A or Part B for any expenses for items or services for which a claim is submitted other than in an electronic form specified by the Secretary. Section 1862(h) of the Act, in turn, provides that the Secretary shall waive such denial in situations in which there is no method available for the submission of claims in an electronic form or the entity submitting the claim is a small provider. In addition, the Secretary also has the authority to waive such denial in such unusual cases as the Secretary finds appropriate. For more information, see the ''Medicare Program; Electronic Submission of Medicare Claims'' final rule (70 FR 71008). Our instructions for the limited number of Medicare claims submitted on paper are available at *http://www.cms.gov/manuals/downloads/clm104c25.pdf.*

Section 3 of the ASCA operates in the context of the administrative simplification provisions of HIPAA, which include, among others, the requirements for transaction standards and code sets codified in 45 CFR, parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered health care providers, to conduct covered electronic transactions according to the applicable transaction standards. (See the CMS program claim memoranda at *http://www.cms.gov/ElectronicBillingEDITrans/* and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600).

The MAC processes the claim through its software system. This software system includes pricing programming called the ''Pricer'' software. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the teaching status adjustment that became effective as of FY 2006, as discussed in the FY 2006 IRF PPS final rule (70 FR 47880).

D. Advancing Health Information Exchange

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and

support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care. The Office of the National Coordinator for Health Information Technology (ONC) and CMS work collaboratively to advance interoperability across settings of care, including post-acute care.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113–185) (IMPACT Act) requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers. To further interoperability in post-acute care, CMS is developing a Data Element Library to serve as a publically available centralized, authoritative resource for standardized data elements and their associated mappings to health IT standards. These interoperable data elements can reduce provider burden by supporting the use and reuse of healthcare data, support provider exchange of electronic health information for care coordination, person-centered care, and support real-time, data driven, clinical decision making. Once available, standards in the Data Element Library can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA). The 2018 Interoperability Standards Advisory (ISA) is available at: *https://www.healthit.gov/isa/.*

Most recently, the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, requires HHS to take new steps to enable the electronic sharing of health information ensuring interoperability for providers and settings across the care continuum. Specifically, Congress directed ONC to ''develop or support a trusted exchange framework, including a common agreement among health information networks nationally.'' This framework (*https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement*) outlines a common set of principles for trusted exchange and minimum terms and conditions for trusted exchange in order to enable interoperability across disparate health information networks. In another important provision, Congress defined ''information blocking'' as practices likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information, and established new authority for HHS to discourage these practices. We invite providers to learn more about these important developments and how they are likely to affect IRFs.

II. Summary of Provisions of the Proposed Rule

In this rule, we propose to update the IRF prospective payment rates for FY 2019 and to alleviate administrative burden for IRFs by removing the FIM™ instrument and associated Function Modifiers from the IRF–PAI in accordance with section 1886(j)(2)(D) of the Act and revising certain IRF coverage requirements to reduce the amount of required paperwork in the IRF setting. In addition, we are soliciting comments on removing the face-to-face requirement for rehabilitation physician visits and expanding the use of non-physician practitioners (that is, nurse practitioners and physician assistants) in meeting the IRF coverage requirements. For the IRF QRP, we are proposing to add a new quality measure removal factor, remove two quality measures from the measure set, and codify in our regulations a number of requirements.

The proposed updates to the IRF prospective payment rates for FY 2019 are as follows:

- Update the IRF PPS relative weights and average length of stay values for FY 2019 using the most current and complete Medicare claims and cost report data in a budget-neutral manner, as discussed in section III. of this proposed rule.
- Describe the continued use of FY 2014 facility-level adjustment factors, as discussed in section IV. of this proposed rule.
- Update the IRF PPS payment rates for FY 2019 by the proposed market basket increase factor, based upon the most current data available, with a 0.75 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act and a proposed productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section V. of this proposed rule.
- Update the FY 2019 IRF PPS payment rates by the FY 2019 wage index and the labor-related share in a budget-neutral manner, as discussed in section V. of this proposed rule.
- Describe the calculation of the IRF standard payment conversion factor for FY 2019, as discussed in section V. of this proposed rule.
- Update the outlier threshold amount for FY 2019, as discussed in section VI. of this proposed rule.
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2019, as discussed in section VI. of this proposed rule.
- Remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020 to reduce administrative burden for IRFs, as discussed in section VII. of this proposed rule.
- Revise certain IRF coverage requirements to reduce administrative burden for IRFs beginning with FY 2019, as discussed in section VIII. of this proposed rule.
- Solicit comments on removing the face-to-face requirement for rehabilitation physician visits, as discussed in section VIII. of this proposed rule.
- Solicit comments on expanding the use of non-physician practitioners (that is, nurse practitioners and physician assistants) in meeting the IRF coverage requirements, as discussed in section VIII. of this proposed rule.
- Update the requirements for the IRF QRP, as discussed in section IX. of this proposed rule.

III. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2019

As specified in § 412.620(b)(1), we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1. Relative weights account for the variance in cost per discharge due to the variance in resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care, as well as provider efficiency.

In this proposed rule, we propose to update the CMG relative weights and average length of stay values for FY 2019. As required by statute, we always use the most recent available data to update the CMG relative weights and average lengths of stay. For FY 2019, we propose to use the FY 2017 IRF claims and FY 2016 IRF cost report data. These data are the most current and complete data available at this time. Currently, only a small portion of the FY 2017 IRF cost report data are available for analysis, but the majority of the FY 2017 IRF claims data are available for analysis.

In this rule, we propose to apply these data using the same methodologies that we have used to update the CMG relative weights and average length of stay values each fiscal year since we implemented an update to the methodology to use the more detailed CCR data from the cost reports of IRF subprovider units of primary acute care

hospitals, instead of CCR data from the associated primary care hospitals, to calculate IRFs' average costs per case, as discussed in the FY 2009 IRF PPS final rule (73 FR 46372). In calculating the CMG relative weights, we use a hospital-specific relative value method to estimate operating (routine and ancillary services) and capital costs of IRFs. The process used to calculate the CMG relative weights for this proposed rule is as follows:

Step 1. We estimate the effects that comorbidities have on costs.

Step 2. We adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step.

Step 3. We use the adjusted costs from the second step to calculate CMG relative weights, using the hospital-specific relative value method.

Step 4. We normalize the FY 2019 CMG relative weights to the same average CMG relative weight from the CMG relative weights implemented in the FY 2018 IRF PPS final rule (82 FR 36238).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we propose to update the CMG relative weights for FY 2019 in such a way that total estimated aggregate payments to IRFs for FY 2019 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget neutrality factor to the standard payment amount. To calculate the appropriate budget neutrality factor for use in updating the FY 2019 CMG relative weights, we use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2019 (with no changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2019 by applying the changes to the CMG relative weights (as discussed in this proposed rule).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the budget neutrality factor (0.9980) that would maintain the same total estimated aggregate payments in FY 2019 with and without the changes to the CMG relative weights.

Step 4. Apply the budget neutrality factor (0.9980) to the FY 2018 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V.E. of this proposed rule, we discuss the proposed use of the existing methodology to calculate the standard payment conversion factor for FY 2019.

In Table 2, ''Proposed Relative Weights and Average Length of Stay Values for Case-Mix Groups,'' we present the proposed CMGs, the comorbidity tiers, the corresponding relative weights, and the average length of stay values for each CMG and tier for FY 2019. The average length of stay for each CMG is used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment.

TABLE 2—PROPOSED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidities tier	Tier 1	Tier 2	Tier 3	No comorbidities tier
0101	Stroke M>51.05	0.8486	0.7367	0.6761	0.6461	8	11	8	8
0102	Stroke M>44.45 and M<51.05 and C>18.5	1.0722	0.9308	0.8542	0.8164	11	12	10	10
0103	Stroke M>44.45 and M<51.05 and C<18.5	1.2409	1.0772	0.9886	0.9448	12	13	11	12
0104	Stroke M>38.85 and M<44.45	1.2952	1.1244	1.0319	0.9862	12	13	12	12
0105	Stroke M>34.25 and M<38.85	1.4885	1.2922	1.1859	1.1333	14	14	14	13
0106	Stroke M>30.05 and M<34.25	1.6651	1.4455	1.3266	1.2678	16	16	15	15
0107	Stroke M>26.15 and M<30.05	1.8665	1.6203	1.4871	1.4211	18	18	16	16
0108	Stroke M<26.15 and A>84.5	2.3075	2.0031	1.8384	1.7569	22	21	20	20
0109	Stroke M>22.35 and M<26.15 and A<84.5	2.0873	1.8120	1.6630	1.5893	19	19	18	18
0110	Stroke M<22.35 and A<84.5	2.7646	2.4000	2.2027	2.1049	26	26	23	23
0201	Traumatic brain injury M>53.35 and C>23.5	0.8228	0.6676	0.5960	0.5565	9	9	8	7
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5.	1.1423	0.9270	0.8274	0.7726	10	11	10	10
0203	Traumatic brain injury M>44.25 and C<23.5	1.2601	1.0225	0.9128	0.8523	13	13	11	10
0204	Traumatic brain injury M>40.65 and M<44.25	1.3722	1.1135	0.9940	0.9281	13	13	11	11
0205	Traumatic brain injury M>28.75 and M<40.65	1.6209	1.3153	1.1741	1.0963	14	15	13	13
0206	Traumatic brain injury M>22.05 and M<28.75	1.9535	1.5852	1.4150	1.3212	18	18	15	15
0207	Traumatic brain injury M<22.05	2.4678	2.0025	1.7875	1.6691	31	22	19	18
0301	Non-traumatic brain injury M>41.05	1.1740	0.9497	0.8712	0.8146	11	11	10	10
0302	Non-traumatic brain injury M>35.05 and M<41.05.	1.4336	1.1597	1.0639	0.9948	12	13	12	12
0303	Non-traumatic brain injury M>26.15 and M<35.05.	1.6587	1.3419	1.2309	1.1510	15	14	13	13
0304	Non-traumatic brain injury M<26.15	2.1196	1.7147	1.5729	1.4708	20	19	16	16
0401	Traumatic spinal cord injury M>48.45	1.0031	0.8112	0.7498	0.6853	10	10	9	9
0402	Traumatic spinal cord injury M>30.35 and M<48.45.	1.4909	1.2056	1.1144	1.0186	14	13	13	12
0403	Traumatic spinal cord injury M>16.05 and M<30.35.	2.3615	1.9096	1.7650	1.6133	25	22	19	18
0404	Traumatic spinal cord injury M<16.05 and A>63.5.	4.0165	3.2479	3.0021	2.7440	45	36	31	30
0405	Traumatic spinal cord injury M<16.05 and A<63.5.	3.5422	2.8643	2.6476	2.4199	26	33	27	26
0501	Non-traumatic spinal cord injury M>51.35	0.9175	0.7147	0.6615	0.6076	9	10	8	8
0502	Non-traumatic spinal cord injury M>40.15 and M<51.35.	1.2206	0.9508	0.8800	0.8083	11	11	10	10
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15.	1.5123	1.1781	1.0903	1.0015	14	13	12	12
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25.	1.7404	1.3557	1.2548	1.1526	16	14	14	13
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25.	1.9922	1.5519	1.4363	1.3194	18	17	16	15
0506	Non-traumatic spinal cord injury M<23.75	2.6966	2.1006	1.9441	1.7858	26	23	21	20

TABLE 2—PROPOSED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS—Continued

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidities tier	Tier 1	Tier 2	Tier 3	No comorbidities tier
0601	Neurological M>47.75	1.0727	0.8220	0.7615	0.6941	9	9	9	8
0602	Neurological M>37.35 and M<47.75	1.3940	1.0681	0.9896	0.9019	12	12	11	10
0603	Neurological M>25.85 and M<37.35	1.7135	1.3130	1.2164	1.1087	14	14	13	13
0604	Neurological M<25.85	2.2159	1.6979	1.5730	1.4337	19	17	16	16
0701	Fracture of lower extremity M>42.15	1.0293	0.8388	0.7954	0.7177	10	10	9	9
0702	Fracture of lower extremity M>34.15 and M<42.15.	1.3091	1.0668	1.0115	0.9128	12	12	12	11
0703	Fracture of lower extremity M>28.15 and M<34.15.	1.5608	1.2720	1.2061	1.0883	15	14	14	13
0704	Fracture of lower extremity M<28.15	1.9933	1.6244	1.5402	1.3899	18	18	17	16
0801	Replacement of lower extremity joint M>49.55	0.8362	0.6820	0.6159	0.5727	8	8	8	7
0802	Replacement of lower extremity joint M>37.05 and M<49.55.	1.0782	0.8793	0.7941	0.7384	11	9	9	9
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5.	1.4172	1.1557	1.0438	0.9706	13	13	12	11
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5.	1.2741	1.0390	0.9384	0.8726	12	12	11	10
0805	Replacement of lower extremity joint M>22.05 and M<28.65.	1.5185	1.2383	1.1184	1.0399	14	14	12	12
0806	Replacement of lower extremity joint M<22.05	1.8736	1.5279	1.3800	1.2832	17	17	15	14
0901	Other orthopedic M>44.75	1.0336	0.8091	0.7490	0.6903	11	10	9	8
0902	Other orthopedic M>34.35 and M<44.75	1.3077	1.0236	0.9476	0.8734	12	12	11	10
0903	Other orthopedic M>24.15 and M<34.35	1.6323	1.2777	1.1828	1.0902	14	14	13	12
0904	Other orthopedic M<24.15	2.0449	1.6006	1.4818	1.3657	17	17	16	15
1001	Amputation, lower extremity M>47.65	1.0914	0.9202	0.8209	0.7566	11	10	10	9
1002	Amputation, lower extremity M>36.25 and M<47.65.	1.3986	1.1792	1.0520	0.9696	13	13	12	12
1003	Amputation, lower extremity M<36.25	2.0249	1.7073	1.5231	1.4038	18	18	16	15
1101	Amputation, non-lower extremity M>36.35	1.3802	0.9958	0.9958	0.8947	12	11	11	11
1102	Amputation, non-lower extremity M<36.35	1.9397	1.3995	1.3995	1.2574	17	14	15	13
1201	Osteoarthritis M>37.65	1.1131	0.9558	0.8693	0.7900	11	10	10	9
1202	Osteoarthritis M>30.75 and M<37.65	1.4086	1.2096	1.1001	0.9998	13	13	12	12
1203	Osteoarthritis M<30.75	1.7059	1.4648	1.3323	1.2108	15	16	15	14
1301	Rheumatoid, other arthritis M>36.35	1.0974	0.9616	0.8870	0.8378	10	10	10	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35.	1.4376	1.2598	1.1620	1.0976	12	13	13	13
1303	Rheumatoid, other arthritis M<26.15	1.7313	1.5171	1.3994	1.3218	14	17	15	15
1401	Cardiac M>48.85	0.9240	0.7515	0.6781	0.6099	9	8	8	7
1402	Cardiac M>38.55 and M<48.85	1.2392	1.0078	0.9093	0.8180	11	11	10	10
1403	Cardiac M>31.15 and M<38.55	1.4776	1.2017	1.0843	0.9753	13	13	12	11
1404	Cardiac M<31.15	1.8592	1.5120	1.3643	1.2272	17	16	14	13
1501	Pulmonary M>49.25	1.0096	0.8767	0.7953	0.7609	9	10	9	8
1502	Pulmonary M>39.05 and M<49.25	1.2873	1.1178	1.0140	0.9702	11	11	10	11
1503	Pulmonary M>29.15 and M<39.05	1.5272	1.3262	1.2030	1.1511	14	13	12	12
1504	Pulmonary M<29.15	1.9278	1.6740	1.5186	1.4530	19	16	15	14
1601	Pain syndrome M>37.15	1.2093	0.9269	0.8786	0.7937	9	11	10	10
1602	Pain syndrome M>26.75 and M<37.15	1.5344	1.1760	1.1148	1.0070	11	12	12	12
1603	Pain syndrome M<26.75	1.8652	1.4295	1.3551	1.2241	12	16	15	14
1701	Major multiple trauma without brain or spinal cord injury M>39.25.	1.2867	0.9776	0.9126	0.8224	14	11	11	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25.	1.5500	1.1777	1.0993	0.9907	13	14	12	12
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05.	1.8117	1.3765	1.2849	1.1580	15	15	14	13
1704	Major multiple trauma without brain or spinal cord injury M<25.55.	2.3035	1.7502	1.6337	1.4724	20	19	17	16
1801	Major multiple trauma with brain or spinal cord injury M>40.85.	1.1210	1.0101	0.8484	0.7937	12	11	10	10
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85.	1.6611	1.4967	1.2572	1.1761	16	17	14	13
1803	Major multiple trauma with brain or spinal cord injury M<23.05.	2.5942	2.3375	1.9634	1.8368	30	25	20	20
1901	Guillian Barre M>35.95	1.4128	1.0101	0.9494	0.9109	15	13	11	11
1902	Guillian Barre M>18.05 and M<35.95	2.4873	1.7782	1.6714	1.6037	24	21	18	18
1903	Guillian Barre M<18.05	4.2909	3.0677	2.8833	2.7665	46	31	30	30
2001	Miscellaneous M>49.15	0.9692	0.7714	0.7164	0.6501	9	9	8	8
2002	Miscellaneous M>38.75 and M<49.15	1.2596	1.0025	0.9311	0.8449	11	11	10	10
2003	Miscellaneous M>27.85 and M<38.75	1.5478	1.2319	1.1442	1.0382	14	14	12	12
2004	Miscellaneous M<27.85	1.9731	1.5704	1.4585	1.3235	18	17	15	15
2101	Burns M>0	1.9150	1.5473	1.5040	1.3189	22	16	16	14
5001	Short-stay cases, length of stay is 3 days or fewer.	.....	.....	.....	0.1601	.....	.....	.....	2
5101	Expired, orthopedic, length of stay is 13 days or fewer.	.....	.....	.....	0.7561	.....	.....	.....	8
5102	Expired, orthopedic, length of stay is 14 days or more.	.....	.....	.....	1.6523	.....	.....	.....	18
5103	Expired, not orthopedic, length of stay is 15 days or fewer.	.....	.....	.....	0.8114	.....	.....	.....	8

TABLE 2—PROPOSED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS—Continued

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidities tier	Tier 1	Tier 2	Tier 3	No comorbidities tier
5104	Expired, not orthopedic, length of stay is 16 days or more.	.....	.....	.....	2.1193	.....	.....	.....	21

Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 3 shows how we estimate that the application of the proposed revisions for FY 2019 would affect particular CMG relative weight values, which would affect the overall distribution of payments within CMGs and tiers. Note that, because we propose to implement the CMG relative weight revisions in a budget-neutral manner (as previously described), total estimated aggregate payments to IRFs for FY 2019 would not be affected as a result of the proposed CMG relative weight revisions. However, the proposed revisions would affect the distribution of payments within CMGs and tiers.

TABLE 3—DISTRIBUTIONAL EFFECTS OF THE PROPOSED CHANGES TO THE CMG RELATIVE WEIGHTS

[FY 2018 values compared with FY 2019 values]

Percentage change in CMG relative weights	Number of cases affected	Percentage of cases affected
Increased by 15% or more	19	0.0
Increased by between 5% and 15%	1,600	0.4
Changed by less than 5%	394,149	99.3
Decreased by between 5% and 15%	1,193	0.3
Decreased by 15% or more	74	0.0

As Table 3 shows, 99.3 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the revisions for FY 2019. The largest estimated increase in the proposed CMG relative weight values that affects the largest number of IRF discharges would be a 3.4 percent change in the CMG relative weight value for CMG 0806 Replacement of lower extremity joint, with a motor score less than 22.05—with no tier adjustment. In the FY 2017 claims data, 1,580 IRF discharges (0.4 percent of all IRF discharges) were classified into this CMG and tier.

The largest estimated decrease in a CMG relative weight value affecting the largest number of IRF cases would be a 2.1 percent decrease in the CMG relative weight for CMG 0304—Non-traumatic brain injury, with a motor score less than 26.5—with no tier adjustment. In the FY 2017 IRF claims data, this change would have affected 3,354 cases (0.8 percent of all IRF cases).

The proposed changes in the average length of stay values for FY 2019, compared with the FY 2018 average length of stay values, are small and do not show any particular trends in IRF length of stay patterns.

We invite public comment on our proposed updates to the CMG relative weights and average length of stay values for FY 2019.

IV. Facility-Level Adjustment Factors

Section 1886(j)(3)(A)(v) of the Act confers broad authority upon the Secretary to adjust the per unit payment rate by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. Under this authority, we currently adjust the prospective payment amount associated with a CMG to account for facility-level characteristics such as an IRF's LIP, teaching status, and location in a rural area, if applicable, as described in § 412.624(e).

Based on the substantive changes to the facility-level adjustment factors that were adopted in the FY IRF PPS 2014 final rule (78 FR 47860, 47868 through 47872), in the FY 2015 IRF PPS final rule (79 FR 45872, 45882 through 45883), we froze the facility-level adjustment factors at the FY 2014 levels for FY 2015 and all subsequent years (unless and until we propose to update them again through future notice-and-comment rulemaking). For FY 2019, we will continue to hold the adjustment factors at the FY 2014 levels as we continue to monitor the most current IRF claims data available and continue to evaluate and monitor the effects of the FY 2014 changes.

V. Proposed FY 2019 IRF PPS Payment Update

A. Background

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the IRF PPS payment, which is referred to as a market basket index. According to section 1886(j)(3)(A)(i) of the Act, the increase factor shall be used to update the IRF prospective payment rates for each FY. Section 1886(j)(3)(C)(ii)(I) of the Act requires the application of a productivity adjustment. In addition, sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act require the application of a 0.75 percentage point reduction to the market basket increase factor for FY 2019. Thus, we propose to update the IRF PPS payments for FY 2019 by a market basket increase factor as required by section 1886(j)(3)(C) of the Act, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.75 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act.

Beginning with the FY 2016 IRF PPS, we created and adopted a stand-alone IRF market basket, which was referred to as the 2012-based IRF market basket, reflecting the operating and capital cost structures for freestanding IRFs and hospital-based IRFs. The FY 2016 IRF

PPS final rule (80 FR 47046 through 47068) contains a complete discussion of the development of the 2012-based IRF market basket.

B. Proposed FY 2019 Market Basket Update and Productivity Adjustment

For FY 2018, we applied an increase factor of 1.0 percent to update the IRF prospective payment rates in accordance with section 1886(j)(3)(C)(iii) of the Act, as added by section 411(b) of MACRA. However, as discussed previously, for FY 2019, we propose to update the IRF PPS payments by a market basket increase factor as required by section 1886(j)(3)(C) of the Act, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.75 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act. For FY 2019, we propose to use the same methodology described in the FY 2017 IRF PPS final rule (81 FR 52071) to compute the FY 2019 market basket increase factor to update the IRF PPS base payment rate.

Consistent with historical practice, we are proposing to estimate the market basket update for the IRF PPS based on the most up-to-date forecast of price indexes used in the market basket as forecasted by IHS Global Inc. (''IGI''). IGI is a nationally recognized economic and financial forecasting firm with which we contract to forecast the components of the market baskets and MFP. Based on IGI's first quarter 2018 forecast with historical data through the fourth quarter of 2017, the 2012-based IRF market basket increase factor for FY 2019 is projected to be 2.9 percent. Therefore, consistent with our historical practice of estimating market basket increases based on the best available data, we are proposing that the 2012-based IRF market basket increase factor for FY 2019 would be 2.9 percent. We are also proposing that if more recent data are subsequently available (for example, a more recent estimate of the market basket update), we would use such data to determine the FY 2019 market basket update in the final rule.

According to section 1886(j)(3)(C)(i) of the Act, the Secretary shall establish an increase factor based on an appropriate percentage increase in a market basket of goods and services. Section 1886(j)(3)(C)(ii) of the Act then requires that, after establishing the increase factor for a FY, the Secretary shall reduce such increase factor for FY 2012 and each subsequent FY, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be 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 FY, year, cost reporting period, or other annual period) (the ''MFP adjustment''). The BLS publishes the official measure of private nonfarm business MFP. Please see *http://www.bls.gov/mfp* for the BLS historical published MFP data. A complete description of the MFP projection methodology is available on the CMS website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html.*

Using IGI's first quarter 2018 forecast, the MFP adjustment for FY 2019 (the 10-year moving average of MFP for the period ending FY 2019) is projected to be 0.8 percent. Thus, in accordance with section 1886(j)(3)(C) of the Act, we are proposing to base the FY 2019 market basket update, which is used to determine the applicable percentage increase for the IRF payments, on the most recent estimate of the 2012-based IRF market basket. We are proposing to then reduce this percentage increase by the most recent estimate of the MFP adjustment for FY 2019 of 0.8 percentage point. Following application of the MFP adjustment, we are proposing to further reduce the applicable percentage increase by 0.75 percentage point, as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act. Therefore, the proposed FY 2019 IRF update is 1.35 percent (2.9 percent market basket update, less 0.8 percentage point MFP adjustment, less 0.75 percentage point statutorily required adjustment). Furthermore, we propose that if more recent data are subsequently available (for example, a more recent estimate of the MFP adjustment), we will use such data to determine the FY 2019 MFP adjustment in the final rule.

For FY 2019, the Medicare Payment Advisory Commission (MedPAC) recommends that we reduce IRF PPS payment rates by 5 percent. As discussed, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary is proposing to update the IRF PPS payment rates for FY 2019 by an adjusted market basket increase factor of 1.35 percent, as section 1886(j)(3)(C) of the Act does not provide the Secretary with the authority to apply a different update factor to IRF PPS payment rates for FY 2019.

We invite public comment on the proposed market basket update and productivity adjustment.

C. Proposed Labor-Related Share for FY 2019

Section 1886(j)(6) of the Act specifies that the Secretary is to adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs of the prospective payment rates computed under section 1886(j)(3) of the Act for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

Based on our definition of the labor-related share and the cost categories in the 2012-based IRF market basket, we propose to calculate the labor-related share for FY 2019 as the sum of the FY 2019 relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor- Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-related Services, and a portion of the Capital-Related cost weight from the 2012-based IRF market basket. For more details regarding the methodology for determining specific cost categories for inclusion in the 2012-based IRF labor-related share, see the FY 2016 IRF final rule (80 FR 47066 through 47068).

Using this method and IGI's first quarter 2018 forecast for the 2012-based IRF market basket, the proposed IRF labor-related share for FY 2019 is 70.6 percent. We propose that if more recent data are subsequently available (for example, a more recent estimate of the labor-related share), we will use such data to determine the FY 2019 IRF labor-related share in the final rule.

Incorporating the most recent estimate of the 2012-based IRF market basket based on IGI's first quarter 2018 forecast with historical data through the fourth quarter of 2017, the sum of the relative importance for FY 2019 operating costs (Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-related Services) using the 2012-based

IRF market basket is 66.8 percent. We propose that the portion of Capital-Related Costs that is influenced by the local labor market is estimated to be 46 percent. Incorporating the most recent estimate of the FY 2019 relative importance of Capital-Related costs from the 2012-based IRF market basket based on IGI's first quarter 2018 forecast with historical data through the fourth quarter of 2017, which is 8.2 percent, we take 46 percent of 8.2 percent to determine the labor-related share of Capital for FY 2019. We propose to then add this amount (3.8 percent) to the sum of the relative importance for FY 2019 operating costs (66.8 percent) to determine the total labor-related share for FY 2019 of 70.6 percent. Thus, the proposed FY 2019 labor-related share is 70.6 percent. By comparison, the FY 2018 labor-related share was 70.7 percent.

TABLE 4—IRF LABOR-RELATED SHARE

	FY 2019 proposed labor-related share [1]	FY 2018 final labor related share [2]
Wages and salaries	47.8	47.8
Employee Benefits	11.1	11.2
Professional Fees: Labor-related	3.4	3.4
Administrative and Facilities Support Services	0.8	0.8
Installation, Maintenance, and Repair Services	1.9	1.9
All Other: Labor-related Services	1.8	1.8
Subtotal	66.8	66.9
Labor-related portion of capital (46%)	3.8	3.8
Total Labor-Related Share	70.6	70.7

[1] Based on the 2012-based IRF Market Basket, IGI's 1st quarter 2018 forecast with historical data through the 4th quarter of 2017.
[2] **Federal Register** (82 FR 36249).

We invite public comment on the proposed labor-related share for FY 2019.

D. Proposed Wage Adjustment for FY 2019

1. Background

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion of rehabilitation facilities' costs attributable to wages and wage-related costs (as estimated by the Secretary from time to time) by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. The Secretary is required to update the IRF PPS wage index on the basis of information available to the Secretary on the wages and wage-related costs to furnish rehabilitation services. Any adjustment or updates made under section 1886(j)(6) of the Act for a FY are made in a budget-neutral manner.

For FY 2019, we propose to maintain the policies and methodologies described in the FY 2018 IRF PPS final rule (82 FR 36238, 36249 through 36250) related to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we propose to use the CBSA labor market area definitions and the FY 2018 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2018 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2013, and before October 1, 2014 (that is, FY 2014 cost report data).

The labor market designations made by the OMB include some geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the IRF PPS wage index. We propose to continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation for the FY 2019 IRF PPS wage index.

We invite public comment on this proposal.

2. Core-Based Statistical Areas (CBSAs) for the Proposed FY 2019 IRF Wage Index

The wage index used for the IRF PPS is calculated using the pre-reclassification and pre-floor acute care hospital wage index data and is assigned to the IRF on the basis of the labor market area in which the IRF is geographically located. IRF labor market areas are delineated based on the CBSAs established by the OMB. The current CBSA delineations (which were implemented for the IRF PPS beginning with FY 2016) are based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13–01. OMB Bulletin No. 13–01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published on June 28, 2010, in the **Federal Register** (75 FR 37246 through 37252). We refer readers to the FY 2016 IRF PPS final rule (80 FR 47068 through 47076) for a full discussion of our implementation of the OMB labor market area delineations beginning with the FY 2016 wage index.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013. The complete list of statistical areas incorporating these changes is provided in OMB Bulletin No. 15–01. In the FY 2018 IRF PPS final rule (82 FR 36250 through 36251), we

adopted the updates set forth in OMB Bulletin No. 15–01 effective October 1, 2017, beginning with the FY 2018 wage index. For a complete discussion of the adoption of the updates set forth in OMB Bulletin No. 15–01, we refer readers to the FY 2018 IRF PPS final rule.

For FY 2019, we propose to continue using the OMB delineations that we adopted beginning with FY 2016 to calculate the area wage indexes, with the updates set forth in OMB Bulletin No. 15–01 that we adopted beginning with the FY 2018 wage index.

We invite public comment on this proposal.

3. Codes for Constituent Counties in CBSAs

CBSAs are made up of one or more constituent counties. Each CBSA and constituent county has its own unique identifying codes. There are two different lists of codes associated with counties: Social Security Administration (SSA) codes and Federal Information Processing Standard (FIPS) codes. Historically, we have used SSA and FIPS county codes to identify and crosswalk counties to CBSA codes for purposes of the IRF wage index. We have learned that SSA county codes are no longer being maintained and updated. However, the FIPS codes continue to be maintained by the U.S. Census Bureau. The Census Bureau's most current statistical area information is derived from ongoing census data received since 2010; the most recent data are from 2015. For purposes of cross-walking counties to CBSA codes, we are proposing to discontinue the use of SSA county codes and continue using only the FIPS county codes. We are proposing to use the FIPS county codes to calculate area wage indexes in a manner that is generally consistent with the CBSA-based methodologies finalized in the FY 2006 IRF final rule (70 FR 47880) and the FY 2016 IRF final rule (80 FR 47036). The use of the FIPS codes for cross-walking counties to CBSAs does not result in any changes to the constituent counties of any CBSA. Thus, there is no impact or change for any IRF due to the use of the FIPS county codes. We believe that using the latest FIPS codes will allow us to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions.

As discussed in the FY 2018 Inpatient prospective payment system (IPPS) and Long-Term Care Hospital (LTCH) PPS final rule (82 FR 38130), this change was implemented under the IPPS beginning on October 1, 2017. Therefore, we are proposing to implement this revision for the IRF PPS beginning October 1, 2018, consistent with our historical practice of modeling IRF PPS adoption of updates to labor market areas after IPPS adoption of these changes.

We invite public comments on this proposal.

4. Wage Adjustment

The proposed wage index applicable to FY 2019 is available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.* Table A is for urban areas, and Table B is for rural areas.

To calculate the wage-adjusted facility payment for the payment rates set forth in this proposed rule, we multiply the unadjusted federal payment rate for IRFs by the FY 2019 labor-related share based on the 2012-based IRF market basket (70.6 percent) to determine the labor-related portion of the standard payment amount. A full discussion of the calculation of the labor-related share is located in section V.C of this proposed rule. We then multiply the labor-related portion by the applicable IRF wage index from the tables in the addendum to this proposed rule. These tables are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html.*

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget-neutral manner. We propose to calculate a budget-neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45689), codified at § 412.624(e)(1), as described in the steps below. We propose to use the listed steps to ensure that the FY 2019 IRF standard payment conversion factor reflects the proposed update to the wage indexes (based on the FY 2014 hospital cost report data) and the labor-related share in a budget-neutral manner:

Step 1. Determine the total amount of the estimated FY 2018 IRF PPS payments, using the FY 2018 standard payment conversion factor and the labor-related share and the wage indexes from FY 2018 (as published in the FY 2018 IRF PPS final rule (82 FR 36238)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the proposed FY 2019 standard payment conversion factor and the proposed FY 2019 labor-related share and CBSA urban and rural wage indexes.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the proposed FY 2019 budget-neutral wage adjustment factor of 1.0000.

Step 4. Apply the proposed FY 2019 budget-neutral wage adjustment factor from step 3 to the FY 2018 IRF PPS standard payment conversion factor after the application of the increase factor to determine the proposed FY 2019 standard payment conversion factor.

We discuss the calculation of the proposed standard payment conversion factor for FY 2019 in section V.E. of this proposed rule.

We invite public comment on the proposed IRF wage adjustment for FY 2019.

E. Description of the Proposed IRF Standard Payment Conversion Factor and Payment Rates for FY 2019

To calculate the proposed standard payment conversion factor for FY 2019, as illustrated in Table 5, we begin by applying the proposed increase factor for FY 2019, as adjusted in accordance with sections 1886(j)(3)(C) and (D) of the Act, to the standard payment conversion factor for FY 2018 ($15,838). Applying the proposed 1.35 percent increase factor for FY 2019 to the standard payment conversion factor for FY 2018 of $15,838 yields a standard payment amount of $16,052. Then, we apply the proposed budget neutrality factor for the FY 2019 wage index and labor-related share of 1.0000, which results in a proposed standard payment amount of $16,052. We next apply the proposed budget neutrality factor for the revised CMG relative weights of 0.9980, which results in the proposed standard payment conversion factor of $16,020 for FY 2019.

TABLE 5—CALCULATIONS TO DETERMINE THE PROPOSED FY 2019 STANDARD PAYMENT CONVERSION FACTOR

Explanation for adjustment	Calculations
Standard Payment Conversion Factor for FY 2018	$15,838

TABLE 5—CALCULATIONS TO DETERMINE THE PROPOSED FY 2019 STANDARD PAYMENT CONVERSION FACTOR—Continued

Explanation for adjustment	Calculations
Market Basket Increase Factor for FY 2019 (2.9 percent), reduced by 0.8 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and reduced by 0.75 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act	x 1.0135
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x 1.0000
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x 0.9980
Proposed FY 2019 Standard Payment Conversion Factor	= $16,020

We invite public comment on the proposed FY 2019 standard payment conversion factor.

After the application of the proposed CMG relative weights described in section III of this proposed rule to the proposed FY 2019 standard payment conversion factor ($16,020), the resulting unadjusted IRF prospective payment rates for FY 2019 are shown in Table 6.

TABLE 6—PROPOSED FY 2019 PAYMENT RATES

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
0101	$13,594.57	$11,801.93	$10,831.12	$10,350.52
0102	17,176.64	14,911.42	13,684.28	13,078.73
0103	19,879.22	17,256.74	15,837.37	15,135.70
0104	20,749.10	18,012.89	16,531.04	15,798.92
0105	23,845.77	20,701.04	18,998.12	18,155.47
0106	26,674.90	23,156.91	21,252.13	20,310.16
0107	29,901.33	25,957.21	23,823.34	22,766.02
0108	36,966.15	32,089.66	29,451.17	28,145.54
0109	33,438.55	29,028.24	26,641.26	25,460.59
0110	44,288.89	38,448.00	35,287.25	33,720.50
0201	13,181.26	10,694.95	9,547.92	8,915.13
0202	18,299.65	14,850.54	13,254.95	12,377.05
0203	20,186.80	16,380.45	14,623.06	13,653.85
0204	21,982.64	17,838.27	15,923.88	14,868.16
0205	25,966.82	21,071.11	18,809.08	17,562.73
0206	31,295.07	25,394.90	22,668.30	21,165.62
0207	39,534.16	32,080.05	28,635.75	26,738.98
0301	18,807.48	15,214.19	13,956.62	13,049.89
0302	22,966.27	18,578.39	17,043.68	15,936.70
0303	26,572.37	21,497.24	19,719.02	18,439.02
0304	33,955.99	27,469.49	25,197.86	23,562.22
0401	16,069.66	12,995.42	12,011.80	10,978.51
0402	23,884.22	19,313.71	17,852.69	16,317.97
0403	37,831.23	30,591.79	28,275.30	25,845.07
0404	64,344.33	52,031.36	48,093.64	43,958.88
0405	56,746.04	45,886.09	42,414.55	38,766.80
0501	14,698.35	11,449.49	10,597.23	9,733.75
0502	19,554.01	15,231.82	14,097.60	12,948.97
0503	24,227.05	18,873.16	17,466.61	16,044.03
0504	27,881.21	21,718.31	20,101.90	18,464.65
0505	31,915.04	24,861.44	23,009.53	21,136.79
0506	43,199.53	33,651.61	31,144.48	28,608.52
0601	17,184.65	13,168.44	12,199.23	11,119.48
0602	22,331.88	17,110.96	15,853.39	14,448.44
0603	27,450.27	21,034.26	19,486.73	17,761.37
0604	35,498.72	27,200.36	25,199.46	22,967.87
0701	16,489.39	13,437.58	12,742.31	11,497.55
0702	20,971.78	17,090.14	16,204.23	14,623.06
0703	25,004.02	20,377.44	19,321.72	17,434.57
0704	31,932.67	26,022.89	24,674.00	22,266.20
0801	13,395.92	10,925.64	9,866.72	9,174.65
0802	17,272.76	14,086.39	12,721.48	11,829.17
0803	22,703.54	18,514.31	16,721.68	15,549.01
0804	20,411.08	16,644.78	15,033.17	13,979.05
0805	24,326.37	19,837.57	17,916.77	16,659.20
0806	30,015.07	24,476.96	22,107.60	20,556.86
0901	16,558.27	12,961.78	11,998.98	11,058.61
0902	20,949.35	16,398.07	15,180.55	13,991.87
0903	26,149.45	20,468.75	18,948.46	17,465.00
0904	32,759.30	25,641.61	23,738.44	21,878.51
1001	17,484.23	14,741.60	13,150.82	12,120.73
1002	22,405.57	18,890.78	16,853.04	15,532.99

TABLE 6—PROPOSED FY 2019 PAYMENT RATES—Continued

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
1003	32,438.90	27,350.95	24,400.06	22,488.88
1101	22,110.80	15,952.72	15,952.72	14,333.09
1102	31,073.99	22,419.99	22,419.99	20,143.55
1201	17,831.86	15,311.92	13,926.19	12,655.80
1202	22,565.77	19,377.79	17,623.60	16,016.80
1203	27,328.52	23,466.10	21,343.45	19,397.02
1301	17,580.35	15,404.83	14,209.74	13,421.56
1302	23,030.35	20,182.00	18,615.24	17,583.55
1303	27,735.43	24,303.94	22,418.39	21,175.24
1401	14,802.48	12,039.03	10,863.16	9,770.60
1402	19,851.98	16,144.96	14,566.99	13,104.36
1403	23,671.15	19,251.23	17,370.49	15,624.31
1404	29,784.38	24,222.24	21,856.09	19,659.74
1501	16,173.79	14,044.73	12,740.71	12,189.62
1502	20,622.55	17,907.16	16,244.28	15,542.60
1503	24,465.74	21,245.72	19,272.06	18,440.62
1504	30,883.36	26,817.48	24,327.97	23,277.06
1601	19,372.99	14,848.94	14,075.17	12,715.07
1602	24,581.09	18,839.52	17,859.10	16,132.14
1603	29,880.50	22,900.59	21,708.70	19,610.08
1701	20,612.93	15,661.15	14,619.85	13,174.85
1702	24,831.00	18,866.75	17,610.79	15,871.01
1703	29,023.43	22,051.53	20,584.10	18,551.16
1704	36,902.07	28,038.20	26,171.87	23,587.85
1801	17,958.42	16,181.80	13,591.37	12,715.07
1802	26,610.82	23,977.13	20,140.34	18,841.12
1803	41,559.08	37,446.75	31,453.67	29,425.54
1901	22,633.06	16,181.80	15,209.39	14,592.62
1902	39,846.55	28,486.76	26,775.83	25,691.27
1903	68,740.22	49,144.55	46,190.47	44,319.33
2001	15,526.58	12,357.83	11,476.73	10,414.60
2002	20,178.79	16,060.05	14,916.22	13,535.30
2003	24,795.76	19,735.04	18,330.08	16,631.96
2004	31,609.06	25,157.81	23,365.17	21,202.47
2101	30,678.30	24,787.75	24,094.08	21,128.78
5001				2,564.80
5101				12,112.72
5102				26,469.85
5103				12,998.63
5104				33,951.19

F. Example of the Methodology for Adjusting the Proposed Prospective Payment Rates

Table 7 illustrates the methodology for adjusting the proposed federal prospective payments (as described in section V. of this proposed rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified into CMG 0110 (without comorbidities). The proposed unadjusted prospective payment rate for CMG 0110 (without comorbidities) appears in Table 6.

Example: One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a rural non-teaching hospital has a Disproportionate Share Hospital (DSH) percentage of 5 percent (which would result in a LIP adjustment of 1.0156), a wage index of 0.8088, and a rural adjustment of 14.9 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0454 percent), a wage index of 0.8689, and a teaching status adjustment of 0.0784.

To calculate each IRF's labor and non-labor portion of the proposed prospective payment, we begin by taking the unadjusted prospective payment rate for CMG 0110 (without comorbidities) from Table 6. Then, we multiply the proposed labor-related share for FY 2019 (70.6 percent) described in section V.C. of this proposed rule by the proposed unadjusted prospective payment rate. To determine the non-labor portion of the proposed prospective payment rate, we subtract the labor portion of the proposed federal payment from the proposed unadjusted prospective payment.

To compute the proposed wage-adjusted prospective payment, we multiply the labor portion of the proposed federal payment by the appropriate wage index located in Tables A and B. These tables are available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Inpatient RehabFacPPS/Data-Files.html.* The resulting figure is the wage-adjusted labor amount. Next, we compute the proposed wage-adjusted federal payment by adding the wage-adjusted labor amount to the non-labor portion of the proposed federal payment.

Adjusting the proposed wage-adjusted federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.0784, in this example) by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the

additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted prospective payment rates. Table 7 illustrates the components of the adjusted payment calculation.

TABLE 7—EXAMPLE OF COMPUTING THE FY 2019 IRF PROSPECTIVE PAYMENT

Steps		Rural facility A (Spencer Co., IN)	Urban facility B (Harrison Co., IN)
1	Unadjusted Payment	$33,720.50	$33,720.50
2	Labor Share	× 0.706	× 0.706
3	Labor Portion of Payment	= $23,806.67	= $23,806.67
4	CBSA-Based Wage Index (shown in the Addendum, Tables A and B).	× 0.8088	× 0.8689
5	Wage-Adjusted Amount	= $19,254.83	= $20,685.62
6	Non-Labor Amount	+ $9,913.83	+ $9,913.83
7	Wage-Adjusted Payment	= $29,168.66	= $30,599.45
8	Rural Adjustment	× 1.149	× 1.000
9	Wage- and Rural-Adjusted Payment	= $33,514.79	= $30,599.45
10	LIP Adjustment	× 1.0156	× 1.0454
11	Wage-, Rural- and LIP-Adjusted Payment	= $34,037.62	= $31,988.67
12	Wage- and Rural-Adjusted Payment	$33,514.79	$30,599.45
13	Teaching Status Adjustment	× 0	× 0.0784
14	Teaching Status Adjustment Amount	= $0.00	= $2,399.00
15	Wage-, Rural-, and LIP-Adjusted Payment	+ $34,037.62	+ $31,988.67
16	Total Adjusted Payment	= $34,037.62	= $34,387.67

Thus, the proposed adjusted payment for Facility A would be $34,037.62, and the proposed adjusted payment for Facility B would be $34,387.67.

VI. Proposed Update to Payments for High-Cost Outliers Under the IRF PPS for FY 2019

A. Proposed Update to the Outlier Threshold Amount for FY 2019

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of a case by multiplying the IRF's overall CCR by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, we make an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

In the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), we discussed our rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments. For the 2002 IRF PPS final rule, we analyzed various outlier policies using 3, 4, and 5 percent of the total estimated payments, and we concluded that an outlier policy set at 3 percent of total estimated payments would optimize the extent to which we could reduce the financial risk to IRFs of caring for high-cost patients, while still providing for adequate payments for all other (non-high cost outlier) cases.

Subsequently, we updated the IRF outlier threshold amount in the FYs 2006 through 2018 IRF PPS final rules and the FY 2011 and FY 2013 notices (70 FR 47880, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, 75 FR 42836, 76 FR 47836, 76 FR 59256, 77 FR 44618, 78 FR 47860, 79 FR 45872, 80 FR 47036, 81 FR 52056, and 82 FR 36238, respectively) to maintain estimated outlier payments at 3 percent of total estimated payments. We also stated in the FY 2009 final rule (73 FR 46370 at 46385) that we would continue to analyze the estimated outlier payments for subsequent years and adjust the outlier threshold amount as appropriate to maintain the 3 percent target.

To update the IRF outlier threshold amount for FY 2019, we propose to use FY 2017 claims data and the same methodology that we used to set the initial outlier threshold amount in the FY 2002 IRF PPS final rule (66 FR 41316 and 41362 through 41363), which is also the same methodology that we used to update the outlier threshold amounts for FYs 2006 through 2018. The outlier threshold is calculated by simulating aggregate payments and using an iterative process to determine a threshold that results in outlier payments being equal to 3 percent of total payments under the simulation. To determine the outlier threshold for FY 2019, we estimate the amount of FY 2019 IRF PPS aggregate and outlier payments using the most recent claims available (FY 2017) and the proposed FY 2019 standard payment conversion factor, labor-related share, and wage indexes, incorporating any applicable budget-natural adjustment factors. The outlier threshold is adjusted either up or down in this simulation until the estimated outlier payments equal 3 percent of the estimated aggregate payments. Based on an analysis of the preliminary data used for the proposed rule, we estimated that IRF outlier payments as a percentage of total estimated payments would be approximately 3.4 percent in FY 2018. Therefore, we propose to update the outlier threshold amount from $8,679 for FY 2018 to $10,509 for FY 2019 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2019.

We invite public comment on the proposed update to the FY 2019 outlier threshold amount to maintain estimated outlier payments at approximately 3 percent of total estimated IRF payments.

B. Proposed Update to the IRF Cost-to-Charge Ratio Ceiling and Urban/Rural Averages for FY 2019

Cost-to-charge ratios are used to adjust charges from Medicare claims to costs and are computed annually from facility-specific data obtained from Medicare cost reports. IRF specific cost-

to-charge ratios are used in the development of the CMG relative weights and the calculation of outlier payments under the IRF prospective payment system. In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR 45674, 45692 through 45694), we propose to apply a ceiling to IRFs' CCRs. Using the methodology described in that final rule, we propose to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2019, based on analysis of the most recent data that is available. We apply the national urban and rural CCRs in the following situations:

- New IRFs that have not yet submitted their first Medicare cost report.
- IRFs whose overall CCR is in excess of the national CCR ceiling for FY 2019, as discussed below in this section.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2019, we propose to estimate a national average CCR of 0.470 for rural IRFs, which we calculated by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, we propose to estimate a national average CCR of 0.392 for urban IRFs, which we calculated by taking an average of the CCRs for all urban IRFs using their most recently submitted cost report data. We apply weights to both of these averages using the IRFs' estimated costs, meaning that the CCRs of IRFs with higher total costs factor more heavily into the averages than the CCRs of IRFs with lower total costs. For this proposed rule, we have used the most recent available cost report data (FY 2016). This includes all IRFs whose cost reporting periods begin on or after October 1, 2015, and before October 1, 2016. If, for any IRF, the FY 2016 cost report was missing or had an ''as submitted'' status, we used data from a previous fiscal year's (that is, FY 2004 through FY 2015) settled cost report for that IRF. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care.

In accordance with past practice, we propose to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, we proposed a national CCR ceiling of 1.31 for FY 2019. This means that, if an individual IRF's CCR were to exceed this proposed ceiling of 1.31 for FY 2019, we would replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF). We calculated the proposed national CCR ceiling by:

Step 1. Taking the national average CCR (weighted by each IRF's total costs, as previously discussed) of all IRFs for which we have sufficient cost report data (both rural and urban IRFs combined).

Step 2. Estimating the standard deviation of the national average CCR computed in step 1.

Step 3. Multiplying the standard deviation of the national average CCR computed in step 2 by a factor of 3 to compute a statistically significant reliable ceiling.

Step 4. Adding the result from step 3 to the national average CCR of all IRFs for which we have sufficient cost report data, from step 1.

The proposed national average rural and urban CCRs and the proposed national CCR ceiling in this section will be updated in the final rule if more recent data becomes available to use in these analyses.

We invite public comment on the proposed update to the IRF CCR ceiling and the urban/rural averages for FY 2019.

VII. Proposed Removal of the FIM™ Instrument and Associated Function Modifiers From the IRF–PAI Beginning With FY 2020 and Proposed Refinements to the Case-Mix Classification System Beginning With FY 2020

A. Proposed Removal of the FIM™ Instrument and Associated Function Modifiers From the IRF–PAI Beginning With FY 2020

Under section 1886(j)(2)(D) of the Act, the Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the IRF PPS. In the FY 2002 IRF PPS final rule (66 FR 41324 through 41328), we finalized the use of the IRF–PAI, through which IRFs are now required to collect and electronically submit patient data for all Medicare Part A FFS and Medicare Part C (Medicare Advantage) patients. Data collected in the IRF–PAI is used to classify patients into distinct payment groups based on clinical characteristics and expected resource needs as well as to monitor the quality of care furnished in IRFs.

The IRF–PAI currently in use under the IRF PPS (IRF–PAI version 2.0) was originally developed based on a modified version of the Uniform Data System for medical rehabilitation (UDSmr) patient assessment instrument, commonly referred to as the FIM™. Item 39 of the IRF–PAI version 2.0 contains 18 of the FIM™ data elements and the FIM™ measurement scale that are used to score both motor and cognitive functioning at admission and discharge. The FIM™ data elements and measurement scale are collectively referred to as the FIM™ instrument. Additionally, items 29 through 38 of the IRF–PAI version 2.0 contain Function Modifiers associated with the FIM™ instrument. The FIM™ instrument and associated Function Modifiers are currently used to assign a patient into a CMG for payment purposes under the IRF PPS based on the patient's ability to perform specific activities of daily living and, in some cases, the patient's cognitive ability.

In the FY 2012 IRF PPS final rule (76 FR 47873 through 47883), we established the IRF QRP in accordance with section 1886(j)(7) of the Act and finalized revisions to the IRF–PAI to begin collecting data items under the IRF QRP. Under the IRF QRP, the following data items are collected in the Quality Indicators section of the IRF–PAI:

- GG0130A1 Eating
- GG0130B1 Oral hygiene
- GG0130C1 Toileting hygiene
- GG0130E1 Shower/bathe self
- GG0130F1 Upper-body dressing
- GG0130G1 Lower-body dressing
- GG0130H1 Putting on/taking off footwear
- GG0170A1 Roll left and right
- GG0170B1 Sit to lying
- GG0170C1 Lying to sitting on side of bed
- GG0170D1 Sit to stand
- GG0170E1 Chair/bed-to-chair transfer
- GG0170F1 Toilet transfer
- GG0170I1 Walk 10 feet
- GG0170J1 Walk 50 feet with two turns
- GG0170K1 Walk 150 feet
- GG0170M1 One step curb
- H0350 Bladder continence
- H0400 Bowel continence
- BB0700 Expression of ideas and wants
- BB0800 Understanding verbal content
- C0500 Brief Interview for Mental Status (BIMS) summary score

Because these data items collect data that are similar in nature to, and overlap with, data collected through the FIM™ instrument and associated Function Modifiers, we are proposing to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020 to reduce administrative burden on IRFs.

Currently, data elements in the FIM™ instrument and associated Function Modifiers capture data on eating, grooming, bathing, dressing upper body, dressing lower body, toileting, bladder management, bowel management, transfer to bed/chair/wheelchair, transfer to toilet, transfer to tub/shower, walking or wheelchair use, stair climbing, comprehension, expression, social interaction, problem solving, and memory. The Function Modifiers are used to assist in the scoring of the related FIM™ instrument data elements and provide additional information as to how the FIM™ instrument data element score has been determined. For example, item 29 (Bladder Level of Assistance) and item 30 (Bladder Frequency of Accidents) are used to determine the score for the item 39G, the Bladder data element contained in the FIM™ instrument.

Data items in the Quality Indicators section of the IRF–PAI capture data on functional status, cognitive function, and changes in function and cognitive function among other elements used for quality reporting. For example, the data items in the Quality Indicators section of the IRF–PAI capture data on eating, oral hygiene, toileting hygiene, shower/bathing, dressing upper body, dressing lower body, bowel continence, bladder continence, chair/bed-to-chair transfer, toilet transfer, walking, stair climbing, expression of ideas and wants, understanding verbal and non-verbal content, temporal orientation, and memory/recall ability.

As the data elements in the FIM™ instrument (item 39 of the IRF–PAI) and associated Function Modifiers (items 29 through 38 of the IRF–PAI) overlap, directly or indirectly, with data items in the Quality Indicators section of the IRF–PAI, and as we can now use data items in the Quality Indicators section of the IRF–PAI to assign patients to CMGs for payment under the IRF PPS, we believe that the collection of the FIM™ instrument and associated Function Modifiers is no longer necessary. Accordingly, we believe that continuing to collect the FIM™ instrument and associated Function Modifiers places undue burden on IRFs. Additionally, the removal of the FIM™ instrument and associated Function Modifiers from the IRF–PAI supports the broader goal to standardize data collection across PAC settings as several of the data items we are proposing to incorporate into the IRF case-mix system are similar to data elements that are also collected on Skilled Nursing Facility (SNF) and LTCH assessment instruments. For a discussion of how the data items located in the Quality Indicators section of the IRF–PAI will be incorporated into the case-mix classification system please refer to section VII.B of this proposed rule. In support of our goal to reduce administrative burden on providers, we are proposing to remove the FIM™ instrument (item 39) and associated Function Modifiers (items 29 through 38) from the IRF–PAI beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019.

We invite public comment on our proposal to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019.

B. Proposed Refinements to the Case-Mix Classification System Beginning With FY 2020

1. IRF Classification System Overview

Section 1886(j)(2) of the Act requires the Secretary to establish case-mix groups for payment under the IRF PPS. Under section 1886(j)(2)(B) of the Act, the Secretary must assign each case-mix group a weighting factor that reflects the relative facility resources used for patients classified within the group as compared to patients classified within other groups. Additionally, section 1886(j)(2)(C)(i) of the Act requires the Secretary from time to time to adjust the classifications and weighting factors as appropriate to reflect changes in treatment patterns, technology, case-mix, number of payment units for which payment is made under title XVIII of the Act, and other factors which may affect the relative use of resources. Such adjustments must be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

In the FY 2002 IRF PPS final rule (66 FR 41316), we established a case-mix classification system for IRFs under the IRF PPS. Under the case-mix classification system, a patient's principal diagnosis or impairment is used to classify the patient into a RIC. The patient is then placed into a CMG within the RIC, based on the patient's functional status (motor and cognitive scores) and sometimes age. Other special circumstances, such as the occurrence of very short stays, or cases where the patient expired, are also considered in determining the appropriate CMG. CMGs are further divided into tiers based on the presence of certain comorbidities. These tiers reflect the differential cost of care compared with the average beneficiary in a CMG. We refer readers to the FY 2002 final rule (66 FR 41316) and the FY 2006 IRF final rule (70 FR 47886) for a detailed discussion of the development of, and refinements to, the IRF case-mix classification system.

As discussed in section VII.A of this proposed rule, we are proposing to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019. This would necessitate the incorporation of the data items collected on admission and located in the Quality Indicators section of the IRF–PAI version 2.0 into the CMG classification system, as the FIM™ data would no longer be available to assign patients to CMGs for purposes of payment under the IRF PPS. In accordance with section 1886(j)(2)(C)(i) of the Act and as specified in § 412.620(c) we are proposing to replace our use of the FIM™ items in assigning CMGs with use of data items located in the Quality Indicators section of the IRF–PAI. In addition, to ensure that IRF payments are accurately calculated using the data items located in the Quality Indicators section of the IRF–PAI, we also propose to update the functional status scores used in the case-mix system and to revise the CMGs and update the relative weights and average length of stay values associated with the revised CMGs. We propose to implement these revisions to the case-mix classification system in a budget neutral manner.

We are proposing to make these changes effective beginning with FY 2020, that is, for discharges occurring on or after October 1, 2019, as they require extensive systems changes. That is, we are proposing to implement these changes with a one-year delayed effective date to allow adequate time for providers and vendors to make the necessary systems changes. These proposals are discussed in detail below. We are not proposing any changes to the methodology used to update the CMGs, relative weights and average length of stay values for FY 2019, that is, for discharges occurring on or after October 1, 2018, and on or before September 30, 2019. For information on the proposed updates to the CMG relative weights and average length of stay values for FY 2019, please refer to section III of this proposed rule.

2. Proposed Changes to the Functional Status Scores Beginning With FY 2020

As discussed in the FY 2006 IRF final rule (70 FR 47886), under the CMG case-mix classification system, a patient's

principal diagnosis or impairment is used to classify the patient into a RIC. After using the RIC to define the first division among the inpatient rehabilitation groups, a patient's motor and cognitive scores and age are used to partition the cases further. To classify a patient into a CMG, IRFs use the admission assessment data from the IRF–PAI to score a patient's functional status. Currently, the functional status scores consist of what are termed ''motor'' items and ''cognitive'' items. In addition to the functional status scores, the patient's age may also influence the patient's CMG classification. The motor items are generally indications of the patient's physical functioning level. The cognitive items are generally indications of the patient's mental functioning level, and are related to the patient's ability to process and respond to empirical factual information, use judgment, and accurately perceive what is happening. Under the current case-mix system, the motor and cognitive scores are derived from a combination of data elements in the FIM ™ instrument (item 39 of the IRF–PAI). Eating, grooming, bathing, dressing upper body, dressing lower body, toileting, bladder management, bowel management, transfer to bed/chair/wheelchair, transfer to toilet, walking or wheelchair use, and stair climbing are the data elements collected through the FIM ™ instrument that are currently used to compute a patient's weighted motor score. Comprehension, expression, social interaction, problem solving, and memory are the data elements collected through the FIM ™ instrument that are used to compute a patient's cognitive score. Each data element is recorded on the IRF–PAI and scored on a scale of 1 to 7, with a 7 indicating complete independence in this area of functioning, and a one indicating that a patient is very impaired in this area of functioning. Additionally, a value of zero is used to indicate that an activity did not occur. The scores for each data element above are then used to determine the patient's weighted motor score and cognitive score, which may be used to group a patient into a CMG for payment purposes under the IRF PPS.

As discussed in section VII.A of this proposed rule, we are proposing to remove the FIM ™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020. As the data in the FIM ™ instrument section will no longer be available to determine the motor and cognitive scores used to assign patients to CMGs, we are proposing to use data items collected on admission and located in the Quality Indicators section of the IRF–PAI to derive the functional status scores used to assign patients to a CMG for payment purposes under the IRF PPS. The Quality Indicators section of the IRF–PAI includes data items that are similar to the data elements located in the FIM ™ instrument, in addition to new data elements that capture additional functional status information.

In the summer of 2013, we contracted with Research Triangle Institute, International (RTI) to explore use of the data items collected in the Quality Indicators section of the IRF–PAI in setting IRF PPS payments. Some of the data items collected in the Quality Indicators section of the IRF–PAI were originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration (PAC–PRD) version of the Continuity Assessment Record and Evaluation (CARE) Item Set. The CARE item set was developed in response to a mandate in section 5008 of the Deficit Reduction Act of 2005 (Pub. L. 109–171, enacted on February 8, 2006) (DRA) to develop a uniform patient assessment instrument to assess patients across all types of acute and PAC providers.

In the first stage of this analysis, RTI hosted a Technical Expert Panel (TEP) on September 18, 2014, which brought together researchers, clinicians, and representatives from provider associations to discuss exploratory research on the potential to incorporate the CARE data items in the current case-mix system utilized in the IRF PPS. We received helpful feedback on the exploratory research including clinicians' views of the importance and significance of various findings, input on the methodology used to incorporate the CARE items, and potential limitations of the analysis. RTI's analysis of the original CARE data set, along with guidance from the TEP, suggested the need to derive different functional status measures from the data collected in the Quality Indicators section of the IRF–PAI. The data items from the Quality Indicators section of the IRF–PAI contain slightly different information and utilize a different rating system than the items collected on the FIM ™ instrument. Thus, we are proposing to modify the IRF case-mix classification system to calculate IRF PPS payments correctly using the admission data items from the Quality Indicators section of the IRF–PAI. RTI considered a broad range of the data items in the Quality Indicators section of the IRF–PAI to identify the best predictors of IRF costs. These analyses examined all motor, cognitive, and additional items collected at admission to predict costs. The regression analysis indicated that the components of functional status that were found to best predict costs were the patient's motor function, a memory function, a communication function based on comprehension and expression, and age.

The proposed motor items used to derive the additive motor score are eating, oral hygiene, toileting hygiene, shower bathe/self, upper body dressing, lower body dressing, putting on/taking off footwear, bladder continence, bowel continence, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, walk 10 feet, walk 50 feet with two turns, walk 150 feet, and 1 step (curb). The proposed item used to derive the memory score is the BIMS summary score, which is based on the repetition of three words, temporal orientation, and recall. The proposed communication score is derived from the hearing, speech, and vision items including expression of ideas and wants and understanding verbal and non-verbal content. We are proposing to incorporate a motor score, a memory score, a communication score, and age into the IRF case-mix classification system. Currently, the IRF case-mix system uses a weighted motor score and an unweighted cognitive score. We are not proposing to apply a weighting methodology to the motor score at this time. We are proposing to derive the scores for each respective group of the functional status items described above by calculating the sum of the items that constitute each functional status component. For a more detailed discussion of these analysis please refer to the technical report, ''*Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System,*'' available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Research.html.*

At this time, we believe that it is appropriate to utilize the admission data items located in the Quality Indicators section of the IRF–PAI, as described above, in place of the FIM ™ items to determine functional status, as the data items located in the Quality Indicators section are now available and collected by all IRF providers for purposes of the IRF QRP. We believe the proposed motor score, a memory score, a communication score, and age should compose the functional status scores in the IRF case-mix classification system, as our analysis determined these to be the best predictors of cost. The proposed removal of the FIM ™ instrument and the proposed incorporation of certain

items from the Quality Indicators section of the IRF–PAI to assign patients to CMGs support our efforts to reduce burden on providers. Additionally, the removal of the FIM ™ instrument and the incorporation of certain items from the Quality Indicators section of the IRF–PAI into the CMG case-mix system support our broader goal of standardizing assessment data collection across PAC settings.

We are proposing to utilize certain data items located in the Quality Indicators section of the IRF–PAI, as described above, to generate the functional status scores that will be used to group patients into CMGs for payment purposes under the IRF PPS beginning in FY 2020.

We invite public comments on the proposed use of certain data items located in the Quality Indicators section of the IRF–PAI, as described above, for payment purposes under the IRF PPS beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019.

3. Proposed Updates to the Score Reassignment Methodology Beginning With FY 2020

As previously noted, the data items located in the Quality Indicators section of the IRF–PAI utilize a different rating system than the FIM ™ instrument. There are several important differences to note regarding the rating systems for the data items from the Quality Indicators section of the IRF–PAI and the data contained in the FIM ™ instrument. First, the data items from the Quality Indicators section of the IRF–PAI are assessed based on a patient's usual performance during the assessment period in contrast to the FIM ™ items, which are assessed based on the patients lowest functional score during the assessment period. The data items from the Quality Indicators section of the IRF–PAI are generally assessed using a 6 level rating scale for the self-care and mobility elements and a 4 level scale for the cognitive elements. The FIM ™ data items use a 7 level scale. Additionally, the FIM ™ scale includes a value of zero to indicate an activity did not occur or was not observed. The data items from the Quality Indicators section of the IRF–PAI utilize the following four codes to indicate why an activity did not occur: the patient refused to complete an activity (code 07), the patient did not perform this activity (code 09), the activity was not attempted due to environmental limitations (code 10), or the activity was not attempted due to a medical condition or safety concern (code 88).

As the rating scale for the data items in the Quality Indicators section of the IRF–PAI captures multiple reasons an activity did not occur, we are proposing to modify the methodology currently used to reassign values indicating an activity did not occur or was not observed, when they are recorded on an item used for payment, beginning with FY 2020. Currently, when a code of 0 appears for one of the FIM ™ items on the IRF–PAI used to determine payment, the item is reassigned another value to determine the appropriate payment for the patient. In the FY 2002 IRF PPS final rule (66 FR 41316), we finalized a methodology to assign a code of 1 (indicating the patient needed total assistance) whenever the recorded code indicated that the activity did not occur. Subsequently, in the FY 2006 IRF PPS final rule, we revised this methodology to assign a value of 2 when the transfer to toilet item was coded with a zero value. For more information on the rationale behind this decision we refer readers to the 2006 IRF PPS final rule (70 FR 47896 through 47902). As the data items from the Quality Indicators section of the IRF–PAI now utilize 4 values to indicate an activity did not occur and a dash to indicate ''no information'', we are proposing to modify the reassignment methodology to incorporate the new codes. For the self-care and mobility items identified above, we are proposing to recode values of 07, 09, 10, 88, and the presence of a dash (''-'') to 1, the most dependent level, except the toilet transfer item, which is recoded to 2. These recodes are consistent with the current reassignment methodology rules. We are also proposing to change the way we treat specific values for the bowel continence and bladder continence items, as our analysis of these items and current coding guidelines indicate these changes are necessary. The bladder continence and bowel continence items utilize a different scale than the other function items and may capture clinical information that is not necessarily reflective of a patient's functional ability. For instance, the bladder continence scale includes the options ''no urine output'' or ''not applicable'' for cases where a patient may have renal failure or an indwelling catheter. A clinical review of these cases determined that patients for whom these values are coded are similar in terms of resource needs and costliness to patients for whom functional ability is captured. Based on this review, we are proposing to recode these values to be able to score the functional status of a patient when these values are coded on the IRF–PAI. For the bladder continence item, we are proposing to reassign a value of 1 (stress incontinence only) to 0 (always continent), a value of 5 (no urine output) to 0 (always continent), and a value of 9 (not applicable) to 4 (always incontinent). For the bowel continence item, we are proposing to reassign a value of 9 (not rated) to 2 (frequently incontinent). For both items, we are proposing to reassign a missing score to 0 (always continent). We believe these changes are necessary to update the score reassignment methodology used to derive the functional status scores to reflect use of the new data items from the Quality Indicators section of the IRF–PAI and to accurately assign payments based on a patients' expected costliness.

We welcome public comments on the proposed updates to the score reassignment methodology beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019.

4. Proposed Refinements to the CMGs Beginning With FY 2020

As previously noted, we are proposing to modify the methodology used to update the CMGs used to classify IRF patients for purposes of establishing payment amounts, beginning with FY 2020. We are proposing to implement revisions to the CMGs in a budget-neutral manner. As discussed in the FY 2006 IRF PPS final rule (70 FR 47886 through 47887), the current CMGs were derived through Classification and Regression Trees (CART) analysis that incorporated a patient's functional status (motor score and cognitive score) and age into the construction of the CMGs. Under the IRF case-mix classification system, a patient's principal diagnosis or impairment is used to classify the patient into a RIC. Currently, there are 21 diagnosis-based RICs. The RICs are then further subdivided into 92 CMGs. Of the 92 CMGs, patients are assigned to 87 of the CMGs based on the patient's primary reason for rehabilitation care, age and functional status. There are also five special CMGs to account for very short stays and for patients who expire in the IRF.

The CART method is useful in identifying statistical relationships among data and, using these relationships, constructing a predictive model for organizing and separating a large set of data into smaller, similar groups. CART ensures that the proposed CMGs recognize that patients with clinically distinct resource needs are appropriately grouped in the case-mix

classification system. CART is an iterative process that creates initial groups of patients then searches for ways to split the initial groups to further decrease the clinical and cost variances within a group and increase the explanatory power of the CMGs.

As noted previously, the data items from the Quality Indicators section of the IRF–PAI contain slightly different information and utilize a different rating system than the items collected on the FIM ™ instrument. Thus, we have to update the IRF case-mix classification system to ensure that IRF PPS payments reflect as closely as possible the costs of care when we convert to using the admission data items from the Quality Indicators section of the IRF–PAI. To convert from using the FIM ™ items to using the data items from the Quality Indicators section of the IRF–PAI, RTI first had to identify which quality indicator data items would be the best predictors of cost, as previously discussed. Then, RTI used CART analysis to modify the CMG definitions to reflect the use of the different assessment items.

To develop CMGs based on the data items from the Quality Indicators section of the IRF–PAI, RTI used CART analysis to divide patients into payment groups based on similarities in their clinical characteristics and relative costs. As part of this analysis, RTI imposed certain restraints on these groupings to decrease the resulting number of CMGs (to ensure that the payment system did not become unduly complicated). For a more detailed discussion of these analyses or for more information on the development of the CMGs, we refer readers to the technical report, ''*Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System*'', available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Research.html.*

In developing the revised CMGs, RTI's analysis indicated that RIC 16 and RIC 17 should incorporate the CMGs shown in Table 8, based on motor score and cognitive function, derived from the memory and communication scores.

TABLE 8—CART-BASED CMGS FOR RIC 16 (PAIN SYNDROME) AND RIC 17 (MAJOR MULTIPLE TRAUMA WITHOUT BRAIN OR SPINAL CORD INJURY)

RIC	CMG	Cases	Average Cost	Rule 1	Rule 2	Rule 3
16	1	255	$ 11,088.65	Motor >= 70		
16	2	270	13,402.22	Motor < 70	Motor >= 61	
16	3	188	14,775.04	Motor < 61	Cognition < 7	
16	4	260	16,806.16	Motor < 61	Cognition >= 7	
17	1	1149	12,911.91	Motor >= 62		
17	2	1557	15,504.35	Motor < 62	Motor >= 51	
17	3	624	17,273.01	Motor < 51	Motor >= 47	
17	4	927	19,209.23	Motor < 47	Motor >= 39	
17	5	289	20,245.80	Motor < 51	Motor < 39	Cognition < 8
17	6	205	23,465.77	Motor < 51	Motor < 39	Cognition >= 8

We considered proposing to revise the CMGs for RIC 16 and RIC 17 as shown above. However, these CMGs indicate higher costs for patients with no cognitive impairment as compared to those with any level of impairment. As this unexpected result may be driven by small sample size, we are proposing to combine CMG 03 and 04 for RIC 16 and to combine CMG 05 and 06 for RIC 17 as shown in Table 9.

Table 9 contains the proposed new CMGs and their respective descriptions, including the functional status scores and age that we are proposing to use to classify discharges into CMGs. Table 9 also contains the proposed CMG relative weights and average length of stay values for the proposed CMGs. We are not proposing any changes to methodology used to determine the CMG relative weights that was finalized in the FY 2002 IRF final rule (66 FR 41351 through 41357) and revised in the FY 2009 IRF final rule (73 FR 46372 through 46374). For more information on the methodology used to calculate the CMG relative weights please refer to section III. of this proposed rule.

TABLE 9—PROPOSED REVISED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE PROPOSED CASE-MIX GROUPS

CMG	CMG Description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidity tier	Tier 1	Tier 2	Tier 3	No comorbidity tier
0101	Stroke M >= 77	1.0570	0.9232	0.8492	0.8050	11	11	10	10
0102	Stroke M < 77 and M >= 68	1.3370	1.1678	1.0741	1.0182	13	13	12	12
0103	Stroke M < 68 and M >= 55	1.6848	1.4715	1.3535	1.2831	15	16	15	15
0104	Stroke M < 55 and M >= 47	2.1484	1.8764	1.7260	1.6361	19	20	19	19
0105	Stroke M < 47 and A >= 85	2.4137	2.1081	1.9391	1.8382	22	22	21	20
0106	Stroke M < 47 and A < 85	2.7956	2.4417	2.2460	2.1291	26	27	24	23
0201	Traumatic Brain Injury M >= 73	1.2418	1.0426	0.9376	0.8708	12	12	11	11
0202	Traumatic Brain Injury M < 73 and M >= 64.	1.4929	1.2534	1.1272	1.0468	14	14	13	12
0203	Traumatic Brain Injury M < 64 and M >= 51.	1.7699	1.4859	1.3363	1.2411	16	17	15	14
0204	Traumatic Brain Injury M < 51 and M >= 36.	2.1753	1.8263	1.6424	1.5254	21	20	18	17
0205	Traumatic Brain Injury M < 36	2.6959	2.2634	2.0355	1.8904	36	24	22	19
0301	Non-Traumatic Brain Injury M >= 70	1.2192	1.0096	0.9348	0.8735	11	11	11	10
0302	Non-Traumatic Brain Injury M < 70 and M >= 57.	1.5403	1.2755	1.1810	1.1034	14	14	13	13

TABLE 9—PROPOSED REVISED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE PROPOSED CASE-MIX GROUPS—Continued

CMG	CMG Description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidity tier	Tier 1	Tier 2	Tier 3	No comorbidity tier
0303	Non-Traumatic Brain Injury M < 57 and M >= 45.	1.8496	1.5316	1.4182	1.3251	17	16	15	15
0304	Non-Traumatic Brain Injury M < 45 and A >= 79.	2.0666	1.7113	1.5846	1.4806	20	18	17	16
0305	Non-Traumatic Brain Injury M < 45 and A < 79.	2.2755	1.8843	1.7447	1.6302	21	21	18	17
0401	Traumatic Spinal Cord Injury M >= 64.	1.2999	1.0952	1.0122	0.9370	13	12	12	11
0402	Traumatic Spinal Cord Injury M < 64 and M >= 57.	1.6630	1.4011	1.2949	1.1987	15	15	15	14
0403	Traumatic Spinal Cord Injury M < 57 and M >= 46.	1.9672	1.6574	1.5318	1.4180	15	18	17	16
0404	Traumatic Spinal Cord Injury M < 46 and M >= 36.	2.6209	2.2082	2.0408	1.8892	25	24	23	21
0405	Traumatic Spinal Cord Injury M < 36 and A < 63.	3.1923	2.6895	2.4857	2.3010	34	29	27	24
0406	Traumatic Spinal Cord Injury M < 36 and A >= 63.	3.6963	3.1142	2.8782	2.6643	46	34	28	29
0501	Non-Traumatic Spinal Cord Injury M >= 75.	1.1291	0.9068	0.8382	0.7642	10	11	10	9
0502	Non-Traumatic Spinal Cord Injury M < 75 and M >= 63.	1.4096	1.1322	1.0464	0.9541	14	13	12	11
0503	Non-Traumatic Spinal Cord Injury M < 63 and M >= 52.	1.7905	1.4381	1.3292	1.2119	16	15	15	14
0504	Non-Traumatic Spinal Cord Injury M < 52 and M >= 44.	2.2191	1.7823	1.6473	1.5020	21	19	18	17
0505	Non-Traumatic Spinal Cord Injury M < 44.	2.8377	2.2792	2.1065	1.9206	27	24	22	21
0601	Neurological M >= 69	1.3205	1.0500	0.9795	0.8873	12	12	11	10
0602	Neurological M < 69 and M >= 57	1.6324	1.2981	1.2109	1.0969	14	14	13	13
0603	Neurological M < 57 and M >= 47	1.9170	1.5244	1.4220	1.2882	16	16	15	14
0604	Neurological M < 47	2.2218	1.7667	1.6481	1.4929	20	18	17	16
0701	Fracture of Lower Extremity M >= 67.	1.1960	0.9851	0.9487	0.8595	11	11	11	10
0702	Fracture of Lower Extremity M < 67 and M >= 55.	1.5308	1.2608	1.2142	1.1001	14	14	14	13
0703	Fracture of Lower Extremity M < 55 and M >= 45.	1.8510	1.5245	1.4682	1.3302	17	17	16	15
0704	Fracture of Lower Extremity M < 45	2.0790	1.7124	1.6491	1.4941	18	18	18	17
0801	Replacement of Lower Extremity Joint M >= 67.	1.0475	0.8892	0.8044	0.7437	10	10	9	9
0802	Replacement of Lower Extremity Joint M < 67 and M >= 56.	1.2925	1.0972	0.9926	0.9176	12	12	11	11
0803	Replacement of Lower Extremity Joint M < 56 and M >= 47.	1.5469	1.3132	1.1880	1.0982	15	15	13	12
0804	Replacement of Lower Extremity Joint M < 47.	1.8517	1.5719	1.4220	1.3146	16	17	15	15
0901	Other Orthopedic M >= 69	1.1749	0.9376	0.8792	0.8083	11	11	10	10
0902	Other Orthopedic M < 69 and M >= 55.	1.5103	1.2052	1.1302	1.0390	13	14	13	12
0903	Other Orthopedic M < 55 and M >= 47.	1.8117	1.4457	1.3557	1.2463	15	16	15	14
0904	Other Orthopedic M < 47	2.0393	1.6273	1.5261	1.4029	17	17	16	16
1001	Amputation Lower Extremity M >= 67.	1.3231	1.1340	1.0276	0.9487	12	13	12	11
1002	Amputation Lower Extremity M < 67 and M >= 59.	1.6372	1.4032	1.2715	1.1739	15	15	14	14
1003	Amputation Lower Extremity M < 59 and M >= 49.	1.8961	1.6251	1.4726	1.3596	17	16	16	15
1004	Amputation Lower Extremity M < 49	2.1617	1.8527	1.6788	1.5500	19	20	18	17
1101	Amputation Non-Lower Extremity	1.8322	1.3022	1.3022	1.0585	15	14	13	12
1201	Osteoarthritis M >= 65	1.3071	1.0757	0.9575	0.8777	11	12	11	11
1202	Osteoarthritis M < 65 and M >= 49	1.6787	1.3816	1.2297	1.1273	14	15	14	13
1203	Osteoarthritis M < 49	1.9145	1.5756	1.4024	1.2857	16	16	16	15
1301	Rheumatoid Other Arthritis M >= 69	1.1111	0.9753	0.9076	0.8570	10	11	10	11
1302	Rheumatoid Other Arthritis M < 69 and M >= 58.	1.3176	1.1567	1.0764	1.0164	12	13	12	12
1303	Rheumatoid Other Arthritis M < 58 and A >= 72.	1.6691	1.4652	1.3635	1.2875	13	17	14	14
1304	Rheumatoid Other Arthritis M < 58 and A < 72.	1.7642	1.5487	1.4412	1.3609	14	17	15	15
1401	Cardiac M >= 70	1.1839	0.9920	0.8991	0.8023	11	11	10	9
1402	Cardiac M < 70 and M >= 59	1.4635	1.2263	1.1115	0.9918	13	13	12	11
1403	Cardiac M < 59 and M >= 51	1.7034	1.4272	1.2936	1.1544	15	15	14	13
1404	Cardiac M < 51	1.9704	1.6510	1.4964	1.3353	18	17	16	14
1501	Pulmonary M >= 84	1.0149	0.9214	0.8346	0.7907	7	10	9	9
1502	Pulmonary M < 84 and M >= 74	1.2323	1.1187	1.0133	0.9601	11	12	11	10

TABLE 9—PROPOSED REVISED RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR THE PROPOSED CASE-MIX GROUPS—Continued

CMG	CMG Description (M=motor, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	No comorbidity tier	Tier 1	Tier 2	Tier 3	No comorbidity tier
1503	Pulmonary M < 74 and M >= 59	1.4557	1.3215	1.1970	1.1341	13	13	12	12
1504	Pulmonary M < 59 and M >= 46	1.7464	1.5853	1.4360	1.3606	15	15	14	14
1505	Pulmonary M < 46	2.0273	1.8404	1.6670	1.5794	20	17	15	16
1601	Pain Syndrome M >= 70	1.2293	0.9242	0.8776	0.7774	10	11	10	10
1602	Pain Syndrome M < 70 and M >= 61.	1.5216	1.1439	1.0863	0.9622	12	12	12	11
1603	Pain Syndrome M < 61	1.8391	1.3826	1.3129	1.1630	13	15	14	13
1701	Major Multiple Trauma Without Brain or Spinal Cord Injury M >= 62.	1.4355	1.1154	1.0668	0.9504	14	13	12	11
1702	Major Multiple Trauma Without Brain or Spinal Cord Injury M < 62 and M >= 51.	1.7939	1.3938	1.3330	1.1876	16	15	15	14
1703	Major Multiple Trauma Without Brain or Spinal Cord Injury M < 51 and M >= 47.	2.0059	1.5585	1.4906	1.3280	17	16	16	15
1704	Major Multiple Trauma Without Brain or Spinal Cord Injury M < 47 and M >= 39.	2.1848	1.6975	1.6236	1.4465	19	18	17	16
1705	Major Multiple Trauma Without Brain or Spinal Cord Injury M < 39.	2.4250	1.8841	1.8020	1.6055	21	21	19	17
1801	Major Multiple Trauma With Brain or Spinal Cord Injury M >= 72.	1.1980	1.0351	0.8752	0.8233	13	11	10	10
1802	Major Multiple Trauma With Brain or Spinal Cord Injury M < 72 and M >= 58.	1.5335	1.3250	1.1204	1.0539	14	16	12	12
1803	Major Multiple Trauma With Brain or Spinal Cord Injury M < 58 and M >= 42.	2.0608	1.7806	1.5056	1.4162	23	19	16	16
1804	Major Multiple Trauma With Brain or Spinal Cord Injury M < 42.	2.9220	2.5248	2.1348	2.0081	34	25	23	22
1901	Guillain-Barré M >= 54	1.5211	1.2331	1.1228	1.0834	16	15	12	13
1902	Guillain-Barré M < 54	3.4558	2.8014	2.5507	2.4613	39	28	27	27
2001	Miscellaneous M >= 70	1.2339	1.0047	0.9349	0.8447	11	11	10	10
2002	Miscellaneous M < 70 and M >= 58	1.5240	1.2410	1.1547	1.0433	14	13	12	12
2003	Miscellaneous M < 58 and M >= 49	1.7837	1.4525	1.3515	1.2211	16	15	14	14
2004	Miscellaneous M < 49	2.0373	1.6589	1.5436	1.3947	19	17	16	15
2101	Burns	1.9058	1.5390	1.5118	1.3015	22	16	16	14
5001	Short-stay cases, length of stay is 3 days or fewer.				0.1801				3
5101	Expired, orthopedic, length of stay is 13 days or fewer.				0.6240				7
5102	Expired, orthopedic, length of stay is 14 days or more.				1.7071				18
5103	Expired, not orthopedic, length of stay is 15 days or fewer.				0.6795				7
5104	Expired, not orthopedic, length of stay is 16 days or more.				2.1069				21

The following would be the most significant differences between the current CMGs and the proposed revised CMGs:

- There would be fewer CMGs than before (88 instead of 92 currently).
- There would be fewer CMGs in RICs 1, 2, 5, 8, 11, and 19, while there would be more CMGs in RICs 3, 4, 10, 13, 15, 17, and 18.
- A patient's age would affect assignment for CMGs in RICs 1, 3, 4, and 13 whereas it currently affects assignment for CMGs in RICs 1, 4, and 8.

We are proposing to utilize the CMGs based on the data items from the Quality Indicators section of the IRF–PAI to classify IRF patients for purposes of establishing payment under the IRF PPS beginning with FY 2020. We are proposing to implement these revisions in a budget neutral manner. For more information on the specific impacts of this proposal, we refer readers to Table 10. We are also proposing to update the CMG relative weights and average length of stay values associated with the proposed CMGs based on the data items from the Quality Indicators section of the IRF–PAI. We believe it is appropriate to update the CMGs and relative weights for FY 2020 to better align IRF payments with the costs of caring for IRF patients, given the new information that is captured by the data items from the Quality Indicators section of the IRF–PAI. Additionally, changes in treatment patterns, technology, case-mix, and other factors affecting the relative use of resources in IRFs since the current CMGs were last revised, likely require an update to the classification system.

TABLE 10—DISTRIBUTIONAL EFFECTS OF THE PROPOSED CHANGES TO THE CMGS

Facility classification (1)	Number of IRFs (2)	Number of Cases (3)	Percent Change in Mean Payment (4)
Total	1,111	369,684	0
Urban unit	702	155,121	3
Rural unit	133	20,074	3
Urban hospital	265	190,431	−2
Rural hospital	11	4,058	−1
Urban For-Profit	339	185,702	−2
Rural For-Profit	37	7,388	2
Urban Non-Profit	529	137,321	2
Rural Non-Profit	84	13,338	2
Urban Government	99	22,529	3
Rural Government	23	3,406	4
Urban	967	345,552	0
Rural	144	24,132	2
Urban by region:			
Urban New England	29	15,514	−2
Urban Middle Atlantic	134	48,194	−2
Urban South Atlantic	144	69,040	0
Urban East North Central	173	46,132	3
Urban East South Central	56	24,250	−1
Urban West North Central	73	18,333	0
Urban West South Central	180	75,717	−1
Urban Mountain	81	26,683	−1
Urban Pacific	97	21,689	4
Rural by region:			
Rural New England	4	1,048	−6
Rural Middle Atlantic	11	1,244	3
Rural South Atlantic	16	3,491	−1
Rural East North Central	21	3,599	2
Rural East South Central	21	4,174	4
Rural West North Central	21	2,829	2
Rural West South Central	40	6,765	4
Rural Mountain	7	722	4
Rural Pacific	3	260	2
Teaching status:			
Non-teaching	842	303,102	−1
Teaching	269	66,582	2
Bed Size:			
< 25	563	85,835	3
25–49	314	107,858	1
50–74	134	85,923	−1
75–99	58	48,564	−2
100–124	19	14,527	−2
125+	23	26,977	−1

Table 10 shows how we estimate that the application of the proposed revisions to the case-mix system for FY 2020 would affect particular groups. Table 10 categorizes IRFs by geographic location, including urban or rural location, and location for CMS's 9 Census divisions of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities, ownership (otherwise called for-profit, non-profit, and government), by teaching status, and bed size. The proposed changes to the case-mix classification system are expected to affect the overall distribution of payments across CMGs. Note that, because we propose to implement the revisions to the case-mix classification system in a budget-neutral manner, total estimated aggregate payments to IRFs would not be affected as a result of the proposed revisions to the CMGs. However, these proposed revisions may affect the distribution of payments across CMGs.

We invite public comment on the proposed refinements to the CMGs beginning with FY 2020, that is, for all discharges beginning on or after October 1, 2019.

VIII. Proposed Revisions to Certain IRF Coverage Requirements Beginning With FY 2019

We are committed to transforming the health care delivery system, and the Medicare program, by putting an additional focus on patient-centered care and working with providers and physicians to improve patient outcomes. As an agency, we recognize it is imperative that we develop and implement policies that allow providers and physicians to focus the majority of their time treating patients rather than completing paperwork. Moreover, we believe it is essential for us to reexamine current regulations and administrative requirements, to assure that we are not

placing unnecessary burden on providers.

We believe the agency initiative of treating patients over paperwork will improve patient outcomes, decrease provider costs, and ensure that patients and providers are making the best heath care choices possible. In the FY 2018 IRF PPS proposed rule (82 FR 20743), we included a request for information (RFI) to solicit comments from stakeholders requesting information on CMS flexibilities and efficiencies. The purpose of the RFI was to receive feedback regarding ways in which we could reduce burden for hospitals and physicians, improve quality of care, decrease costs and ensure that patients receive the best care. We received comments from IRF industry associations, state and national hospital associations, industry groups representing hospitals, and individual IRF providers in response to the solicitation. We are appreciative of the feedback. As discussed in more detail in each of the proposals below, we are in some cases using the commenters' specific suggestions to propose changes to regulatory requirements to alleviate provider burden. In other cases, however, we are proposing additional changes to the regulatory requirements that we believe will be responsive to stakeholder feedback and helpful to providers in reducing administrative burden.

In the FY 2010 IRF PPS final rule (74 FR 39788 through 39798), we updated the IRF coverage criteria requirements to reflect changes that had occurred in medical practice since the IRF PPS was first implemented in 2002. IRF care is only considered by Medicare to be reasonable and necessary under section 1862(a)(1) of the Act if the patient meets all of the IRF coverage requirements outlined in § 412.622(a)(3), (4), and (5). Failure to meet the IRF coverage criteria in a particular case will result in denial of the IRF claim. The IRF coverage requirements have not been updated since they became effective on January 1, 2010. To reduce unnecessary burden on IRF providers and physicians, we are proposing to revise the current IRF coverage criteria as suggested by some of the comments received in response to the RFI. Specifically, we are focused on reducing documentation requirements that we believe have become overly burdensome to IRF providers over time.

A. Proposed Changes to the Physician Supervision Requirement Beginning With FY 2019

In response to the RFI, several commenters suggested that we consider decreasing the number of required weekly face-to-face visits that the rehabilitation physician must complete. Commenters suggested that the decrease in visits would not only assist with reducing the documentation burden on rehabilitation physicians, but it would also afford the rehabilitation physician more time to focus on higher-acuity, more complex patients resulting in improved outcomes and lower readmission rates. Additionally, we received comments suggesting that we consider either eliminating the post-admission physician evaluation altogether in an effort to reduce paperwork and duplicative requirements or that we allow the post-admission physician evaluation to count as one of the required face-to-face visits completed by the rehabilitation physician. We agree with the commenters and are proposing to move forward with a combination of these two suggested ideas in order to reduce unnecessary burden on rehabilitation physicians.

Under § 412.622(a)(3)(iv), for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation at the time of the patient's admission to the IRF that the patient requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Under § 412.622(a)(4)(ii), to document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in § 412.622(a)(3) at the time of admission, the patient's medical record at the IRF must contain a post-admission physician evaluation that meets all of the requirements specified in the regulation. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, sections 110.1.2 and 110.2.4 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

While the purpose of the physician supervision requirement is to ensure that the patient's medical and functional statuses are being continuously monitored as the patient's overall plan of care is being carried out, the purpose of the post-admission physician evaluation is to document the patient's status on admission, identify any relevant changes that may have occurred since the preadmission screening, and provide the rehabilitation physician with the necessary information to begin development of the patient's overall plan of care. When the coverage criteria were initially implemented, we believed that the post-admission physician evaluation should not be used as a way to fulfill one of the face-to-face visits required under § 412.622(a)(3)(iv) because we considered them to be different types of assessments. We also believed it was in the patient's best interest to be seen by a rehabilitation physician at least four times in the first week of the IRF admission when the patient is in the most critical phase of their recovery process.

While we continue to believe that the post-admission physician evaluation and the face-to-face physician visits are two different types of assessments, after reevaluating these coverage criteria, we believe that the rehabilitation physician should have the flexibility to assess the patient and conduct the post-admission physician evaluation during one of the three face-to-face physician visits required in the first week of the IRF admission. Additionally, based on the comments that we received in response to the RFI, we believe that it should be the responsibility of the rehabilitation physician to use his or her best clinical judgment to determine whether the patient needs to be seen more than three times in the first week of the IRF admission. Therefore, allowing these two requirements to be met concurrently would reduce redundancy and regulatory burden while still ensuring adequate care to the patient.

Therefore, we are proposing to modify § 412.622(a)(3)(iv) to provide that the post-admission physician evaluation required under § 412.622(a)(4)(ii) may count as one of the face-to-face physician visits required under § 412.622(a)(3)(iv) beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018. To clarify, we are not proposing to modify § 412.622(a)(4)(ii), including the 24-hour timeframe within which the post-admission physician evaluation requirement must be completed.

We invite public comment on our proposal to modify § 412.622(a)(3)(iv) to provide that the post-admission physician evaluation required under § 412.622(a)(4)(ii) may count as one of the face-to-face physician visits required under § 412.622(a)(3)(iv) beginning with

FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018.

B. Proposed Changes to the Interdisciplinary Team Meeting Requirement Beginning With FY 2019

Under § 412.622(a)(5), for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, the patient must require an interdisciplinary team approach to care, as evidenced by documentation in the patient's medical record of weekly interdisciplinary team meetings that meet all of the requirements specified in the regulation. Among those requirements are that the team meetings must be led by a rehabilitation physician and that the results and findings of the team meetings, and the concurrence by the rehabilitation physician with those results and findings, are retained in the patient's medical record. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, section 110.2.5 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

We understand that it may occasionally be difficult for the rehabilitation physician to be physically present in the team meetings and for that reason we have always instructed providers that the rehabilitation physician may participate in the interdisciplinary team meetings by telephone as long as it is clearly demonstrated in the documentation of the IRF medical record that the meeting was led by the rehabilitation physician. However, with the advancements in technology since the inception of the IRF coverage criteria in 2010, we believe it is appropriate to allow rehabilitation physicians to lead the meeting remotely via another mode of communication, such as video or telephone conferencing. Therefore, we are proposing to amend § 412.622(a)(5)(A) to expressly provide that the rehabilitation physician may lead the interdisciplinary meeting remotely without any additional documentation requirements. We believe this proposed change will allow time management flexibility and convenience for all rehabilitation physicians, especially those located in rural areas who may need to travel greater distances between facilities. At this time, we are proposing for this change to apply only to the rehabilitation physician and not the other required interdisciplinary team meeting attendees to give IRFs time to adapt to this proposed change. However, we may consider expanding this policy to include other interdisciplinary team meeting attendees in future rulemaking.

Therefore, we are proposing to amend § 412.622(a)(5)(A) to expressly provide that the rehabilitation physician may lead the interdisciplinary meeting remotely without any additional documentation requirements. We believe that other communication modes such as video and telephone conferencing are acceptable ways of leading the interdisciplinary team meeting. Please note that the requirement that the rehabilitation physician must lead the interdisciplinary team meeting will remain the same.

We invite public comment on our proposal to amend § 412.622(a)(5)(A) to expressly provide that the rehabilitation physician may lead the interdisciplinary team meeting remotely without additional documentation requirements.

C. Proposed Changes to the Admission Order Documentation Requirement Beginning With FY 2019

In response to the RFI, several commenters suggest that in general, we should consider eliminating duplicative requirements. Commenters stated that duplicative requirements placed unnecessary administrative burden on facilities trying to make sure they comply with each nuance of each requirement. We agree with the commenters and for that reason we are proposing to remove § 412.606(a) as we believe that IRFs are already required to fulfill this requirement under §§ 482.12(c), 482.24(c), and 412.3.

Under § 412.606(a), at the time that each Medicare Part A FFS patient is admitted, the IRF must have physician orders for the patient's care during the time the patient is hospitalized. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, section 110.1.4 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

Additionally, under § 412.3(a) of the hospital payment requirements, for the purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient under an order for inpatient admission by a physician or other qualified practitioner in accordance with §§ 412.3, 482.24(c), 482.12(c), and 485.638(a)(4)(iii) for a critical access hospital.

In an effort to reduce duplicative requirements, we believe that if we remove the admission order documentation requirement at § 412.606(a), this requirement would continue to be appropriately addressed through the enforcement of § 482.12(c) and § 482.24(c) of the hospital conditions of participation (CoPs), as well as the hospital admission order payment requirements at § 412.3. IRFs are responsible for meeting all of the inpatient hospital CoPs and the hospital admission order payment requirements at § 412.3, and, therefore, we believe that by removing the admission order documentation requirement at § 412.606(a), we would be reducing both regulatory redundancy as well as administrative burden.

Therefore, we are proposing to amend § 412.606(a) to remove the admission order documentation requirement beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018. IRFs would continue to meet the requirements at §§ 482.12(c), 482.24(c), and 412.3.

We invite public comment on our proposal to amend § 412.606(a) to remove the admission order documentation requirement beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018.

D. Solicitation of Comments Regarding Additional Changes to the Physician Supervision Requirement

As discussed in section VIII.A of this proposed rule, under § 412.622(a)(3)(iv), for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation at the time of the patient's admission to the IRF that the patient requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, section 110.2.4 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

When the IRF coverage criteria were initially implemented in 2010, we

believed that the rehabilitation physician visits should be completed face-to-face to ensure that the patient receives the most comprehensive in-person care by a rehabilitation physician throughout the IRF stay.

As part of our efforts to assist in reducing unnecessary regulatory burden on IRFs, this is an issue we would like to further explore. We are interested in soliciting public comments on whether the rehabilitation physician should have the flexibility to determine that some of the IRF visits can be appropriately conducted remotely via another mode of communication, such as video or telephone conferencing. Given the level of complexity of IRF patients, we have some concerns about whether this approach would have an impact on the quality of care provided to IRF patients. To maintain the hospital level of care that IRF patients require, we would continue to expect that the majority of IRF physician visits would continue to be performed face-to-face. However, we are interested in feedback from stakeholders on whether we should allow a limited number of visits to be conducted remotely. In order to better assist us in balancing the needs of the patient, as well as retaining the hospital level quality of care provided in an IRF with the goal of reducing the regulatory burden on rehabilitation physicians, we are seeking feedback from stakeholders about potentially amending the face-to-face visit requirement for rehabilitation physicians. Specifically, we would appreciate feedback regarding the following:

- Do stakeholders believe that the rehabilitation physician would be able to fully assess both the medical and functional needs and progress of the patient remotely?
- Would this assist facilities in rural areas where it may be difficult to employ an abundance of physicians?
- Do stakeholders believe that assessing the patient remotely would affect the quality or intensity of the physician visit in any way?
- How many and what types of visits do stakeholders believe should be able to be performed remotely?
- From an operational standpoint, how would the remote visit work?
- What type of clinician would need to be present in the room with the patient while the rehabilitation physician was in a remote location?

Thus, to assist us in generating ideas and information for analyzing potential refinements in this area, we are seeking feedback from stakeholders on whether the rehabilitation physician should have the flexibility to determine that some of the IRF visits can be appropriately conducted remotely via another mode of communication, such as video or telephone conferencing, while maintaining a hospital level high quality of care for IRF patients.

E. Solicitation of Comments Regarding Changes to the Use of Non-Physician Practitioners in Meeting the Requirements Under § 412.622(a)(3), (4), and (5)

Several of the requirements under § 412.622(a)(3), (4), and (5) require documentation that a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation, visited each patient admitted to an IRF and performed an assessment of the patient. For example, under § 412.622(a)(3)(iv), for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation at the time of the patient's admission to the IRF that the patient requires physician supervision by a rehabilitation physician. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. For more information, please refer to the Medicare Benefit Policy Manual, chapter 1, section 110.2.4 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

In addition, under § 412.622(a)(4)(ii), to document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in § 412.622(a)(3) at the time of admission, the patient's medical record at the IRF must contain a post-admission physician evaluation that must, among other requirements, be completed by a rehabilitation physician within 24 hours of the patient's admission to the IRF. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, section 110.1.2 (Pub. 100–02), which can be downloaded from the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs.html.*

In the feedback that we received in response to the RFI, it was suggested that we consider amending the requirements in § 412.622(a)(3)(iv) and § 412.622(a)(4)(ii) to enable IRFs to expand their use of non-physician practitioners (physician assistants and nurse practitioners) to fulfill some of the requirements that rehabilitation physicians are currently required to complete. The commenters suggested that expanding the use of non-physician practitioners in meeting some of the IRF requirements would ease the documentation burden on rehabilitation physicians.

In exploring this issue, we have questions about whether non-physician practitioners have the specialized training in inpatient rehabilitation that would enable them to adequately assess the interaction between patients' medical and functional care needs in an IRF. Another concern that has been raised regarding this issue, is whether IRF patients will continue to receive the hospital level and quality of care that is necessary to treat such complex conditions.

To better assist us in balancing the needs of the patient with the desire to reduce the regulatory burden on rehabilitation physicians, we are seeking feedback from stakeholders about potentially allowing IRFs to expand their use of non-physician practitioners to fulfill some of the requirements that rehabilitation physicians are currently required to complete. Specifically, we would appreciate feedback regarding the following:

- Do non-physician practitioners have the specialized training in rehabilitation that they need to have to assess IRF patients both medically and functionally?
- How would the non-physician practitioner's credentials be documented and monitored to ensure that IRF patients are receiving high quality care?
- Are non-physician practitioners required to do rotations in inpatient rehabilitation facilities as part of their training, or could this be added to their training programs in the future?
- Do stakeholders believe that utilizing non-physician practitioners to fulfill some of the requirements that are currently required to be completed by a rehabilitation physician would have an impact of the quality of care for IRF patients?

Thus, to assist us in generating ideas and information for analyzing potential refinements in this area, we are seeking feedback from stakeholders on the ways in which the role of non-physician practitioners could be expanded in the IRF setting while maintaining a hospital

level high quality of care for IRF patients.

IX. Proposed Revisions and Updates to the IRF Quality Reporting Program (QRP)

A. Background

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) is authorized by section 1886(j)(7) of the Act, and it applies to freestanding IRFs, as well as inpatient rehabilitation units of hospitals or critical access hospitals (CAHs) paid by Medicare under the IRF PPS. Under the IRF QRP, the Secretary reduces the annual increase factor for discharges occurring during such fiscal year by 2 percentage points for any IRF that does not submit data in accordance with the requirements established by the Secretary. For more information on the background and statutory authority for the IRF QRP, we refer readers to the FY 2012 IRF PPS final rule (76 FR 47873 through 47874), the CY 2013 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) Payment Systems and Quality Reporting Programs final rule (77 FR 68500 through 68503), the FY 2014 IRF PPS final rule (78 FR 47902), the FY 2015 IRF PPS final rule (79 FR 45908), the FY 2016 IRF PPS final rule (80 FR 47080 through 47083), the FY 2017 IRF PPS final rule (81 FR 52080 through 52081), and the FY 2018 IRF PPS final rule (82 FR 36269 through 36270).

Although we have historically used the preamble to the IRF PPS proposed and final rules each year to remind stakeholders of all previously finalized program requirements, we have concluded that repeating the same discussion each year is not necessary for every requirement, especially if we have codified it in our regulations. Accordingly, the following discussion is limited as much as possible to a discussion of our proposals for future years of the IRF QRP, and represents the approach we intend to use in our rulemakings for this program going forward.

B. General Considerations Used for the Selection of Measures for the IRF QRP

1. Background

For a detailed discussion of the considerations we historically used for the selection of IRF QRP quality, resource use, and others measures, we refer readers to the FY 2016 IRF PPS final rule (80 FR 47083 through 47084).

2. Accounting for Social Risk Factors in the IRF QRP

In the FY 2018 IRF PPS final rule (82 FR 36273 through 36274), we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex patients, as well as those with social risk factors, receive excellent care. We discussed how studies show that social risk factors, such as being near or below the poverty level as determined by HHS, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes and how some of this disparity is related to the quality of health care.[3] Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex patients as well as those with social risk factors receive excellent care. Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in our value-based purchasing programs.[4] As we noted in the FY 2018 IRF PPS final rule (82 FR 36273 through 36274), ASPE's report to Congress, which was required by the IMPACT Act, found that, in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that they examined and tested. ASPE is continuing to examine this issue in its second report required by the IMPACT Act, which is due to Congress in the fall of 2019. In addition, as we noted in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38428), the National Quality Forum (NQF) undertook a 2-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate for these measures.[5] The trial period ended in April 2017 and a final report is available at *http://www.qualityforum.org/SES_Trial_Period.aspx.* The trial concluded that ''measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship'' between social risk factors and the outcomes measured. This discrepancy may be explained in part by the methods used for adjustment and the limited availability of robust data on social risk factors. NQF has extended the socioeconomic status (SES) trial,[6] allowing further examination of social risk factors in outcome measures.

In the FY/CY 2018 proposed rules for our quality reporting and value-based purchasing programs, we solicited feedback on which social risk factors provide the most valuable information to stakeholders and the methodology for illuminating differences in outcomes rates among patient groups within a provider that would also allow for a comparison of those differences, or disparities, across providers. Feedback we received across our quality reporting programs included encouraging CMS to explore whether factors that could be used to stratify or risk adjust the measures (beyond dual eligibility); to consider the full range of differences in patient backgrounds that might affect outcomes; to explore risk adjustment approaches; and to offer careful consideration of what type of information display would be most useful to the public.

We also sought public comment on confidential reporting and future public reporting of some of our measures stratified by patient dual eligibility. In general, commenters noted that stratified measures could serve as tools for hospitals to identify gaps in outcomes for different groups of patients, improve the quality of health care for all patients, and empower consumers to make informed decisions about health care. Commenters encouraged CMS to stratify measures by other social risk factors such as age, income, and educational attainment. With regard to value-based purchasing programs, commenters also cautioned to balance fair and equitable payment while avoiding payment penalties that mask health disparities or discouraging the provision of care to more medically complex patients. Commenters also noted that value-based payment program measure selection, domain weighting, performance scoring, and payment methodology must account for social risk.

[3] See, for example, United States Department of Health and Human Services. ''Healthy People 2020: Disparities. 2014,'' *http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities* or National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: National Academies of Sciences, Engineering, and Medicine 2016.

[4] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), ''Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs.'' December 2016, *https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.*

[5] Available at *http://www.qualityforum.org/SES_Trial_Period.aspx.*

[6] Available at: *http://www.qualityforum.org/SES_Trial_Period.aspx*

As a next step, we are considering options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities, as shown by quality measures. We also are considering how this work applies to other CMS quality programs in the future. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38403 through 38409) for more details where we discuss the potential stratification of certain Hospital Inpatient Quality Reporting Program outcome measures. Furthermore, we continue to consider options to address equity and disparities in our value-based purchasing programs.

We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.

C. Proposed New Removal Factor for Previously Adopted IRF QRP Measures

As part of our Meaningful Measures Initiative, discussed in section D.1. of the Executive Summary of this proposed rule, we strive to put patients first, ensuring that they, along with their clinicians, are empowered to make decisions about their own healthcare using data-driven information that is increasingly aligned with a parsimonious set of meaningful quality measures. We began reviewing the IRF QRP's measures in accordance with the Meaningful Measures Initiative discussed in section D.1 of the Executive Summary, and we are working to identify how to move the IRF QRP forward in the least burdensome manner possible, while continuing to incentivize improvement in the quality of care provided to patients.

Specifically, we believe the goals of the IRF QRP and the measures used in the program cover most of the Meaningful Measures Initiative priorities, including making care safer, strengthening person and family engagement, promoting coordination of care, promoting effective prevention and treatment, and making care affordable.

We also evaluated the appropriateness and completeness of the IRF QRP's current measure removal factors. We have previously finalized that we would use notice and comment rulemaking to remove measures from the IRF QRP based on the following factors (77 FR 68502 through 68503): [7]

- Factor 1. Measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
- Factor 2. Performance or improvement on a measure does not result in better patient outcomes.
- Factor 3. A measure does not align with current clinical guidelines or practice.
- Factor 4. A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.
- Factor 5. A measure that is more proximal in time to desired patient outcomes for the particular topic is available.
- Factor 6. A measure that is more strongly associated with desired patient outcomes for the particular topic is available.
- Factor 7. Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

We continue to believe these measure removal factors are appropriate for use in the IRF QRP. However, even if one or more of the measure removal factors applies, we might nonetheless choose to retain the measure for certain specified reasons. Examples of such instances could include when a particular measure addresses a gap in quality that is so significant that removing the measure could in turn result in poor quality, or in the event that a given measure is statutorily required. We note further that, consistent with other quality reporting programs, we apply these factors on a case-by-case basis.

We are proposing to adopt an additional factor to consider when evaluating measures for removal from the IRF QRP measure set:

Factor 8. The costs associated with a measure outweigh the benefit of its continued use in the program.

As we discussed in section D.1. of the Executive Summary of this proposed rule, to our new Meaningful Measures Initiative, we are engaging in efforts to ensure that the IRF QRP measure set continues to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program. We believe these costs are multifaceted and include not only the burden associated with reporting, but also the costs associated with implementing and maintaining the program. We have identified several different types of costs, including, but not limited to: (1) Provider and clinician information collection burden and burden associated with the submitting/reporting of quality measures to CMS; (2) the provider and clinician cost associated with complying with other programmatic requirements; (3) the provider and clinician cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs; (4) the cost to CMS associated with the program oversight of the measure including measure maintenance and public display; and (5) the provider and clinician cost associated with compliance to other federal and/or state regulations (if applicable).

For example, it may be needlessly costly and/or of limited benefit to retain or maintain a measure which our analyses show no longer meaningfully supports program objectives (for example, informing beneficiary choice). It may also be costly for health care providers to track confidential feedback, preview reports, and publicly reported information on a measure where we use the measure in more than one program. We may also have to expend unnecessary resources to maintain the specifications for the measure, including the tools needed to collect, validate, analyze, and publicly report the measure data. Furthermore, beneficiaries may find it confusing to see public reporting on the same measure in different programs.

When these costs outweigh the evidence supporting the continued use of a measure in the IRF QRP, we believe it may be appropriate to remove the measure from the program. Although we recognize that one of the main goals of the IRF QRP is to improve beneficiary outcomes by incentivizing health care providers to focus on specific care issues and making public data related to those issues, we also recognize that those goals can have limited utility where, for example, the publicly reported data is of limited use because it cannot be easily interpreted by beneficiaries and used to influence their choice of providers. In these cases, removing the measure from the IRF QRP may better accommodate the costs of program administration and compliance without sacrificing improved health outcomes and beneficiary choice.

We are proposing that we would remove measures based on this factor on a case-by-case basis. We might, for example, decide to retain a measure that is burdensome for health care providers to report if we conclude that the benefit to beneficiaries is so high that it justifies

[7] We refer readers to the FY 2013 CY 2013 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) Payment Systems and Quality Reporting Programs final rule (77 FR 68502 through 68503) and FY 2018 IRF PPS final rule (82 FR 36276) for more information on the factors we consider for removing measures and standardized patient assessment data.

the reporting burden. Our goal is to move the program forward in the least burdensome manner possible, while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients.

We are inviting public comment on our proposal to adopt an additional measure removal Factor 8, ''the costs associated with a measure outweigh the benefit of its continued use in the program.''

We also are proposing to revise § 412.634(b)(2) of our regulations to codify both the removal factors we have previously finalized for the IRF QRP, as well as the new measure removal factor that we are proposing to adopt in this proposed rule. We are also proposing to remove the reference to the payment impact from the heading of § 412.634(b) and, as discussed more fully in section X.J. of this proposed rule, remove the language in current § 412.634(b)(2) related to the two percentage point payment reduction because that payment reduction is also addressed at § 412.624(c)(4).

We invite public comment on these proposals.

D. Quality Measures Currently Adopted for the FY 2020 IRF QRP

The IRF QRP currently has 18 measures for the FY 2020 program year, which are outlined in Table 11.

TABLE 11—QUALITY MEASURES CURRENTLY ADOPTED FOR THE FY 2020 IRF QRP

Short name	Measure name and data source
IRF–PAI	
Pressure Ulcer	Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678).*
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Patient Influenza Vaccine	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680).
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Application of Functional Assessment	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues-Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).
Change in Self-Care	IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
Change in Mobility	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
NHSN	
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure (NQF #0138).
MRSA	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716).
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717).
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431).
Claims-Based	
MSPB IRF	Medicare Spending Per Beneficiary (MSPB)-Post Acute Care (PAC) PAC IRF QRP.
DTC	Discharge to Community—PAC IRF QRP.
PPR 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP.*
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs.

* The measure will be replaced with the Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury measure, effective October 1, 2018.

E. Proposed Removal of Two IRF QRP Measures

We are proposing to remove two measures from the IRF QRP measure set. Beginning with the FY 2020 IRF QRP, we are proposing to remove the National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure (NQF #1716). We are also proposing to remove one measure beginning with the FY 2021 IRF QRP: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680). We discuss these proposals below.

1. Proposed Removal of National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) Beginning With the FY 2020 IRF QRP

We are proposing to remove the measure, Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716), from the IRF QRP measure set

beginning with the FY 2020 IRF QRP under our proposed measure removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the IRF QRP.

We originally adopted this measure in the FY 2015 IRF PPS final rule (79 FR 45911 through 45913). The measure assesses MRSA infections caused by a strain of MRSA bacteria that has become resistant to antibiotics commonly used to treat MRSA infections. The measure is reported as a Standardized Infection Ratio (SIR) of hospital-onset unique blood source MRSA laboratory-identified events among all inpatients in the facility.

The data on this measure is submitted by IRFs via the National Health Safety Network (NHSN), and we adopted it for use in several quality reporting programs because we believe that MRSA is a serious healthcare associated infection. To calculate a measure rate for an individual IRF, we must be able to attribute to the IRF at least one expected MRSA infection during the reporting period. However, we have found that the number of IRFs with expected MRSA infections during a given reporting period is extraordinarily low. For 99.9 percent of IRFs, the expected MRSA infection incident rate is less than one, which is too low to use for purposes of generating a reliable standardized infection ratio. As a result, we are unable to calculate reliable measure rates and publicly report those rates for almost all IRFs because their expected infection rates during a given reporting period are less than one. Therefore, while we still recognize that MRSA is a serious healthcare associated infection, the benefit of this NHSN Facility-wide Inpatient Hospital-onset MRSA Bacteremia Outcome Measure (NQF #1716) is small. For this reason, we believe that the burden required for data collection and submission on this measure and the costs associated with this measure, which include the costs to maintain and publicly report it for the IRF QRP and the costs for a small number of IRFs to track their rates when reliable rates cannot be calculated for most IRFs, outweigh the benefit of its continued use in the program.

Therefore, we are proposing to remove this measure from the IRF QRP, beginning with the FY 2020 IRF QRP.

If finalized as proposed, IRFs would no longer be required to submit data on this measure for the purposes of the IRF QRP beginning with October 1, 2018 admissions and discharges.

We are inviting public comment on this proposal.

2. Proposed Removal of Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) Beginning With the FY 2021 IRF QRP

We are proposing to remove the measure, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680), from the IRF QRP beginning with the FY 2021 IRF QRP under measure removal Factor 1, measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

In the FY 2014 IRF PPS final rule (78 FR 47910 through 47911), we adopted the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) to assess vaccination rates among IRF patients because many patients receiving care in the IRF setting are 65 years and older and considered to be the target population for the influenza vaccination.

This process measure reports the percentage of stays in which the patient was assessed and appropriately given the influenza vaccine for the most recent influenza vaccination season. In our evaluation of this measure, we identified that IRF performance has been high and relatively stable, demonstrating nominal improvements across influenza seasons since data collection began. Our analysis of this particular measure revealed that for the 2015–2016 and the 2016–2017 influenza seasons, nearly every IRF patient was assessed and more than 75 percent of IRFs (n = 836) are vaccinating IRF patients who have not already received a flu vaccination at 90 percent or higher. Further, throughout the last two influenza seasons, the number of IRFs who achieved a perfect score (100 percent) on this measure has grown substantially, increasing by approximately 50 percent from 146 IRFs (12.9 percent) in the 2015–2016 influenza season to 210 IRFs (18.8 percent) in the 2016–2017 influenza season.

The Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) measure rates are also unvarying. With respect to the 2015–2016 influenza season, the mean performance score was 91.04 percent, and with respect to the 2016–2017 influenza season, the mean performance score on this measure was 93.88 percent. The proximity of these mean rates to the maximum score of 100 percent suggests a potential ceiling effect and a lack of variation that restricts distinction between facilities. Given that performance among IRFs has remained so high and that no meaningful distinction in performance can be made across the majority of IRFs, we are proposing the removal of this measure.

Therefore, we are proposing to remove this measure from the IRF QRP beginning with the FY 2021 IRF QRP under of measure removal Factor 1, measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

If finalized as proposed, IRFs would no longer be required to submit data on this measure for the purposes of the IRF QRP beginning with patients discharged on or after October 1, 2018. We plan to remove these data elements from the IRF–PAI version 3.0, effective October 1, 2019. Beginning with October 1, 2018 discharges, IRFs should enter a dash (–) for O0250A, O0250B, and O0250C until the IRF–PAI version 3.0 is released.

We are inviting public comment on this proposal.

F. IMPACT Act Implementation Update

In the FY 2018 IRF PPS final rule (82 FR 36285 through 36286), we stated that we intended to specify two measures that would satisfy the domain of accurately communicating the existence and provision of the transfer of health information and care preferences under section 1899B(c)(1)(E) of the Act no later than October 1, 2018, and intended to propose to adopt them for the FY 2021 IRF QRP with data collection beginning on or about October 1, 2019.

As a result of the input provided during a public comment period between November 10, 2016 and December 11, 2016, input provided by a technical expert panel (TEP) convened by our contractor, and pilot measure testing conducted in 2017, we are engaging in continued development work on these two measures, including supplementary measure testing and providing the public with an opportunity for comment in 2018. Further, we expect to reconvene a TEP for these measures in mid-2018. We now intend to specify the measures under section 1899B(c)(1)(E) of the Act no later than October 1, 2019, and intend to propose to adopt the measures for the FY 2022 IRF QRP, with data collection beginning with patients discharged on or after October 1, 2020. For more information on the pilot testing, we refer readers to: *https://*

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.

G. Form, Manner, and Timing of Data Submission Under the IRF QRP

Under our current policy, IRFs report data on IRF QRP assessment-based measures and standardized patient assessment data by completing applicable sections of the IRF–PAI and submitting the IRF–PAI to CMS through the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. For more information on IRF QRP reporting through the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) system, refer to the ''Related Links'' section at the bottom of *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html.* Data on IRF QRP measures that are also collected by the Centers for Disease Control and Prevention (CDC) for other purposes are reported by IRFs to the CDC through the NHSN, and the CDC then transmits the relevant data to CMS. Information regarding the CDC's NHSN is available at: *https://www.cdc.gov/nhsn/index.html.* We refer readers to the FY 2018 IRF PPS final rule (82 FR 36291 through 36292) for the data collection and submission timeframes that we finalized for the IRF QRP.

We previously codified at § 412.634(b)(1) of our regulations the requirement that IRFs submit data on measures specified under sections 1886(j)(7)(D), 1899B(c)(1), and 1899B(d)(1) of the Act in the form and manner, and at a time, specified by CMS. We are proposing in this proposed rule to revise § 412.634(b)(1) to include the policy we previously finalized in the FY 2018 IRF PPS Final Rule (82 FR 36292 through 36293) that IRFs must also submit standardized patient assessment data required under section 1899B(b)(1) of the Act in the form and manner, and at a time, specified by CMS.

We are inviting public comment on this proposal.

H. Proposed Changes to Reconsiderations Requirements Under the IRF QRP

Section 412.634(d)(1) of our regulations states, in part, that IRFs found to be non-compliant with the quality reporting requirements for a particular fiscal year will receive a letter of non-compliance through the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES–ASAP) system, as well as through the United States Postal Service.

We are proposing to revise § 412.634(d)(1) to expand the methods by which we would notify an IRF of non-compliance with the IRF QRP requirements for a program year. Revised § 412.634(d)(1) would state that we would notify IRFs of non-compliance with the IRF QRP requirements via a letter sent through at least one of the following notification methods: The QIES–ASAP system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC). We believe that this change will address the feedback from providers requesting additional methods for notification.

We are also proposing to revise § 412.634(d)(5) to clarify that we will notify IRFs, in writing, of our final decision regarding any reconsideration request using the same notification process.

We are inviting public comments on these proposals.

I. Proposed Policies Regarding Public Display of Measure Data for the IRF QRP

Section 1886(j)(7)(E) of the Act requires the Secretary to establish procedures for making the IRF QRP data available to the public after ensuring that an IRF has the opportunity to review its data prior to public display. Measure data are currently displayed on the *IRF Compare* website, an interactive web tool that assists individuals by providing information on IRF quality of care to those who need to select an IRF. For more information on *IRF Compare,* we refer readers to: *https://www.medicare.gov/inpatient rehabilitationfacilitycompare/.*

We propose to begin publicly displaying data on the following four assessment-based measures in CY 2020, or as soon thereafter as technically feasible: (1) Change in Self-Care (NQF #2633); (2) Change in Mobility Score (NQF #2634); (3) Discharge Self-Care Score (NQF #2635); (4) and Discharge Mobility Score (NQF #2636). Data collection for these four assessment-based measures began with patients discharged on or after October 1, 2016. We are proposing to display data for these assessment-based measures based on four rolling quarters of data, initially using discharges from January 1, 2019 through December 31, 2019 (Quarter 1 2019 through Quarter 4 2019). To ensure the statistical reliability of the data for these four assessment-based measures, we are also proposing that if an IRF has fewer than 20 cases during any four consecutive rolling quarters of data that we are displaying for any of these measures, then we would note in our public display of that measure that with respect to that IRF the number of cases/patient stays is too small to publicly report.

We invite public comment on these proposals

J. Method for Applying the Reduction to the FY 2019 IRF Increase Factor for IRFs That Fail To Meet the Quality Reporting Requirements

As previously noted, section 1886(j)(7)(A)(i) of the Act requires the application of a 2-percentage point reduction of the applicable market basket increase factor for payments for discharges occurring during such fiscal year for IRFs that fail to comply with the quality data submission requirements. We propose to apply a 2-percentage point reduction to the applicable FY 2019 market basket increase factor in calculating a proposed adjusted FY 2019 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements. As previously noted, application of the 2-percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

We invite public comment on the proposed method for applying the reduction to the FY 2019 IRF increase factor for IRFs that fail to meet the quality reporting requirements.

Table 12 shows the calculation of the proposed adjusted FY 2019 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the applicable reporting period.

TABLE 12—CALCULATIONS TO DETERMINE THE PROPOSED ADJUSTED FY 2019 STANDARD PAYMENT CONVERSION FACTOR FOR IRFS THAT FAILED TO MEET THE QUALITY REPORTING REQUIREMENT

Explanation for adjustment	Calculations	
Standard Payment Conversion Factor for FY 2018		$ 15,838
Market Basket Increase Factor for FY 2019 (2.9 percent), reduced by 0.8 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, reduced by 0.75 percentage point in accordance with sections 1886(j)(3)(C) and (D) of the Act and further reduced by 2 percentage points for IRFs that failed to meet the quality reporting requirement	×	0.9935
Budget Neutrality Factor for the Wage Index and Labor-Related Share	×	1.0000
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	×	0.9980
Adjusted FY 2019 Standard Payment Conversion Factor	=	$ 15,704

Our regulations currently address the two percentage point payment reduction for failure to meet requirements under the IRF QRP in two places: § 412.624(c)(4) and § 412.634(b)(2). We believe that these provisions are duplicative and are proposing to revise the regulations so that the payment reduction is addressed only in § 412.624(c)(4). As noted in this proposed rule, we are proposing to remove the language regarding the payment reduction that is currently at § 412.634(b)(2) and to codify that section instead the retention and removal policies for the IRF QRP.

We are also proposing to revise § 412.624(c)(4)(i) to clarify that an IRF's failure to submit data under the IRF QRP in accordance with § 412.634 will result in the 2 percentage point reduction to the applicable increase factor specified in § 412.624(a)(3).

Finally, we are proposing to revise § 412.624(c)(4) for greater consistency with the language of section 1886(j)(7)(A)(i) of the Act. Specifically, we would revise paragraph (i) to clarify that the 2 percentage point reduction is applied ''after application of subparagraphs (C)(iii) and (D) of section 1886(j)(3) of the Act.'' In addition, we would add a new paragraph (iii) that clarifies that the 2 percentage point reduction required under section 1886(j)(7)(A)(i) of the Act may result in an update that is less than 0.0 for a fiscal year.

We invite public comment on these proposals.

X. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

Currently, Medicare- and Medicaid-participating providers and suppliers are at varying stages of adoption of health information technology (health IT). Many hospitals have adopted electronic health records (EHRs), and CMS has provided incentive payments to eligible hospitals, critical access hospitals (CAHs), and eligible professionals who have demonstrated meaningful use of certified EHR technology (CEHRT) under the Medicare EHR Incentive Program. As of 2015, 96 percent of Medicare- and Medicaid-participating non-Federal acute care hospitals had adopted certified EHRs with the capability to electronically export a summary of clinical care.[8] While both adoption of EHRs and electronic exchange of information have grown substantially among hospitals, significant obstacles to exchanging electronic health information across the continuum of care persist. Routine electronic transfer of information post-discharge has not been achieved by providers and suppliers in many localities and regions throughout the nation.

CMS is firmly committed to the use of certified health IT and interoperable EHR systems for electronic healthcare information exchange to effectively help hospitals and other Medicare- and Medicaid-participating providers and suppliers improve internal care delivery practices, support the exchange of important information across care team members during transitions of care, and enable reporting of electronically specified clinical quality measures (eCQMs). The Office of the National Coordinator for Health Information Technology (ONC) acts as the principal federal entity charged with coordination of nationwide efforts to implement and use health information technology and the electronic exchange of health information on behalf of the Department of Health and Human Services.

In 2015, ONC finalized the 2015 Edition health IT certification criteria (2015 Edition), the most recent criteria for health IT to be certified to under the ONC Health IT Certification Program. The 2015 Edition facilitates greater interoperability for several clinical health information purposes and enables health information exchange through new and enhanced certification criteria, standards, and implementation specifications. CMS requires eligible hospitals and CAHs in the Medicare and Medicaid EHR Incentive Programs and eligible clinicians in the Quality Payment Program (QPP) to use EHR technology certified to the 2015 Edition beginning in CY 2019.

In addition, several important initiatives will be implemented over the next several years to provide hospitals and other participating providers and suppliers with access to robust infrastructure that will enable routine electronic exchange of health information. Section 4003 of the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, and amending section 3000 of the Public Health Service Act (42 U.S.C. 300jj), requires HHS to take steps to advance the electronic exchange of health information and interoperability for participating providers and suppliers in various settings across the care continuum. Specifically, Congress directed that ONC ''. . . for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally.'' In January 2018, ONC released a draft version of its proposal for the Trusted Exchange Framework and Common Agreement,[9] which outlines principles and minimum terms and conditions for trusted exchange to enable interoperability across disparate health information networks (HINs). The Trusted Exchange Framework (TEF) is focused on achieving the following

[8] These statistics can be accessed at: *https://dashboard.healthit.gov/quickstats/pages/FIG-Hospital-EHR-Adoption.php.*

[9] The draft version of the trusted Exchange Framework may be accessed at *https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement.*

four important outcomes in the long-term:

- Professional care providers, who deliver care across the continuum, can access health information about their patients, regardless of where the patient received care.
- Patients can find all of their health information from across the care continuum, even if they do not remember the name of the professional care provider they saw.
- Professional care providers and health systems, as well as public and private health care organizations and public and private payer organizations accountable for managing benefits and the health of populations, can receive necessary and appropriate information on groups of individuals without having to access one record at a time, allowing them to analyze population health trends, outcomes, and costs; identify at-risk populations; and track progress on quality improvement initiatives.
- The health IT community has open and accessible application programming interfaces (APIs) to encourage entrepreneurial, user-focused innovation that will make health information more accessible and improve EHR usability.

ONC will revise the draft TEF based on public comment and ultimately release a final version of the TEF that will subsequently be available for adoption by HINs and their participants seeking to participate in nationwide health information exchange. The goal for stakeholders that participate in, or serve as, a HIN is to ensure that participants will have the ability to seamlessly share and receive a core set of data from other network participants in accordance with a set of permitted purposes and applicable privacy and security requirements. Broad adoption of this framework and its associated exchange standards is intended to both achieve the outcomes described above while creating an environment more conducive to innovation.

In light of the widespread adoption of EHRs along with the increasing availability of health information exchange infrastructure predominantly among hospitals, we are interested in hearing from stakeholders on how we could use the CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs (that is, the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation (RfPs) for Long Term Care Facilities) to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers. Specifically, CMS might consider revisions to the current CMS CoPs for hospitals such as: Requiring that hospitals transferring medically necessary information to another facility upon a patient transfer or discharge do so electronically; requiring that hospitals electronically send required discharge information to a community provider via electronic means if possible and if a community provider can be identified; and requiring that hospitals make certain information available to patients or a specified third-party application (for example, required discharge instructions) via electronic means if requested.

On November 3, 2015, we published a proposed rule (80 FR 68126) to implement the provisions of the IMPACT Act and to revise the discharge planning CoP requirements that hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Hospitals (IRFs), Inpatient Psychiatric Hospitals (IPFs), Children's Hospitals, and Cancer Hospitals), critical access hospitals (CAHs), and home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. However, several of the proposed requirements directly address the issue of communication between providers and between providers and patients, as well as the issue of interoperability:

- Hospitals and CAHs would be required to transfer certain necessary medical information and a copy of the discharge instructions and discharge summary to the patient's practitioner, if the practitioner is known and has been clearly identified;
- Hospitals and CAHs would be required to send certain necessary medical information to the receiving facility/post-acute care providers, at the time of discharge; and
- Hospitals, CAHs and HHAs, would need to comply with the IMPACT Act requirements that would require hospitals, CAHs, and certain post-acute care providers to use data on quality measures and data on resource use measures to assist patients during the discharge planning process, while taking into account the patient's goals of care and treatment preferences.

We published another proposed rule (81 FR 39448), on June 16, 2016, that updated a number of CoP requirements that hospitals and CAH must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. One of the proposed hospital CoP revisions in that rule directly addresses the issues of communication between providers and patients, patient access to their medical records, and interoperability. We proposed that patients have the right to access their medical records, upon an oral or written request, in the form and format requested by such patients, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, including current medical records, within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

We also published a final rule (81 FR 68688), on October 4, 2016, that revised the requirements that LTC facilities must meet to participate in the Medicare and Medicaid programs, where we made a number of revisions based on the importance of effective communication between providers during transitions of care, such as transfers and discharges of residents to other facilities or providers, or to home. Among these revisions was a requirement that the transferring LTC facility must provide all necessary information to the resident's receiving provider, whether it is an acute care hospital, a LTC hospital, a psychiatric facility, another LTC facility, a hospice, home health agency, or another community-based provider or practitioner. We specified that necessary information must include the following:

- Contact information of the practitioner responsible for the care of the resident;
- Resident representative information including contact information;
- Advance directive information;
- Special instructions or precautions for ongoing care;
- The resident's comprehensive care plan goals; and
- All other necessary information, including a copy of the resident's discharge or transfer summary and any other documentation to ensure a safe and effective transition of care.

We note that the discharge summary mentioned above must include reconciliation of the resident's medications, as well as a recapitulation of the resident's stay, a final summary of the resident's status, and the post-discharge plan of care. And in the preamble to the rule, we encouraged LTC facilities to electronically exchange

this information if possible and to identify opportunities to streamline the collection and exchange of resident information by using information that the facility is already capturing electronically.

Additionally, we specifically invite stakeholder feedback on the following questions regarding possible new or revised CoPs/CfCs/RfPs for interoperability and electronic exchange of health information:

- If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?
- Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?
- Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?
- What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?
- Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?
- Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?
- Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?
- What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

We would also like to directly address the issue of communication between hospitals (as well as the other providers and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records. Privacy and security of patient data will be at the center of all CMS efforts in this area. CMS must protect the confidentiality of patient data, and CMS is completely aligned with the Department of Veterans Affairs (VA), the National Institutes of Health (NIH), ONC, and the rest of the federal government, on this objective.

While some Medicare beneficiaries have had, for quite some time, the ability to download their Medicare claims information, in pdf or Excel formats, through the CMS Blue Button platform, the information was provided without any context or other information that would help beneficiaries understand what the data was really telling them. For beneficiaries, their claims information is useless if it is either too hard to obtain or, as was the case with the information provided through previous versions of Blue Button, hard to understand. In an effort to fully contribute to the federal government's MyHealthEData initiative, CMS developed and launched the new Blue Button 2.0, which represents a major step toward giving patients meaningful control of their health information in an easy-to-access and understandable way. Blue Button 2.0 is a developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to secure applications, services, and research programs they trust. The possibilities for better care through Blue Button 2.0 data are exciting, and might include enabling the creation of health dashboards for Medicare beneficiaries to view their health information in a single portal, or allowing beneficiaries to share complete medication lists with their doctors to prevent dangerous drug interactions.

To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records. We also welcome the public's ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers. We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.

We note that this is a Request for Information only. Respondents are encouraged to provide complete but concise and organized responses, including any relevant data and specific examples. However, respondents are not required to address every issue or respond to every question discussed in this Request for Information to have their responses considered. In accordance with the implementing

regulations of the Paperwork Reduction Act at 5 CFR 1320.3(h)(4), all responses will be considered provided they contain information CMS can use to identify and contact the commenter, if needed.

This Request for Information is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This Request for Information does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this Request for Information and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this Request for Information; all costs associated with responding to this Request for Information will be solely at the interested party's expense.

We note that not responding to this Request for Information does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this Request for Information announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this Request for Information. CMS will not respond to comment submissions in response to this Request for Information in the FY 2019 IPPS/LTCH PPS final rule. Rather, CMS will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. CMS may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this Request for Information. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this Request for Information may be used by the Government for program planning on a nonattribution basis. Respondents should not include any information that might be considered proprietary or confidential.

This Request for Information should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. CMS may publically post the public comments received, or a summary of those public comments.

XI. Collection of Information Requirements

A. Statutory Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995 (PRA), 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 OMB for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA 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.

This proposed rule makes reference to associated information collections that are not discussed in the regulation text contained in this document.

B. Collection of Information Requirements for Updates Related to the IRF PPS

As discussed in section VIII.A of this proposed rule, we are proposing to modify § 412.622(a)(3)(iv) to provide that the post-admission physician evaluation required under § 412.622(a)(4)(ii) may count as one of the face-to-face physician visits required under § 412.622(a)(3)(iv) beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018. As discussed in section VIII.B of this proposed rule, we are proposing to modify § 412.622(a)(5) to allow rehabilitation physicians to attend interdisciplinary team meetings remotely beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018. As discussed in section VIII.C of this proposed rule, we are proposing to modify § 412.606 to remove subsection (a) and eliminate the admission order requirement beginning with FY 2019, that is, for all IRF discharges beginning on or after October 1, 2018.

We estimate the cost savings associated with our proposal to allow the post-admission physician evaluation to count as one of the required face-to-face physician visits, as discussed in section VIII.A of this proposed rule, in the following way. We first estimate that the post-admission physician evaluation takes approximately 60 minutes to complete and the required face-to-face physician visits take, on average, 30 minutes each to complete. Both of these requirements must be fulfilled by a rehabilitation physician. To estimate the burden reduction of this proposal, therefore, we obtained the hourly wage rate for a physician (there was not a specific wage rate for a rehabilitation physician) from the Bureau of Labor Statistics (*http://www.bls.gov/ooh/healthcare/home.htm*) to be $98.83. The hourly wage rate including fringe benefits and overhead is $197.66.

In FY 2017, we estimate that there were approximately 1,124 total IRFs and on average 357 discharges per IRF annually. Therefore, there were an estimated seven patients (357 discharges/52 weeks) at the IRF per week. The rehabilitation physician spends 357 hours (60 minutes × 357 discharges) annually completing the post-admission physician evaluation. If on average each IRF has seven patients per week and each face-to-face visit takes an estimated 30 minutes for the rehabilitation physician to complete, annually the rehabilitation physician spends an estimated 546 hours ((7 patients × 3 visits × 0.5 hours) × 52 weeks) completing the required face-to-face physician visits. On average, a rehabilitation physician currently spends 903 hours (357 hours + 546 hours) annually completing post-admission physician evaluations and the required face-to-face physician visits.

If we allow the post-admission physician evaluation to count as one of the face-to-face required physician visits, we would need to estimate the average time spent on one face-to-face visit ((7 patients × 1 visit × 0.5 hours) × 52 weeks). Removing one of the face-to-face visits required in the first week of the IRF admission will save the rehabilitation physician approximately 182 hours ((7 patients × 1 visit × 0.5 hours) × 52 weeks) annually per IRF. This is a savings of 204,568 hours across all IRFs annually (1,124 IRFs × 182 hours).

To estimate the total cost savings per IRF annually, we multiply 182 hours by $197.66 (average physician's salary doubled to account for fringe and overhead costs). Therefore, we can estimate the total cost savings per IRF will be $36,000 annually. We estimate that the total cost savings for allowing the post-admission physician evaluation to count as one of the required face-to-face physician visits, will be $40.5

million (1,124 IRFs × $36,000) annually across the IRF setting. We would like to note that all of the cost savings reflected in this estimate will occur on the Medicare Part B side, in the form of reduced Part B payments to physicians under the physician fee schedule. Physician services provided in an IRF are billed directly to Part B therefore, IRFs do not pay physicians for their services.

We do not estimate a cost savings in removing the admission order coverage criteria requirements as IRFs are still required to comply with the enforcement of the admission requirements located in §§ 482.24(c), 482.12(c) and 412.3. Any increase in Medicare payments due to the proposed change would be negligible given the anticipated low volume of claims that would be payable under this proposed policy that would not have been paid under the current policy. Therefore, we believe that the reduction of burden in this proposed removal is in reducing the redundancy of requirements only.

As discussed in section VII.A of this proposed rule, we are proposing to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning with FY 2020, that is, for all IRF discharges beginning on or after October 1, 2019. The proposed removal of the FIM™ instrument and associated Function Modifiers from the IRF PAI would result in the removal of 11 data items. As a result, we estimate the burden and costs associated with the collection of this data will be reduced for IRFs. Specifically, we estimate the proposed removal of the FIM™ instrument and the associated Function Modifiers will save 25 minutes of nursing/clinical staff time used to report data on both admission and discharge which was the estimated time needed to complete these items when the FIM™ instrument was added to the IRF–PAI in the FY 2002 IRF PPS Final Rule (66 FR 41375). We believe that the FIM™ items we are proposing to remove may be completed by social service assistants, Licensed Practical Nurses (LPN), recreational therapists, social workers, dietitians and nutritionists, Registered Nurses (RN), Occupational Therapists (OT), Speech Language Pathologists (SLP) and audiologists, and or Physical Therapists (PT), depending on the item. To estimate the burden associated with the collection of these data items, we obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates (*https://www.bls.gov/oes/2016/may/oes_nat.htm*) and doubled them to account for overhead and fringe benefits. We estimate IRF–PAI preparation and coding costs using a social worker hourly wage rate of $48.76, a social work assistant's hourly wage rate of $32.82, an RN hourly wage rate of $69.40, an LPN hourly wage rate of $43.12, a recreation therapist hourly wage rate of $46.34, a dietitian/nutritionist hourly wage rate of $57.38, a speech-language pathologist hourly wage rate of $75.20, an audiologist hourly wage rate of $76.24, an occupational therapist hourly wage rate of $80.50, and a physical therapist hourly wage rate of $83.86. Using the mean hourly wages (doubled to account for overhead and fringe benefits) for the staffing categories above, we calculate an average rate of $61.36. The $61.36 rate is a blend of all of these categories, and reflects the fact that IRF providers have historically used all of these clinicians for preparation and coding for the IRF–PAI.

To estimate the burden reduction associated with this proposal, we estimate that there are approximately 401,760 discharges from 1,124 IRFs in FY 2017 resulting in an approximate average of 357 discharges per IRF annually. This equates to a reduction of 167,400 hours for all IRFs ((401,760 discharges × 25 minutes)/60 minutes). This is 149 hours (167,400 hours/1,124 IRFs) per IRF annually. We estimate the total cost savings per IRF will be approximately $9,100 (149 hours × $61.36) annually. We estimate that the total cost savings for all IRF providers will be approximately $10.2 million (1,124 IRFs × $9,100) annually.

C. Collection of Information Requirements for Updates Related to the IRF QRP

An IRF that does not meet the requirements of the IRF QRP for a fiscal year will receive a 2 percentage point reduction to its otherwise applicable annual increase factor for that fiscal year. Information is not currently available to determine the precise number of IRFs that will receive less than the full annual increase factor for FY 2019 due to non-compliance with the requirements of the IRF QRP.

We believe that the burden associated with the IRF QRP is the time and effort associated with complying with the requirements of the IRF QRP. As of February 1, 2018, there are approximately 1,124 IRFs reporting quality data to CMS. For the purposes of calculating the costs associated with the collection of information requirements, we obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). To account for overhead and fringe benefits, we have doubled the hourly wage. These amounts are detailed in Table 13.

TABLE 13—U.S. BUREAU OF LABOR STATISTICS' MAY 2016 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Overhead and fringe benefit ($/hr)	Adjusted hourly wage ($/hr)
Registered Nurse (RN)	29–1141	$34.70	$34.70	$69.40
Medical Records and Health Information Technician	29–2071	19.93	19.93	39.86

As discussed in section IX.4. of this proposed rule, we are proposing to remove two measures from the IRF QRP.

In section IX.4.2 of this proposed rule, we are proposing to remove the measure, Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680), beginning with the FY 2021 IRF QRP. IRFs will no longer be required to submit data on this measure beginning with patients discharged on October 1, 2018, and the items will be removed from the IRF–PAI V3.0, effective October 1, 2019. As a result, the estimated burden and cost for IRFs for complying with requirements of the FY 2021 IRF QRP will be reduced. Specifically, we believe that there will be a 4.8 minute reduction in clinical staff time to report data per patient stay. We estimate 401,760 discharges from 1,124 IRFs annually. This equates to a decrease of 32,141 hours in burden for all IRFs (0.08 hours per assessment × 401,760 discharges). Given 4.8 minutes

of RN time at $69.40 per hour completing an average of 357 sets of IRF–PAI assessments per provider per year, we estimate that the total cost will be reduced by $1,982 per IRF annually, or $2,227,768 for all IRFs annually. This decrease in burden will be accounted for in the information collection under OMB control number (0938–0842).

In addition, we are proposing to remove one CDC NHSN measure, beginning with the FY 2020 IRF QRP, which will result in a decrease in burden and cost for IRFs. Providers will no longer be required to submit data beginning with October 1, 2018 admissions and discharges. We estimate that the removal of the National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) measure will result in a 3-hour (15 minutes per MRSA submission × 12 estimated submissions IRF per year) reduction in clinical staff time annually to report data which equates to a decrease of 3,372 hours (3 hours burden per IRF per year × 1,124 total IRFs) in burden for all IRFs. Given 10 minutes of RN time at $69.40 per hour, and 5 minutes of Medical Records or Health Information Technician at $39.86 per hour, for the submission of MRSA data to the NHSN per IRF per year, we estimate that the total cost of complying with requirements of the IRF QRP will be reduced by $178.66 per IRF annually, or $200,813.84 for all IRFs annually.

In summary, the proposed IRF QRP measure removals will result in a burden reduction of $2160.66 per IRF annually, and $2,428,581.84 for all IRFs annually.

XII. Response to Public 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 proposed rule, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XIV. Regulatory Impact Analysis

A. Statement of Need

This proposed rule updates the IRF prospective payment rates for FY 2019 as required under section 1886(j)(3)(C) of the Act. It responds to section 1886(j)(5) of the Act, which requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the IRF PPS's case-mix groups, and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

This proposed rule also implements sections 1886(j)(3)(C) and (D) of the Act. Section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a multi-factor productivity adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010 through 2019.

Furthermore, this proposed rule also adopts policy changes under the statutory discretion afforded to the Secretary under section 1886(j)(7) of the Act. Specifically, we propose to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI, revise certain IRF coverage requirements, and remove two measures and codify policies that have been finalized under the IRF QRP.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2) and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate the total impact of the policy updates described in this proposed rule by comparing the estimated payments in FY 2019 with those in FY 2018. This analysis results in an estimated $75 million increase for FY 2019 IRF PPS payments. Additionally we estimate that costs associated with the proposals to revise certain IRF coverage requirements and update the reporting requirements under the IRF quality reporting program result in an estimated $42.9 million reduction in costs in FY 2019 for IRFs. We estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Also, the rule has been reviewed by OMB. Accordingly, we have prepared a Regulatory Impact Analysis that, to the best of our ability, presents the costs and benefits of the rulemaking.

C. Anticipated Effects

1. Effects on IRFs

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 IRFs and most other providers and suppliers are small entities, either by having revenues of $7.5 million to $38.5 million or less in any 1 year depending on industry classification, or by being nonprofit organizations that are not dominant in their markets. (For details, see the Small Business Administration's final rule that set forth size standards for health care industries, at 65 FR 69432 at *http://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf,* effective March 26, 2012 and updated on February 26, 2016.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs or the proportion of IRFs' revenue that is derived from

Medicare payments. Therefore, we assume that all IRFs (an approximate total of 1,120 IRFs, of which approximately 55 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. The HHS generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 14, we estimate that the net revenue impact of this proposed rule on all IRFs is to increase estimated payments by approximately 0.9 percent. The rates and policies set forth in this proposed rule will not have a significant impact (not greater than 3 percent) on a substantial number of small entities. Medicare Administrative Contractors are not considered to be small entities. Individuals and states are not included in the definition of a small entity. 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 603 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. As discussed in detail below in this section, the rates and policies set forth in this proposed rule will not have a significant impact (not greater than 3 percent) on a substantial number of rural hospitals based on the data of the 137 rural units and 11 rural hospitals in our database of 1,124 IRFs for which data were available.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–04, enacted on March 22, 1995) (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately $150 million. This proposed rule does not mandate any requirements for State, local, or tribal governments, or for the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. As stated, this proposed rule will not have a substantial effect on state and local governments, preempt state law, or otherwise have a federalism implication.

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017 and requires that the costs associated with significant new regulations ''shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' This proposed rule, if finalized, is considered an E.O. 13771 deregulatory action. We estimate that this rule would generate $46.49 million in annualized cost savings, discounted at 7 percent relative to year 2016, over a perpetual time horizon. Details on the estimated costs savings of this rule can be found in the preceding analyses.

2. Detailed Economic Analysis

This proposed rule proposes updates to the IRF PPS rates contained in the FY 2018 IRF PPS final rule (82 FR 36238). Specifically, this proposed rule would update the CMG relative weights and average length of stay values, the wage index, and the outlier threshold for high-cost cases. This proposed rule would apply a MFP adjustment to the FY 2019 IRF market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.75 percentage point reduction to the FY 2019 IRF market basket increase factor in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(v) of the Act. Further, this proposed rule contains proposed revisions to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI beginning in FY 2020, revise certain IRF coverage requirements, and to revise and update the IRF quality reporting requirements that are expected to result in some additional financial effects on IRFs. In addition, section IX.J. of this proposed rule discusses the implementation of the required 2 percentage point reduction of the market basket increase factor for any IRF that fails to meet the IRF quality reporting requirements, in accordance with section 1886(j)(7) of the Act.

We estimate that the impact of the changes and updates described in this proposed rule will be a net estimated increase of $75 million in payments to IRF providers. This estimate does not include the implementation of the required 2 percentage point reduction of the market basket increase factor for any IRF that fails to meet the IRF quality reporting requirements (as discussed in section IX.J. of this proposed rule). The impact analysis in Table 14 of this proposed rule represents the projected effects of the updates to IRF PPS payments for FY 2019 compared with the estimated IRF PPS payments in FY 2018. We determine the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as number of discharges or case-mix.

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 forecasting errors because of other changes in the forecasted impact time period. Some examples could be legislative changes made by the Congress to the Medicare program that would impact program funding, or changes specifically related to IRFs. Although some of these changes may not necessarily be specific to the IRF 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 IRFs.

In updating the rates for FY 2019, we are proposing standard annual revisions described in this proposed rule (for example, the update to the wage and market basket indexes used to adjust the federal rates). We are also implementing a productivity adjustment to the FY 2019 IRF market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.75 percentage point reduction to the FY 2017 IRF market basket increase factor in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(v) of the Act. We estimate the total increase in payments to IRFs in FY 2019, relative to FY 2018, will be approximately $75 million.

This estimate is derived from the application of the FY 2019 IRF market basket increase factor, as reduced by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.75 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(v) of the Act, which yields an estimated increase in aggregate payments to IRFs of $110 million. Furthermore, there is an additional estimated $35 million decrease in aggregate payments to IRFs due to the proposed update to the outlier threshold amount. Outlier payments are estimated to decrease from approximately 3.4 percent in FY 2018 to 3.0 percent in FY 2019. Therefore, summed together, we estimate that these updates will result in a net increase in estimated payments of $75 million from FY 2018 to FY 2019.

The effects of the proposed updates that impact IRF PPS payment rates are shown in Table 14. The following proposed updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the proposed update to the outlier threshold amount, from approximately 3.4 percent to 3.0 percent of total estimated payments for FY 2019, consistent with section 1886(j)(4) of the Act.
- The effects of the proposed annual market basket update (using the IRF market basket) to IRF PPS payment rates, as required by section 1886(j)(3)(A)(i) and sections 1886(j)(3)(C) and (D) of the Act, including a productivity adjustment in accordance with section 1886(j)(3)(C)(i)(I) of the Act, and a 0.75 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(v) of the Act.
- The effects of applying the proposed budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the proposed budget-neutral changes to the CMG relative weights and average length of stay values, under the authority of section 1886(j)(2)(C)(i) of the Act.
- The total change in estimated payments based on the proposed FY 2019 payment changes relative to the estimated FY 2018 payments.

3. Description of Table 14

Table 14 categorizes IRFs by geographic location, including urban or rural location, and location for CMS's 9 Census divisions (as defined on the cost report) of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities, ownership (otherwise called for-profit, non-profit, and government), by teaching status, and by disproportionate share patient percentage (DSH PP). The top row of Table 14 shows the overall impact on the 1,124 IRFs included in the analysis.

The next 12 rows of Table 14 contain IRFs categorized according to their geographic location, designation as either a freestanding hospital or a unit of a hospital, and by type of ownership; all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and all rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 976 IRFs located in urban areas included in our analysis. Among these, there are 707 IRF units of hospitals located in urban areas and 269 freestanding IRF hospitals located in urban areas. There are 148 IRFs located in rural areas included in our analysis. Among these, there are 137 IRF units of hospitals located in rural areas and 11 freestanding IRF hospitals located in rural areas. There are 386 for-profit IRFs. Among these, there are 346 IRFs in urban areas and 40 IRFs in rural areas. There are 621 non-profit IRFs. Among these, there are 534 urban IRFs and 87 rural IRFs. There are 117 government-owned IRFs. Among these, there are 96 urban IRFs and 21 rural IRFs.

The remaining four parts of Table 14 show IRFs grouped by their geographic location within a region, by teaching status, and by DSH PP. First, IRFs located in urban areas are categorized for their location within a particular one of the nine Census geographic regions. Second, IRFs located in rural areas are categorized for their location within a particular one of the nine Census geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. IRFs are then grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent. Finally, IRFs are grouped by DSH PP, including IRFs with zero DSH PP, IRFs with a DSH PP less than 5 percent, IRFs with a DSH PP between 5 and less than 10 percent, IRFs with a DSH PP between 10 and 20 percent, and IRFs with a DSH PP greater than 20 percent.

The estimated impacts of each policy described in this proposed rule to the facility categories listed are shown in the columns of Table 14. The description of each column is as follows:

- Column (1) shows the facility classification categories.
- Column (2) shows the number of IRFs in each category in our FY 2019 analysis file.
- Column (3) shows the number of cases in each category in our FY 2019 analysis file.
- Column (4) shows the estimated effect of the proposed adjustment to the outlier threshold amount.
- Column (5) shows the estimated effect of the proposed update to the IRF labor-related share and wage index, in a budget-neutral manner.
- Column (6) shows the estimated effect of the proposed update to the CMG relative weights and average length of stay values, in a budget-neutral manner.
- Column (7) compares our estimates of the payments per discharge, incorporating all of the proposed policies reflected in this proposed rule for FY 2019 to our estimates of payments per discharge in FY 2018.

The average estimated increase for all IRFs is approximately 0.9 percent. This estimated net increase includes the effects of the proposed IRF market basket increase factor for FY 2019 of 2.9 percent, reduced by a productivity adjustment of 0.8 percentage point in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and further reduced by 0.75 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(v) of the Act. It also includes the approximate 0.4 percent overall decrease in estimated IRF outlier payments from the proposed update to the outlier threshold amount. Since we are making the proposed updates to the IRF wage index and the CMG relative weights in a budget-neutral manner, they will not be expected to affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they will be expected to affect the estimated distribution of payments among providers.

TABLE 14—IRF IMPACT TABLE FOR FY 2019

[Columns 4 through 7 in percentage]

Facility classification	Number of IRFs	Number of cases	Outlier	FY 2019 CBSA wage index and labor-share	CMG weights	Total percent change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Total	1,124	401,760	−0.4	0.0	0.0	0.9
Urban unit	707	169,671	−0.7	0.0	0.0	0.7
Rural unit	137	22,160	−0.5	−0.3	0.1	0.6
Urban hospital	269	205,565	−0.2	0.0	0.0	1.2
Rural hospital	11	4,364	−0.1	0.2	0.1	1.5
Urban For-Profit	346	202,800	−0.2	0.0	0.0	1.2
Rural For-Profit	40	8,534	−0.3	0.0	0.1	1.2
Urban Non-Profit	534	149,934	−0.6	0.0	0.0	0.8
Rural Non-Profit	87	14,874	−0.6	−0.4	0.1	0.5
Urban Government	96	22,502	−0.8	−0.1	0.0	0.5
Rural Government	21	3,116	−0.5	−0.2	0.1	0.7
Urban	976	375,236	−0.4	0.0	0.0	1.0
Rural	148	26,524	−0.5	−0.2	0.1	0.7
Urban by region:						
Urban New England	29	16,647	−0.2	0.0	0.0	1.1
Urban Middle Atlantic	141	53,238	−0.4	0.0	0.0	0.9
Urban South Atlantic	111	49,452	−0.4	−0.3	0.0	0.6
Urban East North Central	172	48,452	−0.5	0.1	0.1	1.0
Urban East South Central	55	35,750	−0.2	0.0	−0.1	1.1
Urban West North Central	109	37,580	−0.4	−0.1	0.0	0.9
Urban West South Central	183	81,790	−0.3	0.4	0.0	1.4
Urban Mountain	78	28,685	−0.4	−0.3	0.0	0.7
Urban Pacific	98	23,642	−0.9	0.1	0.0	0.5
Rural by region:						
Rural New England	5	1,279	−0.5	2.0	0.0	2.8
Rural Middle Atlantic	11	1,439	−0.6	−0.5	0.0	0.3
Rural South Atlantic	13	2,703	−0.2	−0.5	0.0	0.6
Rural East North Central	25	4,533	−0.4	−0.6	0.1	0.3
Rural East South Central	15	3,713	−0.2	−0.2	0.1	1.1
Rural West North Central	29	4,665	−0.6	0.0	0.1	0.9
Rural West South Central	40	7,141	−0.4	−0.5	0.1	0.5
Rural Mountain	6	699	−1.1	0.3	0.2	0.7
Rural Pacific	4	352	−1.9	−0.4	0.0	−0.9
Teaching status:						
Non-teaching	1,016	356,200	−0.4	0.0	0.0	1.0
Resident to ADC less than 10%	65	34,206	−0.5	0.0	0.0	0.8
Resident to ADC 10%–19%	31	9,372	−0.7	0.0	0.0	0.7
Resident to ADC greater than 19%	12	1,982	−0.5	0.5	0.0	1.4
Disproportionate share patient percentage (DSHPP):						
DSH PP = 0%	36	10,174	−1.2	0.3	0.0	0.5
DSH PP <5%	140	54,050	−0.3	0.0	0.0	1.1
DSH PP 5%–10%	294	126,929	−0.3	0.0	0.0	1.1
DSH PP 10%–20%	371	134,581	−0.4	0.0	0.0	0.9
DSH PP greater than 20%	283	76,026	−0.5	−0.1	0.0	0.7

[1] This column includes the impact of the updates in columns (4), (5), and (6) above, and of the IRF market basket increase factor for FY 2019 (2.9 percent), reduced by 0.8 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and reduced by 0.75 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and -(D)(v) of the Act.

4. Impact of the Proposed Update to the Outlier Threshold Amount

The estimated effects of the proposed update to the outlier threshold adjustment are presented in column 4 of Table 14. In the FY 2018 IRF PPS final rule (82 FR 36238), we used FY 2016 IRF claims data (the best, most complete data available at that time) to set the outlier threshold amount for FY 2018 so that estimated outlier payments would equal 3 percent of total estimated payments for FY 2018.

For this proposed rule, we are using preliminary FY 2017 IRF claims data, and, based on that preliminary analysis, we estimate that IRF outlier payments as a percentage of total estimated IRF payments would be 3.4 percent in FY 2018. Thus, we propose to adjust the outlier threshold amount in this proposed rule to set total estimated outlier payments equal to 3 percent of total estimated payments in FY 2019. The estimated change in total IRF payments for FY 2019, therefore, includes an approximate 0.4 percent decrease in payments because the estimated outlier portion of total payments is estimated to decrease from approximately 3.4 percent to 3 percent.

The impact of this proposed outlier adjustment update (as shown in column 4 of Table 14) is to decrease estimated overall payments to IRFs by about 0.4 percent. We estimate the largest decrease in payments from the update to the outlier threshold amount to be 1.9 percent for rural IRFs in the Pacific region.

5. Impact of the Proposed CBSA Wage Index and Labor-Related Share

In column 5 of Table 14, we present the effects of the proposed budget-neutral update of the wage index and labor-related share. The proposed changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related share portion of payments, so the proposed changes in the two have a combined effect on payments to providers. As discussed in section V.C. of this proposed rule, we are proposing to update the labor-related share from 70.7 percent in FY 2018 to 70.6 percent in FY 2019.

6. Impact of the Proposed Update to the CMG Relative Weights and Average Length of Stay Values

In column 6 of Table 14, we present the effects of the proposed budget-neutral update of the CMG relative weights and average length of stay values. In the aggregate, we do not estimate that these proposed updates will affect overall estimated payments of IRFs. However, we do expect these updates to have small distributional effects.

7. Effects of the Proposed Removal of the FIM™ Instrument and Associated Function Modifiers From the IRF–PAI Beginning in FY 2020

As discussed in section VII. of this proposed rule, we are proposing to remove the FIM™ Instrument and Associated Function Modifiers from the IRF–PAI beginning in FY 2020. We estimate that removal of these data items from the IRF–PAI will reduce administrative burden on IRF providers and reduce the costs incurred by IRFs by $10.2 million for FY 2020.

8. Effects of Proposed Revisions to Certain IRF PPS Requirements

As discussed in section VIII. of this proposed rule, in response to the RFI, we are proposing to remove and amend certain IRF coverage criteria requirements that are overly burdensome on IRF providers beginning in FY 2019, that is, all IRF discharges on or after October 1, 2018. We estimate that the removal and updates to these requirements will reduce unnecessary regulatory and administrative burden on IRF providers and reduce the costs incurred by IRFs by 40.5 million for FY 2019.

9. Effects of Proposed Requirements for the IRF QRP for FY 2020

In accordance with section 1886(j)(7) of the Act, we will reduce by 2 percentage points the market basket increase factor otherwise applicable to an IRF for a fiscal year if the IRF does not comply with the requirements of the IRF QRP for that fiscal year. In section VII.K of this proposed rule, we discuss the proposed method for applying the 2 percentage point reduction to IRFs that fail to meet the IRF QRP requirements.

As discussed in section IX.4. of this proposed rule, we are proposing to remove two measures from the IRF QRP: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) and National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716).

We describe the estimated burden and cost reductions for both of these measures in section XI.C of this rule. In summary, the proposed IRF QRP measure removals will result in a burden reduction of $2,160.66 per IRF annually, and $2,428,581.84 for all IRFs annually. We intend to continue to closely monitor the effects of the quality reporting program on IRFs and to help perpetuate successful reporting outcomes through ongoing stakeholder education, national trainings, IRF announcements, website postings, CMS Open Door Forums, and general and technical help desks.

D. Alternatives Considered

The following is a discussion of the alternatives considered for the IRF PPS updates contained in this proposed rule.

Section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services. Thus, we did not consider alternatives to updating payments using the estimated IRF market basket increase factor for FY 2019. However, as noted previously in this proposed rule, section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a productivity adjustment to the market basket increase factor for FY 2019, and sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(v) of the Act require the Secretary to apply a 0.75 percentage point reduction to the market basket increase factor for FY 2019. Thus, in accordance with section 1886(j)(3)(C) of the Act, we propose to update the IRF federal prospective payments in this proposed rule by 1.35 percent (which equals the 2.9 percent estimated IRF market basket increase factor for FY 2019 reduced by a 0.8 percentage point productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act and further reduced by 0.75 percentage point).

We considered maintaining the existing CMG relative weights and average length of stay values for FY 2019. However, in light of recently available data and our desire to ensure that the CMG relative weights and average length of stay values are as reflective as possible of recent changes in IRF utilization and case-mix, we believe that it is appropriate to propose to update the CMG relative weights and average length of stay values at this time to ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs.

We considered updating facility-level adjustment factors for FY 2019. However, as discussed in more detail in the FY 2015 final rule (79 FR 45872), we believe that freezing the facility-level adjustments at FY 2014 levels for FY 2015 and all subsequent years (unless and until the data indicate that they need to be further updated) will allow us an opportunity to monitor the effects of the substantial changes to the adjustment factors for FY 2014, and will allow IRFs time to adjust to the previous changes.

We considered maintaining the existing outlier threshold amount for FY 2019. However, analysis of updated FY 2019 data indicates that estimated outlier payments would be higher than 3 percent of total estimated payments for FY 2019, by approximately 0.4 percent, unless we updated the outlier threshold amount. Consequently, we propose adjusting the outlier threshold amount in this proposed rule to reflect a 0.4 percent decrease thereby setting the total outlier payments equal to 3 percent, instead of 3.4 percent, of aggregate estimated payments in FY 2019.

We considered not proposing to remove the FIM™ instrument and associated Function Modifiers from the IRF–PAI in this proposed rule. However, in light of recently available data located in the Quality Indicators section of the IRF–PAI, we believe that removal of the FIM™ instrument and associated Function Modifiers is appropriate at this time. As the data items located in the Quality Indicators section of the IRF–PAI are now collected for all IRFs, we believe the collection of the FIM data is no longer necessary and creates undue burden on providers. Consequently, we propose removing these data items from the IRF–PAI beginning with FY 2020. Additionally, the proposed removal of

the FIM™ Instrument and associated Function Modifiers would necessitate the incorporation of the data items from the Quality Indicators section of the IRF–PAI into the CMG classification system. To ensure that the CMGs, relative weights, and average length of stay values are as reflective as possible of recent changes in IRF utilization and case-mix, we believe that it is appropriate to incorporate the data items from the Quality Indicators section of the IRF–PAI into the development of the CMGs beginning with FY 2020.

We considered not proposing revisions to certain IRF PPS requirements in order to reduce burden in this proposed rule. However, after the response that we received from providers regarding the RFI solicitation, we believed that there were areas in which we could reduce unnecessary regulatory and administrative burden on IRF providers, while ensuring that IRF patients would continue to receive adequate care.

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on FY 2018 IRF PPS proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule. It is possible that not all commenters reviewed the FY 2018 IRF PPS proposed rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We seek comments on this assumption.

Using the wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $105.16 per hour, including overhead and fringe benefits *https://www.bls.gov/oes/current/oes_nat.htm.* Assuming an average reading speed, we estimate that it would take approximately 2 hours for the staff to review half of this proposed rule. For each IRF that reviews the rule, the estimated cost is $210.32 (2 hours × $105.16). Therefore, we estimate that the total cost of reviewing this regulation is $15,984.32 ($210.32 × 76 reviewers).

F. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a004/a-4.pdf*), in Table 15, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 15 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the proposed updates presented in this proposed rule based on the data for 1,124 IRFs in our database. In addition, Table 15 presents the costs associated with the proposed new IRF quality reporting program requirements for FY 2019.

TABLE 15—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURE

Change in estimated transfers from FY 2018 IRF PPS to FY 2019 IRF PPS	
Category	Transfers
Annualized Monetized Transfers	$75 million.
From Whom to Whom?	Federal Government to IRF Medicare Providers.
Change in Estimated Costs	
Category	Costs
Annualized monetized cost in FY 2019 for IRFs due to the removal of certain IRF coverage requirements.	Reduction of $40.5 million.
Annualized monetized cost in FY 2020 for IRFs due to the removal of FIM™ instrument and associated Function Modifiers from the IRF–PAI.	Reduction of $10.2 million.
Annualized monetized cost in FY 2019 for IRFs due to new quality reporting program requirements.	Reduction of $2.4 million.

G. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2019 are projected to increase by 0.9 percent, compared with the estimated payments in FY 2018, as reflected in column 7 of Table 15.

IRF payments per discharge are estimated to increase by 1.0 percent in urban areas and 0.7 percent in rural areas, compared with estimated FY 2018 payments. Payments per discharge to rehabilitation units are estimated to increase 0.7 percent in urban areas and 0.6 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 1.2 percent in urban areas and increase 1.5 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the proposed policies in this proposed rule. The largest payment increase is estimated to be a 2.8 percent increase for rural IRFs located in the New England region. The analysis above, together with the remainder of this preamble, provides a Regulatory Impact Analysis.

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

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department of Health and

Human Services proposes to amend 42 CFR chapter IV as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh); sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332); sec. 1206 of Pub. L. 113–67; sec. 112 of Pub. L. 113–93; sec. 231 of Pub. L. 114–113; and secs. 15004, 15006, 15007, 15008, 15009, and 15010 of Pub. L. 114–255.

§ 412.606 [Amended]

■ 2. Section 412.606 is amended by—
■ a. Removing paragraph (a); and
■ b. Redesignating paragraphs (b) and (c) as paragraphs (a) and (b).
■ 3. Section 412.622 is amended by—
■ a. Revising paragraph (a)(3)(iv);
■ b. Redesignating paragraphs (a)(5)(A) through (C) as paragraphs (a)(5)(i) through (iii); and
■ c. Revising newly redesignated paragraph (a)(5)(i).

The revisions read as follows:

§ 412.622 Basis of payment.

(a) * * *

(3) * * *

(iv) Requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. The post-admission physician evaluation described in paragraph (a)(4)(ii) of this section may count as one of the face-to-face visits.

* * * * *

(5) * * *

(i) The team meetings are led by a rehabilitation physician as defined in paragraph (a)(3)(iv) of this section, and further consist of a registered nurse with specialized training or experience in rehabilitation; a social worker or case manager (or both); and a licensed or certified therapist from each therapy discipline involved in treating the patient. All team members must have current knowledge of the patient's medical and functional status. The rehabilitation physician may lead the interdisciplinary team meeting remotely via a mode of communication such as video or telephone conferencing.

* * * * *

■ 4. Section 412.624 is amended by revising paragraph (c)(4)(i) and adding paragraph (c)(4)(iii) to read as follows:

§ 412.624 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) * * *

(4) * * *

(i) In the case of an IRF that is paid under the prospective payment system specified in § 412.1(a)(3) of this part that does not submit quality data to CMS in accordance with § 412.634, the applicable increase factor specified in paragraph (a)(3) of this section, after application of paragraphs (C)(iii) and (D) of section 1886(j)(3) of the Act, is reduced by 2 percentage points.

* * * * *

(iii) The 2 percentage point reduction described in paragraph (c)(4)(i) of this section may result in the applicable increase factor specified in paragraph (a)(3) of this section being less than 0.0 for a fiscal year, and may result in payment rates under the prospective payment system specified in § 412.1(a)(3) of this part for a fiscal year being less than such payment rates for the preceding fiscal year.

* * * * *

■ 5. Section 412.634 is amended by revising the paragraph (b) subject heading and paragraphs (b)(1) and (2) and (d)(1) and (5) to read as follows:

§ 412.634 Requirements under the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).

* * * * *

(b) *Submission requirements.* (1) IRFs must submit to CMS data on measures specified under sections 1886(j)(7)(D), 1899B(c)(1), 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act, as applicable. Such data must be submitted in the form and manner, and at a time, specified by CMS.

(2) CMS may remove a quality measure from the IRF QRP based on one or more of the following factors:

(i) Measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made;

(ii) Performance or improvement on a measure does not result in better patient outcomes;

(iii) The measure does not align with current clinical guidelines or practice;

(iv) A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available;

(v) A measure that is more proximal in time to desired patient outcomes for the particular topic is available;

(vi) A measure that is more strongly associated with desired patient outcomes for the particular topic is available;

(vii) The collection or public reporting of the measure leads to negative unintended consequences other than patient harm;

(viii) The costs associated with the measure outweigh the benefit of its continued use in the IRF QRP.

* * * * *

(d) * * *

(1) IRFs that do not meet the requirement in paragraph (b) of this section for a program year will receive a written notification of non-compliance through at least one of the following methods: Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

* * * * *

(5) CMS will notify IRFs, in writing, of its final decision regarding any reconsideration request through at least one of the following methods: QIES ASAP system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

* * * * *

Dated: April 18, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 20, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2018–08961 Filed 4–27–18; 4:15 pm]

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Part IV

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 411, 413 and 424

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 411, 413, and 424

[CMS–1696–P]

RIN 0938–AT24

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2019. This proposed rule also proposes to replace the existing case-mix classification methodology, the Resource Utilization Groups, Version IV (RUG–IV) model, with a revised case-mix methodology called the Patient-Driven Payment Model (PDPM) effective October 1, 2019. It also proposes revisions to the regulation text that describes a beneficiary's SNF ''resident'' status under the consolidated billing provision and the required content of the SNF level of care certification. The proposed rule also includes proposals for the SNF Quality Reporting Program (QRP) and the Skilled Nursing Facility Value-Based Purchasing (VBP) Program that will affect Medicare payment to SNFs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 26, 2018.

ADDRESSES: In commenting, please refer to file code CMS–1696–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1696–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–1696–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT:

Penny Gershman, (410) 786–6643, for information related to SNF PPS clinical issues.

John Kane, (410) 786–0557, for information related to the development of the payment rates and case-mix indexes.

Kia Sidbury, (410) 786–7816, for information related to the wage index.

Bill Ullman, (410) 786–5667, for information related to level of care determinations, consolidated billing, and general information.

Mary Pratt, (410) 786–6867, for information related to skilled nursing facility quality reporting program.

Celeste Bostic, (410) 786–5603, for information related to the skilled nursing facility value-based purchasing program.

SUPPLEMENTARY INFORMATION:

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

Availability of Certain Tables Exclusively Through the Internet on the CMS Website

As discussed in the FY 2014 SNF PPS final rule (78 FR 47936), tables setting forth the Wage Index for Urban Areas Based on CBSA Labor Market Areas and the Wage Index Based on CBSA Labor Market Areas for Rural Areas are no longer published in the **Federal Register**. Instead, these tables are available exclusively through the internet on the CMS website. The wage index tables for this proposed rule can be accessed on the SNF PPS Wage Index home page, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

Readers who experience any problems accessing any of these online SNF PPS wage index tables should contact Kia Sidbury at (410) 786–7816.

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

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I. Executive Summary

A. Purpose

This proposed rule would update the SNF prospective payment rates for FY 2019 as required under section 1888(e)(4)(E) of the Social Security Act (the Act). It would also respond to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication in the **Federal Register**, before the August 1 that precedes the start of each fiscal year (FY), certain specified information relating to the payment update (see section II.C. of this proposed rule). This proposed rule also proposes to replace the existing case-mix classification methodology, the Resource Utilization Groups, Version IV (RUG–IV) model, with a revised case-mix methodology called the Patient-Driven Payment Model (PDPM) effective October 1, 2019. This proposed rule also proposes updates to the Skilled Nursing Facility Quality Reporting Program (SNF QRP) and Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP).

B. Summary of Major Provisions

In accordance with sections 1888(e)(4)(E)(ii)(IV) and 1888(e)(5) of the Act, the federal rates in this proposed rule would reflect an update to the rates that we published in the SNF PPS final rule for FY 2018 (82 FR 36530), as corrected in the FY 2018 SNF PPS correction notice (82 FR 46163), which reflects the SNF market basket update for FY 2019, as required by section 1888(e)(5)(B)(iv) of the Act (as added by section 53111 of the Bipartisan Budget Act of 2018) . This proposed rule also proposes to replace the existing case-mix classification methodology, the Resource Utilization Groups, Version IV (RUG–IV) model, with a revised case-mix methodology called the Patient-Driven Payment Model (PDPM). It also proposes revisions at 42 CFR 411.15(p)(3)(iv), which describes a beneficiary's SNF ''resident'' status under the consolidated billing provision, and 42 CFR 424.20(a)(1)(i), which describes the required content of the SNF level of care certification. Furthermore, in accordance with section 1888(h) of the Act, this proposed rule proposes, beginning October 1, 2018, to reduce the adjusted federal per diem rate determined under section 1888(e)(4)(G) of the Act by 2 percent, and to adjust the resulting rate by the value-based incentive payment amount earned by the SNF for that fiscal year under the SNF VBP Program. Additionally, this proposed rule proposes to update requirements for the SNF VBP, including requirements that would apply to the FY 2021 SNF VBP program year, changes to the SNF VBP scoring methodology, and an Extraordinary Circumstances Exception policy for the SNF VBP Program. Finally, this rule proposes to update requirements for the SNF QRP, including adopting a new quality measure removal factor and codifying in our regulations a number of requirements.

C. Summary of Cost and Benefits

TABLE 1—COST AND BENEFITS

Provision description	Total transfers
Proposed FY 2019 SNF PPS payment rate update	The overall economic impact of this proposed rule would be an estimated increase of $850 million in aggregate payments to SNFs during FY 2019.
Proposed FY 2019 SNF VBP changes	The overall economic impact of the SNF VBP Program is an estimated reduction of $211 million in aggregate payments to SNFs during FY 2019.

D. Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

Regulatory reform and reducing regulatory burden are high priorities for us. To reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care, in October 2017, we launched the Meaningful Measures Initiative.[1] This initiative is one component of our agency-wide Patients Over Paperwork Initiative,[2] which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes. The Meaningful Measures Initiative represents a new approach to quality measures that fosters operational efficiencies, and will reduce costs including, the collection and reporting burden while producing quality measurement that is more focused on meaningful outcomes.

The Meaningful Measures Framework has the following objectives:

- Address high-impact measure areas that safeguard public health;
- Patient-centered and meaningful to patients;
- Outcome-based where possible;
- Fulfill each program's statutory requirements;
- Minimize the level of burden for health care providers (for example, through a preference for EHR-based measures where possible, such as electronic clinical quality measures);
- Significant opportunity for improvement;
- Address measure needs for population based payment through alternative payment models; and
- Align across programs and/or with other payers.

In order to achieve these objectives, we have identified 19 Meaningful Measures areas and mapped them to six overarching quality priorities as shown in Table 2:

[1] Meaningful Measures web page: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.*

[2] See Remarks by Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit, as prepared for delivery on October 30, 2017 *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html.*

TABLE 2—MEANINGFUL MEASURES FRAMEWORK DOMAINS AND MEASURE AREAS

Quality priority	Meaningful measure area
Making Care Safer by Reducing Harm Caused in the Delivery of Care	Healthcare-Associated Infections. Preventable Healthcare Harm.
Strengthen Person and Family Engagement as Partners in Their Care	Care is Personalized and Aligned with Patient's Goals.
	End of Life Care according to Preferences.
	Patient's Experience of Care.
	Patient Reported Functional Outcomes.
Promote Effective Communication and Coordination of Care	Medication Management.
	Admissions and Readmissions to Hospitals.
	Transfer of Health Information and Interoperability.
Promote Effective Prevention and Treatment of Chronic Disease	Preventive Care.
	Management of Chronic Conditions.
	Prevention, Treatment, and Management of Mental Health.
	Prevention and Treatment of Opioid and Substance Use Disorders.
	Risk Adjusted Mortality.
Work with Communities to Promote Best Practices of Healthy Living	Equity of Care.
	Community Engagement.
Make Care Affordable	Appropriate Use of Healthcare.
	Patient-focused Episode of Care.
	Risk Adjusted Total Cost of Care.

By including Meaningful Measures in our programs, we believe that we can also address the following cross-cutting measure criteria:

- Eliminating disparities;
- Tracking measurable outcomes and impact;
- Safeguarding public health;
- Achieving cost savings;
- Improving access for rural communities; and
- Reducing burden.

We believe that the Meaningful Measures Initiative will improve outcomes for patients, their families, and health care providers while reducing burden and costs for clinicians and providers and promoting operational efficiencies.

E. Advancing Health Information Exchange

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care. The Office of the National Coordinator for Health Information Technology (ONC) and CMS work collaboratively to advance interoperability across settings of care, including post-acute care.

The IMPACT Act requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers. To further interoperability in post-acute care, CMS is developing a Data Element Library to serve as a publicly available centralized, authoritative resource for standardized data elements and their associated mappings to health IT standards. These interoperable data elements can reduce provider burden by allowing the use and reuse of healthcare data, support provider exchange of electronic health information for care coordination, person-centered care, and support real-time, data driven, clinical decision making. Once available, standards in the Data Element Library can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA). The 2018 Interoperability Standards Advisory (ISA) is available at *https://www.healthit.gov/standards-advisory.*

Most recently, the 21st Century Cures Act (Pub. L. 114–255), enacted in late 2016, requires HHS to take new steps to enable the electronic sharing of health information ensuring interoperability for providers and settings across the care continuum. Specifically, Congress directed ONC to ''develop or support a trusted exchange framework, including a common agreement among health information networks nationally.'' This framework (*https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement*) outlines a common set of principles for trusted exchange and minimum terms and conditions for trusted exchange in order to enable interoperability across disparate health information networks. In another important provision, Congress defined ''information blocking'' as practices likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information, and established new authority for HHS to discourage these practices.

We invite providers to learn more about these important developments and how they are likely to affect SNFs.

II. Background on SNF PPS

A. Statutory Basis and Scope

As amended by section 4432 of the Balanced Budget Act of 1997 (BBA 1997, Pub. L. 105–33, enacted on August 5, 1997), section 1888(e) of the Act provides for the implementation of a PPS for SNFs. This methodology uses prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services defined in section 1888(e)(2)(A) of the Act. The SNF PPS is effective for cost reporting periods beginning on or after July 1, 1998, and covers all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities and bad debts. Under section 1888(e)(2)(A)(i) of the Act, covered SNF services include post-hospital extended care services for which benefits are provided under Part A, as well as those items and services (other than a small number of excluded services, such as physicians' services) for which payment may otherwise be made under Part B and which are furnished to Medicare beneficiaries who are residents in a SNF during a covered Part A stay. A comprehensive discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252). In addition, a detailed discussion of the legislative history of the SNF PPS is available online at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_04152015.pdf.*

Section 215(a) of Protecting Access to Medicare Act of 2014 (Pub. L. 113–93, enacted on April 1, 2014) (PAMA) added section 1888(g) to the Act requiring the Secretary to specify an all-cause all-condition hospital readmission

measure and an all-condition risk-adjusted potentially preventable hospital readmission measure for the SNF setting. Additionally, section 215(b) of PAMA added section 1888(h) to the Act requiring the Secretary to implement a VBP program for SNFs. Finally, section 2(c)(4) of the IMPACT Act added section 1888(e)(6) to the Act, which requires the Secretary to implement a quality reporting program for SNFs under which SNFs report data on measures and resident assessment data.

B. Initial Transition for the SNF PPS

Under sections 1888(e)(1)(A) and 1888(e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the federal case-mix adjusted rate. The transition extended through the facility's first 3 cost reporting periods under the PPS, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full federal rate effective with cost reporting periods beginning in FY 2002. As we now base payments for SNFs entirely on the adjusted federal per diem rates, we no longer include adjustment factors under the transition related to facility-specific rates for the upcoming FY.

C. Required Annual Rate Updates

Section 1888(e)(4)(E) of the Act requires the SNF PPS payment rates to be updated annually. The most recent annual update occurred in a final rule that set forth updates to the SNF PPS payment rates for FY 2018 (82 FR 36530), as corrected in the FY 2018 SNF PPS correction notice (82 FR 46163).

Section 1888(e)(4)(H) of the Act specifies that we provide for publication annually in the **Federal Register** of the following:

- The unadjusted federal per diem rates to be applied to days of covered SNF services furnished during the upcoming FY.
- The case-mix classification system to be applied for these services during the upcoming FY.
- The factors to be applied in making the area wage adjustment for these services.

Along with other proposed revisions discussed later in this preamble, this proposed rule would provide the required annual updates to the per diem payment rates for SNFs for FY 2019.

III. SNF PPS Rate Setting Methodology and FY 2019 Update

A. Federal Base Rates

Under section 1888(e)(4) of the Act, the SNF PPS uses per diem federal payment rates based on mean SNF costs in a base year (FY 1995) updated for inflation to the first effective period of the PPS. We developed the federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the federal rates also incorporated a Part B add-on, which is an estimate of the amounts that, prior to the SNF PPS, would have been payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

In developing the rates for the initial period, we updated costs to the first effective year of the PPS (the 15-month period beginning July 1, 1998) using a SNF market basket index, and then standardized for geographic variations in wages and for the costs of facility differences in case mix. In compiling the database used to compute the federal payment rates, we excluded those providers that received new provider exemptions from the routine cost limits, as well as costs related to payments for exceptions to the routine cost limits. Using the formula that the BBA 1997 prescribed, we set the federal rates at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and weighted mean of all SNF costs (hospital-based and freestanding) combined. We computed and applied separately the payment rates for facilities located in urban and rural areas, and adjusted the portion of the federal rate attributable to wage-related costs by a wage index to reflect geographic variations in wages.

B. SNF Market Basket Update

1. SNF Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Accordingly, we have developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. In the SNF PPS final rule for FY 2018 (82 FR 36548 through 36566), we revised and rebased the market basket index, which included updating the base year from FY 2010 to 2014.

The SNF market basket index is used to compute the market basket percentage change that is used to update the SNF federal rates on an annual basis, as required by section 1888(e)(4)(E)(ii)(IV) of the Act. This market basket percentage update is adjusted by a forecast error correction, if applicable, and then further adjusted by the application of a productivity adjustment as required by section 1888(e)(5)(B)(ii) of the Act and described in section III.B.4. of this proposed rule. For FY 2019, the growth rate of the 2014-based SNF market basket is estimated to be 2.7 percent, which is based on the IHS Global Insight, Inc. (IGI) first quarter 2018 forecast with historical data through fourth quarter 2017, before the multifactor productivity adjustment is applied.

However, we note that section 53111 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123, enacted on February 9, 2018) (BBA 2018) amended section 1888(e) of the Act to add section 1888(e)(5)(B)(iv) of the Act. Section 1888(e)(5)(B)(iv) of the Act establishes a special rule for FY 2019 that requires the market basket percentage, after the application of the productivity adjustment, to be 2.4 percent. In accordance with section 1888(e)(5)(B)(iv) of the Act, we will use a market basket percentage of 2.4 percent to update the federal rates set forth in this proposed rule. We propose to revise § 413.337(d) to reflect this statutorily required 2.4 percent market basket percentage for FY 2019. In addition, to conform with section 1888(e)(5)(B)(iii) of the Act, we propose to update the regulations to reflect the 1 percent market basket percentage required for FY 2018 (as discussed in the FY 2018 SNF PPS final rule, 82 FR 36533). Accordingly, we are proposing to revise paragraph (d)(1) of § 413.337, which sets forth the market basket update formula, by revising paragraph (d)(1)(v), and by adding paragraphs (d)(1)(vi) and (d)(1)(vii). The proposed revision to add paragraph (d)(1)(vi) would reflect section 1888(e)(5)(B)(iii) of the Act (as added by section 411(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10)), which establishes a special rule for FY 2018 that requires the market basket percentage, after the application of the productivity adjustment, to be 1.0 percent. The proposed revision to add paragraph (d)(1)(vii) would reflect section 1888(e)(5)(B)(iv) of the Act (as added by section 53111 of BBA 2018), which establishes a special rule for FY 2019

that requires the market basket percentage, after the application of the productivity adjustment, to be 2.4 percent. These statutory provisions are self-implementing and do not require the exercise of discretion by the Secretary. In section III.B.5. of this proposed rule, we discuss the specific application of the BBA 2018-specified market basket adjustment to the forthcoming annual update of the SNF PPS payment rates. In addition, in section III.B.5 of this proposed rule, we discuss the 2 percent reduction applied to the market basket update for those SNFs that fail to submit measures data as required by section 1888(e)(6)(A) of the Act.

2. Use of the SNF Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index from the midpoint of the previous FY to the midpoint of the current FY. Absent the addition of section 1888(e)(5)(B)(iv) of the Act, added by section 53111 of BBA 2018, we would have used the percentage change in the SNF market basket index to compute the update factor for FY 2019. This factor is based on the IGI first quarter 2018 forecast (with historical data through the fourth quarter 2017) of the FY 2019 percentage increase in the 2014-based SNF market basket index reflecting routine, ancillary, and capital-related expenses. The estimated SNF market basket percentage is 2.7 percent for FY 2019. As discussed in sections III.B.3. and III.B.4. of this proposed rule, this market basket percentage change would be reduced by the applicable forecast error correction (as described in § 413.337(d)(2)) and by the MFP adjustment as required by section 1888(e)(5)(B)(ii) of the Act. As noted previously, section 1888(e)(5)(B)(iv) of the Act, added by section 53111 of the BBA 2018, requires us to update the SNF PPS rates for FY 2019 using a 2.4 percent market basket percentage change, instead of the estimated 2.7 percent market basket percentage change adjusted by the multifactor productivity adjustment as described below. Additionally, as discussed in section II.B. of this proposed rule, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates, because the initial three-phase transition period from facility-specific to full federal rates that started with cost reporting periods beginning in July 1998 has expired.

3. Forecast Error Adjustment

As discussed in the June 10, 2003 supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003 final rule (68 FR 46057 through 46059), § 413.337(d)(2) provides for an adjustment to account for market basket forecast error. The initial adjustment for market basket forecast error applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002, resulting in an increase of 3.26 percent to the FY 2004 update. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data, and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent FYs. As we stated in the final rule for FY 2004 that first issued the market basket forecast error adjustment (68 FR 46058, August 4, 2003), the adjustment will reflect both upward and downward adjustments, as appropriate.

For FY 2017 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 2.7 percentage points, while the actual increase for FY 2017 was 2.7 percentage points, resulting in the actual increase being the same as the estimated increase. Accordingly, as the difference between the estimated and actual amount of change in the market basket index does not exceed the 0.5 percentage point threshold, the FY 2019 market basket percentage change of 2.7 percent would not have been adjusted to account for the forecast error correction. Table 3 shows the forecasted and actual market basket amounts for FY 2017.

TABLE 3—DIFFERENCE BETWEEN THE FORECASTED AND ACTUAL MARKET BASKET INCREASES FOR FY 2017

Index	Forecasted FY 2017 increase *	Actual FY 2017 increase **	FY 2017 difference
SNF	2.7	2.7	0.0

* Published in **Federal Register**; based on second quarter 2016 IGI forecast (2010-based index).
** Based on the first quarter 2018 IGI forecast, with historical data through the fourth quarter 2017 (2010-based index).

4. Multifactor Productivity Adjustment

Section 1888(e)(5)(B)(ii) of the Act, as added by section 3401(b) of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010) (Affordable Care Act) requires that, in FY 2012 and in subsequent FYs, the market basket percentage under the SNF payment system (as described in section 1888(e)(5)(B)(i) of the Act) is to be reduced annually by the multifactor productivity (MFP) adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, in turn, defines the MFP adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost-reporting period, or other annual period). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. We refer readers to the BLS website at *http://www.bls.gov/mfp* for the BLS historical published MFP data.

MFP is derived by subtracting the contribution of labor and capital inputs growth from output growth. The projections of the components of MFP are currently produced by IGI, a nationally recognized economic forecasting firm with which CMS contracts to forecast the components of the market baskets and MFP. To generate a forecast of MFP, IGI replicates the MFP measure calculated by the BLS, using a series of proxy variables derived from IGI's U.S. macroeconomic models. For a discussion of the MFP projection methodology, we refer readers to the FY 2012 SNF PPS final rule (76 FR 48527 through 48529) and the FY 2016 SNF PPS final rule (80 FR 46395). A

complete description of the MFP projection methodology is available on our website at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html.*

a. Incorporating the MFP Adjustment Into the Market Basket Update

Per section 1888(e)(5)(A) of the Act, the Secretary shall establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Section 1888(e)(5)(B)(ii) of the Act, added by section 3401(b) of the Affordable Care Act, requires that for FY 2012 and each subsequent FY, after determining the market basket percentage described in section 1888(e)(5)(B)(i) of the Act, the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act (which we refer to as the MFP adjustment). Section 1888(e)(5)(B)(ii) of the Act further states that the reduction of the market basket percentage by the MFP adjustment may result in the market basket percentage being less than zero for a FY, and may result in payment rates under section 1888(e) of the Act being less than such payment rates for the preceding fiscal year.

The MFP adjustment, calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2019, is estimated to be 0.8 percent. Also, consistent with section 1888(e)(5)(B)(i) of the Act and § 413.337(d)(2), the market basket percentage for FY 2019 for the SNF PPS would be based on IGI's first quarter 2018 forecast of the SNF market basket percentage, which is estimated to be 2.7 percent.

If not for the enactment of section 53111 of the BBA 2018, the FY 2019 update would be calculated in accordance with section 1888(e)(5)(B)(i) and (ii) of the Act, pursuant to which the market basket percentage determined under section 1888(e)(5)(B)(i) of the Act (that is, 2.7 percent) would be reduced by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2019) of 0.8 percent, which would be calculated as described above and based on IGI's first quarter 2018 forecast. Absent the enactment of section 53111 of the BBA 2018, the resulting MFP-adjusted SNF market basket update would have been equal to 1.9 percent, or 2.7 percent less 0.8 percentage point. However, as discussed above, section 1888(e)(5)(B)(iv) of the Act, added by section 53111 of the BBA 2018, requires us to apply a 2.4 percent market basket percentage increase in determining the FY 2019 SNF payment rates set forth in this proposed rule (without regard to the MFP adjustment described above).

5. Market Basket Update Factor for FY 2019

Sections 1888(e)(4)(E)(ii)(IV) and 1888(e)(5)(i) of the Act require that the update factor used to establish the FY 2019 unadjusted federal rates be at a level equal to the market basket index percentage change. Accordingly, we determined the total growth from the average market basket level for the period of October 1, 2017, through September 30, 2018 to the average market basket level for the period of October 1, 2018, through September 30, 2019. This process yields a percentage change in the 2014-based SNF market basket of 2.7 percent.

As further explained in section III.B.3. of this proposed rule, as applicable, we adjust the market basket percentage change by the forecast error from the most recently available FY for which there is final data and apply this adjustment whenever the difference between the forecasted and actual percentage change in the market basket exceeds a 0.5 percentage point threshold. Since the difference between the forecasted FY 2017 SNF market basket percentage change and the actual FY 2017 SNF market basket percentage change (FY 2017 is the most recently available FY for which there is historical data) did not exceed the 0.5 percentage point threshold, the FY 2019 market basket percentage change of 2.7 percent would not be adjusted by the forecast error correction.

If not for the enactment of section 53111 of the BBA 2018, the SNF market basket for FY 2019 would be determined in accordance with section 1888(e)(5)(B)(ii) of the Act, which requires us to reduce the market basket percentage change by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2019) of 0.8 percent, as described in section III.B.4. of this proposed rule. Thus, absent the enactment of the BBA 2018, the resulting net SNF market basket update would equal 1.9 percent, or 2.7 percent less the 0.8 percentage point MFP adjustment. We note that our policy has been that, if more recent data become available (for example, a more recent estimate of the SNF market basket and/or MFP adjustment), we would use such data, if appropriate, to determine the SNF market basket percentage change, labor-related share relative importance, forecast error adjustment, and MFP adjustment in the SNF PPS final rule.

Historically, we have used the SNF market basket, adjusted as described above, to adjust each per diem component of the federal rates forward to reflect the change in the average prices from one year to the next. However, section 1888(e)(5)(B)(iv) of the Act, as added by section 53111 of the BBA 2018, requires us to use a market basket percentage of 2.4 percent, after application of the MFP to adjust the federal rates for FY 2019. Under section 1888(e)(5)(B)(iv) of the Act, the market basket percentage increase used to determine the federal rates set forth in this proposed rule will be 2.4 percent for FY 2019. Tables 4 and 5 reflect the updated components of the unadjusted federal rates for FY 2019, prior to adjustment for case-mix.

TABLE 4—FY 2019 UNADJUSTED FEDERAL RATE PER DIEM—URBAN

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$181.50	$136.71	$18.01	$92.63

TABLE 5—FY 2019 UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$173.39	$157.65	$19.23	$94.34

In addition, we note that section 1888(e)(6)(A)(i) of the Act provides that, beginning with FY 2018, SNFs that fail to submit data, as applicable, in accordance with sections 1888(e)(6)(B)(i)(II) and (III) of the Act for a fiscal year will receive a 2.0 percentage point reduction to their market basket update for the fiscal year involved, after application of section 1888(e)(5)(B)(ii) of the Act (the MFP adjustment) and section 1888(e)(5)(B)(iii) of the Act (the 1 percent market basket increase for FY 2018). In addition, section 1888(e)(6)(A)(ii) of the Act states that application of the 2.0 percentage point reduction (after application of section 1888(e)(5)(B)(ii) and (iii) of the Act) may result in the market basket index percentage change being less than 0.0 for a fiscal year, and may result in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Section 1888(e)(6)(A)(iii) of the Act further specifies that the 2.0 percentage point reduction is applied in a noncumulative manner, so that any reduction made under section 1888(e)(6)(A)(i) of the Act applies only with respect to the fiscal year involved, that the reduction cannot be taken into account in computing the payment amount for a subsequent fiscal year.

Accordingly, we propose that for SNFs that do not satisfy the reporting requirements for the FY 2019 SNF QRP, we would apply a 2.0 percentage point reduction to the SNF market basket percentage change for that fiscal year, after application of any applicable forecast error adjustment as specified in § 413.337(d)(2) and the MFP adjustment as specified in § 413.337(d)(3). For FY 2019, the application of this reduction to SNFs that have not met the requirements for the FY 2019 SNF QRP would result in a market basket index percentage change for FY 2019 that is less than zero (specifically, a net update of negative 0.1 percentage point, derived by subtracting 2 percent from the MFP-adjusted market basket update of 1.9 percent), and would also result in FY 2019 payment rates that are less than such payment rates for the preceding FY. We invite comments on these proposals.

C. Case-Mix Adjustment

Under section 1888(e)(4)(G)(i) of the Act, the federal rate also incorporates an adjustment to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment data and other data that the Secretary considers appropriate. In the interim final rule with comment period that initially implemented the SNF PPS (63 FR 26252, May 12, 1998), we developed the RUG–III case-mix classification system, which tied the amount of payment to resident resource use in combination with resident characteristic information. Staff time measurement (STM) studies conducted in 1990, 1995, and 1997 provided information on resource use (time spent by staff members on residents) and resident characteristics that enabled us not only to establish RUG–III, but also to create case-mix indexes (CMIs). The original RUG–III grouper logic was based on clinical data collected in 1990, 1995, and 1997. As discussed in the SNF PPS proposed rule for FY 2010 (74 FR 22208), we subsequently conducted a multi-year data collection and analysis under the Staff Time and Resource Intensity Verification (STRIVE) project to update the case-mix classification system for FY 2011. The resulting Resource Utilization Groups, Version 4 (RUG–IV) case-mix classification system reflected the data collected in 2006 through 2007 during the STRIVE project, and was finalized in the FY 2010 SNF PPS final rule (74 FR 40288) to take effect in FY 2011 concurrently with an updated new resident assessment instrument, version 3.0 of the Minimum Data Set (MDS 3.0), which collects the clinical data used for case-mix classification under RUG–IV.

We note that case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy services. The case-mix classification system uses clinical data from the MDS to assign a case-mix group to each patient that is then used to calculate a per diem payment under the SNF PPS. As discussed in section IV.A. of this proposed rule, the clinical orientation of the case-mix classification system supports the SNF PPS's use of an administrative presumption that considers a beneficiary's initial case-mix classification to assist in making certain SNF level of care determinations. Further, because the MDS is used as a basis for payment, as well as a clinical assessment, we have provided extensive training on proper coding and the time frames for MDS completion in our Resident Assessment Instrument (RAI) Manual. For an MDS to be considered valid for use in determining payment, the MDS assessment must be completed in compliance with the instructions in the RAI Manual in effect at the time the assessment is completed. For payment and quality monitoring purposes, the RAI Manual consists of both the Manual instructions and the interpretive guidance and policy clarifications posted on the appropriate MDS website at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.*

In addition, we note that section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173, enacted December 8, 2003) (MMA) amended section 1888(e)(12) of the Act to provide for a temporary increase of 128 percent in the PPS per diem payment for any SNF residents with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special add-on for SNF residents with AIDS was to remain in effect only until the Secretary certifies that there is an appropriate adjustment in the case mix to compensate for the increased costs associated with such residents. The MMA add-on for SNF residents with AIDS is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at *www.cms.gov/transmittals/downloads/r160cp.pdf.* In the SNF PPS final rule for FY 2010 (74 FR 40288), we did not address this certification in that final rule's implementation of the case-mix refinements for RUG–IV, thus allowing the add-on payment required by section 511 of the MMA to remain in effect for the time being. (We discuss in section V.I. of this proposed rule the specific payment adjustments that we are proposing under the proposed PDPM to provide for an appropriate adjustment in the case mix to compensate for the increased costs associated with such residents.)

For the limited number of SNF residents that qualify for the MMA add-on, there is a significant increase in payments. As explained in the FY 2016 SNF PPS final rule (80 FR 46397 through 46398), on October 1, 2015 (consistent with section 212 of PAMA), we converted to using ICD–10–CM code B20 to identify those residents for whom it is appropriate to apply the AIDS add-on established by section 511 of the MMA. For FY 2019, an urban facility with a resident with AIDS in RUG–IV group ''HC2'' would have a case-mix adjusted per diem payment of 453.68 (see Table 6) before the application of the MMA adjustment. After an increase of 128 percent, this urban facility would receive a case-mix

adjusted per diem payment of approximately 1,034.39.

Under section 1888(e)(4)(H), each update of the payment rates must include the case-mix classification methodology applicable for the upcoming FY. The FY 2019 payment rates set forth in this proposed rule reflect the use of the RUG–IV case-mix classification system from October 1, 2018, through September 30, 2019. We list the proposed case-mix adjusted RUG–IV payment rates for FY 2019, provided separately for urban and rural SNFs, in Tables 6 and 7 with corresponding case-mix values. We use the revised OMB delineations adopted in the FY 2015 SNF PPS final rule (79 FR 45632, 45634) to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to the facility. Tables 6 and 7 do not reflect the add-on for SNF residents with AIDS enacted by section 511 of the MMA, which we apply only after making all other adjustments (such as wage index and case-mix). Additionally, Tables 6 and 7 do not reflect adjustments which may be made to the SNF PPS rates as a result of either the SNF Quality Reporting Program (QRP), discussed in section VI.B. of this proposed rule, or the SNF Value Based-Purchasing (VBP) program, discussed in section VI.C. of this proposed rule.

TABLE 6—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—URBAN

RUG–IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	2.67	1.87	$484.61	$255.65		$92.63	$832.89
RUL	2.57	1.87	466.46	255.65		92.63	814.74
RVX	2.61	1.28	473.72	174.99		92.63	741.34
RVL	2.19	1.28	397.49	174.99		92.63	665.11
RHX	2.55	0.85	462.83	116.20		92.63	671.66
RHL	2.15	0.85	390.23	116.20		92.63	599.06
RMX	2.47	0.55	448.31	75.19		92.63	616.13
RML	2.19	0.55	397.49	75.19		92.63	565.31
RLX	2.26	0.28	410.19	38.28		92.63	541.10
RUC	1.56	1.87	283.14	255.65		92.63	631.42
RUB	1.56	1.87	283.14	255.65		92.63	631.42
RUA	0.99	1.87	179.69	255.65		92.63	527.97
RVC	1.51	1.28	274.07	174.99		92.63	541.69
RVB	1.11	1.28	201.47	174.99		92.63	469.09
RVA	1.10	1.28	199.65	174.99		92.63	467.27
RHC	1.45	0.85	263.18	116.20		92.63	472.01
RHB	1.19	0.85	215.99	116.20		92.63	424.82
RHA	0.91	0.85	165.17	116.20		92.63	374.00
RMC	1.36	0.55	246.84	75.19		92.63	414.66
RMB	1.22	0.55	221.43	75.19		92.63	389.25
RMA	0.84	0.55	152.46	75.19		92.63	320.28
RLB	1.50	0.28	272.25	38.28		92.63	403.16
RLA	0.71	0.28	128.87	38.28		92.63	259.78
ES3	3.58		649.77		18.01	92.63	760.41
ES2	2.67		484.61		18.01	92.63	595.25
ES1	2.32		421.08		18.01	92.63	531.72
HE2	2.22		402.93		18.01	92.63	513.57
HE1	1.74		315.81		18.01	92.63	426.45
HD2	2.04		370.26		18.01	92.63	480.90
HD1	1.60		290.40		18.01	92.63	401.04
HC2	1.89		343.04		18.01	92.63	453.68
HC1	1.48		268.62		18.01	92.63	379.26
HB2	1.86		337.59		18.01	92.63	448.23
HB1	1.46		264.99		18.01	92.63	375.63
LE2	1.96		355.74		18.01	92.63	466.38
LE1	1.54		279.51		18.01	92.63	390.15
LD2	1.86		337.59		18.01	92.63	448.23
LD1	1.46		264.99		18.01	92.63	375.63
LC2	1.56		283.14		18.01	92.63	393.78
LC1	1.22		221.43		18.01	92.63	332.07
LB2	1.45		263.18		18.01	92.63	373.82
LB1	1.14		206.91		18.01	92.63	317.55
CE2	1.68		304.92		18.01	92.63	415.56
CE1	1.50		272.25		18.01	92.63	382.89
CD2	1.56		283.14		18.01	92.63	393.78
CD1	1.38		250.47		18.01	92.63	361.11
CC2	1.29		234.14		18.01	92.63	344.78
CC1	1.15		208.73		18.01	92.63	319.37
CB2	1.15		208.73		18.01	92.63	319.37
CB1	1.02		185.13		18.01	92.63	295.77
CA2	0.88		159.72		18.01	92.63	270.36
CA1	0.78		141.57		18.01	92.63	252.21
BB2	0.97		176.06		18.01	92.63	286.70
BB1	0.90		163.35		18.01	92.63	273.99
BA2	0.70		127.05		18.01	92.63	237.69
BA1	0.64		116.16		18.01	92.63	226.80
PE2	1.50		272.25		18.01	92.63	382.89

TABLE 6—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—URBAN—Continued

RUG–IV category	Nursing index	Therapy index	Nursing component	Therapy Component	Non-case mix therapy comp	Non-case mix component	Total rate
PE1	1.40		254.10		18.01	92.63	364.74
PD2	1.38		250.47		18.01	92.63	361.11
PD1	1.28		232.32		18.01	92.63	342.96
PC2	1.10		199.65		18.01	92.63	310.29
PC1	1.02		185.13		18.01	92.63	295.77
PB2	0.84		152.46		18.01	92.63	263.10
PB1	0.78		141.57		18.01	92.63	252.21
PA2	0.59		107.09		18.01	92.63	217.73
PA1	0.54		98.01		18.01	92.63	208.65

TABLE 7—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—RURAL

RUG–IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	2.67	1.87	$462.95	$294.81		$94.34	$852.10
RUL	2.57	1.87	445.61	294.81		94.34	834.76
RVX	2.61	1.28	452.55	201.79		94.34	748.68
RVL	2.19	1.28	379.72	201.79		94.34	675.85
RHX	2.55	0.85	442.14	134.00		94.34	670.48
RHL	2.15	0.85	372.79	134.00		94.34	601.13
RMX	2.47	0.55	428.27	86.71		94.34	609.32
RML	2.19	0.55	379.72	86.71		94.34	560.77
RLX	2.26	0.28	391.86	44.14		94.34	530.34
RUC	1.56	1.87	270.49	294.81		94.34	659.64
RUB	1.56	1.87	270.49	294.81		94.34	659.64
RUA	0.99	1.87	171.66	294.81		94.34	560.81
RVC	1.51	1.28	261.82	201.79		94.34	557.95
RVB	1.11	1.28	192.46	201.79		94.34	488.59
RVA	1.10	1.28	190.73	201.79		94.34	486.86
RHC	1.45	0.85	251.42	134.00		94.34	479.76
RHB	1.19	0.85	206.33	134.00		94.34	434.67
RHA	0.91	0.85	157.78	134.00		94.34	386.12
RMC	1.36	0.55	235.81	86.71		94.34	416.86
RMB	1.22	0.55	211.54	86.71		94.34	392.59
RMA	0.84	0.55	145.65	86.71		94.34	326.70
RLB	1.50	0.28	260.09	44.14		94.34	398.57
RLA	0.71	0.28	123.11	44.14		94.34	261.59
ES3	3.58		620.74		19.23	94.34	734.31
ES2	2.67		462.95		19.23	94.34	576.52
ES1	2.32		402.26		19.23	94.34	515.83
HE2	2.22		384.93		19.23	94.34	498.50
HE1	1.74		301.70		19.23	94.34	415.27
HD2	2.04		353.72		19.23	94.34	467.29
HD1	1.60		277.42		19.23	94.34	390.99
HC2	1.89		327.71		19.23	94.34	441.28
HC1	1.48		256.62		19.23	94.34	370.19
HB2	1.86		322.51		19.23	94.34	436.08
HB1	1.46		253.15		19.23	94.34	366.72
LE2	1.96		339.84		19.23	94.34	453.41
LE1	1.54		267.02		19.23	94.34	380.59
LD2	1.86		322.51		19.23	94.34	436.08
LD1	1.46		253.15		19.23	94.34	366.72
LC2	1.56		270.49		19.23	94.34	384.06
LC1	1.22		211.54		19.23	94.34	325.11
LB2	1.45		251.42		19.23	94.34	364.99
LB1	1.14		197.66		19.23	94.34	311.23
CE2	1.68		291.30		19.23	94.34	404.87
CE1	1.50		260.09		19.23	94.34	373.66
CD2	1.56		270.49		19.23	94.34	384.06
CD1	1.38		239.28		19.23	94.34	352.85
CC2	1.29		223.67		19.23	94.34	337.24
CC1	1.15		199.40		19.23	94.34	312.97
CB2	1.15		199.40		19.23	94.34	312.97
CB1	1.02		176.86		19.23	94.34	290.43
CA2	0.88		152.58		19.23	94.34	266.15
CA1	0.78		135.24		19.23	94.34	248.81
BB2	0.97		168.19		19.23	94.34	281.76
BB1	0.90		156.05		19.23	94.34	269.62

TABLE 7—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—RURAL—Continued

RUG–IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
BA2	0.70		121.37		19.23	94.34	234.94
BA1	0.64		110.97		19.23	94.34	224.54
PE2	1.50		260.09		19.23	94.34	373.66
PE1	1.40		242.75		19.23	94.34	356.32
PD2	1.38		239.28		19.23	94.34	352.85
PD1	1.28		221.94		19.23	94.34	335.51
PC2	1.10		190.73		19.23	94.34	304.30
PC1	1.02		176.86		19.23	94.34	290.43
PB2	0.84		145.65		19.23	94.34	259.22
PB1	0.78		135.24		19.23	94.34	248.81
PA2	0.59		102.30		19.23	94.34	215.87
PA1	0.54		93.63		19.23	94.34	207.20

D. Wage Index Adjustment

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the federal rates to account for differences in area wage levels, using a wage index that the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data in developing a wage index to be applied to SNFs. We propose to continue this practice for FY 2019, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS. As explained in the update notice for FY 2005 (69 FR 45786), the SNF PPS does not use the hospital area wage index's occupational mix adjustment, as this adjustment serves specifically to define the occupational categories more clearly in a hospital setting; moreover, the collection of the occupational wage data also excludes any wage data related to SNFs. Therefore, we believe that using the updated wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF payments. For FY 2019, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2014 and before October 1, 2015 (FY 2015 cost report data).

We note that section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554, enacted on December 21, 2000) (BIPA) authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. However, to date, this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data. More specifically, auditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the Inpatient Prospective Payment System (IPPS) wage index, would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. Adopting such an approach would require a significant commitment of resources by CMS and the Medicare Administrative Contractors, potentially far in excess of those required under the IPPS given that there are nearly five times as many SNFs as there are inpatient hospitals. Therefore, while we continue to believe that the development of such an audit process could improve SNF cost reports in such a manner as to permit us to establish a SNF-specific wage index, we do not regard an undertaking of this magnitude as being feasible within the current level of programmatic resources.

In addition, we propose to continue to use the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals, and thus, no hospital wage index data on which to base the calculation of the FY 2019 SNF PPS wage index. For rural geographic areas that do not have hospitals, and therefore, lack hospital wage data on which to base an area wage adjustment, we would use the average wage index from all contiguous Core-Based Statistical Areas (CBSAs) as a reasonable proxy. For FY 2019, there are no rural geographic areas that do not have hospitals, and thus, this methodology would not be applied. For rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we would use the average wage indexes of all of the urban areas within the state to serve as a reasonable proxy for the wage index of that urban CBSA. For FY 2019, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA. The proposed wage index applicable to FY 2019 is set forth in Tables A and B available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for MSAs and the creation of micropolitan statistical areas and combined statistical areas. In adopting the CBSA geographic designations, we provided for a 1-year transition in FY 2006 with a blended wage index for all providers. For FY 2006, the wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both using FY 2002 hospital data). We referred to the blended wage index as the FY 2006 SNF PPS transition wage index. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45041), since the expiration of this 1-year transition on September 30, 2006, we have used the full CBSA-based wage index values.

In the FY 2015 SNF PPS final rule (79 FR 45644 through 45646), we finalized changes to the SNF PPS wage index based on the newest OMB delineations, as described in OMB Bulletin No. 13–01, beginning in FY 2015, including a 1-year transition with a blended wage index for FY 2015. OMB Bulletin No.

13–01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published on June 28, 2010 in the **Federal Register** (75 FR 37246 through 37252). Subsequently, on July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013. As we previously stated in the FY 2008 SNF PPS proposed and final rules (72 FR 25538 through 25539, and 72 FR 43423), we wish to note that this and all subsequent SNF PPS rules and notices are considered to incorporate any updates and revisions set forth in the most recent OMB bulletin that applies to the hospital wage data used to determine the current SNF PPS wage index.

On August 15 2017, OMB announced that one Micropolitan Statistical Area now qualifies as a Metropolitan Statistical Areas (OMB Bulletin No. 17–01). The new urban CBSA is as follows:

• Twin Falls, Idaho (CBSA 46300). This CBSA is comprised of the principal city of Twin Falls, Idaho in Jerome County, Idaho and Twin Falls County, Idaho. The OMB bulletin is available on the OMB website at *https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/bulletins/2017/b-17-01.pdf.* We note, we did not have sufficient time to include this change in the computation of the proposed FY 2019 wage index, rate setting, and tables. This new CBSA may affect the budget neutrality factor and wage indexes, depending on the impact of the overall payments of the hospital located in this new CBSA. In this proposed rule, we are providing an estimate of this new area's wage index based on the estimated average hourly wage, unadjusted for occupational mix, for new CBSA 46300 and the national average hourly wages from the wage data for the proposed FY 2019 wage index. Currently, provider 130002 is the only hospital located in Twin Falls County, Idaho, and there are no hospitals located in Jerome County, Idaho. Thus, the proposed wage index for CBSA 46300 is calculated using the average hourly wage data for one provider (provider 130002).

Taking the estimated unadjusted average hourly wage of 35.833564813 of new CBSA 46300 and dividing by the national average hourly wage of 42.990625267 results in the estimated wage index of 0.8335 for CBSA 46300.

In the final rule, we would incorporate this change into the final FY 2019 wage index, rate setting and tables. Thus, for FY 2019, we would use the OMB delineations that were adopted beginning with FY 2015 to calculate the area wage indexes, with updates as reflected in OMB Bulletin Nos. 15–01 and 17–01. As noted above, the proposed wage index applicable to FY 2019 (without the CBSA update from OMB Bulletin No. 17–01 specified above) is set forth in Tables A and B available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

Once calculated, we would apply the wage index adjustment to the labor-related portion of the federal rate. Each year, we calculate a revised labor-related share, based on the relative importance of labor-related cost categories (that is, those cost categories that are labor-intensive and vary with the local labor market) in the input price index. In the SNF PPS final rule for FY 2018 (82 FR 36548 through 36566), we finalized a proposal to revise the labor-related share to reflect the relative importance of the 2014-based SNF market basket cost weights for the following cost categories: Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair Services; All Other: Labor-Related Services; and a proportion of Capital-Related expenses.

We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2019. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2019 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2019 in four steps. First, we compute the FY 2019 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2019 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2019 relative importance for each cost category by multiplying this ratio by the base year (2014) weight. Finally, we add the FY 2019 relative importance for each of the labor-related cost categories (Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-related services, and a portion of Capital-Related expenses) to produce the FY 2019 labor-related relative importance. Table 8 summarizes the proposed updated labor-related share for FY 2019, compared to the labor-related share that was used for the FY 2018 SNF PPS final rule.

TABLE 8—LABOR-RELATED RELATIVE IMPORTANCE, FY 2018 AND FY 2019

	Relative importance, labor-related, FY 2018 17:2 forecast [1]	Relative importance, labor-related, FY 2019 18:1 forecast [2]
Wages and salaries	50.3	50.3
Employee benefits	10.2	10.2
Professional Fees: Labor-Related	3.7	3.7
Administrative and facilities support services	0.5	0.5
Installation, Maintenance and Repair Services	0.6	0.6
All Other: Labor Related Services	2.5	2.5

TABLE 8—LABOR-RELATED RELATIVE IMPORTANCE, FY 2018 AND FY 2019—Continued

	Relative importance, labor-related, FY 2018 17:2 forecast [1]	Relative importance, labor-related, FY 2019 18:1 forecast [2]
Capital-related (.391)	3.0	2.9
Total	70.8	70.7

[1] Published in the FEDERAL REGISTER; based on second quarter 2017 IGI forecast.
[2] Based on first quarter 2018 IGI forecast, with historical data through fourth quarter 2017.

Tables 9 and 10 show the proposed RUG–IV case-mix adjusted federal rates for FY 2019 by labor-related and non-labor-related components. Tables 9 and 10 do not reflect the add-on for SNF residents with AIDS enacted by section 511 of the MMA, which we apply only after making all other adjustments (such as wage index and case-mix). Additionally, Tables 9 and 10 do not reflect adjustments which may be made to the SNF PPS rates as a result of either the SNF Quality Reporting Program (QRP), discussed in section VI.B. of this proposed rule, or the SNF Value Based-Purchasing (VBP) program, discussed in section VI.C. of this proposed rule.

TABLE 9—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT

RUG–IV category	Total rate	Labor portion	Non-Labor portion
RUX	$832.89	$588.85	$244.04
RUL	814.74	576.02	238.72
RVX	741.34	524.13	217.21
RVL	665.11	470.23	194.88
RHX	671.66	474.86	196.80
RHL	599.06	423.54	175.52
RMX	616.13	435.60	180.53
RML	565.31	399.67	165.64
RLX	541.10	382.56	158.54
RUC	631.42	446.41	185.01
RUB	631.42	446.41	185.01
RUA	527.97	373.27	154.70
RVC	541.69	382.97	158.72
RVB	469.09	331.65	137.44
RVA	467.27	330.36	136.91
RHC	472.01	333.71	138.30
RHB	424.82	300.35	124.47
RHA	374.00	264.42	109.58
RMC	414.66	293.16	121.50
RMB	389.25	275.20	114.05
RMA	320.28	226.44	93.84
RLB	403.16	285.03	118.13
RLA	259.78	183.66	76.12
ES3	760.41	537.61	222.80
ES2	595.25	420.84	174.41
ES1	531.72	375.93	155.79
HE2	513.57	363.09	150.48
HE1	426.45	301.50	124.95
HD2	480.90	340.00	140.90
HD1	401.04	283.54	117.50
HC2	453.68	320.75	132.93
HC1	379.26	268.14	111.12
HB2	448.23	316.90	131.33
HB1	375.63	265.57	110.06
LE2	466.38	329.73	136.65
LE1	390.15	275.84	114.31
LD2	448.23	316.90	131.33
LD1	375.63	265.57	110.06
LC2	393.78	278.40	115.38
LC1	332.07	234.77	97.30
LB2	373.82	264.29	109.53
LB1	317.55	224.51	93.04
CE2	415.56	293.80	121.76
CE1	382.89	270.70	112.19
CD2	393.78	278.40	115.38
CD1	361.11	255.30	105.81
CC2	344.78	243.76	101.02
CC1	319.37	225.79	93.58

TABLE 9—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUG–IV category	Total rate	Labor portion	Non-Labor portion
CB2	319.37	225.79	93.58
CB1	295.77	209.11	86.66
CA2	270.36	191.14	79.22
CA1	252.21	178.31	73.90
BB2	286.70	202.70	84.00
BB1	273.99	193.71	80.28
BA2	237.69	168.05	69.64
BA1	226.80	160.35	66.45
PE2	382.89	270.70	112.19
PE1	364.74	257.87	106.87
PD2	361.11	255.30	105.81
PD1	342.96	242.47	100.49
PC2	310.29	219.38	90.91
PC1	295.77	209.11	86.66
PB2	263.10	186.01	77.09
PB1	252.21	178.31	73.90
PA2	217.73	153.94	63.79
PA1	208.65	147.52	61.13

TABLE 10—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT

RUG–IV category	Total rate	Labor portion	Non-Labor portion
RUX	$852.10	$602.43	$249.67
RUL	834.76	590.18	244.58
RVX	748.68	529.32	219.36
RVL	675.85	477.83	198.02
RHX	670.48	474.03	196.45
RHL	601.13	425.00	176.13
RMX	609.32	430.79	178.53
RML	560.77	396.46	164.31
RLX	530.34	374.95	155.39
RUC	659.64	466.37	193.27
RUB	659.64	466.37	193.27
RUA	560.81	396.49	164.32
RVC	557.95	394.47	163.48
RVB	488.59	345.43	143.16
RVA	486.86	344.21	142.65
RHC	479.76	339.19	140.57
RHB	434.67	307.31	127.36
RHA	386.12	272.99	113.13
RMC	416.86	294.72	122.14
RMB	392.59	277.56	115.03
RMA	326.70	230.98	95.72
RLB	398.57	281.79	116.78
RLA	261.59	184.94	76.65
ES3	734.31	519.16	215.15
ES2	576.52	407.60	168.92
ES1	515.83	364.69	151.14
HE2	498.50	352.44	146.06
HE1	415.27	293.60	121.67
HD2	467.29	330.37	136.92
HD1	390.99	276.43	114.56
HC2	441.28	311.98	129.30
HC1	370.19	261.72	108.47
HB2	436.08	308.31	127.77
HB1	366.72	259.27	107.45
LE2	453.41	320.56	132.85
LE1	380.59	269.08	111.51
LD2	436.08	308.31	127.77
LD1	366.72	259.27	107.45
LC2	384.06	271.53	112.53
LC1	325.11	229.85	95.26
LB2	364.99	258.05	106.94
LB1	311.23	220.04	91.19
CE2	404.87	286.24	118.63
CE1	373.66	264.18	109.48
CD2	384.06	271.53	112.53

TABLE 10—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUG–IV category	Total rate	Labor portion	Non-Labor portion
CD1	352.85	249.46	103.39
CC2	337.24	238.43	98.81
CC1	312.97	221.27	91.70
CB2	312.97	221.27	91.70
CB1	290.43	205.33	85.10
CA2	266.15	188.17	77.98
CA1	248.81	175.91	72.90
BB2	281.76	199.20	82.56
BB1	269.62	190.62	79.00
BA2	234.94	166.10	68.84
BA1	224.54	158.75	65.79
PE2	373.66	264.18	109.48
PE1	356.32	251.92	104.40
PD2	352.85	249.46	103.39
PD1	335.51	237.21	98.30
PC2	304.30	215.14	89.16
PC1	290.43	205.33	85.10
PB2	259.22	183.27	75.95
PB1	248.81	175.91	72.90
PA2	215.87	152.62	63.25
PA1	207.20	146.49	60.71

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index in a manner that does not result in aggregate payments under the SNF PPS that are greater or less than would otherwise be made if the wage adjustment had not been made. For FY 2019 (federal rates effective October 1, 2018), we would apply an adjustment to fulfill the budget neutrality requirement. We would meet this requirement by multiplying each of the components of the unadjusted federal rates by a budget neutrality factor equal to the ratio of the weighted average wage adjustment factor for FY 2018 to the weighted average wage adjustment factor for FY 2019. For this calculation, we would use the same FY 2017 claims utilization data for both the numerator and denominator of this ratio. We define the wage adjustment factor used in this calculation as the labor share of the rate component multiplied by the wage index plus the non-labor share of the rate component. The budget neutrality factor for FY 2019 would be 1.0002.

As discussed above, we have historically used, and propose to continue using, pre-reclassified IPPS hospital wage data, unadjusted for occupational mix and the rural and imputed floors, as the basis for the SNF wage index. That being said, we note that we have received recurring comments in prior rulemaking (most recently in the FY 2018 SNF PPS final rule (82 FR 36539 through 36541)) regarding the development of a SNF-specific wage index. It has been suggested that we develop a SNF-specific wage index utilizing SNF cost report wage data instead of hospital wage data. We have noted, in response that developing such a wage index would require a resource-intensive audit process similar to that used for IPPS hospital data, to improve the quality of the SNF cost report data in order for it to be used as part of this analysis. This audit process is quite extensive in the case of approximately 3,300 hospitals, and it would be significantly more so in the case of approximately 15,000 SNFs. As discussed previously in this rule, we believe auditing all SNF cost reports, similar to the process used to audit inpatient hospital cost reports for purposes of the IPPS wage index, would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. We also believe that adopting such an approach would require a significant commitment of resources by CMS and the Medicare Administrative Contractors, potentially far in excess of those required under the IPPS given that there are nearly five times as many SNFs as there are hospitals. Therefore, while we continue to review all available data and contemplate the potential methodological approaches for a SNF-specific wage index in the future, we continue to believe that in the absence of the appropriate SNF-specific wage data, using the pre-reclassified, pre-rural and imputed floor hospital inpatient wage data (without the occupational mix adjustment) is appropriate and reasonable for the SNF PPS.

As an alternative to a SNF-specific wage index, it has also been suggested that we consider adopting certain wage index policies in use under the IPPS, such as geographic reclassification or rural floor. Although we have the authority under section 315 of BIPA to establish a geographic reclassification procedure specific to SNFs under certain conditions, as discussed previously, under BIPA, we cannot adopt a reclassification policy until we have collected the data necessary to establish a SNF-specific wage index. Thus, we cannot adopt a reclassification procedure at this time. With regard to adopting a rural floor policy, as we stated in the FY 2017 SNF PPS final rule (82 FR 36540), MedPAC has recommended eliminating the rural floor policy (which actually sets a floor for urban hospitals) from the calculation of the IPPS wage index (see, for example, Chapter 3 of MedPAC's March 2013 Report to Congress on Medicare Payment Policy, available at *http://medpac.gov/docs/default-source/reports/mar13_ch03.pdf,* which notes on page 65 that in 2007, MedPAC had ''. . . recommended eliminating these special wage index adjustments and adopting a new wage index system to avoid geographic inequities that can occur due to current wage index policies (Medicare Payment Advisory Commission 2007b.''). As we stated in the FY 2017 SNF PPS final rule, if we were to adopt the rural floor under the SNF PPS, we believe that the SNF PPS wage index could become vulnerable to problems similar to those that MedPAC

identified in its March 2013 Report to Congress.

Given the perennial nature of these comments and responses on the SNF PPS wage index policy, we are requesting further comments on the issues discussed above. Specifically, we request comment on how a SNF-specific wage index may be developed without creating significant administrative burdens for providers, CMS, or its contractors. Further, we request comments on specific alternatives we may consider in future rulemaking which could be implemented in advance of, or in lieu of, a SNF-specific wage index.

E. SNF Value-Based Purchasing Program

Beginning with payment for services furnished on October 1, 2018, section 1888(h) of the Act requires the Secretary to reduce the adjusted Federal per diem rate determined under section 1888(e)(4)(G) of the Act otherwise applicable to a SNF for services furnished during a fiscal year by 2 percent, and to adjust the resulting rate for a SNF by the value-based incentive payment amount earned by the SNF based on the SNF's performance score for that fiscal year under the SNF VBP Program. To implement these requirements, we propose to add a new paragraph (f) to § 413.337. See section VI.C. of this proposed rule for further information regarding the SNF VBP Program, including a discussion of the methodology we would use to make the payment adjustments.

F. Adjusted Rate Computation Example

Using the hypothetical SNF XYZ, Table 11 shows the adjustments made to the federal per diem rates (prior to application of any adjustments under the SNF QRP and SNF VBP programs as discussed above) to compute the provider's actual per diem PPS payment for FY 2019. We derive the Labor and Non-labor columns from Table 9. The wage index used in this example is based on the proposed wage index, which may be found in Table A available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* As illustrated in Table 11, SNF XYZ's total PPS payment for FY 2019 would equal $48,801.32.

TABLE 11—ADJUSTED RATE COMPUTATION EXAMPLE SNF XYZ: LOCATED IN FREDERICK, MD (URBAN CBSA 43524) WAGE INDEX: 0.9882

[See Proposed Wage Index in Table A] [1]

RUG–IV group	Labor	Wage index	Adjusted labor	Non-labor	Adjusted rate	Percent adjustment	Medicare days	Payment
RVX	$524.13	0.9882	$517.95	$217.21	$735.16	$735.16	14	$10,292.24
ES2	$420.84	0.9882	$415.87	$174.41	$590.28	$590.28	30	$17,708.40
RHA	$264.42	0.9882	$261.30	$109.58	$370.88	$370.88	16	$5,934.08
CC2[2]	$243.76	0.9882	$240.88	$101.02	$341.90	$779.53	10	$7,795.30
BA2	$168.05	0.9882	$166.07	$69.64	$235.71	$235.71	30	$7,071.30
							100	$48,801.32

[1] Available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*
[2] Reflects a 128 percent adjustment from section 511 of the MMA.

IV. Additional Aspects of the SNF PPS

A. SNF Level of Care—Administrative Presumption

The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the existing resident assessment process and case-mix classification system discussed in section III.C. of this proposed rule. This approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 52 RUGs of the current 66-group RUG–IV case-mix classification system to assist in making certain SNF level of care determinations.

In accordance with the regulations at § 413.345, we include in each update of the federal payment rates in the **Federal Register** a discussion of the resident classification system that provides the basis for case-mix adjustment. Under that discussion, we designate those specific classifiers under the case-mix classification system that represent the required SNF level of care, as provided in § 409.30. As set forth in the FY 2011 SNF PPS update notice (75 FR 42910), this designation reflects an administrative presumption under the 66-group RUG–IV system that beneficiaries who are correctly assigned to one of the upper 52 RUG–IV groups on the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date (ARD) on the 5-day Medicare-required assessment.

A beneficiary assigned to any of the lower 14 RUG–IV groups is not automatically classified as either meeting or not meeting the definition, but instead receives an individual level of care determination using the existing administrative criteria. This presumption recognizes the strong likelihood that beneficiaries assigned to one of the upper 52 RUG–IV groups during the immediate post-hospital period require a covered level of care, which would be less likely for those beneficiaries assigned to one of the lower 14 RUG–IV groups.

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure. The FY 2018 final rule (82 FR 36544) further specified that we would henceforth disseminate the standard description of the administrative presumption's designated groups via the SNF PPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html* (where such designations appear in the paragraph entitled ''Case Mix Adjustment''), and would publish such designations in rulemaking only to the extent that we actually intend to make changes in them. (We discuss in section V.H. of this proposed rule the modifications to the administrative level of care presumption that we are proposing in order to accommodate the case-mix classification system under the proposed PDPM.)

However, we note that this administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely, including a review to confirm that the services prompting the assignment of one of the designated case-mix classifiers (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary. As we explained in the FY 2000 SNF PPS final rule (64 FR 41667), the administrative presumption:

> . . . is itself rebuttable in those individual cases in which the services actually received by the resident do not meet the basic statutory criterion of being reasonable and necessary to diagnose or treat a beneficiary's condition (according to section 1862(a)(1) of the Act). Accordingly, the presumption would not apply, for example, in those situations in which a resident's assignment to one of the upper . . . groups is itself based on the receipt of services that are subsequently determined to be not reasonable and necessary.

Moreover, we want to stress the importance of careful monitoring for changes in each patient's condition to determine the continuing need for Part A SNF benefits after the ARD of the 5-day assessment.

B. Consolidated Billing

Sections 1842(b)(6)(E) and 1862(a)(18) of the Act (as added by section 4432(b) of the BBA 1997) require a SNF to submit consolidated Medicare bills to its Medicare Administrative Contractor (MAC) for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, section 1862(a)(18) of the Act places the responsibility with the SNF for billing Medicare for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a noncovered stay. (Please refer to section VI.A. of this rule for a discussion of a proposed revision to the regulation text that describes a beneficiary's status as a SNF ''resident'' for consolidated billing purposes.) Section 1888(e)(2)(A) of the Act excludes a small list of services from the consolidated billing provision (primarily those services furnished by physicians and certain other types of practitioners), which remain separately billable under Part B when furnished to a SNF's Part A resident. These excluded service categories are discussed in greater detail in section V.B.2. of the May 12, 1998 interim final rule (63 FR 26295 through 26297).

A detailed discussion of the legislative history of the consolidated billing provision is available on the SNF PPS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_04152015.pdf.* In particular, section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106–113, enacted on November 29, 1999) (BBRA) amended section 1888(e)(2)(A) of the Act by further excluding a number of individual high-cost, low probability services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the SNF PPS proposed and final rules for FY 2001 (65 FR 19231 through 19232, April 10, 2000, and 65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB–00–18 (Change Request #1070), issued March 2000, which is available online at *www.cms.gov/transmittals/downloads/ab001860.pdf.*

As explained in the FY 2001 proposed rule (65 FR 19232), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary the authority to designate additional, individual services for exclusion within each of the specified service categories. In the proposed rule for FY 2001, we also noted that the BBRA Conference report (H.R. Rep. No. 106–479 at 854 (1999) (Conf. Rep.)) characterizes the individual services that this legislation targets for exclusion as high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment SNFs receive under the PPS. According to the conferees, section 103(a) of the BBRA is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs. By contrast, the amendments enacted in section 103 of the BBRA do not designate for exclusion any of the remaining services within those four categories (thus, leaving all of those services subject to SNF consolidated billing), because they are relatively inexpensive and are furnished routinely in SNFs.

As we further explained in the final rule for FY 2001 (65 FR 46790), and as is consistent with our longstanding policy, any additional service codes that we might designate for exclusion under our discretionary authority must meet the same statutory criteria used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA: They must fall within one of the four service categories specified in the BBRA; and they also must meet the same standards of high cost and low probability in the SNF setting, as discussed in the BBRA Conference report. Accordingly, we characterized this statutory authority to identify additional service codes for exclusion as essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice) (65 FR 46791). In this proposed rule, we specifically invite public comments identifying HCPCS codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing. We may consider excluding a particular service if it meets our criteria for exclusion as specified above. Commenters should identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.

We note that the original BBRA amendment (as well as the implementing regulations) identified a set of excluded services by means of specifying HCPCS codes that were in effect as of a particular date (in that case, as of July 1, 1999). Identifying the excluded services in this manner made it possible for us to utilize program issuances as the vehicle for accomplishing routine updates of the excluded codes, to reflect any minor revisions that might subsequently occur in the coding system itself (for example, the assignment of a different code number to the same service). Accordingly, in the event that we identify through the current rulemaking cycle any new services that would actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, we would identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, as of October 1, 2018). By making any new exclusions in this manner, we could similarly accomplish routine

future updates of these additional codes through the issuance of program instructions.

C. Payment for SNF-Level Swing-Bed Services

Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute- or SNF-level care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF-level services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, SNF-level services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. As explained in the FY 2002 final rule (66 FR 39562), this effective date is consistent with the statutory provision to integrate swing-bed rural hospitals into the SNF PPS by the end of the transition period, June 30, 2002.

Accordingly, all non-CAH swing-bed rural hospitals have now come under the SNF PPS. Therefore, all rates and wage indexes outlined in earlier sections of this proposed rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. A complete discussion of assessment schedules, the MDS, and the transmission software (RAVEN–SB for Swing Beds) appears in the FY 2002 final rule (66 FR 39562) and in the FY 2010 final rule (74 FR 40288). As finalized in the FY 2010 SNF PPS final rule (74 FR 40356 through 40357), effective October 1, 2010, non-CAH swing-bed rural hospitals are required to complete an MDS 3.0 swing-bed assessment which is limited to the required demographic, payment, and quality items. The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.* We refer readers to section V.E.2. of this proposed rule for a discussion of the revisions we are proposing to the MDS 3.0 swing-bed assessment effective October 1, 2019.

V. Proposed Revisions to SNF PPS Case-Mix Classification Methodology

A. Issues Relating to the Current Case-Mix System for Payment of Skilled Nursing Facility Services Under Part A of the Medicare Program

Section 1888(e)(4)(G)(i) of the Act requires the Secretary to make an adjustment to the per diem rates to account for case-mix. The statute specifies that the adjustment is to be based on both a resident classification system that the Secretary establishes that accounts for the relative resource use of different resident types, as well as resident assessment and other data that the Secretary considers appropriate.

In general, the case-mix classification system currently used under the SNF PPS classifies residents into payment classification groups, called RUGs, based on various resident characteristics and the type and intensity of therapy services provided to the resident. Under the existing SNF PPS methodology, there are two case-mix-adjusted components of payment: Nursing and therapy. Each RUG is assigned a CMI for each payment component to reflect relative differences in cost and resource intensity. The higher the CMI, the higher the expected resource utilization and cost associated with residents assigned to that RUG. The case-mix-adjusted nursing component of payment reflects relative differences in a resident's associated nursing and non-therapy ancillary (NTA) costs, based on various resident characteristics, such as resident comorbidities, and treatments. The case-mix-adjusted therapy component of payment reflects relative differences in a resident's associated therapy costs, which is based on a combination of PT, OT, and SLP services. Resident classification under the existing therapy component is based primarily on the amount of therapy the SNF chooses to provide to a SNF resident. Under the RUG–IV model, residents are classified into rehabilitation groups, where payment is determined primarily based on the intensity of therapy services received by the resident, and into nursing groups, based on the intensity of nursing services received by the resident and other aspects of the resident's care and condition. However, only the higher paying of these groups is used for payment purposes. For example, if a resident is classified into a both the RUA (Rehabilitation) and PA1 (Nursing) RUG–IV groups, where RUA has a higher per-diem payment rate than PA1, the RUA group is used for payment purposes. It should be noted that the vast majority of Part A covered SNF days (over 90 percent) are paid using a rehabilitation RUG. A variety of concerns have been raised with the current SNF PPS, specifically the RUG–IV model, which we discuss below.

When the SNF PPS was first implemented in 1998 (63 FR 26252), we developed the RUG–III case-mix classification model, which tied the amount of payment to resident resource use in combination with resident characteristic information. Staff time measurement (STM) studies conducted in 1990, 1995, and 1997 provided information on resource use (time spent by staff members on residents) and resident characteristics that enabled us not only to establish RUG–III but also to create CMIs. This initial RUG–III model was refined by changes finalized in the FY 2006 SNF PPS final rule (70 FR 45032), which included adding nine case-mix groups to the top of the original 44-group RUG–III hierarchy, which created the RUG–53 case-mix model.

In the FY 2010 SNF PPS proposed rule (74 FR 22208), we proposed the RUG–IV model based on, among other reasons, concerns that incentives in the SNF PPS had changed the relative amount of nursing resources required to treat SNF residents (74 FR 22220). These concerns led us to conduct a new Staff Time Measurement (STM) study, the Staff Time and Resource Intensity Verification (STRIVE) project, which served as the basis for developing the current SNF PPS case-mix classification model, RUG–IV, which became effective in FY 2011. At that time, we considered alternative case mix models, including predictive models of therapy payment based on resident characteristics; however, we had a ''great deal of concern that by separating payment from the actual provision of services, the system, and more importantly, the beneficiaries would be vulnerable to underutilization.'' (74 FR 22220) Other options considered at the time included a non-therapy ancillary (NTA) payment model based on resident characteristics (74 FR 22238) and a DRG-based payment model that relied on information from the prior inpatient stay (74 FR 22220); these and other options are discussed in detail in a CMS Report to Congress issued in December 2006 (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf*).

In the years since we implemented the SNF PPS, finalized RUG–IV, and made statements regarding our concerns about underutilization of services in previously considered models, we have witnessed a significant trend that has caused us to reconsider these concerns. More specifically, as discussed in section V.E. of the FY 2015 SNF PPS proposed rule (79 FR 25767), we documented and discussed trends observed in therapy utilization in a memo entitled ''Observations on Therapy Utilization Trends'' (which

may be accessed at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Therapy_Trends_Memo_04212014.pdf*). The two most notable trends discussed in that memo were that the percentage of residents classifying into the Ultra-High therapy category has increased steadily and, of greater concern, that the percentage of residents receiving just enough therapy to surpass the Ultra-High and Very-High therapy thresholds has also increased. In that memo, we state ''the percentage of claims-matched MDS assessments in the range of 720 minutes to 739 minutes, which is just enough to surpass the 720 minute threshold for RU groups, has increased from 5 percent in FY 2005 to 33 percent in FY 2013'' and this trend has continued since that time. While it might be possible to attribute the increasing share of residents in the Ultra-High therapy category to increasing acuity within the SNF population, we believe the increase in ''thresholding'' (that is, of providing just enough therapy for residents to surpass the relevant therapy thresholds) is a strong indication of service provision predicated on financial considerations rather than resident need. We discussed this issue in response to comments in the FY 2015 SNF PPS final rule, where, in response to comments regarding the lack of ''current medical evidence related to how much therapy a given resident should receive,'' we stated the following:

> With regard to the comments which highlight the lack of existing medical evidence for how much therapy a given resident should receive, we would note that . . . the number of therapy minutes provided to SNF residents within certain therapy RUG categories is, in fact, clustered around the minimum thresholds for a given therapy RUG category. However, given the comments highlighting the lack of medical evidence related to the appropriate amount of therapy in a given situation, it is all the more concerning that practice patterns would appear to be as homogenized as the data would suggest. (79 FR 45651)

In response to comments related to factors which may explain the observed trends, we stated the following:

> With regard to the comment which highlighted potential explanatory factors for the observed trends, such as internal pressure within SNFs that would override clinical judgment, we find these potential explanatory factors troubling and entirely inconsistent with the intended use of the SNF benefit. Specifically, the minimum therapy minute thresholds for each therapy RUG category are certainly not intended as ceilings or targets for therapy provision. As discussed in Chapter 8, Section 30 of the Medicare Benefit Policy Manual (Pub. 100–02), to be covered, the services provided to a SNF resident must be ''reasonable and necessary for the treatment of a patient's illness or injury, that is, are consistent with the nature and severity of the individual's illness or injury, *the individual's particular medical needs,* and accepted standards of medical practice.'' (emphasis added) Therefore, services which are not specifically tailored to meet the individualized needs and goals of the resident, based on the resident's condition and the evaluation and judgment of the resident's clinicians, may not meet this aspect of the definition for covered SNF care, and we believe that internal provider rules should not seek to circumvent the Medicare statute, regulations and policies, or the professional judgment of clinicians. (79 FR 45651 through 45652)

In addition to this discussion of observed trends, others have also identified potential areas of concern within the current SNF PPS. The two most notable sources are the Office of the Inspector General (OIG) and the Medicare Payment Advisory Commission (MedPAC).

For the OIG, three recent OIG reports describe the OIG's concerns with the current SNF PPS. In December 2010, the OIG released a report entitled ''Questionable Billing by Skilled Nursing Facilities'' (which may be accessed at *https://oig.hhs.gov/oei/reports/oei-02-09-00202.pdf*). In this report, among its findings, the OIG found that ''from 2006 to 2008, SNFs increasingly billed for higher paying RUGs, even though beneficiary characteristics remained largely unchanged'' (OEI–02–09–00202, ii), and among other things, recommended that we should ''consider several options to ensure that the amount of therapy paid for by Medicare accurately reflects beneficiaries' needs'' (OEI–02–09–00202, iii). Further, in November 2012, the OIG released a report entitled ''Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009'' (which may be accessed at *https://oig.hhs.gov/oei/reports/oei-02-09-00200.pdf*). In this report, the OIG found that ''SNFs billed one-quarter of all claims in error in 2009'' and that the ''majority of the claims in error were upcoded; many of these claims were for ultrahigh therapy.'' (OEI–02–09–00200, Executive Summary). Among its recommendations, the OIG stated that ''the findings of this report provide further evidence that CMS needs to change how it pays for therapy'' (OEI–02–09–00200, 15). Finally, in September 2015, the OIG released a report entitled ''The Medicare Payment System for Skilled Nursing Facilities Needs to be Reevaluated'' (which may be accessed at *https://oig.hhs.gov/oei/reports/oei-02-13-00610.pdf*). Among its findings, the OIG found that ''Medicare payments for therapy greatly exceed SNFs' costs for therapy,'' further noting that ''the difference between Medicare payments and SNFs' costs for therapy, combined with the current payment method, creates an incentive for SNFs to bill for higher levels of therapy than necessary'' (OEI–02–13–00610, 7). Among its recommendations, the OIG stated that CMS should ''change the method of paying for therapy'', further stating that ''CMS should accelerate its efforts to develop and implement a new method of paying for therapy that relies on beneficiary characteristics or care needs.'' (OEI–02–13–00610, 12).

For MedPAC's recommendations in this area, Chapter 8 of MedPAC's March 2017 Report to Congress (available at *http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch8.pdf*) includes the following recommendation: ''The Congress should . . . direct the Secretary to revise the prospective payment system (PPS) for skilled nursing facilities'' and ''. . . make any additional adjustments to payments needed to more closely align payment with costs.'' (March 2017 MedPAC Report to Congress, 220). This recommendation is seemingly predicated on MedPAC's own analysis of the current SNF PPS, where they state that ''almost since its inception the SNF PPS has been criticized for encouraging the provision of excessive rehabilitation therapy services and not accurately targeting payments for nontherapy ancillaries'' (March 2017 MedPAC Report to Congress, 202). Finally, with regard to the possibility of changing the existing SNF payment system, MedPAC stated that ''since 2015, [CMS] has gathered four expert panels to receive input on aspects of possible design features before it proposes a revised PPS'' and further that ''the designs under consideration are consistent with those recommended by the Commission'' (March 2017 MedPAC Report to Congress, 203).

The combination of the observed trends in the current SNF PPS discussed above (which strongly suggest that providers may be basing service provision on financial reasons rather than resident need), the issues raised in the OIG reports discussed above, and the issues raised by MedPAC, has caused us to consider significant revisions to the existing SNF PPS, in keeping with our overall responsibility to ensure that payments under the SNF PPS accurately reflect both resident needs and resource utilization.

Under the RUG–IV system, therapy service provision determines not only

therapy payments but also nursing payments. This is because, as noted above, payment is based on the highest RUG category that the resident could be assigned to, so only one of a resident's assigned RUG groups, rehabilitation or nursing, is used for payment purposes. Each rehabilitation group is assigned a nursing CMI to reflect relative differences in nursing costs for residents in those rehabilitation groups, which is less specifically tailored to the individual nursing costs for a given resident than the nursing CMIs assigned for the nursing RUGs. Given that, as mentioned above, most resident days are paid using a rehabilitation RUG, and since assignment into a rehabilitation RUG is based on therapy service provision, this means that therapy service provision effectively determines nursing payments for those residents who are assigned to a rehabilitation RUG. Thus, we believe any attempts to revise the SNF PPS payment methodology to better account for therapy service provision under the SNF PPS would need to be comprehensive and affect both the therapy and nursing case-mix components. Moreover, in the FY 2015 SNF PPS final rule, in response to comments regarding access for certain ''specialty'' populations (such as those with complex nursing needs), we stated the following:

> With regard to the comment on specialty populations, we agree with the commenter that access must be preserved for all categories of SNF residents, particularly those with complex medical and nursing needs. As appropriate, we will examine our current monitoring efforts to identify any revisions which may be necessary to account appropriately for these populations. (79 FR 45651)

In addition, MedPAC, in its March 2017 Report to Congress, stated that it has previously recommended that we revise the current SNF PPS to ''base therapy payments on patient characteristics (not service provision), remove payments for NTA services from the nursing component, [and] establish a separate component within the PPS that adjusts payments for NTA services'' (March 2017 MedPAC Report to Congress, 202). Accordingly, we note that included among the proposed revisions we discuss in this proposed rule, are revisions to the SNF PPS to address longstanding concerns regarding the ability of the RUG–IV system to account for variation in nursing and NTA services, as described in sections V.D.3.e. of this proposed rule.

In May 2017, CMS released an Advance Notice of Proposed Rulemaking with comment (82 FR 20980) (the ANPRM), in which we discussed the history of and analyses conducted during the SNF Payment Models Research (PMR) project, which sought to address these concerns with the RUG–IV model, and sought comments on a possible replacement to the current RUG–IV model, which we called the Resident Classification System, Version I (RCS–I). This model was intended as an improvement over the RUG–IV model because it would better account for resident characteristics and care needs, thus better aligning SNF PPS payments with resource use and eliminating therapy provision-related financial incentives inherent in the current payment model used in the SNF PPS. We received many comments from stakeholders on a wide variety of aspects of the RCS–I model. After considering these comments, we made significant revisions to the RCS–I model to account for the concerns or questions raised by stakeholders, resulting in a revised case-mix classification model which we are proposing in this rule. To make clear the purpose and intent of replacing the existing RUG–IV system, the model we are proposing in this rule is called the Patient-Driven Payment Model (PDPM).

In the sections that follow, we describe the comprehensive proposed revisions to the current SNF PPS case-mix classification system and its replacement with PDPM, effective October 1, 2019. Specifically, we discuss a proposed alternative to the existing RUG–IV, called the Patient-Driven Payment Model (PDPM), effective for payments beginning October 1, 2019. As further detailed below, we believe that the PDPM represents an improvement over the RUG–IV model and the RCS–I model because it would better account for resident characteristics and care needs while reducing both systemic and administrative complexity. To better ensure that resident care decisions appropriately reflect each resident's actual care needs, we believe it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from verifiable resident characteristics.

B. Summary of the Skilled Nursing Facility Payment Models Research Project

As noted above, since 1998, Medicare Part A has paid for SNF services on a per diem basis through the SNF PPS. Currently, therapy payments under the SNF PPS are based primarily on the amount of therapy furnished to a patient, regardless of that patient's specific characteristics and care needs. Beginning in 2013, we contracted with Acumen, LLC to identify potential alternatives to the existing methodology used to pay for services under the SNF PPS. The recommendations developed under this contract, entitled the SNF PMR project, form the basis of the proposals contained in the sections below.

The SNF PMR operated in four phases. In the first phase of the project, which focused exclusively on therapy payment issues, Acumen reviewed past research studies and policy issues related to SNF PPS therapy payment and options for improving or replacing the current therapy payment methodology. After consideration of multiple potential alternatives, such as competitive bidding and a hybrid model combining resource-based pricing (for example, how therapy payments are made under the current SNF PPS) with resident characteristics, we identified a model that relies on resident characteristics rather than the amount of therapy received as the most appropriate replacement for the existing therapy payment model. As stated above, we believe that relying on resident characteristics would improve the resident-centeredness of the model and discourage resident care decisions predicated on service-based financial incentives. A report summarizing Acumen's activities and recommendations during the first phase of the SNF PMR contract, the SNF Therapy Payment Models Base Year Final Summary Report, is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Summary_Report_20140501.pdf.*

In the second phase of the project, Acumen used the findings from the Base Year Final Summary Report as a guide to identify potential models suitable for further analysis. During this phase of the project, in an effort to establish a comprehensive approach to Medicare Part A SNF payment reform, we expanded the scope of the SNF PMR to encompass other aspects of the SNF PPS beyond therapy. Although we always intended to ensure that any revisions specific to therapy payment would be considered as part of an integrated approach with the remaining payment methodology, we believed it was prudent to examine potential improvements and refinements to the overall SNF PPS payment system as well.

During this phase of the SNF PMR, Acumen hosted four Technical Expert Panels (TEPs), which brought together industry experts, stakeholders, and clinicians with the research team to

discuss different topics within the overall analytic framework. In February 2015, Acumen hosted a TEP to discuss questions and issues related to therapy case-mix classification. In November 2015, Acumen hosted a second TEP focused on questions and issues related to nursing case-mix classification, as well as to discuss issues related to payment for NTAs. In June 2016, Acumen hosted a third TEP to provide stakeholders with an outline of a potential revised SNF PPS payment structure, including new case-mix adjusted components and potential companion policies, such as variable per diem payment adjustments. Finally, in October 2016, Acumen hosted a fourth TEP, during which Acumen presented the case-mix components for a potential revised SNF PPS, as well as an initial impact analysis associated with the potential revised SNF PPS payment model. The presentation slides used during each of the TEPs, as well as a summary report for each TEP, is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

In the third phase of the contract, we tasked Acumen to assist in developing supporting language and documentation, most notably a technical report (the SNF PMR technical report), related to an earlier version of the alternative SNF PPS case-mix classification model we were considering, which we named the Resident Classification System, Version I (RCS–I). The SNF PMR technical report associated with the ANPRM is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

The final phase of the project, which began in October 2017, was focused on refinements to the alternative model. We received a large number of comments in response to the ANPRM introducing the RCS–I model. During the revision phase, Acumen conducted additional analyses based on the comments received and made a number of modifications to the payment model. The resulting case-mix classification model is the PDPM we are proposing. During the final phase of the project, Acumen produced a second technical report that presents the analyses and results that were used to develop the proposed revised payment model described in this proposed rule (the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).*

In the sections below, we outline each aspect of the proposed PDPM, as well as additional revisions to the SNF PPS which we are proposing along with the proposed implementation of the PDPM. We invite comments on any and all aspects of the proposed PDPM, including the research analyses described in this proposed rule, the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*) and the SNF PMR technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*).

C. Revisions to SNF PPS Federal Base Payment Rate Components

1. Background on SNF PPS Federal Base Payment Rates and Components

Section 1888(e)(4) of the Act requires that the SNF PPS per diem federal payment rates be based on FY 1995 costs, updated for inflation to the first effective period of the PPS. These base rates are then required to be adjusted to reflect differences among facilities in patient case-mix and in average wage levels by area. In keeping with this statutory requirement, the base per diem payment rates were set in 1998 and reflect average SNF costs in a base year (FY 1995), updated for inflation to the first period of the SNF PPS, which was the 15-month period beginning on July 1, 1998. The federal base payment rates were calculated separately for urban and rural facilities and based on allowable costs from the FY 1995 cost reports of hospital-based and freestanding SNFs, where allowable costs included all routine, ancillary, and capital-related costs (excluding those related to approved educational activities) associated with SNF services provided under Part A, and all services and items for which payment could be made under Part B prior to July 1, 1998.

In general, routine costs are those included by SNFs in a daily service charge and include regular room, dietary, and nursing services, medical social services and psychiatric social services, as well as the use of certain facilities and equipment for which a separate charge is not made. Ancillary costs are directly identifiable to residents and cover specialized services, including therapy, drugs, and laboratory services. Lastly, capital-related costs include the costs of land, building, and equipment and the interest incurred in financing the acquisition of such items. (63 FR 26253)

There are four federal base payment rate components which may factor into SNF PPS payment. Two of these components, ''nursing case-mix'' and ''therapy case-mix,'' are case-mix adjusted components, while the remaining two components, ''therapy non-case-mix'' and ''non-case-mix,'' are not case-mix adjusted. While we discuss the details of the proposed PDPM and justifications for certain associated policies we are proposing throughout section V of this proposed rule, we note that, as part of the PDPM case-mix model, we propose to bifurcate the ''nursing case-mix'' component of the federal base payment rate into two case-mix adjusted components and separate the ''therapy case-mix'' component of the federal base payment rate into three case-mix adjusted components, thereby creating five case-mix adjusted components of the federal base per diem rate. More specifically, we propose to separate the ''therapy case-mix'' rate component into a ''Physical Therapy'' (PT) component, ''Occupational Therapy'' (OT) component, and a ''Speech-Language Pathology'' (SLP) component. Our rationale for separating the therapy case-mix component in this manner is presented in section V.D.3.b. of this proposed rule. Based on the results of the SNF PMR, we also propose to separate the ''nursing case-mix'' rate component into a ''Nursing'' component and a ''Non-Therapy Ancillary'' (NTA) component. Our rationale for proposing to bifurcate the nursing case-mix component in this manner is presented in section V.D.3.d. of this proposed rule. Given that all SNF residents under PDPM would be assigned to a classification group for each of the three proposed therapy-related case-mix adjusted components as further discussed below, we propose eliminating the ''therapy non-case-mix'' rate component under PDPM and distributing the dollars associated with this current rate component amongst the proposed PDPM therapy components. The existing non-case-mix component would be maintained as it is currently constituted under the existing SNF PPS. Although the case-mix components of the proposed PDPM case-mix classification system would address costs associated with individual resident care based on an individual's specific needs and characteristics, the non-case-mix component addresses consistent costs that are incurred for all residents, such as room and board and various capital-related expenses. As these costs are not likely to change, regardless of what changes we might make to the SNF PPS, we propose to maintain the non-case-mix component as it is currently used.

In the next section, we discuss the methodology used to create the proposed PDPM case-mix adjusted components, as well as the data sources used in this calculation. The proposed methodology does not calculate new federal base payment rates but simply proposes to modify the existing base rate case-mix components for therapy and nursing. The methodology and data used in this calculation are based on the data and methodology used in the calculation of the original federal payment rates in 1998, as further discussed below.

2. Data Sources Utilized for Proposed Revision of Federal Base Payment Rate Components

Section II.A.2. of the interim final rule with comment period that initially implemented the SNF PPS (63 FR 26256 through 26260) provides a detailed discussion of the data sources used to calculate the original federal base payment rates in 1998. Except as discussed below, we propose to use the same data sources (that is, cost information from FY 1995 cost reports) to determine the portion of the therapy case-mix component base rate that would be assigned to each of the proposed therapy component base rates (PT, OT, and SLP). We believe that using the same data sources, to the extent possible, that were used to calculate the original federal base payment rates in 1998 results in base rates for the components that resemble as closely as possible what they would have been had these components initially been established in 1998. The portion of the nursing component base rate that corresponds to NTA costs was already calculated using the same data source used to calculate the federal base payment rates in 1998. As explained below, we used the previously calculated percentage of the nursing component base rate corresponding to NTA costs to set the NTA base rate and verified this calculation with the analysis described in section V.C.3. of this proposed rule. Therefore, the steps described below address the calculations performed to separate out the therapy base rates alone.

The percentage of the current therapy case-mix component of the federal base payment rates that would be assigned to the three proposed therapy components (PT, OT, and SLP) of the federal base payment rates was determined using cost information from FY 1995 cost reports, after making the following exclusions and adjustments: First, only settled and as-submitted cost reports for hospital-based and freestanding SNFs for periods beginning in FY 1995 and spanning 10 to 13 months were included. This set of restrictions replicates the restrictions used to derive the original federal base payment rates as set forth in the 1998 interim final rule with comment period (63 FR 26256). Following the methodology used to derive the SNF PPS base rates, routine and ancillary costs from as-submitted cost reports were adjusted down by 1.31 and 3.26 percent, respectively. As discussed in the 1998 interim final rule with comment period, the specific adjustment factors were chosen to reflect average adjustments resulting from cost report settlement and were based on a comparison of as-submitted and settled reports from FY 1992 to FY 1994 (63 FR 26256); these adjustments are in accordance with section 1888(e)(4)(A)(i) of the Act. We used similar data, exclusions, and adjustments as in the original base rates calculation so the resulting base rates for the components would resemble as closely as possible what they would have been had they been established in 1998. However, there were two ways in which the PT, OT, and SLP percentage calculations deviate from the 1998 base rates calculation. First, the 1998 calculation of the base rates excluded reports for facilities exempted from cost limits in the base year. The available data do not identify which facilities were exempted from cost limits in the base year, so this restriction was not implemented. We do not believe this had a notable impact on our estimate of the PT, OT, and SLP percentages, because only a small fraction of facilities were exempted from cost limits. Consistent with the 1998 base rates calculation, we excluded facilities with per diem costs more than three standard deviations higher than the geometric mean across facilities. Therefore, facilities with unusually high costs did not influence our estimate. Second, the 1998 calculation of the base rates excluded costs related to exceptions payments and costs related to approved educational activities. The available cost report data did not identify costs related to exceptions payments nor indicate what percentage of overall therapy costs or costs by therapy discipline were related to approved educational activities, so these costs are not excluded from the PT, OT, and SLP percentage calculations. Because exceptions were only granted for routine costs, we believe the inability to exclude these costs should not affect our estimate of the PT, OT, and SLP percentages as exceptions would not apply to therapy costs. Additionally, the data indicate that educational costs made up less than one-hundredth of 1 percent of overall SNF costs. Therefore, we believe that the inability to exclude educational costs should have a negligible impact on our estimates.

In addition to Part A costs from the cost report data, the 1998 federal base rates calculation incorporated estimates of amounts payable under Part B for covered SNF services provided to Part A SNF residents, as required by section 1888(e)(4)(A)(ii) of the Act. In calculating the PT, OT, and SLP percentages, we also estimated the amounts payable under Part B for covered SNF services provided to Part A residents. All Part B claims associated with Part A SNF claims overlapping with FY 1995 cost reports were matched to the corresponding facility's cost report. For each cost center (PT, OT, and SLP) in each cost report, a ratio was calculated to determine the amount by which Part A costs needed to be increased to account for the portion of costs payable under Part B. This ratio for each cost center was determined by dividing the total charges from the matched Part B claims by the total charges from the Part A SNF claims overlapping with the cost report. The 1998 interim final rule (63 FR 26256) states that to estimate the amounts payable under Part B for covered SNF services provided to Part A SNF residents, CMS (then known as HCFA) matched 100 percent of Part B claims associated with Part A covered SNF stays to the corresponding facility's cost report. Part B allowable charges were then incorporated at the facility level by the appropriate cost report center. Although the interim final rule does not provide further detail on how Part B allowable charges were incorporated at the facility level, we believe that our methodology reasonably approximates the methodology described in the interim final rule, and provides a reasonable estimate of the amounts payable under Part B for covered SNF services provided to Part A residents for purposes of calculating the PT, OT, and SLP percentages. Therefore, we believe it is reasonable to use this methodology to calculate the PT, OT, and SLP percentages of the therapy case-mix component.

Finally, the 1998 federal base rates calculation standardized the cost data for each facility to control for the effects of case-mix and geographic-related wage differences, as required by section 1888(e)(4)(C) of the Act. When calculating the PT, OT and SLP shares of the current therapy base rate, we replicated the method used in 1998 to standardize for wage differences, as

described in the 1998 interim final rule with comment period (63 FR 26259 through 26260). We applied a hospital wage index to the labor-related share of costs, estimated at 75.888 percent, and used an index composed of hospital wages from FY 1994. The PT, OT, and SLP percentage calculations did not include the case-mix adjustment used in the 1998 calculation because the 1998 adjustment relied on the obsolete RUG–III classification system. In the 1998 federal base rates calculation, information from SNF and inpatient claims was mapped to RUG–III clinical categories at the resident level to case-mix adjust facility per diem costs. However, the 1998 interim final rule did not document this mapping, and the data used as the basis for this adjustment are no longer available, and therefore, this step could not be replicated. We believe that the inability to apply the case-mix adjustment likely has a small impact on our estimate of the PT, OT, and SLP percentages. The 1998 interim final rule indicates that the case-mix adjustment was applied by dividing facility per diem costs for a given component by average facility case mix for that component; in other words, multiplying by the inverse of average facility case mix. As long as average facility case-mix values are within a relatively narrow range, adjustment for facility case mix should not have a large impact on the estimated PT, OT, and SLP percentages. Because the RUG–III case-mix indexes shown in the 1998 interim final rule are within a relatively narrow range (for example, therapy indexes range from 0.43 to 2.25), we do not expect the inability to apply the case-mix adjustment to facility per diem costs to have a large influence on the estimated PT, OT, and SLP percentages. These data sources are described in more detail in section 3.10. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

We invite comments on the data sources used to determine the PT, OT, and SLP rate components, as discussed above.

3. Methodology Used for the Calculation of Proposed Federal Base Payment Rate Components

As discussed previously in this section, we are proposing to separate the current therapy components into a PT component, an OT component, and an SLP component. To do this, we calculated the percentage of the current therapy component of the federal base rate that corresponds to each of the three proposed PDPM therapy components (PT, OT, and SLP) in accordance with the methodology set forth below.

The data described in section V.C.2. of this proposed rule (primarily, cost information from FY 1995 cost reports) provides cost estimates for the Medicare Part A SNF population for each cost report that met the inclusion criteria. Cost reports stratify costs by a number of cost centers that indicate different types of services. For instance, costs are reported separately for each of the three therapy disciplines (PT, OT, and SLP). Cost reports also include the number of Medicare Part A utilization days during the cost reporting period. This allows us to calculate both average total therapy costs per day and average therapy costs by discipline in the facility during the cost reporting period. Therapy costs are defined as the sum of costs for the three therapy disciplines.

The goal of this methodology is to estimate the fraction of therapy costs that corresponds to each of the three therapy disciplines. We use the facility-level per-diem costs developed from 1995 cost reports to derive average per diem amounts for both total therapy costs and for PT, OT, and SLP costs separately. To do this, we followed the methodology outlined in section II.A.3. of the 1998 interim final rule with comment period (63 FR 26260), which was used by CMS (then known as HCFA) to create the federal base payment rates:

(1) For each of the four measures of cost (PT, OT, SLP, and total therapy costs per day), we computed the mean based on data from freestanding SNFs only. This mean was weighted by the total number of Medicare days of the facility.

(2) For each of the four measures of cost (PT, OT, SLP, and total therapy costs per day), we computed the mean based on data from both hospital-based and freestanding SNFs. This mean was weighted by the total number of Medicare days of the facility.

(3) For each of the four measures of cost (PT, OT, SLP, and total therapy costs per day), we calculated the arithmetic mean of the amounts determined under steps (1) and (2) above.

In section 3.10.3. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*), we show the results of these calculations.

The three steps outlined above produce a measure of costs per day by therapy discipline and a measure of total therapy costs per day. We divided the discipline-specific (PT, OT, SLP) cost measure by the total therapy cost measure to obtain the percentage of the therapy component that corresponds to each therapy discipline. We believe that following a methodology to derive the discipline-specific therapy percentages that is consistent with the methodology used to determine the base rates in the 1998 interim final rule with comment period is appropriate because a consistent methodology helps to ensure that the resulting base rates for the components resemble what they would be had they been established in 1998. We found that PT, OT, and SLP costs correspond to 43.4 percent, 40.4 percent, and 16.2 percent of the therapy component of the federal per diem rate for urban SNFs, and 42.9 percent, 39.4 percent, and 17.7 percent of the therapy component of the federal per diem rate for rural SNFs. Under the proposed PDPM, the current therapy case-mix component would be separated into a Physical Therapy component, an Occupational Therapy component, and a Speech-Language Pathology component using the percentages derived above. This process would be done separately for urban and for rural facilities. In the appendix of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*) we provide the specific cost centers used to identify PT, OT, and SLP costs.

In addition, we propose to separate the current nursing case-mix component into a nursing case-mix component and an NTA component. Similar to the therapy component, we calculated the percentage of the current nursing component of the federal base rates that corresponds to each of the two proposed PDPM components (NTA and nursing). The 1998 reopening of the comment period for the interim final rule (63 FR 65561, November 27, 1998) states that NTA costs comprise 43.4 percent of the current nursing component of the urban federal base rate, and the remaining 56.6 percent accounts for nursing and social services salary costs. These percentages for the nursing component of the federal base rate for rural facilities are 42.7 percent and 57.3 percent, respectively (63 FR 65561). Therefore, we propose to assign 43 percent of the current nursing component of the federal base rates to the proposed new NTA component of the federal base rates and assign the remaining 57 percent to the new nursing component of the federal base rates to reflect what the base rates would have been for these components if they had been separately established in 1998.

We verified the 1998 calculation of the percentages of the nursing component federal base rates that correspond to NTA costs by developing a measure of NTA costs per day for urban and rural facilities. We used the same data (that is, cost information from 1995 cost reports) and followed the same methodology described above to develop measures of PT, OT, and SLP costs per day and total therapy costs per day. The measure of NTA costs per day produced by this analysis is $47.70 for urban facilities and $47.30 for rural facilities. The original 1998 federal base rates for the nursing component, which relied on a similar methodology, were $109.48 for urban facilities and $104.88 for rural facilities. Therefore, our measure of NTA costs in urban facilities was equivalent to 43.6 percent of the urban 1998 federal nursing base rate, and our measure of NTA costs in rural facilities was equivalent to 45.1 percent of the rural 1998 federal nursing base rate. These results are similar to the estimates published in the 1998 reopening of the comment period for the interim final rule (63 FR 65561, November 27, 1998), which we believe supports the validity of the 43 percent figure stated above.

For illustration purposes, Tables 12 and 13 set forth what the unadjusted federal per diem rates would be for each of the case-mix adjusted components if we were to apply the proposed PDPM to the proposed FY 2019 base rates given in Tables 4 and 5. These are derived by dividing the proposed FY 2019 SNF PPS base rates according to the percentages described above. Tables 12 and 13 also show what the unadjusted federal per diem rates for the non-case-mix component would be, which are not affected by the change in case-mix methodology from RUG–IV to PDPM. We use these unadjusted federal per diem rates in calculating the impact analysis discussed in section V.J. of this proposed rule.

TABLE 12—FY 2019 PDPM UNADJUSTED FEDERAL RATE PER DIEM—URBAN [3]

Rate component	Nursing	NTA	PT	OT	SLP	Non-case-mix
Per Diem Amount	$103.46	$78.05	$59.33	$55.23	$22.15	$92.63

[3] The rates shown in Tables 12 and 13 illustrate what the unadjusted federal per diem rates would be for each of the case-mix adjusted components if we were to apply the proposed PDPM to the proposed FY 2019 base rates given in Tables 4 and 5.

TABLE 13—FY 2019 PDPM UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	Nursing	NTA	PT	OT	SLP	Non-case-mix
Per Diem Amount	$98.83	$74.56	$67.63	$62.11	$27.90	$94.34

We invite comments on the proposed data sources and proposed methodology for calculating the unadjusted federal per diem rates that would be used in conjunction with the proposed PDPM effective October 1, 2019.

4. Proposed Updates and Wage Adjustments of Revised Federal Base Payment Rate Components

In section III.B. of this proposed rule, we describe the process used to update the federal per diem rates each year. Additionally, as discussed in section III.B.4 of this proposed rule, SNF PPS rates are adjusted for geographic differences in wages using the most recent hospital wage index data. Under PDPM, we propose to continue to update the federal base payment rates and adjust for geographic differences in wages following the current methodology used for such updates and wage index adjustments under the SNF PPS. Specifically, we propose to continue the practice of using the SNF market basket, adjusted as described in section III.B. of this proposed rule to update the federal base payment rates and to adjust for geographic differences in wages as described in section III.B.4. of this proposed rule.

D. Proposed Design and Methodology for Case-Mix Adjustment of Federal Rates

1. Background on Proposed PDPM

Section 1888(e)(4)(G)(i) of the Act requires that the Secretary provide an appropriate adjustment to account for case mix and that such an adjustment shall be based on a resident classification system that accounts for the relative resource utilization of different patient types. The current case-mix classification system uses a combination of resident characteristics and service intensity metrics (for example, therapy minutes) to assign residents to one of 66 RUGs, each of which corresponds to a therapy CMI and a nursing CMI, which are indicative of the relative cost to a SNF of treating residents within that classification category. However, as noted in section V.A. of this proposed rule, incorporating service-based metrics into the payment system can incentivize the provision of services based on a facility's financial considerations rather than resident needs. To better ensure that resident care decisions appropriately reflect each resident's actual care needs, we believe it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from verifiable resident characteristics that are patient, and not facility, centered. To that end, the proposed PDPM was developed to be a payment model which derives payment classifications almost exclusively from verifiable resident characteristics.

Additionally, the current RUG–IV case-mix classification system reduces the varied needs and characteristics of a resident into a single RUG–IV group that is used for payment. As of FY 2017, of the 66 possible RUG classifications, over 90 percent of covered SNF PPS days are billed using one of the 23 Rehabilitation RUGs, with over 60 percent of covered SNF PPS days billed using one of the three Ultra-High Rehabilitation RUGs. The implication of this pattern is that more than half of the days billed under the SNF PPS effectively utilize only a resident's therapy minutes and Activities of Daily Living (ADL) score to determine the appropriate payment for all aspects of a resident's care. Both of these metrics, more notably a resident's therapy minutes, may not derive so much from the resident's own characteristics, but rather, from the type and amount of care the SNF decides to provide to the resident. Even assuming that the facility takes the resident's needs and unique characteristics into account in making these service decisions, the focus of payment remains centered, to a potentially great extent, on the facility's

own decision making and not on the resident's needs.

While the RUG–IV model utilizes a host of service-based metrics (type and amount of care the SNF decides to provide) to classify the resident into a single RUG–IV group, the proposed PDPM would separately identify and adjust for the varied needs and characteristics of a resident's care and combine this information together to determine payment. We believe that the proposed PDPM would improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care. For these reasons, we propose that, effective October 1, 2019, SNF residents would be classified using the PDPM, as further discussed below. As discussed in section V.J. below, we propose to implement the PDPM on October 1, 2019 to allow all stakeholders adequate time for systems updates and staff training needed to assure smooth implementation.

2. Data Sources Utilized for Developing Proposed PDPM

To understand, research, and analyze the costs of providing Part A services to SNF residents, we utilized a variety of data sources in the course of research. In this section, we discuss these sources and how they were used in the SNF PMR in developing the proposed PDPM. A more thorough discussion of the data sources used during the SNF PMR is available in section 3.1. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*).

a. Medicare Enrollment Data

Beneficiary enrollment and demographic information was extracted from the CMS enrollment database (EDB) and Common Medicare Environment (CME). Beneficiaries' Medicare enrollment was used to apply restrictions to create a study population for analysis. For example, beneficiaries were required to have continuous Medicare Part A enrollment during a SNF stay. Demographic characteristics (for example, age) were incorporated as being predictive of resource use. Furthermore, enrollment and demographic information from these data sources were used to assess the impact of the proposed PDPM on subpopulations of interest. In particular, the EDB and CME include indicators for potentially vulnerable subpopulations, such as those dually-enrolled in Medicaid and Medicare.

b. Medicare Claims Data

Medicare Parts A and B claims from the CMS Common Working File (CWF) were used to conduct claims analyses as part of the SNF PMR. SNF claims (CMS–1450 form, OMB control number 0938–0997), including type of bill (TOB) 21x (SNF Inpatient Part A) and 18x (hospital swing bed), were used to identify Medicare Part A stays paid under the SNF PPS. Part A stays were constructed by linking claims that share the same beneficiary, facility CMS Certification Number (CCN), and admission date. Stays created from SNF claims were linked to other claims data and assessment data via beneficiary identifiers.

Acute care hospital stays that qualified the beneficiary for the SNF benefit were identified using Medicare inpatient hospital claims. The dates of the qualifying hospital stay listed in the span codes of the SNF claim were used to connect inpatient claims with those dates listed as the admission and discharge dates. Although there are exceptions, the claims from the preceding inpatient hospitalization commonly contain clinical and service information relevant to the care administered during a SNF stay. Components of this information were used in the regression models predicting therapy and NTA costs and to better understand patterns of post-acute care (PAC) referrals for patients requiring SNF services. Additionally, the most recent hospital stay was matched to the SNF stay, which often (though not always) was the same as the preceding inpatient hospitalization, and used in the regression models.

Other Medicare claims, including outpatient hospital, physician, home health, hospice, durable medical equipment, and drug prescriptions, were incorporated, as necessary, into the analysis in one of three ways: (1) to verify information found on assessments or on SNF or inpatient claims; (2) to provide additional resident characteristics to test outside of those found in assessment and SNF and inpatient claims data; and (3) to stratify modeling results to identify effects of the system on beneficiary subpopulations. These claims were linked to SNF claims using beneficiary identifiers.

c. Assessment Data

Minimum Data Set (MDS) assessments were the primary source of resident characteristic information used to explain resource utilization in the SNF setting. The data repositories include MDS assessments submitted by SNFs and swing-bed hospitals. MDS version 2.0 assessments were submitted until October 2010, at which point MDS version 3.0 assessments began. MDS data were extracted from the Quality Improvement Evaluation System (QIES). MDS assessments were then matched to SNF claims data using the beneficiary identifier, assessment indicator, assessment date, and Resource Utilization Group (RUG).

d. Facility Data

Facility characteristics, while not considered as explanatory variables when modeling service use, were used for impact analyses. By incorporating this facility-level information, we could identify any disproportionate effects of the proposed case-mix classification system on different types of facilities.

Facility-level characteristics were taken from the Certification and Survey Provider Enhanced Reports (CASPER). From CASPER, we draw facility-level characteristics such as ownership, location, facility size, and facility type. CASPER data were supplemented with information from publicly available data sources. The principal data sources that are publicly available include the Medicare Cost Reports (Form 2540–10, 2540–96, and 2540–92) extracted from the Healthcare Cost Report Information System (HCRIS) files, Provider-Specific Files (PSF), Provider of Service files (POS), and Nursing Home Compare (NHC). These data sources have information on facility costs, payment, and characteristics that directly affect PPS calculations.

3. Proposed Resident Classification Under PDPM

a. Background

As noted above, section 1888(e)(4)(G)(i) of the Act requires that the Secretary provide for an appropriate adjustment to account for case mix and that such an adjustment shall be based on a resident classification system that accounts for the relative resource utilization of different patient types. The proposed PDPM was developed to be a payment model which derives almost exclusively from resident characteristics. The proposed PDPM would separately identify and adjust five different case-mix components for the varied needs and characteristics of a resident's care and then combine these together with the non-case-mix component to form the full SNF PPS per diem rate for that resident.

As with any case-mix classification system based on resident characteristics, the proposed predictors that would be part of case-mix classification under

PDPM are those which our analysis identified as associated with variation in costs for the given case-mix component. The proposed federal per diem rates discussed above serve as ''base rates'' specifically because they set the basic average cost of treating a typical SNF resident. Based on the presence of certain needs or characteristics, caring for certain residents may cost more or less than that average cost. A case-mix system identifies certain aspects of a resident or of a resident's care which, when present, lead to average costs for that group being higher or lower than the average cost of treating a typical SNF resident. For example, if we found that therapy costs were the same for two residents regardless of having a particular condition, then that condition would not be relevant in predicting increases in therapy costs. If, however, we found that, holding all else constant, the presence of a given condition was correlated with an increase in therapy costs for residents with that condition over those without that condition, then this could mean that this condition is indicative, or predictive, of increased costs relative to the average cost of treating SNF residents generally.

In the subsections that follow, we describe each of the five proposed case-mix adjusted components under the proposed PDPM and the basis for each of the proposed predictors that would be used within the proposed PDPM to classify residents for payment purposes.

b. Proposed Physical and Occupational Therapy Case-Mix Classification

A fundamental aspect of the proposed PDPM is to use resident characteristics to predict the costs of furnishing similarly situated residents with SNF care. Costs derived from the charges on claims and cost-to-charge ratios (CCRs) on facility cost reports were used as the measure of resource use to develop the proposed PDPM. Costs better reflect differences in the relative resource use of residents as opposed to charges, which partly reflect decisions made by providers about how much to charge payers for certain services. Costs derived from charges are reflective of therapy utilization as they are correlated to the therapy minutes recorded for each therapy discipline. Under the current RUG–IV case-mix model, therapy minutes for all three therapy disciplines (PT, OT, SLP) are added together to determine the appropriate case-mix classification for the resident. However, as shown in section 3.3.1. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*), when we began to investigate resident characteristics predictive of therapy costs for each therapy discipline, we found that PT and OT costs per day are only weakly correlated with SLP costs per day (correlation coefficient of 0.04). The set of resident characteristics from the MDS that predicted PT and OT utilization was different than the set of characteristics predicting SLP utilization. Additionally, many predictors of high PT and OT costs per day predicted lower SLP costs per day, and vice versa. For example, residents with cognitive impairments receive less physical and occupational therapy but receive more speech-language pathology. As a result of this analysis, we found that basing case-mix classification on total therapy costs per day obscured differences in the determinants of PT, OT, and SLP utilization.

In contrast, the correlation coefficient between PT and OT costs per day was high (0.62). Additionally, regression analyses found that predictors of high PT costs per day were also predictive of high OT costs per day. For example, the analyses found that late-loss ADLs are strong predictors of both PT and OT costs per day. We then used a range of resident characteristics to predict PT and OT costs per day separately and we found that the coefficients in both models followed similar patterns. Finally, resident characteristics were found to be better predictors of the sum of PT and OT costs per day than for either PT or OT costs separately. These analyses used a variety of items from the MDS as independent variables and used PT, OT, and SLP costs per day as dependent variables. More information on these analyses can be found in section 3.3.1. of the SNF PMR technical report that accompanied the ANPRM available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

Given the results of this analytic work as well as feedback from multiple stakeholders, we propose three separate case-mix adjusted components, one corresponding to each therapy discipline: PT, OT, and SLP. In the original RCS–I model presented in the ANPRM, we stated that we were considering addressing PT and OT services through a single component, given the strong correlation between PT and OT costs and our finding that very similar predictors explained variation in the utilization of both therapy disciplines. However, commenters on the ANPRM stated that having a single combined PT and OT component could encourage providers to inappropriately substitute PT for OT and vice versa. This belief comports with feedback received from professional organizations and other stakeholders during technical expert panels (TEPs). The TEP commenters stated that PT and OT services should be addressed via separate components given the different aims of the two therapy disciplines and differences in the clinical characteristics of the resident subpopulations for which PT or OT services are warranted. For example, clinicians consulted during development of PDPM advised that personal hygiene, dressing, and upper extremity motion may bear a closer clinical relationship to OT utilization, while lower extremity motion may be more closely related to PT utilization. While we do not believe that RCS–I, which included two separate components for PT/OT and SLP, contained stronger incentives for substitution across therapy disciplines compared to RUG–IV, which reimburses all three therapy disciplines through a single therapy component, we concur with the TEP commenters that PT and OT have different aims and that there are clinically relevant differences between residents who could benefit from PT, residents who could benefit from OT, and residents who could benefit from both disciplines. For the foregoing reasons, we decided to separate the combined PT/OT component presented in the ANPRM into two separate case-mix adjusted components in the proposed PDPM. Because of the strong correlation between the dependent variables used for both components and the similarity in predictors, we decided to maintain the same case-mix classification model for both components. In practice, this means that the same resident characteristics will determine a resident's classification for PT and OT payment. However, each resident will be assigned separate case-mix groups for PT and OT payment, which correspond to separate case-mix indexes and payment rates. We believe that providing separate case-mix-adjusted payments for PT and OT may allay concerns about inappropriate substitution across disciplines and encourage provision of these services according to clinical need. As clinical practices evolve independently of incentives created by the current RUG–IV payment model, we would re-evaluate the different sets of resident characteristics that are predictive of PT and OT utilization after the proposed PDPM is implemented. If based on this re-evaluation we determine that

different sets of characteristics are predictive of PT and OT resource utilization, we can consider revising the payment model to better reflect clinical differences between residents who receive PT services and those who receive OT services.

After delineating the three separate case-mix adjusted therapy components, we continued our analysis by identifying resident characteristics that were best predictive of PT and OT costs per day. To accomplish this, we conducted cost regressions with a host of variables from the MDS assessment, the prior inpatient claims, and the SNF claims that were believed to be potentially predictive of relative increases in PT and OT costs. The variables were selected with the goal of being as inclusive as possible with respect to characteristics related to the SNF stay and the prior inpatient stay. The selection also incorporated clinical input. These initial costs regressions were exploratory and meant to identify a broad set of resident characteristics that are predictive of PT and OT resource utilization. The results were used to inform which variables should be investigated further and ultimately included in the payment system. A table of all of the variables considered as part of this analysis appears in the appendix of the SNF PMR technical report that accompanied the ANPRM available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* Based on our regression analyses, we found that the three most relevant categories of predictors of PT and OT costs per day were the clinical reasons for the SNF stay, the resident's functional status, and the presence of a cognitive impairment. More information on this analysis can be found in section 3.4.1. of the SNF PDPM technical report available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

Under the RUG–IV case-mix model, residents are first categorized based on being a rehabilitation resident or a non-rehabilitation resident, then categorized further based on additional aspects of the resident's care. Under the proposed PDPM, for the purposes of determining the resident's PT and OT groups and, as will be discussed below, the resident's SLP group, the resident would first be categorized based on the clinical reasons for the resident's SNF stay. Empirical analyses demonstrated that the clinical basis for the resident's stay (that is, the primary reason the resident is in the SNF) is a strong predictor of therapy costs. For example, all of the clinical categories (described below) developed to characterize the primary reason for a SNF stay (except the clinical category used as the reference group) were found to be statistically significant predictors of therapy costs per day. More detail on these analyses can be found in section 3.4.1. of the SNF PMR technical report that accompanied the ANPRM (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).* In consultation with stakeholders (industry representatives, beneficiary representatives, clinicians, and payment policy experts) at multiple technical expert panels (TEPs), we created a set of ten inpatient clinical categories that we believe capture the range of general resident types which may be found in a SNF. These proposed clinical categories are provided in Table 14.

TABLE 14—PROPOSED PDPM CLINICAL CATEGORIES

Major Joint Replacement or Spinal Surgery	Cancer.
Non-Surgical Orthopedic/Musculoskeletal	Pulmonary.
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Cardiovascular and Coagulations.
Acute Infections	Acute Neurologic.
Medical Management	Non-Orthopedic Surgery.

We propose to categorize a resident into a PDPM clinical category using item I8000 on the MDS 3.0. Providers would use the first line in item I8000 to report the ICD–10–CM code that represents the primary reason for the resident's Part A SNF stay. This code would be mapped to one of the ten clinical categories provided in Table 14. The mapping between ICD–10–CM codes and the ten clinical categories is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* The mapping indicates that in some cases, a single ICD–10–CM code maps to more than one clinical category because the care plan for a resident with this diagnosis may differ depending on the inpatient procedure history. In these cases, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the immediately preceding inpatient stay that relates to the primary reason for the Part A SNF stay and typically requires extensive post-surgical rehabilitation or nursing care. If the resident did not receive a related surgical procedure during the prior inpatient stay that typically requires extensive post-surgical rehabilitation or nursing care, the resident may be categorized into a non-surgical clinical category. For example, certain wedge compression fractures that were treated with an invasive surgical procedure such as a fusion during the prior inpatient stay would be categorized as Major Joint Replacement or Spinal Surgery, but if these cases were not treated with a surgical procedure they would be categorized as Non-Surgical Orthopedic/Musculoskeletal. For residents who received a related surgical procedure during the prior inpatient stay, a provider would need to indicate the type of surgical procedure performed for the resident to be appropriately classified under PDPM. Thus, in these cases we are proposing to require providers to record the type of inpatient surgical procedure performed during the prior inpatient stay so that residents can be appropriately classified into a PDPM clinical category for purposes of PT, OT, and SLP classification. We propose that providers record the type of surgical procedure performed during the prior inpatient stay by coding an ICD–10–PCS code that corresponds to the inpatient surgical procedure in the second line of item I8000 in cases where inpatient surgical information is required to appropriately categorize a resident under PDPM. If we were to use the second line of item I8000 to record inpatient surgical information, we would provide a list of ICD–10–PCS codes that map to the surgical clinical categories. We believe this approach would allow for patients to be appropriately classified under the PDPM because it would provide sufficient information on the primary reason for SNF care and inpatient surgical procedures to assign a resident to the appropriate surgical or non-surgical clinical category. We invite comments on this proposal. In addition, we solicit comments on alternative methods for recording the type of inpatient surgical procedure to

appropriately classify a patient into a clinical category. The clinical category into which the resident is classified would be used to classify the resident into a PT and OT category as discussed below, as well as an SLP category, as explained in section V.D.3.c. of this proposed rule.

As discussed above, we propose to categorize a resident into a PDPM clinical category for purposes of PT, OT, and SLP classification using the ICD–10–CM code in the first line of item I8000, and if applicable, the ICD–10 PCS code in the second line of item I8000. As an alternative to using item I8000 to classify a resident into a clinical category, we are considering using a resident's primary diagnosis as reflected in MDS item I0020 as the basis for assigning the resident to a clinical category, and are evaluating the categories provided in item I0020 to determine if there is sufficient overlap between the categories used in item I0020 and the proposed PDPM clinical categories provided in Table 14 above that this item could serve as the basis for a resident's initial classification into a clinical category under PDPM. The MDS item I0020 would require facilities to select a primary diagnosis from a pre-populated list of primary diagnoses representing the most common types of beneficiaries treated in a SNF, while item I8000, if used to assign residents to clinical categories, would require facilities to code a specific ICD–10–CM code that corresponds to the primary reason for the resident's Part A SNF stay. As indicated above, we are also proposing that providers would code a specific ICD–10–PCS code in the second line of item I8000 when surgical information from the prior inpatient stay is necessary to assign a resident to a clinical category. If we were to use item I0020 to categorize residents under PDPM, we would not require providers to record additional information on inpatient surgical procedures as we expect the primary diagnosis information provided through item I0020 to be adequate to appropriately assign a resident to a clinical category. We invite comments on our proposal to categorize a resident into a PDPM clinical category using the ICD–10–CM code recorded in the first line of item I8000 on the MDS 3.0, and the ICD–10–PCS code recorded on the second line of item I8000 on the MDS 3.0. In addition, we solicit comments on the alternative of using item I0020 on the MDS 3.0, as discussed above, as the basis for resident classification into one of the ten clinical categories in Table 14.

Once we identified these clinical categories as being generally predictive of resource utilization in a SNF, we then undertook the necessary work to identify those categories predictive of PT and OT costs specifically. We conducted additional regression analyses to determine if any of these categories predicted similar levels of PT and OT as other categories, which may provide a basis for combining categories. As a result of this analysis, for the RCS–I model presented in the ANPRM, we found that the ten inpatient clinical categories could be collapsed into five clinical categories, which predict varying degrees of PT and OT costs. However, we received comments on the ANPRM regarding the number of possible case-mix group combinations under RCS–I, so we sought to try and reduce this number of possible case-mix group combinations by further simplifying the model. As part of that effort, we observed similar PT and OT resource utilization patterns in the clinical categories of Non-Orthopedic Surgery and Acute Neurologic and, therefore, propose to collapse these categories for the purpose of PT and OT classification. Additionally, as reflected in the RCS–I model presented in the ANPRM, we propose that under PDPM, the remaining clinical categories would be collapsed as follows: Acute infections, cancer, pulmonary, cardiovascular and coagulations, and medical management would be collapsed into one clinical category entitled ''Medical Management'' because their residents had similar PT and OT costs. Similarly, we propose that orthopedic surgery (except major joint replacement or spinal surgery) and non-surgical orthopedic/musculoskeletal would be collapsed into a new ''Other Orthopedic'' category for equivalent reasons. Finally, the remaining category, Major Joint Replacement, showed a distinct PT and OT cost profile and, thus, we propose to retain it as an independent category. More information on this analysis can be found in section 3.4.2. of the SNF PMR technical report that accompanied the ANPRM and in section 3.4.2. of the SNF PDPM technical report, both available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* These proposed collapsed categories, which would be used to categorize a resident initially under the proposed PT and OT case-mix components, are presented in Table 15.

TABLE 15—PROPOSED COLLAPSED CLINICAL CATEGORIES FOR PT AND OT CLASSIFICATION

PDPM clinical category	Collapsed PT and OT clinical category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery.
Non-Orthopedic Surgery	Non-Orthopedic Surgery and Acute Neurologic.
Acute Neurologic	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic.
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	
Medical Management	Medical Management.
Acute Infections	
Cancer	
Pulmonary	
Cardiovascular and Coagulations	

As discussed previously in this section, regression analyses demonstrated that the resident's functional status is also predictive of PT and OT costs in addition to the resident's initial clinical categorization. In the RCS–I model discussed in the ANPRM, we presented a function score similar to the existing ADL score to measure functional abilities for the purposes of PT and OT payment. In response to the ANPRM, we received comments requesting that we consider replacing the functional items used to build the RCS–I function score with newer, IMPACT Act-compliant items from section GG. Therefore, we constructed, and are proposing as discussed below, a new function score for PT and OT payment based on section GG functional items.

Under the RUG–IV case-mix system, a resident's ADL or function score is calculated based on a combination of self-performance and support items coded by SNFs in section G of the MDS 3.0 for four ADL areas: Transfers, eating, toileting, and bed mobility. These four areas are referred to as late-loss ADLs because they are typically the last functional abilities to be lost as a resident's function declines. Each ADL is assigned a score of up to four points, with a potential total score as high as 16 points. Under the proposed PDPM, we propose that section G items would be replaced with functional items from section GG of the MDS 3.0 (Functional Abilities and Goals) as the basis for calculating the function score for resident classification used under PDPM. Section GG offers standardized and more comprehensive measures of functional status and therapy needs. Additionally, the use of section GG items better aligns the payment model with other quality initiatives. SNFs have been collecting section GG data since October 2016 as part of the requirements for the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Given the advantages of section GG and of using a more comprehensive measure of functional abilities, we received numerous comments in response to ANPRM requesting the incorporation of section GG items and of early ADLs items into the function score.

Multiple stakeholders commented that late-loss items do not adequately reflect functional abilities on their own. These commenters stated that early-loss ADL items also capture essential clinical information on functional status. Therefore, in building a new function score based on section GG items, we also investigated the incorporation of early-loss items. To explore the incorporation of section GG items, we evaluated each item's relationship with PT and OT costs. We ran individual regressions using each of the 12 section GG item assessed at admission to separately predict PT and OT costs per day. The regression results showed that early-loss items are indeed strong predictors of PT and OT costs, with the exception of two wheeling items. Both wheeling items were excluded from the functional measure due to their weak predictive relationship with PT and OT costs. We observed high predictive ability among the remaining items. In total, we selected ten items for inclusion in the functional measure for the PT and OT components based on the results of the analysis. Thus, under the proposed functional measure for the PT and OT components, a resident's function would be measured using four late-loss ADL activities (bed mobility, transfer, eating, and toileting) and two early-loss ADL activities (oral hygiene and walking). Specifically, the proposed measure includes: Two bed mobility items, three transfer items, one eating item, one toileting item, one oral hygiene item, and two walking items that were all found to be highly predictive of PT and OT costs per day. A list of proposed section GG items that would be included in the functional measure for the PT and OT components is shown in Table 18. Section 3.4.1. in the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html)* provides more detail on these analyses.

Similar to the RUG–IV ADL score, each of these ADL areas would be assigned a score of up to 4 points. However, in contrast to the RUG–IV ADL score, points are assigned to each response level to track functional independence rather than functional dependence. In other words, higher points are assigned to higher levels of independence. This approach is consistent with functional measures in other care settings, such as the IRF PPS. Further, under the RUG–IV model, if the SNF codes that the ''activity did not occur'' or ''occurred only once,'' these items are assigned the same point value as ''independent.'' However, we observed that residents who were unable to complete an activity had similar PT and OT costs as dependent residents. Therefore, when the activity cannot be completed, the equivalent section GG responses (''Resident refused,'' ''Not applicable,'' ''Not attempted due to medical condition or safety concerns'') are grouped with ''dependent'' for the purpose of point assignment. For the two walking items, we propose an additional response level to reflect residents who skip the walking assessment due to their inability to walk. We believe this is appropriate because this allows us to assess the functional abilities of residents who cannot walk and assign them a function score. Without this modification, we could not calculate a function score for residents who cannot walk because they would not be assessed on the two walking items included in the function score. Residents who are coded as unable to walk receive the same score as dependent residents to match with clinical expectations. In Tables 16 and 17, we provide the proposed scoring algorithm for the PT and OT functional measure.

TABLE 16—PROPOSED PT AND OT FUNCTION SCORE CONSTRUCTION (EXCEPT WALKING ITEMS)

	Response	Score
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted	0

TABLE 17—PROPOSED PT AND OT FUNCTION SCORE CONSTRUCTION FOR WALKING ITEMS

	Response	Score
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted, Resident Cannot Walk *	0

* Coded based on response to GG0170H1 (Does the resident walk?).

Unlike section G, section GG measures functional areas with more than one item. This results in substantial overlap between the two bed mobility items, the three transfer items, and the two walking items. Because of this overlap, a simple sum of all scores for each item may inappropriately overweight functional areas measured by multiple items. Therefore, to adjust for this overlap, we propose to calculate an average score for these related items. That is, we would average the scores for the two bed mobility items, the three transfer items, and the two walking items. The average bed mobility, transfer, and walking scores would then be summed with the scores for eating, oral hygiene, and toileting hygiene, resulting in equal weighting of the six activities. This proposed scoring algorithm produces a function score that ranges from 0 to 24. In section 3.4.1. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html),* we provide additional information on the analyses that led to the construction of this proposed function score.

TABLE 18—PROPOSED SECTION GG ITEMS INCLUDED IN PT AND OT FUNCTIONAL MEASURE

	Section GG item	Score
GG0130A1	Self-care: Eating	0–4
GG0130B1	Self-care: Oral Hygiene	0–4
GG0130C1	Self-care: Toileting Hygiene	0–4
GG0170B1	Mobility: Sit to lying	0–4 (average of 2 items).
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0–4 (average of 3 items).
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0–4 (average of 2 items).
GG0170K1	Mobility: Walk 150 feet	

Under the RCS–I case-mix model presented in the ANPRM, we used cognitive status to classify residents under the PT and OT components in addition to the primary reason for SNF care and functional ability. As will be explained in greater detail below, after publication of the ANPRM, we removed cognitive status as a determinant of resident classification for the PT and OT components. Still, although cognitive status was not ultimately selected as a determinant of PT and OT classification, it was considered as a possible element in developing the proposed resident groups for these components via the Classification and Regression Trees (CART) algorithm described in greater detail below. Because we included cognitive status as an independent variable in the CART analysis used to develop case-mix groups for PT and OT, we believe it is appropriate to discuss construction of the proposed new cognitive measure here even though it was not ultimately selected as a determinant of payment for PT and OT. Thus, we will discuss construction of the instrument used to measure cognitive status under the proposed PDPM here, rather than introducing it when discussing SLP classification, in which we propose cognitive status as a determinant of resident classification. Under the current SNF PPS, cognitive status is used to classify a small portion of residents that fall into the Behavioral Symptoms and Cognitive Performance RUG–IV category. For all other residents, cognitive status is not used in determining the appropriate payment for a resident's care. However, industry representatives and clinicians at multiple TEPs suggested that a resident's cognitive status can have a significant impact on a resident's PT and OT costs. Based on this feedback, we explored a resident's cognitive status as a predictor of PT and OT costs.

Under the RUG–IV model, cognitive status is assessed using the Brief Interview for Mental Status (BIMS) on the MDS 3.0. The BIMS is based on three items: ''repetition of three words,'' ''temporal orientation,'' and ''recall.'' These items are summed to produce the BIMS summary score. The BIMS score ranges from 0 to 15, with 0 assigned to residents with the worst cognitive performance and 15 assigned to residents with the highest performance. Residents with a BIMS score less than or equal to 9 classify for the Behavioral Symptoms and Cognitive Performance category. Residents with a summary score greater than 9 but not 99 (resident interview was not successful) are considered cognitively intact for the purpose of classification under RUG–IV.

In approximately 15 percent of 5-day MDS assessments, the BIMS is not completed: In 12 percent of cases the interview is not attempted, and for 3 percent of cases the interview is attempted but cannot be completed. The MDS directs assessors to skip the BIMS if the resident is rarely or never understood (this is scored as ''skipped''). In these cases, the MDS requires assessors to complete the Staff Assessment for Mental Status (items C0700 through C1000). The Cognitive Performance Scale (CPS) is then used to assess cognitive function based on the Staff Assessment for Mental Status and other MDS items (''Comatose'' (B0100), ''Makes Self Understood'' (B0700), and the self-performance items of the four late-loss ADLs). The Staff Assessment for Mental Status consists of four items: ''Short-term Memory OK,'' ''Long-term Memory OK,'' ''Memory/Recall Ability,'' and ''Cognitive Skills for Daily Decision Making.'' Only ''Short-term Memory OK'' and ''Cognitive Skills for Daily Decision Making'' are currently used for payment. In MDS 2.0, the CPS was used as the sole measure of cognitive status. A resident was assigned a CPS score from 0 to 6 based on the Staff Assessment for Mental Status and other MDS items, with 0 indicating the resident was cognitively intact and 6 indicating the highest level of cognitive impairment. In addition to the items on the Staff Assessment for Mental Status, MDS items ''Comatose'' (B0100), ''Makes Self Understood'' (B0700), and the self-performance items of the four late-loss ADLs factored into the CPS score. Any score of 3 or above was considered cognitively impaired. The CPS on the current version of the MDS (3.0) functions very similarly. Instead of assigning a score to each resident, a resident is determined to be cognitively impaired if he or she meets the criteria to receive a score of 3 or above on the CPS, based on the MDS items mentioned above. In other words, whereas the MDS 2.0 assigned a CPS score to each resident, the MDS 3.0 only determines whether a resident's score is greater than or equal to 3 and does not

assign a specific score to each resident for whom the CPS is used to assess cognitive status. Residents who are determined to be cognitively impaired based on the CPS are classified in the Behavioral Symptoms and Cognitive Performance category under RUG–IV, if they do not meet the criteria for a higher-paying category.

Given that the 15 percent of residents who are not assessed on the BIMS must be assessed using a different scale that relies on a different set of MDS items, there is currently no single measure of cognitive status that allows comparison across all residents. To address this issue, Thomas et al., in a 2015 paper, proposed use of a new cognitive measure, the Cognitive Function Scale (CFS), which combines scores from the BIMS and CPS into one scale that can be used to compare cognitive function across all residents (Thomas KS, Dosa D, Wysocki A, Mor V; *The Minimum Data Set 3.0 Cognitive Function Scale.* Med Care. *https://www.ncbi.nlm.nih.gov/pubmed/?term=25763665*). Following a suggestion from the June 2016 TEP, we explored using the CFS as a measure of cognition and found that there is a relationship between the different levels of the cognitive scale and resident costs. Specifically, we observed that as cognitive function declines, PT and OT costs per day decrease, while SLP costs per day more than double. More information on this analysis can be found in section 3.4.1. of the SNF PMR technical report that accompanied the ANPRM available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* Based on these initial investigations, we used the CFS as a cognitive measure in the RCS–I payment model described in the ANPRM. As we noted above, the RUG–IV system incorporates both the BIMS and CPS score separately, but the CFS blends them together into one measure of cognitive status. Details on how the BIMS score and CPS score are determined using the MDS assessment are described above. The CFS uses these scores to place residents into one of four cognitive performance categories, as shown in Table 19. After publication of the ANPRM, we received stakeholder comments questioning this scoring methodology, specifically the classification of a CPS score of 0 as ''mildly impaired.'' Based on a subsequent analysis showing that residents with a CPS score of 0 were similar to residents classified as ''cognitively intact'' under the CFS methodology, as well as clinical feedback, we determined that it was appropriate to reclassify residents with a CPS score of 0 as cognitively intact, consistent with ANPRM feedback. This analysis is described in more detail in section 3.4.1. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* The scoring methodology for the proposed PDPM cognitive measure is shown in Table 20. We would note once again that while we discuss this scoring methodology in this section because cognitive status was considered in developing the PT and OT classification, the cognitive score is not being proposed as a factor of classification for the PT and OT components under PDPM, as further discussed below.

TABLE 19—COGNITIVE FUNCTION SCALE (CFS) SCORING METHODOLOGY

Cognitive level	BIMS score	CPS score
Cognitively Intact	13–15	—
Mildly Impaired	8–12	0–2
Moderately Impaired	0–7	3–4
Severely Impaired	—	5–6

TABLE 20—PROPOSED PDPM COGNITIVE MEASURE CLASSIFICATION METHODOLOGY

Cognitive level	BIMS score	CPS score
Cognitively Intact	13–15	0
Mildly Impaired	8–12	1–2
Moderately Impaired	0–7	3–4
Severely Impaired	—	5–6

Once each of these variables—clinical reasons for the SNF stay, the resident's functional status, and the presence of a cognitive impairment—was identified, we then used a statistical regression technique called Classification and Regression Trees (CART) to explore the most appropriate splits in PT and OT case-mix groups using these three variables. In other words, CART was used to investigate how many PT and OT case-mix groups should exist under the proposed PDPM and what types of residents or score ranges should be combined to form each of those PT and OT case-mix groups. CART is a non-parametric decision tree learning technique that produces either classification or regression trees, depending on whether the dependent variable is categorical or numeric, respectively. Using the CART technique to create payment groups is advantageous because it is resistant to both outliers and irrelevant parameters. The CART algorithm has been used to create payment groups in other Medicare settings. For example, it was used to determine Case Mix Groups (CMGs) splits within rehabilitation impairment groups (RICs) when the inpatient rehabilitation facility (IRF) PPS was developed. This methodology is more thoroughly explained in section 3.4.2. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*).

We used CART to develop splits within the four collapsed clinical categories shown in Table 15. Splits within each of these four collapsed clinical categories were based on the two independent variables included in the algorithm: Function score and cognitive status. The CART algorithm split residents into 18 groups for the PT component and 14 groups for the OT component. These splits are primarily based on differences in resident function. In the CART-generated groups, cognitive status plays a role in categorizing less than half of the PT groups and only two of the 14 OT groups. In addition, to create the

proposed resident classification for the PT and OT components, we made certain administrative decisions that further refined the PT and OT case-mix classification groups beyond those produced through use of the CART algorithm. For example, while CART may have created slightly different breakpoints for the function score in different clinical categories, we believe that using a consistent split in scores across clinical categories improves the simplicity of the case-mix model without compromising its accuracy. Therefore, we used the splits created by the CART algorithm as the basis for the consistent splits selected for the case-mix groups, simplifying the CART output while retaining important features of the CART-generated splits. In our proposed classification for the PT and OT components, we retained function as the sole determinant of resident categorization within each of the four collapsed clinical categories. We created function score bins based on breakpoints that recurred in the CART splits, such as 5, 9, and 23. As noted above, we dropped cognitive status as a determinant of classification because of the reduced role it played in categorizing residents within the CART-generated groups. Finally, we used the same function score bins to categorize residents within each of the four collapsed clinical categories for both the PT and OT components. As shown in section 3.4.2. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html)*, using the proposed case-mix groups for the PT and OT components results in a reduction of 0.005 in the R-squared values for both PT and OT classification models. This shows that although the proposed case-mix groups improve simplicity by removing one predictor revealed to be less important in categorizing residents (cognitive status) and grouping residents similarly (using the same function score bins) across clinical categories, these decisions have only a minor negative impact on predictive accuracy. These analyses are described in further detail in section 3.4.2. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*).

Based on the CART results and the administrative decisions described above, we propose 16 case-mix groups to classify residents for PT and OT payment. We would note that this represents a marked reduction in the number of case-mix groups for PT and OT classification under the RCS–I model discussed in the ANPRM. As discussed throughout the sections above, after publication of the ANPRM, we received feedback from stakeholders that the RCS–I payment model was overly complex. In particular, commenters expressed concern about the relatively large number of possible combinations of case-mix groups. Based on this feedback, we sought to reduce the number of resident groups in the PT and OT components. First, because we observed similar PT and OT resource utilization patterns in the clinical categories of Non-Orthopedic Surgery and Acute Neurologic, we decided to collapse these categories for the purpose of PT and OT classification. In addition, as discussed in this section, we replaced the section G-based functional measure from RCS–I with a new functional measure based on section GG items. The inclusion of the section GG-based functional measure in the CART algorithm resulted in case-mix groups in which cognitive function played a less important role in classification. Based on these results, we determined that we could remove cognitive function as a determinant of PT and OT classification without a notable loss in the predictive ability of the payment model, as discussed above. We also consulted with clinicians who advised CMS during development of PDPM, who confirmed the appropriateness of this decision. The decisions to collapse Non-Orthopedic Surgery and Acute Neurologic into one clinical category and remove cognitive status resulted in a large reduction in the number of PT and OT case-mix groups, from the 30 in RCS–I to the 16 in the proposed PDPM provided in Table 21. We provide the criteria for each of these groups along with its CMI for both the PT and OT components in Table 21. As shown in Table 21, two factors would be used to classify each resident for PT and OT payment: clinical category and function score. Each case-mix group corresponds to one clinical category and one function score range. We propose classifying each SNF resident into one of the 16 groups shown in Table 21 based on these two factors.

To help ensure that payment reflects the average relative resource use at the per diem level, CMIs would be set to reflect relative case-mix related differences in costs across groups. This method helps ensure that the share of payment for each case-mix group would be equal to its share of total costs of the component. CMIs for the PT and OT components are calculated based on two factors. One factor is the average per diem costs of a case-mix group relative to the population average. The other factor is the average variable per diem adjustment factor of the group relative to the population average. In this calculation, average per diem costs equal total PT or OT costs in the group divided by number of utilization days in the group. Similarly, the average variable per diem adjustment factor equals the sum of variable per diem adjustment factors corresponding to a given component (PT or OT) for all utilization days in the group divided by the number of utilization days in the group. We calculate CMIs such that they equal the ratio of relative average per diem costs for a group to the relative average variable per diem adjustment factor for the group. In this calculation, relative average per diem costs and the relative average variable per diem adjustment factor are weighted by length of stay to account for the different length of stay distributions across case-mix groups (as further discussed in section 3.11.1. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*). The relative average variable per diem adjustment factors for a given PT group and the corresponding OT group are the same because residents are classified into the same case-mix group under both components. However, relative average per diem costs are different across the two corresponding PT and OT groups, therefore the resulting CMIs calculated for each group are different, as shown in Table 21. After calculating CMIs as described above, we then apply adjustments to help ensure that the distribution of resources across payment components is aligned with the statutory base rates. The base rates implicitly allocate resources to case-mix components in proportion to the relative magnitude of the respective component base rates. For example, if the base rate for one component were twice as large as the base rate for another component, this would imply that the component with the larger base rate should receive double the resources of the other component. To ensure that the distribution of resources across payment components is aligned with the statutory base rates, we set CMIs such that the average product of the CMI and the variable per diem adjustment factor for a day of care equals 1.0 for each of the five case-mix-adjusted components in PDPM. If the average product of the CMI and the variable per diem adjustment factor for a day of care were

different across case-mix components, this would result in allocating resources in a manner inconsistent with the distribution of resources implied by the statutory base rates.

After adjusting the CMIs to align the distribution of resources across payment components with the statutory base rates, a parity adjustment is then applied by multiplying the CMIs by the ratio of case-mix-related payments in RUG–IV over estimated case-mix-related payments in PDPM, as further discussed in section V.J. of this proposed rule. More information on the variable per diem adjustment factors is discussed in section V.D.4. of this proposed rule. The full methodology used to develop CMIs is presented in section 3.11. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*).

TABLE 21—PROPOSED PT AND OT CASE-MIX CLASSIFICATION GROUPS

Clinical category	Section GG function score	PT OT case-mix group	PT case-mix index	OT case-mix index
Major Joint Replacement or Spinal Surgery	0–5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6–9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10–23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0–5	TE	1.42	1.41
Other Orthopedic	6–9	TF	1.61	1.59
Other Orthopedic	10–23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0–5	TI	1.13	1.17
Medical Management	6–9	TJ	1.42	1.44
Medical Management	10–23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0–5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6–9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10–23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

Under the proposed PDPM, all residents would be classified into one and only one of these 16 PT and OT case-mix groups for each of the two components. As opposed to the RUG–IV system that determines therapy payments based only on the amount of therapy provided, these groups classify residents based on the two resident characteristics shown to be most predictive of PT and OT utilization: Clinical category and function score. Thus, we believe that the PT and OT case-mix groups better reflect relative resource use of clinically relevant resident subpopulations and therefore provide for more appropriate payment under the SNF PPS. We invite comments on the approach we are proposing above to classify residents for PT and OT payment.

c. Proposed Speech-Language Pathology Case-Mix Classification

As discussed above, many of the resident characteristics that we found to be predictive of increased PT and OT costs were predictive of lower SLP costs. As a result of this inverse relationship, using the same set of predictors to case-mix adjust all three therapy components would obscure important differences in variables predicting variation in costs across therapy disciplines and make any model that attempts to predict total therapy costs inherently less accurate. Therefore, we believe it is appropriate to have a separately adjusted case-mix SLP component that is specifically designed to predict relative differences in SLP costs. As discussed in the prior section, costs derived from the charges on claims and CCRs on facility cost reports were used as the measure of resource use to develop an alternative payment model. Costs are reflective of therapy utilization as they are correlated to therapy minutes recorded for each therapy discipline.

Following the same methodology we used to identify predictors of PT and OT costs, our project team conducted cost regressions with a host of variables from the MDS assessment, prior inpatient claims, and SNF claims that were identified as likely to be predictive of relative increases in SLP costs. The variables were selected with the goal of being as inclusive of the measures recorded on the MDS assessment as possible and also included diagnostic information from the prior inpatient stay. The selection process also incorporated clinical input from TEP panelists, the contractor's clinical staff, and CMS clinical staff. These initial costs regressions were exploratory and meant to identify a broad set of resident characteristics that are predictive of SLP resource utilization. The results were used to inform which variables should be investigated further and ultimately included in the payment system. A table of all of the variables considered in this analysis appears in the appendix of the SNF PMR technical report that accompanied the ANPRM (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*).

Based on these cost regressions, we identified a set of three categories of predictors relevant in predicting relative differences in SLP costs: Clinical reasons for the SNF stay, presence of a swallowing disorder or mechanically-altered diet, and the presence of an SLP-related comorbidity or cognitive impairment. A model using these predictors to predict SLP costs per day accounted for 14.5 percent of the variation in SLP costs per day, while a very extensive model using 1,016 resident characteristics only predicted 19.3 percent of the variation. This shows that these predictors alone explain a large share of the variation in SLP costs per day that can be explained with resident characteristics.

As with the proposed PT and OT components, we began with the set of clinical categories identified in Table 14 meant to capture general differences in resident resource utilization and ran cost regressions to determine which categories may be predictive of generally higher relative SLP costs. Through this analysis, we found that one clinical category, the Acute Neurologic group, was particularly predictive of increased SLP costs. More detail on this investigation can be found in section 3.5.2. of the SNF PMR

technical report that accompanied the ANPRM, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* Therefore, to determine the initial resident classification into an SLP group under the proposed PDPM, residents would first be categorized into one of two groups using the clinical reasons for the resident's SNF stay recorded on the first line of Item I8000 on the MDS assessment: Either the ''Acute Neurologic'' clinical category or a ''Non-Neurologic'' group that includes the remaining clinical categories in Table 14 (Major Joint Replacement or Spinal Surgery; Non-Surgical Orthopedic/Musculoskeletal; Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery); Acute Infections; Cancer; Pulmonary; Non-Orthopedic Surgery; Cardiovascular and Coagulations; and Medical Management).

In addition to the clinical reason for the SNF stay, based on cost regressions and feedback from TEP panelists, we also identified the presence of a swallowing disorder or a mechanically-altered diet (which refers to food that has been altered to make it easier for the resident to chew and swallow to address a specific resident need) as a predictor of relative increases in SLP costs. First, residents who exhibited the signs and symptoms of a swallowing disorder, as identified using K0100Z on the MDS 3.0, demonstrated significantly higher SLP costs than those who did not exhibit such signs and symptoms. Therefore, we considered including the presence of a swallowing disorder as a component in predicting SLP costs. However, when this information was presented during the October 2016 TEP, stakeholders indicated that the signs and symptoms of a swallowing disorder may not be as readily observed when a resident is on a mechanically-altered diet and requested that we also consider evaluating the presence of a mechanically-altered diet, as determined by item K0510C2 on the MDS 3.0, as an additional predictor of increased SLP costs. Our project team conducted this analysis and found that there was an associated increase in SLP costs when a mechanically-altered diet was present. Moreover, this analysis revealed that while SLP costs may increase when either a swallowing disorder or mechanically-altered diet is present, resident SLP costs increased even more when both of these items were present. More detail on this investigation and these analyses can be found in section 3.5.3. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* As a result, we agree with the stakeholders that both swallowing disorder and mechanically-altered diet are important components of predicting relative increases in resident SLP costs, and thus, in addition to the clinical categorization, we propose classifying residents as having either a swallowing disorder, being on a mechanically altered diet, both, or neither for the purpose of classifying the resident under the SLP component. We note that we do plan to monitor specifically for any increases in the use of mechanically altered diet among the SNF population that may suggest that beneficiaries are being prescribed such a diet based on facility financial considerations, rather than for clinical need.

As a final aspect of the proposed SLP component case-mix adjustment, we explored how SLP costs vary according to cognitive status and the presence of an SLP-related comorbidity. We observed that SLP costs were notably higher for residents who had a mild to severe cognitive impairment (as defined by the PDPM cognitive measure methodology described in Table 20) or who had an SLP-related comorbidity present. For each condition or service included as an SLP-related comorbidity, the presence of the condition or service was associated with at least a 43 percent increase in average SLP costs per day. The presence of a mild to severe cognitive impairment was associated with at least a 100 percent increase in average SLP costs per day. Similar to the analysis conducted in relation to the PT and OT components, the project team ran cost regressions on a broad list of possible conditions. Based on that analysis, and in consultation with stakeholders during our TEPs and clinicians, we identified the conditions listed in Table 22 as SLP-related comorbidities which we believe best predict relative differences in SLP costs. We used diagnosis codes on the most recent inpatient claim and the first SNF claim as well as MDS items on the 5-day assessment for each SNF stay to identify these diagnoses and found that residents with these conditions had much higher SLP costs per day. Rather than accounting for each SLP-related comorbidity separately, all conditions were combined into a single flag. If the resident has at least one SLP-related comorbidity, the combined flag is turned on. We combined all SLP-related comorbidities into a single flag because we found that the predictive ability of including a combined SLP comorbidity flag is comparable to the predictive ability of including each SLP-related comorbidity as an individual predictor. Additionally, using a combined SLP-related comorbidity flag greatly improves the simplicity of the payment model. More detail on these analyses can be found in section 3.5.1. of the SNF PMR technical report that accompanied the ANPRM (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*).

TABLE 22—PROPOSED SLP-RELATED COMORBIDITIES

Aphasia	Laryngeal cancer
CVA, TIA, or Stroke	Apraxia.
Hemiplegia or Hemiparesis	Dysphagia.
Traumatic Brain Injury	ALS.
Tracheostomy Care (While a Resident)	Oral Cancers.
Ventilator or Respirator (While a Resident)	Speech and Language Deficits.

Once each of these variables—clinical reasons for the SNF stay, presence of a swallowing disorder or mechanically-altered diet, and the presence of an SLP-related comorbidity or cognitive impairment—found to be useful in predicting resident SLP costs was identified, we used the CART algorithm, as we discussed above in relation to the PT and OT components, to determine appropriate splits in SLP case-mix groups based on CART output breakpoints using these three variables. We then further refined the SLP case-mix classification groups beyond those produced by the CART algorithm. We used consistent criteria to group residents into 18 payment groups across

the two clinical categories determined to be relevant to SLP utilization (Acute Neurologic and Non-Neurologic). These groups simplified the SLP case-mix classification by reducing the number of groups while maintaining the CART predictive power in terms of R-squared. This methodology and the results of our analysis are more thoroughly explained in sections 3.4.2. and 3.5.2. of the SNF PMR technical report that accompanied the ANPRM (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*).

Under the original RCS–I SLP component, a resident could be classified into one of 18 possible case-mix groups. Comments received in response to the ANPRM expressed concern over the complexity of the payment model due to the high number of possible combinations of case-mix groups. To reduce the number of possible SLP case-mix groups, we simplified the consistent splits model selected for RCS–I. To accomplish this, we combined clinical category (Acute Neurologic or Non-Neurologic), cognitive impairment, and the presence of an SLP-related comorbidity into a single predictor due to the clinical relationship between acute neurologic conditions, cognition, and SLP comorbidities. These three predictors are highly interrelated as acute neurologic conditions may often result in cognitive impairment or SLP-related comorbidities such as speech and language deficits. Using this combined variable along with presence of a swallowing disorder or mechanically-altered diet results in 12 groups. We compared the predictive ability of the simplified model with more complex classification options, including the original RCS–I SLP model. Regression results showed that the reduction in case-mix groups by collapsing independent variables had little to no effect on payment accuracy. Specifically, the proposed PDPM SLP model has an R-squared value almost identical to that of the original RCS–I SLP model, while reducing the number of resident groups from 18 to 12. Therefore, we determined that 12 case-mix groups would be necessary to classify residents adequately in terms of their SLP costs in a manner that captures sufficient variation in SLP costs without creating unnecessarily granular separations. More information on this analysis can be found in section 3.5.2. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*). We provide the criteria for each of these groups along with its CMI in Table 23.

To help ensure that payment reflects the average relative resource use at the per diem level, CMIs would be set to reflect relative case-mix related differences in costs across groups. This method helps ensure that the share of payment for each case-mix group would be equal to its share of total costs of the component. CMIs for the SLP component are calculated based on the average per diem costs of a case-mix group relative to the population average. Relative average differences in costs are weighted by length of stay to account for the different length of stay distributions across case-mix groups (as further discussed in section 3.11.1. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*). In this calculation, average per diem costs equal total SLP costs in the group divided by number of utilization days in the group. Because the SLP component does not have a variable per diem schedule (as further discussed in section 3.9.1. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*), variable per diem adjustment factors are not involved in SLP CMI calculation. A parity adjustment is then applied by multiplying the CMI by the ratio of case-mix-related payments in RUG–IV over estimated case-mix-related payments in PDPM, as further discussed in section V.J. of this proposed rule. This method helps ensure that the share of payment for each case-mix group is equal to its share of total costs of the component and that PDPM is budget neutral relative to RUG–IV. The full methodology used to develop CMIs is presented in section 3.11. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*).

TABLE 23—PROPOSED SLP CASE-MIX CLASSIFICATION GROUPS

Presence of acute neurologic condition, SLP-related comorbidity, or cognitive impairment	Mechanically altered diet or swallowing disorder	SLP case-mix group	SLP case-mix index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

As with the proposed PT and OT components, all residents would be classified into one and only one of these 12 SLP case-mix groups under the proposed PDPM. As opposed to the RUG–IV system that determines therapy payments based only on the amount of therapy provided, under the proposed PDPM, residents would be classified into SLP case-mix groups based on resident characteristics shown to be predictive of SLP utilization. Thus, we believe that the proposed SLP case-mix groups would provide a better measure of resource use and would provide for more appropriate payment under the SNF PPS. We invite comments on the approach we are proposing above to classify residents for SLP payment under the proposed PDPM.

d. Proposed Nursing Case-Mix Classification

The RUG–IV classification system first divides residents into ''rehabilitation residents'' and ''non-rehabilitation residents'' based on the

amount of therapy a resident receives. Differences in nursing needs can be obscured for rehabilitation residents, where the primary driver of payment classification is the intensity of therapy services that a resident receives. For example, for two residents classified into the RUB RUG–IV category, which would occur on the basis of therapy intensity and ADL score alone, the nursing component for each of these residents would be multiplied by a CMI of 1.56. This reflects that residents in that group were found, during our previous Staff time measurement (STM) work, to have nursing costs 56 percent higher than residents with a 1.00 index. We would note that while this CMI also includes adjustments made in FY 2010 and FY 2012 for budget-neutrality purposes, what is clear is that two residents, who may have significantly different nursing needs, are nevertheless deemed to have the very same nursing costs, and SNFs would receive the same nursing payment for each. Given the discussion above, which noted that approximately 60 percent of resident days are billed using one of three Ultra-High Rehabilitation RUGs (two of which have the same nursing index), the current case-mix model effectively classifies a significant portion of SNF therapy residents as having exactly the same degree of nursing needs and requiring exactly the same amount of nursing resources. As such, we believe that further refinement of the case-mix model would be appropriate to better differentiate among patients, particularly those who receive therapy services with different nursing needs.

An additional concern in the RUG–IV system is the use of therapy minutes to determine not only therapy payments but also nursing payments. For example, residents classified into the RUB RUG fall in the same ADL score range as residents classified into the RVB RUG. The only difference between those residents is the number of therapy minutes that they received. However, the difference in payment that results from this difference in therapy minutes impacts not only the RUG–IV therapy component but also the nursing component: Nursing payments for RUB residents are 40 percent higher than nursing payments for RVB residents. As a result of this feature of the RUG–IV system, the amount of therapy minutes provided to a resident is one of the main sources of variation in nursing payments, while other resident characteristics that may better reflect nursing needs play a more limited role in determining payment.

The more nuanced and resident-centered classifications in current RUG–IV non-rehabilitation categories are obscured under the current payment model, which utilizes only a single RUG–IV category for payment purposes and has over 90 percent of resident days billed using a rehabilitation RUG. The RUG–IV non-rehabilitation groups classify residents based on their ADL score, the use of extensive services, the presence of specific clinical conditions such as depression, pneumonia, or septicemia, and the use of restorative nursing services, among other characteristics. These characteristics are associated with nursing utilization, and the STRIVE study accounted for relative differences in nursing staff time across groups. Therefore, we propose to use the existing RUG–IV methodology for classifying residents into non-rehabilitation RUGs to develop a proposed nursing classification that helps ensure nursing payment reflects expected nursing utilization rather than therapy utilization.

For example, consider two residents. The first patient classifies into the RUB rehabilitation RUG (on the basis of the resident's therapy minutes) and into the CC1 non-rehabilitation RUG (on the basis of having pneumonia), while the second classifies into the RUB rehabilitation RUG (on the basis of the resident's therapy minutes) and the HC1 non-rehabilitation RUG (on the basis of the resident having quadriplegia and a high ADL score). Under the current RUG–IV based payment model, the billing for both residents would utilize only the RUB rehabilitation RUG, despite clear differences in their associated nursing needs and resident characteristics. We propose an approach where, for the purpose of determining payment under the nursing component, the first resident would be classified into CC1, while the second would be classified into HC1 under the PDPM. We believe that classifying the residents in this manner for payment purposes would capture variation in nursing costs in a more accurate and granular way than relying on the rehabilitation RUG's nursing CMI.

While resident classification in the proposed PDPM nursing component is guided by RUG–IV methodology, we propose to make several modifications to the RUG–IV nursing RUGs and classification methodology under the proposed PDPM. First, the proposed PDPM would reduce the number of nursing RUGs by decreasing distinctions based on function. Under RUG–IV, residents with a serious medical condition/service such as septicemia or respiratory therapy are classified into one of eight nursing RUGs in the Special Care High category. The specific RUG into which a resident is placed depends on the resident's ADL score and whether the resident is depressed. RUG–IV groups ADL score into bins for simplicity (for example, 2–5 and 6–10). For example, under RUG–IV, a resident in the Special Care High category who has depression and an ADL score of 3 would fall into the 2–5 ADL score bin and therefore be classified into the HB2 RUG, which corresponds to Special Care High residents with depression and an ADL score between 2 and 5 (a mapping of clinical traits and ADL score to RUG–IV nursing groups is shown in the appendix of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*). To explore options to reduce the number of nursing RUGs, we compared average nursing utilization across all 43 RUG–IV nursing RUGs. The dependent variable used in this investigation was the average wage-weighted staff time (WWST) for each nursing RUG from the STRIVE study. WWST is a measure of nursing resource utilization used in the STRIVE study. As discussed in more detail in section 3.2.1. of the PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*), we were unable to construct a measure of nursing utilization based on current data because facilities do not report resident-specific nursing costs. We observed that nursing resource use as measured by WWST does not vary markedly between nursing case-mix groups defined by contiguous ADL score bins (for example, 11–14 and 15–16) but otherwise sharing the same clinical traits (for example, classified into Special Care High and depressed). This suggests that collapsing contiguous ADL score bins for RUGs that are otherwise defined by the same set of clinical traits is unlikely to notably affect payment accuracy. Section 3.6.1. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*) provides more detail on this analysis.

In the Special Care High, Special Care Low, Clinically Complex, and Reduced Physical Function classification groups (RUGs beginning with H, L, C, or P), for nursing groups that were otherwise defined with the same clinical traits (for example, extensive services, medical conditions, depression, restorative nursing services received), we propose to combine the following pairs of second characters due to their

contiguous ADL score bins: (E, D) and (C, B). These characters correspond to ADL score bins (15 to 16, 11 to 14) and (6 to 10, 2 to 5), respectively. We observed that nursing utilization did not vary notably across these contiguous ADL score bins, therefore we believe it is appropriate to collapse pairs of RUGs in these classification groups that correspond to contiguous ADL score bins but are otherwise defined by the same clinical traits. For example, HE2 and HD2, which are both in the Special Care High group and both indicate the presence of depression, would be collapsed into a single nursing case-mix group. Similarly, PC1 and PB1 (Reduced Physical Function and 0 to 1 restorative nursing services) also would be combined into a single nursing case-mix group. Section 3.6.1. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*) provides more detail on this analysis. In the Behavioral and Cognitive Performance classification group (RUGs beginning with B), for RUGs that are otherwise defined by the same number of restorative nursing services (0 to1 or 2 or more), we propose to combine RUGs with the second character B and A, which correspond to contiguous ADL score bins 2 to 5 and 0 to 1, respectively. We observed that nursing utilization did not vary notably across these contiguous ADL score bins, therefore we believe it is appropriate to collapse pairs of RUGs in this classification group that correspond to contiguous ADL score bins but are otherwise defined by the same clinical traits. In other words, BB2 and BA2 would be combined into a single nursing group, and BB1 and BA1 would also be combined into a single nursing group. Section 3.6.1. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*) provides more detail on this analysis. The proposed PDPM would maintain CA1, CA2, PA1, and PA2 as separate case-mix groups. We observed that these RUGs do not share similar levels of nursing resource use with RUGs in adjacent ADL score bins that are otherwise defined by the same clinical traits (for example, medical conditions, depression, restorative nursing services received). Rather, CA1, CA2, PA1, and PA2 are associated with distinctly lower nursing utilization compared to RUGs that otherwise have the same clinical traits (for example, medical conditions, depression, restorative nursing services received) but higher ADL score bins. Section 3.6.1. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*) provides more detail on this analysis. ES3, ES2, and ES1 also would be maintained as separate case-mix groups under the nursing component of the proposed PDPM because, although they are defined by the same ADL score bin, they are defined by different clinical traits unlike the pairs of RUGs that were combined. Specifically, ES3, ES2, and ES1 are defined by different combinations of extensive services. We believe that collapsing case-mix groups based on ADL score for the RUGs specified above would reduce model complexity by decreasing the number of nursing case-mix groups from 43 to 25, which thereby decreases the total number of possible combinations of case-mix groups under the proposed PDPM. Table 26 shows the proposed 25 case-mix groups for nursing payment. Section 3.6.1. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*) provides more detail on the analyses and data supporting these proposals.

The second modification to the RUG–IV nursing classification methodology would update the nursing ADL score to incorporate section GG items. Currently, the RUG–IV ADL score is based on four late-loss items from section G of MDS 3.0: Eating, toileting, transfer, and bed mobility. Under the proposed PDPM, these section G items would be replaced with an eating item, a toileting item, three transfer items, and two bed mobility items from the admission performance assessment of section GG. In contrast to the RUG–IV ADL score, the proposed PDPM score assigns higher points to higher levels of independence. Therefore, an ADL score of 0 (independent) corresponds to a section GG-based function score of 16, while an ADL score of 16 (dependent) corresponds to a section GG-based function score of 0. This scoring methodology is consistent with the proposed PDPM PT and OT function score as well as functional scores in other care settings, such as the IRF PPS. The proposed nursing scoring methodology also assigns 0 points when an activity cannot be completed (''Resident refused,'' ''Not applicable,'' ''Not attempted due to medical condition or safety concerns''). As described in section V.D.3.c. (PT and OT Case-Mix Classification) of this proposed rule, grouping these responses with ''dependent'' aligns with clinical expectations of resource utilization for residents who cannot complete an ADL activity. The proposed scoring methodology is shown in Table 24. As discussed in section V.D.3.c., section GG measures functional areas with more than one item, which results in substantial overlap between the two bed mobility items and the three transfer items. To address overlap, we propose to calculate an average score for each of these related items. That is, we would average the scores for the two bed mobility items and for the three transfer items. This averaging approach is also used in the proposed PT and OT function scores and is illustrated in Table 25. The final score sums the average bed mobility and transfer scores with eating and toileting scores, resulting in a nursing function score that ranges from 0 to 16.

TABLE 24—PROPOSED NURSING FUNCTION SCORE CONSTRUCTION

	Response	ADL Score
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
03	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 88	Dependent, Refused, N/A, Not Attempted	0

TABLE 25—SECTION GG ITEMS INCLUDED IN PROPOSED NURSING FUNCTIONAL MEASURE

	Section GG Item	ADL Score
GG0130A1	Self-care: Eating	0–4

TABLE 25—SECTION GG ITEMS INCLUDED IN PROPOSED NURSING FUNCTIONAL MEASURE—Continued

	Section GG Item	ADL Score
GG0130C1	Self-care: Toileting Hygiene	0–4
GG0170B1	Mobility: Sit to lying	0–4 (average of 2 items).
GG0170C1	Mobility: Lying to sitting on side of bed.	
GG0170D1	Mobility: Sit to stand	0–4 (average of 3 items).
GG0170E1	Mobility: Chair/bed-to-chair transfer.	
GG0170F1	Mobility: Toilet transfer.	

In addition to proposing to replace the nursing ADL score with a function score based on section GG items and to collapse certain nursing RUGs, we also propose to update the existing nursing CMIs using the STRIVE staff time measurement data that were originally used to create these indexes. Under the current payment system, non-rehabilitation nursing indexes were calculated to capture variation in nursing utilization by using only the staff time collected for the non-rehabilitation population. We believe that, to provide a more accurate reflection of the relative nursing resource needs of the SNF population, the nursing indexes should reflect nursing utilization for all residents. To accomplish this, we replicated the methodology described in the FY 2010 SNF PPS rule (74 FR 22236 through 22238) but classified the full STRIVE study population under non-rehabilitation RUGs using the RUG–IV classification rules. The methodology for updating resource use estimates for each nursing RUG proceeded according to the following steps:

(1) Calculate average wage-weighted staff time (WWST) for each STRIVE study resident using FY 2015 SNF wages.

(2) Assign the full STRIVE population to the appropriate non-rehabilitation RUG.

(3) Apply sample weights to WWST estimates to allow for unbiased population estimates. The reason for this weighting is that the STRIVE study was not a random sample of residents. Certain key subpopulations, such as residents with HIV/AIDS, were over-sampled to ensure that there were enough residents to draw conclusions on the subpopulations' resource use. As a result, STRIVE researchers also developed sample weights, equal to the inverse of each resident's probability of selection, to permit calculation of unbiased population estimates. Applying the sample weights to a summary statistic results in an estimate that is representative of the actual population. The sample weight method is explained in Phase I of the STRIVE study. A link to the STRIVE study is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/TimeStudy.html.*

(4) Smooth WWST estimates that do not match RUG hierarchy in the same manner as the STRIVE study. RUG–IV, from which the nursing RUGs are derived, is a hierarchical classification in which payment should track clinical acuity. It is intended that residents who are more clinically complex or who have other indicators of acuity, including a higher ADL score, depression, or restorative nursing services, would receive higher payment. When STRIVE researchers estimated WWST for each RUG, several inversions occurred because of imprecision in the means. These are defined as WWST estimates that are not in line with clinical expectations. The methodology used to smooth WWST estimates is explained in Phase II of the STRIVE study. A link to the STRIVE study is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/TimeStudy.html.*

(5) Calculate nursing indexes, which reflect the average WWST for each of the 25 nursing case-mix groups divided by the average WWST for the study population used throughout our research. To impute WWST for each stay in the population, we assigned each resident the average WWST of the collapsed nursing RUG into which they are categorized. To derive the average WWST of each collapsed RUG, we first estimate the average WWST of the original 43 nursing RUGs based on steps 1 through 4 above, then calculate a weighted mean of the average WWST of the two RUGs that form the collapsed RUG. More details on this analysis can be found in section 3.6.3. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).*

Through this refinement, we believe the nursing indexes under the proposed PDPM better reflect the varied nursing resource needs of the full SNF population. In Table 26, we provide the nursing indexes under the proposed PDPM.

To help ensure that payment reflects the average relative resource use at the per diem level, nursing CMIs would be set to reflect case-mix related relative differences in WWST across groups. Nursing CMIs would be calculated based on the average per diem nursing WWST of a case-mix group relative to the population average. In this calculation, average per diem WWST equals total WWST in the group divided by number of utilization days in the group. Because the nursing component does not have a variable per diem schedule (as further discussed in section 3.9.1. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*), variable per diem adjustment factors are not involved in nursing CMI calculation. We then apply a parity adjustment by multiplying the CMI by the ratio of case-mix-related payments in RUG–IV over estimated case-mix-related payments in PDPM, as discussed further in section V.J. of this proposed rule. The full methodology used to develop CMIs is presented in section 3.11. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*).

TABLE 26—PROPOSED NURSING INDEXES UNDER PROPOSED PDPM CLASSIFICATION MODEL

RUG–IV nursing RUG	Extensive services	Clinical conditions	Depression	Number of restorative nursing services	GG-based function score	PDPM nursing case-mix group	Nursing case-mix index
ES3	Tracheostomy & Ventilator				0–14	ES3	4.04

TABLE 26—PROPOSED NURSING INDEXES UNDER PROPOSED PDPM CLASSIFICATION MODEL—Continued

RUG–IV nursing RUG	Extensive services	Clinical conditions	Depression	Number of restorative nursing services	GG-based function score	PDPM nursing case-mix group	Nursing case-mix index
ES2	Tracheostomy or Ventilator				0–14	ES2	3.06
ES1	Infection				0–14	ES1	2.91
HE2/HD2		Serious medical conditions e.g. comatose, septicemia, respiratory therapy.	Yes		0–5	HDE2	2.39
HE1/HD1		Serious medical conditions e.g. comatose, septicemia, respiratory therapy.	No		0–5	HDE1	1.99
HC2/HB2		Serious medical conditions e.g. comatose, septicemia, respiratory therapy.	Yes		6–14	HBC2	2.23
HC1/HB1		Serious medical conditions e.g. comatose, septicemia, respiratory therapy.	No		6–14	HBC1	1.85
LE2/LD2		Serious medical conditions e.g. radiation therapy or dialysis.	Yes		0–5	LDE2	2.07
LE1/LD1		Serious medical conditions e.g. radiation therapy or dialysis.	No		0–5	LDE1	1.72
LC2/LB2		Serious medical conditions e.g. radiation therapy or dialysis.	Yes		6–14	LBC2	1.71
LC1/LB1		Serious medical conditions e.g. radiation therapy or dialysis.	No		6–14	LBC1	1.43
CE2/CD2		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	Yes		0–5	CDE2	1.86
CE1/CD1		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	No		0–5	CDE1	1.62
CC2/CB2		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	Yes		6–14	CBC2	1.54
CA2		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	Yes		15–16	CA2	1.08
CC1/CB1		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	No		6–14	CBC1	1.34
CA1		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	No		15–16	CA1	0.94
BB2/BA2		Behavioral or cognitive symptoms		2 or more	11–16	BAB2	1.04
BB1/BA1		Behavioral or cognitive symptoms		0–1	11–16	BAB1	0.99
PE2/PD2		Assistance with daily living and general supervision		2 or more	0–5	PDE2	1.57
PE1/PD1		Assistance with daily living and general supervision		0–1	0–5	PDE1	1.47
PC2/PB2		Assistance with daily living and general supervision		2 or more	6–14	PBC2	1.21
PA2		Assistance with daily living and general supervision		2 or more	15–16	PA2	0.70
PC1/PB1		Assistance with daily living and general supervision		0–1	6–14	PBC1	1.13
PA1		Assistance with daily living and general supervision		0–1	15–16	PA1	0.66

As with the previously discussed components, all residents would be classified into one and only one of these 25 nursing case-mix groups under the proposed PDPM.

We also used the STRIVE data to quantify the effects of an HIV/AIDS diagnosis on nursing resource use. We controlled for case mix by including the proposed PDPM resident groups (in this case, the nursing RUGs) as independent variables. The results show that even after controlling for nursing RUG, HIV/AIDS status is associated with a positive and significant increase in nursing utilization. Based on the results of regression analyses, we found that wage-weighted nursing staff time is 18 percent higher for residents with HIV/AIDS. (The estimate of average wage-weighted nursing staff time for the SNF population is adjusted to account for the deliberate over-sampling of certain sub-populations in the STRIVE study. Specifically, we apply sample weights from the STRIVE dataset equal to the inverse of each resident's probability of selection to permit calculation of an unbiased estimate.) Based on these findings, we concluded that the proposed PDPM nursing groups may not fully capture the additional nursing costs associated with HIV/AIDS residents. More information on this analysis can be found in section 3.8.2. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*). Thus, as part of the case-mix adjustment of the nursing component, we are proposing an 18 percent increase in payment for the nursing component for residents with HIV/AIDS. This adjustment would be applied based on the presence of ICD–10–CM code B20 on the SNF claim. In cases where a resident is coded as having this diagnosis, the nursing component per diem rate for this resident would be multiplied by 1.18, to account for the 18 percent increase in nursing costs for residents with this diagnosis. We discuss this proposal, as well as its relation to the existing AIDS add-on payment under RUG–IV, in section V.I. of this proposed rule.

We invite comments on the approach we are proposing above to classify residents for nursing payment under the proposed PDPM.

e. Proposed Non-Therapy Ancillary Case-Mix Classification

Under the current SNF PPS, payments for NTA costs incurred by SNFs are incorporated into the nursing component. This means that the CMIs used to adjust the nursing component of the SNF PPS are intended to reflect not only differences in nursing resource use but also NTA costs. However, there have been concerns that the current nursing CMIs do not accurately reflect the basis for or the magnitude of relative differences in resident NTA costs. In its March 2016 Report to Congress, MedPAC wrote: ''Almost since its inception, the SNF PPS has been criticized for encouraging the provision of unnecessary rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) services such as drugs (Government Accountability Office 2002, Government Accountability Office 1999, White et al. 2002)'' (available at *http://medpac.gov/docs/default-source/reports/chapter-7-skilled-nursing-*

facility-services-march-2016-report-.pdf). While the proposed PT, OT, and SLP components were designed to address the issue related to provision of therapy services raised by MedPAC above, the proposed NTA component discussed in this section was designed to address the issue related to accurately targeting payments for NTA services—specifically, that the current manner of using the RUG–IV case-mix system to determine NTA payment levels inadequately adjusts for relative differences in resident NTA costs.

As noted in the quotation from MedPAC above, MedPAC is not the only group to offer this critique of the SNF PPS. Just as the aforementioned criticisms that MedPAC cited have existed almost since the inception of the SNF PPS itself, ideas for addressing this concern have a similarly long history. In response to comments on the 1998 interim final rule which served to establish the SNF PPS, we published a final rule on July 30, 1999 (64 FR 41644). In this final rule, we acknowledged the commenters' concerns about the new system's ability to account accurately for NTA costs, such as the following:

> There were a number of comments expressing concern with the adequacy of the PPS rates to cover the costs of ancillary services other than occupational, physical, and speech therapy (non-therapy ancillaries), including such things as drugs, laboratory services, respiratory therapy, and medical supplies. Prescription drugs or medication therapy were frequently noted areas of concern due to their potentially high cost for particular residents. Some commenters suggested that the RUG–III case-mix classification methodology does not adequately provide for payments that account for the variation in, or the real costs of, these services provided to their residents. (64 FR 41647)

In response to those comments, we stated that ''we are funding substantial research to examine the potential for refinements to the case-mix methodology, including an examination of medication therapy, medically complex patients, and other nontherapy ancillary services'' (64 FR 41648). In this proposed rule, we are proposing a methodology that we believe would case-mix adjust SNF PPS payments more appropriately to reflect differences in NTA costs.

Following the same methodology we used for the proposed PT, OT, and SLP components, the project team ran cost regression models to determine which resident characteristics may be predictive of relative increases in NTA costs. The three categories of cost-related resident characteristics identified through this analysis were resident comorbidities, the use of extensive services (services provided to residents that are particularly expensive and/or invasive), and resident age. However, we removed age from further consideration as part of the NTA component based on concerns shared by TEP panelists during the June 2016 TEP. Particularly, some panelists expressed concern that including age as a determinant of NTA payment could create access issues for older populations. Additionally, the CART algorithm used to explore potential resident groups for the NTA component only selected age as a determinant of classification for 2 of the 7 groups created. We also tested a classification option that used age as a determinant of classification for every NTA group. This only led to a 5 percent increase in the R-squared value of the NTA classification. More information on these analyses can be found in section 3.7.1. of the SNF PMR technical report available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

With regard to capturing comorbidities and extensive services associated with high NTA utilization, we used multiple years of data (FY 2014 to FY 2017) to estimate the impact of comorbidities and extensive services on NTA costs. This is in response to comments on the ANPRM that the design of the NTA component should be more robust and remain applicable in light of potential changes in the SNF population and care practices over time. Conditions and services were defined in three ways. First, clinicians identified MDS items that correspond to conditions/extensive services likely related to NTA utilization. However, since many conditions/extensive services related to NTA utilization are not included on the MDS assessment, we then mapped ICD–10 diagnosis codes from the prior inpatient claim, the first SNF claim, and section I8000 of the 5-day MDS assessment to condition categories from the Part C risk adjustment model (CCs) and the Part D risk adjustment model (RxCCs). The CCs and RxCCs define conditions by aggregating related diagnosis codes into a single condition flag. We use the condition flags defined by the CCs and RxCCs to predict Part A and B expenditures or Part D expenditures, respectively for Medicare beneficiaries. The predicted relationship between the conditions defined in the respective models and Medicare expenditures is then used to risk-adjust capitated payments to Part C and Part D sponsors. Similarly, our comorbidities investigation aimed to use a comprehensive list of conditions and services to predict resource utilization for beneficiaries in Part A-covered SNF stays. Ultimately, the predicted relationship between these conditions/services and utilization of NTA services would be used to case-mix adjust payments to SNF providers, in a process similar to risk adjustment of capitated payments. Given these similarities, we decided to use the diagnosis-defined conditions from the Part C and Part D risk adjustment models to define conditions and services that were not defined on the MDS. Because the CCs were developed to predict utilization of Part A and B services, while the RxCCs were developed to predict Part D drug costs, the largest component of NTA costs, we believe that using both sources allows us to define the conditions and services potentially associated with NTA utilization more comprehensively. Lastly, we used ICD–10 diagnosis codes to define additional conditions that clinicians who advised CMS during PDPM development identified as being potentially associated with increased NTA service utilization but are not fully reflected in either the MDS or the CCs/RxCCs. The resulting list was meant to encompass as many diverse and expensive conditions and extensive services as possible from the MDS assessment, the CCs, the RxCCs, and diagnoses. Using cost regressions, we found that certain comorbidity conditions and extensive services were highly predictive of relative differences in resident NTA costs. These conditions and services are identified in Table 27. More information on this analysis can be found in section 3.7.1. of the SNF PDPM technical report available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* We would note that certain conditions that were associated with higher NTA utilization were nevertheless excluded from the list because of clinical concerns. Esophageal reflux was excluded because it is a very common condition in the SNF population and clinicians noted that coding can be discretionary. Migraine headache was also excluded due to clinicians' concerns about coding reliability. Additionally, clinicians stated that in many cases migraine headache is not treated by medication, the largest component of NTA costs.

Having identified the list of relevant conditions and services for adjusting NTA payments, we considered different options for how to capture the variation

in NTA costs explained by these identified conditions and services. One such method would be merely to count the number of comorbidities and services a resident receives and assign a score to that resident based on this count. We found that this option accounts for the additive effect of having multiple comorbidities and extensive services but did not adequately reflect the relative differences in the impact of certain higher-cost conditions and services. We also considered a tier system similar to the one used in the IRF PPS, where SNF residents would be placed into payment tiers based on the costliest comorbidity or extensive service. However, we found that this option did not account for the additive effect noted above. To address both of these issues, we propose basing a resident's NTA score, which would be used to classify the resident into an NTA case-mix classification group, on a weighted-count methodology. Specifically, as shown in Table 27, each of the comorbidities and services that factor into a resident's NTA classification is assigned a certain number of points based on its relative impact on a resident's NTA costs. Those conditions and services with a greater impact on NTA costs are assigned more points, while those with less of an impact are assigned fewer points. The relative impacts are estimated based the coefficients of an ordinary least squares (OLS) regression that used the selected conditions and extensive services to predict NTA costs per day. Points are assigned by grouping together conditions and extensive services with similar OLS regression estimates. More information on this methodology and analysis can be found in section 3.7.1. of the SNF PDPM technical report available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* The effect of this methodology is that the NTA component would adequately reflect relative differences in the NTA costs for each condition or service as well as the additive effect of having multiple comorbidities.

A resident's total comorbidity score, which would be the sum of the points associated with all of a resident's comorbidities and services, would be used to classify the resident into an NTA case-mix group. For conditions and services where the source is indicated as MDS item I8000, section 3.7.1. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*) provides a crosswalk between the listed condition and the ICD–10–CM codes which may be coded to qualify that condition to serve as part of the resident's NTA classification. MDS item I8000 is an open-ended item in the MDS assessment where the assessment provider can fill in additional active diagnoses that are not explicitly on the MDS for the resident in the form of ICD–10 codes . In the case of Parenteral/IV Feeding, we observed that NTA costs per day increase as the amount of intake through parenteral or tube feeding increases. For this reason, we propose to separate this item into a high intensity item and a low intensity item, similar to how it is defined in the RUG–IV system. In order for a resident to qualify for the high intensity category, the percent of calories taken in by the resident by parenteral or tube feeding, as reported in item K0710A2 on the MDS 3.0, must be greater than 50 percent. In order to qualify for the low intensity category, the percent of calories taken in by the resident by parenteral or tube feeding, as reported in item K0710A2 on the MDS 3.0, must be greater than 25 percent but less than or equal to 50 percent, and the resident must receive an average fluid intake by IV or tube feeding of at least 501cc per day, as reported in item K0710B2 of the MDS 3.0.

We also want to note that the source of the HIV/AIDS diagnosis is listed as the SNF claim. This is because 16 states have state laws that prevent the reporting of HIV/AIDS diagnosis information to CMS through the current assessment system and/or prevent CMS from seeing such diagnosis information within that system, should that information be mistakenly reported. The states are Alabama, Alaska, California, Colorado, Connecticut, Idaho, Illinois, Massachusetts, Nevada, New Hampshire, New Jersey, New Mexico, South Carolina, Texas, Washington, and West Virginia. Given this restriction, it would not be possible to have SNFs utilize the MDS 3.0 as the vehicle to report HIV/AIDS diagnosis information for purposes of determining a resident's NTA classification. We note that the current SNF PPS uses a claims reporting mechanism as the basis for the temporary AIDS add-on payment which exists under RUG–IV. To address the issue discussed above with respect to reporting of HIV/AIDS diagnosis information under the proposed PDPM, we propose to utilize this existing claims reporting mechanism to determine a resident's HIV/AIDS status for the purpose of NTA classification. More specifically, HIV/AIDS diagnosis information reported on the MDS would be ignored by the GROUPER software used to classify a resident into an NTA case-mix group. Instead, providers would be instructed to locate the HIPPS code provided to the SNF on the validation report associated with that assessment and report it to CMS on the associated SNF claim. Following current protocol, the provider would then enter ICD–10–CM code B20 on the associated SNF claim as if it were being coded to receive payment through the current AIDS add-on payment. The PRICER software, which we use to determine the appropriate per diem payment for a provider based on their wage index and other factors, would make the adjustment to the resident's NTA case-mix group based on the presence of the B20 code on the claim as well as adjust the associated per diem payment based on the adjusted resident HIPPS code. Again, we note that this methodology follows the same logic that the SNF PPS currently uses to pay the temporary AIDS add-on adjustment but merely changes the target and type of adjustment from the SNF PPS per diem to the NTA component of the proposed PDPM. The difference is that while under the current system, the presence of the B20 code would lead to a 128 percent increase in the per diem rate, under the proposed PDPM, the presence of the B20 code would mean the addition of 8 points (as determined by the OLS regression described above) to the resident's NTA score, the categorization of the resident into the appropriate NTA group, and an adjustment to the nursing component, as described in section V.D.3.d. of this proposed rule. Section 1888(e)(12) of the Social Security Act enacted a temporary 128 percent increase in the PPS per diem payment for SNF residents with HIV/AIDS and stipulated that the temporary adjustment was to be applied only until the Secretary certifies that there is an appropriate case-mix adjustment to compensate for the increased costs associated with this population. Based on this language, we conducted an analysis similar to that used to determine the HIV/AIDS add-on for the nursing component to examine the adequacy of payment for ancillary services (all non-nursing services: PT, OT, SLP, and NTA) for residents with HIV/AIDS under the proposed PDPM. This analysis determined that after accounting for the 8 points assigned for HIV/AIDS in the NTA component and controlling for case-mix classification across the three therapy components and NTA component, HIV/AIDS was

not associated with an increase in ancillary costs. Nursing costs were not included in this regression because we separately investigated the increased nursing utilization associated with HIV/AIDS, as described in section V.D.3.d. of this proposed rule. Based on the results of this investigation, we concluded that the four ancillary case-mix components (PT, OT, SLP, and NTA) adequately reimburse costs associated with residents with HIV/AIDS. Therefore, we do not believe an HIV/AIDS add-on is warranted for the ancillary cost components. More information on this analysis can be found in section 3.8.2. of the PDPM technical report available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

Table 27 provides the proposed list of conditions and extensive services that would be used for NTA classification, the source of that information, and the associated number of points for that condition.

TABLE 27—PROPOSED CONDITIONS AND EXTENSIVE SERVICES USED FOR NTA CLASSIFICATION

Condition/extensive service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2.	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2.	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Active Diagnoses: Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis—Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	MDS Item I2900	2
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer—Stage 4	MDS Item M0300X1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code.	MDS Item M1040A, M1040B, M1040C.	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I8000	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy—Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Active Diagnoses: Malnutrition Code	MDS Item I5600	1
Disorders of Immunity—Except: RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

Given the NTA scoring methodology described above and following the same methodology used for the PT, OT, and SLP components, we used the CART algorithm to determine the most appropriate splits in resident NTA case-mix groups. This methodology is more thoroughly explained in sections 3.4.2. and 3.7.2. of the SNF PDPM technical

report available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* Based on the breakpoints generated by the CART algorithm, we determined that 6 case-mix groups would be necessary to classify residents adequately in terms of their NTA costs in a manner that captures sufficient variation in NTA costs without creating unnecessarily granular separations. We made certain administrative decisions that further refined the NTA case-mix classification groups beyond those produced through use of the CART algorithm but maintained the CART output predictive accuracy. The proposed NTA case-mix classification departs from the CART comorbidity score bins in grouping residents with a comorbidity score of 1 with residents with scores of 2 instead of with residents with scores of 0. This is to maintain the distinction between residents with no comorbidities and the rest of the population. In addition, we grouped residents with score of 5 together with residents with scores of 3 to 4 based on their similarity in average NTA costs per day. More information on this analysis can be found in section 3.7.2. of the SNF PDPM technical report available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* We provide the criteria for each of these groups along with its CMI in Table 28.

To help ensure that payment reflects the average relative resource use at the per diem level, CMIs would be set to reflect relative case-mix related differences in costs across groups. This method helps ensure that the share of payment for each case-mix group would be equal to its share of total costs of the component. CMIs for the NTA component are calculated based on two factors. One factor is the average per diem costs of a case-mix group relative to the population average. The other factor is the average variable per diem adjustment factor of the group relative to the population average. In this calculation, average per diem costs equal total NTA costs in the group divided by number of utilization days in the group. Similarly, the average variable per diem adjustment factor equals the sum of NTA variable per diem adjustment factors for all utilization days in the group divided by the number of utilization days in the group. We calculate CMIs such that they equal the ratio of relative average per diem costs for a group to the relative average variable per diem adjustment factor for the group. In this calculation, relative average per diem costs and the relative average variable per diem adjustment factor are weighted by length of stay to account for the different length of stay distributions across case-mix groups (as further discussed in section 3.11.1. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*). After calculating CMIs as described above, we then apply adjustments to ensure that the distribution of resources across payment components is aligned with the statutory base rates as discussed in section V.D.3.b. of this proposed rule. We also apply a parity adjustment by multiplying the CMIs by the ratio of case-mix-related payments in RUG–IV over estimated case-mix-related payments in PDPM, as further discussed in section V.J. of this proposed rule. More information on the variable per diem adjustment factor is discussed in section V.D.4. of this proposed rule. The full methodology used to develop CMIs is presented in section 3.11. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).*

TABLE 28—PROPOSED NTA CASE-MIX CLASSIFICATION GROUPS

NTA score range	NTA case-mix group	NTA case-mix index
12+	NA	3.25
9–11	NB	2.53
6–8	NC	1.85
3–5	ND	1.34
1–2	NE	0.96
0	NF	0.72

As with the previously discussed components, all residents would be classified into one and only one of these 6 NTA case-mix groups under the proposed PDPM. The proposed PDPM would create a separate payment component for NTA services, as opposed to combining NTA and nursing into one component as in the RUG–IV system. This separation would allow payment for NTA services to be based on resident characteristics that predict NTA resource utilization rather than nursing staff time. Thus, we believe that the proposed NTA case-mix groups would provide a better measure of resource utilization and lead to more accurate payments under the SNF PPS.

We invite comments on the approach proposed above to classify residents for NTA payment under the proposed PDPM.

f. Payment Classifications Under Proposed PDPM

RUG–IV classifies each resident into a single RUG, with a single payment for all services. By contrast, the proposed PDPM would classify each resident into five components (PT, OT, SLP, NTA, and nursing) and provide a single payment based on the sum of these individual classifications. The payment for each component would be calculated by multiplying the CMI for the resident's group first by the component federal base payment rate, then by the specific day in the variable per diem adjustment schedule (as discussed in section V.D.4 of this proposed rule). Additionally, for residents with HIV/AIDS indicated on their claim, the nursing portion of payment would be multiplied by 1.18 (as discussed in section V.D.3.d. of this proposed rule). These payments would then be added together along with the non-case-mix component payment rate to create a resident's total SNF PPS per diem rate under the proposed PDPM. This section describes how two hypothetical residents would be classified into payment groups under the current RUG–IV model and proposed PDPM. To begin, consider two residents, Resident A and Resident B, with the resident characteristics identified in Table 29.

TABLE 29—HYPOTHETICAL RESIDENT CHARACTERISTICS

Resident characteristics	Resident A	Resident B
Rehabilitation Received?	Yes	Yes.
Therapy Minutes	730	730.
Extensive Services	No	No.
ADL Score	9	9.
Clinical Category	Acute Neurologic	Major Joint Replacement.
PT and OT Function Score	10	10.
Nursing Function Score	7	7.

TABLE 29—HYPOTHETICAL RESIDENT CHARACTERISTICS—Continued

Resident characteristics	Resident A	Resident B
Cognitive Impairment	Moderate	Intact.
Swallowing Disorder?	No	No
Mechanically Altered Diet?	Yes	No.
SLP Comorbidity?	No	No.
Comorbidity Score	7 (IV Medication and DM)	1 (Chronic Pancreatitis).
Other Conditions	Dialysis	Septicemia.
Depression?	No	Yes.

Currently under the SNF PPS, Resident A and Resident B would be classified into the same RUG–IV group. They both received rehabilitation, did not receive extensive services, received 730 minutes of therapy, and have an ADL score of 9. This places the two residents into the ''RUB'' RUG–IV group and SNFs would be paid at the same rate, despite the many differences between these two residents in terms of their characteristics, expected care needs, and predicted costs of care.

Under the proposed PDPM, however, these two residents would be classified very differently. With regard to the PT and OT components, Resident A would fall into group TO, as a result of his categorization in the Acute Neurologic group and a function score within the 10 to 23 range. Resident B, however, would fall into group TC for the PT and OT components, as a result of his categorization in the Major Joint Replacement group and a function score within the 10 to 23 range. For the SLP component, Resident A would be classified into group SH, based on his categorization in the Acute Neurologic group, the presence of moderate cognitive impairment, and the presence of Mechanically-Altered Diet, while Resident B would be classified into group SA, based on his categorization in the Non-Neurologic group, the absence of cognitive impairment or any SLP-related comorbidity, and the lack of any swallowing disorder or mechanically-altered diet. For the Nursing component, following the existing nursing case-mix methodology, Resident A would fall into group LBC1, based on his use of dialysis services and a nursing function score of 7, while Resident B would fall into group HBC2, due to the diagnosis of septicemia, presence of depression, and a nursing function score of 7. Finally, with regard to NTA classification, Resident A would be classified in group NC, with an NTA score of 7, while Resident B would be classified in group NE, with an NTA score of 1. This demonstrates that, under the proposed PDPM, more aspects of a resident's unique characteristics and needs factor into determining the resident's payment classification, which makes for a more resident-centered case-mix model while also eliminating, or greatly reducing, the number of service-based factors which are used to determine the resident's payment classification. Because this system is based on specific resident characteristics predictive of resource utilization for each component, we expect that payments will be better aligned with resident need.

4. Proposed Variable Per Diem Adjustment Factors and Payment Schedule

Section 1888(e)(4)(G)(i) of the Act provides that payments must be adjusted for case mix, based on a resident classification system which accounts for the relative resource utilization of different types of residents. Additionally, section 1888(e)(1)(B) of the Act specifies that payments to SNFs through the SNF PPS must be made on a per-diem basis. Currently under the SNF PPS, each RUG is paid at a constant per diem rate, regardless of how many days a resident is classified in that particular RUG. However, during the course of the SNF PMR project, analyses on cost over the stay for each of the case-mix adjusted components revealed different trends in resource utilization over the course of the SNF stay. These analyses utilized costs derived from claim charges as a measure of resource utilization. Costs were derived by multiplying charges from claims by the CCRs on facility-level costs reports. As described in section V.B.3.b. of this proposed rule, costs better reflect differences in the relative resource use of residents as opposed to charges, which partly reflect decisions made by providers about how much to charge payers for certain services. In examining costs over a stay, we found that for certain categories of SNF services, notably PT, OT and NTA services, costs declined over the course of a stay. Based on the claim submission schedule and variation in the point during the month when a stay began, we were able to estimate resource use for a specific day in a stay. Facilities are required to submit monthly claims. Each claim covers the period from the first day during the month a resident is in the facility to the end of the month. If a resident was admitted on the first day of the month, remains in the facility, and continues to have Part A SNF coverage until the end of the month, the claim for that month will include all days in the month. However, if a resident is admitted after the first day of the month, the first claim associated with the resident's stay will be shorter than a month. To estimate resource utilization for each day in the stay, we used the marginal estimated cost from claims of varying length based on random variation in the day of a month when a stay began. Using this methodology, we observed a decline in the marginal estimated cost of each additional day of SNF care over the course of the stay. To supplement this analysis, we also looked at changes in the number of therapy minutes reported in different assessments throughout the stay. Because therapy minutes are recorded on the MDS, the presence of multiple assessments throughout the stay provided information on changes in resource use. For example, it was clear whether the number of therapy minutes a resident received changed from the 5-day assessment to the 14-day assessment. The results from this analysis were consistent with the cost from claims analysis and showed that, on average, the number of therapy minutes is lower for assessments conducted later in the stay. This finding is consistent across different lengths of stay. More information on these analyses can be found in section 3.9. of the SNF PDPM technical report and section 3.9. of the SNF PMR technical report that accompanied the ANPRM, both available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

Analyses of the SLP component revealed that the per diem costs remain relatively constant over time, while the PT, OT, and NTA component cost analyses indicate that the per diem cost for these three components decline over

the course of the stay. In the case of the PT and OT components, costs start higher at the beginning of the stay and decline slowly over the course of the stay. The NTA component cost analyses indicate significantly increased NTA costs at the beginning of a stay that then drop to a much lower level that holds relatively constant over the remainder of the SNF stay. This is consistent with how most SNF drug costs are typically incurred at the outset of a SNF stay. These results indicate that resource utilization for PT, OT, and NTA services changes over the course of the stay. More information on these analyses can be found in section 3.9.1. of the SNF PMR technical report that accompanied the ANPRM available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* We were unable to assess potential changes in the level of nursing costs over a resident's stay, in particular because nursing charges are not separately identifiable in SNF claims, and nursing minutes are not reported on the MDS assessments. However, stakeholders (industry representatives and clinicians) at multiple TEPs indicated that nursing costs tend to remain relatively constant over the course of a resident's stay.

Constant per diem rates, by definition, do not track variations in resource use throughout a SNF stay. We believe this may lead to too few resources being allocated for SNF providers at the beginning of a stay. Given the trends in resource utilization over the course of a SNF stay discussed above, and that section 1888(e)(4)(G)(i) of the Act requires the case-mix classification system to account for relative resource use, we are proposing adjustments to the PT, OT, and NTA components in the proposed PDPM to account for changes in resource utilization over a stay. These adjustments are referred to as the variable per diem adjustments. We are not proposing such adjustments to the SLP and nursing components based on findings and stakeholder feedback, as discussed above, that resource use tends to remain relatively constant over the course of a SNF stay.

As noted above and discussed more thoroughly in section 3.9. of the SNF PMR technical report that accompanied the ANPRM (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*), PT and OT costs decline at a slower rate than the decline in NTA costs. Therefore, in addition to proposing a variable per diem adjustment, we further are proposing separate adjustment schedules and indexes for the PT and OT components and the NTA component to more closely reflect the rate of decline in resource utilization for each component. Table 30 provides the adjustment factors and schedule we are proposing for the PT and OT components, while Table 31 provides the adjustment factors and schedule we are proposing for the NTA component.

In Table 30, the adjustment factor for the PT and OT components is 1.00 for days 1 to 20. This is because the analyses described above indicated that PT and OT costs remain relatively high for the first 20 days and then decline. The estimated daily rates of decline for PT and OT costs relative to the initial 20 days are both 0.3 percent. A convenient and appropriate way to reflect this is to bin days in the PT and OT variable per diem adjustment schedules such that payment declines at less frequent intervals, while still reflecting a 0.3 percent daily rate of decline in PT and OT costs. Therefore, we propose to set the adjustment factors such that payment would decline 2 percent every 7 days after day 20 (0.3 * 7 = 2.1). The 0.3 percent rate of decline is derived from a regression model that estimates the level of resource use for each day in the stay relative to the beginning of the stay. The regression methodology and results are presented in section 3.9. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

As described previously in this section, NTA resource utilization exhibits a somewhat different pattern. The analyses described above indicate that NTA costs are very high at the beginning of the stay, drop rapidly after the first three days, and remain relatively stable from the fourth day of the stay. Starting on day 4 of a stay, the per diem costs drop to roughly one-third of the per diem costs in the initial 3 days. This suggests that many NTA services are provided in the first few days of a SNF stay. Therefore, we propose setting the NTA adjustment factor to 3.00 for days 1 to 3 to reflect the extremely high initial costs, then setting it at 1.00 (two-thirds lower than the initial level) for subsequent days. The value of the adjustment factor was set at 3.00 for the first 3 days and 1.00 after (rather than, for example, 1.00 and 0.33, respectively) for simplicity. The results are presented in section 3.9. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

Case-mix adjusted federal per diem payment for a given component and a given day would be equal to the base rate for the relevant component (either urban or rural), multiplied by the CMI for that resident, multiplied by the variable per diem adjustment factor for that specific day, as applicable. Additionally, as described in further detail in section V.D.3.d. of this proposed rule, an additional 18 percent would be added to the nursing per-diem payment to account for the additional nursing costs associated with residents who have HIV/AIDS. These payments would then be added together along with the non-case-mix component payment rate to create a resident's total SNF PPS per diem rate under the proposed PDPM.

We invite comments on the proposed variable per diem adjustment factors and payment schedules discussed in this section.

TABLE 30—PROPOSED VARIABLE PER-DIEM ADJUSTMENT FACTORS AND SCHEDULE—PT AND OT

Medicare payment days	Adjustment factor
1–20	1.00
21–27	0.98
28–34	0.96
35–41	0.94
42–48	0.92
49–55	0.90
56–62	0.88
63–69	0.86
70–76	0.84
77–83	0.82
84–90	0.80
91–97	0.78
98–100	0.76

TABLE 31—PROPOSED VARIABLE PER-DIEM ADJUSTMENT FACTORS AND SCHEDULE—NTA

Medicare payment days	Adjustment factor
1–3	3.0
4–100	1.0

E. Use of the Resident Assessment Instrument—Minimum Data Set, Version 3

1. Proposed Revisions to Minimum Data Set (MDS) Completion Schedule

Consistent with section 1888(e)(6)(B) of the Act, to classify residents under the SNF PPS, we use the MDS 3.0 Resident Assessment Instrument. Within the SNF PPS, there are two categories of assessments, scheduled and unscheduled. In terms of scheduled assessments, SNFs are currently

required to complete assessments on or around days 5, 14, 30, 60, and 90 of a resident's Part A SNF stay, including certain grace days. Payments based on these assessments depend upon standard Medicare payment windows associated with each scheduled assessment. More specifically, each of the Medicare-required scheduled assessments has defined days within which the Assessment Reference Date (ARD) must be set. The ARD is the last day of the observation (or ''look-back'') period that the assessment covers for the resident. The facility is required to set the ARD on the MDS form itself or in the facility software within the appropriate timeframe of the assessment type being completed. The clinical data collected from the look-back period is used to determine the payment associated with each assessment. For example, the ARD for the 5-day PPS Assessment is any day between days 1 to 8 (including Grace Days). The clinical data collected during the look-back period for that assessment is used to determine the SNF payment for days 1 to 14. Unscheduled assessments, such as the Start of Therapy (SOT) Other Medicare Required Assessment (OMRA), the End of Therapy OMRA (EOT OMRA), the Change of Therapy (COT) OMRA, and the Significant Change in Status Assessment (SCSA or Significant Change), may be required during the resident's Part A SNF stay when triggered by certain defined events.

For example, if a resident is being discharged from therapy services, but remaining within the facility to continue the Part A stay, then the facility may be required to complete an EOT OMRA. Each of the unscheduled assessments affects payment in different and defined manners. A description of the SNF PPS scheduled and unscheduled assessments, including the criteria for using each assessment, the assessment schedule, payment days covered by each assessment, and other related policies, are set forth in the MDS 3.0 RAI manual on the CMS website (available at *https://downloads.cms.gov/files/MDS-30-RAI-Manual-v115-October-2017.pdf*).

Table 32 outlines when each SNF PPS assessment is required to be completed and its effect on SNF PPS payment.

TABLE 32—CURRENT PPS ASSESSMENT SCHEDULE

Medicare MDS assessment schedule type	Assessment reference date	Assessment reference date grace days	Applicable standard Medicare payment days
Scheduled PPS assessments			
5-day	Days 1–5	6–8	1 through 14.
14-day	Days 13–14	15–18	15 through 30.
30-day	Days 27–29	30–33	31 through 60.
60-day	Days 57–59	60–63	61 through 90.
90-day	Days 87–89	90–93	91 through 100.
Unscheduled PPS assessments			
Start of Therapy OMRA	5–7 days after the start of therapy		Date of the first day of therapy through the end of the standard payment period.
End of Therapy OMRA	1–3 days after all therapy has ended		First non-therapy day through the end of the standard payment period.
Change of Therapy OMRA	Day 7 (last day) of the COT observation period		The first day of the COT observation period until end of standard payment period, or until interrupted by the next COT–OMRA assessment or scheduled or unscheduled PPS Assessment.
Significant Change in Status Assessment.	No later than 14 days after significant change identified.		ARD of Assessment through the end of the standard payment period.

An issue which has been raised in the past with regard to the existing SNF PPS assessment schedule is that the sheer number of assessments, as well as the complex interplay of the assessment rules, significantly increases the administrative burden associated with the SNF PPS. Case-mix classification under the proposed SNF PDPM that we are proposing relies to a much lesser extent on characteristics that may change very frequently over the course of a resident's stay (for example, therapy minutes may change due to resident refusal or unexpected changes in resident status), but instead relies on more stable predictors of resource utilization by tying case-mix classification, to a much greater extent, to resident characteristics such as diagnosis information. In view of the greater reliance of the proposed SNF PDPM (as compared to the RUG–IV model) on resident characteristics that are relatively stable over a stay and our general focus on reducing administrative burden for providers across the Medicare program, we are making an effort to reduce the administrative burden on providers by concurrently proposing to revise the assessments that would be required under the proposed SNF PDPM. Specifically, we are proposing to use the 5-day SNF PPS scheduled assessment to classify a resident under the proposed SNF PDPM for the entirety of his or her Part A SNF stay effective beginning FY 2020 in conjunction with the implementation of the proposed PDPM, except as described below. If we were to finalize this proposal, we would propose revisions to the regulations at § 413.343(b) during the FY 2020 rulemaking cycle so that such regulations would no longer reflect the RUG–IV SNF PPS assessment schedule as of the proposed conversion to the PDPM on October 1, 2019.

We also understand that Medicare beneficiaries are each unique and can experience clinical changes which may require a SNF to reassess the resident to capture changes in the resident's condition. Therefore, to allow SNFs to capture these types of changes, effective October 1, 2019 in conjunction with the proposed implementation of the PDPM, we propose to require providers to reclassify residents as appropriate from

the initial 5-day classification using a new assessment called an Interim Payment Assessment (IPA), which would be comprised of the 5-day SNF PPS MDS Item Set (Item Set NP). Providers would be required to complete an IPA in cases where the following two criteria are met:

(1) There is a change in the resident's classification in at least one of the first tier classification criteria for any of the components under the proposed PDPM (which are those clinical or nursing payment criteria identified in the first column in Tables 21, 23, 26, and 27), such that the resident would be classified into a classification group for that component that differs from that provided by the 5-day scheduled PPS assessment, and the change in classification group results in a change in payment either in one particular payment component or in the overall payment for the resident; and

(2) The change(s) are such that the resident would not be expected to return to his or her original clinical status within a 14-day period.

In addition, we propose that the Assessment Reference Date (ARD) for the IPA would be no later than 14 days after a change in a resident's first tier classification criteria is identified. The IPA is meant to capture substantial changes to a resident's clinical condition and not every day, frequent changes. We believe 14 days gives the facility an adequate amount of time to determine whether the changes identified are in fact routine or substantial. To clarify, the change in classification group described above refers to not only a change in one of the first tier classification criteria in any of the proposed payment components, but also to one that would be sufficient to change payment in either one component or in the overall payment for the resident. For example, given the collapsed categories under the PT and OT components, this would mean that a change from the medical management group to the cancer group would not necessitate an IPA, as they are both collapsed under the medical management group for purposes of the PT and OT components. However, a change from the major joint replacement group to the medical management group would necessitate an IPA, as this would change the resident's clinical category group for purposes of categorization under the PT and OT components and would result in a change in payment.

We believe that the proposed requirement to complete an IPA balances the need to ensure accurate payment and monitor for changes in the resident's condition with the importance of ensuring a more streamlined assessment approach under the proposed PDPM.

In cases where the IPA is required and a facility fails to complete one, we propose that the facility would follow the guidelines for late and missed unscheduled MDS assessments which are explained in Chapters 2.13 and 6.8 of the MDS RAI Manual (*https://downloads.cms.gov/files/MDS-30-RAI-Manual-v115-October-2017.pdf*). Specifically, if the SNF fails to set the ARD within the defined ARD window for an IPA, and the resident is still in a Part A stay, the SNF would be required to complete a late assessment. The ARD can be no earlier than the day the error was identified. If the ARD on the late assessment is set for a date that is prior to the end of the time period during which the assessment would have controlled the payment, had the ARD been set timely, the SNF would bill the default rate for the number of days that the assessment is out of compliance. This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD). For example, a SNF Part A resident who is in the major joint replacement payment category for the PT and OT components develops a skin ulcer that is of such a quality that, in terms of developing a care and treatment plan for this resident, the skin ulcer takes precedence as the resident's primary diagnosis. As a result, the resident's primary diagnosis, as coded in item I8000, is for this skin ulcer, which would cause him to be classified into the medical management category for these components. The facility notes this clinical change on November 10, 2018. However, they do not complete the IPA until November 26, 2018 which is 16 days after the change in criteria was identified and two days after the ARD window. The facility would bill the default rate for the two days that it was out of compliance. If the SNF fails to set the ARD for an IPA within the defined ARD window for that assessment, and the resident has been discharged from Part A, the assessment is missed and cannot be completed. All days that would have been paid by the missed assessment (had it been completed timely) are considered provider-liable. Taking the example above, if the facility recognized the IPA needed to be completed after the resident has left the building, the facility would be liable for all days from November 10, 2018 until the date of the resident's Part A Discharge. We invite comments on these proposals.

In addition to requiring the completion of the IPA as described above, we have also considered the implications of a SNF completing an IPA on the variable per diem adjustment schedule described in section V.D.4. this proposed rule. More specifically, we have considered whether an SNF completing an IPA should cause a reset in the variable per diem adjustment schedule for the associated resident. In examining costs over a stay, we found that for certain categories of SNF services, notably PT, OT and NTA services, costs declined over the course of a stay. Our analyses showed that, on average, the number of therapy minutes is lower for assessments conducted later in the stay. Additionally, we are concerned that by providing for the variable per diem adjustment schedule to be reset after an IPA is completed, providers may be incentivized to conduct multiple IPAs during the course of a resident's stay to reset the variable per diem adjustment schedule each time the adjustment is reduced. Therefore, in cases where an IPA is completed, we are proposing that this assessment would reclassify the resident for payment purposes as outlined in Table 33, but the resident's variable per diem adjustment schedule would continue rather than being reset on the basis of completing the IPA.

Finally, we believe that, regardless of the payment system or case-mix classification model used, residents should continue to receive therapy that is appropriate to their care needs, and this includes both the intensity and modes of therapy utilized. However, we recognize that because the initial 5-day PPS assessment would classify a resident for the entirety of his or her Part A SNF stay (except in cases where a IPA is completed) as outlined above, there is no mechanism by which SNFs are required to report the amount of therapy provided to a resident over the course of the stay or by which we may monitor that they are in compliance with the proposed 25 percent group and concurrent therapy limit as described in section V.F. of this proposed rule. Therefore, for these reasons, under the proposed PDPM, we propose to require that SNFs continue to complete the PPS Discharge Assessment, as appropriate (including the proposed therapy items discussed in section V.E.3. of this proposed rule), for each SNF Part A resident at the time of Part A or facility discharge (see section V.E. of this proposed rule for a discussion of our proposed revisions to this assessment to include therapy items). Under the current instructions in the MDS 3.0 RAI

manual, the Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility (MDS 3.0 RAI Manual Chapter 2.7). However, we are proposing to require this assessment to be completed at the time of facility discharge for Part A residents as well. Thus, we would continue to collect data on therapy provision as proposed in section V.F. of this proposed rule, to assure that residents are receiving therapy that is reasonable, necessary, and specifically tailored to meet their unique needs. We believe that the combination of the 5-day Scheduled PPS Assessment, the IPA Assessment, and PPS Discharge Assessment would provide flexibility for providers to capture and report accurately the resident's condition, as well as accurately reflect resource utilization associated with that resident, while minimizing the administrative burden on providers under the proposed SNF PDPM.

In addition to the proposed changes above, we also examined the current use of grace days in the MDS assessment schedule. Grace days have been a longstanding part of the SNF PPS. They were created in order to allow clinical flexibility when setting ARD dates of scheduled PPS assessments. In the FY 2012 final rule (76 FR 48519), we discussed that in practice, there is no difference between regular ARD windows and grace days and we encouraged the use of grace days if their use would allow a facility more clinical flexibility or would more accurately capture therapy and other treatments:

> Thus, we do not intend to penalize any facility that chooses to use the grace days for assessment scheduling or to audit facilities based solely on their regular use of grace days. We may explore the option of incorporating the grace days into the regular ARD window in the future; nevertheless, we will retain them as part of the assessment schedule at the present time consistent with the current policy and the new assessment schedule proposed in the proposed rule.

We propose, effective beginning October 1, 2019, in conjunction with the proposed implementation of the PDPM, to incorporate the grace days into the existing assessment window. This proposal would eliminate grace days from the SNF PPS assessment calendar and provide for only a standard assessment window. As discussed, there is no practical difference between the regular assessment window and grace days and there is no penalty for using grace days. As such, we believe it would be appropriate to eliminate the use of grace days in PPS assessments.

Table 33 sets forth the proposed SNF PPS assessment schedule, incorporating our proposed revisions above, which would be effective October 1, 2019 concurrently with the proposed PDPM.

TABLE 33—PROPOSED PPS ASSESSMENT SCHEDULE UNDER PDPM

Medicare MDS assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
5-day Scheduled PPS Assessment	Days 1–8	All covered Part A days until Part A discharge (unless an IPA is completed).
Interim Payment Assessment (IPA)	No later than 14 days after change in resident's first tier classification criteria is identified.	ARD of the assessment through Part A discharge (unless another IPA assessment is completed).
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date.	N/A.

We would note that, as in previous years, we intend to continue to work with providers and software developers to assist them in understanding changes we are proposing to the MDS. Further, we would note that none of the proposals related to changes to the MDS assessment schedule should be understood to change any assessment requirements which derive from the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), which establishes assessment requirements for all nursing home residents, regardless of payer. We invite comments on our proposals to revise the SNF PPS assessment schedule and related policies as discussed above. We also solicit comment on the extent to which implementing these proposals would reduce provider burden.

2. Proposed Item Additions to the Swing Bed PPS Assessment

Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, these services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. A more detailed discussion of this provision appears in section III.B.4. of this proposed rule.

For purposes of the proposed PDPM, we propose to add three items to the Swing Bed PPS Assessment. Until now, these additional items have not been part of the Swing Bed PPS Assessment form because they have not been used for payment. However, the presence of each of these items would be used to classify swing bed residents under the proposed SNF PDPM as explained in section V.D. of this proposed rule. Thus, we believe it is necessary and appropriate to include these items in the Swing Bed PPS Assessment beginning October 1, 2019, in conjunction with the proposed implementation of the PDPM. The items we propose to add to the Swing Bed PPS assessment are provided in Table 34. We invite comments on this proposal.

TABLE 34—PROPOSED ITEMS TO ADD TO SWING BED PPS ASSESSMENT

MDS item No.	Item name	Related PDPM payment component
K0100	Swallowing Disorder	SLP
I4300	Active Diagnoses: Aphasia	SLP
O0100D2	Special Treatments, Procedures and Programs: Suctioning, While a Resident	NTA

3. Proposed Items to be Added to the PPS Discharge Assessment

As noted above, under the MDS 3.0, the Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility (MDS 3.0 RAI Manual Chapter 2.7). The PPS Discharge Assessment uses the Item Set NPE and does not currently contain section O of the MDS 3.0. The therapy items in section O of the MDS allow CMS to collect data from providers on the volume, type (physical therapy, occupational therapy and speech-language pathology), and mode (individual, concurrent, or group therapy) of the therapy provided to SNF residents. As noted in comments received on the ANPRM in relation to therapy provision, this data would be particularly important to monitor. Specifically, a significant number of commenters expressed concerns that the amount of therapy provided to SNF residents, were RCS–I to have been implemented, would drop considerably as compared to the amount currently delivered under RUG–IV. Commenters noted that this is because the incentive to provide a high volume of therapy services to SNF residents to achieve the highest resident therapy group classification, would no longer exist under RCS–I, leading providers to potentially significantly reduce the amount of therapy provided to SNF residents.

Given that the RCS–I model and PDPM both present the potential for providers to significantly reduce the amount of therapy provided to SNF residents, as compared to RUG–IV, we believe that the same potential result may occur under the proposed PDPM as commenters identified with RCS–I. To better track therapy utilization under PDPM, and to better ensure that residents continue to receive an appropriate amount of therapy commensurate with their needs, given the reduction in the frequency of resident assessments required under the proposed PDPM, we propose to add therapy collection items to PPS Discharge assessment and to require providers to complete these items beginning October 1, 2019, in conjunction with the proposed implementation of the PDPM.

Specifically, we propose to add the items listed in Table 35 to the PPS Discharge Assessment.

TABLE 35—PROPOSED ITEMS TO ADD TO SNF PPS DISCHARGE ASSESSMENT

MDS item No.	Item name
O0400A5	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Therapy Start Date.
O0400A6	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Therapy End Date.
O0400A7	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Individual Minutes.
O0400A8	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Concurrent Minutes.
O0400A9	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Group Minutes.
O0400A10	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Days.
O0400B5	Special Treatments, Procedures and Programs: Occupational Therapy: Therapy Start Date.
O0400B6	Special Treatments, Procedures and Programs: Occupational Therapy: Therapy End Date.
O0400B7	Special Treatments, Procedures and Programs: Occupational Therapy: Total Individual Minutes.
O0400B8	Special Treatments, Procedures and Programs: Occupational Therapy: Total Concurrent Minutes.
O0400B9	Special Treatments, Procedures and Programs: Occupational Therapy: Total Group Minutes.
O0400B10	Special Treatments, Procedures and Programs: Occupational Therapy: Total Days.
O0400C5	Special Treatments, Procedures and Programs: Physical Therapy: Therapy Start Date.
O0400C6	Special Treatments, Procedures and Programs: Physical Therapy: Therapy End Date.
O0400C7	Special Treatments, Procedures and Programs: Physical Therapy: Total Individual Minutes.
O0400C8	Special Treatments, Procedures and Programs: Physical Therapy: Total Concurrent Minutes.
O0400C9	Special Treatments, Procedures and Programs: Physical Therapy: Total Group Minutes.
O0400C10	Special Treatments, Procedures and Programs: Physical Therapy: Total Days.

For the proposed items which refer to the total number of minutes for each therapy discipline and each therapy mode, this would allow CMS to both conduct reviews of changes in the volume and intensity of therapy services provided to SNF residents under the proposed PDPM, compared to that provided under RUG–IV, as well as to assess compliance with the proposed group and concurrent therapy limit discussed in section V.F of this proposed rule. The proposed ''total days'' items for each discipline and mode of therapy would further support our monitoring efforts for therapy, as requested by commenters on the ANPRM, by allowing us to monitor not just the total minutes of therapy provided to SNF residents under the proposed PDPM, but also assess the daily intensity of therapy provided to SNF residents under the proposed PDPM, as compared to that provided under RUG–IV. Ultimately, these proposed items would allow facilities to easily report therapy minutes provided to SNF residents and allow us to monitor the volume and intensity of therapy services provided to SNF residents under the proposed PDPM, as suggested by commenters on the ANPRM. If we discover that the amount of therapy provided to SNF residents does change significantly under the proposed PDPM, if implemented, then we will assess the need for additional policies to ensure that SNF residents continue to receive sufficient and appropriate therapy services consistent with their unique needs and goals. We invite comments on our proposals above to add items to the SNF PPS Assessment.

F. Proposed Revisions to Therapy Provision Policies Under the SNF PPS

Currently, almost 90 percent of residents in a Medicare Part A SNF stay receive therapy services. Under the current RUG–IV model, therapy services are case mix-adjusted primarily based on the therapy minutes reported on the MDS. When the original SNF PPS model was developed, most therapy services were furnished on an individual basis, and the minutes reported on the MDS served as a proxy for the staff resource time needed to provide the therapy care. Over the years, we have monitored provider behavior and have made policy changes as it became apparent that, absent safeguards like quality measurement to ensure that the amount of therapy provided did not exceed the resident's actual needs, there were certain inherent incentives for providers to furnish as much therapy as possible.

Thus, for example, in the SNF PPS FY 2010 final rule (74 FR 40315 through 40319), we decided to allocate concurrent therapy minutes for purposes of establishing the RUG–IV group to which the patient belongs, and to limit concurrent therapy to two patients at a time who were performing different activities.

Following the decision to allocate concurrent therapy, using STRIVE data as a baseline, we found two significant provider behavior changes with regard to therapy provision under the RUG–IV payment system. First, there was a significant decrease in the amount of concurrent therapy that was provided in SNFs. Simultaneously, we observed a significant increase in the provision of group therapy, which was not subject to allocation at that time. We concluded that the manner in which group therapy minutes were counted in determining a patient's RUG–IV group created a payment incentive to provide group therapy rather than individual therapy or concurrent therapy, even in cases where individual therapy (or concurrent therapy) was more appropriate for the resident. Thus, we made two policy changes regarding group therapy in the FY 2012 SNF PPS final rule (76 FR 48511 through 48517). We defined group therapy as exactly four residents who are performing the same or similar therapy activities. Additionally, we allocated group therapy among the four patients participating in group therapy—meaning that the total amount of time that a therapist spent with a group would be divided by 4 (the number of patients that comprise a group) to establish the RUG–IV group to which the patient belongs.

Since we began allocating group therapy and concurrent therapy, these modes of therapy (group and concurrent) represent less than one percent of total therapy provided to SNF residents. Table 36, which appeared in the FY 2014 SNF PPS Proposed Rule (78 FR 26464) and sets forth our findings with respect to the effect of policies finalized in the FY 2012 SNF PPS Final Rule, demonstrates the change in therapy provision between the STRIVE study and the implementation of the therapy policy changes in FY 2012. We would note that the distribution of therapy modes presented in Table 36 reflecting therapy provision in FY 2012 is also an accurate reflection of current therapy provision based on resident data collected in the QIES Database and continued monitoring of therapy utilization.

TABLE 36—MODE OF THERAPY PROVISION

	Strive	FY 2011	FY 2012
Individual	74%	91.8%	99.5%
Concurrent	25	0.8	0.4
Group	<1	7.4	0.1

Based on our prior experience with the provision of concurrent and group therapy in SNFs, we again are concerned that if we were to implement the proposed SNF PDPM, providers may base decisions regarding the particular mode of therapy to use for a given resident on financial considerations rather than on the clinical needs of SNF residents. Because the proposed SNF PDPM would not use the minutes of therapy provided to a resident to classify the resident for payment purposes, we are concerned that SNFs may once again become incentivized to emphasize group and concurrent therapy, over the kind of individualized therapy which is tailored to address each beneficiary's specific care needs which we believe is generally the most appropriate mode of therapy for SNF residents. As we stated in the FY 2012 proposed rule (76 CFR 26387):

> While . . . group therapy can play an important role in SNF patient care, we note that group therapy is not appropriate for either all patients or for all conditions, and is primarily effective as a supplement to individual therapy, which we maintain should be considered the primary therapy mode and standard of care in therapy services provided to SNF residents. As evidenced by the application of a cap on the amount of group therapy services that may be provided to SNF residents, we do not believe that a SNF providing the preponderance of therapy in the form of group therapy would be demonstrating the intensity of therapy appropriate to this most frail and vulnerable nursing home population.

Since the inception of the SNF PPS, we have limited the amount of group therapy provided to each SNF Part A resident to 25 percent of the therapy provided to them by discipline. As stated in the FY 2000 final rule (64 FR 41662):

> Although we recognize that receiving PT, OT, or ST as part of a group has clinical merit in select situations, we do not believe that services received within a group setting should account for more than 25 percent of the Medicare resident's therapy regimen during the SNF stay. For this reason, no more than 25 percent of the minutes reported in the MDS may be provided within a group setting. This limit is to be applied for each therapy discipline; that is, only 25 percent of the PT minutes reported in the MDS may be minutes received in a group setting and, similarly, only 25 percent of the OT, or the ST minutes reported may be minutes received in a group setting.

Although we recognize that group and concurrent therapy may have clinical merit in specific situations, we also continue to believe that individual therapy is generally the best way of providing therapy to a resident because it is most tailored to that specific resident's care needs.

As such, individual therapy should represent the majority of the therapy services received by SNF residents both from a clinical and payment perspective. As stated in the FY 2012 proposed rule (76 CFR 26372):

> Moreover, even under the previous RUG–53 model, it is clear that the predominant mode of therapy that the payment rates were designed to address was individual therapy rather than concurrent or group therapy.

To help ensure that SNF residents would receive the majority of therapy services on an individual basis, if we were to implement the proposed PDPM, we believe concurrent and group therapy combined should be limited to no more than 25 percent of a SNF resident's therapy minutes by discipline. In combination, this limit would ensure that at least 75 percent of a resident's therapy minutes are provided on an individual basis. Because the change in how therapy services would be used to classify residents under the proposed PDPM gives rise to the concern that providers may begin to utilize more group and concurrent therapy due to financial considerations, we are proposing to set a combined 25 percent limit on concurrent therapy and group therapy for each discipline of therapy provided. For example, if a resident received 800 minutes of physical therapy, no more than 200 minutes of this therapy could be provided on a concurrent or group basis. Finally, we note that under RUG–IV, we currently allocate minutes of therapy because we pay for therapy

based on therapy minutes and not resident characteristics. Given that therapy minutes would no longer be a factor in determining payment classifications for residents under the proposed PDPM, we would utilize the total, unallocated number of minutes by therapy mode reported on the MDS, to determine compliance with the proposed limit. Utilizing unallocated therapy minutes also serves to underscore the patient-driven nature of the PDPM, as it focuses the proposed limit on concurrent and group therapy on the way in which the therapy is received by the beneficiary, rather than furnished by the therapist, and would better ensure that individual therapy represents at least a vast majority of the therapy services received by a resident.

We considered other possible limits, and even no limit, on group and concurrent therapy. For example, we considered placing no limit on group or concurrent therapy, in order to afford providers the greatest degree of flexibility in designing a therapy program for each SNF resident. However, even in response to this option to have no limit on concurrent and group therapy, many commenters on the ANPRM expressed concerns regarding the lack of appropriate safeguards for ensuring that SNF residents continue to receive an appropriate level of therapy under the revised case-mix model. We agree with these commenters and believe that there should be some limit on the amount of group and concurrent therapy that is provided to residents in order to ensure that residents receive an appropriate amount of individual therapy that is tailored to their specific needs. Also, in the ANPRM, we discussed the possibility of proposing a 25 percent limit on each of concurrent and group therapy, allowing for up to 50 percent of therapy services provided in the SNF to be provided in a non-individual modality. This option sought to balance the flexibility afforded to therapists in designing an appropriate therapy plan that meets the needs and goals of the specific resident with the importance of ensuring that SNF residents receive an appropriate level of individual therapy. However, we are concerned that a separate 25 percent limit for group and concurrent therapy would not provide sufficient assurance that at least a majority of a resident's therapy would be provided on an individual basis. Therefore, we believe that the separate 25 percent limits on concurrent and group therapy discussed in the ANPRM, or any option which would impose a higher limit on group and concurrent therapy, would not provide the necessary protection for SNF residents. By contrast, we believe that a combined 25 percent limit on group and concurrent therapy would provide sufficient assurance that at least a majority of each resident's therapy would be provided on an individual basis, consistent with our position that individual therapy is generally the best way of providing therapy to SNF residents because it is most tailored to their care needs. We would also note that, assuming that existing therapy delivery patterns (as set forth in Table 36) are accurate and they reflect the individually-tailored needs of SNF residents currently being treated under the SNF benefit, the number of group and concurrent minutes that have been reported by SNFs thus far are significantly lower than the limit described in this proposal. In other words, based on the data presented in Table 36, the proposed limit on group and concurrent therapy affords a significantly greater degree of flexibility on therapy modality than appears to be required to meet the needs of SNF residents, given that less than one percent of therapy currently being delivered is either group or concurrent therapy. Therefore, a combined limit of 25 percent for group and concurrent therapy should provide SNFs with more than enough flexibility with respect to therapy mode to meet the care needs of their residents.

We believe that individual therapy is usually the best mode of therapy provision as it permits the greatest degree of interaction between the resident and therapist, and should therefore represent, at a minimum, the majority of therapy provided to an SNF resident. However, we recognize that, in very specific clinical situations, group or concurrent therapy may be the more appropriate mode of therapy provision, and therefore, we would want to allow providers the flexibility to be able to utilize these modes. We continue to stress that group and concurrent therapy should not be utilized to satisfy therapist or resident schedules, and that all group and concurrent therapy should be well documented in a specific way to demonstrate why they are the most appropriate mode for the resident and reasonable and necessary for his or her individual condition. We invite comments on the proposal discussed above. In addition, we solicit comments on other ways in which therapy limits may be applied to appropriately meet the care needs of SNF residents.

Currently the RUG–IV grouper calculates the percentage of group therapy each resident receives in the SNF based on the algorithms described in section 6.6 of the MDS RAI Manual (found at *https://downloads.cms.gov/files/MDS-30-RAI-Manual-v115-October-2017.pdf*). When a resident is found to have exceeded the 25 percent group therapy limit, the minutes of therapy received in excess are not counted towards the calculation of the RUG–IV therapy classification. Because the proposed PDPM would not use the minutes of therapy provided to a resident to classify the resident for payment purposes, we would need to determine a way under the proposed PDPM to address situations in which facilities exceed the combined 25 percent group and concurrent therapy limit.

Therefore, we are proposing that at a component level (PT, OT, SLP), when the amount of group and concurrent therapy exceeds 25 percent within a given therapy discipline, that providers would receive a non-fatal warning edit on the validation report that the provider receives when submitting an assessment which would alert the provider to the fact that the therapy provided to that resident exceeded the threshold. To explain, a fatal error in the QIES ASAP system occurs when one or more items in the submitted record fail to pass the requirements identified in the MDS data submission specifications. A warning error occurs when an item or combination of items in the submitted record trigger a non-fatal edit in the QIES ASAP system. The non-fatal warning would serve as a reminder to the facility that they are out of compliance with the proposed limit for group and concurrent therapy. As part of our regular monitoring efforts on SNF Part A services, we would monitor group and concurrent therapy utilization under the proposed PDPM and consider making future proposals to address abuses of this proposed policy or flag providers for additional review should an individual provider be found to consistently exceed the proposed threshold after the implementation of the proposed PDPM. We would note that as the proportion of group and/or concurrent therapy (which are, by definition, non-individual modes of therapy provision) increases, the chances that the provider is still meeting the individualized needs of each resident would diminish. Given that meeting the individualized needs of the resident is a component of meeting the coverage requirements for SNF Part A services, as described in section 1814(a)(2)(B) of the Act and further described in Section 30 of Chapter 8 of the Medicare Benefit Policy Manual

(accessible at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf*) where it states that services furnished to SNF residents may be considered reasonable and necessary insomuch as the services are consistent with ''the individual's particular medical needs'', excessive levels of group and/or concurrent therapy could constitute a reason to deny SNF coverage for such stays. We invite comments on this proposed compliance mechanism.

G. Proposed Interrupted Stay Policy

Under section 1812(a)(2)(A) of the Act, Medicare Part A covers a maximum of 100 days of SNF services per spell of illness, or ''benefit period''. A benefit period starts on the day the beneficiary begins receiving inpatient hospital or SNF benefits under Medicare Part A. (See section 1861(a) of the Act; § 409.60). SNF coverage also requires a prior qualifying, inpatient hospital stay of at least 3 consecutive days' duration (counting the day of inpatient admission but not the day of discharge). (See section 1861(i) of the Act; § 409.30(a)(1)). Once the 100 available days of SNF benefits are used, the current benefit period must end before a beneficiary can renew SNF benefits under a new benefit period. For the current benefit period to end so a new benefit period can begin, a period of 60 consecutive days must elapse throughout which the beneficiary is neither an inpatient of a hospital nor receiving skilled care in a SNF. (See section 1861(a) of the Act; § 409.60). Once a benefit period ends, the beneficiary must have another qualifying 3-day inpatient hospital stay and meet the other applicable requirements before Medicare Part A coverage of SNF care can resume. (See section 1861(i); § 409.30) While the majority of SNF benefit periods, approximately 77 percent, involve a single SNF stay, it is possible for a beneficiary to be readmitted multiple times to a SNF within a single benefit period, and such cases represent the remaining 23 percent of SNF benefit periods. For instance, a resident can be readmitted to a SNF within 30 days after a SNF discharge without requiring a new qualifying 3-day inpatient hospital stay or beginning a new benefit period. SNF admissions that occur between 31 and 60 days after a SNF discharge require a new qualifying 3-day inpatient hospital stay, but fall within the same benefit period. (See sections 1861(a) and (i) of the Act; §§ 409.30, 409.60)

Other Medicare post-acute care (PAC) benefits have ''interrupted stay'' policies that provide for a payment adjustment when the beneficiary temporarily goes to another setting, such as an acute care hospital, and then returns within a specific timeframe. In the inpatient rehabilitation facility (IRF) and inpatient psychiatric facility (IPF) settings, for instance, an interrupted stay occurs when a patient returns to the same facility (or in the case of an IPF, the same or another IPF) within 3 days of discharge. The interrupted stay policy for long-term care hospitals (LTCHs) is more complex, consisting of several policies depending on the length of the interruption and, at times, the discharge destination: An interruption of 3 or fewer days is always treated as an interrupted stay, which is similar to the IRF PPS and IPF PPS policies; if there is an interruption of more than 3 days, the length of the gap required to trigger a new stay varies depending on the discharge setting. In these three settings, when a beneficiary is discharged and returns to the facility within the interrupted stay window, Medicare treats the two segments as a single stay.

While other Medicare PAC benefit categories have interrupted stay policies, the SNF benefit under the RUG–IV case-mix model has had no need for such a policy because given a resident's case-mix group, payment does not change over the course of a stay. In other words, assuming no change in a patient's condition or treatment, the payment rate is the same on Day 1 of a covered SNF stay as it is at Day 7. Accordingly, a beneficiary's readmission to the SNF—even if only a few days may have elapsed since a previous discharge—could essentially be treated as a new and different stay without affecting the payment rates.

However, as described in section V.D. of this proposed rule, the proposed PDPM would adjust the per diem rate across the length of a stay (the variable per diem adjustment) to better reflect how and when costs are incurred and resources used over the course of the stay, such that earlier days in a given stay receive higher payments, with payments trending lower as the stay continues. In other words, the adjusted payment rate on Day 1 and Day 7 of a SNF stay may not be the same. Although we believe this variable per diem adjustment schedule more accurately reflects the increased resource utilization in the early portion of a stay for *single-stay benefit periods* (which represent the majority of cases), we considered whether and how such an adjustment should be applied to payment rates for cases involving multiple stays per benefit period. In other words, we considered instances in which a resident has a Part A stay in a SNF, leaves the facility for some reason, and then is readmitted to the same SNF or a different SNF; and how this readmission should be viewed in terms of both resident classification and the variable per diem adjustment schedule under the proposed PDPM. Application of the variable per diem adjustment is of particular concern because providers may consider discharging a resident and then readmitting the resident shortly thereafter to reset the resident's variable per diem adjustment schedule and maximize the payment rates for that resident.

Given the potential harm which may be caused to the resident if discharged inappropriately, and other concerns outlined previously in this section, we discussed in the ANPRM the possibility of adopting an interrupted stay policy under the SNF PPS in conjunction with the implementation of the RCS–I case-mix model. Several commenters expressed support for this interrupted stay policy in responding to the ANPRM, saying that the interrupted stay policy is in alignment with similar policies in other post-acute settings, and that a similar policy would likely be implemented under any cross-setting PAC payment system.

Thus, we are proposing to implement an interrupted stay policy as part of the SNF PPS, effective beginning FY 2020 in conjunction with the proposed implementation of the SNF PDPM. Specifically, in cases where a resident is discharged from a SNF and returns to the same SNF by 12:00 a.m. at the end of the third day of the interruption window (as defined below), we propose treating the resident's stay as a continuation of the previous stay for purposes of both resident classification and the variable per diem adjustment schedule. In cases where the resident's absence from the SNF exceeds this 3-day interruption window (as defined below), or in any case where the resident is readmitted to a different SNF, we propose treating the readmission as a new stay, in which the resident would receive a new 5-day assessment upon admission and the variable per diem adjustment schedule for that resident would reset to Day 1. Consistent with the existing interrupted stay policies for the IRF and IPF settings, we would define the interruption window as the 3-day period starting with the calendar day of discharge and additionally including the 2 immediately following calendar days. For the purposes of the interrupted stay policy, the source of the readmission would not be relevant. That is, the beneficiary may be readmitted from the community, from an

intervening hospital stay, or from a different kind of facility, and the interrupted stay policy would operate in the same manner. The only relevant factors in determining if the interrupted stay policy would apply are the number of days between the resident's discharge from a SNF and subsequent readmission to a SNF, and whether the resident is readmitted to the same or a different SNF.

Consider the following examples, which we believe aid in clarifying how this policy would be implemented:

Example A: A beneficiary is discharged from a SNF on Day 3 of the stay. Four days after the date of discharge, the beneficiary is then readmitted (as explained above, this readmission would be in the same benefit period) to the same SNF. The SNF would conduct a new 5-day assessment at the start of the second admission and reclassify the beneficiary accordingly. In addition, for purposes of the variable per diem adjustment schedule, the payment schedule for the second admission would reset to Day 1 payment rates for the beneficiary's new case-mix classification.

Example B: A beneficiary is discharged from a SNF stay on Day 7 and is readmitted to the *same* SNF within the 3-day interruption window. For the purposes of classification and payment, this would be considered a continuation of the previous stay (an interrupted stay). The SNF would not conduct a new 5-day assessment to reclassify the patient and for purposes of the variable per diem adjustment schedule, the payment schedule would continue where it left off; in this case, the first day of the second stay would be paid at the Day 8 per diem rates under that schedule.

Example C: A beneficiary is discharged from a SNF stay on Day 7 and is readmitted to a *different* SNF within the 3-day interruption window. The SNF would conduct a new 5-day assessment at the start of the second admission and classify the beneficiary accordingly. In addition, for purposes of the variable per diem adjustment schedule, the payment schedule for the second admission would reset to Day 1 payment rates for the beneficiary's new case-mix classification.

We also considered alternative ways of structuring the interrupted stay policy. For example, we considered possible ranges for the interrupted stay window other than the three calendar day window proposed in this rule. For example, we considered windows of fewer than 3 days (for example, 1 or 2 day windows for readmission) as well as windows of more than 3 days (for example, 4 or 5 day windows for readmission). However, we believe that 3 days represents a reasonable window after which it is more likely that a resident's condition and resource needs will have changed. We also believe that consistency with other payment systems, like that of IRF and IPF, is helpful in providing clarity and consistency to providers in understanding Medicare payment systems, as well as making progress toward standardization among PAC payment systems.

In addition, to determine how best to operationalize an interrupted stay policy within the SNF setting, we considered three broad categories of benefit periods consisting of multiple stays. The first type of scenario, SNF-to-SNF transfers, is one in which a resident is transferred directly from one SNF to a different SNF. The second case we considered, and the most common of all three multiple-stay benefit period scenarios, is a benefit period that includes a readmission following a new hospitalization between the two stays—for instance, a resident who was discharged from a SNF back to the community, re-hospitalized at a later date, and readmitted to a SNF (the same SNF or a different SNF) following the new hospital stay. The last case we considered was a readmission to the same SNF or a different SNF following a discharge to the community, with no intervening re-hospitalization.

To simplify the analysis, we primarily examined benefit periods with two stays. Benefit periods with exactly two stays account for a large majority (70 percent) of all benefit periods with multiple stays, and benefit periods with more than two stays represent a very small portion (less than 7 percent) of all benefit periods overall. We therefore assume the data for cases where there are exactly two stays in a benefit period are representative of all benefit periods with multiple stays. Of cases where there are exactly two stays in a benefit period, over three quarters (76.4 percent) consist of re-hospitalization and readmission (to the same SNF or a different SNF). Discharge to the community and readmission without re-hospitalization cases represent approximately 14 percent of cases, while direct SNF-to-SNF transfers represent approximately 10 percent.

For each of these case types, in which a resident was readmitted to a SNF after discharge, we examined whether (1) the variable per diem adjustment schedule should be ''reset'' back to the Day 1 rates at the outset of the second stay versus ''continuing'' the variable per diem adjustment schedule at the point at which the previous stay ended, and (2) a new 5-day assessment and resident classification should be required at the start of the subsequent SNF stay.

With regard to the first question above, specifically whether or not a readmission to a SNF within the proposed 3-day interruption window would reset the resident's variable per diem adjustment schedule, in each of the cases described above, we were concerned generally that an interrupted stay policy that ''restarts'' the variable per diem adjustment schedule to Day 1 after readmissions could incentivize unnecessary discharges with quick readmissions. This concern is particularly notable in the second and third cases described above, as the beneficiary may return to the same facility. To investigate this question, we conducted linear regression analyses to examine changes in costs in terms of both PT/OT and NTA costs per day from the first to second admission for the three scenarios described above (SNF-to-SNF direct transfers, readmissions following re-hospitalization, and readmissions following community discharge). As discussed in section V.D.4. of this proposed rule, investigations revealed that utilization of PT, OT, and NTA services changes over the course of a stay. Based on both empirical analysis and feedback from multiple technical expert panels, we determined that SLP and nursing utilization remained fairly constant over a stay. Therefore, we are proposing variable per diem adjustment schedules for the PT, OT, and NTA components but not for the SLP or nursing components. Because the analysis of changes in costs across two stays in a single benefit period is relevant to determining how the variable per diem payment adjustments should apply to benefit periods with multiple stays, we restricted our analysis to the three payment components for which we are proposing variable per diem adjustments (PT, OT, and NTA). For this analysis, both the re-hospitalization and community discharge cases were separated into two sub-cases: When the resident returns to the same SNF, and when the resident is admitted to a different SNF. By definition, SNF-to-SNF transfer cases always have different providers for the first and second stays. The regression results showed that PT/OT costs from the first to second admission were very similar for SNF-to-SNF transfers and for readmissions to a different provider following re-hospitalization or discharge to community, suggesting that the second admission is comparable to a new stay. NTA costs from the first to second admission also were very similar for SNF-to-SNF transfers. For readmissions following re-hospitalization or discharge to community, NTA costs for readmissions to the same provider were notably less than NTA costs for readmissions to a different provider.

Overall, these results suggest that a readmission to a *different* SNF, regardless of whether it was a direct SNF-to-SNF transfer, or whether the beneficiary was re-hospitalized or discharged to the community before the second admission, are more comparable to a new stay than an interrupted stay. Thus, we are proposing to always reset the variable per diem adjustment schedule to Day 1 whenever residents are discharged and readmitted to a different SNF. We acknowledge that this could lead to patterns of inappropriate discharges and readmissions that could be inconsistent with the intent of this policy; for example, we would be concerned about patients in SNF A consistently being admitted to SNF B to the exclusion of other SNFs in the area. Should we discover such behavior, we will flag these facilities for additional scrutiny and review and consider potential policy changes in future rulemaking. However, based on the results of our regression analyses, and because of the concern that a SNF provider could discharge and promptly readmit a resident to reset the variable per diem adjustment schedule to Day 1, in cases where a resident returns to the *same* provider we are proposing to allow the payment schedule to reset only when the resident has been out of the facility for at least 3 days. As previously mentioned, we believe that 3 days represents a reasonable window after which it is more likely that a resident's condition and resource needs will have changed, and this 3-day requirement is also consistent with the interrupted stay policies of similar Medicare PAC benefits. Moreover, while we found that PT and OT costs for cases where the gap is longer than 3 days are similar to PT and OT costs for cases where the gap is shorter than 3 days, NTA costs are notably higher for cases where the gap is longer than 3 days. This provides further support for resetting the variable per diem schedule for cases where the gap is longer than 3 days (as costs tend to be higher, similar to a new stay). More information on these analyses can be found in section 3.10.3. of the SNF PMR technical report available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.*

With regard to the question of whether or not SNFs would be required to complete a new 5-day assessment and reclassify the resident after returning to the SNF within the proposed 3-day interruption window, we investigated changes in resident characteristics from the first to the second stay within a benefit period. First, we looked at changes in clinical categories from the first to second stay for residents with an intervening re-hospitalization. This analysis could only be conducted for residents with a re-hospitalization because, as described in section 3.10.2. of the SNF PMR technical report, for research purposes, classification into clinical categories was based on the diagnosis from the prior inpatient stay. For those residents who had a re-hospitalization and were readmitted to a SNF (either the same or a different SNF), and therefore could be reclassified into a new clinical category (because of new diagnostic information as a result of the intervening re-hospitalization), we found that a majority had the same clinical category for both the first and second admission. Because we could not conduct this investigation for SNF-to-SNF transfers or community discharge cases (as they lack a new hospitalization), we separately investigated changes in function from the first to second stay for SNF-to-SNF transfers and for readmissions following community discharge. We found that in a large majority of cases, there was no change in function from the first to second stay, regardless of whether the second provider was the same or different as the first provider. Thus, we believe it would be appropriate to maintain the classification from the first stay for those residents returning to the same SNF no more than 3 calendar days after discharge from the same facility. However, because we are proposing to exclude from the interrupted stay policy readmissions to a different SNF (regardless of the number of days between admissions) and readmissions to the same SNF when the gap between admissions is longer than 3 days, and to treat these readmissions as new stays for purpose of the variable per diem adjustment schedule, we believe it would be appropriate and consistent to treat these cases as new stays for purposes of clinical classification and to require a new 5-day PPS assessment. More information on these analyses can be found in section 3.10.2. of the SNF PMR technical report available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.* Additionally, we note that under the approach discussed in section V.E.1. of this proposed rule, providers would be afforded the flexibility to use the IPA, which would allow for resident reclassification under certain circumstances.

We invite comments on the proposals outlined above. We would also note that we believe that frequent SNF readmissions may be indicative of poor quality care being provided by the SNF. Given this belief, we plan to monitor the use of this policy closely to identify those facilities whose beneficiaries experience frequent readmission, particularly facilities where the readmissions occur just outside the three-day window used as part of the proposed interrupted stay policy. Should we discover such behavior, we will flag these facilities for additional scrutiny and review and consider potential policy changes in future rulemaking.

H. Proposed Relationship of the PDPM to Existing Skilled Nursing Facility Level of Care Criteria

As discussed previously in section IV.A. of this proposed rule, the establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the case-mix adjustment aspect of the SNF PPS has been based, in part, on the beneficiary's need for skilled nursing care and therapy, we have coordinated claims review procedures with the existing resident assessment process and case-mix classification system. This approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 52 RUGs of the 66-group RUG–IV system to assist in making certain SNF level of care determinations.

As further discussed below, we propose to adopt a similar approach under the PDPM effective October 1, 2019, by retaining an administrative presumption mechanism that would utilize the initial assignment of one of the case-mix classifiers that we designate for this purpose to assist in making certain SNF level of care determinations. This designation would reflect an administrative presumption under the PDPM that beneficiaries who are correctly assigned one of the designated case-mix classifiers on the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date on the 5-day Medicare required assessment.

As under the existing RUG–IV administrative presumption, a beneficiary who is not assigned one of the designated classifiers would not automatically be classified as either meeting or not meeting the level of care definition, but instead would receive an individual level of care determination

using the existing administrative criteria. The use of the administrative presumption reflects the strong likelihood that those beneficiaries who are assigned one of the designated classifiers during the immediate post-hospital period require a covered level of care, which would be less likely for other beneficiaries.

In the ANPRM (82 FR 21007), we discussed some potential adaptations of the RUG–IV model's administrative presumption to accommodate specific features of the RCS–I model, including the possible designation of the following case-mix classifiers for purposes of the administrative presumption:

- Continued designation of the same nursing (non-rehabilitation) groups that currently comprise the Extensive Services, Special Care High, Special Care Low, and Clinically Complex categories under RUG–IV, as those groups would crosswalk directly from RUG–IV to the RCS–I model we were considering;
- In addition, designation of the most intensive functional score (14 to 18) under the RCS–I model's combined PT/OT component, as well as the uppermost comorbidity score (11+) under its NTA component.

In response, a number of comments expressed concern that the possible adaptations of the presumption could adversely affect access to care for some beneficiaries. Others asked whether using the PT/OT component's highest functional score bin (14 to 18) as a trigger for the presumption would be appropriate, inasmuch as the residents that typically require the most therapy are those with only moderate functional impairments. In addition, commenters questioned the discussion's inclusion of the RCS–I model's NTA component as a possible classifier under the presumption, as well as its omission of RCS–I's SLP component.

Regarding the commenters' concerns about access to care, we note that we have indicated in the ANPRM and in previous rulemaking that the actual purpose of the level of care presumption has always been to afford a streamlined and simplified administrative procedure for readily identifying those beneficiaries with the *greatest likelihood* of meeting the level of care criteria; however, we have also emphasized that in focusing on such beneficiaries, this approach in no way serves to disadvantage *other* beneficiaries who may *also* meet the level of care criteria. As we noted in the ANPRM,

> . . . an individual beneficiary's inability to qualify for the administrative presumption would not in itself serve to disqualify that resident from receiving SNF coverage . . . while such residents are not automatically presumed to require a skilled level of care, neither are they automatically classified as requiring nonskilled care. Rather, any resident who does not qualify for the presumption would instead receive an individual level of care determination using the existing administrative criteria (82 FR 21007).

As we further explained in the FY 2016 SNF PPS final rule, structuring the presumption in this manner serves ''. . . specifically to ensure that the presumption does not disadvantage such residents, by providing them with an individualized level of care determination that fully considers all pertinent factors'' (80 FR 46406, August 4, 2015).

As for concerns about the appropriateness of certain classifiers, including the possible use of the PT/OT component's highest functional score bin (14 to 18) for this purpose under RCS–I, we note that the case-mix classification model for PT and OT that we are now proposing in connection with the PDPM would essentially reconfigure the PT/OT component from the RCS–I model. As discussed in section V.D.3.b. of this proposed rule, the proposed PDPM would divide the RCS–I model's combined PT/OT component into two separate case-mix adjusted components, under which each resident would be assigned separate case-mix groups for PT and OT payment. Those groups would classify residents based on clinical category and function score, the two resident characteristics shown to be most predictive of PT and OT utilization.

Further, as we noted in section III.B.4. of the ANPRM (''Variable Per Diem Adjustment Factors and Payment Schedule'') and section V.D.4. of this proposed rule, our initial analyses revealed that in contrast to the SLP component—where per diem costs remain relatively constant over time—costs for the PT, OT, and NTA components typically are highest at the outset and then decline over the course of the stay. Our research to date continues to show a strong correlation between the dependent variables used for the proposed separate PT and OT components and a similarity in predictors, in that the associated costs for both therapy disciplines remain highest in the initial (and typically most intensive) portion of the SNF stay. This heightened resource intensity during the initial part of the SNF stay under the PT, OT, and NTA components, in turn, more closely reflects the distinctive utilization patterns that served as the original foundation for the level of care presumption itself—that is, the tendency as noted in the FY 2000 SNF PPS final rule for ''. . . SNF stays to be at their most intensive and unstable immediately following admission as justifying a presumption of coverage at the very outset of the SNF stay'' (64 FR 41667, July 30, 1999). We believe this would make the most intensive classifiers within each of these three proposed components well-suited to serve as clinical proxies for identifying those beneficiaries with the most intensive care needs and greatest likelihood of requiring an SNF level of care.

Accordingly, for purposes of the administrative presumption under the proposed PDPM, we propose to continue utilizing the same designated nursing (non-rehabilitation) categories under the PDPM as have been used to date under RUG–IV. We note that the most direct crosswalk between the existing RUG–IV model and the proposed PDPM would involve nursing services, for which, under the proposed PDPM, each resident would continue to be classified into one of the groups that fall within the existing non-rehabilitation RUG–IV categories. (As explained in section V.D.3.d. of this proposed rule, while the total number of nursing case-mix groups would be streamlined from the current 43 under RUG–IV down to 25 under PDPM through the consolidation of similar groups *within* individual categories, the overall number and structure of the nursing categories themselves would remain the same.) Under our proposal, effective in conjunction with the proposed implementation of the PDPM (that is, as of October 1, 2019), the administrative presumption would apply to those groups encompassed by the same nursing categories as are currently designated for this purpose under the existing RUG–IV model:

- Extensive Services;
- Special Care High;
- Special Care Low; and,
- Clinically Complex.

In addition, along with the continued use of the RUG–IV nursing categories above, we also propose to apply the administrative presumption using those other classifiers under the proposed PDPM that we believe would relate the most directly to identifying a patient's need for skilled care at the outset of the SNF stay. As explained below, we would designate such classifiers for this purpose based on their ability to fulfill the administrative presumption's role as described in the FY 2000 SNF PPS final rule—that is, to identify those ''. . . situations that involve a high

probability of the need for skilled care . . . when taken in combination with the characteristic tendency . . . for an SNF resident's condition to be at its most unstable and intensive state at the outset of the SNF stay'' (64 FR 41668 through 41669, July 30, 1999).

Specifically, we additionally propose to designate for this purpose proposed PT and OT case-mix groups TB, TC, TD, TF, and TG, the groups displayed in Table 21 that collectively account for the five highest case-mix indexes for PT as well as for OT and, thus, would consistently be associated with the most resource-intensive care across both of these therapy disciplines. We also propose to designate the uppermost comorbidity group (11+) under the NTA component, as we believe this particular classifier would serve to identify those cases that are the most likely to involve the kind of complex medication regimen (for example, a highly intensive drug requiring specialized expertise to administer, or an exceptionally large and diverse assortment of medications posing an increased risk of adverse drug interactions) that would require skilled oversight to manage safely and effectively.

Under this proposed approach, those residents not classifying into a case-mix group in one of the designated nursing RUG categories under the proposed PDPM on the initial, 5-day Medicare-required assessment could nonetheless still qualify for the administrative presumption on that assessment by being placed in one of the designated case-mix groups for either the PT or OT components, or by receiving the uppermost comorbidity score (11+) under the NTA component. We believe that these particular clinical indicators would appropriately serve to fulfill the administrative presumption's role of identifying those cases with the highest probability of requiring an SNF level of care throughout the initial portion of the SNF stay. We note that in order to help improve the accuracy of these newly-designated groups in serving this function, we would continue to review the new designations going forward and may make further adjustments to the proposed designations over time as we gain actual operating experience under the new classification model. As discussed above, this administrative presumption mechanism would take effect October 1, 2019 in conjunction with the proposed PDPM. We invite comments on our proposed administrative presumption mechanism under the proposed PDPM.

I. Effect of Proposed PDPM on Temporary AIDS Add-on Payment

As discussed in section III.C. of this proposed rule and also in section III.E. of the ANPRM, section 511(a) of the MMA amended section 1888(e)(12) of the Act to provide for a temporary increase of 128 percent in the PPS per diem payment for any SNF residents with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special add-on for SNF residents with AIDS was intended to be of limited duration, as the MMA legislation specified that it was to remain in effect only until the Secretary certifies that there is an appropriate adjustment in the case mix to compensate for the increased costs associated with such residents.

The temporary add-on for SNF residents with AIDS is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at *www.cms.gov/transmittals/downloads/r160cp.pdf.* In the SNF PPS final rule for FY 2010 (74 FR 40288, August 11, 2009), we did not address this certification in that final rule's implementation of the case-mix refinements for RUG–IV, thus allowing the add-on payment required by section 511 of the MMA to remain in effect for the time being.

In the House Ways and Means Committee Report that accompanied the MMA, the explanation of the MMA's temporary AIDS adjustment notes the following under *Reason for Change:* ''According to prior work by the Urban Institute, AIDS patients have much higher costs than other patients in the same resource utilization groups in skilled nursing facilities. The adjustment is based on that data analysis'' (H. Rep. No. 108–178, Part 2 at 221). The data analysis from that February 2001 Urban Institute study (entitled ''Medicare Payments for Patients with HIV/AIDS in Skilled Nursing Facilities''), in turn, had been conducted under a Report to Congress mandated under a predecessor provision, section 105 of the BBRA. This earlier BBRA provision, which ultimately was superseded by the temporary AIDS add-on provision required by the MMA, had amended section 1888(e)(12) of the Act to provide for special consideration for facilities serving specialized patient populations (that is, those who are ''immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary'').

As we noted in the ANPRM, at this point over a decade and a half has elapsed since the Urban Institute conducted its study on AIDS patients in SNFs, a period that has seen major advances in the state of medical practice in treating this condition. These advances have notably included the introduction of powerful new drugs and innovative prescription regimens that have dramatically improved the ability to manage the viral load (the amount of human immunodeficiency virus (HIV) in the blood). The decrease in viral load secondary to medications has contributed to a shift from intensive nursing services for AIDS-related illnesses to an increase in antiretroviral therapy. This phenomenon, in turn, is reflected in our recent analysis of differences in SNF resource utilization, which indicates that while the overall historical disparity in costs between AIDS and non-AIDS patients has not entirely disappeared, that disparity is now far greater with regard to drugs than it is for nursing. Specifically, NTA costs per day for residents with AIDS were 151 percent higher than those for other residents while the difference in wage-weighted nursing staff time between the two groups was only 19 percent, as discussed in section 3.8.3. of the SNF PRM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*), which the ANPRM referenced for further information on the underlying data analysis (82 FR 21007 through 21008). In the ANPRM, we also described how the RCS–I model would account for those NTA costs, including drugs, which specifically relate to residents with AIDS (82 FR 20997 through 20999). We additionally discussed the possibility of making a specific 19 percent AIDS adjustment as part of the case-mix adjustment of the nursing component (82 FR 20995 through 20997). We further expressed our belief that,

> . . . when taken collectively, these adjustments . . . would appropriately serve to justify issuing the certification prescribed under section 511(a) of the MMA . . . which would permit the MMA's existing, temporary AIDS add-on to be replaced by a permanent adjustment in the case mix . . . that appropriately compensates for the increased costs associated with these residents (82 FR 21008).

In response, we received comments expressing concerns that a projected 40 percent drop in overall payments for SNF residents with AIDS under the RCS–I model could adversely affect access to care for this patient population. Regarding those concerns,

we note that the special add-on for SNF residents with AIDS itself was never meant to be permanent, and does not serve as a specific benchmark for use in establishing either the appropriate methodology or level of payment for this patient population. Rather, as discussed in the ANPRM, it was designed to be only a temporary measure, representing a general approximation that reflected the current state of research and clinical practice at the time (82 FR 21007 through 21008). As such, the special add-on would not account for the significant changes in the care and treatment of this condition that have occurred over the intervening years. Moreover, as a simple across-the-board multiplier, the MMA adjustment by its very nature is not accurately targeted at those particular rate components that actually account for the disparity in cost between AIDS patients and others.

As discussed previously in section V.D.3.e. of this proposed rule, based on our updated investigations into the adequacy of payments under the proposed PDPM for residents with HIV/AIDS, we believe that the four proposed ancillary payment components (PT, OT, SLP, and NTA) adequately reimburse ancillary costs associated with HIV/AIDS residents (see section 3.8.2. of the SNF PDPM technical report, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html).* Therefore, we believe it would be appropriate to issue the prescribed certification under section 511(a) of the MMA on the basis of the proposed PDPM's ancillary case-mix adjustment alone, as effectively providing the required appropriate adjustment in the case mix to compensate for the increased costs associated with such residents. However, to further ensure that the proposed PDPM would account as fully as possible for any remaining disparity with regard to nursing costs, as discussed in section V.D.3.d., we are additionally proposing to include a specific AIDS adjustment as part of the case-mix adjustment of the nursing component. As discussed in section V.D.3.d. of this proposed rule, we used the STRIVE data to quantify the effects of HIV/AIDS diagnosis on nursing resource use. Regression analyses found that wage-weighted nursing staff time is 18 percent higher for residents with HIV/AIDS, controlling for the non-rehabilitation RUG of the resident. We note that this figure is slightly lower than the 19 percent increase in wage-weighted nursing staff time reported in the ANPRM and the SNF PRM technical report because the updated investigation uses a FY 2017 study population and is based on the PDPM case-mix groups, while the earlier analysis was based on a FY 2014 study population and the RCS–I case-mix groups. More information on this analysis can be found in section 3.8.2. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*). Thus, we are proposing an 18 percent increase in payment for the nursing component for residents with HIV/AIDS under the proposed PDPM to account for the increased nursing costs for such residents. Similar to the NTA adjustment for residents with HIV/AIDS discussed in section V.D.3.e. of this proposed rule, this adjustment would be identified by ICD–10–CM code B20 on the SNF claim and would be processed through the PRICER software used by CMS to set the appropriate payment rate for a resident's SNF stay. The 18 percent adjustment would be applied to the unadjusted base rate for the nursing component, and then this amount would be further case-mix adjusted per the resident's PDPM classification.

We believe that when taken collectively, these adjustments under the proposed PDPM would appropriately serve to justify issuing the certification prescribed under section 511(a) of the MMA effective with the proposed conversion to the PDPM on October 1, 2019, thus permitting the MMA's existing, temporary AIDS add-on to be replaced by a permanent adjustment in the case mix (as proposed under the PDPM) that appropriately compensates for the increased costs associated with these residents. We invite comments on this proposal.

At the same time, we acknowledge that even with an accurately targeted model that compensates for the increased costs of SNF residents with AIDS, an abrupt conversion to an altogether different payment methodology might nevertheless be potentially disruptive for facilities, particularly those that serve a significant number of patients with AIDS and may have become accustomed to operating under the existing payment methodology for those patients. Accordingly, we specifically invite comments on possible ways to help mitigate any potential disruption stemming from the proposed replacement of the special add-on payment with the permanent case-mix adjustments for SNF residents with AIDS under the proposed PDPM.

J. Potential Impacts of Implementing the Proposed PDPM and Proposed Parity Adjustment

This section outlines the projected impacts of implementing the proposed PDPM effective October 1, 2019 under the SNF PPS and the related policy proposals in sections V.A. through V.I of this proposed rule that would be effective in conjunction with the proposed PDPM.

This impact analysis makes a series of assumptions, as described below. First, the impacts presented here assume consistent provider behavior in terms of how care is provided under RUG–IV and how care might be provided under the proposed PDPM, as we do not make any attempt to anticipate or predict provider reactions to the implementation of the proposed PDPM. That being said, we acknowledge the possibility that implementing the proposed PDPM could substantially affect resident care and coding behaviors. Most notably, based on the concerns raised during a number of TEPs, we acknowledge the possibility that, as therapy payments under the proposed PDPM would not have the same connection to service provision as they do under RUG–IV, it is possible that some providers may choose to reduce their provision of therapy services to increase margins under the proposed PDPM. However, we do not have any basis on which to assume the approximate nature or magnitude of these behavioral responses, nor have we received any sufficiently specific guidance on the likely nature or magnitude of behavioral responses from ANPRM commenters, TEP panelists, or other sources of feedback. As a result, lacking an appropriate basis to forecast behavioral responses, we do not adjust our analyses of resident and provider impacts discussed in this section for projected changes in provider behavior. However, we do intend to monitor behavior which may occur in response to the implementation of PDPM, if finalized, and may consider proposing policies to address such behaviors to the extent determined appropriate. Additionally, we acknowledge that a number of states utilize some form of the RUG–IV case-mix classification system as part of their Medicaid programs and that any change in Medicare policy can have an impact on state programs. Again, we do not have any basis on which to assume the approximate nature or magnitude of these responses, for the same reasons cited above. Additionally, we do not expect impacts on state Medicaid programs resulting from PDPM

implementation to have a notable impact on payments for Medicare-covered SNF stays, which are the basis for the impact analyses discussed in this section. Therefore, we do not consider possible changes to state Medicaid programs when conducting these analyses. We invite comments on our assumptions that behavior would remain unchanged under the proposed PDPM and that changes in state Medicaid programs resulting from PDPM implementation would not have a notable impact on payments for Medicare-covered SNF stays. We also invite comment on the impact of these policy proposals on state Medicaid programs.

As with prior system transitions, we propose to implement the proposed PDPM case-mix system, along with the other policy changes discussed in section V of this proposed rule, in a budget neutral manner through application of a parity adjustment to the case-mix weights under the proposed PDPM, as further discussed below. We are proposing to implement the PDPM in a budget neutral manner because, as with prior system transitions, in proposing changes to the case-mix methodology, we do not intend to change the aggregate amount of Medicare payments to SNFs. Rather, we aim to utilize a case-mix methodology to classify residents in such a manner as to best ensure that payments made for specific residents are an accurate reflection of resource utilization without introducing potential incentives which could encourage inappropriate care delivery, as we believe may exist under the current case-mix methodology. Therefore, the impact analysis presented here assumes implementation of these proposed changes in a budget neutral manner. We invite comments on the proposal, as further discussed below, to implement the PDPM in a budget neutral manner. In addition, we solicit comment on whether it would be appropriate to implement the proposed PDPM in a manner that is not budget neutral.

As discussed above, the impact analysis presented here assumes implementation of these changes in a budget neutral manner without a behavioral change. The prior sections describe how case-mix weights are set to reflect relative resource use for each case-mix group. The proposed PDPM payment before application of a parity adjustment would be calculated using the unadjusted CMI for each component, the variable per diem payment adjustment schedule, the unadjusted urban and rural federal per diem rates shown in Tables 12 and 13, the labor-related share, and the geographic wage indexes. In applying a parity adjustment to the case-mix weights, we would maintain the relative value of each CMI but would multiply every CMI by a ratio to achieve parity in overall SNF PPS payments under the proposed PDPM and under the RUG–IV case-mix model. The parity adjustment multiplier is calculated through the following steps. First, we calculate RUG–IV total payment. Total RUG–IV payments are calculated by adding total allowed amounts across all FY 2017 SNF claims. The total allowed amount in the study population is the summation of Medicare and non-Medicare payments for Medicare-covered days. More specifically, it is the sum of Medicare claim payment amount, National Claim History (NCH) primary payer claim paid amount, NCH beneficiary inpatient deductible amount, NCH beneficiary Part A coinsurance liability amount, and NCH beneficiary blood deductible liability amount. Second, we calculate what total payment would have been under the proposed PDPM in FY 2017 before application of the parity adjustment. Total estimated payments under PDPM are calculated by summing the predicted payment for each case-mix component together for all FY 2017 SNF stays. This represents the total allowed amount if PDPM had been in place in FY 2017. Total estimated FY 2017 payments under the proposed PDPM are calculated using resident information from FY 2017 SNF claims, the MDS assessment, and other Medicare claims, as well as the unadjusted CMI for each component, the variable per diem payment adjustment schedule, the unadjusted urban and rural federal per diem rates shown in Tables 12 and 13, the labor-related share, and the geographic wage indexes. After calculating total actual RUG–IV payments and total estimated case-mix-related PDPM payments, we subtract non-case-mix component payments from total RUG–IV payments, as this component does not change across systems. This subtraction does not include the temporary add-on for residents with HIV/AIDS in the RUG–IV system, which PDPM replaces with additional payments for residents with HIV/AIDS through the NTA and nursing components (as discussed in sections V.I. of this proposed rule). By retaining the portion of non-case-mix component payments associated with the temporary HIV/AIDS add-on in total RUG–IV payments, all payments associated with the add-on under RUG–IV are re-allocated to the case-mix-adjusted components in PDPM. This is appropriate because, as discussed, under the proposed PDPM, additional payments for residents with HIV/AIDS are made exclusively through the case-mix-adjusted components (that is, the nursing and NTA components). Lastly, in calculating budget neutrality, we must set total estimated case-mix-related payment under PDPM such that it equals total allowable Medicare payments under RUG–IV. To do this, we divide the remaining total RUG–IV payments over the remaining total estimated PDPM payments prior to the parity adjustment. This division yields a ratio (parity adjustment) of 1.46 by which the proposed PDPM CMIs are multiplied so that total estimated payments under the proposed PDPM would be equal to total actual payments under RUG–IV, assuming no changes in the population, provider behavior, and coding. If this parity adjustment had not been applied, total estimated payments under the proposed PDPM would be 46 percent lower than total actual payments under RUG–IV, therefore the implementation of the proposed PDPM would not be budget neutral. We invite comments on our proposal discussed above to apply a parity adjustment to the CMIs under the proposed PDPM and to implement the proposed PDPM in a budget neutral manner. More details regarding this calculation and analysis are described in section 3.11.2. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*). The impact analysis presented in this section focuses on how payments under the proposed PDPM would be re-allocated across different resident groups and among different facility types, assuming implementation in a budget neutral manner.

The projected resident-level impacts are presented in Table 37. The first column identifies different resident subpopulations and the second column shows what percent of SNF stays in FY 2017 are represented by the given subpopulation. The third column shows the projected change in total payments for residents in a given subpopulation, represented as a percentage change in actual FY 2017 payments made for that subpopulation under RUG–IV versus estimated payments which would have been made to that subpopulation in FY 2017 had the proposed PDPM been in place. Total RUG–IV payments are calculated by adding total allowed amounts across all FY 2017 SNF claims associated with a resident subpopulation. The total allowed

amount in the study population is the summation of Medicare and non-Medicare payments for Medicare-covered days. More specifically, it is the summation of Medicare claim payment amount, NCH primary payer claim paid amount, NCH beneficiary inpatient deductible amount, NCH beneficiary Part A coinsurance liability amount, and NCH beneficiary blood deductible liability amount. Payments corresponding to the non-case-mix component are subtracted from the RUG–IV total payments, not including the portion of non-case-mix payments corresponding to the temporary add-on for residents with HIV/AIDS. Total estimated payments under PDPM are calculated by summing the predicted payment for each case-mix component together for all FY 2017 SNF stays associated with a resident subpopulation. Positive changes in this column represent a projected positive shift in payments for that subpopulation under the proposed PDPM, while negative changes in this column represent projected negative shifts in payment for that subpopulation. More information on the construction of current payments under RUG–IV and payments under the proposed PDPM for purposes of this impact analysis can be found in section 3.12. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*). Based on the data presented in Table 37, we observe that the most significant shift in payments created by implementation of the proposed PDPM would be to redirect payments away from residents who are receiving very high amounts of therapy under the current SNF PPS, which strongly incentivizes the provision of therapy, to residents with more complex clinical needs. For example, we project that for residents whose most common therapy level is RU (ultra-high therapy)—the highest therapy level, there would be a reduction in associated payments of 8.4 percent, while payments for residents currently classified as non-rehabilitation would increase by 50.5 percent. Other resident types for which there may be higher relative payments under the proposed PDPM are: Residents who have high NTA costs, receive extensive services, are dually enrolled in Medicare and Medicaid, use IV medication, have ESRD, diabetes, or a wound infection, receive amputation/prosthesis care, and/or have longer prior inpatient stays.

In response to comments received on the ANPRM, we investigated a few additional subpopulations that commenters believed were not adequately accounted for under the RCS–I model, including residents with addictions, bleeding disorders, behavioral issues, chronic neurological conditions, and bariatric care. Table 37 shows that the proposed PDPM is projected to increase the proportion of total payment associated with each of those subpopulations.

TABLE 37—PROPOSED PDPM IMPACT ANALYSIS, RESIDENT-LEVEL

Resident characteristics	% of stays	Percent change
All Stays	100.0	0.0
Sex:		
Female	60.3	−0.8
Male	39.7	1.2
Age:		
Below 65 years	10.3	7.2
65–74 years	24.1	3.1
75–84 years	32.5	−0.4
85–89 years	17.6	−3.1
Over 90 years	15.6	−4.3
Race/Ethnicity:		
White	83.8	−0.2
Black	11.2	0.8
Hispanic	1.7	0.9
Asian	1.3	−0.6
Native American	0.5	7.1
Other or Unknown	1.5	0.8
Medicare/Medicaid Dual Status:		
Dually Enrolled	34.7	3.3
Not Dually Enrolled	65.3	−2.1
Original Reason for Medicare Enrollment:		
Aged	74.6	−1.7
Disabled	24.5	4.8
ESRD	0.9	10.5
Utilization Days:		
1–15 days	35.4	13.7
16–30 days	33.8	0.0
31+ days	30.9	−2.5
Utilization Days = 100:		
No	98.4	0.1
Yes	1.6	−1.9
Length of Prior Inpatient Stay:		
0–2 days	2.2	1.3
3 days	22.5	−3.3
4–30 days	73.6	0.7
31+ days	1.7	6.7
Most Common Therapy Level:		
RU	58.4	−8.4
RV	22.4	11.4
RH	6.8	27.4
RM	3.3	41.1

TABLE 37—PROPOSED PDPM IMPACT ANALYSIS, RESIDENT-LEVEL—Continued

Resident characteristics	% of stays	Percent change
RL	0.1	67.5
Non-Rehab	9.1	50.5
Number of Therapy Disciplines Used:		
0	2.3	63.1
1	2.4	44.2
2	51.6	1.6
3	43.7	−3.1
Physical Therapy Utilization:		
No	3.7	50.9
Yes	96.3	−0.7
Occupational Therapy Utilization:		
No	4.5	47.7
Yes	95.5	−0.8
Speech Language Pathology Utilization:		
No	55.0	2.8
Yes	45.0	−2.5
Therapy Utilization:		
PT+OT+SLP	43.7	−3.1
PT+OT Only	50.8	1.3
PT+SLP Only	0.4	27.3
OT+SLP Only	0.4	30.1
PT Only	1.3	41.3
OT Only	0.6	47.9
SLP Only	0.5	46.8
Non-Therapy	2.3	63.1
NTA Costs ($):		
0–10	13.7	−3.5
10–50	44.5	−3.2
50–150	32.2	4.2
150+	9.6	18.7
NTA Comorbidity Score:		
0	23.5	−10.4
1–2	30.5	−4.7
3–5	31.0	4.0
6–8	9.9	15.0
9–11	3.6	24.4
12+	1.4	27.2
Extensive Services Level:		
Tracheostomy and Ventilator/Respirator	0.3	22.2
Tracheostomy or Ventilator/Respirator	0.6	7.3
Infection Isolation	1.1	9.1
Neither	98.0	−0.3
CFS Level:		
Cognitively Intact	58.5	−0.3
Mildly Impaired	20.7	−0.2
Moderately Impaired	16.8	−0.7
Severely Impaired	3.9	8.8
Clinical Category:		
Acute Infections	6.5	3.4
Acute Neurologic	6.4	−3.7
Cancer	4.6	−3.2
Cardiovascular and Coagulations	9.8	0.5
Major Joint Replacement or Spinal Surgery	8.6	−2.1
Medical Management	30.4	0.0
Non-Orthopedic Surgery	10.8	5.7
Non-Surgical Orthopedic/Musculoskeletal	5.9	−6.1
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	8.9	−2.4
Pulmonary	8.1	5.4
Level of Complications in MS–DRG of Prior Inpatient Stay:		
No Complication	35.8	−3.1
CC/MCC	64.2	1.7
Stroke:		
No	90.9	0.0
Yes	9.1	0.3
HIV/AIDS:		
No	99.7	0.3
Yes	0.3	−40.5
IV Medication:		
No	91.7	−2.1
Yes	8.3	23.5
Diabetes:		

TABLE 37—PROPOSED PDPM IMPACT ANALYSIS, RESIDENT-LEVEL—Continued

Resident characteristics	% of stays	Percent change
No	64.0	−3.0
Yes	36.0	5.4
Wound Infection:		
No	98.9	−0.3
Yes	1.1	22.2
Amputation/Prosthesis Care:		
No	100.0	0.0
Yes	0.0	6.4
Presence of Dementia:		
No	70.9	0.5
Yes	29.1	−1.2
MDS Alzheimer's:		
No	95.2	0.0
Yes	4.8	−0.3
Unknown	0.0	5.0
Presence of Addictions:		
No	94.6	−0.1
Yes	5.4	1.8
Presence of Bleeding Disorders:		
No	90.9	−0.1
Yes	9.1	1.5
Presence of Behavioral Issues:		
No	53.1	−0.9
Yes	46.9	1.0
Presence of Chronic Neurological Conditions:		
No	74.4	−0.2
Yes	25.6	0.6
Presence of Bariatric Care:		
No	91.3	−0.6
Yes	8.7	6.5

The projected provider-level impacts are presented in Table 38. The first column identifies different facility subpopulations and the second column shows what percentage of SNFs in FY 2017 are represented by the given subpopulation. The third column shows the projected change in total payments for facilities in a given subpopulation, represented as a percentage change in actual FY 2017 payments made for that subpopulation under RUG–IV versus estimated payments which would have been made to that subpopulation in FY 2017 had the proposed PDPM been in place. Total RUG–IV payments are calculated by adding total allowed amounts across all FY 2017 SNF claims associated with a facility subpopulation. The total allowed amount in the study population is the summation of Medicare and non-Medicare payments for Medicare-covered days. More specifically, it is the summation of Medicare claim payment amount, NCH primary payer claim paid amount, NCH beneficiary inpatient deductible amount, NCH beneficiary Part A coinsurance liability amount, and NCH beneficiary blood deductible liability amount. Payments corresponding to the non-case-mix component are subtracted from the RUG–IV total payments, not including the portion of non-case-mix payments corresponding to the temporary add-on for residents with HIV/AIDS. Total estimated payments under PDPM are calculated by summing the predicted payment for each case-mix component together for all FY 2017 SNF stays associated with a facility subpopulation. Positive changes in this column represent a projected positive shift in payments for that subpopulation under the proposed PDPM, while negative changes in this column represent projected negative shifts in payment for that subpopulation. More information on the construction of current payments under RUG–IV and payments under the proposed PDPM for purposes of this impact analysis can be found in section 3.12. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*). Based on the data presented in Table 38, we observe that the most significant shift in Medicare payments created by implementation of the proposed PDPM would be from facilities with a high proportion of rehabilitation residents (particularly facilities with high proportions of Ultra-High Rehabilitation residents) to facilities with high proportions of non-rehabilitation residents. We project that payments to facilities that bill 0 to 10 percent of utilization days as RU (ultra-high rehabilitation) would increase an estimated 27.6 percent under the proposed PDPM while facilities that bill 90 to 100 percent of utilization days as RU would see an estimated decrease in payments of 9.8 percent. Other facility types that may see higher relative payments under the proposed PDPM are small facilities, non-profit facilities, government-owned facilities, and hospital-based and swing-bed facilities.

TABLE 38—PROPOSED PDPM IMPACT ANALYSIS, FACILITY-LEVEL

Provider characteristics	% of providers	Percent change
All Stays	100.0	0.0
Ownership:		

TABLE 38—PROPOSED PDPM IMPACT ANALYSIS, FACILITY-LEVEL—Continued

Provider characteristics	% of providers	Percent change
For profit	72.0	−0.7
Non-profit	22.6	1.9
Government	5.4	4.2
Number of Certified SNF Beds:		
0–49	10.0	3.5
50–99	38.2	0.6
100–149	34.7	−0.2
150–199	11.1	−0.3
200+	5.9	−1.8
Location:		
Urban	72.7	−0.7
Rural	27.3	3.8
Facility Type:		
Freestanding	96.2	−0.3
Hospital-Based/Swing Bed	3.8	16.7
Location by Facility Type:		
Urban | Freestanding	70.6	−1.0
Urban | Hospital-Based/Swing Bed	2.2	15.3
Rural | Freestanding	25.6	3.2
Rural | Hospital-Based/Swing Bed	1.6	21.1
Census Division:		
New England	5.9	2.0
Middle Atlantic	10.8	−2.6
East North Central	20.6	0.7
West North Central	12.5	6.7
South Atlantic	15.7	−0.4
East South Central	6.6	1.0
West South Central	13.1	−1.0
Mountain	4.7	1.1
Pacific	10.1	−0.8
Location by Region:		
Urban | New England	5.1	1.8
Urban | Middle Atlantic	9.5	−2.9
Urban | East North Central	14.4	−0.1
Urban | West North Central	6.0	4.6
Urban | South Atlantic	12.6	−1.1
Urban | East South Central	3.6	0.3
Urban | West South Central	8.7	−1.2
Urban | Mountain	3.4	0.1
Urban | Pacific	9.5	−0.9
Rural | New England	0.8	4.0
Rural | Middle Atlantic	1.3	2.7
Rural | East North Central	6.2	3.6
Rural | West North Central	6.5	10.5
Rural | South Atlantic	3.1	4.2
Rural | East South Central	3.0	2.1
Rural | West South Central	4.4	−0.1
Rural | Mountain	1.3	6.2
Rural | Pacific	0.6	2.2
% Stays with Maximum Utilization Days = 100:		
0–10%	94.4	0.1
10–25%	5.1	−2.8
25–100%	0.4	−3.6
% Medicare/Medicaid Dual Enrollment:		
0–10%	8.6	−1.3
10–25%	17.5	−1.3
25–50%	36.0	0.3
50–75%	26.5	1.3
75–90%	8.2	0.4
90–100%	3.1	1.6
% Utilization Days Billed as RU:		
0–10%	8.9	27.6
10–25%	8.0	15.5
25–50%	24.1	7.0
50–75%	39.2	−0.4
75–90%	17.2	−6.0
90–100%	2.6	−9.8
% Utilization Days Billed as Non-Rehab:		
0–10%	79.8	−1.5
10–25%	16.6	8.6
25–50%	2.7	23.1

TABLE 38—PROPOSED PDPM IMPACT ANALYSIS, FACILITY-LEVEL—Continued

Provider characteristics	% of providers	Percent change
50–75%	0.4	35.8
75–90%	0.2	41.8
90–100%	0.4	33.6

In addition to the impacts discussed throughout this section, we also note that we expect a significant reduction in regulatory burden under the SNF PPS, due to the changes we are proposing in the MDS assessment schedule, as discussed above in section V.E.1. of this proposed rule. Based on the calculations outlined in section VII.B.1. of this proposed rule, we anticipate that the proposed assessment schedule changes discussed in this rule would reduce administrative costs for each provider by approximately $12,000 and reduce the time for administrative issues by approximately 183 hours for each provider. We anticipate that this proposed reduction in administrative burden would permit providers greater flexibility in interacting with their patients and focusing on their patient's individual care needs.

With regard to the proposed changes to the SNF PPS discussed in section V of this proposed rule, we provide an accounting of our reasons for each of the proposed policies throughout the subsections in section V and invite comments on any of those proposed changes. In this section, we discuss alternatives considered which relate generally to implementation of the proposed changes discussed in section V, most notably the implementation of the proposed PDPM.

We are proposing to implement the PDPM effective beginning in FY 2020 (that is, October 1, 2019). This proposed effective date incorporates a one year period to allow time for provider education and training, internal system transitions, and to allow states to make any Medicaid program changes which may be necessary based on the proposed changes related to PDPM.

When making major system changes, CMS often considers possible transition options for providers and other stakeholders between the former system and the new system. For example, when we updated OMB delineations used to establish a provider's wage index under the SNF PPS in FY 2015, we utilized a blended rate in the first year of implementation, whereby 50 percent of the provider's payment was derived from their former OMB delineation and 50 percent from their new OMB delineation (79 FR 45644–45646).

However, due to the fundamental nature of the change from the current RUG–IV case-mix model to the proposed PDPM, which includes differences in resident assessment, payment algorithms, and other policies, we believe that proposing a blended rate for the whole system (that would require two full case-mix systems (RUG–IV and the proposed PDPM) to run concurrently) is not advisable as part of any transition strategy for implementing the proposed PDPM, due to the significant administrative and logistical issues that would be associated with such a transition strategy. Specifically, CMS and providers would be required to manage both the RUG–IV payment model and proposed PDPM simultaneously, creating significant burden and undue complexity for all involved parties. Furthermore, providers would be required to follow both sets of MDS assessment rules, each of which carries with it its own level of complexity. CMS would also be required to process assessments and claims under each system, which would entail a significant amount of resources and burden for CMS, MACs, and providers. Finally, a blended rate option would also mitigate some of the burden reduction associated with implementing PDPM, estimated to save SNFs close to $200 million per year as compared to estimated burden under RUG–IV, given that the current assessment schedule would need to continue until full implementation of PDPM was achieved. We believe these issues also would be implicated in any alternative transition strategy which would require both case-mix systems to exist concurrently, such as giving providers a choice in the first year of implementation of operating under either the RUG–IV or PDPM. Therefore, we did not pursue any alternatives which required concurrent operation of both the RUG–IV and PDPM.

We then considered alternative effective dates for implementing the proposed PDPM, and other policy changes proposed in section V of this rule. We considered implementing the new case-mix model effective beginning in FY 2019, but we believe that this would not permit sufficient time for providers and other stakeholders, including CMS, to make the necessary preparations for this magnitude of a change in the SNF PPS. We also believe that such a quick transition would not be in keeping with how similar types of SNF PPS changes have been implemented in the past. We also considered implementing PDPM more than one year after being finalized, such as implementing the proposed PDPM effective beginning October 1, 2020 (FY 2021). However, we believe that setting the effective date of PDPM this far out is not necessary, based on our prior experience with similar SNF PPS changes. As is customary, we plan to continue to provide free software to providers which can be used to group residents under the proposed PDPM, as well as providing data specifications for this grouper software as soon as is practicable, should the proposed PDPM be finalized, thereby mitigating potential concerns around software vendors having sufficient time to develop products for PDPM. Moreover, given the issues identified throughout this proposed rule with the current RUG–IV model, notably the issues surrounding the burdensome and complex PPS assessment schedule under the SNF PPS currently and concerns around the incentives for therapy provision under the RUG–IV system, we believe it appropriate to implement the proposed PDPM as soon as is practicable. Therefore, we propose to implement the PDPM, as well as the other proposed changes discussed in section V of this proposed rule, effective beginning October 1, 2019.

Finally, we considered alternatives related to the proposal discussed in section V.I., specifically the proposed certification that we have met the requirements set forth in section 511(a) of the MMA, which would permit us to use the PDPM's proposed permanent case-mix adjustments for SNF residents with AIDS to replace the temporary special add-on in the PPS per diem payment for such residents. As noted in section V.I. above, this special add-on for SNF residents with AIDS was intended to be of limited duration, as the MMA legislation specified that it was to remain in effect only until the Secretary certifies that there is an appropriate adjustment in the case mix

to compensate for the increased costs associated with such residents. We considered maintaining this adjustment under the proposed PDPM. However, given the adjustment incorporated into the NTA and nursing components under the proposed PDPM to account for the increased costs of treating residents with AIDS, this would result in a substantial increase in payment for such residents beyond even the current add-on payment. Moreover, as discussed in section V.I., we believe that the proposed PDPM provides a tailored case-mix adjustment that more accurately accounts for the additional costs and resource use of residents with AIDS, as compared to an undifferentiated add-on which simply applies an across-the-board multiplier to the full SNF PPS per diem. Finally, as stated in section 3.8.2. of the SNF PDPM technical report (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*), HIV/AIDS was associated with a negative and statistically significant decrease in PT, OT and SLP costs per day. This means inherently that, to the extent that the existing add-on is applied against the full SNF PPS per diem payment, the magnitude of the add-on payment increases with increases in therapy payment, which conflicts with the data described above regarding the relationship between therapy costs and the presence of an AIDS diagnosis. As a result, maintaining the current add-on would create an inconsistency between how SNF payments would be made and the data regarding AIDS diagnoses and resident therapy costs. Therefore, we are proposing to replace this add-on payment with appropriate case-mix adjustments for the increased costs of care for this population of residents through the proposed NTA and nursing components of the proposed PDPM.

We invite comments on the projected impacts and on the proposals and alternatives discussed throughout this section.

VI. Other Issues

A. Other Proposed Revisions to the Regulation Text

Along with our proposals to revise the regulations as discussed elsewhere in this proposed rule, we are also proposing to make two other revisions in the regulation text. The first involves § 411.15(p)(3)(iv), which specifies that whenever a beneficiary is formally discharged (or otherwise departs) from the SNF, this event serves to end that beneficiary's status as a ''resident'' of the SNF for purposes of consolidated billing (the SNF ''bundling'' requirement), unless he or she is readmitted (or returns) to that or another SNF ''by midnight of the day of departure.'' In initially establishing this so-called ''midnight rule,'' the FY 2001 SNF PPS final rule (65 FR 46770, July 31, 2000) noted in this particular context that:

> As we explained in the proposed rule, a patient ''day'' begins at 12:01 a.m. and ends the following midnight, so that the phrase ''midnight of the day of departure'' refers to the midnight that immediately follows the actual moment of departure, rather than to the midnight that immediately precedes it (65 FR 46792).

However, the Medicare program's standard practice for counting inpatient days is actually one in which an inpatient day would begin at midnight (see, for example, § 20.1 in the Medicare Benefit Policy Manual, Chapter 3, which specifies that in counting inpatient days, ''. . . *a day begins at midnight* and ends 24 hours later'' (emphasis added)). Accordingly, in order to ensure consistency with that approach, we now propose to revise § 411.15(p)(3)(iv) to specify that for consolidated billing purposes, a beneficiary's ''resident'' status ends whenever he or she is formally discharged (or otherwise departs) from the SNF, unless he or she is readmitted (or returns) to that or another SNF ''before the following midnight.'' We note that this revision would not alter the underlying principle that a beneficiary's SNF ''resident'' status in this context ends upon departure from the SNF unless he or she returns to that or another SNF later on that same day; rather, it would simply serve to conform the actual wording of the applicable regulations text with the Medicare manual's standard definition of the starting point of a patient ''day.''

We are also proposing a technical correction to § 424.20(a)(1)(i), which describes the required content of the SNF level of care certification, in order to conform it more closely to that of the corresponding statutory requirements at section 1814(a)(2)(B) of the Act. This statutory provision defines the SNF level of care in terms of skilled services furnished on a daily basis which, as a practical matter, can only be provided on an inpatient basis in a SNF. In addition, it provides that the SNF-level care must be for either:

- An ongoing condition that was one of the conditions that the beneficiary had during the qualifying hospital stay; or
- A new condition that arose while the beneficiary was in the SNF for treatment of that ongoing condition.

In setting forth the SNF level of care definition itself, the implementing regulations at § 409.31 reflect both of the above two points (at paragraphs (b)(2)(i) and (b)(2)(ii), respectively); however, the regulations describing the content of the initial level of care certification at § 424.20(a)(1)(i) have inadvertently omitted the second point. Accordingly, we now propose to revise § 424.20(a)(1)(i) to rectify this omission, so that it more accurately tracks the language in the corresponding statutory authority at section 1814(a)(2)(B) of the Act.

We invite comments on our proposed revisions to § 411.15(p)(3)(iv) and § 424.20(a)(1)(i).

B. Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

1. Background

The Skilled Nursing Facility Quality Reporting Program (SNF QRP) is authorized by section 1888(e)(6) of the Act and it applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals. Under the SNF QRP, the Secretary reduces by 2 percentage points the annual market basket percentage update described in section 1888(e)(5)(B)(i) of the Act applicable to a SNF for a fiscal year, after application of section 1888(e)(5)(B)(ii) of the Act (the MFP adjustment) and section 1888(e)(5)(B)(iii) of the Act (the 1 percent market basket increase for FY 2018), in the case of a SNF that does not submit data in accordance with sections 1888(e)(6)(B)(i) of the Act for that fiscal year. For more information on the requirements we have adopted for the SNF QRP, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46427 through 46429), FY 2017 SNF PPS final rule (81 FR 52009 through 52010) and FY 2018 SNF PPS final rule (82 FR 36566).

Although we have historically used the preamble to the SNF PPS proposed and final rules each year to remind stakeholders of all previously finalized program requirements, we have concluded that repeating the same discussion each year is not necessary for every requirement, especially if we have codified it in our regulations. Accordingly, the following discussion is limited as much as possible to a discussion of our proposals for future years of the SNF QRP, and it represents the approach we intend to use in our rulemakings for this program going forward.

2. General Considerations Used for the Selection of Measures for the SNF QRP

a. Background

For a detailed discussion of the considerations we historically used for the selection of SNF QRP quality, resource use, and other measures, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46429 through 46431).

b. Accounting for Social Risk Factors in the SNF QRP

In the FY 2018 SNF PPS final rule (82 FR 36567 through 36568), we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex residents, as well as those with social risk factors, receive excellent care. We discussed how studies show that social risk factors, such as being near or below the poverty level as determined by HHS, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes and how some of this disparity is related to the quality of health care.[4] Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex residents as well as those with social risk factors receive excellent care. Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in our value-based purchasing programs.[5] As we noted in the FY 2018 SNF PPS final rule (82 FR 36567 through 36568), ASPE's report to Congress, which was required by the IMPACT Act, found that, in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that they examined and tested. ASPE is continuing to examine this issue in its second report required by the IMPACT Act, which is due to Congress in the fall of 2019. In addition, as we noted in the FY 2018 SNF PPS final rule (82 FR 36357), the National Quality Forum (NQF) undertook a 2-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate for these measures.[6] The trial period ended in April 2017 and a final report is available at *http://www.qualityforum.org/SES_Trial_Period.aspx.* The trial concluded that ''measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship'' between social risk factors and the outcomes measured. This discrepancy may be explained in part by the methods used for adjustment and the limited availability of robust data on social risk factors. NQF has extended the socioeconomic status (SES) trial,[7] allowing further examination of social risk factors in outcome measures.

In the FY 2018/CY 2018 proposed rules for our quality reporting and value-based purchasing programs, we solicited feedback on which social risk factors provide the most valuable information to stakeholders and the methodology for illuminating differences in outcomes rates among patient groups within a provider that would also allow for a comparison of those differences, or disparities, across providers. Feedback we received across our quality reporting programs included encouraging us to explore whether factors that could be used to stratify or risk adjust the measures (beyond dual eligibility); to consider the full range of differences in resident backgrounds that might affect outcomes; to explore risk adjustment approaches; and to offer careful consideration of what type of information display would be most useful to the public.

We also sought public comment on confidential reporting and future public reporting of some of our measures stratified by resident dual eligibility. In general, commenters noted that stratified measures could serve as tools for SNFs to identify gaps in outcomes for different groups of residents, improve the quality of health care for all residents, and empower consumers to make informed decisions about health care. Commenters encouraged us to stratify measures by other social risk factors such as age, income, and educational attainment. With regard to value-based purchasing programs, commenters also cautioned CMS to balance fair and equitable payment while avoiding payment penalties that mask health disparities or discouraging the provision of care to more medically complex patients. Commenters also noted that value-based payment program measure selection, domain weighting, performance scoring, and payment methodology must account for social risk.

As a next step, we are considering options to improve health disparities among patient-groups within and across hospitals by increasing the transparency of disparities as shown by quality measures. We also are considering how this work applies to other CMS quality programs in the future. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38403 through 38409) for more details, where we discuss the potential stratification of certain Hospital Inpatient Quality Reporting (IQR) Program outcome measures. Furthermore, we continue to consider options to address equity and disparities in our value-based purchasing programs.

We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.

3. Proposed New Measure Removal Factor for Previously Adopted SNF QRP Measures

As a part of our Meaningful Measures Initiative discussed in section I.D. of this proposed rule, we strive to put patients first, ensuring that they, along with their clinicians, are empowered to make decisions about their own healthcare using data-driven information that is increasingly aligned with a parsimonious set of meaningful quality measures. We began reviewing the SNF QRP's measures in accordance with the Meaningful Measures Initiative, and we are working to identify how to move the SNF QRP forward in the least burdensome manner possible while continuing to incentivize improvement in the quality of care provided to patients.

Specifically, we believe the goals of the SNF QRP and the measures used in the program cover most of the Meaningful Measures Initiative priorities, including making care safer, strengthening person and family engagement, promoting coordination of care, promoting effective prevention and treatment, and making care affordable.

[4] See, for example United States Department of Health and Human Services. ''Healthy People 2020: Disparities. 2014.'' Available at *http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities;* or National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: National Academies of Sciences, Engineering, and Medicine 2016.

[5] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), ''Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs.'' December 2016. Available at *https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.*

[6] Available at *http://www.qualityforum.org/SES_Trial_Period.aspx.*

[7] Available at *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86357.*

We also evaluated the appropriateness and completeness of the SNF QRP's current measure removal factors. We have previously finalized that we would use notice and comment rulemaking to remove measures from the SNF QRP based on the following factors (80 FR 46431 through 46432):[8]

- *Factor 1.* Measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
- *Factor 2.* Performance or improvement on a measure does not result in better resident outcomes.
- *Factor 3.* A measure does not align with current clinical guidelines or practice.
- *Factor 4.* A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.
- *Factor 5.* A measure that is more proximal in time to desired resident outcomes for the particular topic is available.
- *Factor 6.* A measure that is more strongly associated with desired resident outcomes for the particular topic is available.
- *Factor 7.* Collection or public reporting of a measure leads to negative unintended consequences other than resident harm.

We continue to believe that these measure removal factors are appropriate for use in the SNF QRP. However, even if one or more of the measure removal factors applies, we may nonetheless choose to retain the measure for certain specified reasons. Examples of such instances could include when a particular measure addresses a gap in quality that is so significant that removing the measure could in turn result in poor quality, or in the event that a given measure is statutorily required. We note further that, consistent with other quality reporting programs, we apply these factors on a case-by-case basis.

We are proposing to adopt an additional factor to consider when evaluating potential measures for removal from the SNF QRP measure set:

- *Factor 8.* The costs associated with a measure outweigh the benefit of its continued use in the program.

As we discussed in section I.D. of this proposed rule, with respect to our new Meaningful Measures Initiative, we are engaging in efforts to ensure that the SNF QRP measure set continues to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program. We believe these costs are multifaceted and include not only the burden associated with reporting, but also the costs associated with implementing and maintaining the program. We have identified several different types of costs, including, but not limited to: (1) The provider and clinician information collection burden and burden associated with the submission/reporting of quality measures to CMS; (2) the provider and clinician cost associated with complying with other programmatic requirements; (3) the provider and clinician cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs; (4) the cost to CMS associated with the program oversight of the measure including measure maintenance and public display; and (5) the provider and clinician cost associated with compliance with other federal and/or state regulations (if applicable).

For example, it may be needlessly costly and/or of limited benefit to retain or maintain a measure which our analyses show no longer meaningfully supports program objectives (for example, informing beneficiary choice). It may also be costly for health care providers to track the confidential feedback, preview reports, and publicly reported information on a measure where we use the measure in more than one program. CMS may also have to expend unnecessary resources to maintain the specifications for the measure, as well as the tools we need to collect, validate, analyze, and publicly report the measure data. Furthermore, beneficiaries may find it confusing to see public reporting on the same measure in different programs.

When these costs outweigh the evidence supporting the continued use of a measure in the SNF QRP, we believe it may be appropriate to remove the measure from the program. Although we recognize that one of the main goals of the SNF QRP is to improve beneficiary outcomes by incentivizing health care providers to focus on specific care issues and making data public related to those issues, we also recognize that those goals can have limited utility where, for example, the publicly reported data is of limited use because it cannot be easily interpreted by beneficiaries and used to influence their choice of providers. In these cases, removing the measure from the SNF QRP may better accommodate the costs of program administration and compliance without sacrificing improved health outcomes and beneficiary choice.

We are proposing that we would remove measures based on this factor on a case-by-case basis. We might, for example, decide to retain a measure that is burdensome for health care providers to report if we conclude that the benefit to beneficiaries justifies the reporting burden. Our goal is to move the program forward in the least burdensome manner possible, while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients.

We are inviting public comment on our proposal to adopt an additional measure removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.

We also are proposing to add a new § 413.360(b)(3) to our regulations that would codify the removal factors we have previously finalized for the SNF QRP as well as the new measure removal factor that we are proposing to adopt in this proposed rule.

We are inviting public comment on these proposals.

4. Quality Measures Currently Adopted for the FY 2020 SNF QRP

The SNF QRP currently has 12 measures for the FY 2020 program year, which are outlined in Table 39.

[8] We refer readers to the FY 2016 SNF PPS final rule (80 FR 46431 through 46432) for more information on the factors we consider for removing measures.

TABLE 39—QUALITY MEASURES CURRENTLY ADOPTED FOR THE FY 2020 SNF QRP

Short name	Measure name and data source
Resident Assessment Instrument Minimum Data Set	
Pressure Ulcer	Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678).*
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Application of Functional Assessment/Care Plan.	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
Change in Self-Care Score	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
DTC	Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

*The measure will be replaced with the Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury measure, effective October 1, 2018.

5. IMPACT Act Implementation Update

In the FY 2018 SNF PPS final rule (82 FR 36596 through 36597), we stated that we intended to specify two measures that would satisfy the domain of accurately communicating the existence and provision of the transfer of health information and care preferences under section 1899B(c)(1)(E) of the Act no later than October 1, 2018, and intended to propose to adopt them for the FY 2021 SNF QRP, with data collection beginning on or about October 1, 2019.

As a result of the input provided during a public comment period initiated by our contractor between November 10, 2016 and December 11, 2016, input provided by a technical expert panel (TEP) convened by our contractor, and pilot measure testing conducted in 2017, we are engaging in continued development work on these two measures, including supplementary measure testing and providing the public with an opportunity for comment in 2018. Further we expect to reconvene a TEP for these measures in mid-2018. We now intend to specify the measures under section 1899B(c)(1)(E) of the Act no later than October 1, 2019, and intend to propose to adopt the measures for the FY 2022 SNF QRP, with data collection beginning with residents admitted as well as discharged on or after October 1, 2020. For more information on the pilot testing, we refer readers to *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html.*

6. Form, Manner, and Timing of Data Submission Under the SNF QRP

Under our current policy, SNFs report data on SNF QRP assessment-based measures and standardized resident assessment data by reporting the designated data elements for each applicable resident on the Minimum Data Set (MDS) resident assessment instrument and then submitting completed instruments to CMS using the using the Quality Improvement Evaluation System Assessment Submission and Processing (QIES ASAP) system. We refer readers to the FY 2018 SNF PPS final rule (82 FR 36601 through 36603) for the data collection and submission time frames for assessment-based measures and standardized resident assessment data that we finalized for the SNF QRP.

7. Proposed Changes to the SNF QRP Reconsideration Requirements

Section 413.360(d)(1) of our regulations states, in part, that SNFs that do not meet the SNF QRP requirements for a program year will receive a letter of non-compliance through the QIES ASAP system, as well as through the United States Postal Service.

We are proposing to revise § 413.360(d)(1) to expand the methods by which we would notify a SNF of non-compliance with the SNF QRP requirements for a program year. Revised § 413.360(d)(1) would state that we would notify SNFs of non-compliance with the SNF QRP requirements via a letter sent through at least one of the following notification methods: the QIES ASAP system; the United States Postal Service; or via an email from the Medicare Administrative Contractor (MAC). We believe that this change will address feedback from providers requesting additional methods for notification.

In addition, § 413.360(d)(4) currently states that we will make a decision on the request for reconsideration and provide notice of the decision to the SNF through the QIES ASAP system and via letter sent through the United States Postal Service.

We are proposing to revise § 413.360(d)(4) to state that we will notify SNFs, in writing, of our final decision regarding any reconsideration request via a letter sent through at least one of the following notification methods: the QIES ASAP system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

We are inviting public comments on these proposals.

8. Proposed Policies Regarding Public Display for the SNF QRP

Section 1899B(g) of the Act requires the Secretary to establish procedures for the public reporting of SNFs' performance on measures under sections 1899B(c)(1) and 1899B(d)(1) of the Act. Measure data will be displayed on the Nursing Home Compare website, an interactive web tool that assists individuals by providing information on SNF quality of care to those who need to select a SNF.

In the FY 2018 SNF PPS final rule (82 FR 36606 through 36607), we finalized that we would publicly display the Medicare Spending Per Beneficiary-PAC SNF QRP and Discharge to Community-PAC SNF QRP measures in calendar year 2018 based on discharges from October 1, 2016 through September 30, 2017. In this proposed rule, we are proposing to increase the number of years of data used to calculate the Medicare Spending Per Beneficiary-PAC SNF QRP and Discharge to Community-PAC SNF QRP measures for purposes of display from 1 year to 2 years. Under this proposal, data on these measures would be publicly reported in CY 2019, or as soon thereafter as operationally feasible, based on discharges from October 1, 2016 through September 30, 2018.

Increasing the measure calculation and public display periods from 1 to 2 years of data increases the number of SNFs with enough data adequate for public reporting for the Medicare Spending Per Beneficiary-PAC SNF QRP measure from 86 percent (based on 2016 Medicare FFS claims data) to 95 percent (based on 2015 through 2016 Medicare FFS claims data), and for the Discharge to Community-PAC SNF QRP measure from 83 percent (based on 2016 Medicare FFS claims data) to 94 percent (based on 2015 through 2016 Medicare FFS claims data). Increasing measure public display periods to 2 years also aligns with the public display periods of these measures in the IRF and LTCH QRPs.

We also propose to begin publicly displaying data in CY 2020, or as soon thereafter as is operationally feasible, on the following four assessment-based measures: (1) Change in Self-Care Score (NQF #2633); (2) Change in Mobility Score (NQF #2634); (3) Discharge Self-Care Score (NQF #2635); and (4) Discharge Mobility Score (NQF #2636). SNFs are required to submit data on these four assessment-based measures with respect to admissions as well as discharges occurring on or after October 1, 2018. We are proposing to display data for these assessment-based measures based on 4 rolling quarters of data, initially using 4 quarters of discharges from January 1, 2019 through December 31, 2019. To ensure the statistical reliability of the measure rates for these four assessment-based measures, we are also proposing that if a SNF has fewer than 20 eligible cases during any 4 consecutive rolling quarters of data that we are displaying for any of these measures, then we would note in our public display of that measure that with respect to that SNF, the number of cases/resident stays is too small to publicly report.

We are inviting public comment on these proposals.

C. Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

1. Background

Section 215(b) of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93) authorized the SNF VBP Program (the ''Program'') by adding section 1888(h) to the Act. As a prerequisite to implementing the SNF VBP Program, in the FY 2016 SNF PPS final rule (80 FR 46409 through 46426), we adopted an all-cause, all-condition hospital readmission measure, as required by section 1888(g)(1) of the Act. In the FY 2017 SNF PPS final rule (81 FR 51986 through 52009), we adopted an all-condition, risk-adjusted potentially preventable hospital readmission measure for SNFs, as required by section 1888(g)(2) of the Act. In the FY 2018 SNF PPS final rule (82 FR 36608 through 36623), we adopted additional policies for the Program, including an exchange function methodology for disbursing value-based incentive payments.

Section 1888(h)(1)(B) of the Act requires that the SNF VBP Program apply to payments for services furnished on or after October 1, 2018. The SNF VBP Program applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals. We believe the implementation of the SNF VBP Program is an important step towards transforming how care is paid for, moving increasingly towards rewarding better value, outcomes, and innovations instead of merely rewarding volume.

For additional background information on the SNF VBP Program, including an overview of the SNF VBP Report to Congress and a summary of the Program's statutory requirements, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46409 through 46410). We also refer readers to the FY 2017 SNF PPS final rule (81 FR 51986 through 52009) for discussion of the policies that we adopted related to the potentially preventable hospital readmission measure, scoring, and other topics. Finally, we refer readers to the FY 2018 SNF PPS final rule (82 FR 36608 through 36623) for discussions of the policies that we adopted related to value-based incentive payments, the exchange function, and other topics.

In this proposed rule, we are proposing additional requirements for the FY 2021 SNF VBP Program, as well as other program policies.

2. Measures

For background on the measures we have adopted for the SNF VBP Program, we refer readers to the FY 2016 SNF PPS final rule (80 FR 46419), where we finalized the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) (NQF #2510) that we are currently using for the SNF VBP Program. We also refer readers to the FY 2017 SNF PPS final rule (81 FR 51987 through 51995), where we finalized the Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) that we will use for the SNF VBP Program instead of the SNFRM as soon as practicable, as required by statute.

We are not proposing any changes to the Program's measures at this time.

a. Accounting for Social Risk Factors in the SNF VBP Program

In the FY 2018 SNF PPS final rule (82 FR 36611 through 36613), we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex patients, as well as those with social risk factors, receive excellent care. We discussed how studies show that social risk factors, such as being near or below the poverty level as determined by HHS, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes and how some of this disparity is related to the quality of health care.[9] Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex patients, as well as those with social risk factors,

[9] See, for example United States Department of Health and Human Services. ''Healthy People 2020: Disparities. 2014.'' Available at *http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities;* or National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: National Academies of Sciences, Engineering, and Medicine 2016.

receive excellent care. Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in our value-based purchasing programs.[10] As we noted in the FY 2018 SNF PPS final rule (82 FR 36611), ASPE's report to Congress found that, in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that they examined and tested. In addition, as noted in the FY 2018 SNF PPS final rule, the National Quality Forum (NQF) undertook a 2-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate for these measures.[11] The trial period ended in April 2017 and a final report is available at *http://www.qualityforum.org/SES_Trial_Period.aspx.* The trial concluded that ''measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship'' between social risk factors and the outcomes measured. This discrepancy may be explained in part by the methods used for adjustment and the limited availability of robust data on social risk factors. NQF has extended the socioeconomic status (SES) trial,[12] allowing further examination of social risk factors in outcome measures.

In the FY 2018/CY 2018 proposed rules for our quality reporting and value-based purchasing programs, we solicited feedback on which social risk factors provide the most valuable information to stakeholders and the methodology for illuminating differences in outcomes rates among patient groups within a provider that would also allow for a comparison of those differences, or disparities, across providers. Feedback we received across our quality reporting programs included encouraging CMS to explore whether factors that could be used to stratify or risk adjust the measures (beyond dual eligibility); to consider the full range of differences in patient backgrounds that might affect outcomes; to explore risk adjustment approaches; and to offer careful consideration of what type of information display would be most useful to the public.

We also sought public comment on confidential reporting and future public reporting of some of our measures stratified by patient dual eligibility. In general, commenters noted that stratified measures could serve as tools for hospitals to identify gaps in outcomes for different groups of patients, improve the quality of health care for all patients, and empower consumers to make informed decisions about health care. Commenters encouraged us to stratify measures by other social risk factors such as age, income, and educational attainment. With regard to value-based purchasing programs, commenters also cautioned CMS to balance fair and equitable payment while avoiding payment penalties that mask health disparities or discouraging the provision of care to more medically complex patients. Commenters also noted that value-based payment program measure selection, domain weighting, performance scoring, and payment methodology must account for social risk.

As a next step, we are considering options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities as shown by quality measures. We also are considering how this work applies to other CMS quality programs in the future. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38403 through 38409) for more details, where we discuss the potential stratification of certain Hospital Inpatient Quality Reporting Program outcome measures. Furthermore, we continue to consider options to address equity and disparities in our value-based purchasing programs.

We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences

3. Proposed Performance Standards

a. Proposed FY 2021 Performance Standards

We refer readers to the FY 2017 SNF PPS final rule (81 FR 51995 through 51998) for a summary of the statutory provisions governing performance standards under the SNF VBP Program and our finalized performance standards policy, as well as the numerical values for the achievement threshold and benchmark for the FY 2019 program year. We also responded to public comments on these policies in that final rule.

We published the final numerical values for the FY 2020 performance standards in the FY 2018 SNF PPS final rule (82 FR 36613), and for reference, we are displaying those values again here.

TABLE 40—FINAL FY 2020 SNF VBP PROGRAM PERFORMANCE STANDARDS

Measure ID	Measure description	Achievement threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.80218	0.83721

We will continue to adopt the achievement threshold and benchmark as previously finalized in our rules. However, due to timing constraints associated with the compilation of the FY 2017 MedPAR file to include 3 months of data following the last discharge date, we are unable to provide estimated numerical values for the FY 2021 Program year's performance standards at this time. As discussed further below, we are proposing to adopt FY 2017 as the baseline period for the FY 2021 program year. While we do not expect either the achievement threshold or benchmark to change significantly from what was finalized for the FY 2020 Program year, we intend to publish the final numerical values for the performance standards based on the FY 2017 baseline period in the FY 2019 SNF PPS final rule.

We welcome public comment on this approach.

[10] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), ''Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs.'' December 2016. Available at *https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.*

[11] Available at *http://www.qualityforum.org/SES_Trial_Period.aspx.*

[12] Available at *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86357.*

b. Proposal To Correct Performance Standard Numerical Values in Cases of Errors

As we described above, section 1888(h)(3)(C) of the Act requires that we establish and announce the performance standards for a fiscal year not later than 60 days prior to the performance period for the fiscal year involved. However, we currently do not have a policy that would address the situation where, subsequent to publishing the numerical values for the finalized performance standards for a program year, we discover an error that affects those numerical values. Examples of the types of errors that we could subsequently discover are inaccurate variables on Medicare claims, programming errors, excluding data should have been included in the performance standards calculations, and other technical errors that resulted in inaccurate achievement threshold and benchmark calculations. While we do not have reason to believe that the SNF VBP Program has previously published inaccurate numerical values for performance standards, we are concerned about the possibility that we would discover an error in the future and have no ability to correct the numerical values.

We are aware that SNFs rely on the performance standards that we publicly display in order to target quality improvement efforts, and we do not believe that it would be fair to SNFs to repeatedly update our finalized performance standards if we were to identify multiple errors. In order to balance the need of SNFs to know what performance standards they will be held accountable to for a SNF VBP program year with our obligation to provide SNFs with the most accurate performance standards that we can based on the data available at the time, we are proposing that if we discover an error in the calculations subsequent to having published the numerical values for the performance standards for a program year, we would update the numerical values to correct the error. We are also proposing that we would only update the numerical values one time, even if we subsequently identified a second error, because we believe that a one-time correction would allow us to incorporate new information into the calcuations without subjecting SNFs to multiple updates. Any update we would make to the numerical values based on a calculation error would be announced via the CMS website, listservs, and other available channels to ensure that SNFs are made fully aware of the update.

We welcome public comments on this proposal.

4. Proposed FY 2021 Performance Period and Baseline Period and for Subsequent Years

a. Background

We refer readers to the FY 2016 SNF PPS final rule (80 FR 46422) for a discussion of our considerations for determining performance periods under the SNF VBP Program. Based on those considerations, as well as public comment, we adopted CY 2017 as the performance period for the FY 2019 SNF VBP Program, with a corresponding baseline period of CY 2015.

Additionally, in the FY 2018 SNF PPS final rule (82 FR 36613 through 36614), we adopted FY 2018 as the performance period for the FY 2020 SNF VBP Program, with a corresponding baseline period of FY 2016. We refer readers to that rule for a discussion of the need to shift the Program's measurement periods from the calendar year to the fiscal year.

b. FY 2021 Proposals

As we discussed with respect to the FY 2019 and FY 2020 SNF VBP Program years, we continue to believe that a 12-month duration for the performance and baseline period is most appropriate for the SNF VBP Program. Therefore, we propose to adopt FY 2019 (October 1, 2018 through September 30, 2019) as the performance period for the FY 2021 SNF VBP Program year. We also propose to adopt FY 2017 (October 1, 2016 through September 30, 2017) hospital discharges as the baseline period for the FY 2021 SNF VBP Program year.

We welcome public comment on these proposals.

c. Proposed Performance Periods and Baseline Periods for Subsequent Program Years

As we have described in previous rules (see, for example, the FY 2016 SNF PPS final rule, 80 FR 46422), we strive to link performance furnished by SNFs as closely as possible to the program year to ensure clear connections between quality measurement and value-based payment. We also strive to measure performance using a sufficiently reliable population of patients that broadly represent the total care provided by SNFs.

Therefore, we propose that beginning with the FY 2022 program year and for subsequent program years, we would adopt for each program year, a performance period that is the 1 year period following the performance period for the previous program year. We also propose that beginning with the FY 2022 program year and for subsequent program years, we would adopt for each program year a baseline period that is the 1 year period following the baseline period for the previous year. Under this policy, the performance period for the FY 2022 program year would be FY 2020 (the 1 year period following the proposed FY 2021 performance period of FY 2019), and the baseline period for the FY 2022 program year would be FY 2018 (the 1 year period following the proposed FY 2021 baseline period of FY 2017). We believe adopting this policy will provide SNFs with certainty about the performance and basline periods during which their performance will be assessed for future program years.

We welcome public comments on this proposal.

5. SNF VBP Performance Scoring

a. Background

We refer readers to the FY 2017 SNF PPS final rule (81 FR 52000 through 52005) for a detailed discussion of the scoring methodology that we have finalized for the Program, along with responses to public comments on our policies and examples of scoring calculations. We also refer readers to the FY 2018 SNF PPS final rule (82 FR 36614 through 36616) for discussion of the rounding policy we adopted, our request for comments on SNFs with zero readmissions, and our request for comments on a potential extraordinary circumstances exception policy.

b. Proposed Scoring Policy for SNFs Without Sufficient Baseline Period Data

In some cases, a SNF will not have sufficient baseline period data available for scoring for a Program year, whether due to the SNF not being open during the baseline period, only being open for a small portion of the baseline period, or other reasons (such as receiving an extraordinary circumstance exception, if that proposal described below is finalized). The availability of baseline data for each SNF is an integral component of our scoring methodology, and we are concerned that the absence of sufficient baseline data for a SNF will preclude us from being able to score that SNF on improvement for a program year. As discussed further below, with respect to the proposed scoring adjustment for a SNF without sufficient data in the performance period to create a reliable SNF performance score, we are concerned that measuring SNFs with fewer than 25 eligible stays (or index SNF stays that would be included in the calculation of the SNF readmission measure) during the baseline period

may result in unreliable improvement scores, and as a result, unreliable SNF performance scores. We considered policy options to address this issue.

We continue to believe it is important to compare SNF performance during the same periods to control for factors that may not be attributable to the SNF, such as increased patient case-mix acuity during colder weather periods when influenza, pneumonia, and other seasonal conditions and illnesses are historically more prevalent in the beneficiary population. Using a 12-month performance and baseline period for all SNFs ensures that, to the greatest extent possible, differences in performance can be attributed to the SNF's care quality rather than to exogenous factors.

Additionally, because we have proposed that for FY 2021 and future Program years, the start of the performance period for a Program year would begin exactly 12 months after the end of the baseline period for that Program year and there would not be sufficient time to compute risk-standardized readmission rates from another 12-month baseline period before the performance period if a SNF had insufficient data during the baseline period. For the FY 2021 Program, for example, the proposed baseline period would conclude at the end of FY 2017 (September 30, 2017) and the proposed performance period would begin on the first day of FY 2019 (October 1, 2018). We also do not believe it would be equitable to score SNFs without sufficient baseline period data using data from a different period. Doing so would, in our view, impede our ability to compare SNFs' performance on the Program's quality measure fairly, as additional factors that may affect SNFs' care could arise when comparing performance during different time periods. Therefore, we have concluded that it is not operationally feasible or equitable to use different baseline periods for purposes of awarding improvement scores to SNFs for a Program year.

We believe that SNFs without sufficient data from a single baseline period, which we would define for this purpose as SNFs with fewer than 25 eligible stays during the baseline period for a fiscal year based on an analysis of Pearson correlation coefficients at various denominator counts, should not be measured on improvement for that Program year. Accordingly, we are proposing to score these SNFs based only on their achievement during the performance period for any Program year for which they do not have sufficient baseline period data. The analysis of Pearson correlation coefficients at various denominator counts used in developing this proposal is available on our website at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNFRM-Reliability-Testing-Memo.docx.*

We are proposing to codify this proposal by adding § 413.338(d)(1)(iv) to our regulations. We welcome public comment on this proposal.

c. Proposed SNF VBP Scoring Adjustment for Low-Volume SNFs

In previous rules, we have discussed and sought comment on policies related to SNFs with zero readmissions during the performance period. For example, in the FY 2018 SNF PPS rule (82 FR 36615 through 36616), we sought comment on policies we should consider for SNFs with zero readmissions during the performance period because under the risk adjustment and the statistical approach used to calculate the SNFRM, outlier values are shifted towards the mean, especially for smaller SNFs. As a result, SNFs with observed readmission rates of zero may receive risk-standardized readmission rates that are greater than zero. We continue to be concerned about the effects of the SNFRM's risk adjustment and statistical approach on the scores that we award to SNFs under the Program. We are specifically concerned that as a result of this approach, the SNFRM is not sufficiently reliable to generate accurate performance scores for SNFs with a low number of eligible stays during the performance period. We would like to ensure that the Program's scoring methodology results in fair and reliable SNF performance scores because those scores are linked to a SNF's ranking and payment.

Therefore, we considered whether we should make changes to our methodology for assessing the total performance of SNFs for a Program year that better accounts for SNFs with zero or low numbers of eligible stays during the performance period. Because the number of eligible SNF stays makes up the denominator of the SNFRM, we have concluded that the reliability of a SNF's measure rate and resulting performance score is adversely impacted if the SNF has less than 25 eligible stays during the performance period, as the Pearson correlation coefficient is lower at denominator counts of 5, 10, 15, and 20 eligible stays in comparison to 25 eligible stays. The analysis of Pearson correlation coefficients at various denominator counts used in developing this proposal is available on our website at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNFRM-Reliability-Testing-Memo.docx.*

We believe that the most appropriate way to ensure that low-volume SNFs (which we define for purposes of the SNF VBP Program as SNFs with fewer than 25 eligible stays during the performance period) receive sufficiently reliable SNF performance scores is to adopt an adjustment to the scoring methodology we use for the SNF VBP Program. We are proposing that if a SNF has less than 25 eligible stays during a performance period for a Program year, we would assign a performance score to the SNF for that Program year. That assigned performance score would, when used to calculate the value-based incentive payment amount for the SNF, result in a value-based incentive payment amount that is equal to the adjusted Federal per diem rate that the SNF would have received for the fiscal year in the absence of the Program. The actual performance score that we would assign to an individual low-volume SNF for a Program year would be identified based on the distribution of all SNFs' performance scores for that Program year after calculating the exchange function. We would then assign that score to an individual low-volume SNF, and we would notify the low-volume SNF that it would be receiving an assigned performance score for the Program year in the SNF Performance Score Report that we provide not later than 60 days prior to the fiscal year involved.

We believe this scoring adjustment policy would appropriately ensure that our SNF performance score methodology is fair and reliable for SNFs with fewer than 25 eligible stays during the performance period for a Program year.

In section X.A.6. of this proposed rule, we estimate that $527.4 million will be withheld from SNFs' payments for the FY 2019 Program year based on the most recently available data. Additionally, the 60 percent payback percentage will result in an estimated $316.4 million being paid to SNFs in the form of value-based incentive payments with respect to FY 2019 services. Of the $316.4 amount, we estimate that $8.6 million will be paid to low-volume SNFs. However, if our proposal to adopt a scoring adjustment for low-volume SNFs is finalized, we estimate that we would redistribute an additional $6.7 million in value-based incentive payments to low-volume SNFs with respect to FY 2019 services, for a total

of $15.3 million of the estimated $527.4 million available for value-based incentive payments for that Program year. The additional $6.7 million in value-based incentive payments that would result from finalizing this proposal would increase the 60 percent payback percentage for FY 2019 by approximately 1.28 percent, which would result in a payback percentage 61.28 percent of withheld funds. The payback percentage would similarly increase for all other Program years, however the actual amount of the increase for a particular Program year would vary based on the number of low-volume SNFs that we identify for that Program year and the distribution of all SNFs' performance scores for that Program year.

As an alternative, we also considered assigning a performance score to SNFs with fewer than 25 eligible stays during the performance period that would result in a value-based incentive payment percentage of 1.2 percent, or 60 percent of the 2 percent withhold. This amount would match low-volume SNFs' incentive payment percentages with the finalized SNF VBP Program payback percentage of 60 percent, and would represent a smaller adjustment to low-volume SNFs' incentive payment percentages than the proposed policy described above. We estimate that this alternative would redistribute an additional $1 million with respect to FY 2019 services to low-volume SNFs. We also estimate that this alternative would increase the 60 percent payback percentage for FY 2019 by approximately 0.18 percent of the approximately $527.4 million of the total withheld from SNFs' payments, which would result in a payback percentage of 60.18 percent of the estimated $527.4 million in withheld funds for that Program year. However, as with the proposal above, the specific amount by which the payback percentage would increase for each Program year would vary based on the number of low-volume SNFs that we identify for each Program year and the distribution of all SNFs' performance scores for that Program year.

We welcome public comments on this proposal and on the alternative that we considered. We are also proposing to codify the definition of low-volume SNF at § 413.338(a)(16) of our regulations, and the definition of eligible stay at § 413.338(a)(17) of our regulations. We are proposing to codify the low-volume scoring adjustment proposal at § 413.338(d)(3) of our regulations. We are also proposing a conforming edit to the payback percentage policy at § 413.338(c)(2)(i).

d. Proposed Extraordinary Circumstances Exception Policy for the SNF VBP Program

In the FY 2018 SNF PPS final rule (82 FR 36616), we summarized public comments that we received on the topic of a possible extraordinary circumstances exception policy for the SNF VBP Program. As we stated in that rule, in other value-based purchasing and quality reporting programs, we have adopted Extraordinary Circumstances Exceptions (ECE) policies intended to allow facilities to receive relief from program requirements due to natural disasters or other circumstances beyond the facility's control that may affect the facility's ability to provide high-quality health care.

In other programs, we have defined a ''disaster'' as any natural or man-made catastrophe which causes damages of sufficient severity and magnitude to partially or completely destroy or delay access to medical records and associated documentation or otherwise affect the facility's ability to continue normal operations. Natural disasters could include events such as hurricanes, tornadoes, earthquakes, volcanic eruptions, fires, mudslides, snowstorms, and tsunamis. Man-made disasters could include such events as terrorist attacks, bombings, flood caused by man-made actions, civil disorders, and explosions. A disaster may be widespread and impact multiple structures or be isolated and affect a single site only. As a result of either a natural or man-made disaster, we are concerned that SNFs' care quality and subsequent impact on measure performance in the SNF VBP Program may suffer, and as a result, SNFs might be penalized under the Program's quality measurement and scoring methodology. However, we do not wish to penalize SNFs in these circumstances. For example, we recognize that SNFs might receive patients involuntarily discharged from hospitals facing mandatory evacuation due to probable flooding, and these patients might be readmitted to inpatient acute care hospitals and result in poorer readmission measure performance in the SNF VBP Program. We are therefore proposing to adopt an ECE policy for the SNF VBP Program to provide relief to SNFs affected by natural disasters or other circumstances beyond the facility's control that affect the care provided to the facility's patients. We propose that if a SNF can demonstrate that an extraordinary circumstance affected the care that it provided to its patients and subsequent measure performance, we would exclude from the calculation of the measure rate for the applicable baseline and performance periods the calendar months during which the SNF was affected by the extraordinary circumstance. Under this proposal, a SNF requesting an ECE would indicate the dates and duration of the extraordinary circumstance in its request, along with any available evidence of the extraordinary circumstance, and if approved, we would exclude the corresponding calendar months from that SNF's measure rate for the applicable measurement period and by extension, its SNF performance score.

We further propose that SNFs must submit this ECE request to CMS by filling out the ECE request form that we will place on the QualityNet website to the *SNFVBPinquiries@cms.hhs.gov* mailbox within 90 days following the extraordinary circumstance.

To accompany an ECE request, SNFs must provide any available evidence showing the effects of the extraordinary circumstance on the care they provided to their patients, including, but not limited to, photographs, newspaper and other media articles, and any other materials that would aid CMS in making its decision. We will review exception requests, and at our discretion based on our evaluation of the impact of the extraordinary circumstances on the SNF's care, provide a response to the SNF as quickly as feasible.

We intend for this policy to offer relief to SNFs whose care provided to patients suffered as a result of the disaster or other extraordinary circumstance, and we believe that excluding calendar months affected by extraordinary circumstances from SNFs' measure performance under the Program appropriately ensures that such circumstances do not unduly affect SNFs' performance rates or performance scores. We developed this process to align with the ECE process adopted by the SNF Quality Reporting Program to the greatest extent possible and to minimize burden on SNFs. This proposal is not intended to preclude us from granting exceptions to SNFs that have not requested them when we determine that an extraordinary circumstance, such as an act of nature, affects an entire region or locale. If we make the determination to grant an exception to all SNFs in a region or locale, we propose to communicate this decision through routine communication channels to SNFs and vendors, including but not limited to, issuing memos, emails, and notices on our SNF VBP website at *https://www.cms.gov/Medicare/Quality-*

Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html.

We note that if we finalize this policy, we would score any SNFs receiving ECEs on achievement and improvement for any remaining months during the performance period, provided the SNF had at least 25 eligible stays during both of those periods as we have proposed above. If a SNF should receive an approved ECE for 6 months of the performance period, for example, we would score the SNF on its achievement during the remaining 6 months on the Program's measure as long as the SNF met the proposed 25 eligible stay threshold during the performance period. We would also score the SNF on improvement as long as it met the proposed 25 eligible stay threshold during the applicable baseline period.

We welcome public comments on this proposal. We are also proposing to codify this proposal at § 413.338(d)(4) of our regulations.

6. SNF Value-Based Incentive Payments

We refer readers to the FY 2018 SNF PPS final rule (82 FR 36616 through 36621) for discussion of the exchange function methodology that we have adopted for the Program, as well as the specific form of the exchange function (logistic, or S-shaped curve) that we finalized, and the payback percentage of 60 percent. We adopted these policies for FY 2019 and subsequent fiscal years.

As required by section 1888(h)(7) of the Act, we will inform each SNF of the adjustments to its Medicare payments as a result of the SNF VBP Program that we will make not later than 60 days prior to the fiscal year involved. We will fulfill that requirement via SNF Performance Score Reports that we will circulate to SNFs using the QIES–CASPER system, which is also how we distribute the quarterly confidential feedback reports that we are required to provide to SNFs under section 1888(g)(5) of the Act. The SNF Performance Score Reports will contain the SNF's performance score, ranking, and value-based incentive payment adjustment factor that will be applied to claims submitted for the applicable fiscal year. Additionally, as we finalized in the FY 2018 SNF PPS final rule (82 FR 36622 through 36623), the provision of the SNF Performance Score Report will trigger the Phase Two Review and Corrections Process, and SNFs will have 30 days from the date we post the report on the QIES–CASPER system to submit corrections to their SNF performance score and ranking to the *SNFVBPinquiries@cms.hhs.gov* mailbox.

Finally, as we discussed in the FY 2018 SNF PPS final rule (82 FR 36618), beginning with FY 2019 (October 1, 2018) payments, we intend to make the 2 percent reduction and the SNF-specific value-based incentive payment adjustment to SNF claims simultaneously. Beginning with FY 2019, we will identify the adjusted federal per diem rate for each SNF for claims under the SNF PPS. We will then reduce that amount by 2 percent by multiplying the per diem amount by 0.98, in accordance with the requirements in section 1888(h)(6) of the Act. We will then multiply the result of that calculation by each SNF's specific value-based incentive payment adjustment factor, which will be based on each SNF's performance score for the program year and will be calculated by the exchange function, to generate the value-based incentive payment amount that applies to the SNF for the fiscal year. Finally, we will add the value-based incentive payment amount to the reduced rate, resulting in a new adjusted federal per diem rate that applies to the SNF for the fiscal year.

At the time of the publication of this proposed rule, we will not have completed SNF performance score calculations for the FY 2019 program year. However, we intend to provide the range of value-based incentive payment adjustment factors applicable to the FY 2019 program year in the FY 2019 SNF PPS final rule.

We are proposing to codify the SNF VBP Program's payment adjustments at § 413.337(f) of our regulations.

VII. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

Currently, Medicare- and Medicaid-participating providers and suppliers are at varying stages of adoption of health information technology (health IT). Many hospitals have adopted electronic health records (EHRs), and CMS has provided incentive payments to eligible hospitals, critical access hospitals (CAHs), and eligible professionals who have demonstrated meaningful use of certified EHR technology (CEHRT) under the Medicare EHR Incentive Program. As of 2015, 96 percent of Medicare- and Medicaid-participating non-Federal acute care hospitals had adopted certified EHRs with the capability to electronically export a summary of clinical care.[13] While both adoption of EHRs and electronic exchange of information have grown substantially among hospitals, significant obstacles to exchanging electronic health information across the continuum of care persist. Routine electronic transfer of information post-discharge has not been achieved by providers and suppliers in many localities and regions throughout the nation.

CMS is firmly committed to the use of certified health IT and interoperable EHR systems for electronic healthcare information exchange to effectively help hospitals and other Medicare- and Medicaid-participating providers and suppliers improve internal care delivery practices, support the exchange of important information across care team members during transitions of care, and enable reporting of electronically specified clinical quality measures (eCQMs). The Office of the National Coordinator for Health Information Technology (ONC) acts as the principal federal entity charged with coordination of nationwide efforts to implement and use health information technology and the electronic exchange of health information on behalf of the Department of Health and Human Services.

In 2015, ONC finalized the 2015 Edition health IT certification criteria (2015 Edition), the most recent criteria for health IT to be certified to under the ONC Health IT Certification Program. The 2015 Edition facilitates greater interoperability for several clinical health information purposes and enables health information exchange through new and enhanced certification criteria, standards, and implementation specifications. CMS requires eligible hospitals and CAHs in the Medicare and Medicaid EHR Incentive Programs and eligible clinicians in the Quality Payment Program (QPP) to use EHR technology certified to the 2015 Edition beginning in CY 2019.

In addition, several important initiatives will be implemented over the next several years to provide hospitals and other participating providers and suppliers with access to robust infrastructure that will enable routine electronic exchange of health information. Section 4003 of the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, and amending section 3000 of the Public Health Service Act (42 U.S.C. 300jj), requires HHS to take steps to advance the electronic exchange of health information and

[13] These statistics can be accessed at: *https://dashboard.healthit.gov/quickstats/pages/FIG-Hospital-EHR-Adoption.php.*

interoperability for participating providers and suppliers in various settings across the care continuum. Specifically, Congress directed that ONC ''. . . for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally.'' In January 2018, ONC released a draft version of its proposal for the Trusted Exchange Framework and Common Agreement,[14] which outlines principles and minimum terms and conditions for trusted exchange to enable interoperability across disparate health information networks (HINs). The Trusted Exchange Framework (TEF) is focused on achieving the following four important outcomes in the long-term:

- Professional care providers, who deliver care across the continuum, can access health information about their patients, regardless of where the patient received care.
- Patients can find all of their health information from across the care continuum, even if they do not remember the name of the professional care provider they saw.
- Professional care providers and health systems, as well as public and private health care organizations and public and private payer organizations accountable for managing benefits and the health of populations, can receive necessary and appropriate information on groups of individuals without having to access one record at a time, allowing them to analyze population health trends, outcomes, and costs; identify at-risk populations; and track progress on quality improvement initiatives.
- The health IT community has open and accessible application programming interfaces (APIs) to encourage entrepreneurial, user-focused innovation that will make health information more accessible and improve EHR usability.

ONC will revise the draft TEF based on public comment and ultimately release a final version of the TEF that will subsequently be available for adoption by HINs and their participants seeking to participate in nationwide health information exchange. The goal for stakeholders that participate in, or serve as, a HIN is to ensure that participants will have the ability to seamlessly share and receive a core set of data from other network participants in accordance with a set of permitted purposes and applicable privacy and security requirements. Broad adoption of this framework and its associated exchange standards is intended to both achieve the outcomes described above while creating an environment more conducive to innovation.

In light of the widespread adoption of EHRs along with the increasing availability of health information exchange infrastructure predominantly among hospitals, we are interested in hearing from stakeholders on how we could use the CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs (that is, the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation (RfPs) for Long Term Care Facilities) to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers. Specifically, CMS might consider revisions to the current CMS CoPs for hospitals such as: requiring that hospitals transferring medically necessary information to another facility upon a patient transfer or discharge do so electronically; requiring that hospitals electronically send required discharge information to a community provider via electronic means if possible and if a community provider can be identified; and requiring that hospitals make certain information available to patients or a specified third-party application (for example, required discharge instructions) via electronic means if requested.

On November 3, 2015, we published a proposed rule (80 FR 68126) to implement the provisions of the IMPACT Act and to revise the discharge planning CoP requirements that hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Hospitals (IRFs), Inpatient Psychiatric Hospitals (IPFs), Children's Hospitals, and Cancer Hospitals), critical access hospitals (CAHs), and home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. However, several of the proposed requirements directly address the issue of communication between providers and between providers and patients, as well as the issue of interoperability:

- Hospitals and CAHs would be required to transfer certain necessary medical information and a copy of the discharge instructions and discharge summary to the patient's practitioner, if the practitioner is known and has been clearly identified;
- Hospitals and CAHs would be required to send certain necessary medical information to the receiving facility/post-acute care providers, at the time of discharge; and
- Hospitals, CAHs and HHAs, would need to comply with the IMPACT Act requirements that would require hospitals, CAHs, and certain post-acute care providers to use data on quality measures and data on resource use measures to assist patients during the discharge planning process, while taking into account the patient's goals of care and treatment preferences.

We published another proposed rule (81 FR 39448), on June 16, 2016, that updated a number of CoP requirements that hospitals and CAH must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. One of the proposed hospital CoP revisions in that rule directly addresses the issues of communication between providers and patients, patient access to their medical records, and interoperability. We proposed that patients have the right to access their medical records, upon an oral or written request, in the form and format requested by such patients, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, including current medical records, within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

We also published a final rule (81 FR 68688), on October 4, 2016, that revised the requirements that LTC facilities must meet to participate in the Medicare and Medicaid programs, where we made a number of revisions based on the importance of effective communication between providers during transitions of care, such as transfers and discharges of residents to other facilities or providers, or to home. Among these revisions was a requirement that the transferring LTC facility must provide all necessary information to the resident's receiving provider, whether it is an acute care hospital, a LTC hospital, a psychiatric facility, another LTC facility, a hospice, home health agency, or another

[14] The draft version of the trusted Exchange Framework may be accessed at *https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement.*

community-based provider or practitioner. We specified that necessary information must include the following:

- Contact information of the practitioner responsible for the care of the resident;
- Resident representative information including contact information;
- Advance directive information;
- Special instructions or precautions for ongoing care;
- The resident's comprehensive care plan goals; and
- All other necessary information, including a copy of the resident's discharge or transfer summary and any other documentation to ensure a safe and effective transition of care.

We note that the discharge summary mentioned above must include reconciliation of the resident's medications, as well as a recapitulation of the resident's stay, a final summary of the resident's status, and the post-discharge plan of care. And in the preamble to the rule, we encouraged LTC facilities to electronically exchange this information if possible and to identify opportunities to streamline the collection and exchange of resident information by using information that the facility is already capturing electronically.

Additionally, we specifically invite stakeholder feedback on the following questions regarding possible new or revised CoPs/CfCs/RfPs for interoperability and electronic exchange of health information:

- If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?
- Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?
- Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?
- What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?
- Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?
- Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?
- Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?
- What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

We would also like to directly address the issue of communication between hospitals (as well as the other providers and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records. Privacy and security of patient data will be at the center of all CMS efforts in this area. CMS must protect the confidentiality of patient data, and CMS is completely aligned with the Department of Veterans Affairs (VA), the National Institutes of Health (NIH), ONC, and the rest of the federal government, on this objective.

While some Medicare beneficiaries have had, for quite some time, the ability to download their Medicare claims information, in pdf or Excel formats, through the CMS Blue Button platform, the information was provided without any context or other information that would help beneficiaries understand what the data was really telling them. For beneficiaries, their claims information is useless if it is either too hard to obtain or, as was the case with the information provided through previous versions of Blue Button, hard to understand. In an effort to fully contribute to the federal government's MyHealthEData initiative, CMS developed and launched the new Blue Button 2.0, which represents a major step toward giving patients meaningful control of their health information in an easy-to-access and understandable way. Blue Button 2.0 is a developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to secure applications, services, and research programs they trust. The possibilities for better care through Blue Button 2.0 data are exciting, and might include enabling the creation of health dashboards for Medicare beneficiaries to view their health information in a single portal, or allowing beneficiaries to share complete medication lists with their doctors to prevent dangerous drug interactions.

To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records. We also welcome the public's ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through

revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers. We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.

We note that this is a Request for Information only. Respondents are encouraged to provide complete but concise and organized responses, including any relevant data and specific examples. However, respondents are not required to address every issue or respond to every question discussed in this Request for Information to have their responses considered. In accordance with the implementing regulations of the Paperwork Reduction Act at 5 CFR 1320.3(h)(4), all responses will be considered provided they contain information CMS can use to identify and contact the commenter, if needed.

This Request for Information is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This Request for Information does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this Request for Information and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this Request for Information; all costs associated with responding to this Request for Information will be solely at the interested party's expense.

We note that not responding to this Request for Information does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this Request for Information announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this Request for Information. CMS will not respond to comment submissions in response to this Request for Information in the FY 2019 IPPS/LTCH PPS final rule. Rather, CMS will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. CMS may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this Request for Information. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this Request for Information may be used by the Government for program planning on a nonattribution basis. Respondents should not include any information that might be considered proprietary or confidential.

This Request for Information should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. CMS may publically post the public comments received, or a summary of those public comments.

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), we are required to publish a 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.

To fairly evaluate whether an information collection should be approved by OMB, PRA section 3506(c)(2)(A) 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 burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.

We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs).

A. Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2016 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). In this regard, Table 41 presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage. The wage rates provided in Table 41 are used to calculate the wages to derive burden estimates in this section.

TABLE 41—NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Registered Nurse	29–1141	34.70	34.70	69.40
Health Information Technician	29–2071	19.93	19.93	39.86

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

B. Proposed Information Collection Requirements (ICRs)

1. ICRs Regarding the SNF PPS Assessment Schedule Under the Proposed PDPM

The following sets out the proposed requirements and burden associated

with the MDS assessment schedule that would be effective October 1, 2019 under the SNF PPS in conjunction with implementation of the proposed PDPM. The proposed requirements and burden will be submitted to OMB for approval under control number 0938–1140 (CMS–10387).

Section V.C of this preamble proposes, effective October 1, 2019, to revise the current SNF PPS assessment schedule to require only two scheduled assessments (as opposed to the current requirement for five scheduled assessments) for each SNF stay: A 5-day scheduled PPS assessment and a discharge assessment.

The current 5-day scheduled PPS assessment would be used as the admission assessment under this rule's proposed PDPM and set the resident's case-mix classification for the resident's SNF stay. The PPS discharge assessment (which is already required for all SNF Part A residents) would serve as the discharge assessment and be used for monitoring purposes. This rule also proposes to require SNFs to reclassify residents under the proposed PDPM using the Interim Payment Assessment (IPA) if certain criteria are met, as discussed in section V.D.1. of this preamble. Thus, the 5-day SNF PPS scheduled assessment would be the only PPS assessment required to classify a resident under the proposed PDPM for payment purposes, except when an IPA would be required as provided in section V.E.1. This would eliminate the requirement for the following assessments under the SNF PPS: 14-Day scheduled PPS assessment, 30-day scheduled PPS assessment, 60-day scheduled PPS assessment, 90-day scheduled PPS assessment, Start of Therapy Other Medicare Required Assessment (OMRA), End of Therapy OMRA, and Change of Therapy OMRA.

In estimating the amount of time to complete a PPS assessment, we utilize the OMRA assessment, or the NO/SO item set (consistent with the currently approved PRA Supporting Statement at *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201703-0938-018*- click on View Supporting Statement and Other Documents and then click *OMB 0938-1140 Supporting Statement Revision_nonsub_V4–4–5–2017 (rev 04–07–2017 by OSORA PRA).docx*) as a proxy for all assessments. In section V.D.3. of this preamble, we propose to add 18 items to the PPS discharge assessment in order to calculate and monitor the total amount of therapy provided during a SNF stay. The proposed items are listed in Table 35 under section V.D.3 of this proposed rule. Given that the PPS OMRA assessment has 272 items (as compared to 125 items currently on the PPS discharge assessment) we believe that the items that we propose to add to the PPS discharge assessment—while increasing burden for each of the respective assessments—is accounted for by using the longer PPS OMRA assessment as a proxy for the time required to complete all assessments.

When calculating the burden for each assessment, we estimate that it will take 40 minutes (0.6667 hours) for an RN to collect the information necessary for preparing the assessment, 10 minutes (0.1667 hours) for staff to code the responses, and 1 minute (0.0167 hours) for a health information technician to transmit the results. In total, we estimate that it would take 51 minutes (0.85 hours) to complete a single PPS assessment.

The ongoing burden associated with the proposed revisions to the SNF PPS assessment schedule is the time and effort it would take each of the 15,455 Medicare Part A SNFs to complete the 5-day PPS and discharge assessments. Based on FY 2017 data, we estimate that 2,406,401 5-day PPS assessments would be completed and submitted by Part A SNFs each year under the proposed PDPM. We are using the same number of assessments (2,406,401) as a proxy for the number of PPS discharge assessments that would be completed and submitted each year, since all residents who require a 5-day PPS assessment will also require a discharge assessment under the SNF PDPM.

We are using the Significant Change in Status Assessment (SCSA) as a proxy to estimate the number of IPAs as the criteria for completing an SCSA is similar to that for the proposed IPA. Based on FY 2017 data, 92,240 IPAs would be completed per year. We estimate that the total number of 5-day scheduled PPS assessments, IPAs, and PPS discharge assessments that would be completed across all facilities is 4,905,042 (2,406,401 + 92,240 + 2,406,401, respectively). For all assessments under the proposed SNF PDPM, we estimate a burden of 4,169,286 hours (4,905,042 assessments × 0.85 hr/assessment) at a cost of $274,878,554 (4,905,042 assessments × $56.04/assessment) (see calculation of the cost estimate for each assessment below).

Based on the same FY 2017 data, there were 5,833,476 non-discharge related assessments (scheduled and unscheduled PPS assessments) completed under the RUG- IV payment system. To this number we add the same proxy as above for the number of discharge assessments (2,406,401), since every resident under RUG–IV who required a 5-day scheduled PPS assessment would also require a discharge assessment. This brings the total number of estimated assessments under RUG–IV to 8,239,877. Using the same wage and time estimates (per assessment), we estimate a burden of 7,003,895 hours (8,239,877 assessments × 0.85 hr/assessment) at a cost of $461,762,707 (8,239,877 assessments × $56.04/assessment).

When comparing the currently approved RUG–IV burden with the proposed PDPM burden, we estimate a savings of 2,834,609 administrative hours (7,003,895 RUG–IV hours—4,169,286 proposed PDPM hours) or approximately 183 hours per provider per year (2,834,609 hours/15,455 providers). As depicted in Table 42, we also estimate a cost savings of $186,884,153 ($461,762,707 RUG–IV costs—$274,878,554 proposed PDPM costs) or $12,092 per provider per year ($186,884,153/15,455 providers). This represents a significant decrease in administrative burden for providers under the proposed PDPM.

TABLE 42—PDPM SAVINGS

Burden reconciliation	Respondents	Responses (assessments)	Burden per response (hours)	Total annual burden (hours)	Cost ($)
RUG–IV	15,455	8,239,877	0.85	7,003,895	461,762,707
Proposed PDPM	15,455	4,905,042	0.85	4,169,286	274,878,554
SAVINGS	No change	(3,334,835)	No change	(2,834,609)	(186,884,153)

When calculating the burden for each assessment, we estimate that it will take 40 minutes (0.6667 hours) at $69.40/hr for an RN to collect the information necessary for preparing the assessment, 10 minutes (0.1667 hours) at $54.63/hr (the average hourly wage for RN ($69.40/hr) and health information technician ($39.86/hr) for staff to code the responses, and 1 minute (0.0167 hours) at $39.86/hr for a health information technician to transmit the results. In total, we estimate that it would take 51 minutes (0.85 hours) to complete a single PPS assessment. Based on the adjusted hourly wages for the noted staff, we estimate that it would cost $56.04 to prepare, code, and transmit each PPS assessment [($69.40/hr × 0.6667 hr) + ($54.63/hr × 0.1667 hr) + ($39.86/hr × 0.0167 hr)].

Finally, in section V.C.1.a of this preamble, we propose to add 3 items, as listed in Table 34 of this preamble, to the MDS 3.0 for Nursing Homes and Swing Bed Providers. Based on the small number of items being added and the small percentage of assessments that Swing Bed providers make up, we do not believe this action will cause any measurable adjustments to our currently approved burden estimates. Consequently, we are not revising any of those estimates.

2. ICRs Regarding the SNF VBP Program

In section VI.C.5.d. of this rule, we propose to adopt an Extraordinary Circumstances Exception (ECE) process for the SNF VBP. Because the same CMS Extraordinary Circumstances Exceptions (ECE) Request Form would be used across ten quality programs: Hospital IQR Program, Hospital Outpatient Reporting Program, Inpatient Psychiatric Facility Quality Reporting Program, PPS-Exempt Cancer Hospital Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, Hospital VBP Program, Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program, End Stage Renal Disease Quality Incentive Program, and Skilled Nursing Facility Value-Based Purchasing Program—the form and its associated requirements/burden will be submitted to OMB for approval under one information collection request (CMS–10210, OMB control number: 0938–1022) and in association with our IPPS proposed rule (CMS–1694–P; RIN 0938–AT27). To avoid double counting we are not setting out the form's SNF-related burden in this rulemaking.

Separately, we are not proposing any new or revised SNF VBP measures in this proposed rule. Nor are we proposing any new or revised collection burden. Consequently, this proposed rule does not set out any new VBP-related collections of information that would be subject to OMB approval under the authority of the PRA.

3. ICRs for the SNF Quality Reporting Program (QRP)

This rule does not propose to add, remove, or revise any measures under the SNF QRP. Consequently, we are not revising the burden related to the Program's measures.

C. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. The requirements are not effective until they have been approved by OMB.

We invite public comments on these information collection requirements. If you wish to comment, please identify the rule (CMS–1696–P) and, where applicable, the preamble section, and the ICR section. See this rule's **DATES** and **ADDRESSES** sections for the comment due date and for additional instructions.

IX. 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.

X. Economic Analyses

A. Regulatory Impact Analysis

1. Statement of Need

This proposed rule would update the FY 2018 SNF prospective payment rates as required under section 1888(e)(4)(E) of the Act. It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to provide for publication in the **Federal Register** before the August 1 that precedes the start of each FY, the unadjusted federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustment. As these statutory provisions prescribe a detailed methodology for calculating and disseminating payment rates under the SNF PPS, we do not have the discretion to adopt an alternative approach on these issues. We note that we did not include the impacts of the proposed PDPM and related policies in the sections that follow, as we have included this discussion in section V.J. of this proposed rule.

2. Introduction

We have examined the impacts of this proposed 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), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an economically significant rule, under section 3(f)(1) of Executive Order 12866. Accordingly, we have prepared a regulatory impact analysis (RIA) as further discussed below. Also, the rule has been reviewed by OMB.

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. OMB's implementation guidance, issued on April 5, 2017, explains that ''Federal spending regulatory actions that cause only income transfers between taxpayers and program beneficiaries (for example, regulations associated with . . . Medicare spending) are considered 'transfer rules' and are not covered by E.O. 13771. . . . However . . . such regulatory actions may impose requirements apart from transfers . . . In those cases, the actions would need to be offset to the extent they impose more than de minimis costs. Examples of ancillary requirements that may require offsets include new reporting or recordkeeping requirements.'' As discussed in section VII of this proposed rule, we estimate that this proposed rule would lead to paperwork cost savings of approximately $187 million per year on

an ongoing basis. This proposed rule is expected to be an E.O. 13771 deregulatory action, if finalized.

3. Overall Impacts

This proposed rule sets forth proposed updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2018 (82 FR 36530). Based on the above, we estimate that the aggregate impact would be an increase of approximately $850 million in payments to SNFs in FY 2019, resulting from the SNF market basket update to the payment rates, as required by section 53111 of the BBA 2018. Absent the application of section 53111 of the BBA 2018, the aggregate impact from the 1.9 percentage point market basket increase factor would have been approximately $670 million. We note that these impact numbers do not incorporate the SNF VBP reductions mentioned in section IX.A.6. of this proposed rule.

We would note that events may occur to limit the scope or accuracy of our impact analysis, as this analysis is future-oriented, and thus, very susceptible to forecasting errors due to events that may occur within the assessed impact time period.

In accordance with sections 1888(e)(4)(E) and 1888(e)(5) of the Act, we update the FY 2018 payment rates by a factor equal to the market basket index percentage change adjusted by the MFP adjustment to determine the payment rates for FY 2019. As discussed previously, section 53111 of the BBA 2018 stipulates a market basket increase factor of 2.4 percent. The impact to Medicare is included in the total column of Table 43. In updating the SNF PPS rates for FY 2019, we made a number of standard annual revisions and clarifications mentioned elsewhere in this proposed rule (for example, the update to the wage and market basket indexes used for adjusting the federal rates).

The annual update set forth in this proposed rule applies to SNF PPS payments in FY 2019. Accordingly, the analysis of the impact of the annual update that follows only describes the impact of this single year. Furthermore, in accordance with the requirements of the Act, we will publish a rule or notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

4. Detailed Economic Analysis

The FY 2019 SNF PPS payment impacts appear in Table 43. Using the most recently available data, in this case FY 2017, we apply the current FY 2018 wage index and labor-related share value to the number of payment days to simulate FY 2018 payments. Then, using the same FY 2017 data, we apply the proposed FY 2019 wage index and labor-related share value to simulate FY 2019 payments. We tabulate the resulting payments according to the classifications in Table 43 (for example, facility type, geographic region, facility ownership), and compare the simulated FY 2018 payments to the simulated FY 2019 payments to determine the overall impact. The breakdown of the various categories of data Table 43 follows:

- The first column shows the breakdown of all SNFs by urban or rural status, hospital-based or freestanding status, census region, and ownership.
- The first row of figures describes the estimated effects of the various changes on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban, and rural categories. The next nineteen rows show the effects on facilities by urban versus rural status by census region. The last three rows show the effects on facilities by ownership (that is, government, profit, and non-profit status).
- The second column shows the number of facilities in the impact database.
- The third column shows the effect of the annual update to the wage index. This represents the effect of using the most recent wage data available. The total impact of this change is 0 percent; however, there are distributional effects of the change.
- The fourth column shows the effect of all of the changes on the FY 2019 payments. The update of 2.4 percent is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will increase by 2.4 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 43, the combined effects of all of the changes vary by specific types of providers and by location. For example, due to changes proposed in this rule, providers in the urban Pacific region would experience a 3.4 percent increase in FY 2019 total payments.

TABLE 43—PROJECTED IMPACT TO THE SNF PPS FOR FY 2019

	Number of facilities FY 2019	Update wage data (%)	Total change (%)
Group:			
Total	15,455	0.0	2.4
Urban	11,031	0.0	2.4
Rural	4,424	0.1	2.5
Hospital-based urban	498	0.0	2.4
Freestanding urban	10,533	0.0	2.4
Hospital-based rural	551	0.0	2.4
Freestanding rural	3,873	0.1	2.5
Urban by region:			
New England	789	−0.7	1.7
Middle Atlantic	1,479	0.0	2.4
South Atlantic	1,869	−0.2	2.2
East North Central	2,126	−0.4	2.0
East South Central	555	−0.3	2.1
West North Central	920	−0.4	2.0
West South Central	1,344	0.2	2.6
Mountain	525	−0.6	1.8
Pacific	1,419	1.0	3.4
Outlying	5	−0.7	1.7
Rural by region:			
New England	135	−0.7	1.7
Middle Atlantic	215	0.2	2.6

TABLE 43—PROJECTED IMPACT TO THE SNF PPS FOR FY 2019—Continued

	Number of facilities FY 2019	Update wage data (%)	Total change (%)
South Atlantic	494	0.0	2.4
East North Central	930	0.2	2.6
East South Central	523	−0.5	1.9
West North Central	1,072	0.4	2.8
West South Central	733	0.8	3.2
Mountain	227	0.5	2.9
Pacific	95	−0.8	1.5
Ownership:			
Government	1,011	−0.1	2.3
Profit	10,872	0.0	2.4
Non-Profit	3,572	−0.1	2.3

Note: The Total column includes the 2.4 percent market basket increase required by section 53111 of the BBA 2018. Additionally, we found no SNFs in rural outlying areas.

5. Estimated Impacts for the SNF QRP

With no proposals to add or remove measures in the SNF QRP, there are no impacts associated with the SNF QRP Program.

6. Estimated Impacts for the SNF VBP Program

Estimated impacts of the FY 2019 SNF VBP Program are based on historical data that appear in Table 44. We modeled SNFs' performance in the Program using SNFRM data from CY 2014 as the baseline period and FY 2016 as the performance period. Additionally, we modeled a logistic exchange function with a payback percentage of 60 percent, as we finalized in the FY 2018 SNF PPS final rule (82 FR 36619 through 36621). As required by section 1888(h)(6)(A) of the Act, we will reduce adjusted federal per diem rates determined under section 1888(e)(4)(G) of the Act, otherwise applicable to a skilled nursing facility for services furnished by such facility during FY 2019 by the applicable percent, which is defined in section 1888(h)(6)(B) of the Act, as 2 percent. We estimate the total reductions to payments required by section 1888(h)(6) of the Act, to be $527.4 million for FY 2019. Based on the 60 percent payback percentage, we estimate that we will disburse approximately $316.4 million in value-based incentive payments to SNFs in FY 2019, which means that the SNF VBP Program is estimated to result in approximately $211 million in savings to the Medicare program in FY 2019.

We also modeled the estimated impacts of the proposed scoring adjustment for low-volume SNFs based on historical data in Table 45. We estimate that the scoring adjustment policy proposal would redistribute an additional $6.7 million to the group of low volume SNFs.

We estimate that this proposal would result in increasing low-volume SNFs' value-based incentive payment percentages by approximately 0.99 percent, on average, from the value-based incentive payment percentage that they would receive in the absence of the low-volume adjustment. An increase in value-based incentive payment percentages by 0.99 percent is needed to bring low-volume SNFs back to the 2.0 percent that was withheld from their payments. We also estimate that if this proposal is finalized, we would pay an additional $6.7 million in incentive payments to low-volume SNFs, which would increase the 60 percent payback percentage for FY 2019 by approximately 1.28 percent, making the new payback percentage for FY 2019 equal to 61.28 percent of the estimated $527.4 million in withheld funds for that fiscal year.

TABLE 44—ESTIMATED FY 2019 SNF VBP PROGRAM IMPACTS WITHOUT A LOW-VOLUME SCORING ADJUSTMENT

Category	Criterion	Number of facilities	RSRR (mean)	Mean SNF performance score	Mean incentive multiplier (60% payback) (%)	% of proposed payback
Group	Total	15,460	0.18874	40.982	1.163	*99.9
	Urban	10,995	0.18826	40.538	1.154	83.8
	Rural	4,465	0.18612	40.433	1.139	16.0
Urban by Region	Total	10,995				
	01 = Boston	793	0.18941	37.53033	1.063	4.8
	02 = New York	905	0.18929	40.50641	1.148	11.5
	03 = Philadelphia	1,120	0.18586	44.99993	1.310	10.0
	04 = Atlanta	1,878	0.19245	37.29765	1.050	13.1
	05 = Chicago	2,325	0.18683	42.32786	1.213	16.1
	06 = Dallas	1,363	0.19166	34.59615	0.939	6.3
	07 = Kansas City	658	0.18916	39.14296	1.099	2.7
	08 = Denver	319	0.17823	53.44707	1.618	2.9
	09 = San Francisco	1,296	0.18666	39.95157	1.132	12.4
	10 = Seattle	338	0.17752	55.34239	1.664	4.1
Rural by Region	Total	4,465				
	01 = Boston	135	0.18176	50.72243	1.510	0.9
	02 = New York	87	0.18414	49.10573	1.494	0.5
	03 = Philadelphia	274	0.18686	42.10613	1.216	1.3

TABLE 44—ESTIMATED FY 2019 SNF VBP PROGRAM IMPACTS WITHOUT A LOW-VOLUME SCORING ADJUSTMENT—Continued

Category	Criterion	Number of facilities	RSRR (mean)	Mean SNF performance score	Mean incentive multiplier (60% payback) (%)	% of proposed payback
	04 = Atlanta	882	0.19040	36.35979	1.013	3.3
	05 = Chicago	1,100	0.18350	45.84850	1.313	4.7
	06 = Dallas	783	0.19100	34.12362	0.917	1.9
	07 = Kansas City	789	0.18557	41.35057	1.136	1.4
	08 = Denver	268	0.18049	46.96957	1.341	0.8
	09 = San Francisco	62	0.16434	54.12133	1.670	0.6
	10 = Seattle	85	0.17587	56.60310	1.683	0.7
Ownership Type	Total	15,462				
	Government	1,017	0.18332	43.477	1.245	6.2
	Profit	10,867	0.18905	39.176	1.102	71.2
	Non-Profit	3,578	0.18458	45.067	1.307	22.6
Number of Beds	Total	15,462				
	1st Quartile	3,898	0.18463	40.881	1.128	22.7
	2nd Quartile	3,834	0.18715	40.891	1.167	23.5
	3rd Quartile	3,945	0.18947	40.203	1.144	25.2
	4th Quartile	3,785	0.18932	41.339	1.197	28.7

* This category does not add to 100 because a small number of SNFs did not have urban/rural designations in our data.

TABLE 45—ESTIMATED SNF VBP PROGRAM IMPACTS INCLUDING EFFECTS OF THE PROPOSED LOW-VOLUME SCORING ADJUSTMENT

Category	Criterion	Number of facilities	RSRR (mean)	Mean SNF performance score	Mean incentive multiplier (60% Payback) (%)	% of proposed payback
Group	Total	12,845	0.18912	41.371	1.192	* 99.9
	Urban	9,604	0.18957	40.956	1.177	84.4
	Rural	3,241	0.18779	41.011	1.181	15.4
Urban by Region	Total	9,604				
	01 = Boston	713	0.19089	37.26777	1.059	4.9
	02 = New York	836	0.19029	40.90383	1.165	11.8
	03 = Philadelphia	1,040	0.18601	45.31896	1.325	10.1
	04 = Atlanta	1,767	0.19332	37.28735	1.052	13.3
	05 = Chicago	1,961	0.18784	43.06368	1.246	16.0
	06 = Dallas	1,134	0.19416	34.53275	0.949	6.1
	07 = Kansas City	510	0.19057	39.26278	1.132	2.6
	08 = Denver	241	0.17832	57.62596	1.790	2.9
	09 = San Francisco	1,098	0.18908	40.80722	1.176	12.5
	10 = Seattle	304	0.17808	56.67839	1.713	4.2
Rural by Region	Total	3,241				
	01 = Boston	115	0.18133	51.89294	1.568	0.9
	02 = New York	77	0.18366	50.48193	1.569	0.5
	03 = Philadelphia	240	0.18789	42.12621	1.218	1.3
	04 = Atlanta	764	0.19283	36.51452	1.032	3.3
	05 = Chicago	818	0.18397	47.85089	1.399	4.5
	06 = Dallas	557	0.19355	34.00868	0.952	1.7
	07 = Kansas City	421	0.18634	42.64769	1.236	1.2
	08 = Denver	132	0.18000	52.38900	1.544	0.7
	09 = San Francisco	48	0.17780	61.50419	1.931	0.6
	10 = Seattle	69	0.17628	60.70084	1.836	0.7
Ownership Type	Total	12,847				
	Government	688	0.18529	46.450	1.380	5.2
	Profit	9,250	0.19039	39.526	1.127	72.0
	Non-Profit	2,909	0.18597	46.038	1.353	22.9
Number of Beds	Total	12,847				
	1st Quartile	3,222	0.18760	42.466	1.226	24.6
	2nd Quartile	3,221	0.18878	40.971	1.175	24.4
	3rd Quartile	3,197	0.19048	40.242	1.153	23.3
	4th Quartile	3,207	0.18963	41.800	1.212	27.7

* This category does not add to 100% because a small number of SNFs did not have urban/rural designations in our data.

7. Alternatives Considered

As described in this section, we estimate that the aggregate impact for FY 2019 under the SNF PPS would be an increase of approximately $850 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as required by section 53111 of the BBA 2018. Absent application of section 53111 of the BBA 2018, the market basket increase factor of 1.9 percent would have resulted in an aggregate increase in payments to SNFs of approximately $670 million.

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for cost reporting periods beginning on or after July 1, 1998. This section of the statute prescribes a detailed formula for calculating base payment rates under the SNF PPS, and does not provide for the use of any alternative methodology. It specifies that the base year cost data to be used for computing the SNF PPS payment rates must be from FY 1995 (October 1, 1994, through September 30, 1995). In accordance with the statute, we also incorporated a number of elements into the SNF PPS (for example, case-mix classification methodology, a market basket index, a wage index, and the urban and rural distinction used in the development or adjustment of the federal rates). Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new FY through the **Federal Register**, and to do so before the August 1 that precedes the start of the new FY; accordingly, we are not pursuing alternatives for this process.

As discussed in Section VI.C.5.c., we also considered an alternative SNF VBP low-volume scoring policy. This alternative scoring assignment would result in a value-based incentive payment percentage of 1.2 percent, or 60 percent of the 2 percent withhold. This amount would match low-volume SNFs' incentive payment percentages with the finalized SNF VBP Program payback percentage of 60 percent, and would represent a smaller adjustment to low-volume SNFs' incentive payment percentages than the proposed policy described above. We estimate that this alternative would redistribute an additional $1 million with respect to FY 2019 services to low-volume SNFs. We also estimate that this alternative would increase the 60 percent payback percentage for FY 2019 by approximately 0.18 percent of the approximately $527.4 million of the total withheld from SNFs' payments, which would result in a payback percentage of 60.18 percent of the estimated $527.4 million in withheld funds for that Program year. We estimate that this alternative would pay back SNFs about $5.7 million less than the proposed low-volume scoring methodology adjustment in total estimated payments on an annual basis. However, as with the proposal above, the specific amount by which the payback percentage would increase for each Program year would vary based on the number of low-volume SNFs that we identify for each Program year and the distribution of all SNFs' performance scores for that Program year.

8. Accounting Statement

As required by OMB Circular A–4 (available online at *www.whitehouse.gov/sites/default/files/omb/assets/regulatory_matters_pdf/a-4.pdf*), in Tables 46 and 47, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule for FY 2019. Table 46 provides our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies in this proposed rule, based on the data for 15,455 SNFs in our database. Tables 44, 45, and 47 provide our best estimate of the possible changes in Medicare payments under the SNF VBP as a result of the policies in this proposed rule.

TABLE 46—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2018 SNF PPS FISCAL YEAR TO THE 2019 SNF PPS FISCAL YEAR

Category	Transfers
Annualized Monetized Transfers	$850 million.*
From Whom To Whom?	Federal Government to SNF Medicare Providers.

* The net increase of $850 million in transfer payments is a result of the market basket increase of $850 million.

TABLE 47—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR THE FY 2019 SNF VBP PROGRAM

Category	Transfers
Annualized Monetized Transfers	$316.4 million.*
From Whom To Whom?	Federal Government to SNF Medicare Providers.

* This estimate does not include the two percent reduction to SNFs' Medicare payments (estimated to be $527.4 million) required by statute.

9. Conclusion

This proposed rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2018 (82 FR 36530). Based on the above, we estimate the overall estimated payments for SNFs in FY 2019 are projected to increase by approximately $850 million, or 2.4 percent, compared with those in FY 2018. We estimate that in FY 2019 under RUG–IV, SNFs in urban and rural areas would experience, on average, a 2.4 percent increase and 2.5 percent increase, respectively, in estimated payments compared with FY 2018. Providers in the urban Pacific region would experience the largest estimated increase in payments of approximately 3.4 percent. Providers in the rural Pacific region would experience the smallest estimated increase in payments of 1.5 percent.

B. Regulatory Flexibility Act Analysis

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, non-profit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by reason of their non-profit status or by having revenues of $27.5 million or less in any 1 year. We utilized the revenues of individual SNF providers (from recent Medicare Cost Reports) to classify a

small business, and not the revenue of a larger firm with which they may be affiliated. As a result, for the purposes of the RFA, we estimate that almost all SNFs are small entities as that term is used in the RFA, according to the Small Business Administration's latest size standards (NAICS 623110), with total revenues of $27.5 million or less in any 1 year. (For details, see the Small Business Administration's website at *http://www.sba.gov/category/navigation-structure/contracting/contracting-officials/eligibility-size-standards*). In addition, approximately 20 percent of SNFs classified as small entities are non-profit organizations. Finally, individuals and states are not included in the definition of a small entity.

This proposed rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2018 (82 FR 36530). Based on the above, we estimate that the aggregate impact for FY 2019 would be an increase of $850 million in payments to SNFs, resulting from the SNF market basket update to the payment rates. While it is projected in Table 43 that providers would experience a net increase in payments, we note that some individual providers within the same region or group may experience different impacts on payments than others due to the distributional impact of the FY 2019 wage indexes and the degree of Medicare utilization.

Guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA. In their March 2017 Report to Congress (available at *http://medpac.gov/docs/default-source/reports/mar17_medpac_ch8.pdf*), MedPAC states that Medicare covers approximately 11 percent of total patient days in freestanding facilities and 21 percent of facility revenue (March 2017 MedPAC Report to Congress, 202). As a result, for most facilities, when all payers are included in the revenue stream, the overall impact on total revenues should be substantially less than those impacts presented in Table 43. As indicated in Table 43, the effect on facilities is projected to be an aggregate positive impact of 2.4 percent for FY 2019. As the overall impact on the industry as a whole, and thus on small entities specifically, is less than the 3 to 5 percent threshold discussed previously, the Secretary has determined that this proposed rule would not have a significant impact on a substantial number of small entities for FY 2019.

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 603 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 an MSA and has fewer than 100 beds. This proposed rule would affect small rural hospitals that (1) furnish SNF services under a swing-bed agreement or (2) have a hospital-based SNF. We anticipate that the impact on small rural hospitals would be similar to the impact on SNF providers overall. Moreover, as noted in previous SNF PPS final rules (most recently, the one for FY 2018 (82 FR 36530)), the category of small rural hospitals would be included within the analysis of the impact of this proposed rule on small entities in general. As indicated in Table 43, the effect on facilities for FY 2019 is projected to be an aggregate positive impact of 2.4 percent. As the overall impact on the industry as a whole is less than the 3 to 5 percent threshold discussed above, the Secretary has determined that this proposed rule would not have a significant impact on a substantial number of small rural hospitals for FY 2019.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately $150 million. This proposed rule will impose no mandates on state, local, or tribal governments or on the private sector.

D. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. This proposed rule would have no substantial direct effect on state and local governments, preempt state law, or otherwise have federalism implications.

E. Congressional Review Act

This proposed regulation 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.

F. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We seek comments on this assumption.

Using the wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $105.16 per hour, including overhead and fringe benefits *https://www.bls.gov/oes/current/oes_nat.htm* . Assuming an average reading speed, we estimate that it would take approximately 4 hours for the staff to review half of this proposed rule. For each SNF that reviews the rule, the estimated cost is $420.64 (4 hours × $105.16). Therefore, we estimate that the total cost of reviewing this regulation is $103,740 ($420.64 × 247 reviewers).

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

List of Subjects

42 CFR Part 411

Diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

§ 411.15 [Amended]

■ 2. Section 411.15 is amended in paragraph (p)(3)(iv) by removing the phrase ''by midnight of the day of departure'' and adding in its place the phrase ''before the following midnight''.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES; PAYMENT FOR ACUTE KIDNEY INJURY DIALYSIS

■ 3. The authority citation for part 413 continues 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 Public Law 106–113, 113 Stat. 1501A–332; sec. 3201 of Public Law 112–96, 126 Stat. 156; sec. 632 of Public Law 112–240, 126 Stat. 2354; sec. 217 of Public Law 113–93, 129 Stat. 1040; and sec. 204 of Public Law 113–295, 128 Stat. 4010; and sec. 808 of Public Law 114–27, 129 Stat. 362.

■ 4. Section 413.337 is amended by revising paragraph (d)(1)(v) and adding paragraphs (d)(1)(vi) and (vii) and (f) to read as follows:

§ 413.337 Methodology for calculating the prospective payment rates.

* * * * *

(d) * * *

(1) * * *

(v) For each subsequent fiscal year, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a factor equal to the SNF market basket index percentage change for the fiscal year involved, except as provided in paragraphs (d)(1)(vi) and (vii) of this section.

(vi) For fiscal year 2018, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a SNF market basket index percentage change of 1 percent (after application of paragraphs (d)(2) and (3) of this section).

(vii) For fiscal year 2019, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a SNF market basket index percentage change of 2.4 percent (after application of paragraphs (d)(2) and (3) of this section).

* * * * *

(f) *Adjustments to payment rates under the SNF Value-Based Purchasing Program.* Beginning with payment for services furnished on October 1, 2018, the adjusted Federal per diem rate (as defined in § 413.338(a)(2)) otherwise applicable to a SNF for the fiscal year is reduced by the applicable percent (as defined in § 413.338(a)(3)). The resulting amount is then adjusted by the value-based incentive payment amount (as defined in § 413.338(a)(14)) based on the SNF's performance score for that fiscal year under the SNF Value-Based Purchasing Program, as calculated under § 413.338.

■ 5. Section 413.338 is amended by—

■ a. Adding paragraphs (a)(16) and (17);

■ b. Revising paragraph (c)(2)(i); and

■ c. Adding paragraphs (d)(1)(iv) and (d)(3) and (4).

The additions and revision read as follows:

§ 413.338 Skilled Nursing Facility Value-Based Purchasing

(a) * * *

(16) *Low-volume SNF* means a SNF with fewer than 25 eligible stays included in the SNF readmission measure denominator during the performance period for a fiscal year.

(17) *Eligible stay* means, for purposes of the SNF readmission measure, an index SNF admission that would be included in the denominator of that measure.

* * * * *

(c) * * *

(2) * * *

(i) *Total amount available for a fiscal year.* The total amount available for value-based incentive payments for a fiscal year is at least 60 percent of the total amount of the reduction to the adjusted SNF PPS payments for that fiscal year, as estimated by CMS, and will be increased as appropriate for each fiscal year to account for the assignment of a performance score to low-volume SNFs under paragraph (d)(3) of this section.

(d) * * *

(1) * * *

(iv) CMS will not award points for improvement to a SNF that has fewer than 25 eligible stays during the baseline period.

* * * * *

(3) If CMS determines that a SNF is a low-volume SNF with respect to a fiscal year, CMS will assign a performance score to the SNF for the fiscal year that, when used to calculate the value-based incentive payment amount (as defined in paragraph (a)(14) of this section), results in a value-based incentive payment amount that is equal to the adjusted Federal per diem rate (as defined in paragraph (a)(2) of this section) that would apply to the SNF for the fiscal year without application of § 413.337(f).

(4) *Exception requests.* (i) A SNF may request and CMS may grant exceptions to the SNF Value-Based Purchasing Program's requirements under this section for one or more calendar months when there are certain extraordinary circumstances beyond the control of the SNF.

(ii) A SNF may request an exception within 90 days of the date that the extraordinary circumstances occurred by sending an email to *SNFVBPinquiries@cms.hhs.gov* that includes a completed Extraordinary Circumstances Request form (available on the SNF VBP section of QualityNet at *https://www.qualitynet.org/*) and any available evidence of the impact of the extraordinary circumstances on the care that the SNF furnished to patients, including, but not limited to, photographs, newspaper, and other media articles.

(iii) Except as provided in paragraph (d)(4)(iv) of this section, CMS will not consider an exception request unless the SNF requesting such exception has complied fully with the requirements in this paragraph (d).

(iv) CMS may grant exceptions to SNFs without a request if it determines that an extraordinary circumstance affects an entire region or locale.

(v) CMS will calculate a SNF performance score for a fiscal year for a SNF for which it has granted an exception request that does not include its performance on the SNF readmission

measure during the calendar months affected by the extraordinary circumstance.

* * * * *

■ 6. Section 413.360 is amended by adding paragraph (b)(3) and revising paragraphs (d)(1) and (4) to read as follows:

§ 413.360 Requirements under the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

* * * * *

(b) * * *

(3) CMS may remove a quality measure from the SNF QRP based on one or more of the following factors:

(i) Measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better resident outcomes.

(iii) A measure does not align with current clinical guidelines or practice.

(iv) A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.

(v) A measure that is more proximal in time to desired resident outcomes for the particular topic is available.

(vi) A measure that is more strongly associated with desired resident outcomes for the particular topic is available.

(vii) Collection or public reporting of a measure leads to negative unintended consequences other than resident harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

* * * * *

(d) * * *

(1) SNFs that do not meet the requirements in paragraph (b) of this section for a program year will receive a written notification of non-compliance through at least one of the following methods: Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC). A SNF may request reconsideration no later than 30 calendar days after the date identified on the letter of non-compliance.

* * * * *

(4) CMS will notify SNFs, in writing, of its final decision regarding any reconsideration request through at least one of the following notification methods: QIES ASAP system, the United States Postal Service, or via email from the Medicare Administrative Contractor (MAC).

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 6. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 424.20 [Amended]

■ 7. Section 424.20 is amended in paragraph (a)(1)(i) by removing the language ''a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in § 409.3 of this chapter; or'' and adding in its place the language ''a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in § 409.3 of this chapter, or for a new condition that arose while the individual was receiving care in the SNF or swing-bed hospital for a condition for which he or she received inpatient care in a participating or qualified hospital; or''.

Dated: April 17, 2018.

Seema Verma

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 19, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

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Part V

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 412

Medicare Program; FY 2019 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2018 (FY 2019); Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1690–P]

RIN 0938–AT32

Medicare Program; FY 2019 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2018 (FY 2019)

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs), which include psychiatric hospitals and excluded psychiatric units of an acute care hospital or critical access hospital. These changes would be effective for IPF discharges occurring during the fiscal year (FY) beginning October 1, 2018 through September 30, 2019 (FY 2019). This rule also proposes to update the IPF labor-related share, to update the IPF wage index for FY 2019, update the International Classification of Diseases 10th Revision, Clinical Modification (ICD–10–CM) codes for FY 2019, make technical corrections to the IPF regulations, and update quality measures and reporting requirements under the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. In addition, it would update providers on the status of IPF PPS refinements. Finally, this proposed rule includes a Request for Information related to health information technology.

DATES: *Comment Date:* To be assured consideration, comments must be received at one of the addresses provided in the **ADDRESSES** section, no later than 5 p.m. on June 26, 2018.

ADDRESSES: In commenting, refer to file code CMS–1690–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1690–P, P.O. Box 8010, Baltimore, MD 21244–8010.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1690–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT:

The IPF Payment Policy mailbox at *IPFPaymentPolicy@cms.hhs.gov* for general information.

Mollie Knight (410) 786–7948 or Hudson Osgood (410) 786–7897, for information regarding the market basket update or the labor related share.

Theresa Bean (410) 786–2287 or James Hardesty (410) 786–2629, for information regarding the regulatory impact analysis.

James Poyer (410) 786–2261 or Jeffrey Buck (410) 786–0407, for information regarding the inpatient psychiatric facility quality reporting program.

Scott Cooper (410) 786–9465, for information regarding the health information technology Request for Information.

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

Availability of Certain Tables Exclusively Through the internet on the CMS Website

Tables setting forth the fiscal year (FY) 2019 Wage Index for Urban Areas Based on Core-Based Statistical Area (CBSA) Labor Market Areas and the FY 2019 Wage Index Based on CBSA Labor Market Areas for Rural Areas are available exclusively through the internet, on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/IPFPPS/Wage Index.html.*

In addition, tables showing the complete listing of ICD–10 Clinical Modification (CM) and Procedure Coding System (PCS) codes underlying the FY 2019 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) for comorbidity adjustment, code first, and electroconvulsive therapy (ECT) are available online at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsych FacilPPS/tools.html.* Addenda B–1 to B–4 to this proposed rule show the tables of the ICD–10–CM/PCS codes, which affect FY 2019 IPF PPS comorbidity categories, code first, and non-specific codes with regards to laterality.

I. Executive Summary

A. Purpose

This proposed rule would update the prospective payment rates, the outlier threshold, and the wage index for Medicare inpatient hospital services provided by Inpatient Psychiatric Facilities (IPFs) for discharges occurring during the Fiscal Year (FY) beginning October 1, 2018 through September 30, 2019. Additionally, this proposed rule would make technical corrections to the IPF regulations and would propose updates to the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program.

B. Summary of the Major Provisions

1. Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS)

In this proposed rule, we would update the IPF PPS, as specified in 42 CFR 412.428. The proposed updates include the following:

- For FY 2019, we would adjust the 2012-based IPF market basket update (currently estimated to be 2.8 percent) by a reduction for economy-wide productivity (currently estimated to be 0.8 percentage point) as required by section 1886(s)(2)(A)(i) of the Social Security Act (the Act). We would further reduce the 2012-based IPF market basket update by 0.75 percentage point as required by section 1886(s)(2)(A)(ii) of the Act, resulting in a proposed estimated IPF payment rate update of 1.25 percent for FY 2019.
- The 2012-based IPF market basket would result in a labor-related share of 74.8 percent for FY 2019.
- We propose to update the IPF PPS federal per diem base rate from $771.35 to $782.01.
- We propose that providers who failed to report quality data for FY 2019 payment would receive a FY 2019 federal per diem base rate of $766.56.

• We propose to update the electroconvulsive therapy (ECT) payment per treatment from $332.08 to $336.67. We propose that providers who failed to report quality data for FY 2019 payment would receive a FY 2019 ECT payment per treatment of $330.02.

• We propose an updated labor-related share of 74.8 percent (based on the 2012-based IPF market basket) and core base statistical area (CBSA) rural and urban wage indices for FY 2019, and propose a wage index budget-neutrality adjustment of 1.0013.

• We propose to update the fixed dollar loss threshold amount from $11,425 to $12,935 to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF PPS payments.

• We propose minor technical corrections to IPF regulations.

2. Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

We are making several proposals related to measures and one proposal related to data submission for the IPFQR Program. Specifically, we are proposing to remove eight (8) measures beginning with the FY 2020 payment determination.

1. Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431);

2. Alcohol Use Screening, SUB–1 (NQF #1661);

3. Assessment of Patient Experience of Care;

4. Use of an Electronic Health Record;

5. Tobacco Use Screening, TOB–1 (NQF #1651);

6. Hours of Physical Restraint Use (NQF #0640);

7. Hours of Seclusion Use (NQF #0641); and

8. Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use

Treatment at Discharge, TOB–3 and TOB–3a (NQF #1656).

In addition, we are proposing to no longer require facilities to submit the sample size count for measures for which sampling is performed beginning with the FY 2020 Payment Determination (that is, data reported during summer of CY 2019).

3. Summary of Impacts

Provision description	Total transfers and cost reductions
FY 2019 IPF PPS payment update	The overall economic impact of this proposed rule is an estimated $50 million in increased payments to IPFs during FY 2019.
Updated quality reporting program (IPFQR) Program requirements.	The total reduction in costs beginning in FY 2018 calculated in 2018 dollars for IPFs as a result of the proposed updates to quality reporting requirements is estimated to be $68.1 million.

II. Background

A. Overview of the Legislative Requirements

Section 124 of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) required the establishment and implementation of an IPF PPS. Specifically, section 124 of the BBRA mandated that the Secretary of the Department of Health and Human Services (the Secretary) develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and excluded psychiatric units including an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and excluded psychiatric units. ''Excluded'' psychiatric unit mean a psychiatric unit in an acute care hospital that is excluded from the Inpatient Prospective Payment System (IPPS), or a psychiatric unit in a Critical Access Hospital (CAH) that is excluded from the CAH payment system. These excluded psychiatric units would be paid under the IPF PPS.

Section 405(g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) extended the IPF PPS to psychiatric distinct part units of CAHs.

Sections 3401(f) and 10322 of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by section 10319(e) of that Act and by section 1105(d) of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (hereafter referred to jointly as ''the Affordable Care Act'') added subsection (s) to section 1886 of the Social Security Act (the Act).

Section 1886(s)(1) of the Act titled ''Reference to Establishment and Implementation of System,'' refers to section 124 of the BBRA, which relates to the establishment of the IPF PPS.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the rate year (RY) beginning in 2012 (that is, a RY that coincides with a fiscal year (FY)) and each subsequent RY. As noted in our FY 2018 IPF PPS notice, published in the **Federal Register** on August 7, 2017 (82 FR 36771 through 36789), for the RY beginning in 2017, the productivity adjustment currently in place is equal to 0.6 percentage point.

Section 1886(s)(2)(A)(ii) of the Act requires the application of an ''other adjustment'' that reduces any update to an IPF PPS base rate by percentages specified in section 1886(s)(3) of the Act for the RY beginning in 2010 through the RY beginning in 2019. As noted in the FY 2018 IPF PPS notice, for the RY beginning in 2017, section 1886(s)(3)(D) of the Act requires that the reduction currently in place be equal to 0.75 percentage point.

Sections 1886(s)(4)(A) and 1886(s)(4)(B) of the Act require that for RY 2014 and each subsequent rate year, IPFs that fail to report required quality data with respect to such a RY shall have their annual update to a standard federal rate for discharges reduced by 2.0 percentage points. This may result in an annual update being less than 0.0 for a RY, and may result in payment rates for the upcoming rate year being less than such payment rates for the preceding rate year. Any reduction for failure to report required quality data shall apply only to the RY involved, and the Secretary shall not take into account such reduction in computing the payment amount for a subsequent RY. Please see section II.B of this proposed rule for an explanation of the IPF RY. More information about the specifics of the current IPFQR Program is available in the FY 2018 IPPS/Long-Term Care Hospital (LTCH) PPS final rule (82 FR 38461 through 38474).

To implement and periodically update these provisions, we have published various proposed and final rules and notices in the **Federal Register**. For more information regarding these documents, see the Center for Medicare & Medicaid (CMS) website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html?redirect=/InpatientPsychFacilPPS/.*

B. Overview of the IPF PPS

The November 2004 IPF PPS final rule (69 FR 66922) established the IPF

PPS, as required by section 124 of the BBRA and codified at 42 CFR part 412, subpart N. The November 2004 IPF PPS final rule set forth the federal per diem base rate for the implementation year (the 18-month period from January 1, 2005 through June 30, 2006), and provided payment for the inpatient operating and capital costs to IPFs for covered psychiatric services they furnish (that is, routine, ancillary, and capital costs, but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IPF PPS). Covered psychiatric services include services for which benefits are provided under the fee-for-service Part A (Hospital Insurance Program) of the Medicare program.

The IPF PPS established the federal per diem base rate for each patient day in an IPF derived from the national average daily routine operating, ancillary, and capital costs in IPFs in FY 2002. The average per diem cost was updated to the midpoint of the first year under the IPF PPS, standardized to account for the overall positive effects of the IPF PPS payment adjustments, and adjusted for budget-neutrality.

The federal per diem payment under the IPF PPS is comprised of the federal per diem base rate described previously and certain patient- and facility-level payment adjustments that were found in the regression analysis to be associated with statistically significant per diem cost differences.

The patient-level adjustments include age, Diagnosis-Related Group (DRG) assignment, and comorbidities; additionally, there are variable per diem adjustments to reflect higher per diem costs at the beginning of a patient's IPF stay. Facility-level adjustments include adjustments for the IPF's wage index, rural location, teaching status, a cost-of-living adjustment for IPFs located in Alaska and Hawaii, and an adjustment for the presence of a qualifying emergency department (ED).

The IPF PPS provides additional payment policies for outlier cases, interrupted stays, and a per treatment payment for patients who undergo electroconvulsive therapy (ECT). During the IPF PPS mandatory 3-year transition period, stop-loss payments were also provided; however, since the transition ended as of January 1, 2008, these payments are no longer available.

A complete discussion of the regression analysis that established the IPF PPS adjustment factors can be found in the November 2004 IPF PPS final rule (69 FR 66933 through 66936).

Section 124 of the BBRA did not specify an annual rate update strategy for the IPF PPS and was broadly written to give the Secretary discretion in establishing an update methodology. Therefore, in the November 2004 IPF PPS final rule, we implemented the IPF PPS using the following update strategy:

- Calculate the final federal per diem base rate to be budget-neutral for the 18-month period of January 1, 2005 through June 30, 2006.
- Use a July 1 through June 30 annual update cycle.
- Allow the IPF PPS first update to be effective for discharges on or after July 1, 2006 through June 30, 2007.

In RY 2012, we proposed and finalized switching the IPF PPS payment rate update from a RY that begins on July 1 and ends on June 30, to one that coincides with the federal FY that begins October 1 and ends on September 30. In order to transition from one timeframe to another, the RY 2012 IPF PPS covered a 15-month period from July 1, 2011 through September 30, 2012. Therefore, the IPF RY has been equivalent to the October 1 through September 30 federal FY since RY 2013. For further discussion of the 15-month market basket update for RY 2012 and changing the payment rate update period to coincide with a FY period, we refer readers to the RY 2012 IPF PPS proposed rule (76 FR 4998) and the RY 2012 IPF PPS final rule (76 FR 26432).

C. Annual Requirements for Updating the IPF PPS

In November 2004, we implemented the IPF PPS in a final rule that published on November 15, 2004 in the **Federal Register** (69 FR 66922). In developing the IPF PPS, and to ensure that the IPF PPS is able to account adequately for each IPF's case-mix, we performed an extensive regression analysis of the relationship between the per diem costs and certain patient and facility characteristics to determine those characteristics associated with statistically significant cost differences on a per diem basis. For characteristics with statistically significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments.

In that final rule, we explained the reasons for delaying an update to the adjustment factors, derived from the regression analysis, including waiting until we have IPF PPS data that yields as much information as possible regarding the patient-level characteristics of the population that each IPF serves. We indicated that we did not intend to update the regression analysis and the patient-level and facility-level adjustments until we complete that analysis. Until that analysis is complete, we stated our intention to publish a notice in the **Federal Register** each spring to update the IPF PPS (69 FR 66966).

On May 6, 2011, we published a final rule in the **Federal Register** titled, ''Inpatient Psychiatric Facilities Prospective Payment System—Update for Rate Year Beginning July 1, 2011 (RY 2012)'' (76 FR 26432), which changed the payment rate update period to a RY that coincides with a FY update. Therefore, final rules are now published in the **Federal Register** in the summer to be effective on October 1. When proposing changes in IPF payment policy, a proposed rule would be issued in the spring and the final rule in the summer to be effective on October 1. For further discussion on changing the IPF PPS payment rate update period to a RY that coincides with a FY, we refer readers to our RY 2012 IPF PPS final rule (76 FR 26434 through 26435). For a detailed list of updates to the IPF PPS, we refer readers to our regulations at 42 CFR 412.428.

Our most recent IPF PPS annual update was published in a notice with comment period on August 7, 2017 in the **Federal Register** titled, ''Medicare Program; FY 2018 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update'' (82 FR 36771), which updated the IPF PPS payment rates for FY 2018. That notice with comment period updated the IPF PPS federal per diem base rates that were published in the FY 2017 IPF PPS notice (81 FR 50502) in accordance with our established policies.

III. Provisions of the FY 2019 IPF PPS Proposed Rule

A. Proposed Update to the FY 2019 Market Basket for the IPF PPS

1. Background

The input price index that was used to develop the IPF PPS was the ''Excluded Hospital with Capital'' market basket. This market basket was based on 1997 Medicare cost reports for Medicare participating inpatient rehabilitation facilities (IRFs), IPFs, LTCHs, cancer hospitals, and children's hospitals. Although ''market basket'' technically describes the mix of goods and services used in providing health care at a given point in time, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies) derived from that market basket. Accordingly, the term market basket, as used in this document, refers to an input price index.

Since the IPF PPS inception, the market basket used to update IPF PPS payments has been rebased and revised to reflect more recent data on IPF cost structures. We last rebased and revised the IPF market basket in the FY 2016 IPF PPS rule, where we adopted a 2012-based IPF market basket, using Medicare cost report data for both Medicare participating psychiatric hospitals and excluded psychiatric units. We refer readers to the FY 2016 IPF PPS final rule for a detailed discussion of the 2012-based IPF PPS Market Basket and its development (80 FR 46656 through 46679). The FY 2016 IPS PPS final rule also includes references to the historical market baskets used to update IPF PPS payments since PPS implementation.

2. Proposed FY 2019 IPF Market Basket Update

For FY 2019 (beginning October 1, 2018 and ending September 30, 2019), we propose to use an estimate of the 2012-based IPF market basket increase factor to update the IPF PPS base payment rate. Consistent with historical practice, we propose to estimate the market basket update for the IPF PPS based on IHS Global, Inc.'s (IGI) forecast. IGI is a nationally recognized economic and financial forecasting firm that contracts with the CMS to forecast the components of the market baskets and multifactor productivity (MFP). Based on IGI's first quarter 2018 forecast with historical data through the fourth quarter of 2017, the 2012-based IPF market basket increase factor for FY 2019 is 2.8 percent.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (a RY that coincides with a FY) and each subsequent RY. For this FY 2019 IPF PPS proposed rule, based on IGI's first quarter 2018 forecast, the proposed MFP adjustment for FY 2019 (the 10-year moving average of MFP for the period ending FY 2019) is projected to be 0.8 percent. We reduced the 2.8 percent IPF market basket update by this 0.8 percentage point productivity adjustment, as mandated by the Act. For more information on the productivity adjustment, we refer reader to the discussion in the FY 2016 IPF PPS final rule (80 FR 46675).

In addition, for FY 2019 the 2012-based IPF PPS market basket update is further reduced by 0.75 percentage point as required by sections 1886(s)(2)(A)(ii) and 1886(s)(3)(E) of the Act. This results in a proposed estimated FY 2019 IPF PPS payment rate update of 1.25 percent (2.8 − 0.8 − 0.75 = 1.25). We are also proposing that if more recent data subsequently become available, we would use such data, if appropriate, to determine the FY 2019 IPF market basket update and MFP adjustment for the final rule.

3. Proposed IPF Labor-Related Share

Due to variations in geographic wage levels and other labor-related costs, we believe that payment rates under the IPF PPS should continue to be adjusted by a geographic wage index, which would apply to the labor-related portion of the federal per diem base rate (hereafter referred to as the labor-related share).

The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

Based on our definition of the labor-related share and the cost categories in the 2012-based IPF market basket, we are proposing to continue to include in the labor-related share the sum of the relative importance of Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair; All Other: Labor-related Services; and a portion (46 percent) of the Capital-Related cost weight from the 2012-based IPF market basket. The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2012) and FY 2019. Using IGI's first quarter 2018 forecast for the 2012-based IPF market basket, the proposed IPF labor-related share for FY 2019 is the sum of the FY 2019 relative importance of each labor-related cost category. For more information on the labor-related share and its calculation, we refer readers to the FY 2016 IPF PPS final rule (80 FR 46676 through 46679). For FY 2019, the proposed update to the labor-related share based on IGI's first quarter 2018 forecast of the 2012-based IPF PPS market basket is 74.8 percent. We are also proposing that if more recent data subsequently become available, we would use such data, if appropriate, to determine the FY 2019 labor-related share for the final rule.

B. Proposed Updates to the IPF PPS Rates for FY Beginning October 1, 2018

The IPF PPS is based on a standardized federal per diem base rate calculated from the IPF average per diem costs and adjusted for budget-neutrality in the implementation year. The federal per diem base rate is used as the standard payment per day under the IPF PPS and is adjusted by the patient-level and facility-level adjustments that are applicable to the IPF stay. A detailed explanation of how we calculated the average per diem cost appears in the November 2004 IPF PPS final rule (69 FR 66926).

1. Determining the Standardized Budget-Neutral Federal Per Diem Base Rate

Section 124(a)(1) of the BBRA required that we implement the IPF PPS in a budget-neutral manner. In other words, the amount of total payments under the IPF PPS, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the IPF PPS were not implemented. Therefore, we calculated the budget-neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) methodology had the IPF PPS not been implemented. A step-by-step description of the methodology used to estimate payments under the TEFRA payment system appears in the November 2004 IPF PPS final rule (69 FR 66926).

Under the IPF PPS methodology, we calculated the final federal per diem base rate to be budget-neutral during the IPF PPS implementation period (that is, the 18-month period from January 1, 2005 through June 30, 2006) using a July 1 update cycle. We updated the average cost per day to the midpoint of the IPF PPS implementation period (October 1, 2005), and this amount was used in the payment model to establish the budget-neutrality adjustment.

Next, we standardized the IPF PPS federal per diem base rate to account for the overall positive effects of the IPF PPS payment adjustment factors by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. Additional information concerning this standardization can be found in the November 2004 IPF PPS final rule (69 FR 66932) and the RY 2006 IPF PPS final rule (71 FR 27045). We then reduced the standardized federal per diem base rate to account for the outlier policy, the stop loss provision, and anticipated behavioral changes. A complete discussion of how we calculated each component of the budget-neutrality adjustment appears in the November 2004 IPF PPS final rule (69 FR 66932 through 66933) and in the RY 2007 IPF PPS final rule (71 FR 27044

through 27046). The final standardized budget-neutral federal per diem base rate established for cost reporting periods beginning on or after January 1, 2005 was calculated to be $575.95.

The federal per diem base rate has been updated in accordance with applicable statutory requirements and § 412.428 through publication of annual notices or proposed and final rules. A detailed discussion on the standardized budget-neutral federal per diem base rate and the electroconvulsive therapy (ECT) payment per treatment appears in the FY 2014 IPF PPS update notice (78 FR 46738 through 46739). These documents are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html.*

IPFs must include a valid procedure code for ECT services provided to IPF beneficiaries in order to bill for ECT services, as described in our Medicare Claims Processing Manual, Chapter 3, Section 190.7.3 (available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf.*) There were no changes to the ECT procedure codes used on IPF claims as a result of the preliminary update to the ICD–10–PCS code set for FY 2019.

2. Proposed Update of the Federal Per Diem Base Rate and Electroconvulsive Therapy Payment Per Treatment

The current (FY 2018) federal per diem base rate is $771.35 and the ECT payment per treatment is $332.08. For the proposed FY 2019 federal per diem base rate, we applied the proposed payment rate update of 1.25 percent (that is, the 2012-based IPF market basket increase for FY 2019 of 2.8 percent less the productivity adjustment of 0.8 percentage point, and further reduced by the 0.75 percentage point required under section 1886(s)(3)(E) of the Act), and the proposed wage index budget-neutrality factor of 1.0013 (as discussed in section III.D.1.e of this proposed rule) to the FY 2018 federal per diem base rate of $771.35, yielding a proposed federal per diem base rate of $782.01 for FY 2019. Similarly, we applied the proposed 1.25 percent payment rate update and the proposed 1.0013 wage index budget-neutrality factor to the FY 2018 ECT payment per treatment, yielding a proposed ECT payment per treatment of $336.67 for FY 2019.

Section 1886(s)(4)(A)(i) of the Act requires that for RY 2014 and each subsequent RY, in the case of an IPF that fails to report required quality data with respect to such rate year, the Secretary shall reduce any annual update to a standard federal rate for discharges during the RY by 2.0 percentage points. Therefore, we are applying a 2.0 percentage point reduction to the proposed federal per diem base rate and the proposed ECT payment per treatment as follows:

- For IPFs that fail requirements under the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program, we would apply a −0.75 percent payment rate update (that is, the IPF market basket increase for FY 2019 of 2.8 percent less the productivity adjustment of 0.8 percentage point, further reduced by the 0.75 percentage point for a proposed update of 1.25 percent, and further reduced by 2 percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act, which results in a negative update percentage) and the proposed wage index budget-neutrality factor of 1.0013 to the FY 2018 federal per diem base rate of $771.35, yielding a federal per diem base rate of $766.56 for FY 2019.
- For IPFs that fail to meet requirements under the IPFQR Program, we would apply the proposed −0.75 percent annual payment rate update and the proposed 1.0013 wage index budget-neutrality factor to the FY 2018 ECT payment per treatment of $332.08, yielding a proposed ECT payment per treatment of $330.02 for FY 2019.

C. Proposed Updates to the IPF PPS Patient-Level Adjustment Factors

1. Overview of the IPF PPS Adjustment Factors

The IPF PPS payment adjustments were derived from a regression analysis of 100 percent of the FY 2002 Medicare Provider and Analysis Review (MedPAR) data file, which contained 483,038 cases. For a more detailed description of the data file used for the regression analysis, see the November 2004 IPF PPS final rule (69 FR 66935 through 66936). We propose to continue to use the existing regression-derived adjustment factors established in 2005 for FY 2019. However, we have used more recent claims data to simulate payments to propose the outlier fixed dollar loss threshold amount and to assess the impact of the IPF PPS updates.

2. IPF PPS Patient-Level Adjustments

The IPF PPS includes payment adjustments for the following patient-level characteristics: Medicare Severity Diagnosis Related Groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments.

a. Proposed Update to MS–DRG Assignment

We believe it is important to maintain the same diagnostic coding and Diagnosis Related Group (DRG) classification for IPFs that are used under the Inpatient Prospective Payment System (IPPS) for providing psychiatric care. For this reason, when the IPF PPS was implemented for cost reporting periods beginning on or after January 1, 2005, we adopted the same diagnostic code set (ICD–9–CM) and DRG patient classification system (MS–DRGs) that were utilized at the time under the IPPS. In the RY 2009 IPF PPS notice (73 FR 25709), we discussed CMS' effort to better recognize resource use and the severity of illness among patients. CMS adopted the new MS–DRGs for the IPPS in the FY 2008 IPPS final rule with comment period (72 FR 47130). In the RY 2009 IPF PPS notice (73 FR 25716), we provided a crosswalk to reflect changes that were made under the IPF PPS to adopt the new MS–DRGs. For a detailed description of the mapping changes from the original DRG adjustment categories to the current MS–DRG adjustment categories, we refer readers to the RY 2009 IPF PPS notice (73 FR 25714).

The IPF PPS includes payment adjustments for designated psychiatric DRGs assigned to the claim based on the patient's principal diagnosis. The DRG adjustment factors were expressed relative to the most frequently reported psychiatric DRG in FY 2002, that is, DRG 430 (psychoses). The coefficient values and adjustment factors were derived from the regression analysis. Mapping the DRGs to the MS–DRGs resulted in the current 17 IPF MS–DRGs, instead of the original 15 DRGs, for which the IPF PPS provides an adjustment. For FY 2019, we are not proposing any changes to the IPF MS–DRG adjustment factors but propose to maintain the existing IPF MS–DRG adjustment factors.

In the FY 2015 IPF PPS final rule published August 6, 2014 in the **Federal Register** titled, ''Inpatient Psychiatric Facilities Prospective Payment System—Update for FY Beginning October 1, 2014 (FY 2015)'' (79 FR 45945 through 45947), we finalized conversions of the ICD–9–CM-based MS–DRGs to ICD–10–CM/PCS-based MS–DRGs, which were implemented on October 1, 2015. Further information on the ICD–10–CM/PCS MS–DRG conversion project can be found on the CMS ICD–10–CM website at *https://www.cms.gov/Medicare/Coding/ICD10/*

ICD-10-MS-DRG-Conversion-Project.html.

For FY 2019, we propose to continue to make the existing payment adjustment for psychiatric diagnoses that group to one of the existing 17 IPF MS–DRGs listed in Addendum A. Addendum A is available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.* Psychiatric principal diagnoses that do not group to one of the 17 designated MS–DRGs would still receive the federal per diem base rate and all other applicable adjustments, but the payment would not include an MS–DRG adjustment.

The diagnoses for each IPF MS–DRG will be updated as of October 1, 2018, using the final IPPS FY 2019 ICD–10–CM/PCS code sets. The FY 2019 IPPS proposed rule includes tables of the changes to the ICD–10–CM/PCS code sets which underlie the FY 2019 IPF MS–DRGs. Both the FY 2019 IPPS proposed rule and the tables of changes to the ICD–10–CM/PCS code sets which underlie the FY 2019 MS–DRGs are available on the IPPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.*

Code First

As discussed in the ICD–10–CM Official Guidelines for Coding and Reporting, certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD–10–CM has a coding convention that requires 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 accordance with the ICD–10–CM Official Guidelines for Coding and Reporting, when a primary (psychiatric) diagnosis code has a ''code first'' note, the provider would follow the instructions in the ICD–10–CM text. The submitted claim goes through the CMS processing system, which will identify the primary diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign a DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment.

For more information on the code first policy, see our November 2004 IPF PPS final rule (69 FR 66945). In the FY 2015 IPF PPS final rule, we provided a code first table for reference that highlights the same or similar manifestation codes where the code first instructions apply in ICD–10–CM that were present in ICD–9–CM (79 FR 46009). In the FY 2019 update to the ICD–10–CM/PCS code sets, there were no changes from the FY 2018 ICD–10–CM/PCS code sets that affect the IPF code first policy. The Code First list is shown in Addendum B–2 on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

b. Proposed Payment for Comorbid Conditions

The intent of the comorbidity adjustments is to recognize the increased costs associated with comorbid conditions by providing additional payments for certain existing medical or psychiatric conditions that are expensive to treat. In our RY 2012 IPF PPS final rule (76 FR 26451 through 26452), we explained that the IPF PPS includes 17 comorbidity categories and identified the new, revised, and deleted ICD–9–CM diagnosis codes that generate a comorbid condition payment adjustment under the IPF PPS for RY 2012 (76 FR 26451).

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, length of stay (LOS), or both treatment and LOS.

For each claim, an IPF may receive only one comorbidity adjustment within a comorbidity category, but it may receive an adjustment for more than one comorbidity category. Current billing instructions for discharge claims, on or after October 1, 2015, require IPFs to enter the complete ICD–10–CM codes for up to 24 additional diagnoses if they co-exist at the time of admission, or develop subsequently and impact the treatment provided.

The comorbidity adjustments were determined based on the regression analysis using the diagnoses reported by IPFs in FY 2002. The principal diagnoses were used to establish the DRG adjustments and were not accounted for in establishing the comorbidity category adjustments, except where ICD–9–CM code first instructions applied. In a code first situation, the submitted claim goes through the CMS processing system, which will identify the principal diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign an MS–DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment.

As noted previously, it is our policy to maintain the same diagnostic coding set for IPFs that is used under the IPPS for providing the same psychiatric care. The 17 comorbidity categories formerly defined using ICD–9–CM codes were converted to ICD–10–CM/PCS in our FY 2015 IPF PPS final rule (79 FR 45947 through 45955). The goal for converting the comorbidity categories is referred to as replication, meaning that the payment adjustment for a given patient encounter is the same after ICD–10–CM implementation as it would be if the same record had been coded in ICD–9–CM and submitted prior to ICD–10–CM/PCS implementation on October 1, 2015. All conversion efforts were made with the intent of achieving this goal. For FY 2019, we propose to use the same comorbidity adjustment factors in effect in FY 2018, which are found in Addendum A, available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

We have updated the ICD–10–CM/PCS codes which are associated with the existing IPF PPS comorbidity categories, based upon the preliminary FY 2019 update to the ICD–10–CM/PCS code set. The FY 2019 ICD–10–CM/PCS updates included ICD–10–CM/PCS codes added to the Drug and/or Alcohol Abuse, Gangrene, Oncology Treatment, and Poisoning comorbidity categories, and codes deleted from the Oncology Treatment comorbidity category. These updates are detailed in Addendum B–3 of this proposed rule, which is available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

In accordance with the policy established in the FY 2015 IPF PPS final rule (79 FR 45949 through 45952), we reviewed all FY 2019 ICD–10–CM codes to remove site unspecified codes from the FY 2019 ICD–10–CM/PCS codes in instances where more specific codes are available. As we stated in the FY 2015 IPF PPS final rule, we believe that specific diagnosis codes that narrowly identify anatomical sites where disease, injury, or condition exist should be used when coding patients' diagnoses whenever these codes are available. We finalized that we would remove site

unspecified codes from the IPF PPS ICD–10–CM/PCS codes in instances in which more specific codes are available, as the clinician should be able to identify a more specific diagnosis based on clinical assessment at the medical encounter. Therefore, we are proposing to remove 3 site unspecified codes from the list of Oncology Treatment Diagnosis codes. See Addendum B–4 to this proposed rule for a listing of the 3 ICD–10–CM/PCS site unspecified codes proposed to be removed. Addendum B–4 is available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

c. Proposed Patient Age Adjustments

As explained in the November 2004 IPF PPS final rule (69 FR 66922), we analyzed the impact of age on per diem cost by examining the age variable (range of ages) for payment adjustments. In general, we found that the cost per day increases with age. The older age groups are more costly than the under 45 age group, the differences in per diem cost increase for each successive age group, and the differences are statistically significant. For FY 2019, we propose to continue to use the patient age adjustments currently in effect in FY 2018, as shown in Addendum A of this proposed rule (see *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html*).

d. Proposed Variable per Diem Adjustments

We explained in the November 2004 IPF PPS final rule (69 FR 66946) that the regression analysis indicated that per diem cost declines as the length of stay (LOS) increases. The variable per diem adjustments to the federal per diem base rate account for ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF. We used a regression analysis to estimate the average differences in per diem cost among stays of different lengths. As a result of this analysis, we established variable per diem adjustments that begin on day 1 and decline gradually until day 21 of a patient's stay. For day 22 and thereafter, the variable per diem adjustment remains the same each day for the remainder of the stay. However, the adjustment applied to day 1 depends upon whether the IPF has a qualifying ED. If an IPF has a qualifying ED, it receives a 1.31 adjustment factor for day 1 of each stay. If an IPF does not have a qualifying ED, it receives a 1.19 adjustment factor for day 1 of the stay. The ED adjustment is explained in more detail in section III.D.4 of this proposed rule.

For FY 2019, we propose to continue to use the variable per diem adjustment factors currently in effect as shown in Addendum A of this proposed rule (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html*). A complete discussion of the variable per diem adjustments appears in the November 2004 IPF PPS final rule (69 FR 66946).

D. Proposed Updates to the IPF PPS Facility-Level Adjustments

The IPF PPS includes facility-level adjustments for the wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED.

1. Wage Index Adjustment

a. Background

As discussed in our RY 2007 IPF PPS final rule (71 FR 27061) and in our RY 2009 IPF PPS (73 FR 25719) and RY 2010 IPF PPS notices (74 FR 20373), in order to provide an adjustment for geographic wage levels, the labor-related portion of an IPF's payment is adjusted using an appropriate wage index. Currently, an IPF's geographic wage index value is determined based on the actual location of the IPF in an urban or rural area, as defined in § 412.64(b)(1)(ii)(A) and (C).

b. Updated Wage Index for FY 2019

Since the inception of the IPF PPS, we have used the pre-floor, pre-reclassified acute care hospital wage index in developing a wage index to be applied to IPFs, because there is not an IPF-specific wage index available. We believe that IPFs compete in the same labor markets as acute care hospitals, so the pre-floor, pre-reclassified hospital wage index should reflect IPF labor costs. As discussed in our RY 2007 IPF PPS final rule (71 FR 27061 through 27067), for RY 2007, under the IPF PPS, the wage index is calculated using the IPPS wage index for the labor market area in which the IPF is located, without taking into account geographic reclassifications, floors, and other adjustments made to the wage index under the IPPS. For a complete description of these IPPS wage index adjustments, we refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53365 through 53374). For FY 2019, we propose to continue to apply the most recent hospital wage index (the FY 2018 pre-floor, pre-reclassified hospital wage index, which is the most appropriate index as it best reflects the variation in local labor costs of IPFs in the various geographic areas) using the most recent hospital wage data (data from hospital cost reports for the cost reporting period beginning during FY 2014) without any geographic reclassifications, floors, or other adjustments. We would apply the FY 2019 IPF wage index to payments beginning October 1, 2018.

We would apply the wage index adjustment to the labor-related portion of the federal rate, which is proposed to change from 75.0 percent in FY 2018 to 74.8 percent in FY 2019. This percentage reflects the labor-related share of the 2012-based IPF market basket for FY 2019 (see section III.A.3 of this proposed rule).

c. Office of Management and Budget Bulletins

Office of Management and Budget (OMB) publishes bulletins regarding Core-Based Statistical Area (CBSA) changes, including changes to CBSA numbers and titles. In the RY 2007 IPF PPS final rule (71 FR 27061 through 27067), we adopted the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for Metropolitan Statistical Areas (MSAs), and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. In adopting the OMB CBSA geographic designations in RY 2007, we did not provide a separate transition for the CBSA-based wage index since the IPF PPS was already in a transition period from TEFRA payments to PPS payments.

In the RY 2009 IPF PPS notice, we incorporated the CBSA nomenclature changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current IPF wage index and stated that we expect to continue to do the same for all the OMB CBSA nomenclature changes in future IPF PPS rules and notices, as necessary (73 FR 25721). The OMB bulletins may be accessed online at *https://www.whitehouse.gov/omb/bulletins/.*

In accordance with our established methodology, we have historically adopted any CBSA changes that are published in the OMB bulletin that corresponds with the hospital wage index used to determine the IPF wage index. For the FY 2015 IPF wage index, we used the FY 2014 pre-floor, pre-reclassified hospital wage index to adjust the IPF PPS payments. On February 28, 2013, OMB issued OMB Bulletin No. 13–01, which established revised delineations for MSAs, Micropolitan Statistical Areas, and Combined Statistical Areas, and

provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at *https://www.whitehouse.gov/omb/bulletins/.*

Because the FY 2014 pre-floor, pre-reclassified hospital wage index was finalized before the issuance of this Bulletin, the FY 2015 IPF wage index, which was based on the FY 2014 pre-floor, pre-reclassified hospital wage index, did not reflect OMB's new area delineations based on the 2010 Census. According to OMB, ''[t]his bulletin provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246 through 37252) and Census Bureau data.'' These OMB Bulletin changes are reflected in the FY 2015 pre-floor, pre-reclassified hospital wage index, upon which the FY 2016 IPF wage index was based. We adopted these new OMB CBSA delineations in the FY 2016 IPF wage index and subsequent IPF wage indexes.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to, and supersedes, OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in the attachment to OMB Bulletin No. 15–01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013. The complete list of statistical areas incorporating these changes is provided in OMB Bulletin No. 15–01. A copy of this bulletin may be obtained at *https://www.whitehouse.gov/omb/bulletins/.*

OMB Bulletin No. 15–01 establishes revised delineations for the Nation's Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas. The bulletin also provides delineations of Metropolitan Divisions as well as delineations of New England City and Town Areas.

In accordance with our longstanding policy, the IPF PPS continues to use the latest labor market area delineations available as soon as is reasonably possible to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. As discussed in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56913), the updated labor market area definitions from OMB Bulletin 15–01 were implemented under the IPPS beginning on October 1, 2016 (FY 2017). Therefore, we implemented these revisions for the IPF PPS beginning October 1, 2017 (FY 2018), consistent with our historical practice of modeling IPF PPS adoption of the labor market area delineations after IPPS adoption of these delineations.

In summary, the FY 2018 pre-floor, pre-reclassified hospital wage index, which is proposed to be used to determine the FY 2019 IPF wage index, has no changes to its OMB designations and already includes changes adopted in previous FYs.

The proposed FY 2019 IPF wage index is located on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html.*

d. Proposed Adjustment for Rural Location

In the November 2004 IPF PPS final rule, we provided a 17 percent payment adjustment for IPFs located in a rural area. This adjustment was based on the regression analysis, which indicated that the per diem cost of rural facilities was 17 percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression. For FY 2019, we propose to continue to apply a 17 percent payment adjustment for IPFs located in a rural area as defined at § 412.64(b)(1)(ii)(C). A complete discussion of the adjustment for rural locations appears in the November 2004 IPF PPS final rule (69 FR 66954).

e. Proposed Budget Neutrality Adjustment

Changes to the wage index are made in a budget-neutral manner so that updates do not increase expenditures. Therefore, for FY 2019, we propose to continue to apply a budget-neutrality adjustment in accordance with our existing budget-neutrality policy. This policy requires us to update the wage index in such a way that total estimated payments to IPFs for FY 2019 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget neutrality factor to the IPF PPS rates. We use the following steps to ensure that the rates reflect the update to the wage indexes (based on the FY 2014 hospital cost report data) and the labor-related share in a budget-neutral manner:

Step 1. Simulate estimated IPF PPS payments, using the FY 2018 IPF wage index values (available on the CMS website) and labor-related share (as published in the FY 2018 IPF PPS notice with comment period (82 FR 35771)).

Step 2. Simulate estimated IPF PPS payments using the proposed FY 2019 IPF wage index values (available on the CMS website) and proposed FY 2019 labor-related share (based on the latest available data as discussed previously).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the proposed FY 2019 budget-neutral wage adjustment factor of 1.0013.

Step 4. Apply the FY 2019 budget-neutral wage adjustment factor from step 3 to the FY 2018 IPF PPS federal per diem base rate after the application of the market basket update described in section III.A.2 of this proposed rule, to determine the FY 2019 IPF PPS federal per diem base rate.

2. Proposed Teaching Adjustment

In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(1)(iii) to establish a facility-level adjustment for IPFs that are, or are part of teaching hospitals. The teaching adjustment accounts for the higher indirect operating costs experienced by hospitals that participate in graduate medical education (GME) programs. The payment adjustments are made based on the ratio of the number of full-time equivalent (FTE) interns and residents training in the IPF and the IPF's average daily census (ADC).

Medicare makes direct GME payments (for direct costs such as resident and teaching physician salaries, and other direct teaching costs) to all teaching hospitals including those paid under a PPS, and those paid under the TEFRA rate-of-increase limits. These direct GME payments are made separately from payments for hospital operating costs and are not part of the IPF PPS. The direct GME payments do not address the estimated higher indirect operating costs teaching hospitals may face.

The results of the regression analysis of FY 2002 IPF data established the basis for the payment adjustments included in the November 2004 IPF PPS final rule. The results showed that the indirect teaching cost variable is significant in explaining the higher costs of IPFs that have teaching

programs. We calculated the teaching adjustment based on the IPF's ''teaching variable,'' which is one plus the ratio of the number of FTE residents training in the IPF (subject to limitations described in this section of this proposed rule to the IPF's ADC).

We established the teaching adjustment in a manner that limited the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. We imposed a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. The cap limits the number of FTE residents that teaching IPFs may count for the purpose of calculating the IPF PPS teaching adjustment, not the number of residents teaching institutions can hire or train. We calculated the number of FTE residents that trained in the IPF during a ''base year'' and used that FTE resident number as the cap. An IPF's FTE resident cap is ultimately determined based on the final settlement of the IPF's most recent cost report filed before November 15, 2004 (publication date of the IPF PPS final rule). A complete discussion of the temporary adjustment to the FTE cap to reflect residents added due to hospital closure and by residency program appears in the RY 2012 IPF PPS proposed rule (76 FR 5018 through 5020) and the RY 2012 IPF PPS final rule (76 FR 26453 through 26456).

In the regression analysis, the logarithm of the teaching variable had a coefficient value of 0.5150. We converted this cost effect to a teaching payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value. We note that the coefficient value of 0.5150 was based on the regression analysis holding all other components of the payment system constant. A complete discussion of how the teaching adjustment was calculated appears in the November 2004 IPF PPS final rule (69 FR 66954 through 66957) and the RY 2009 IPF PPS notice (73 FR 25721). As with other adjustment factors derived through the regression analysis, we do not plan to rerun the teaching adjustment factors in the regression analysis until we more fully analyze IPF PPS data. Therefore, in this FY 2019 proposed rule, we propose to continue to retain the coefficient value of 0.5150 for the teaching adjustment to the federal per diem base rate.

3. Proposed Cost of Living Adjustment for IPFs Located in Alaska and Hawaii

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the county in which the IPF is located. As we explained in the November 2004 IPF PPS final rule, the FY 2002 data demonstrated that IPFs in Alaska and Hawaii had per diem costs that were disproportionately higher than other IPFs. Other Medicare prospective payment systems (for example: The IPPS and LTCH PPS) adopted a cost of living adjustment (COLA) to account for the cost differential of care furnished in Alaska and Hawaii.

We analyzed the effect of applying a COLA to payments for IPFs located in Alaska and Hawaii. The results of our analysis demonstrated that a COLA for IPFs located in Alaska and Hawaii would improve payment equity for these facilities. As a result of this analysis, we provided a COLA in the November 2004 IPF PPS final rule.

A COLA for IPFs located in Alaska and Hawaii is made by multiplying the non-labor-related portion of the federal per diem base rate by the applicable COLA factor based on the COLA area in which the IPF is located.

The COLA factors through 2009 (before being reduced by locality payments) are published on the Office of Personnel Management (OPM) website (*https://www.opm.gov/oca/cola/rates.asp*).

We note that the COLA areas for Alaska are not defined by county as are the COLA areas for Hawaii. In 5 CFR 591.207, the OPM established the following COLA areas:

- City of Anchorage, and 80-kilometer (50-mile) radius by road, as measured from the federal courthouse.
- City of Fairbanks, and 80-kilometer (50-mile) radius by road, as measured from the federal courthouse.
- City of Juneau, and 80-kilometer (50-mile) radius by road, as measured from the federal courthouse.
- Rest of the State of Alaska.

As stated in the November 2004 IPF PPS final rule, we update the COLA factors according to updates established by the OPM. However, sections 1911 through 1919 of the Nonforeign Area Retirement Equity Assurance Act, as contained in subtitle B of title XIX of the National Defense Authorization Act (NDAA) for FY 2010 (Pub. L. 111–84, October 28, 2009), transitions the Alaska and Hawaii COLAs to locality pay. Under section 1914 of NDAA, locality pay was phased in over a 3-year period beginning in January 2010, with COLA rates frozen as of the date of enactment, October 28, 2009, and then proportionately reduced to reflect the phase-in of locality pay.

When we published the proposed COLA factors in the RY 2012 IPF PPS proposed rule (76 FR 4998), we inadvertently selected the FY 2010 COLA rates, which had been reduced to account for the phase-in of locality pay. We did not intend to propose the reduced COLA rates because that would have understated the adjustment. Since the 2009 COLA rates did not reflect the phase-in of locality pay, we finalized the FY 2009 COLA rates for RY 2010 through RY 2014.

In the FY 2013 IPPS/LTCH final rule (77 FR 53700 through 53701), we established a new methodology to update the COLA factors for Alaska and Hawaii, and adopted this methodology for the IPF PPS in the FY 2015 IPF final rule (79 FR 45958 through 45960). We adopted this new COLA methodology for the IPF PPS because IPFs are hospitals with a similar mix of commodities and services. We think it is appropriate to have a consistent policy approach with that of other hospitals in Alaska and Hawaii. Therefore, the IPF COLAs for FY 2015 through FY 2017 were the same as those applied under the IPPS in those years. As finalized in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53700 and 53701), the COLA updates are determined every 4 years, when the IPPS market basket labor-related share is updated during rebasing. Because the labor-related share of the IPPS market basket was updated for FY 2018, the COLA factors were updated in FY 2018 IPPS/LTCH rulemaking (82 FR 38529). As such, we also updated the IPF PPS COLA factors for FY 2018 (82 FR 36780 through 36782) to reflect the updated COLA factors finalized in the FY 2018 IPPS/LTCH rulemaking.

For FY 2019, we propose to continue to use the COLA factors established for the IPF PPS in FY 2018 to adjust the nonlabor-related portion of the per diem amount for IPFs located in Alaska and Hawaii. These factors are shown in Table 1. For comparison purposes, we also are showing the FY 2015 through FY 2017 COLA factors.

TABLE 1—COMPARISON OF IPF PPS COST-OF-LIVING ADJUSTMENT FACTORS: IPFS LOCATED IN ALASKA AND HAWAII

Area	FY 2015 through 2017	FY 2018 and FY 2019
Alaska:		
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.23	1.25
Rest of Alaska	1.25	1.25
Hawaii:		
City and County of Honolulu	1.25	1.25
County of Hawaii	1.19	1.21
County of Kauai	1.25	1.25
County of Maui and County of Kalawao	1.25	1.25

The proposed IPF PPS COLA factors for FY 2019 are shown in Addendum A of this proposed rule, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

4. Proposed Adjustment for IPFs With a Qualifying Emergency Department (ED)

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs. We provide an adjustment to the federal per diem base rate to account for the costs associated with maintaining a full-service ED. The adjustment is intended to account for ED costs incurred by a psychiatric hospital with a qualifying ED or an excluded psychiatric unit of an acute care hospital or a CAH, for preadmission services otherwise payable under the Medicare Hospital Outpatient Prospective Payment System (OPPS), furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the day immediately preceding the date of admission to the IPF (see § 413.40(c)(2)), and the overhead cost of maintaining the ED. This payment is a facility-level adjustment that applies to all IPF admissions (with one exception described below), regardless of whether a particular patient receives preadmission services in the hospital's ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. Those IPFs with a qualifying ED receive an adjustment factor of 1.31 as the variable per diem adjustment for day 1 of each patient stay. If an IPF does not have a qualifying ED, it receives an adjustment factor of 1.19 as the variable per diem adjustment for day 1 of each patient stay.

The ED adjustment is made on every qualifying claim except as described in this section of the proposed rule. As specified in § 412.424(d)(1)(v)(B), the ED adjustment is not made when a patient is discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's excluded psychiatric unit. We clarified in the November 2004 IPF PPS final rule (69 FR 66960) that an ED adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the acute care hospital or through the reasonable cost payment made to the CAH.

Therefore, when patients are discharged from an acute care hospital or CAH and admitted to the same hospital's or CAH's excluded psychiatric unit, the IPF receives the 1.19 adjustment factor as the variable per diem adjustment for the first day of the patient's stay in the IPF. For FY 2019, we propose to continue to retain the 1.31 adjustment factor for IPFs with qualifying EDs. A complete discussion of the steps involved in the calculation of the ED adjustment factor in our November 2004 IPF PPS final rule (69 FR 66959 through 66960) and the RY 2007 IPF PPS final rule (71 FR 27070 through 27072).

E. Proposed Other Payment Adjustments and Policies

1. Outlier Payment Overview

The IPF PPS includes an outlier adjustment to promote access to IPF care for those patients who require expensive care and to limit the financial risk of IPFs treating unusually costly patients. In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(3)(i) to provide a per-case payment for IPF stays that are extraordinarily costly. Providing additional payments to IPFs for extremely costly cases strongly improves the accuracy of the IPF PPS in determining resource costs at the patient and facility level. These additional payments reduce the financial losses that would otherwise be incurred in treating patients who require more costly care and; therefore, reduce the incentives for IPFs to under-serve these patients.

We make outlier payments for discharges in which an IPF's estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the federal per diem payment amount for the case.

In instances when the case qualifies for an outlier payment, we pay 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay (consistent with the median LOS for IPFs in FY 2002), and 60 percent of the difference for day 10 and thereafter. We established the 80 percent and 60 percent loss sharing ratios because we were concerned that a single ratio established at 80 percent (like other Medicare PPSs) might provide an incentive under the IPF per diem payment system to increase LOS in order to receive additional payments.

After establishing the loss sharing ratios, we determined the current fixed dollar loss threshold amount through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target. Each year when we update the IPF PPS, we simulate payments using the latest available data to compute the fixed dollar loss threshold so that outlier payments represent 2 percent of total projected IPF PPS payments.

2. Proposed Update to the Outlier Fixed Dollar Loss Threshold Amount

In accordance with the update methodology described in § 412.428(d), we are proposing to update the fixed dollar loss threshold amount used under the IPF PPS outlier policy. Based on the regression analysis and payment simulations used to develop the IPF PPS, we established a 2 percent outlier policy, which strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the federal per diem base rate for all other cases that are not outlier cases.

Based on an analysis of the latest available data (the December 2017 update of FY 2017 IPF claims) and rate increases, we believe it is necessary to update the fixed dollar loss threshold amount to maintain an outlier percentage that equals 2 percent of total estimated IPF PPS payments. We propose to update the IPF outlier threshold amount for FY 2019 using FY 2017 claims data and the same methodology that we used to set the initial outlier threshold amount in the RY 2007 IPF PPS final rule (71 FR 27072 and 27073), which is also the same methodology that we used to update the outlier threshold amounts for years 2008 through 2018. Based on an analysis of these updated data, we estimate that IPF outlier payments as a percentage of total estimated payments are approximately 2.27 percent in FY 2018. Therefore, we propose to update the outlier threshold amount to $12,935 to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2019.

3. Proposed Update to IPF Cost-to-Charge Ratio Ceilings

Under the IPF PPS, an outlier payment is made if an IPF's cost for a stay exceeds a fixed dollar loss threshold amount plus the IPF PPS amount. In order to establish an IPF's cost for a particular case, we multiply the IPF's reported charges on the discharge bill by its overall cost-to-charge ratio (CCR). This approach to determining an IPF's cost is consistent with the approach used under the IPPS and other PPSs. In the FY 2004 IPPS final rule (68 FR 34494), we implemented changes to the IPPS policy used to determine CCRs for acute care hospitals, because we became aware that payment vulnerabilities resulted in inappropriate outlier payments. Under the IPPS, we established a statistical measure of accuracy for CCRs to ensure that aberrant CCR data did not result in inappropriate outlier payments.

As we indicated in the November 2004 IPF PPS final rule (69 FR 66961), we believe that the IPF outlier policy is susceptible to the same payment vulnerabilities as the IPPS; therefore, we adopted a method to ensure the statistical accuracy of CCRs under the IPF PPS. Specifically, we adopted the following procedure in the November 2004 IPF PPS final rule:

- Calculated two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas.
- Computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and rural IPFs using the most recent CCRs entered in the CY 2018 Provider Specific File.

For FY 2019, we propose to continue to follow this methodology.

To determine the proposed rural and urban ceilings, we multiplied each of the standard deviations by 3 and added the result to the appropriate national CCR average (either rural or urban). The proposed upper threshold CCR for IPFs in FY 2019 is 2.0255 for rural IPFs, and 1.7550 for urban IPFs, based on CBSA-based geographic designations. If an IPF's CCR is above the applicable ceiling, the ratio is considered statistically inaccurate, and we assign the appropriate national (either rural or urban) median CCR to the IPF.

We apply the national CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. We continue to use these national CCRs until the facility's actual CCR can be computed using the first tentatively or final settled cost report.
- IPFs whose overall CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for which the Medicare Administrative Contractor (MAC) obtains inaccurate or incomplete data with which to calculate a CCR.

We propose to continue to update the FY 2019 national median and ceiling CCRs for urban and rural IPFs based on the CCRs entered in the latest available IPF PPS Provider Specific File. Specifically, for FY 2019, to be used in each of the three situations listed previously, using the most recent CCRs entered in the CY 2018 Provider Specific File, we propose an estimated national median CCR of 0.5870 for rural IPFs and a national median CCR of 0.4395 for urban IPFs. These calculations are based on the IPF's location (either urban or rural) using the CBSA-based geographic designations.

A complete discussion regarding the national median CCRs appears in the November 2004 IPF PPS final rule (69 FR 66961 through 66964).

IV. Proposed Technical Corrections to the IPF Regulations

We are proposing to make minor technical corrections to the IPF payment regulations at § 412.27(a), § 412.402 and § 412.428 to update, correct, or clarify existing regulations text. We note that these are technical corrections and they do not affect or change any existing policies.

Excluded Psychiatric Units: Additional Requirements (§ 412.27)

At § 412.27, we set forth additional requirements for excluded psychiatric units. In paragraph (a) we detail admission requirements and state that eligible patients must have a psychiatric principal diagnosis that is listed in the Fourth Edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) or Chapter Five (''Mental Disorders'') of the International Classification of Diseases, Ninth Revision, Clinical Modification. This language has been in place since 2006, but there have since been updates to the versions of these code sets.

In a final rule published on September 5, 2012 (77 FR 54664), the Secretary of HHS adopted ICD–10–CM and ICD–10–PCS, in place of ICD–9–CM, as standard medical data code sets under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This change is reflected in the HIPAA regulations at 45 CFR 162.1002(c). In an August 4, 2014 final rule (79 FR 45128), the Secretary set October 1, 2015 as the compliance date for HIPAA covered entities to use the ICD–10 code sets. Because we are required to use the HIPAA standards, in the FY 2015 IPF PPS final rule published August 6, 2014 in the **Federal Register** titled, ''Inpatient Psychiatric Facilities Prospective Payment System—Update for FY Beginning October 1, 2014 (FY 2015)'' (79 FR 45945 through 45947), we finalized conversions of the ICD–9–CM-based MS–DRGs to ICD–10–CM/PCS-based MS–DRGs. However, we neglected to make a conforming change to § 412.27(a). Therefore, we are proposing to correct § 412.27(a) to state that eligible patients must have a psychiatric principal diagnosis that is listed in ICD–10–CM.

The proposed revision to § 412.27(a) would simply continue our longstanding policy of recognizing psychiatric diagnoses that are DSM diagnosis codes. We note that the DSM diagnosis codes map to ICD–10–CM codes, but the mapping is not exclusive to chapter 5 of the ICD–10–CM, as it was with ICD–9–CM; rather, they map to other chapters in ICD–10–CM as well. Therefore, the proposed correction to § 412.27(a) would no longer reference the DSM and would not specifically mention chapter 5 of ICD–10–CM.

Definitions (§ 412.402)

At § 412.402, there is a typographical error in the definition of ''Principal Diagnosis.'' We inadvertently repeat the language that a principal diagnosis is

also referred to as a primary diagnosis. We propose to correct this error by removing the duplicate language.

Publication of Changes to the Inpatient Psychiatric Facility Prospective Payment System (§ 412.428)

In the FY 2016 IPF PPS regulations, we proposed and finalized an IPF-specific market basket for updating the annual IPF payment rates (80 FR 46656 through 46679). This new IPF-specific market basket replaced the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket, which had been in place for discharges occurring from July 1, 2006 through September 30, 2015. However, in our FY 2016 IPF PPS final rule, we did not update the regulations text at § 412.428 to reflect the adoption of the IPF-specific market basket. Therefore, we propose to update § 412.428 to indicate that the use of the RPL market basket ended as of September 30, 2015, and that the IPF market basket was implemented for use in updating IPF PPS payment rates for discharges occurring on or after October 1, 2015. In addition, we propose to make other technical changes to this section for clarification and consistency.

We solicit public comments on these technical corrections and request that when commenting on this section to reference ''proposed technical corrections.''

V. Update on IPF PPS Refinements and Comment Solicitation

For RY 2012, we identified several areas of concern for future refinement, and we invited comments on these issues in the RY 2012 IPF PPS proposed and final rules. For further discussion of these issues and to review the public comments, we refer readers to the RY 2012 IPF PPS proposed rule (76 FR 4998) and final rule (76 FR 26432).

We have delayed making refinements to the IPF PPS until we have completed a thorough analysis of IPF PPS data on which to base those refinements. Specifically, we will delay updating the adjustment factors derived from the regression analysis until we have IPF PPS data that include as much information as possible regarding the patient-level characteristics of the population that each IPF serves. We have begun and will continue the necessary analysis to better understand IPF industry practices so that we may refine the IPF PPS in the future, as appropriate. Our preliminary analysis has also revealed variation in cost and claim data, particularly related to labor costs, drugs costs, and laboratory services. Some providers have very low labor costs, or very low or missing drug or laboratory costs or charges, relative to other providers. We are soliciting comments about differences in the IPF labor mix, differences in IPF patient mix, and differences in provision of drugs and laboratory services. We anticipate that these comments will better inform our refinement process.

As we noted in the FY 2016 IPF PPS final rule (80 FR 46693 through 46694), our preliminary analysis of 2012 to 2013 IPF data found that over 20 percent of IPF stays reported no ancillary costs, such as laboratory and drug costs, in their cost reports, or laboratory or drug charges on their claims. Because we expect that most patients requiring hospitalization for active psychiatric treatment will need drugs and laboratory services, we again remind providers that the IPF PPS federal per diem base rate includes the cost of all ancillary services, including drugs and laboratory services. On November 17, 2017, we issued Transmittal 12, which made changes to the hospital cost report form CMS–2552–10, and included cost report Level I edit 10710S, effective for cost reporting periods ending on or after August 31, 2017. Edit 10710S now requires that cost reports from psychiatric hospitals include certain ancillary costs, or the cost report will be rejected. On January 30, 2018, we issued Transmittal 13, which changed the implementation date for Transmittal 12 to be for cost reporting periods ending on or after September 30, 2017. For details, we refer readers to see these Transmittals, which are available on the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html.*

We pay only the IPF for services furnished to a Medicare beneficiary who is an inpatient of that IPF (except for certain professional services), and payments are considered to be payments in full for all inpatient hospital services provided directly or under arrangement (see 42 CFR 412.404(d)), as specified in 42 CFR 409.10.

We will continue to analyze data from claims and cost reports that do not include ancillary charges or costs, and will be sharing our findings with CMS Office of the Center for Program Integrity and CMS Office of Financial Management for further investigation, as the results warrant. Our refinement analysis is dependent on recent precise data for costs, including ancillary costs. We will continue to collect these data and analyze them for both timeliness and accuracy with the expectation that these data will be used in a future refinement. It is currently our intent to explore proposing refinements to the adjustments in future rulemaking. Since we are not proposing refinements in this rule, for FY 2019 we will continue to use the existing adjustment factors.

VI. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

A. Background and Statutory Authority

Section 1886(s)(4) of the Act, requires the Secretary to implement a quality reporting program for inpatient psychiatric hospitals and psychiatric units. Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 [1] and each subsequent FY, the Secretary must reduce any annual update to a standard federal rate for discharges occurring during the FY by 2.0 percentage points in the case of a psychiatric hospital or psychiatric unit that does not comply with quality data submission requirements with respect to an applicable FY.

As provided in section 1886(s)(4)(A)(ii) of the Act, the application of the reduction for failure to report under section 1886(s)(4)(A)(i) of the Act may result in an annual update of less than 0.0 percent for a FY, and may result in payment rates under section 1886(s)(1) of the Act being less than the payment rates for the preceding year. In addition, section 1886(s)(4)(B) of the Act requires that the application of the reduction to a standard federal rate update be noncumulative across FYs. Thus, any reduction applied under section 1886(s)(4)(A) of the Act will apply only with respect to the FY rate involved and the Secretary may not take into account the reduction in computing the payment amount under the system described in section 1886(s)(1) of the Act for subsequent years.

Section 1886(s)(4)(C) of the Act requires that, for FY 2014 and each subsequent year, each psychiatric hospital and psychiatric unit must

[1] The statute uses the term ''rate year'' (RY). However, beginning with the annual update of the inpatient psychiatric facility prospective payment system (IPF PPS) that took effect on July 1, 2011 (RY 2012), we aligned the IPF PPS update with the annual update of the ICD codes, effective on October 1 of each year. This change allowed for annual payment updates and the ICD coding update to occur on the same schedule and appear in the same **Federal Register** document, promoting administrative efficiency. To reflect the change to the annual payment rate update cycle, we revised the regulations at 42 CFR 412.402 to specify that, beginning October 1, 2012, the RY update period would be the 12-month period from October 1 through September 30, which we refer to as a ''fiscal year'' (FY) (76 FR 26435). Therefore, with respect to the IPFQR Program, the terms ''rate year,'' as used in the statute, and ''fiscal year'' as used in the regulation, both refer to the period from October 1 through September 30. For more information regarding this terminology change, we refer readers to section III. of the RY 2012 IPF PPS final rule (76 FR 26434 through 26435).

submit to the Secretary data on quality measures as specified by the Secretary. The data must be submitted in a form and manner and at a time specified by the Secretary. Under section 1886(s)(4)(D)(i) of the Act, unless the exception of subclause (ii) applies, measures selected for the quality reporting program must have been endorsed by the entity with a contract under section 1890(a) of the Act. The National Quality Forum (NQF) currently holds this contract.

Section 1886(s)(4)(D)(ii) of the Act provides an exception to the requirement for NQF endorsement of measures: 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 as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

Section 1886(s)(4)(E) of the Act requires the Secretary to establish procedures for making public the data submitted by inpatient psychiatric hospitals and psychiatric units under the IPFQR Program. These procedures must ensure that an inpatient psychiatric facility or unit has the opportunity to review its data before the data are made public. The Secretary must report quality measures that relate to services furnished in inpatient settings and psychiatric hospitals and units on the CMS website.

B. Covered Entities

In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53645), we established that the IPFQR Program's quality reporting requirements cover those psychiatric hospitals and psychiatric units paid under Medicare's IPF PPS (§ 412.404(b)). Generally, psychiatric hospitals and psychiatric units within acute care and critical access hospitals that treat Medicare patients are paid under the IPF PPS. Consistent with previous regulations, we continue to use the term ''inpatient psychiatric facility'' (IPF) to refer to both inpatient psychiatric hospitals and psychiatric units. This usage follows the terminology in our IPF PPS regulations at § 412.402. For more information on covered entities, we refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53645).

C. Previously Finalized Measures and Administrative Procedures

The current IPFQR Program includes 18 measures. For more information on these measures, we refer readers to the following final rules:

- The FY 2013 IPPS/LTCH PPS final rule (77 FR 53646 through 53652);
- The FY 2014 IPPS/LTCH PPS final rule (78 FR 50889 through 50897);
- The FY 2015 IPF PPS final rule (79 FR 45963 through 45975);
- The FY 2016 IPF PPS final rule (80 FR 46695 through 46714); and
- The FY 2017 IPPS/LTCH PPS final rule (81 FR 57238 through 57247).

For more information on previously adopted procedural requirements, we refer readers to the following rules:

- The FY 2013 IPPS/LTCH PPS final rule (77 FR 53653 through 53660);
- The FY 2014 IPPS/LTCH PPS final rule (78 FR 50897 through 50903;
- The FY 2015 IPF PPS final rule (79 FR 45975 through 45978);
- The FY 2016 IPF PPS final rule (80 FR 46715 through 46719);
- The FY 2017 IPPS/LTCH PPS final rule (81 FR 57248 through 57249); and
- The FY 2018 IPPS/LTCH PPS final rule (82 FR 38471 through 38474).

D. Accounting for Social Risk Factors

In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38462 through 38463), we discussed the importance of improving beneficiary outcomes including reducing health disparities. We also discussed our commitment to ensuring that medically complex patients, as well as those with social risk factors, receive excellent care. We discussed how studies show that social risk factors, such as being near or below the poverty level as determined by HHS, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes and how some of this disparity is related to the quality of health care.[2] Among our core objectives, we aim to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex patients as well as those with social risk factors receive excellent care. Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in CMS value-based purchasing programs.[3] As we noted in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38404), ASPE's report to Congress found that, in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that they examined and tested. In addition, as we noted in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38241), the National Quality Forum (NQF) undertook a 2-year trial period in which certain new measures and measures undergoing maintenance review have been assessed to determine if risk adjustment for social risk factors is appropriate for these measures.[4] The trial period ended in April 2017 and a final report is available at: *http://www.qualityforum.org/SES_Trial_Period.aspx.* The trial concluded that ''measures with a conceptual basis for adjustment generally did not demonstrate an empirical relationship'' between social risk factors and the outcomes measured. This discrepancy may be explained in part by the methods used for adjustment and the limited availability of robust data on social risk factors. NQF has extended the socioeconomic status (SES) trial,[5] allowing further examination of social risk factors in outcome measures.

In the FY 2018 and CY 2018 proposed rules for our quality reporting and value-based purchasing programs, we solicited feedback on which social risk factors provide the most valuable information to stakeholders and the methodology for illuminating differences in outcomes rates among patient groups within a hospital or provider that would also allow for a comparison of those differences, or disparities, across providers. Feedback we received across our quality reporting programs included encouraging CMS to explore whether factors that could be used to stratify or risk adjust the measures (beyond dual eligibility); considering the full range of differences in patient backgrounds that might affect outcomes; exploring risk adjustment approaches; and to offer careful consideration of what type of information display would be most useful to the public. We also sought public comment on confidential reporting and future public reporting of

[2] See, for example United States Department of Health and Human Services. ''Healthy People 2020: Disparities. 2014.'' Available at: *http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities;* or National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: National Academies of Sciences, Engineering, and Medicine 2016.

[3] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), ''Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs.'' December 2016. Available at: *https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs.*

[4] Available at: *http://www.qualityforum.org/SES_Trial_Period.aspx.*

[5] Available at: *http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86357.*

some of our measures stratified by patient dual eligibility. In general, commenters stated that stratified measures could serve as tools for hospitals to identify gaps in outcomes for different groups of patients, improve the quality of health care for all patients, and empower consumers to make informed decisions about health care. Commenters encouraged us to stratify measures by other social risk factors such as age, income, and educational attainment. With regard to value-based purchasing programs, commenters also cautioned to balance fair and equitable payment while avoiding payment penalties that mask health disparities or discourage the provision of care to more medically complex patients. Commenters also noted that value-based payment program measure selection, domain weighting, performance scoring, and payment methodology must account for social risk.

As a next step, we are considering options to improve health disparities among patient groups within and across hospitals by increasing the transparency of disparities as shown by quality measures. We also are considering how this work applies to other CMS quality programs in the future. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38403 through 38409) and the FY 2019 IPPS/LTCH PPS Proposed Rule published in the May 7, 2018 **Federal Register** for more details, where we discuss the potential stratification of certain Hospital IQR Program outcome measures. Furthermore, we continue to consider options to address equity and disparities in our value-based purchasing programs.

We plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.

E. Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

Regulatory reform and reducing regulatory burden are high priorities for CMS. To reduce the regulatory burden on the healthcare industry, lower health care costs, and enhance patient care, in October 2017, we launched the Meaningful Measures Initiative.[6] This initiative is one component of our agency-wide Patients Over Paperwork Initiative,[7] which is aimed at evaluating and streamlining regulations with a goal to reduce unnecessary cost and burden, increase efficiencies, and improve beneficiary experience. The Meaningful Measures Initiative is aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes. The Meaningful Measures Initiative represents a new approach to quality measures that fosters operational efficiencies, and will reduce costs including collection and reporting burden while producing quality measurement that is more focused on meaningful outcomes.

The Meaningful Measures Framework has the following objectives:

- Address high-impact measure areas that safeguard public health;
- Patient-centered and meaningful to patients;
- Outcome-based where possible;
- Fulfill each program's statutory requirements;
- Minimize the level of burden for health care providers (for example, through a preference for EHR-based measures where possible, such as electronic clinical quality measures);
- Significant opportunity for improvement;
- Address measure needs for population based payment through alternative payment models and,
- Align across programs and/or with other payers.

In order to achieve these objectives, we have identified 19 Meaningful Measures areas and mapped them to six overarching quality priorities as shown in Table 2:

TABLE 2—MAPPING OF MEANINGFUL MEASURES AREAS TO QUALITY PRIORITIES

Quality priority	Meaningful measure area
Making Care Safer by Reducing Harm Caused in the Delivery of Care	Healthcare-Associated Infections.
	Preventable Healthcare Harm.
Strengthen Person and Family Engagement as Partners in Their Care	Care is Personalized and Aligned with Patient's Goals.
	End of Life Care according to Preferences.
	Patient's Experience of Care.
	Patient Reported Functional Outcomes.
Promote Effective Communication and Coordination of Care	Medication Management.
	Admissions and Readmissions to Hospitals.
	Transfer of Health Information and Interoperability.
Promote Effective Prevention and Treatment of Chronic Disease	Preventive Care.
	Management of Chronic Conditions.
	Prevention, Treatment, and Management of Mental Health.
	Prevention and Treatment of Opioid and Substance Use Disorders.
	Risk Adjusted Mortality.
Work with Communities to Promote Best Practices of Healthy Living	Equity of Care.
	Community Engagement.
Make Care Affordable	Appropriate Use of Healthcare.
	Patient-focused Episode of Care.
	Risk Adjusted Total Cost of Care.

By including Meaningful Measures in our programs, we believe that we can also address the following cross-cutting measure considerations:

- Eliminating disparities;
- Tracking measurable outcomes and impact;
- Safeguarding public health;
- Achieving cost savings;
- Improving access for rural communities; and,
- Reducing burden.

[6] Meaningful Measures web page: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html.*

[7] Remarks by Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit, as prepared for delivery on October 30, 2017. Available at: *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-10-30.html.*

We believe that the Meaningful Measures Initiative will improve outcomes for patients, families, and health care providers while reducing burden and costs for clinicians and providers, as well as promoting operational efficiencies.

F. Proposed Removal or Retention of IPFQR Program Measures

1. Considerations for Removing or Retaining Measures

In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38463 through 38465), we finalized our proposals to adopt considerations for removing or retaining measures within the IPFQR Program. In that final rule, we finalized: (1) Measure removal factors; (2) criteria for determining when a measure is ''topped-out;'' and (3) measure retention factors.

Specifically, the measure removal factors we adopted are:

- Factor 1. Measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (''topped-out'' measures);
- Factor 2. Measure does not align with current clinical guidelines or practice;
- Factor 3. Measure can be replaced by a more broadly applicable measure (across settings or populations) or a measure that is more proximal in time to desired patient outcomes for the particular topic;
- Factor 4. Measure performance or improvement does not result in better patient outcomes;
- Factor 5. Measure can be replaced by a measure that is more strongly associated with desired patient outcomes for the particular topic;
- Factor 6. Measure collection or public reporting leads to negative unintended consequences other than patient harm; and
- Factor 7. Measure is not feasible to implement as specified.

The ''topped out'' criteria that we adopted are that a measure is ''topped-out'' if there is statistically indistinguishable performance at the 75th and 90th percentiles and the truncated coefficient of variation is less than or equal to 0.10.

The measure retention factors that we adopted are:

- Measure aligns with other CMS and HHS policy goals, such as those delineated in the National Quality Strategy or CMS Quality Strategy;
- Measure aligns with other CMS programs, including other quality reporting programs; and
- Measure supports efforts to move IPFs towards reporting electronic measures.

We are not proposing any changes to these previously finalized measure removal or retention factors, or our criteria for determining when a measure is topped-out. However, we are proposing to add an additional measure removal factor. This is discussed in more detail below.

a. Proposed New Removal Factor

We are proposing to adopt the following additional factor to consider when evaluating measures for removal from the IPFQR Program measure set: Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.

As we discussed in section VI.E. of the preamble of this proposed rule on our new Meaningful Measures Initiative,'' we are engaging in efforts to ensure that the IPFQR Program measure set continues to promote improved health outcomes for beneficiaries while minimizing the overall costs associated with the program. We believe these costs are multi-faceted and include not only the burden associated with reporting, but also the costs associated with implementing and maintaining the program. We have identified several different types of costs, including, but not limited to: (1) Provider and clinician information collection burden and related cost and burden associated with the submitting/reporting of quality measures to CMS; (2) the provider and clinician cost associated with complying with other IPFQR programmatic requirements; (3) the provider and clinician cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs; (4) the CMS cost associated with the program oversight of the measure, including maintenance and public display; and/or (5) the provider and clinician cost associated with compliance to other federal and/or State regulations (if applicable). For example, it may be needlessly costly and/or of limited benefit to retain or maintain a measure which our analyses show no longer meaningfully supports program objectives (for example, informing beneficiary choice or payment scoring). It may also be costly for health care providers to track confidential feedback preview reports, and publicly reported information on a measure where we use the measure in more than one program. CMS may also have to expend unnecessary resources to maintain the specifications for the measure, as well as the tools needed to collect, validate, analyze, and publicly report the measure data. Furthermore, beneficiaries may find it confusing to see public reporting on the same measure in different programs.

When these costs outweigh the evidence supporting the continued use of a measure in the IPFQR Program, we believe it may be appropriate to remove the measure from the program. Although we recognize that one of the main goals of the IPFQR Program is to improve beneficiary outcomes by incentivizing health care providers to focus on specific care issues and making public data related to those issues, we also recognize that those goals can have limited utility where, for example, the publicly reported data are of limited use because they cannot be easily interpreted by beneficiaries to influence their choice of providers. In these cases, removing the measure from the IPFQR Program may better accommodate the costs of program administration and compliance without sacrificing improved health outcomes and beneficiary choice.

We are proposing that we would remove measures based on this factor on a case-by-case basis. We might, for example, decide to retain a measure that is burdensome for health care providers to report if we conclude that the benefit to beneficiaries justifies the reporting burden. Our goal is to move the program forward in the least burdensome manner possible, while maintaining a parsimonious set of meaningful quality measures and continuing to incentivize improvement in the quality of care provided to patients.

We are soliciting public comments on our proposal to adopt an additional measure removal factor, ''the costs associated with a measure outweigh the benefit of its continued use in the program,'' effective upon publication of the FY 2019 IPF PPS Final Rule. We refer readers to section VI.F.2.a of the preamble of this proposed rule where we are proposing to remove five measures based on this proposed removal factor.

2. Proposed Measures for Removal

In this proposed rule, we are proposing to remove eight measures from the IPFQR Program. We developed these proposals after conducting an overall review of the program under the Framework associated with our new Meaningful Measures Initiative, which is discussed in more detail in section VI.E. of this proposed rule. We believe that the Framework will allow IPFs and patients to continue to obtain meaningful information about IPF performance and incentivize quality

improvement, while streamlining the measure sets to reduce program complexity so that the costs do not outweigh the benefits of improving beneficiary care. In addition, we note that in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38464), several commenters requested that we evaluate the current measures in the IPFQR Program using the removal and retention factors that we finalized in that rule.

In evaluating the IPFQR Program measure set under our Meaningful Measures Framework and according to our measure removal and retention factors, we identified eight measures which we believe are appropriate to propose for removal from the IPFQR Program for the FY 2020 program year and subsequent years. First, we identified five measures for which the costs associated with each measure outweighs the benefit of its continued use in the program, under new measure removal Factor 8 proposed for adoption in section VI.F.1.a of this proposed rule. We note that if the proposed removal factor is not finalized, removal of these measures would not be finalized. Second, we identified three measures that meet our topped-out criteria. These proposals are discussed in more detail below.

a. Proposed Removal of Measures in Which Costs Outweigh Benefits

i. Proposed Removal of Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)

We are proposing to remove the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) measure from the IPFQR Program beginning with FY 2020 payment determination under our proposed measure removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program. We initially adopted the Influenza Vaccination Coverage Among Healthcare Personnel measure because we recognize that influenza immunization is an important public health issue, especially for vulnerable patients who may have limited access to the healthcare system, such as patients in IPFs. We are proposing to remove the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) measure, a National Healthcare Safety Network (NHSN) measure, based on the proposed removal factor: The costs associated with a measure outweigh the benefit of its continued use in the program.

We adopted the Influenza Vaccination Coverage Among Healthcare Personnel measure (NQF #0431) in in the FY 2015 IPF PPS final rule (79 FR 45968 through 45970) due to public health concerns regarding influenza virus infection among the IPF population. We believe that the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) addresses this public health concern by assessing influenza vaccination in the IPF among healthcare personnel (HCP), who can serve as vectors for influenza transmission. We also adopted Influenza Immunization (IMM–2, NQF #1659) in the FY 2015 IPF PPS final rule (79 FR 45967 through 45968) to address the same public health concern of influenza virus infection in the IPF patient population by assessing patient screening for and provision of influenza vaccinations.

The information collection burden for the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) measure is less than for measures that require chart abstraction of patient data because influenza vaccination among healthcare personnel can be calculated through review of records maintained in administrative systems and because facilities have fewer healthcare personnel than patients and therefore the measure does not require review of as many records; however, this measure does still pose some information collection burden on facilities due to the requirement to identify personnel who have been vaccinated against influenza, and the reason that unvaccinated personnel have not been vaccinated.

Furthermore, as we stated in section VI.F.1.a of this proposed rule, costs are multi-faceted and include not only the burden associated with reporting, but also the costs associated with implementing and maintaining the program. For example, it may be costly for health care providers to maintain general administrative knowledge to report these measures. Additionally, CMS must expend resources in maintaining information collection systems, analyzing reported data, and providing public reporting of the collected information. In our analysis of the IPFQR Program measure set, we recognized that some facilities face challenges with the administrative requirements of the NHSN for reporting the Influenza Vaccination Coverage Among Healthcare Personnel measure (NQF #0431). These administrative requirements (which are unique to the NHSN) include annually completing NHSN system user authentication. Enrolling in NHSN is a five-step process that the CDC estimates takes an average of 263 minutes per facility.[8]

Furthermore, submission via NHSN requires the system security administrator of participating facilities to re-consent electronically, ensure that contact information is kept current, ensure that the IPF has an active facility administrator account, keep Secure Access Management Service (SAMS) credentials active by logging in approximately every 2 months and changing their password, create a monthly reporting plan, and ensure that the facility's CCN information is up-to date. Unlike acute care hospitals which participate in other quality reporting programs which may require NHSN reporting, such as the Hospital IQR Program and HAC Reduction Program, IPFs are only required to participate in NHSN to submit data for this one measure. This may unduly disadvantage smaller IPFs, specifically those that are not part of larger hospital systems, because these IPFs do not have NHSN access for other quality reporting or value-based payment programs. It is our goal to ensure that the IPFQR Program is equitable to all providers and this measure may disproportionately affect small, independent IPFs. Especially for these small, independent IPFs, the incremental costs of this measure over the rest of the IPFQR Program measure set are significant because of the requirements of NHSN participation. As a result, we believe that the costs and burdens associated with this chart-abstracted measure outweigh the benefit of its continued use in the program.

We continue to believe that the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) measure provides the benefit of protecting IPF patients against influenza; however, we believe that these benefits are offset by other efforts to reduce influenza infection among IPF patients, such as numerous healthcare employer requirements for healthcare personnel to be vaccinated against influenza.[9]

We also believe that by continuing to include the Influenza Immunization (IMM–2, NQF #1659) measure in the IPFQR program, the measure set remains responsive to the public health concern of influenza infection within the IPF population by collecting data on

[8] *https://www.cdc.gov/nhsn/ipfs/enroll.html* (the estimates for time to complete are 2 hours 45 minutes for step 1, 10 minutes for step 2, 16 minutes for step 3a, 35 minutes for step 3b, 32 minutes for step 4, and 5 minutes for step 5; totaling 263 minutes).

[9] CDC, Influenza Vaccination Information for Health Care Workers, Accessed at *https://www.cdc.gov/flu/healthcareworkers.htm.*

rates of influenza immunization among IPF patients. Further, we believe that while the Influenza Immunization (IMM–2, NQF #1659) measure has information collection burden associated with chart abstracting data, this measure is less costly than the NHSN Participation required for the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) in the IPF context.

We wish to minimize the level of cost of our programs for providers, as discussed under the Meaningful Measures Initiative in section VI.E. of this proposed rule. In our assessment of the IPFQR measure set, we prioritized measures that align with this Framework, as the most important to the IPF population. Our assessment concluded that while the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) measure continues to provide benefits, these benefits are diminished by other efforts and are outweighed by the significant costs of reporting this measure.

For these reasons, we are proposing to remove the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) measure from the IPFQR Program for the FY 2020 payment determination and subsequent years.

We solicit public comments on this proposal.

ii. Proposed Removal of Alcohol Use Screening Measure (NQF #1661)

We are proposing to remove the Alcohol Use Screening, SUB–1 (NQF #1661) measure from the IPFQR Program beginning with the FY 2020 payment determination under our proposed measure removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program. We adopted the Alcohol Use Screening (SUB–1, NQF #1661) measure in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50890 through 50892) because we believe it is important to address the common comorbidity of alcohol use among IPF patients. This measure requires facilities to chart-abstract measure data on a sample of IPF patient records, in accordance with established sampling policies (FY 2016 IPF PPS final rule, 80 FR 46717 through 46719). We have previously stated our intent to move away from chart-abstracted measures in order to reduce information collection burden in other CMS quality programs (78 FR 50808; 79 FR 50242; 80 FR 49693).

When we introduced the measure to the IPFQR Program, the benefits of this measure were high, because facility performance was not consistent and therefore the measure provided a means of distinguishing facility performance and incentivized facilities to improve rates of screening for this common comorbidity.

Now, data collected for the FY 2016 through FY 2018 payment determinations show high levels of measure performance, as indicated in Table 3.

TABLE 3—PERFORMANCE ANALYSIS FOR ALCOHOL USE SCREENING

Year	Mean	Median	75th percentile	90th percentile	Truncated coefficient of variation (TCV)
2014 (FY 2016 Payment Determination)	74.8	86.8	97.0	100	.32
2015 (FY 2017 Payment Determination)	88.5	97.5	99.6	100	.13
2016 (FY 2018 Payment Determination)	92.4	98.4	99.7	100	.07

These data further show that there is little room for improvement in the Alcohol Use Screening Measure (NQF #1661) measure, and that the benefit from the measure has greatly diminished. Based on these data, we believe that IPFs routinely provide alcohol use screening, and that IPFs will continue to provide alcohol use screening to patients because it has become an embedded part of their clinical workflows. Therefore, we believe that this measure no longer meaningfully supports the program objectives of informing beneficiary choice and driving improvement in IPF screening for alcohol use.

Furthermore, as we stated in section VI.F.1.a of this proposed rule, costs are multi-faceted and include not only the burden associated with reporting, but also the costs associated with implementing and maintaining the program. For example, it may be costly for health care providers to maintain general administrative knowledge to report these measures. Additionally, CMS must expend resources in maintaining information collection systems, analyzing reported data, and providing public reporting of the collected information. Here, IPF information collection burden and related costs associated with reporting this measure to CMS is high because the measure is a chart-abstracted measure. Furthermore, CMS incurs costs associated with the program oversight of the measure for public display. As a result, we believe that the costs and burdens associated with this chart-abstracted measure outweigh the benefit of its continued use in the program.

Therefore, we are proposing to remove the Alcohol Use Screening measure (SUB–1, NQF #1661) from the IPFQR Program beginning with the FY 2020 payment determination.

We solicit public comments on this proposal.

iii. Proposed Removal of the Assessment of Patient Experience of Care Measure and Use of an Electronic Health Record (EHR) Measure

We are proposing to remove two measures: (1) Assessment of Patient Experience of Care measure; and (2) Use of an EHR measure from the IPFQR Program beginning with the FY 2020 payment determination under our proposed measure removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.

We adopted the Assessment of Patient Experience of Care measure as a voluntary information collection in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50896 through 50897) and adopted it as a measure for the IPFQR Program in the FY 2015 IPF PPS final rule (79 FR 45964 through 45965). The Assessment of Patient Experience of Care measure collects data on whether each facility administers a patient experience of care survey. However, it does not provide data on the results of this survey, or the percentage of patients to whom the survey was administered. The measure was adopted in part to inform potential future development of patient experience of care measures. We believe that we have now collected sufficient information to inform development of such a measure and, therefore, the

benefit of collecting this measure has been significantly reduced.

Similarly, we adopted the Use of an EHR measure in the FY 2015 IPF PPS final rule (79 FR 45965 through 45967) because of evidence demonstrating the positive of effects of EHRs on multiple aspects of medical care. The Use of an EHR measure requires facilities to select between the following three statements:

- The facility most commonly used paper documents or other forms of information exchange (for example, email) not involving the transfer of health information using EHR technology at times of transitions in care;
- The facility most commonly exchanged health information using non-certified EHR technology (that is, not certified under the ONC HIT Certification Program) at times of transitions in care; and
- The facility most commonly exchanged health information using certified EHR technology (certified under the ONC HIT Certification Program) at times of transitions in care.

The measure then requires the facility to provide a ''yes'' or ''no'' answer to the following question: ''Did the transfers of health information at times of transitions in care include the exchange of interoperable health information with a health information service provider (HISP)?''

As discussed in section VI.E of the preamble of this proposed rule, one of the goals of the Meaningful Measures Initiative is to reduce costs associated with payment policy, quality measures, documentation requirements, conditions of participation, and health information technology. Another goal of the Meaningful Measures Initiative is to utilize measures that are ''outcome-based where possible.'' As shown above, the Use of an EHR measure is a structural measure that tracks facility-level use of EHR technology, but does not directly measure patient outcomes. Furthermore, performance on this measure has remained relatively static for the past two program years. We believe that we have now collected sufficient data to inform potential future development of measures that more directly target the aspects of medical care addressed using EHRs (for example, care coordination, care transitions, and care provided to individual patients).

While some of the intended objectives of both the Assessment of Patient Experience of Care measure and Use of an EHR measure have been met, keeping both measures in the IPFQR Program's measure set creates administrative cost to hospitals associated with reporting these measures. We believe that removing these measures would alleviate some administrative cost. While the information collection burden associated with these measures is relatively low, as we stated in section VI.F.1.a of this proposed rule, costs are multi-faceted and include not only the burden associated with reporting, but also the costs associated with implementing and maintaining the program. For example, it may be costly for health care providers to maintain general administrative knowledge to report these measures. Additionally, CMS must expend resources in maintaining information collection systems, analyzing reported data, and providing public reporting of the collected information. In light of the fact that the benefits for both the Assessment of Patient Experience of Care measure and Use of an EHR measure have been significantly reduced, the costs of these measures now outweigh their benefits.

Therefore, beginning with the FY 2020 payment determination and subsequent years, we are proposing to remove from the IPFQR Program: (1) Assessment of Patient Experience of Care; and (2) Use of an EHR.

We solicit public comments on this proposal.

iv. Proposed Removal of Tobacco Use Treatment Provided or Offered at Discharge (TOB–3 and TOB–3a, NQF #1656) Measure

We are proposing to remove the Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB–3 and TOB–3a, NQF #1656) from the IPFQR Program beginning with the FY 2020 payment determination under our proposed measure removal Factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program.

Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB–3 and TOB–3a, NQF #1656) measures whether patients were referred to or refused evidence-based outpatient counseling and received or refused a prescription for FDA-approved cessation medication upon discharge and also identifies those IPF patients who were referred to evidence-based outpatient counseling and received a prescription for FDA-approved cessation medication upon discharge. This measure requires facilities to chart-abstract measure data on a sample of IPF patient records, in accordance with established sampling policies (FY 2016 IPF PPS final rule, 80 FR 46717 through 46719). When we introduced the measure to the IPFQR Program, the benefits of this measure were great, because facility performance was not consistent and the measure provided a means of distinguishing facility performance and incentivizing facilities to improve rates of providing treatment for this common comorbidity.

However, we believe the benefit of keeping the Tobacco Use Treatment Provided or Offered at Discharge (TOB–3 and TOB–3a, NQF #1656) measure in the IPFQR Program has now become limited because the same measure data is captured in the data elements required by the Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0647) measure, which was more recently added to the IPFQR Program (80 FR 46701 through 46706) . The transition record created to meet the requirements for inclusion in the numerator of the Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care (NQF #0647) includes elements on major procedures and tests performed during inpatient stay, summary of results, a current medication list, and post-discharge patient instructions. To meet the inclusion criteria for the numerator of this measure, the post-discharge patient instructions must provide information on all recommended actions for the patient after discharge. These post-discharge patient instructions would include tobacco use treatment, if appropriate, and therefore, would capture the same information as the numerator of the Tobacco Use Treatment Provided or Offered at Discharge (TOB–3 and TOB–3a, NQF #1656) measure. Additionally, because the transition record created to meet the requirements for inclusion in the numerator of Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care (NQF #0647) must include a current medication list, this medication list would capture a prescription for an FDA approved cessation medication at discharge, if appropriate, the second element of tobacco use treatment measured by the Tobacco Use Treatment Provided or Offered at Discharge (TOB–3 and TOB–3a, NQF #1656) measure.

Furthermore, as we stated in section VI.F.1.a of this proposed rule, costs are multi-faceted and include not only the burden associated with reporting, but also the costs associated with implementing and maintaining the program. For example, it may be costly

for health care providers to maintain general administrative knowledge to report these measures. Additionally, CMS must expend resources in maintaining information collection systems, analyzing reported data, and providing public reporting of the collected information. For this measure, provider and clinician information collection burden and related cost and burden associated with the submitting of quality measures to CMS is high because it is a chart-abstracted measure. Additionally, CMS incurs costs associated with the program oversight of the measure, including public display.

Therefore, we believe that the benefits provided by the Tobacco Use Treatment Provided or Offered at Discharge (TOB–3 and TOB–3a, NQF #1656) measure have been reduced to the point that they are now outweighed by the costs of the measure. As such, we are proposing to remove the Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB–3 and TOB–3a, NQF #1656) measure from the IPFQR Program beginning with the FY 2020 payment determination and subsequent years.

We solicit public comments on this proposal.

b. Proposed Removal of Topped-Out Measures

In the FY 2018 IPPS/LTCH PPS final rule, we finalized criteria for evaluating whether measures within the IPFQR measure set are topped-out (82 FR 38463). We stated that a measure is topped-out if there is statistically indistinguishable performance at the 75th and 90th percentiles and the TCV is less than or equal to 0.10. Based on our analysis of IPFQR Program measure data for January 1, 2015 through December 31, 2015, IPF performance on the following three measures is topped-out.

i. Proposed Removal of the Tobacco Use Screening (TOB–1, NQF #1651) Measure

We are proposing to remove the Tobacco Use Screening, TOB–1 (NQF #1651) measure from the IPFQR Program beginning with FY 2020 payment determination under our previously finalized measure removal Factor 1, measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (''topped-out'' measures). Based on our analysis of IPFQR Program measure data for January 1, 2015 through December 31, 2015 (that is, FY 2017 payment determination data), IPF performance on Tobacco Use Screening (TOB–1, NQF #1651) is statistically indistinguishable at the 75th and 90th percentiles and the TCV is less than or equal to 0.10. This analysis is captured in Table 4:

TABLE 4—TOPPED-OUT ANALYSIS RESULTS FOR TOBACCO USE SCREENING

Measure	Mean	Median	75th percentile	90th percentile	TCV	Topped-out
TOB–1	93.32	98.79	100	100	0.066	Yes.

The Tobacco Use Screening (TOB–1, NQF #1651) measure meets both of the statistical criteria for topped-out status. Our analysis shows that tobacco use screening is widely in practice and there is little room for improvement. We believe that IPFs will continue this practice even after the measure is removed because we believe that the high performance on this measure shows that this practice has become an embedded part of clinical workflows. Therefore, we believe that utility in the program is limited because measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made. Therefore, we are proposing to remove the Tobacco Use Screening (TOB–1) measure from the IPFQR Program beginning with the FY 2020 payment determination.

We solicit public comments on this proposal.

ii. Proposed Removal of Hours of Physical Restraint Use (HBIPS–2, NQF #0640) and Hours of Seclusion Use (HBIPS–3, NQF #0641) Measures

We are proposing to remove two measures: (1) Hours of Physical Restraint Use, HBIPS–2 (NQF #0640); and (2) Hours of Seclusion Use, HBIPS–3 (NQF #0641) from the IPFQR Program for the FY 2020 payment determination and subsequent years under our previously finalized measure removal Factor 1, measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (''topped-out'' measures). Our finalized policy states that a measure is topped out if there is statistically indistinguishable performance at the 75th and 90th percentiles and the TCV is less than or equal to 0.10. This policy is designed to compare performance at the 75th and 90th percentile of top performing facilities. Because lower results are better for HBIPS–2 and HBIPS–3, the top performing facilities are those at the 25th and 10th percentile. Therefore, we evaluated the 25th and 10th percentile of measure results, which is equivalent to the 75th and 90th percentile of facility performance.

Due to the design of these measures—that lower results are better—we could not apply the second criterion, a TCV that is less than or equal to 0.10. The coefficient of variation is calculated by dividing the standard deviation by the mean. Because the mean is near zero for these measures, this leads to division by a number near zero, which results in a large coefficient of variation, and therefore a large TCV. This means that for measures with a target performance of zero, the second topped-out criterion ''the truncated coefficient of variation is less than or equal to 0.10'' is not applicable. While different than our established topped-out criteria, we believe that our approach for evaluating data for these measures is appropriate because it applies the relevant criterion in a way that assesses performance among the top performing facilities.

Our analysis for Hours of Physical Restraint Use (HBIPS–2, NQF #0640) is captured in Table 5:

TABLE 5—TOPPED-OUT ANALYSIS RESULTS FOR HOURS OF PHYSICAL RESTRAINT USE

Payment determination year	Mean	Median	25th Percentile measure results (75th Percentile of facility performance)	10th Percentile measure results (90th Percentile of facility performance)	TCV	Topped-out
2014	2.2	0.0	0.0	0.0	N/A	Yes.
2015	1.8	0.1	0.0	0.0	N/A	Yes.
2016	0.9	0.1	0.0	0.0	N/A	Yes.
2017	1.4	0.1	0.0	0.0	N/A	Yes.
2018	0.6	0.1	0.0	0.0	N/A	Yes.

Our analysis for Hours of Seclusion Use (HBIPS–3, NQF #0641) is captured in Table 6:

TABLE 6—TOPPED-OUT ANALYSIS RESULTS FOR HOURS OF SECLUSION USE

Payment determination year	Mean	Median	25th Percentile measure results (75th Percentile of facility performance)	10th Percentile measure results (90th Percentile of facility performance)	TCV	Topped-out
2014	0.8	0.0	0.0	0.0	N/A	Yes.
2015	1.1	0.0	0.0	0.0	N/A	Yes.
2016	0.5	0.0	0.0	0.0	N/A	Yes.
2017	1.1	0.0	0.0	0.0	N/A	Yes.
2018	0.4	0.0	0.0	0.0	N/A	Yes.

We continue to believe that the use of physical restraints and seclusion as clinical interventions are important patient safety issues because of the severity of these interventions. However, we note that Hours of Physical Restraint Use (HBIPS–2) and Hours of Seclusion Use (HBIPS–3) have only been one element of the coordinated approach to minimizing the use of physical restraint and seclusion. They are not the primary method by which CMS monitors or assesses the appropriateness of their use. IPFs are subject to the Conditions of Participation concerning patient's rights, which include an extensive section on the use of seclusion and restraints (42 CFR 482.13(e), (f), and (g)). Unannounced surveys by state surveyors and surveys by CMS-approved accreditation organizations (for example, The Joint Commission (TJC)) for deeming purposes are the primary means by which CMS enforces these provisions, which assess compliance with these requirements on a case-by-case basis. This focus on the appropriate use of these interventions has led to consistently high performance on these measures for several years. Our ''topped-out'' analyses of the measures shows that meaningful distinctions and improvements in performance can no longer be made through continued use of these measures in the IPFQR Program, and thus, utility in the program is limited. However, we believe that the continued monitoring of the use of seclusion and restraint by surveyors will continue to protect against patient harm related to inappropriate use of seclusion and restraint.

Therefore, we are proposing to remove from the IPFQR Program beginning with the FY 2020 payment determination both: (1) Hours of Physical Restraint Use (HBIPS–2); and (2) Hours of Seclusion use (HBIPS–3).

We solicit public comments on these proposals.

G. Previously Finalized and Proposed Measure Sets for the FY 2020 Payment Determination and Subsequent Years

1. Previously Finalized Measures for the FY 2020 Payment Determination and Subsequent Years

We previously finalized 18 measures for the FY 2020 payment determination and subsequent years. These measures are set forth in Table 7.

TABLE 7—PREVIOUSLY FINALIZED MEASURES FOR THE FY 2020 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

NQF #	Measure ID	Measure
0640	HBIPS–2	Hours of Physical Restraint Use.
0641	HBIPS–3	Hours of Seclusion Use.
560	HBIPS–5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification.
576	FUH	Follow-up After Hospitalization for Mental Illness.
1661	SUB–1	Alcohol Use Screening.
1663	SUB–2 and SUB–2a	Alcohol Use Brief Intervention Provided or Offered and SUB–2a Alcohol Use Brief Intervention.
1664	SUB–3 and SUB–3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB–3a Alcohol and Other Drug Use Disorder Treatment at Discharge.

TABLE 7—PREVIOUSLY FINALIZED MEASURES FOR THE FY 2020 PAYMENT DETERMINATION AND SUBSEQUENT YEARS—Continued

NQF #	Measure ID	Measure
1651	TOB–1	Tobacco Use Screening.
1654	TOB–2 and TOB–2a	Tobacco Use Treatment Provided or Offered and TOB–2a Tobacco Use Treatment.
1656	TOB–3 and TOB–3a	Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge.
1659	IMM–2	Influenza Immunization.
0431	N/A	Influenza Vaccination Coverage Among Healthcare Personnel.
647	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care).
648	N/A	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care).
N/A	N/A	Screening for Metabolic Disorders.
2860	N/A	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility.
N/A	N/A	Assessment of Patient Experience of Care.
N/A	N/A	Use of an Electronic Health Record.

2. Proposed Measure Set for the FY 2020 Payment Determination and Subsequent Years

If our proposals to remove measures in section VI.F.2. of this rule are finalized as proposed, eight of the previously finalized measures described in Table 7 will be removed for the FY 2020 payment determination and subsequent years. The remaining ten measures are set forth in Table 8.

TABLE 8—PROPOSED MEASURE SET FOR THE FY 2020 PAYMENT DETERMINATION AND SUBSEQUENT YEARS

NQF #	Measure ID	Measure
560	HBIPS–5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification.
576	FUH	Follow-up After Hospitalization for Mental Illness.
1663	SUB–2 and SUB–2a	Alcohol Use Brief Intervention Provided or Offered and SUB–2a Alcohol Use Brief Intervention.
1664	SUB–3 and SUB–3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB–3a Alcohol and Other Drug Use Disorder Treatment at Discharge.
1654	TOB–2 and TOB–2a	Tobacco Use Treatment Provided or Offered and TOB–2a Tobacco Use Treatment.
1659	IMM–2	Influenza Immunization.
647	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care).
648	N/A	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care).
N/A	N/A	Screening for Metabolic Disorders.
2860	N/A	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility.

H. Possible IPFQR Program Measures and Measure Topics for Future Consideration

As we have previously indicated (79 FR 45974 through 45975), we seek to develop a comprehensive set of quality measures to be available for widespread use for informed decision-making and quality improvement in the IPF setting. We are considering development of process and outcomes measures related to treatment and management of depression. In our assessment of the current IPFQR measure set under the Meaningful Measures Initiative, described in section VI.E. of this proposed rule, we recognized the importance of developing a measure that fits into the meaningful measure areas of Prevention, Treatment, and Management of Mental Health and Patient Experience and Functional Outcomes, as we believe that the lack of such a measure is indicative of a gap in the current IPFQR Program measure set.

Specifically, we are considering: (1) Future development and adoption of a process measure that measures administration of a standardized depression assessment instrument (for example, the Patient Health Questionnaire (PHQ)–9) [10] at admission and discharge for patients admitted with depression; and (2) future development and adoption of a patient reported outcome measure, which assesses change in patient reported function based on the change in results on the standardized depression assessment instrument between admission and discharge.

We ultimately wish to adopt a patient reported outcome measure related to treatment and management of depression; however, such a measure would require consistent administration of a standardized assessment instrument at admission and discharge. To ensure that facilities are consistently using a standardized assessment instrument, we believe that it may be necessary to first adopt a process measure that assesses facility administration of a standardized depression assessment, such as the PHQ–9, at both admission and discharge for adult inpatient admissions, thereby, encouraging facilities that do not currently consistently use such an instrument to use one. In the future, we could replace this measure with a patient reported outcome measure that

[10] The PHQ–9 is publicly available at: *http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf.*

we would develop to compare the patient's responses to the standardized depression assessment instrument at admission with the patient's results on the same assessment instrument at discharge. We believe this potential future patient reported outcome measure for patients with depression would address the meaningful measure areas of Prevention, Treatment, and Management of Mental Health, and Patient Experience and Functional Outcomes.

We solicit public comments on: (1) Future development and adoption of a process measure that measures the number of facilities that administer a standardized assessment instrument; (2) future development and adoption of an outcome measure related to treatment and management of depression; and (3) any other possible new measures or new measure topics.

I. Public Display and Review Requirements

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53653 through 53654), the FY 2014 IPPS/LTCH PPS final rule (78 FR 50897 through 50898), and the FY 2017 IPPS/LTCH PPS final rule (81 FR 57248 through 57249). In this proposed rule, we are not proposing any changes to these policies. However, we note that in section VI.D of the preamble of this proposed rule, we discuss potential considerations to provide stratified data by patient dual eligibility status in IPF confidential feedback reports and considerations to make stratified data publicly available on the *Hospital Compare* website in the future.

J. Form, Manner, and Timing of Quality Data Submission for the FY 2020 Payment Determination and Subsequent Years

1. Procedural Requirements for the FY 2020 Payment Determination and Subsequent Years

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53654 through 53655), the FY 2014 IPPS/LTCH PPS final rule (78 FR 50898 through 50899), and the FY 2018 IPPS/LTCH PPS final rule (82 FR 38471 through 38472) for our previously finalized procedural requirements. In this proposed rule, we are not proposing any changes to these policies.

2. Data Submission Requirements for the FY 2020 Payment Determination and Subsequent Years

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53655 through 53657), the FY 2014 IPPS/LTCH PPS final rule (78 FR 50899 through 50900), and the FY 2018 IPPS/LTCH PPS final rule (82 FR 38472 through 38473) for our previously finalized data submission requirements. In this proposed rule, we are not proposing any changes to the data submission requirements.

3. Reporting Requirements for the FY 2020 Payment Determination and Subsequent Years

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53656 through 53657), the FY 2014 IPPS/LTCH PPS final rule (78 FR 50900 through 50901), and the FY 2015 IPF PPS final rule (79 FR 45976 through 45977 for our previously finalized reporting requirements. In this proposed rule, we are not proposing any changes to these policies; however, we are requesting public comment on our consideration to potentially require patient-level measure data in the future. This is discussed in more detail below.

In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53655 through 53656), we finalized that for the FY 2014 payment determination and subsequent years, IPFs must submit aggregated numerator and denominator data for all age groups for all measures on an annual basis, and that the data input forms on the QualityNet website for such submission will require aggregate data for each separate quarter. In the FY 2016 IPF PPS final rule (80 FR 46715 through 46717), we finalized that for the FY 2017 payment determination and subsequent years, facilities would only be required to report data for chart-abstracted measures on an aggregate basis by year, rather than by quarter. In addition, we finalized that facilities would no longer be required to report by age group.

Although we are not proposing any changes to these requirements in this proposed rule, we recognize that reporting aggregate measure data increases the possibility of human error, such as making typographical errors while entering data, which cannot be detected by CMS or by data submission systems. Unlike patient-level data reporting, aggregate measure data reporting does not allow for data accuracy validation (77 FR 53655 through 53656). Therefore, the ability to detect error is lower for aggregate measure data reporting than for patient-level data reporting. For this reason, we are considering requiring patient-level data reporting (that is, data regarding each patient included in a measure and whether the patient was included in each the numerator and denominator of the measure) of IPFQR Program measure data in the future. We note that in the FY 2013 IPPS/LTCH PPS final rule, we previously indicated that we would consider requiring patient-level data in the future and that we would use notice and comment rulemaking to establish any requirements (77 FR 53656).

In this proposed rule, while we are not proposing any changes to the reporting requirements, we are soliciting public comments on the consideration for requiring patient-level measure data in the future.

4. Quality Measure Sampling Requirements

In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53657 through 53658), we finalized that participating IPFs must meet specific population, sample size, and minimum reporting case threshold requirements for individual measures as specified in TJC's Specifications Manual [11] for the FY 2014 payment determination and subsequent years. The Specifications Manual is updated at least twice a year (and may be updated more often as necessary), and IPFs must follow the requirements in the most recent manual. We finalized that the target population for the measures includes all patients, not solely Medicare beneficiaries, to improve quality of care. We believe it is important to require IPFs to submit measures on all patients because quality improvement is of industry-wide importance and should not be focused exclusively on a certain subset of patients. We noted that the Specifications Manual gives IPFs the option of sampling their data quarterly or monthly. We also finalized our policy that IPFs that have no data to report for a given measure must enter zero for the population and sample counts. For example, an IPF that has no hours of physical restraint use (HBIPS–2) to report for a given quarter is still required to submit a zero for its quarterly aggregate population for HBIPS–2 in order to meet the reporting requirement. We note that at the time we finalized this policy, the only measures in the IPFQR Program were HBIPS measures (77 FR 53652).

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50901 through 50902), we stated that for the existing HBIPS measures, we continue to apply our finalized policies for population, sampling, and minimum case threshold as discussed above. However, in that rule, we finalized a new policy for new measures. For new measures finalized for the FY 2016 payment determination and subsequent years, we finalized that

[11] *https://manual.jointcommission.org/releases/TJC2017B2/.*

IPFs must follow sampling and population requirements as specified by the appropriate measure steward (78 FR 50901 through 50902).

In that rule, we also made clear that the Follow-Up After Hospitalization for Mental Illness (FUH, NQF #0576) measure is not eligible for sampling because CMS calculates the measure using administrative claims data, and sampling is not applicable to claims-based measures. We finalized that IPFs must follow the population requirements outlined at: *http://www.ncqa.org/portals/0/Follow-Up%20After%20Hospitalization%20for%20Mental%20Illness.pdf.*

In the FY 2014 IPPS/LTCH PPS final rule, some commenters noted that different sampling requirements in the measures could increase burden on facilities because these differences will require IPFs to have varying policies and procedures in place for each measure (78 FR 50901). Therefore, in the FY 2016 IPF PPS final rule (80 FR 46717 through 46719), in order to provide facilities greater flexibility, we expanded our sampling policy to allow sampling either through: (1) Previously finalized requirements for individual measures as discussed above; or (2) through the use of a uniform sampling methodology beginning with the FY 2018 payment determination. We finalized a uniform sampling methodology that could be applied to both measures that allow sampling and for certain other measures (specifically measures not previously included in TJC's Specifications Manuals, such as Screening for Metabolic Disorders, Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification, HBIPS–5). Specifically, we finalized use of The Joint Commission/CMS Global Initial Patient Population sampling methodology found at: *https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890321190&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D2+9_Global_v4_4.pdf&blobcol=urldata&blobtable=MungoBlobs.* This uniform sampling methodology allows IPFs to utilize one sampling methodology and apply it to all IPFQR Program measures for which sampling is allowed. The Joint Commission/CMS Global Initial Patient Population sampling methodology, as developed, ensures that enough data are represented in the sample to determine accurate measure rates (80 FR 46718).

Therefore currently, IPFs can choose from two options to sample quality measures: (1) Sampling and population requirements as specified by the appropriate measure steward; or (2) a uniform sampling methodology (that is, The Joint Commission/CMS Global Initial Patient Population methodology). These population and sampling options currently apply to the following measures in the IPFQR Program measure set:

- Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS–5, NQF #0560).
- Alcohol Use Screening (SUB–1, NQF #1661) (Proposed for removal in this rule).
- Alcohol Use Screening and Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB–2 and SUB–2a, NQF #1663).
- Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol & Other Drug Use Disorder Treatment at Discharge (SUB–3 and SUB–3a, NQF #1664).
- Tobacco Use Screening (TOB–1, NQF #1651) (Proposed for removal in this rule).
- Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment Provided (TOB–2 and TOB–2a, NQF #1654).
- Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB–3 and TOB–3a, NQF #1656) (Proposed for removal in this rule).
- Influenza Immunization (IMM–2, NQF #1659).
- Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0647).
- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0648).
- Screening for Metabolic Disorders.

We are not proposing any changes to our quality measure sampling policies.

5. Non-Measure Data Collection

In the FY 2015 IPF PPS final rule (79 FR 45973), we finalized that IPFs must submit aggregate population counts for Medicare and non-Medicare discharges by age group, diagnostic group, and quarter for the FY 2017 payment determination and subsequent years. We also finalized that IPFs must report the sample size counts (that is, number of patients included in the sample) for measures for which sampling is performed. Because these data (that is, (1) the aggregate population counts for Medicare and non-Medicare discharges by age group, diagnostic group, and quarter, as well as (2) sample size count for sampled measures) relate to the IPF's entire patient population, rather than the IPF's performance on specific measures, we refer to this data collectively as ''non-measure data.'' When adopting this requirement we expressed our belief that it is vital for IPFs to accurately determine and submit this non-measure data to CMS in order for CMS to assess IPFs' data reporting completeness for their total population, both Medicare and non-Medicare (79 FR 45973). We also stated that in addition to helping to better assess the quality and completeness of measure data, we expected that this information would improve our ability to assess the relevance and impact of potential future measures.

In the FY 2016 IPF PPS final rule (80 FR 46717), we finalized a change to the frequency with which we collect this non-measure data, such that beginning with the FY 2017 payment determination and subsequent years, we require non-measure data to be submitted as an aggregate, yearly count rather than by quarter. Therefore, there are currently five components to the non-measure data that facilities are required to submit on an annual basis: (1) Total annual discharges; (2) annual discharges stratified by age; (3) annual discharges stratified by diagnostic category; (4) annual discharges stratified by Medicare versus non-Medicare payer; (5) the sample size counts for measures for which sampling is performed.

However, the requirement to submit the sample size counts has created confusion for some facilities (for example, for facilities that used more than one sampling methodology such as applying the global sample to some measures and measure specific sampling procedures to others). Therefore, in an effort to reduce confusion and information collection burden, in line with our Meaningful Measures and Patients over Paperwork Initiatives, in this proposed rule we are proposing to no longer require facilities to report the sample size counts for measures for which sampling is performed (that is, item (5) listed above) beginning with the FY 2020 payment determination and subsequent years.

Our data indicate that most facilities avail themselves of the global sampling option (as discussed in section VI.J.4 above). We believe that for most facilities which use sampling, the size of the global sample can be compiled by other means, since information on the global sample size can still be inferred from the denominator values that are

already reported as part of measure data submission. This is because for measures in which the denominator represents the entire patient population (except for any denominator exclusions) the denominator is a good approximation for the global sample size count. Any denominator exclusions represent only a small proportion of the patient population and would not significantly affect the global sample size approximation. Since the global sample applies to all measures for which sampling is performed, the global sample size is consistent across all measures for which sampling is performed, and therefore, can be inferred from the denominator of any measure for which the denominator represents the entire patient population (such as the Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0647) measure). We note that this proposal does not in any way change or affect our requirements concerning quality measure sampling outlined in section VI.J.4 above and would only change the information that IPFs report to CMS on the size of samples used.

Therefore, we are proposing to no longer require facilities to report sample size counts for measures for which sampling is performed as discussed above for the FY 2020 payment determination and subsequent years.

We solicit public comments on this proposal.

6. Data Accuracy and Completeness Acknowledgement (DACA) Requirements

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53658) for our previously finalized DACA requirements. In this proposed rule, we are not proposing any changes to the DACA requirements.

K. Reconsideration and Appeals Procedures

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53658 through 53659) and the FY 2014 IPPS/LTCH PPS final rule (78 FR 50903) for our previously finalized reconsideration and appeals procedures. In this proposed rule, we are not proposing any changes to these procedures.

L. Extraordinary Circumstances Exceptions (ECE) Policy

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53659 through 53660), the FY 2014 IPPS/LTCH PPS final rule (78 FR 50903), the FY 2015 IPF PPS final rule (79 FR 45978), and the FY 2018 IPPS/LTCH PPS final rule (82 FR 38473 through 38474) for our previously finalized ECE policies. In this proposed rule, we are not proposing any changes to these policies.

VII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to publish a 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.

To fairly evaluate whether an information collection should be approved by OMB, PRA section 3506(c)(2)(A) 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 burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.

We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs).

A. Collection of Information Requirements for the IPFQR Program

1. Wage Estimates

Consistent with the FY 2017 IPPS/LTCH PPS final rule (81 FR 57265 through 57266) and our FY 2016 IPF PPS final rule (80 FR 46720), to derive average costs, we used data from the United States Bureau of Labor Statistics (BLS) National Occupational Employment and Wage Estimates for all salary estimates (in this case the May 2016 report).[12] The BLS is ''the principal Federal agency responsible for measuring labor market activity, working conditions, and price changes in the economy.'' [13] Acting as an independent agency, the BLS provides objective information for not only the government, but also for the public. The BLS describes Medical Records and Health Information Technicians as those responsible for organizing and managing health information data. We believe it is reasonable to assume that these individuals would be tasked with abstracting clinical data for these measures. The most recent data from the BLS reflects a median hourly wage of $18.29 for a Medical Records and Health Information Technician.[14] We note that we have already incorporated this updated wage data into other quality reporting programs, for example the Hospital Inpatient Quality Reporting (IQR) Program uses this wage to calculate its burden estimates (82 FR 38501). Therefore, we are updating our wage estimate to reflect this hourly wage for the IPFQR Program.

Table 9 presents the median hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 9—NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Median hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Medical Records and Health Information Technician	29–2071	$18.29	$18.29	$36.58

Under OMB Circular A–76, in calculating direct labor, agencies should not only include salaries and wages, but also ''other entitlements'' such as fringe benefits.[15] As indicated in Table 9 and consistent with our past approach, we have chosen to calculate the cost of overhead at 100 percent of the median hourly wage (81 FR 57266). This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical

[12] *http://www.bls.gov/oes/current/oes_nat.htm.*

[13] *http://www.bls.gov/bls/infohome.htm.*

[14] *https://www.bls.gov/oes/current/oes292071.htm.*

[15] *http://www.whitehouse.gov/omb/circulars_a076_a76_incl_tech_correction.*

alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

2. Proposed ICRs Regarding the IPFQR Program

For a detailed discussion of the information collection burden for the program requirements that we have previously adopted, we refer readers to the currently approved burden estimates under the OMB control number 0938–1171 (CMS–10432) and the following rules:

- The FY 2013 IPPS/LTCH PPS final rule (77 FR 53673);
- The FY 2014 IPPS/LTCH PPS final rule (78 FR 50964);
- The FY 2015 IPF PPS final rule (79 FR 45978 through 45980);
- The FY 2016 IPF PPS final rule (80 FR 46720 through 46721);
- The FY 2017 IPPS/LTCH PPS final rule (81 FR 57265 through 57266); and
- The FY 2018 IPPS/LTCH PPS final rule (82 FR 38507 through 38508).

The following requirements and burden estimates will be submitted to OMB for approval under control number 0938–1171 (CMS–10432). We are soliciting public comments for the information collection in its entirety, that is, both for this rule's proposed changes and for the requirements and burden that are currently approved by OMB under the 0938–1171 control number.

We discuss only the changes in burden resulting from the provisions in this proposed rule. In section VI. of this proposed rule, we propose provisions that impact the FY 2020 payment determination. All of these proposals apply to data collected in CY 2018 and reported in FY 2019. For purposes of calculating burden, we will attribute the costs associated with the proposals to the FY in which these costs begin; for the purposes of all of the provisions in this proposed rule, that year is FY 2018.

a. Estimated Change in Information Collection Burden Due to Proposed Adoption of a New Measure Removal Factor

In section VI.F.1. of this preamble, we proposed to adopt a new measure removal factor, ''the costs associated with a measure outweigh the benefit of its continued use in the program.'' As discussed in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38507 through 38508), the adoption of measure removal or retention factors does not affect the data submission requirements for IPFs. These factors are intended to improve transparency of our measure review and evaluation process, and have no effect on the data collection or submission requirements for IPFs. Therefore, we do not believe there will be any change of burden associated with the proposal to adopt the new measure removal factor.

b. Estimated Change in Information Collection Burden Due to Proposed Removal of Eight Measures

In section VI.F.2. of this preamble, we are proposing to remove the following eight measures for FY 2020 payment determination and subsequent years:

- Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431);
- SUB–1—Alcohol Use Screening (NQF #1661);
- Assessment of Patient Experience of Care;
- Use of an Electronic Health Record;
- TOB–1—Tobacco Use Screening (NQF #1651);
- Hospital-Based Inpatient Psychiatric Services (HBIPS)–2—Hours of Physical Restraint Use (NQF #0640);
- HBIPS–3—Hours of Seclusion Use (NQF #0641); and
- TOB–3—Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB–3a Tobacco Use Treatment at Discharge (NQF #1656).

For the FY 2020 payment determination, CY 2018 data would be reported during the summer of CY 2019. Therefore, for the FY 2020 payment determination proposals, we are correlating the burden reduction to the FY 2018 burden calculation. We believe that approximately 1,734 [16] IPFs will participate in the IPFQR Program for requirements occurring in FY 2018 and subsequent years. Based on data from CY 2017, we believe that each IPF will submit measure data based on approximately 1,213 [17] discharges per year.

i. Chart-Abstracted Measures Estimated Information Collection Burden

We have previously estimated that the reporting burden for chart-abstracted measures is 15 minutes (0.25 hours) per measure per case (81 FR 57265). We continue to use that time estimate to calculate the burden pertaining to this proposed rule. Of the measures we are proposing to remove from the program, the following five are chart-abstracted:

- Hours of Physical Restraint Use (HBIPS–2, NQF #0640).
- Hours of Seclusion Use (HBIPS–3, NQF #0641).
- Alcohol Use Screening (SUB–1, NQF #1661).
- Tobacco Use Screening (TOB–1, NQF #1651).
- Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB–3 and TOB–3a, NQF #1656).

The first two measures, Hours of Seclusion Use (NQF #0641) and Hours of Physical Restraint Use (NQF #0640) require abstraction for all discharges. We estimate that removing these two measures would result in a decrease in burden of 606.5 hours per IPF (2 measures × 1,213 cases/measure × 0.25 hours/case) or 1,051,671 hours across all IPFs (606.5 hours/IPF × 1,734 IPF). The decrease in costs is approximately $22,185.77 per IPF ($36.58/hour × 606.5 hours) or $38,470,125.18 across all IPFs ($22,185.77/IPF × 1,734 IPFs).

The remaining three measures, Alcohol Use Screening (NQF #1661), Tobacco Use Screening (NQF #1651), and Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (NQF #1656), fall under our previously finalized ''global sample,'' (80 FR 46717 through 46718). Under the global sample, we allow facilities to apply the same sampling methodology to all measures eligible for sampling. In the FY 2016 IPF PPS final rule (80 FR 46718), we finalized that facilities with between 609 and 3,056 cases and choose to participate in the global sample would be required to report data for 609 cases. Because most facilities choose to apply the global sample, rather than abstracting data for all patients or applying measure specific sampling methodologies, we believe that the number of cases under the global sample is a good approximation of facility burden associated with these measures. Therefore, for the average IPF discharge rate of 1,213 discharges, the global sample requires abstraction of 609 records. We estimate that removing these three measures would result in a decrease in burden of 456.75 hours per IPF (3 measures × 609 cases/measure × 0.25 hours/case) or 792,004.5 hours across all IPFs (456.75 hours/IPF × 1,734 IPFs). The decrease in costs is approximately $16,707.92 per IPF ($36.58/hour × 456.75 hours) or $28,971,524.61 across all IPFs ($16,707.92/IPF × 1,734 IPFs).

ii. NHSN Measure Estimated Information Collection Burden

We have previously estimated that the reporting burden for the Influenza Vaccination Coverage Among

[16] In the FY 2017 IPPS/LTCH PPS final rule we estimated 1,684 IPFs and are adjusting that estimate by +50 to account for more recent data.

[17] In the FY 2017 IPPS/LTCH PPS final rule we estimated 848 discharges per year and are adjusting that estimate by +365 to account for more recent data.

Healthcare Personnel (NQF #0431) is 15 minutes (0.25 hours) per measure per case and that the average IPF will report on 40 cases per year (79 FR 45979). Therefore, we estimate that removing this measure will result in a decrease in burden of 10 hours per IPF (40 cases × 0.25 hours/case) or 17,340 hours across all IPFs (40 cases × 0.25 hours/case × 1,734 IPFs). The decrease in costs is approximately $365.80 per IPF (10 hours × $36.58/hour) or $634,297.20 across all IPFs ($365.80/IPF × 1,734 IPFs).

We also anticipate cost reduction unrelated to the information collection burden associated with these proposals, and refer readers to section IX.C.5.b for a discussion of these costs.

iii. Attestation Measures Estimated Information Collection Burden

We have previously estimated that the Assessment of Patient Experience of Care measure and the Use of an Electronic Health Record (EHR) measure have no measurable information collection burden because both of these measures require only attestation (79 FR 45979). Therefore, we do not anticipate a reduction in IPF information collection burden associated with the removal of these measures. However, we anticipate cost reduction unrelated to the information collection burden associated with these proposals, and refer readers to section IX.C.5.b for a discussion.

The information collection burden reduction associated with the proposed removal of these eight measures would be 1,861,016 hours at a cost of $68,075,947 (total) or $39,259 (per IPF) as summarized in Table 10.

TABLE 10—TOTAL INFORMATION COLLECTION BURDEN REDUCTION ASSOCIATED WITH PROPOSED REMOVAL OF EIGHT MEASURES

Measure(s)	Hourly burden reduction per IPF	Total hourly burden reduction	Cost burden reduction per IPF	Total cost burden reduction
• (1) Hours of Seclusion Use (NQF #0641)	606.5	1,051,671.00	$22,185.77	$38,470,125.18
• (2) Hours of Physical Restraint Use (NQF #0640).				
• (3) Alcohol Use Screening (NQF #1661)	606.5	1,051,671.00	22,185.77	38,470,125.18
• (4) Tobacco Use Screening (NQF #1651).				
• (5) Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (NQF #1656).				
(6) Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)	10	17,340	365.80	634,297.20
• (7) Remove Assessment of Patient Experience of Care	0	0	0	0
• (8) Use of an Electronic Health Record (EHR)				
Total Burden Reduction	1,073.25	1,861,015.5	39,259.49	68,075,946.99

We solicit public comments on the burden reduction estimate of $68,075,946.99 across all IPFs related to our proposals to remove eight measures from the IPFQR program.

c. Estimated Change in Information Collection Burden Due to Proposed Removal of Sample Size Count Requirement

In section VI.J.4. of this proposed rule, we are proposing to remove the requirement to report the sample size count for measures for which sampling is performed beginning with the FY 2020 payment determination and subsequent years (that is, data collected during CY 2018 and reported during summer of CY 2019). Previously, we estimated that the total burden of reporting non-measure data to be 2.5 hours per IPF (79 FR 45979 through 45980). As discussed in section VI.J.5, the non-measure data encompasses five reporting requirements: (1) Total annual discharges; (2) annual discharges stratified by age; (3) annual discharges stratified by diagnostic category; (4) annual discharges stratified by Medicare versus non-Medicare payer; and (5) the sample size count for measures for which sampling is performed.

We estimate that, because the sample size count is one-fifth of the non-measure data collection, removing this requirement will reduce the non-measure collection burden by one-fifth, (that is, 20 percent) or 0.5 hours per facility (0.20 × 2.5 hours). This results in a reduction of information collection burden of 867 hours across all IPFs (0.5 hours per IPF × 1,734 IPFs). The decrease in costs is approximately $18.29 per IPF (0.5 hours × $36.58/hour) or $31,714.86 across all IPFs ($18.29 per IPF × 1,734 IPFs).

We solicit public comments on the information collection burden reduction estimate of 867 hours and $31,714.86 across all IPFs related to our proposal to no longer require facilities to report sample size counts beginning with the FY 2020 payment determination.

d. Summary of Annual Information Collection Burden Estimates for Proposed Requirements

If our proposals to adopt a new measure removal factor, to remove eight measures from the IPFQR Program, and to no longer require IPFs to the size of the global sample if they apply the global sampling methodology are finalized, we estimate that burden would be reduced by a total of 1,861,882.50 hours or $68,107,661.85, as described in Table 11.

TABLE 11—PROPOSED REDUCTION IN TOTAL IPFQR PROGRAM INFORMATION COLLECTION BURDEN

Preamble section(s)	Proposed action	Respondents	Responses (per respondent)	Burden per response (hours) *	Total annual burden (hours)	Labor cost of reporting ($/hr)	Total cost ($)
VI.F.2	Remove Hours of Seclusion Use and Hours of Physical Restraint Use.	1,734	1,213 per measure	0.25	1,051,671.00 (2 measures × 1,213 cases × 0.25 hr/case × 1,734 IPFs).	36.58	$38,470,125.18

TABLE 11—PROPOSED REDUCTION IN TOTAL IPFQR PROGRAM INFORMATION COLLECTION BURDEN—Continued

Preamble section(s)	Proposed action	Respondents	Responses (per respondent)	Burden per response (hours) *	Total annual burden (hours)	Labor cost of reporting ($/hr)	Total cost ($)
VI.F.2	Remove Alcohol Use Screening, Tobacco Use Screening, and Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge.	1,734	609 per measure	0.25	792,004.50 (3 measures × 609 cases × 0.25 hr/case × 1,734 IPFs).	36.58	28,971,524.61
VI.F.2	Remove Influenza Vaccination Coverage Among Healthcare Personnel.	1,734	40	0.25	17,340 (1 measure × 40 cases × 0.25 hr/case × 1,734 IPFs).	36.58	634,297.20
VI.F.2	Remove Assessment of Patient Experience of Care and Use of an Electronic Health Record (EHR).	1,734	1	0	0	36.58	0
Subtotal (removing 8 measures)		*1,734*	*4,294*	*Varies*	*1,861,016*	*36.58*	*68,075,946.99*
VI.F.1	Adopt a new measure removal factor.	N/A	N/A	N/A	0	N/A	0
VI.J.4	No longer require reporting of sample size counts.	1,734	1	0.5	867	36.58	31,714.86
Total		1734	4,295	Varies	1,861,882.50	36.58	68,107,661.85

3. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. The requirements are not effective until they have been approved by OMB. However, we note that the currently approved information collection expires July 31, 2019.

We solicit public comments on these information collection requirements. If you wish to comment, identify the rule (CMS–1690–P) and, where applicable, the preamble section, and the ICR section. See the **DATES** and **ADDRESSES** sections of this proposed rule for the comment due date and for additional instructions.

VIII. 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.

IX. Regulatory Impact Analysis

A. Statement of Need

This rule proposes updates to the prospective payment rates for Medicare inpatient hospital services provided by IPFs for discharges occurring during FY 2019 (October 1, 2018 through September 30, 2019). We propose to apply the 2012-based IPF market basket increase of 2.8 percent, less the productivity adjustment of 0.8 percentage point as required by 1886(s)(2)(A)(i) of the Act, and further reduced by 0.75 percentage point as required by sections 1886(s)(2)(A)(ii) and 1886(s)(3)(E) of the Act, for a proposed total FY 2019 payment rate update of 1.25 percent. In this proposed rule, we are proposing updates to the IPF labor-related share and updating the IPF wage index for FY 2019. We are also proposing minor technical corrections to three IPF regulations, and proposing updates to the IPF Quality Reporting Program. Finally, we have included a Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers.

B. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96 354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)) and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition,

jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This proposed rule is not economically significant under Executive Order 12866.

We estimate that the total impact of these proposed changes for FY 2019 payments compared to FY 2018 payments will be a net increase of approximately $50 million. This reflects a $60 million increase from the update to the payment rates ($plus;$130 million from the first quarter 2018 IGI forecast of the 2012-based IPF market basket of 2.8 percent, -$40 million for the productivity adjustment of 0.8 percentage point, and -$30 million for the other adjustment of 0.75 percentage point), as well as a $10 million decrease as a result of the update to the outlier threshold amount. Outlier payments are estimated to decrease from 2.27 percent in FY 2018 to 2.00 percent of total estimated IPF payments in FY 2019. We also estimate a total decrease in burden of 1,073.75 hours per IPF or 1,861,882.5 hours across all IPFs, resulting in a total decrease in financial burden of $39,277.78 per IPF or $68,107,661.85 across all IPFs.

C. Anticipated Effects

In this section, we discuss the historical background of the IPF PPS and the impact of this proposed rule on the Federal Medicare budget and on IPFs.

1. Budgetary Impact

As discussed in the November 2004 and RY 2007 IPF PPS final rules, we applied a budget neutrality factor to the federal per diem base rate and ECT payment per treatment to ensure that total estimated payments under the IPF PPS in the implementation period would equal the amount that would have been paid if the IPF PPS had not been implemented. The budget neutrality factor includes the following components: outlier adjustment, stop-loss adjustment, and the behavioral offset. As discussed in the RY 2009 IPF PPS notice (73 FR 25711), the stop-loss adjustment is no longer applicable under the IPF PPS.

As discussed in section III.D.1 of this proposed rule, we are using the wage index and labor-related share in a budget neutral manner by applying a wage index budget neutrality factor to the federal per diem base rate and ECT payment per treatment. Therefore, the budgetary impact to the Medicare program of this proposed rule will be due to the market basket update for FY 2019 of 2.8 percent (see section III.A.2 of this proposed rule) less the productivity adjustment of 0.8 percentage point required by section 1886(s)(2)(A)(i) of the Act; further reduced by the ''other adjustment'' of 0.75 percentage point under sections 1886(s)(2)(A)(ii) and 1886(s)(3)(E) of the Act; and the update to the outlier fixed dollar loss threshold amount.

We estimate that the FY 2019 impact will be a net increase of $50 million in payments to IPF providers. This reflects an estimated $60 million increase from the update to the payment rates and a $10 million decrease due to the update to the outlier threshold amount to set total estimated outlier payments at 2.0 percent of total estimated payments in FY 2019. This estimate does not include the implementation of the required 2.0 percentage point reduction of the market basket increase factor for any IPF that fails to meet the IPF quality reporting requirements (as discussed in section VI.A. of this proposed rule).

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 IPFs and most other providers and suppliers are small entities, either by nonprofit status or having revenues of $7.5 million to $38.5 million or less in any 1 year, depending on industry classification (for details, refer to the SBA Small Business Size Standards found at *http://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf*). Individuals and states are not included in the definition of a small entity.

Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IPFs or the proportion of IPFs' revenue derived from Medicare payments. Therefore, we assume that all IPFs are considered small entities.

The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 12, we estimate that the overall revenue impact of this proposed rule on all IPFs is to increase estimated Medicare payments by approximately 0.98 percent. As a result, since the estimated impact of this proposed rule is a net increase in revenue across almost all categories of IPFs, the Secretary has determined that this proposed rule will have a positive revenue 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. This analysis must conform to the provisions of section 603 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. As discussed in section IX.C.1. of this proposed rule, the rates and policies set forth in this proposed rule will not have an adverse impact on the rural hospitals based on the data of the 272 rural excluded psychiatric units and 67 rural psychiatric hospitals in our database of 1,636 IPFs for which data were available. Therefore, the Secretary has determined that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. Currently, that threshold is approximately $148 million. This proposed rule does not impose spending costs on state, local, or tribal governments in the aggregate, or by the private sector of $148 million or more.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This proposed rule will not have a substantial effect on state and local governments.

2. Impact on Providers

To show the impact on providers of the changes to the IPF PPS discussed in this proposed rule, we compare estimated payments under the IPF PPS rates and factors for FY 2019 versus those under FY 2018. We determined the percent change of estimated FY 2019 IPF PPS payments compared to FY 2018 IPF PPS payments for each category of IPFs. In addition, for each category of IPFs, we have included the estimated percent change in payments resulting from the update to the outlier fixed dollar loss threshold amount; the updated wage index data including the updated labor-related share; and the market basket update for FY 2019, as adjusted by the productivity adjustment according to section 1886(s)(2)(A)(i) of the Act, and the ''other adjustment'' according to sections 1886(s)(2)(A)(ii) and 1886(s)(3)(E) of the Act.

To illustrate the impacts of the FY 2019 changes in proposed rule, our analysis begins with a FY 2018 baseline simulation model based on FY 2017 IPF payments inflated to the midpoint of FY 2018 using IHS Global Inc.'s most recent forecast of the market basket update (see section III.A.2. of this proposed rule); the estimated outlier payments in FY 2018; the FY 2017 pre-floor, pre-reclassified hospital wage index; the FY 2018 labor-related share; and the FY 2018 percentage amount of the rural adjustment. During the simulation, total outlier payments are maintained at 2 percent of total estimated IPF PPS payments.

Each of the following changes is added incrementally to this baseline model in order for us to isolate the effects of each change:

- The proposed update to the outlier fixed dollar loss threshold amount.
- The FY 2018 pre-floor, pre-reclassified hospital wage index and the proposed FY 2019 labor-related share.
- The proposed market basket update for FY 2019 of 2.8 percent less the productivity adjustment of 0.8 percentage point in accordance with section 1886(s)(2)(A)(i) of the Act and further reduced by the ''other adjustment'' of 0.75 percentage point in accordance with sections 1886(s)(2)(A)(ii) and 1886(s)(3)(E) of the Act, for a proposed payment rate update of 1.25 percent.

Our final column comparison in Table 12 illustrates the percent change in payments from FY 2018 (that is, October 1, 2017, to September 30, 2018) to FY 2019 (that is, October 1, 2018, to September 30, 2019) including all the changes in this proposed rule.

TABLE 12—IPF IMPACTS FOR FY 2019

[Percent change in columns 3 through 6]

Facility by type	Number of facilities	Outlier	CBSA wage index and labor share	Payment update [1]	Total percent change [2]
(1)	(2)	(3)	(4)	(5)	(6)
All Facilities	1,636	−0.27	0.00	1.25	0.98
Total Urban	1,297	−0.27	0.04	1.25	1.02
Total Rural	339	−0.28	−0.26	1.25	0.70
Urban unit	826	−0.40	0.05	1.25	0.90
Urban hospital	471	−0.10	0.03	1.25	1.18
Rural unit	272	−0.36	−0.23	1.25	0.66
Rural hospital	67	−0.08	−0.36	1.25	0.81
By Type of Ownership:					
Freestanding IPFs:					
Urban Psychiatric Hospitals:					
Government	126	−0.37	0.10	1.25	0.98
Non-Profit	93	−0.10	0.08	1.25	1.23
For-Profit	252	−0.05	0.00	1.25	1.20
Rural Psychiatric Hospitals:					
Government	32	−0.20	0.49	1.25	1.53
Non-Profit	16	−0.10	−0.23	1.25	0.91
For-Profit	19	−0.01	−0.81	1.25	0.43
IPF Units:					
Urban:					
Government	117	−0.68	0.02	1.25	0.57
Non-Profit	537	−0.38	0.05	1.25	0.91
For-Profit	172	−0.26	0.08	1.25	1.07
Rural:					
Government	71	−0.45	−0.12	1.25	0.68
Non-Profit	144	−0.32	−0.28	1.25	0.64
For-Profit	57	−0.33	−0.22	1.25	0.69
By Teaching Status:					
Non-teaching	1,444	−0.23	0.03	1.25	1.04
Less than 10% interns and residents to beds	111	−0.40	−0.12	1.25	0.72
10% to 30% interns and residents to beds	60	−0.69	−0.12	1.25	0.43
More than 30% interns and residents to beds	21	−0.34	−0.31	1.25	0.60
By Region:					
New England	106	−0.28	−0.04	1.25	0.92
Mid-Atlantic	234	−0.34	0.05	1.25	0.96
South Atlantic	247	−0.15	−0.05	1.25	1.06
East North Central	271	−0.23	−0.19	1.25	0.82
East South Central	163	−0.30	−0.09	1.25	0.86
West North Central	132	−0.43	0.36	1.25	1.18
West South Central	245	−0.25	0.10	1.25	1.10
Mountain	107	−0.15	0.07	1.25	1.17
Pacific	131	−0.37	0.01	1.25	0.89

TABLE 12—IPF IMPACTS FOR FY 2019—Continued

[Percent change in columns 3 through 6]

Facility by type	Number of facilities	Outlier	CBSA wage index and labor share	Payment update [1]	Total percent change [2]
(1)	(2)	(3)	(4)	(5)	(6)
By Bed Size:					
Psychiatric Hospitals					
Beds: 0–24	87	−0.16	−0.33	1.25	0.76
Beds: 25–49	77	−0.06	0.03	1.25	1.21
Beds: 50–75	87	−0.25	−0.36	1.25	0.63
Beds: 76+	287	−0.06	0.12	1.25	1.31
Psychiatric Units					
Beds: 0–24	633	−0.43	0.02	1.25	0.84
Beds: 25–49	290	−0.37	0.16	1.25	1.04
Beds: 50–75	115	−0.36	−0.10	1.25	0.78
Beds: 76+	60	−0.39	−0.19	1.25	0.66

[1] This column reflects the payment update impact of the IPF market basket update for FY 2019 of 2.8 percent, a 0.8 percentage point reduction for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act, and a 0.75 percentage point reduction in accordance with sections 1886(s)(2)(A)(ii) and 1886(s)(3)(E) of the Act.

[2] Percent changes in estimated payments from FY 2018 to FY 2019 include all of the changes presented in this proposed rule. Note, the products of these impacts may be different from the percentage changes shown here due to rounding effects.

3. Impact Results

Table 12 displays the results of our analysis. The table groups IPFs into the categories listed here based on characteristics provided in the Provider of Services (POS) file, the IPF provider specific file, and cost report data from the Healthcare Cost Report Information System:

- Facility Type.
- Location.
- Teaching Status Adjustment.
- Census Region.
- Size.

The top row of the table shows the overall impact on the 1,636 IPFs included in this analysis. In column 3, we present the effects of the update to the outlier fixed dollar loss threshold amount. We estimate that IPF outlier payments as a percentage of total IPF payments are 2.27 percent in FY 2018. Thus, we are adjusting the outlier threshold amount in this proposed rule to set total estimated outlier payments equal to 2.00 percent of total payments in FY 2019. The estimated change in total IPF payments for FY 2019, therefore, includes an approximate 0.27 percent decrease in payments because the outlier portion of total payments is expected to decrease from approximately 2.27 percent to 2.0 percent.

The overall impact of this outlier adjustment update (as shown in column 3 of Table 12), across all hospital groups, is to decrease total estimated payments to IPFs by 0.27 percent. The largest decrease in payments is estimated to be a 0.69 percent decrease in payments for teaching hospitals with 10 to 30 percent interns and residents to beds.

In column 4, we present the effects of the budget-neutral update to the IPF wage index and the Labor-Related Share (LRS). This represents the effect of using the most recent wage data available and taking into account the updated OMB delineations. That is, the impact represented in this column reflects the update from the FY 2018 IPF wage index to the proposed FY 2019 IPF wage index, which includes the LRS update from 75.0 percent in FY 2018 to 74.8 percent in FY 2019. We note that there is no projected change in aggregate payments to IPFs, as indicated in the first row of column 4, however, there will be distributional effects among different categories of IPFs. For example, we estimate the largest increase in payments to be 0.49 percent for rural government psychiatric hospitals, and the largest decrease in payments to be 0.81 percent for for-profit rural psychiatric hospitals.

In column 5, we present the estimated effects of the proposed update to the IPF PPS payment rates of 1.25 percent, which are based on the 2012-based IPF market basket update of 2.8 percent, less the productivity adjustment of 0.8 percentage point in accordance with section 1886(s)(2)(A)(i) of the Act, and further reduced by 0.75 percentage point in accordance with sections 1886(s)(2)(A)(ii) and 1886(s)(3)(E) of the Act.

Finally, column 6 compares our estimates of the total proposed changes reflected in this proposed rule for FY 2019 to the estimates for FY 2018 (without these changes). The average estimated increase for all IPFs is approximately 0.98 percent. This estimated net increase includes the effects of the proposed 2.8 percent market basket update reduced by the productivity adjustment of 0.8 percentage point, as required by section 1886(s)(2)(A)(i) of the Act and further reduced by the ''other adjustment'' of 0.75 percentage point, as required by sections 1886(s)(2)(A)(ii) and 1886(s)(3)(E) of the Act. It also includes the overall estimated 0.27 percent decrease in estimated IPF outlier payments as a percent of total payments from the proposed update to the outlier fixed dollar loss threshold amount.

IPF payments are estimated to increase by 1.02 percent in urban areas and 0.70 percent in rural areas. Overall, IPFs are estimated to experience a net increase in payments as a result of the updates in this proposed rule. The largest payment increase is estimated at 1.53 percent for rural government psychiatric hospitals.

4. Effect on Beneficiaries

Under the IPF PPS, IPFs will receive payment based on the average resources consumed by patients for each day. We do not expect changes in the quality of care or access to services for Medicare beneficiaries under the FY 2019 IPF PPS, but we continue to expect that paying prospectively for IPF services will enhance the efficiency of the Medicare program.

5. Effects of Updates to the IPFQR Program

As discussed in section VI. of this proposed rule and in accordance with section 1886(s)(4)(A)(i) of the Act, we will implement a 2 percentage point

reduction in the FY 2020 annual update to the standard Federal rate for IPFs that have failed to comply with the IPFQR Program requirements for FY 2020. In section VI. of this proposed rule, we discuss how the 2 percentage point reduction will be applied. For FY 2018, of the 1,758 IPFs eligible for the IPFQR Program, 59 IPFs (3.4 percent) did not receive the full market basket update for failure to meet program requirements; of those 59, 24 chose not to participate in the program. We anticipate that even fewer IPFs would receive the reduction for FY 2020 as IPFs become more familiar with the requirements. Thus, we estimate that the policy to apply a 2 percentage point reduction to the annual update for the IPFs that have failed to comply with IPFQR Program requirements will have a negligible impact on overall IPF payments for FY 2020.

a. Effects Related to Information Collection Burden

Based on the proposals made in this rule, we estimate the total decrease in information collection burden to be 1,073.75 hours per IPF or 1,861,882.5 hours across all IPFs, resulting in a total decrease in financial burden of $39,277.78 per IPF or $68,107,661.85 across all IPFs. As discussed in section VII. of this proposed rule, we will attribute the savings associated with the proposals to the year in which these savings begin; for the purposes of all the proposals in this proposed rule, that year is FY 2018. Further information on these estimates can be found in section VII. of this proposed rule.

b. Effects other than Burden related to Information Collection

As stated in section VI.F.1.a and VII.A of the preamble of this rule, we anticipate that in addition to the reduction in information collection burden discussed above, there will be unrelated cost reduction associated with some of our proposals. One example of this cost reduction is that IPFs will no longer have to register with and maintain accounts with NHSN. Because of the administrative complexity of NHSN participation, we believe this will be a substantial reduction in costs. Furthermore, we believe that costs related to reviewing and tracking measure information in feedback reports will be reduced.

In addition to reducing costs to providers, we believe that our proposed policies may simplify use of IPFQR Program data for beneficiaries. For example, by no longer reporting data on both the Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0647) and the Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (NQF #1656), beneficiaries will still be able to identify IPFs that provide high quality discharge information with less data to analyze and evaluate.

Finally, we believe that by no longer maintaining data submission mechanisms, public reporting infrastructure, and program materials for measures which are no longer providing significant benefit, we will be able to better utilize CMS's resources to support quality reporting and quality improvement initiatives among IPFs.

We intend to closely monitor the effects of this quality reporting program on IPFs and help facilitate successful reporting outcomes through ongoing stakeholder education, national trainings, and a technical help desk.

6. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the proposed rule, we assume that the total number of unique commenters on the most recent IPF proposed rule from FY 2016 will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule. It is possible that not all commenters reviewed the FY 2016 IPF proposed rule in detail, and it is also possible that some reviewers chose not to comment on that proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this proposed rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule; therefore, for the purposes of our estimate, we assume that each reviewer reads approximately 50 percent of the proposed rule. We solicit public comments on this assumption.

Using the mean (average) wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this proposed rule is $105.16 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/2016/may/oes_nat.htm*). Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 1.10 hours for the staff to review half of this proposed rule. For each IPF that reviews the proposed rule, the estimated cost is $115.68 (1.10 hours × $105.16). Therefore, we estimate that the total cost of reviewing this proposed rule is $8,791.68 ($115.68 × 76 reviewers).

D. Alternatives Considered

The statute does not specify an update strategy for the IPF PPS and is broadly written to give the Secretary discretion in establishing an update methodology. Therefore, we are updating the IPF PPS using the methodology published in the November 2004 IPF PPS final rule; applying the proposed FY 2019 2012-based IPF PPS market basket update of 2.8 percent, reduced by the statutorily required multifactor productivity adjustment of 0.8 percentage point and the other adjustment of 0.75 percentage point, along with the proposed wage index budget neutrality adjustment to update the payment rates; proposing a FY 2019 IPF wage index which is fully based upon the latest OMB CBSA designations; and proposing changes to the IPF Quality Reporting Program.

E. Accounting Statement

As required by OMB Circular A–4 (available at *www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), in Table 13, we have prepared an accounting statement showing the classification of the expenditures associated with the proposed updates to the IPF wage index and payment rates in this proposed rule. Table 13 provides our best estimate of the increase in Medicare payments under the IPF PPS as a result of the changes presented in this proposed rule and based on the data for 1,636 IPFs in our database.

TABLE 13—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES

Change in Estimated Impacts from FY 2018 IPF PPS to FY 2019 IPF PPS:	
Category	Costs
Annualized Monetized Costs	−$68.1 million.
Category	Transfers
Annualized Monetized Transfers	$50 million.
From Whom to Whom?	Federal Government to IPF Medicare Providers.

F. Regulatory Reform Analysis Under Executive Order 13771

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017 and requires that the costs associated with significant new regulations ''shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.'' This proposed rule, if finalized, is considered an Executive Order 13771 deregulatory action. We estimate that this rule generates $59 million in annualized cost savings, discounted at 7 percent relative to year 2016, over a perpetual time horizon. This $59 million is equal to the estimated $68.1 million in annual cost savings which would begin in 2018, discounted to 2016 for Executive Order 13771 accounting purposes using a 7 percent discount rate. Details on the estimated costs of this rule can be found in the preceding and subsequent analyses.

G. Conclusion

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

X. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange Through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers

Currently, Medicare- and Medicaid-participating providers and suppliers are at varying stages of adoption of health information technology (health IT). Many hospitals have adopted electronic health records (EHRs), and CMS has provided incentive payments to eligible hospitals, critical access hospitals (CAHs), and eligible professionals who have demonstrated meaningful use of certified EHR technology (CEHRT) under the Medicare EHR Incentive Program. As of 2015, 96 percent of Medicare- and Medicaid-participating non-Federal acute care hospitals had adopted certified EHRs with the capability to electronically export a summary of clinical care.[18] While both adoption of EHRs and electronic exchange of information have grown substantially among hospitals, significant obstacles to exchanging electronic health information across the continuum of care persist. Routine electronic transfer of information post-discharge has not been achieved by providers and suppliers in many localities and regions throughout the nation.

CMS is firmly committed to the use of certified health IT and interoperable EHR systems for electronic healthcare information exchange to effectively help hospitals and other Medicare-and Medicaid-participating providers and suppliers improve internal care delivery practices, support the exchange of important information across care team members during transitions of care, and enable reporting of electronically specified clinical quality measures (eCQMs). The Office of the National Coordinator for Health Information Technology (ONC) acts as the principal federal entity charged with coordination of nationwide efforts to implement and use health information technology and the electronic exchange of health information on behalf of the Department of Health and Human Services.

In 2015, ONC finalized the 2015 Edition health IT certification criteria (2015 Edition), the most recent criteria for health IT to be certified to under the ONC Health IT Certification Program. The 2015 Edition facilitates greater interoperability for several clinical health information purposes and enables health information exchange through new and enhanced certification criteria, standards, and implementation specifications. CMS requires eligible hospitals and CAHs in the Medicare and Medicaid EHR Incentive Programs and eligible clinicians in the Quality Payment Program (QPP) to use EHR technology certified to the 2015 Edition beginning in CY 2019.

In addition, several important initiatives will be implemented over the next several years to provide hospitals and other participating providers and suppliers with access to robust infrastructure that will enable routine electronic exchange of health information. Section 4003 of the 21st Century Cures Act (Pub. L. 114–255), enacted in 2016, and amending section 3000 of the Public Health Service Act (42 U.S.C. 300jj), requires HHS to take steps to advance the electronic exchange of health information and interoperability for participating providers and suppliers in various settings across the care continuum. Specifically, Congress directed that ONC ''. . .for the purpose of ensuring full network-to-network exchange of health information, convene public-private and public-public partnerships to build consensus and develop or support a trusted exchange framework, including a common agreement among health information networks nationally.'' In January 2018, ONC released a draft version of its proposal for the Trusted Exchange Framework and Common Agreement,[19] which outlines principles and minimum terms and conditions for trusted exchange to enable interoperability across disparate health information networks (HINs). The Trusted Exchange Framework (TEF) is focused on achieving the following four important outcomes in the long-term:

- Professional care providers, who deliver care across the continuum, can access health information about their patients, regardless of where the patient received care.
- Patients can find all of their health information from across the care continuum, even if they do not remember the name of the professional care provider they saw.

[18] These statistics can be accessed at *https://dashboard.healthit.gov/quickstats/pages/FIG-Hospital-EHR-Adoption.php*.

[19] The draft version of the trusted Exchange Framework may be accessed at *https://beta.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement*).

• Professional care providers and health systems, as well as public and private health care organizations and public and private payer organizations accountable for managing benefits and the health of populations, can receive necessary and appropriate information on groups of individuals without having to access one record at a time, allowing them to analyze population health trends, outcomes, and costs; identify at-risk populations; and track progress on quality improvement initiatives.

• The health IT community has open and accessible application programming interfaces (APIs) to encourage entrepreneurial, user-focused innovation that will make health information more accessible and improve EHR usability.

ONC will revise the draft TEF based on public comment and ultimately release a final version of the TEF that will subsequently be available for adoption by HINs and their participants seeking to participate in nationwide health information exchange. The goal for stakeholders that participate in, or serve as, a HIN is to ensure that participants will have the ability to seamlessly share and receive a core set of data from other network participants in accordance with a set of permitted purposes and applicable privacy and security requirements. Broad adoption of this framework and its associated exchange standards is intended to both achieve the outcomes described above while creating an environment more conducive to innovation.

In light of the widespread adoption of EHRs along with the increasing availability of health information exchange infrastructure predominantly among hospitals, we are interested in hearing from stakeholders on how we could use the CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs (that is, the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation (RfPs) for Long-Term Care Facilities to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers. Specifically, CMS might consider revisions to the current CMS CoPs for hospitals such as: Requiring that hospitals transferring medically necessary information to another facility upon a patient transfer or discharge do so electronically; requiring that hospitals electronically send required discharge information to a community provider via electronic means if possible and if a community provider can be identified; and requiring that hospitals make certain information available to patients or a specified third-party application (for example, required discharge instructions) via electronic means if requested.

On November 3, 2015, we published a proposed rule (80 FR 68126) to implement the provisions of the IMPACT Act and to revise the discharge planning CoP requirements that hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Hospitals (IRFs), Inpatient Psychiatric Hospitals (IPFs), Children's Hospitals, and Cancer Hospitals), critical access hospitals (CAHs), and home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. However, several of the proposed requirements directly address the issue of communication between providers and between providers and patients, as well as the issue of interoperability:

• Hospitals and CAHs would be required to transfer certain necessary medical information and a copy of the discharge instructions and discharge summary to the patient's practitioner, if the practitioner is known and has been clearly identified;

• Hospitals and CAHs would be required to send certain necessary medical information to the receiving facility/post-acute care providers, at the time of discharge; and

• Hospitals, CAHs and HHAs, would need to comply with the IMPACT Act requirements that would require hospitals, CAHs, and certain post-acute care providers to use data on quality measures and data on resource use measures to assist patients during the discharge planning process, while taking into account the patient's goals of care and treatment preferences.

We published another proposed rule (81 FR 39448), on June 16, 2016, that updated a number of CoP requirements that hospitals and CAH must meet in order to participate in the Medicare and Medicaid programs. This proposed rule has not been finalized yet. One of the proposed hospital CoP revisions in that rule directly addresses the issues of communication between providers and patients, patient access to their medical records, and interoperability. We proposed that patients have the right to access their medical records, upon an oral or written request, in the form and format requested by such patients, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, including current medical records, within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.

We also published a final rule (81 FR 68688), on October 4, 2016, that revised the requirements that LTC facilities must meet to participate in the Medicare and Medicaid programs, where we made a number of revisions based on the importance of effective communication between providers during transitions of care, such as transfers and discharges of residents to other facilities or providers, or to home. Among these revisions was a requirement that the transferring LTC facility must provide all necessary information to the resident's receiving provider, whether it is an acute care hospital, a LTC hospital, a psychiatric facility, another LTC facility, a hospice, home health agency, or another community-based provider or practitioner. We specified that necessary information must include the following:

• Contact information of the practitioner responsible for the care of the resident;

• Resident representative information including contact information;

• Advance directive information;

• Special instructions or precautions for ongoing care;

• The resident's comprehensive care plan goals; and

• All other necessary information, including a copy of the resident's discharge or transfer summary and any other documentation to ensure a safe and effective transition of care.

We note that the discharge summary mentioned above must include reconciliation of the resident's medications, as well as a recapitulation of the resident's stay, a final summary of the resident's status, and the post-discharge plan of care. And in the preamble to the rule, we encouraged LTC facilities to electronically exchange this information if possible and to identify opportunities to streamline the collection and exchange of resident information by using information that the facility is already capturing electronically.

Additionally, we specifically invite stakeholder feedback on the following questions regarding possible new or revised CoPs/CfCs/RfPs for interoperability and electronic exchange of health information:

• If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?

• Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden? Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?

• Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?

• What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements? Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?

• Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?

• Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing Medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?

• Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?

• What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements?

We would also like to directly address the issue of communication between hospitals (as well as the other providers and suppliers across the continuum of patient care) and their patients and caregivers. MyHealthEData is a government-wide initiative aimed at breaking down barriers that contribute to preventing patients from being able to access and control their medical records. Privacy and security of patient data will be at the center of all CMS efforts in this area. CMS must protect the confidentiality of patient data, and CMS is completely aligned with the Department of Veterans Affairs (VA), the National Institutes of Health (NIH), ONC, and the rest of the federal government, on this objective.

While some Medicare beneficiaries have had, for quite some time, the ability to download their Medicare claims information, in pdf or Excel formats, through the CMS Blue Button platform, the information was provided without any context or other information that would help beneficiaries understand what the data was really telling them. For beneficiaries, their claims information is useless if it is either too hard to obtain or, as was the case with the information provided through previous versions of Blue Button, hard to understand. In an effort to fully contribute to the federal government's MyHealthEData initiative, CMS developed and launched the new Blue Button 2.0, which represents a major step toward giving patients meaningful control of their health information in an easy-to-access and understandable way. Blue Button 2.0 is a developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to secure applications, services, and research programs they trust. The possibilities for better care through Blue Button 2.0 data are exciting, and might include enabling the creation of health dashboards for Medicare beneficiaries to view their health information in a single portal, or allowing beneficiaries to share complete medication lists with their doctors to prevent dangerous drug interactions.

To fully understand all of these health IT interoperability issues, initiatives, and innovations through the lens of its regulatory authority, CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records. We also welcome the public's ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers. We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well.

We note that this is a Request for Information only. Respondents are encouraged to provide complete but concise and organized responses, including any relevant data and specific examples. However, respondents are not required to address every issue or respond to every question discussed in this Request for Information to have their responses considered. In accordance with the implementing regulations of the Paperwork Reduction Act at 5 CFR 1320.3(h)(4), all responses will be considered provided they contain information CMS can use to identify and contact the commenter, if needed.

This Request for Information is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This Request for Information

does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this Request for Information and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this Request for Information; all costs associated with responding to this Request for Information will be solely at the interested party's expense.

We note that not responding to this Request for Information does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this Request for Information announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this Request for Information. CMS will not respond to comment submissions in response to this Request for Information in the FY 2019 IPPS/LTCH PPS final rule. Rather, CMS will actively consider all input as we develop future regulatory proposals or future subregulatory policy guidance. CMS may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this Request for Information. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this Request for Information may be used by the Government for program planning on a nonattribution basis. Respondents should not include any information that might be considered proprietary or confidential.

This Request for Information should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. CMS may publically post the public comments received, or a summary of those public comments.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, and Reporting and recordkeeping requirements.

For reasons stated in the preamble of this document, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh); sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332); sec. 1206 of Pub. L. 113–67; sec. 112 of Pub. L. 113–93; sec. 231 of Pub. L. 114–113; and secs. 15004, 15006, 15007, 15008, 15009, and 15010 of Pub. L. 114–255.

■ 2. Section 412.27 is amended by revising paragraph (a) to read as follows:

§ 412.27 Excluded psychiatric units: Additional requirements.

* * * * *

(a) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the International Classification of Diseases, Tenth Revision, Clinical Modification.

* * * * *

■ 3. Section 412.402 is amended by revising the definition of ''Principal diagnosis'' to read as follows:

§ 412.402 Definitions.

* * * * *

Principal diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the inpatient psychiatric facility. Principal diagnosis is also referred to as the primary diagnosis.

* * * * *

■ 4. Section 412.428 is amended by revising the section heading, the introductory text, and paragraphs (a) and (b) to read as follows:

§ 412.428 Publication of changes to the inpatient psychiatric facility prospective payment system.

CMS will issue annually in the **Federal Register** information pertaining to changes to the inpatient psychiatric facility prospective payment system. This information includes:

(a) A description of the methodology and data used to calculate the federal per diem base payment amount for the subsequent fiscal year.

(b)(1) For discharges occurring on or after January 1, 2005 but before July 1, 2006, the update, described in § 412.424(a)(2)(iii), for the federal portion of the inpatient psychiatric facility's payments is based on the 1997-based excluded hospital with capital market basket under the applicable percentage increase methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(2)(i) For discharges occurring on or after July 1, 2006 but before October 1, 2015, the update for the federal portion of the inpatient psychiatric facility's payment is based on the rehabilitation, psychiatric, and long-term care market basket.

(ii) For discharges occurring on or after October 1, 2015, the update of the inpatient psychiatric facility's payment is based on the inpatient psychiatric facility market basket.

(3) For discharges occurring on or after January 1, 2005 but before October 1, 2005, the update, described in § 412.424(a)(2)(iii), for the reasonable cost portion of the inpatient psychiatric facility's payment is based on the 1997-based excluded hospital with capital market basket under the updated methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(4) For discharges occurring on or after October 1, 2005 but before July 1, 2008, the update for the reasonable cost portion of the inpatient psychiatric facility's payment is based on the 2002-based excluded hospital market basket.

* * * * *

Dated: April 16, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 17, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2018–09069 Filed 4–27–18; 4:15 pm]

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Part VI

International Trade Commission

19 CFR Parts 201 and 210

Rules of General Application, Adjudication and Enforcement; Final Rule

INTERNATIONAL TRADE COMMISSION

19 CFR Parts 201 and 210

Rules of General Application, Adjudication and Enforcement

AGENCY: International Trade Commission.

ACTION: Final rule.

SUMMARY: The United States International Trade Commission (''Commission'') amends its Rules of Practice and Procedure concerning rules of general application, adjudication, and enforcement. The amendments are necessary to make certain technical corrections, to clarify certain provisions, to harmonize different parts of the Commission's rules, and to address concerns that have arisen in Commission practice. The intended effect of the proposed amendments is to facilitate compliance with the Commission's Rules and improve the administration of agency proceedings.

DATES: Effective June 7, 2018. The rule amendments as stated herein shall apply to investigations instituted subsequent to the aforementioned date.

FOR FURTHER INFORMATION CONTACT: Megan M. Valentine, Office of the General Counsel, United States International Trade Commission, telephone 202–708–2301. Hearing-impaired individuals are advised that information on this matter can be obtained by contacting the Commission's TDD terminal at 202–205–1810. General information concerning the Commission may also be obtained by accessing its internet server at *http://www.usitc.gov.*

SUPPLEMENTARY INFORMATION:

Background

This rulemaking is an effort to improve provisions of the Commission's existing Rules of Practice and Procedure. The Commission proposed amendments to its rules covering investigations under section 337 of the Tariff Act of 1930 (19 U.S.C. 1337), as amended (''section 337''), in order to increase the efficiency of its section 337 investigations and reduce the burdens and costs on the parties and the agency.

The Commission published a notice of proposed rulemaking (''NPRM'') in the **Federal Register** at 80 FR 57553–64 (Sept. 24, 2015), proposing to amend the Commission's Rules of Practice and Procedure concerning rules of general application, adjudication, and enforcement to make certain technical corrections, to clarify certain provisions, to harmonize different parts of the Commission's rules, and to address concerns that have arisen in Commission practice. Consistent with its ordinary practice, the Commission invited the public to comment on all the proposed rules amendments. This practice entails the following steps: (1) Publication of an NPRM; (2) solicitation of public comments on the proposed amendments; (3) Commission review of public comments on the proposed amendments; and (4) publication of final amendments at least thirty days prior to their effective date.

The NPRM requested public comment on the proposed rules within 60 days of publication of the NPRM, *i.e.,* by November 23, 2015. The Commission received six sets of comments from organizations or law firms, including one each from the China Chamber of Commerce for Import and Export of Machinery and Electronic Products (''CCCME''); the ITC Trial Lawyers Association (''ITCTLA''); the Intellectual Property Owners Association (''IPOA''); the ITC Working Group (''ITCWG''); the Law Office of T. Spence Chubb (''Mr. Chubb''); and the law firm of Adduci, Mastriani, & Schaumberg LLP (''Adduci''). The ITCWG consists of industry participants, including Apple, Avaya, Broadcom, Cisco, Google, Hewlett Packard, Intel, and Oracle among others.

The Commission has carefully considered all comments that it received. The Commission's response is provided below in a section-by-section analysis. The Commission appreciates the time and effort of the commentators in preparing their submissions.

Regulatory Analysis of Amendments to the Commission's Rules

The Commission has determined that these rules do not meet the criteria described in section 3(f) of Executive Order 12866 (58 FR 51735, October 4, 1993) and thus do not constitute a ''significant regulatory action'' for purposes of the Executive Order.

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) is inapplicable to this rulemaking because it is not one for which a notice of proposed rulemaking is required under 5 U.S.C. 553(b) or any other statute. Although the Commission chose to publish a notice of proposed rulemaking, these regulations are ''agency rules of procedure and practice,'' and thus are exempt from the notice requirement imposed by 5 U.S.C. 553(b). Moreover, these regulatory amendments are certified as not having a significant economic impact on a substantial number of small entities.

These rules do not contain federalism implications warranting the preparation of a federalism summary impact statement pursuant to Executive Order 13132 (64 FR 43255, August 10, 1999).

No actions are necessary under title II of the Unfunded Mandates Reform Act of 1995, Public Law 104–4 (2 U.S.C. 1531–1538) because the rules will not result in the expenditure by state, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more in any one year (adjusted annually for inflation), and will not significantly or uniquely affect small governments.

These rules are not ''major rules'' as defined by section 251 of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*). Moreover, they are exempt from the reporting requirements of that Act because they contain rules of agency organization, procedure, or practice that do not substantially affect the rights or obligations of non-agency parties.

These rules do not contain any information collection requirements subject to the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*).

Overview of the Amendments to the Regulations

The final regulations contain eleven (11) changes from the proposals in the NPRM. These changes are summarized here.

First, with regard to rule 201.16(f), relating to electronic service by parties, the Commission has determined that the rule should clarify that the administrative law judge may indicate by order what means are acceptable to ensure the document to be served is securely stored and transmitted by the serving party in a manner that prevents unauthorized access and/or receipt by individuals or organizations not authorized to view the specified confidential business information.

Second, the Commission has determined to amend proposed rule 210.10(a)(6) to remove the stated criteria by which the Commission may determine to institute multiple investigations from a single complaint and substitute the single consideration of efficient adjudication.

Third, the Commission has determined to amend proposed rule 210.10(b)(1) to clarify that the notice of investigation will define the scope of the investigation in plain language so as to make explicit what accused products or category of accused products will be the subject of the investigation in accordance with rule 210.12(a)(12), which governs the contents of the complaint.

Fourth, the Commission has determined to amend proposed rule 210.10(b)(3) to clarify that an initial determination ruling on a potentially dispositive issue in a 100-day proceeding is due within 100 days of institution of an investigation so designated. The rule is also amended to clarify that the presiding administrative law judge is authorized, in accordance with section 210.36, to hold expedited hearings on any such designated issue and will also have discretion to stay discovery of any remaining issues during the pendency of the 100-day proceeding.

Fifth, the Commission has determined to amend proposed rule 210.14(h) to clarify that an administrative law judge may determine to sever an investigation into two or more investigations at any time prior to or upon thirty days from institution of the investigation. The rule will also clarify that severance may be based upon a motion from any party. The administrative law judge's decision to sever will be in the form of an order. The newly severed investigation(s) shall remain with the same presiding administrative law judge unless the severed investigation is reassigned at the discretion of the chief administrative law judge. The new severed investigation(s) will be designated with a new investigation number. The final rule also removes limiting criteria for an administrative law judge to sever an investigation beyond the consideration of efficient adjudication.

Sixth, with regard to proposed rule 210.14(i), the Commission has determined that administrative law judges will not be able to designate potentially dispositive issues for inclusion in a 100-day proceeding following institution of an investigation. Therefore, proposed rule 210.14(i) will not appear in the final rules.

Seventh, the Commission has determined to amend proposed rule 210.15 to clarify that the rule is intended to prohibit the filing of any motions before the Commission during preinstitution proceedings except with respect to motions for temporary relief filed under rule 210.53.

Eighth, regarding proposed rule 210.22, the Commission has determined that administrative law judges will not be able to designate potentially dispositive issues for inclusion in a 100-day proceeding following institution of an investigation. Therefore, proposed rule 210.22, which allows parties for file a request for such designation by motion, will not appear in the final rules.

Ninth, regarding proposed rule 210.32(d)(1), the Commission has determined to amend the proposed rule to clarify that a party may serve subpoena objections within the later of 10 days after receipt of the subpoena or within such time as the administrative law judge may allow. In addition, the proposed rule is amended to clarify that, if an objection is made, the party that requested the subpoena may move for a request for judicial enforcement upon reasonable notice to other parties or as otherwise provided by the administrative law judge who issued the subpoena. Similarly, the Commission has determined to amend proposed rule 210.32(d)(2) to clarify that a party may file a motion to quash a subpoena within the later of 10 days after receipt of the subpoena or within such time as the administrative law judge may allow.

Tenth, regarding proposed rule 210.42(a)(3), because the Commission has determined not to implement proposed rule 210.14(i) allowing administrative law judges to designate potentially dispositive issues, the Commission has determined to remove all references to proposed rule 210.14(i) in the final version of rule. In addition, because the administrative law judges may sever investigations by order, the Commission has determined not to adopt proposed rule 210.42(c)(3). The Commission has also determined to add rule 210.42(h)(7) to specify that an initial determination issued pursuant to proposed rule 210.42(a)(3) will become the Commission's final determination 30 days after issuance, absent review.

Eleventh, regarding the proposed amendments to rule 210.43, the Commission has determined to amend proposed rule 210.43(a)(1) to clarify that petitions for review of an initial determination ruling on a potentially dispositive issue must be filed within five business days after service of the initial determination. The Commission has also determined to amend proposed rule 210.43(c) to clarify that the time for filing responses to petitions for review is five business days.

A comprehensive explanation of the rule changes is provided in the section-by-section analysis below. The section-by-section analysis includes a discussion of all modifications suggested by the commentators. As a result of some of the comments, the Commission has determined to modify several of the proposed amendments, including deleting certain sections in the final rule as summarized above. The section-by-section analysis will refer to the rules as they appeared in the NPRM.

Section-by-Section Analysis

19 CFR Part 201

Subpart B—Initiation and Conduct of Investigations

Section 201.16

Section 201.16 provides the general provisions for service of process and other documents. Section 201.16(a)(1) through (3) address allowed methods of service by the Commission and § 201.16(a)(4) addresses when such service is complete. In consideration of the Commission's development of the capability to perfect electronic service, the NPRM proposed amending § 201.16(a)(1) and (4) to provide that the Commission may effect service through electronic means. Under the proposed rule, electronic service would be complete upon transmission of a notification from the Commission that the document has been placed in an appropriate secure repository for retrieval by the person, organization representative, or attorney being served, unless the Commission is notified that the notification was not received by the party served.

In addition, § 201.16(f) authorizes parties to serve documents by electronic means. The NPRM proposed amending § 201.16(f) to require parties serving documents by electronic means to ensure that any such document containing confidential business information subject to an administrative protective order be securely transmitted, in addition to being securely stored, to prevent unauthorized access and/or receipt by individuals or organizations not authorized to view the specified confidential business information. All documents must currently be filed electronically by way of the Commission's Electronic Document Information System pursuant to § 201.8(d).

201.16(a)(1) and (4)

Comments

Adduci generally supports the Commission's efforts to effect electronic service. Adduci cautions, however, that allowing electronic service of process or documents on unrepresented parties may lead to notification issues, particularly with respect to service of complaints on named respondents, and result in due process challenges. Adduci proposes accordingly that the Commission delay electronic service until after the entity being served is represented by an attorney. Specifically, Adduci proposes the following language for § 201.16(a)(1):

By mailing or delivering a copy of the document to the person to be served, to a member of the partnership to be served, to the president, secretary, other executive officer, or member of the board of directors of the corporation, association, or other organization to be served, or, if an attorney represents any of the above before the Commission, by mailing, delivering, or serving by electronic means a copy to such attorney. . . .

The CCCME expresses concern with the statement in the proposed amendments to § 201.16(a)(4) that electronic service by the Commission is completed upon transmission of a notification from the Commission that the service document has been placed in an appropriate secure repository for retrieval by the appropriate party being served. The CCCME requests that § 201.16(a)(4) be worded to state explicitly that electronic service shall be made to the destination designated by the person, organization, representative or attorney being served rather than being placed in an unspecified repository for retrieval.

Commission Response

The Commission considers Adduci's concerns to be adequately addressed by the proposed amendment of § 201.16(a)(1) as stated in the NPRM. The proposed rule indicates that service is to be by mailing, delivery, or electronic service as appropriate. If the Commission is unable to effect electronic service because it lacks a viable email address or other electronic contact information for the intended recipient, then service would be by mailing or delivery. Before an investigation is instituted, the Commission typically does not have electronic contact information for proposed respondents or their representatives. Moreover, proposed respondents usually retain counsel before filing answers to the complaint and providing relevant contact information. As such, electronic service on a party before it retains counsel would be rare. If a party is in default, and thus never provides electronic contact information, the Commission would be unable to effect electronic service on that party.

Regarding the CCCME's comments concerning proposed rule 201.16(a)(4), the language requiring that any electronically served documents be placed in an appropriate repository for retrieval is purposely broad to encompass any secure service option, such as two-factor identification for a drop box. In order to avoid confusion and being overwhelmed with individual requests, the Commission declines to accommodate private party requests for specific service destinations unique to that party.

201.16(f)

Comments

The ITCTLA generally supports the proposed amendments to § 201.16, but expresses concern regarding the clarity of the proposed amendment to § 201.16(f). Specifically, the ITCTLA questions the vagueness of the requirement that service documents ''be securely stored and transmitted by the serving party in a manner that prevents unauthorized access and/or receipt by individuals or organizations not authorized to view the specified confidential business information.'' The ITCTLA notes that the administrative protective order and stipulations between the parties often describe the manner in which to secure and transmit electronic service of documents, and that administrative law judges and parties can continue to designate the manner of such transmission. The ITCTLA does, however, state that it ''expects that the proposed language though vague provides sufficient flexibility for the parties and administrative law judges to delineate what it means to 'be securely stored and transmitted.' ''

The IPOA expresses similar concerns that the proposed language of § 201.16(f) lacks detail sufficient to inform parties how to comply with the requirement that service documents be securely stored and transmitted. The IPOA suggests that the proposed rule could be improved by clarifying whether stipulations among the parties describing a manner of service satisfactory to all parties will satisfy the requirements of proposed rule 201.16(f).

The ITCWG generally supports the proposed amendments to § 201.16, but expresses concern that the provision in § 201.16(f) stating that parties ''may serve documents by electronic means in all matters before the Commission'' could be construed to improperly include service of third-party subpoenas. The ITCWG asserts that service of third-party subpoenas should continue to adhere to current Commission practice to better ensure actual notification to the subpoenaed party in a timely manner.

The CCCME also expresses concern regarding the meaning of ''securely transmitted'' in proposed rule 201.16(f).

Mr. Chubb questions the need for the additional language in proposed rule 201.16(f) requiring secure transmission and storage when parties are effecting electronic service of confidential documents. Mr. Chubb notes that § 201.16(f) has permitted parties to serve documents, including confidential documents, electronically since 2002 apparently without significant problems. Mr. Chubb suggests the Commission identify the problem with the current rule and address the details by which it expects parties to comply with the new procedures, as well as any additional burdens the new procedures will place on parties beyond those currently experienced. Mr. Chubb further suggests that, in the alternative, the Commission forgo any change to § 201.16(f) in favor of current practice.

Commission Response

Regarding the ITCTLA's and IPOA's concerns about the vagueness of the language in proposed rule 201.16(f), the ITCTLA is correct that the language is intended to encompass future improvements in technology. However, the Commission agrees that the proposed rule would benefit by specifying that the administrative law judge may indicate by order what means are acceptable. Regarding the ability of parties to stipulate as to the means of secure transmission or storage, any such stipulation would require approval by the administrative law judge, as the parties may suggest means that are not sufficiently secure. Furthermore, as to the CCCME's comment, the requirement that documents be ''securely transmitted'' is intended to require parties to ensure transmitted documents are properly encrypted or otherwise formatted to prevent unauthorized access. The Commission does not consider further clarification necessary. Parties are reminded that, if they fail to properly safeguard confidential business information or business proprietary information, they may be subjected to investigations concerning the disclosure of any such information and that sanctions may be imposed for a breach of the administrative protective order.

Concerning the ITCWG's comments, the Commission agrees that service of third-party subpoenas may not be effected by electronic means. Service of third-party subpoenas may only be effected by mail or delivery.

Lastly, regarding Mr. Chubb's comments, the proposed amendments are intended to capture the realities of continuing improvements in processes and technology for transmitting information. The Commission is making efforts to continually safeguard confidential business information and business proprietary information, and the rules should reflect this intent while ensuring that parties using new technology are cognizant of the

Commission's concerns regarding the safekeeping of confidential information. Participants in Commission proceedings are reminded of their obligations to comply with Administrative Protective Orders (APOs) and that breaches of APOs are subject to serious sanctions. *See* 19 CFR 210.34; 82 FR 29322 (June 28, 2017).

19 CFR Part 210

Subpart C—Adjudication and Enforcement

Section 210.10

Section 337(b)(1) states that the ''Commission shall investigate any alleged violation of this section on complaint under oath or upon its initiative.'' 19 U.S.C. 1337(b)(1). Accordingly, § 210.10 provides for institution of section 337 investigations by the Commission based upon a properly filed complaint. *See* 19 CFR 210.10(a). The NPRM proposed adding § 210.10(a)(6) to clarify that the Commission may institute multiple investigations based on a single complaint where necessary to limit the number of technologies and/or unrelated patents asserted in a single investigation.

In addition, § 210.10(b) provides that, when instituting an investigation, the Commission shall issue a notice defining the scope of the investigation, including whether the Commission has ordered the presiding administrative law judge to take evidence and to issue a recommended determination concerning the public interest. The NPRM proposed adding § 210.10(b)(1) to provide that the notice of investigation will specify in plain language the accused products that will be within the scope of the investigation in order to avoid disputes between the parties concerning the scope of the investigation. New § 210.10(b)(2) contains the existing language in § 210.10(b), which provides that the Commission may order the presiding administrative law judge to take evidence concerning the public interest.

The Commission has established a ''100-day'' proceeding to provide for the disposition of potentially dispositive issues within a specified time frame following institution of an investigation. The NPRM proposed adding § 210.10(b)(3) to authorize the Commission to direct the presiding administrative law judge to issue an initial determination pursuant to new § 210.42(a)(3), as described below, on a potentially dispositive issue as set forth in the notice of investigation. The specified time frame for issuance of the initial determination is subject to an extension of time for good cause shown. As set forth in the pilot program, the presiding administrative law judge will have discretion to stay discovery of all other issues during the pendency of the 100-day proceeding.

The Commission notes that the 100-day proceeding differs from a summary determination in that the administrative law judge's ruling pursuant to this section is made following an evidentiary hearing. These changes are intended to provide a procedure for the early disposition of potentially dispositive issues identified by the Commission at institution of an investigation. This procedure is not intended to affect summary determination practice under section 210.18 whereby the administrative law judge may dispose of one or more issues in the investigation when there is no genuine issue as to material facts and the moving party is entitled to summary determination as a matter of law.

Section 210.10(a)(6)

Comments

ITCTLA supports the Commission's ability to institute multiple investigations based on a single complaint where necessary to limit the number of unrelated technologies and/or unrelated patents asserted in a single investigation. ITCTLA notes, however, that where the same parties, same or similar accused products, same or similar domestic industry products, or same or similar defenses are presented or implicated by a single complaint, the scope of discovery, relevant issues and administration of the case may so overlap that instituting multiple investigations may lead to increased costs on the parties and use of Commission resources, or create inconsistencies or conflict between investigations, even notwithstanding technically different asserted patent families. The ITCTLA further notes that the circumstance is rare where a single complaint presents such different technologies and issues that institution of multiple investigations or severance of an investigation is in the best interest of the timely and efficient investigation of the complaint. ITCTLA proposed the following amended language for § 210.10(a)(6):

The Commission may determine to institute multiple investigations based on a single complaint where necessary to *allow efficient adjudication and* limit the number of *unrelated* technologies *and products* and/or unrelated patents asserted in a single investigation.

The IPOA comments that the proposed amendments addressing the Commission's ability to institute multiple investigations from a single complaint are unnecessary given the existing, inherent power of administrative law judges to manage their dockets and limit the issues to be decided. The IPOA cautions that this power, including for example, requiring parties to present their cases within an allotted time, limiting the number of pages for witness statements, and limiting the amount of time allowed for live direct testimony, could be compromised by a requirement to split any complaint that fails to satisfy certain, currently unarticulated criteria. The IPOA does, however, propose that clear, enumerated factors governing multiple institutions should be indicated in the rule in order to provide notice to potential parties. The IPOA also suggests that the rules clarify whether a decision to institute multiple investigations can be appealed.

The CCCME suggests that the rules be amended to allow respondents to submit a request for severance of an investigation and to object when the Commission determines to sever an investigation. The CCCME also proposes that the Commission provide detailed requirements for severing investigations (or instituting multiple investigations from a single complaint) to avoid abuse of the provision.

Adduci expresses some skepticism about the need for proposed rule 210.10(a)(6), noting that administrative law judges are already adept at handling multiple-technology, multi-patent investigations and that issues are typically streamlined by the time the evidentiary hearing is held though discovery and other mechanisms, such as *Markman* proceedings. Adduci, however, recommends that the Commission provide the criteria it will consider in evaluating whether to institute multiple investigations based on a single complaint, noting that without such guidance, complainants will face difficulty in determining which technologies and patents to assert in a complaint.

Adduci also notes that the proposed amendment provides no procedure to allow a complainant to avoid institution of multiple investigations under the proposed rule. Adduci contends this failure is potentially problematic as a complainant may not have the resources to litigate simultaneous investigations or may prefer to focus its efforts on a single investigation. Adduci notes that, even if a complainant were to withdraw and/or modify its complaint, there is no procedure through which it may learn what changes are necessary to avoid institution of simultaneous

investigations. Adduci therefore proposes including a provision through which the Commission would notify the complainant of the specific bases that, unless modified, may result in institution of multiple investigations. Adduci further recommends modifying the proposed rule to provide the complainant an opportunity, prior to institution, to either withdraw and refile its complaint or to modify its complaint to avoid institution of multiple investigations. Adduci recommends that the Commission provide two weeks' notice to a complainant that it intends to institute multiple investigations and identify how the patents and/or technologies would be split. Adduci recommends that the Office of Unfair Import Investigations could then be consulted and could advise the complainant on how to best modify its complaint to avoid institution of multiple investigations.

Mr. Chubb generally supports the Commission having the authority to institute multiple investigations based on a single complaint. He also suggests the Commission consider whether § 210.10(a) should additionally be amended to authorize the Commission to institute consolidated investigations. Mr. Chubb notes that existing § 210.10(g) provides for post-institution consolidation, but that the rules do not provide for pre-institution consolidation. Mr. Chubb asserts that, as with situations involving the institution of multiple investigations from a single complaint, pre-institution consolidation would likely be rare. Mr. Chubb notes, however, that the Commission has experienced situations where there have been two pending complaints by a single complainant, and situations where there were two pending complaints by cross-parties. Mr. Chubb also notes that there have been newly filed complaints for which consolidation with an already instituted investigation would be appropriate. Mr. Chubb requests that if his proposed consolidation scheme cannot be considered in this rulemaking that his suggestions be considered for future rulemaking efforts.

Commission Response

Several commentators question the necessity of the proposed amendment to rule 210.10(a)(6), arguing that even where cases are complex, overlapping issues may require a single investigation. Several of the commentators further assert that the administrative law judges already have the ability to handle complex investigations without the need for the Commission preemptively determining to institute multiple investigations from a single complaint. Assuming the Commission decides to adopt this provision, the commentators are nearly unanimous in stating that the proposed rule should state the criteria by which the Commission will determine to institute multiple investigations pursuant to the proposed rule.

Only the ITCTLA proposed any language suggesting any such criteria, *i.e.,* that the Commission will institute multiple investigations ''where necessary to allow efficient adjudication and limit the number of unrelated technologies and products and/or unrelated patents in a single investigation.'' Other commentators appear to prefer more precise enumerated criteria, rather than the more open-ended formulation the ITCTLA suggests.

The Commission has determined to implement rule 210.10(a)(6) with the clarification that the Commission may determine to institute multiple investigations based on a single complaint for efficient adjudication. The Commission considers that providing specific criteria for applying the rule would be unduly restrictive and hamper the Commission's flexibility with respect to managing investigations. The Commission, however, notes that instituting multiple investigations based on a single complaint would likely occur where the complaint alleges a significant number of unrelated technologies, diverse products, unrelated patents, and/or unfair methods of competition or unfair acts such that the resulting investigation, if implemented as one case, may be unduly unwieldy or lengthy.

Several commentators also suggest that the Commission provide complainant(s) with notice when the Commission intends to institute multiple investigations and to allow complainant(s) to withdraw and refile a modified complaint to avoid multiple investigations. Requiring such notice, however, would hinder the Commission's ability to institute investigations within 30 days as stated in rule 210.10(a)(1). Furthermore, rule 210.14(g) allows the Commission to consolidate investigations, providing a procedural mechanism to reunify investigations instituted based on a single complaint under appropriate circumstances.

The Commission expects, however, that the Office of Unfair Import Investigations (''OUII'') will raise the issue of possible multiple investigations with complainants as part of the pre-institution draft complaint review process when these concerns are apparent from the draft complaint. OUII may also suggest modification of the draft complaint during any pre-filing communications to avoid the institution of multiple investigations. While the Commission anticipates the issue may arise during the pre-institution complaint review process, the Commission will independently determine *sua sponte* whether multiple investigations are appropriate.

IPOA requests that the proposed rule be clarified to indicate whether parties can appeal or object to the Commission's decision to institute multiple investigations based on a single complaint. Assuming IPOA believes that the decision should be appealable to the U.S. Court of Appeals for the Federal Circuit (''Federal Circuit''), under section 337(c), the Commission notes that any decision to institute multiple investigations based on a single complaint is not a final determination on violation, making immediate appeal to the Federal Circuit unavailable. If the complainant objects to the Commission's decision to institute multiple investigations, there are procedural mechanisms available to the complainant, such as a motion to terminate one or more of the multiple investigations or claims.

Concerning Mr. Chubb's comment that the Commission should allow pre-institution consolidation of investigations, consideration of such a rule is best tabled until the Commission undertakes a future rulemaking effort.

Section 210.10(b)(1)

Comments

ITCTLA generally supports the Commission's effort to provide notice and avoid disputes regarding the scope of the investigation. ITCTLA, however, cautions that the language of the proposed rule, *i.e.* ''such plain language as to make explicit what accused products will be subject of the investigation,'' is unclear. Specifically, ITCTLA asserts that it is unclear whether the phrase ''plain language'' relates to the requirement in current § 210.12(a)(12) of a ''clear statement in plain English of the category of products accused . . . such as mobile devices, tablets, or computers,'' or ''explicit . . . accused products'' refers more specifically to, for example, specific model names or numbers. ITCTLA proposes the following amended language for § 210.10(b)(1) to address the potential confusion:

An investigation shall be instituted by the publication of a notice in the **Federal Register**. The notice will define the scope of the investigation in such plain language as to

make explicit what accused products *or category of accused products provided in accordance with § 210.12(a)(12)* will be the subject of the investigation, and may be amended as provided in § 210.14(b) and (c).

The IPOA supports proposed rule 210.10(b)(1) to the extent it narrows the variety of products potentially falling within the caption of an investigation to more readily identifiable categories of products, including downstream products. The IPOA, however, questions the meaning of the phrase ''such plain language as to make explicit what accused products will be the subject of the investigation.'' Similar to the ITCTLA, the IPOA suggests replacing this phrase in proposed rule 210.10(b)(1) with language borrowed from § 210.12(a)(12) concerning the requirement that a complaint ''contain a clear statement in plain English of the category of product accused'' to avoid potential inconsistencies.

The IPOA specifically notes that it does not support interpreting the ''plain language'' phrase as requiring model numbers, which it asserts would be inconsistent with the scope of relief afforded under the trade laws and with longstanding Commission practice. The IPOA also suggests that to the extent the proposed rule is intended to narrow the scope of the notice of investigation in order to narrow discovery, administrative law judges should be permitted to extend discovery beyond the scope of the notice of investigation for good cause shown. Accordingly, the IPOA suggests the following amendments to the proposed rule:

An investigation shall be instituted by the publication of a notice in the **Federal Register**. The notice will define the scope of the investigation in such plain language, *consistent with the requirement to provide in the Complaint a clear statement in plain English of the category of products accused pursuant to 19 CFR 210.12(a)(12),* as to make explicit what *one or more* accused *categories* of products will be the subject of the investigation, and may be amended as provided in 210.14(b) and (c). *Discovery beyond the scope of the investigation will be by leave of the administrative law judge for good cause shown.*

The ITCWG supports the proposed rule of § 210.10(b)(1) concerning specifying the scope of the investigation in plain language, noting that currently, complainants often seek improper discovery on product types that have not been formally accused. The ITCWG suggests, however, that the Commission may wish to consider modifying the proposed language to provide that the ''type of accused products'' be specified in the notice and, in particular, requiring that when software is accused, the notice of investigation should enumerate the specific software at issue (*e.g.,* Marshmallow) rather than merely defining the investigation in terms of devices (*e.g.,* smartphones).

The CCCME proposes that the description of the scope of an investigation includes the product code of the named respondents' alleged infringing product to avoid ambiguity.

Adduci recommends amending the proposed rule to clarify that the **Federal Register** notice should identify the categories of accused products rather than specific accused products. Adduci asserts that its proposed amendment would bring proposed rule 210.10(b)(1) in line with existing rule 210.12(a)(12), which requires that a complaint ''[c]ontain a clear statement in plain English of the category of products accused.'' *See* 19 CFR 210.1012(a)(12). Adduci suggests, in order to avoid inconsistencies between the complaint and the **Federal Register** notice of institution, that the notice use the same plain language as used in the complaint to define the categories of accused products. Adduci suggests the following amendments to proposed rule 210.10(b)(1):

An investigation shall be instituted by the publication of a notice in the **Federal Register**. The notice will define the scope of the investigation in such plain language as to make explicit what *categories of* accused products will be the subject of the investigation, and may be amended as provided in § 210.14(b) and (c).

Mr. Chubb discourages implementation of proposed rule 210.10(b)(1), asserting that the rule change would merely add a layer of regulatory complexity to what he calls a straightforward and routine process. Mr. Chubb contends that imposing a formulaic plain language requirement will not prevent disputes from arising as to what the scope of an investigation might be or the burden on the administrative law judge to resolve such disputes. Mr. Chubb cautions that the proposed rule is likely to create confusion by raising questions as to whether the language of the complaint itself continues to play a role in such determinations, especially in view of existing rule 210.12(a)(12), which requires a complainant to describe the accused products in the complaint with ''a clear statement in plain English of the category of products accused.'' *See* 19 CFR 210.12(a)(12). Mr. Chubb asserts that nothing in the current rules constrains the Commission's ability to describe the accused products in whatever language it determines is the most appropriate, including ''plain language'' that makes explicit what the accused products are.

Commission Response

The majority of the commentators support adding the requirement to rule 210.10(b)(1) that the notice of investigation specify the scope of the investigation in plain language. Moreover, most of the commentators suggest that the proposed rule align with the current requirements in rule 210.12(a)(12), which requires the complaint to ''[c]ontain a clear statement in plain English of the category of products accused.'' 19 CFR 210.12(a)(12). In order to align the scope of the investigation stated in the notice of investigation with the statement concerning the scope as stated in the complaint, the Commission has determined to amend proposed rule 210.10(b)(1) to explicitly specify the correlation between that rule and 210.12(a)(12).

The Commission rejects IPOA's suggestion that discovery ''beyond the scope of the investigation be permitted for good cause'' as it is not clear what IPOA means by ''beyond the scope of the investigation.''

The Commission has considered ITCWG's suggestion to require that the notice of investigation indicate specific types of software, and the CCCME's suggestion that the notice indicate specific product codes. Requiring the notice of investigation to indicate accused products by specific names or model numbers does not comport with Commission practice. In particular, the Commission has long held that its remedies apply to any infringing product, not simply the products specifically adjudicated during an investigation. *See, e.g., Certain Ground Fault Circuit Interrupters and Products Containing the Same,* Inv. No. 337–TA–615, Comm'n Op. (Pub. Version) at 27 (Mar. 26, 2009), *rev'd on other grounds, General Protecht Group, Inc.* v. *Int'l Trade Comm'n,* 619 F.3d 1303 (Fed. Cir. 2010). Identifying accused products with such specificity invites the risk of unduly restricting the scope, not only of an investigation, but also of any potential remedy the Commission may issue at the conclusion of that investigation.

210.10(b)(3)

Comments

The IPOA indicates that it generally supports the proposed rule changes involving the 100-day proceeding and that it does not support limiting by example the types of issues that may be designated as potentially dispositive.

With respect to the statement in the NPRM concerning proposed § 210.10(b)(3) which provides that administrative law judges will have discretion to stay discovery during the pendency of a 100-day proceeding, the IPOA asserts that it is critical that the rules provide for a mandatory stay during the pendency of the proceeding and during any subsequent Commission review. Otherwise, the IPOA cautions, a party subject to a 100-day proceeding faces both a fast-track discovery/hearing on the potentially dispositive issue as well as the normal requirements of Commission discovery on other issues. The IPOA suggests the following amended language for proposed § 210.10(b)(3):

> The Commission may order the administrative law judge to issue an initial determination as provided in § 210.42(a)(3)(i) and (ii) ruling on a potentially dispositive issue as set forth in the notice of investigation. *The presiding administrative law judge is authorized, in accordance with section 210.36, to hold expedited hearings on any such designated issue and will also have discretion to stay discovery during the pendency of the 100-day proceeding.*

The Commission notes that, although the IPOA argues for a mandatory stay of the remainder of the investigation, the language it proposes leaves the decision to stay within the administrative law judge's discretion.

The ITCWG generally supports implementation of the 100-day proceeding in the rules and urges that the procedure be used in a greater number of cases. The ITCWG does not provide any specific comments concerning the proposed language of § 210.10(b)(3). The ITCWG does, however, note that the proposed rules do not require a stay of discovery on non-designated issues during pendency of a 100-day proceeding or during Commission review of the administrative law judge's initial determination on the designated issue. Although the ITCWG acknowledges the comment in the NPRM that the administrative law judge has discretion to stay discovery during the pendency of a 100-day proceeding and subsequent Commission review, the ITCWG contends that any final rule should provide for a mandatory stay. The ITCWG cautions that otherwise, a party subject to a 100-day proceeding faces both fast-track discovery and a hearing on the 100-day issue, as well as the task of conducting normal discovery on the remaining issues, thus increasing the burden and expense of the investigation.

The ITCTLA cautions that many of the provisions associated with the proposed 100-day proceeding present significant problems and invite abuse. The ITCTLA asserts that administrative law judges already have sufficient discretion to consider potentially dispositive or otherwise significant issues on an expedited basis at their discretion and that the proposed amendments may unintentionally invite abuse or hamstring, rather than enlarge, the discretion of the administrative law judges on these issues. The ITCTLA notes the use of *Markman* hearings, during which judges may, at their discretion, take evidence, and where the schedule is set in the judge's discretion, taking into account the particulars of the investigation. The ITCTLA also notes former Chief Judge Luckern's practice of requesting written submissions by the parties on issues of particular concern prior to the evidentiary hearing. The ITCTLA further notes that Judge Lord has issued an order to show cause regarding domestic industry in a situation where the issue was potentially dispositive. The ITCTLA notes that instituting a specific single mechanism for the resolution of potentially dispositive issues may lead to the perception that administrative law judges lack the discretion to address dispositive issues at their own discretion and timeline.

The ITCTLA also asserts that the occasions where a 100-day proceeding would be needed to dispose of an investigation early would be very rare, the potential for abuse in the majority of investigations would be great, and such proceedings would impose an increased burden on administrative law judges at the beginning of most investigations. Moreover, the ITCTLA asserts, were it to become increasingly common to address such issues as domestic industry or validity at the preliminary stages of an investigation, the increased number of hearings and the multi-stage discovery, as well as the resultant delay in proceeding with the investigation should the designated issue not dispose of the investigation, creates a strong potential for increased burden on the resources of the Commission and the parties, likely requiring the extension of target dates.

The ITCTLA also notes that the Commission has not identified what constitutes a ''potentially dispositive issue'' and that it is unclear whether the issue must be capable of disposing of an entire investigation or whether, for example, lack of domestic industry on a subset of asserted patents would qualify. The ITCTLA also notes the Commission's statement that the proposed 100-day proceeding differs from summary determination in that the ruling is made following an evidentiary hearing, but cautions that this procedure would increase the number of evidentiary hearings, necessarily duplicating the efforts of the parties and resources of the Commission, while delaying the progress of the investigation.

The ITCTLA concludes that it does not support the addition of a specific mechanism, apart from that set forth in proposed rule 210.10(b)(3) and currently permitted through motions for summary determination and the inherent discretion of the administrative law judges, for the resolution of potentially dispositive issues. Rather, the ITCTLA recommends, administrative law judges should be permitted to continue to exercise their discretion in the timing and conduct of proceedings to address such issues, including any additional hearings. While providing no direct comment on the wording of proposed rule 210.10(b)(3), the ITCTLA urges the Commission to reserve the 100-day proceeding for issues and investigations where it is apparent that the abbreviated proceeding is likely to dispose of the investigation. The ITCTLA cautions that extensive use of the procedure would otherwise delay discovery and proceeding to the merits of investigations for three months, which would also have the effect of extending target dates.

Commission Response

As summarized above, the IPOA and ITCWG generally support the Commission's effort to codify its 100-day program, but request that the rules provide for a mandatory stay of the remainder of the case during pendency of the 100-day proceeding rather than leaving a stay to the discretion of the administrative law judge. The ITCTLA, on the other hand, argues that the 100-day program is unnecessary since administrative law judges already have ability to consider potentially dispositive issues on an expedited basis, for example, through the use of *Markman* proceedings or summary determinations. The ITCTLA asserts that use of the proposed 100-day proceeding could lead to the perception that the administrative law judges lack the authority to address dispositive issues at their own discretion and timeline. However, a purpose of the new rule is to provide the administrative law judges with an additional tool to efficiently adjudicate investigations. Administrative law judges will continue to have all the means currently at their disposal to adjudicate investigations as appropriate.

The Commission notes the ITCTLA's concern regarding the administrative

burden on the administrative law judges, Commission, and parties with respect to additional discovery, hearings, and delay. However, the 100-day proceeding is intended to adjudicate only issues which would entirely dispose of an investigation rather than to decide subsidiary issues, which are best addressed under other available procedures, such as the current summary determination procedure. As such, the types of issues appropriate for the 100-day proceeding are limited. However, identifying in the rules every potential issue that may be appropriate for a 100-day proceeding would unduly restrict the Commission's ability to designate any issue it deems suitable and appropriate. Accordingly, the final rule specifies that a potentially dispositive issue is one that would dispose of the entire investigation without enumerating specific issues that would qualify.

Regarding whether the Commission should impose a mandatory stay of the remainder of the investigation during pendency of a 100-day proceeding, the Commission has decided to leave any stays within the discretion of the administrative law judges. As such, the Commission declines to impose a mandatory stay as requested by the IPOA and ITCWG.

Section 210.11

Section 210.11—in particular, § 210.11(a)—provides that the Commission will, upon institution of an investigation, serve copies of the nonconfidential version of the complaint and the notice of investigation upon the respondent(s), the embassy in Washington, DC of the country in which each respondent is located, and various government agencies. Section 210.11(a)(2) concerns service by the Commission when it has instituted temporary relief proceedings. The NPRM proposed amending § 210.11(a)(2)(i) to clarify that the Commission will serve on each respondent a copy of the nonconfidential version of the motion for temporary relief, in addition to the nonconfidential version of the complaint and the notice of investigation.

No comments concerning the proposed amendments to rule 210.11 were received. The Commission has therefore determined to adopt proposed rule 210.11(a)(2)(i) as stated in the NPRM with a typographical correction.

Section 210.12

Section 210.12 specifies the information that must be included in a complaint requesting institution of an investigation under part 210. In particular, § 210.12(a)(9) details the information a complaint is required to include when alleging a violation of section 337 with respect to the infringement of a valid and enforceable U.S. patent. The NPRM proposed amending § 210.12(a)(9) by adding the requirement that complaints include the expiration date of each asserted patent.

No comments concerning the proposed amendments to rule 210.12 were received. The Commission has therefore determined to adopt proposed rule 210.12(a)(9) as stated in the NPRM.

Section 210.14

Section 210.14 provides for various pre- and post-institution actions, including amending the complaint and notice of investigation, making supplemental submissions, introducing counterclaims, providing submissions on the public interest, and consolidating investigations. The NPRM proposed amending section 210.14 to add paragraph (h), allowing the administrative law judge to sever an investigation into two or more investigations at any time prior to or upon issuance of the procedural schedule, based upon either a motion or upon the administrative law judge's judgment that severance is necessary to allow efficient adjudication. The Commission sought in particular comments regarding whether the administrative law judge's decision to sever should be in the form of an initial determination pursuant to new § 210.42(c)(3) or an order.

The NPRM also proposed adding § 210.14(i), which would authorize the administrative law judge to issue an order designating a potentially dispositive issue for an early ruling under the 100-day procedure. The proposed rule would also provide authority for the presiding administrative law judge to hold expedited hearings on such dispositive issues in accordance with § 210.36.

Section 210.14(h)

Comments

The IPOA notes several potential ''unintended consequences'' of the proposed severance rule, including: increased motions practice; motions for severance filed for the purpose of administrative law judge shopping; potential inconsistencies or conflicts in the results of severed investigations; inefficiency due to assigning severed cases to different administrative law judges with differing procedural schedules; and increased cost. The IPOA also notes that severance, presumably by an administrative law judge after institution, ''would not only require a change to the notice of investigation, but also would warrant continuing the practice of Commission review.'' Moreover, the IPOA proposes that clear, enumerated factors governing severance should be indicated in the rule in order to provide notice to potential parties.

The IPOA also suggests that the rule should not tie the ability of a party to file a motion to sever an investigation pursuant to proposed rule 210.14(h) with issuance of the procedural schedule. The IPOA cautions that doing so could delay issuance of the procedural schedule for a considerable time while the severance motion is briefed and considered by the administrative law judge. The IPOA notes that the rule should also clarify whether severance begins with the administrative law judge's order or after the Commission affirms, and how any severed investigations will be identified (*e.g.,* with new numbers or by adding a, b, c, etc. to the end of the original investigation number). In addition, the IPOA contends that, consistent with current practice, motions impacting the notice of investigation be rendered by initial determination, an administrative law judge's decision to sever an investigation should be issued as an initial determination pursuant to current § 210.42(c)(1).

The ITCTLA supports allowing administrative law judges to sever an investigation where necessary to allow efficient adjudication. The ITCTLA cautions, however, that where parties, accused products, asserted domestic industry products, and asserted defenses presented in a complaint are similar, even notwithstanding technically different asserted patent families or different technologies, the scope of discovery, issues, and administration of the case may so overlap that severing an investigation into multiple investigations may lead to increased costs to the parties, more use of Commission resources, and/or create inconsistencies between investigations. The ITCTLA states that only in rare circumstances would a single complaint present such different technologies and issues that severance of an investigation would best serve the timely and efficient investigation of the complaint.

As such, the ITCTLA cautions that the proposed rule may unintentionally encourage motions to sever, creating additional workload on administrative law judges at the onset of investigations. In addition, the ITCTLA expresses concern that an administrative law judge presiding over severed

investigations would presumably create procedural schedules that either unduly push one investigation forward more quickly or else delays the second investigation. The ITCTLA also cautions that the need for multiple hearings, subpoenas, and motions where the parties are otherwise the same will likely create inefficiencies and possibly extend target dates. ITCTLA posits that, where issues are so dissimilar as to warrant multiple investigations, the complainant will likely itself limit or separate complaints or the Commission can address severance pre-institution. The ITCTLA also suggests the Commission provide guidelines or identify factors supporting severance in the commentary accompanying the final rule.

Regarding the Commission's request for comments addressing whether the administrative law judge's decision to sever should be in the form of an initial determination or an order, the ITCTLA recommends that an order would be most appropriate so as to eliminate the time it takes to petition for review in the interest of expediting the investigation. The ITCTLA recommends the following amendment to proposed rule 210.14(h):

> The administrative law judge may determine to sever an investigation into two or more investigations at any time prior to or upon thirty days from institution, based upon either a motion or upon the administrative law judge's own judgment that severance is necessary to allow efficient adjudication and limit the number of unrelated technologies and products and/or unrelated patents asserted in a single investigation. The administrative law judge's decision will be in the form of an [initial determination] order [pursuant to 210.41(c)(3)].

The ITCWG insists that proposed rule 210.14(h) is unnecessary as the Commission and administrative law judges have had no difficulties severing and consolidating investigations where appropriate. The ITCWG cautions that the proposed rule may have several unintended consequences, for example, inviting motions for severance and, thus, leading to increased motions practice. The ITCWG notes that the potential increase could be exacerbated by the proposed rule's silence as to whether severed cases stay with the originally assigned administrative law judge, and that, if not, the rule could invite motions for severance that are actually attempts at ''administrative law judge shopping.''

The ITCWG suggests certain changes to proposed rule 210.14(h). Specifically, the ITCWG notes the proposed rule requires that the presiding administrative law judge make decisions on severance prior to issuance of the procedural schedule. The ITCWG argues this requirement could delay issuance of the procedural schedule for a considerable time while a severance motion is briefed and considered by the administrative law judge. Furthermore, the ITCWG asserts, it is unclear whether severance would begin with issuance of the administrative law judge's initial determination or after the Commission has affirmed the judge's ruling. The ITCWG also notes that the proposed rule leaves unclear what standard would apply in determining whether patents and technology are sufficiently related. The ITCWG states that reference to the Federal Rules of Civil Procedure may provide guidance, but neglects to identify any specific rules the Commission should consider. Lastly, the ITCWG notes that the Commission should indicate how severed cases would be designated, such as with a new investigation number or with a suffix to the existing investigation number (*e.g.* by adding a, b, c, etc. to the end of the original investigation number).

The CCCME requests that proposed rule 210.14(h) be amended to explicitly allow a respondent to file a motion to sever an investigation. The CCCME also suggests that the proposed rule should state clearly whether, after severance, the investigations will be presided over by the same administrative law judge. The CCCME further suggests the Commission provide detailed requirements for severance to avoid abuse of this procedure.

Although Mr. Chubb generally supports implementation of proposed rule 210.14(h), he cautions that the procedure laid out in the proposed rule (and presumably proposed rule 210.22) would open up the early stages of many investigations to an influx of motions to sever with corresponding uncertainty, which could potentially disrupt the orderly initiation of the discovery process and other aspects of early case development. Mr. Chubb does note, however, that the same concern could be applied to the judge's authority to consolidate cases under existing § 210.14(g), which has not in fact proven to be problematic. Specifically, Mr. Chubb points out that § 210.14(g) authorizes administrative law judges to consolidate investigations only where both investigations are already before the same judge, making cases where it might have applicability quite rare. Mr. Chubb asserts that this limitation would not be relevant in cases of severance, arguably making the applicability of severance more prevalent.

With respect to whether the administrative law judge's decision to sever should be in the form of an order or an initial determination, Mr. Chubb suggests the decision should be by initial determination since severance significantly impacts the fundamental scope of one or more investigations, as well as the number of investigations the Commission undertakes. Mr. Chubb asserts that these are matters on which the Commission should automatically have a say. Lastly, Mr. Chubb suggests that instead of the currently proposed requirement that an administrative law judge determine whether to sever an investigation ''at any time prior to or upon issuance of the procedural schedule,'' that the proposed rule set a deadline of 30 days after publication of the notice of investigation. Mr. Chubb notes that the issuance of a procedural schedule is completely within a judge's discretion and influenced by numerous factors which affect the timing of when such orders are issued and may vary widely from investigation to investigation.

Commission Response

The majority of the commenters agree that the administrative law judges should be able to sever investigations where a large number of technologies or unrelated patents are at issue. However, the commenters do note that the proposed rule could lead to increased motions practice and resultant delay. Several commenters request that the Commission provide criteria for severance under the rule, presumably suggesting any such criteria be consistent with proposed rule 210.10(a)(6). A majority of the commenters disagree with tying severance to issuance of the procedural schedule, with Mr. Chubb suggesting the Commission require the administrative law judge to act within of 30 days after publication of the notice of investigation. Lastly, the commenters express no consensus regarding whether the administrative law judge's decision to sever should be in the form of an order or an initial determination.

As with proposed rule 210.10(a)(6), the Commission declines to impose any rigid criteria for when an administrative law judge might determine that severing an investigation is appropriate. Rather, the Commission notes that severance may be appropriate where, for example, the complaint alleges a significant number of unrelated technologies, diverse products, unrelated patents, and/or unfair methods of competition and unfair acts such that the resulting investigation, if it proceeds as a single case, would be unduly unwieldy or lengthy.

Regarding whether the administrative law judge should issue a severance decision by order or initial determination, the ITCTLA suggests the administrative law judge should issue an order, while Mr. Chubb recommends the administrative law judge issue an initial determination. The ITCWG does not explicitly state a preference, but its response seems to assume that the administrative law judge would issue an initial determination. While the Commission agrees with Mr. Chubb's point that severance of an investigation is a significant event, the Commission disagrees that it fundamentally impacts the scope of an investigation since no part of the complaint would be limited or broadened. Rather, only the administrative aspect of the investigation would be affected, which should not require Commission approval beyond the Commission's initial decision to institute an investigation based on the complaint. The Commission has therefore amended proposed rule 210.14(h) to allow the presiding administrative law judge to sever an investigation by order.

Mr. Chubb suggests a requirement that an administrative law judge decide whether to sever an investigation within 30 days after publication of the notice of investigation, noting that the timing for issuance of a procedural schedule varies with each investigation. The Commission agrees that the timing of the administrative law judge's decision to sever should be predictable. The final rule provides that an administrative law judge may determine to sever an investigation at any time prior to or upon thirty days from institution of the investigation.

Lastly, the ITCWG and CCCME request clarification regarding whether newly severed investigations will be assigned to new administrative law judges and how severed investigations will be designated. Regarding the first point, the final rule provides that the ''new'' investigation(s) will be assigned to the same administrative law judge unless the severed case is reassigned at the discretion of the chief administrative law judge. Moreover, if the Commission has delegated public interest fact finding to the administrative law judge in an investigation, the delegation shall continue to be in effect for any ''new'' investigations resulting from severance. In addition, the newly severed investigation(s) will be designated with a new investigation number.

Section 210.14(i)

Comments

The IPOA argues against adoption of a rule providing that a 100-day proceeding may be designated post-institution *sua sponte* by the administrative law judge. The IPOA cautions that the administrative law judge is unlikely to be in a better position than the Commission to make an assessment concerning which issue(s) are appropriate for early disposition 30 days into an investigation. The IPOA further notes a conflict between proposed rules 210.14(i) and 210.22 in that the former allows an administrative law judge 30 days after institution to designate a potentially dispositive issue for early determination, while the latter allows parties to bring a motion for such designation within 30 days of institution. The IPOA suggest that it would be better if the rules stated that parties may bring a motion to designate, or the judge may designate *sua sponte,* within 30 days of institution, and to add a second deadline by which the judge must rule after a motion is fully briefed.

The ITCWG notes a potential conflict between proposed rules 210.14(i) and 210.22 in that, since proposed rule 210.14(i) allows the administrative law judge 30 days after institution to designate an issue for early disposition it could arguably prevent the administrative law judge from ruling on a motion pursuant to proposed rule 210.22 after 30 days. The ITCWG suggests that, if the rules are implemented, the Commission should import 210.14(i) into 210.22, noting that parties may bring a motion to designate, or the judge may designate *sua sponte,* within 30 days.

The ITCTLA argues that the circumstance where a dispositive issue is not raised before the Commission prior to institution, thus enabling the Commission to designate the issue pre-institution pursuant to proposed rule 210.10(b)(3), would suggest that the issue is not amenable to early identification and resolution. As such, the ITCTLA implies that administrative law judges should not be able to designate an issue post-institution, as enabled by proposed rule 210.14(i). The ITCTLA also suggests clarifying the interaction between proposed rules 210.14(i) and 210.22.

Adduci cautions that it is unclear whether proposed rules 210.14(i) and 210.22 can coexist in the present form. Adduci suggests that, if the parties are permitted a certain period of time during which they may move for an order designating a potentially dispositive issue for an early ruling, the administrative law judge's authority to issue such an order needs to exist for some time period thereafter. Adduci notes, however, that there should be a reasonable deadline for any such order, whether requested by the parties or issued *sua sponte.* To address the inconsistency, Adduci recommends that the Commission extend the administrative law judge's authority beyond the current proposal of 30 days, for example, allowing the judge 45 days to issue an order designating an issue for early disposition, which would allow the judge 15 days to rule on a motion filed on the last day of the 30-day window. Alternatively, Adduci suggests the deadline for parties to file a motion could be shortened, providing parties up to 21 days to file a motion under proposed rule 210.22 and setting a 14-day deadline (from the date of filing) for the administrative law judge to rule on the motion. Adduci notes this would allow parties up to three weeks to prepare and file a motion, while allowing the administrative law judge two full weeks to set a briefing schedule, consider the motion, and issue an order.

Adduci suggests that the Commission should retain the 30-day limit allowing an administrative law judge to designate an issue for early disposition *sua sponte* pursuant to proposed rule 210.14. Adduci notes, however, that it is unclear whether the Commission actually intended to give the administrative law judge authority to issue an order designating a potentially dispositive issue for an early ruling *sua sponte,* or whether such an order would need to be in response to a party's motion under proposed rule 210.22 (discussed below). Adduci requests that the Commission amend proposed rule 210.14(i) to explicitly clarify its intent.

Mr. Chubb recommends that the Commission decline to enact proposed rule 210.14(i) until it has more experience with 100-day proceedings. Mr. Chubb asserts that providing administrative law judges with the authority to designate an issue for early disposition is likely to trigger disruptive motions practice with negative consequences, similar to his comments below with respect to proposed rule 210.22. Mr. Chubb cautions that this disruption may outweigh the marginal utility of providing administrative law judges with the authority to designate, *sua sponte,* potentially dispositive issues for early determination. Mr. Chubb notes that judges retain the authority to grant summary determination motions and the discretion to hold claim construction

hearings and to make claim construction rulings prior to any final evidentiary hearing.

Commission Response

Of the three comments submitted regarding proposed rule 210.14(i), two caution against implementation of the rule, although for slightly different reasons. After further consideration and in view of the concerns expressed by the commentators, the Commission has determined not to implement proposed rule 210.14(i) at this time.

Section 210.15

Section 210.15 provides the procedure and requirements for motions during the pendency of an investigation and related proceedings, whether before an administrative law judge or before the Commission. The proposed rule would amend § 210.15(a)(2) to clarify that this provision does not allow for motions, other than motions for temporary relief, to be filed with the Commission prior to institution of an investigation.

Comments

Mr. Chubb states that the proposed amendment to § 210.15(a)(2) fails to clarify that rule 210.15 is not intended to allow pre-institution motions other than those for temporary relief. Rather, Mr. Chubb states that the proposed language leaves the rule ambiguous as to whether the proposed parties or others are permitted to file motions prior to institution. Mr. Chubb also asserts that the proposed rule mistakenly cites to current rule 210.52, which concerns motions for temporary relief filed with a complaint, and should instead cite to rule 210.53, which concerns motions for temporary relief filed after a complaint is filed but before the Commission determines to institute an investigation based on the complaint. Mr. Chubb suggests proposed rule 210.15(a)(2) be reworded as follows to directly state that motions are not permitted prior to institution, except for motions for temporary relief:

> When an investigation or related proceeding is before the Commission, all motions shall be addressed to the Chairman of the Commission. All motions shall be filed with the Secretary and shall be served upon each party. Motions may not be filed during a preinstitution proceeding except for motions for temporary relief as prescribed by § 210.53.

Mr. Chubb also suggests that, in a future rulemaking, the Commission rescind Commission rule 210.53 noting that the rule is seldom if ever invoked because situations where circumstances warranting temporary relief arise only between the filing of the complaint and institution 30 days later are almost inconceivable. Mr. Chubb further asserts that the rule runs contrary to the Commission's goal of providing maximum notice and disclosure to proposed respondents and the public that temporary relief is being sought by a complainant.

Commission Response

The Commission agrees with Mr. Chubb that the current wording of proposed rule 210.15(a)(2) should be clarified to indicate that the rule is intended to prohibit the filing of any motions before the Commission during preinstitution proceedings except with respect to motions for temporary relief filed under 210.53. The Commission has determined to amend proposed rule 210.15(a)(2) accordingly.

Section 210.19

Section 210.19 provides for intervention in an investigation or related proceeding. The NPRM proposed amending § 210.19 to clarify that motions to intervene may be filed only after institution of an investigation or a related proceeding.

No comments concerning the proposed amendments to rule 210.19 were received. The Commission has therefore determined to adopt proposed rule 210.19 as stated in the NPRM.

Section 210.21

Section 210.21(b)(2) and (c)(2) authorize the presiding administrative law judge to grant by initial determination motions to terminate an investigation due to settlement or consent order, respectively. The paragraphs further provide that the Commission shall notify certain government agencies of the initial determination and the settlement agreement or consent order. Those agencies include the U.S. Department of Health and Human Services, the U.S. Department of Justice, the Federal Trade Commission, the U.S. Customs Service (now U.S. Customs and Border Protection), and such other departments and agencies as the Commission deems appropriate.

Currently, the Commission effects such notice through various electronic means, including posting a public version of the initial determination and public versions of any related settlement agreements or consent orders on its website. The proposed rule would amend § 210.21(b)(2) and (c)(2) to clarify that the Commission need not otherwise specifically notify the listed agencies regarding any such initial determination and related settlement agreements or consent orders. This change is intended to conserve Commission resources and does not relieve the Commission of its obligation under section 337(b)(2) to consult with and seek advice and information from the indicated agencies as the Commission considers appropriate during the course of a section 337 investigation. The Commission has consulted with the agencies in question and they have not requested that the Commission provide direct notice beyond its current practice.

In addition, § 210.21(c)(3) sets out the required contents of a consent order stipulation while § 210.21(c)(4) sets out the required contents of the consent order. The proposed rule would amend § 210.21(c)(3)(ii)(A) to conform to § 210.21(c)(4)(x), which requires that the consent order stipulation and consent order contain a statement that a consent order shall not apply to any intellectual property right that has been held invalid or unenforceable or to any adjudicated article found not to infringe the asserted right or found no longer in violation by the Commission or a court or agency of competent jurisdiction in a final, nonreviewable decision. The proposed rule would also amend § 210.21(c)(4)(viii) to add the phrase ''any asserted patent claims,'' delete the phrase ''the claims of the asserted patent,'' delete the second occurrence of the word ''claims,'' and add the word ''claim'' after ''unfair trade practice'' in the phrase ''validity or enforceability of the claims of the asserted patent claims . . . unfair trade practice in any administrative or judicial proceeding to enforce the Consent Order[.]'' The proposed rule would further amend § 210.21(c)(4)(x) to add the word ''asserted'' before ''claim of the patent. . .'' and to add the word ''claim'' after ''or unfair trade practice . . .'' The proposed rule also would add new § 210.21(c)(4)(xi) to require in the consent order an admission of all jurisdictional facts, similar to the provision requiring such a statement in the consent order stipulation (210.21(c)(3)(i)(A)).

Comments

Adduci notes that, while having no specific comments on or issues with the proposed amendments to § 210.21, it has some concerns with the rule which are not addressed by the proposed amendments. In particular, Adduci notes that § 210.21(c)(4) states that the ''Commission will not issue consent orders with terms beyond those provided for in this section, and will not issue consent orders that are inconsistent with this section.'' Adduci asserts that the language of the rule

suggests that the Commission may issue consent orders that use language different from what is included in the rule so long as the proposed consent order does not contain any additional ''terms'' and is not inconsistent with the rule. Adduci states that the word ''terms'' could be interpreted either to mean the specific words used in the rule or to mean the general provisions of a consent order outlined in § 210.21(c)(3).

Adduci notes that, in recent practice, the administrative law judges and the Commission have interpreted rule 210.21(c)(4) to mean that the language of a proposed consent order must mirror the exact language of the Commission rule (except where otherwise specifically permitted). Adduci cautions that, while this is a reasonable interpretation of the rule, some parties may not be aware of this practice, and extensive public and private resources are sometimes wasted negotiating and reviewing proposed consent orders that differ from the rules and are ultimately deemed noncompliant. Adduci recommends the Commission consider amending the language of rule 210.21(c)(4) to clarify its intent, stating, for example, that the ''Commission will not issue consent orders with language that differs from that provided for in this section, except where specifically permitted.'' Adduci further suggests the Commission clarify which portions of the consent order can differ from the prescribed language of the rule, such as when addressing disposition of existing inventory. Additionally, Adduci suggests the Commission remove the language stating that it will not issue consent orders that are inconsistent with the rules, arguing that such language is unnecessary since, under the recommended amendments, the rules would already limit the consent order to the prescribed language. Adduci recommends that, in lieu of its suggested amendments, to the extent the Commission will permit deviation from the specific language of rule 210.21(c)(3), the Commission should make clear in which sub-paragraphs it will permit alternate language.

Commission Response

The wording of proposed rule 210.21 is clear that the language of the consent order must be consistent with the language of the consent order stipulation except where otherwise specifically permitted. Because the amendments Adduci suggests were not part of the current rulemaking effort, the Commission has determined to reserve them for future consideration. No comments were received concerning the currently proposed amendments to rule 210.21. The Commission has therefore determined to adopt proposed rule 210.21 substantially as stated in the NPRM.

Section 210.22

The proposed rule would add new § 210.22 to allow parties to file a motion within 30 days of institution of the investigation requesting the presiding administrative law judge to issue an order designating a potentially dispositive issue for an early ruling. The proposed rule would also provide authority for the presiding administrative law judge to hold expedited hearings on such issues in accordance with § 210.36.

Comments

The IPOA argues against adoption of a rule providing that a 100-day proceeding may be designated post-institution by motion. The IPOA cautions that parties are unlikely to be in a better position than the Commission to make an assessment concerning which issue(s) are appropriate for early disposition 30 days into an investigation. The IPOA also asserts that the potential flood of unnecessary motions will take significant administrative law judge and attorney time and could contribute to overall delay. As discussed above, the IPOA further notes a conflict between proposed rules 210.14(i) and 210.22 in that the former allows an administrative law judge 30 days after institution to designate a potentially dispositive issue for early determination, while the latter allows parties to bring a motion for such designation within 30 days of institution. The IPOA suggest that it would be better if the rules stated that parties may bring a motion to designate, or the judge may designate *sua sponte,* within 30 days of institution, and to add a second deadline by which the judge must rule after a motion is fully briefed.

The ITCWG expresses concern that proposed rule 210.22 may invite motions practice that will have no meaningful benefit. Specifically, the ITCWG cautions that it is unlikely that parties or the administrative law judge will be in a better position in the first 30 days of an investigation to assess whether an issue is suitable for early disposition than the Commission will be during its pre-institution review. The ITCWG notes, for example, that even if the parties were to serve discovery on potentially dispositive issues immediately upon institution, responses would not be due until after the expiration of the 30-day period. The ITCWG also notes that the proposed 30-day period for filing a motion to designate an issue for early disposition would effectively foreclose the ability of intervenors to move for assignment in the program given the time a motion for intervention takes to be adjudicated. As discussed above, The ITCWG further notes a potential conflict between proposed rules 210.14(i) and 210.22 in that, since proposed rule 210.14(i) allows the administrative law judge 30 days after institution to designate an issue for early disposition it would likely prevent the administrative law judge from ruling on a motion filed 30 days after institution pursuant to proposed rule 210.22. The ITCWG suggests that, if the rules are implemented, the Commission should import § 210.14(i) into § 210.22, noting that parties may bring a motion to designate, or the judge may designate *sua sponte,* within 30 days.

The ITCTLA cautions that, under proposed rule 210.22, many parties will move for the designation of a potentially dispositive issue, even where the issue is likely to be fact-intensive and has historically been examined in the regular course of an investigation. The ITCTLA further warns that such motions create the risk of burdening the administrative law judge with significant motion practice at the onset of many, if not most, investigations.

As noted above, The ITCTLA also suggests clarifying the interaction between proposed rules 210.14(i) and 210.22. The ITCTLA states that, if the administrative law judge must rule on a motion pursuant to proposed rule 210.22 within the 30-day time limit of proposed rule 210.14(i), the deadline for filing such a motion should be sufficiently early to allow the other party to respond and the judge to rule within that timeframe. The ITCTLA notes that, if the administrative law judge is not bound by the time limit indicated in proposed rule 210.14(i), then there appears to be no time limit for ruling on a motion under proposed rule 210.22. In that case, the ITCTLA suggests that proposed rule 210.22 be changed to require the motion to be filed early enough to provide the opposing party an opportunity to respond and to give the administrative law judge an opportunity to rule on the motion in a similar timeframe as set forth in proposed rule 210.14(i). Accordingly, the ITCTLA suggests that proposed rule 210.22 require a moving party to file its request within 14 days of institution of an investigation and that the opposing party be given seven days to respond, allowing the administrative law judge to issue an order within the 30-day time limit set forth in proposed rule 210.14(i).

As noted above, Adduci also cautions that it is unclear whether proposed rules 210.14(i) and 210.22 can coexist in the present form. Adduci suggests that, if the parties are permitted a certain period of time during which they may move for an order designating a potentially dispositive issue for an early ruling, the administrative law judge's authority to issue such an order needs to exist for some time period thereafter. Adduci notes, however, that there should be a reasonable deadline for any such order, whether requested by the parties or issued *sua sponte.* To address the inconsistency, Adduci recommends that the Commission extend the administrative law judge's authority beyond the current proposal of 30 days, for example, allowing the judge 45 days to issue an order designating an issue for early disposition, which would allow the judge 15 days to rule on a motion filed on the last day of the 30-day window. Alternatively, Adduci suggests the deadline for parties to file a motion could be shortened. Adduci cautions, however, that the Commission should be mindful that immediately following institution, many respondents are locating and evaluating counsel and have little time to assess the merits of the case, including whether there is a potentially dispositive issue appropriate for an early ruling. As such, Adduci notes that the Commission should exercise caution in shortening the time during which a party may file a motion under proposed rule 210.22 for an order designating an issue for early disposition.

As a way to balance the concerns of allowing parties sufficient time to retain counsel and determine potentially dispositive issues with ensuring that the administrative law judge has sufficient time to set a briefing schedule and rule on such a motion, Adduci suggests providing parties up to 21 days to file a motion under proposed rule 210.22 and setting a 14-day deadline (from the date of filing) for the administrative law judge to rule on the motion. Adduci notes this would allow parties up to three weeks to prepare and file a motion, while allowing the administrative law judge two full weeks to set a briefing schedule, consider the motion, and issue an order.

Mr. Chubb recommends the Commission decline to enact proposed rule 210.22 until the Commission and administrative law judges have more experience with 100-day proceedings. Mr. Chubb expresses concern that the Commission and administrative law judges will face significant difficulties if the Commission permits parties to file motions for 100-day proceedings and the judges are given authority to initiate such proceedings upon motion after institution of an investigation. Mr. Chubb cautions that respondents will likely file such motions in many, if not a majority of cases, resulting in disruptive and expensive motions practice from the very beginning of an investigation. Mr. Chubb notes that respondents will have little to lose if their motion is denied, but if their motion is granted, there is the likely prospect of the target date being extended if early disposition proves unsuccessful.

Mr. Chubb suggests that, should the Commission decide to adopt proposed rule 210.22, the Commission shorten the time for parties to file a motion for a 100-day proceeding to 15 days, arguing that allowing any additional time would impede the administrative law judge's ability to rule on such a motion within the 30 days allocated in proposed rule 210.14(i). Mr. Chubb states that, together, proposed rules 210.14(i) and 210.22 would shorten the amount of productive time available in which to conduct a 100-day proceeding and thereby jeopardize the parties' ability to prepare for and effectively participate in the proceeding.

Commission Response

The majority of the commenters recommend that the Commission not permit parties to request designation of potentially dispositive issues by motion, citing potential motions practice abuse, delay, and burden to the parties and the administrative law judge. After further consideration and in view of the concerns expressed by the commentators, the Commission has determined not to implement proposed rule 210.22 at this time.

Section 210.25

Section 210.25 provides for the process by which a party may request, and the presiding administrative law judge or the Commission may grant, sanctions. In particular, § 210.25(a)(1) states the grounds for which a party may file a motion for sanctions. The NPRM proposed amending § 210.25(a)(1) to clarify that a motion for sanctions may be filed for abuse of discovery under § 210.27(g)(3).

In addition, § 210.25(a)(2) provides that a presiding administrative law judge or the Commission may raise sanctions issues as appropriate. The NPRM proposed amending § 210.25(a)(2) to clarify paragraph (a)(2) regarding sanctions for abuse of discovery is § 210.27(g)(3).

No comments concerning the proposed amendments to rule 210.25 were received. The Commission has therefore determined to adopt proposed rules 210. 25(a)(1) and (2) as stated in the NPRM.

Section 210.27

Section 210.27 contains the general provisions governing discovery during a section 337 investigation or related proceeding. The NPRM proposed adding § 210.27(e)(5) to be consistent with Federal Rule of Civil Procedure 26 concerning the preservation of privilege between counsel and expert witnesses. In particular, the proposed rule specifies that privilege applies to communications between a party's counsel and any expert witness retained on behalf of that party and to any draft reports or disclosures that the expert prepares at counsel's behest.

Section 210.27(g) details the requirements of providing appropriate signatures with every discovery request, response, and objection, and the consequences for failing to do so. The NPRM proposed amending § 210.27(g)(3) to clarify that a presiding administrative law judge or the Commission may impose sanctions if, without substantial justification, a party certifies a discovery request, response, or objection in violation of § 210.27(g)(2).

No comments concerning the proposed amendments to rule 210.27 were received. The Commission has therefore determined to adopt proposed rules 210.27(e)(5) and (g)(3) as stated in the NPRM.

Section 210.28

Section 210.28 provides for the taking, admissibility, and use of party and witness depositions. In particular, § 210.28(h)(3) provides that the deposition of a witness, whether or not a party, may be used for any purpose if the presiding administrative law judge finds certain circumstances exist. The NPRM proposed adding § 210.28(h)(3)(vi) to allow, within the discretion of the presiding administrative law judge, the use of agreed-upon designated deposition testimony in lieu of live witness testimony absent the circumstances enumerated in § 210.28(h)(3).

No comments concerning the proposed amendments to rule 210.28 were received except for Mr. Chubb's, expressing his approval and noting that allowing designated deposition testimony in lieu of live witness testimony at hearings would eliminate much disagreement and confusion regarding the propriety of this common practice. The Commission has therefore

determined to adopt proposed rule 210.28(h)(3)(vi) as stated in the NPRM.

Section 210.32

Section 210.32 provides for the use of subpoenas during the discovery phase of a section 337 investigation. In particular, § 210.32(d) provides for the filing of motions to quash a subpoena that the presiding administrative law judge has issued. The NPRM proposed amending § 210.32(d) to clarify that a party upon which a subpoena has been served may file an objection to the subpoena within ten days of receipt of the subpoena, with the possibility of requesting an extension of time for filing objections for good cause shown. The NPRM also proposed amending § 210.32(d) to clarify that any motion to quash must be filed within ten days of receipt of the subpoena, with the possibility of requesting an extension of time for good cause shown. The proposed amendment is intended to bring the Commission's subpoena practice into closer conformity with the Federal Rules of Civil Procedure. The Commission requested in particular comments concerning any potential conflicts that may arise from copending objections and motions to quash.

In addition, § 210.32(f) authorizes the payment of fees to deponents or witnesses subject to a subpoena. The NPRM proposed amending § 210.32(f)(1) to clarify that such deponents and witnesses are entitled to receive both fees and mileage in conformance with Federal Rule of Civil Procedure 45(b)(1) and to correct the antecedent basis for ''fees and mileage'' as recited in § 210.32(f)(2).

Comments

The IPOA supports the proposed amendment to § 210.32(d) permitting service of objections to subpoenas. The IPOA does, however, express concern that having objections and motions to quash due within the same short ten-day period will not provide adequate opportunity for parties to negotiate subpoena-related issues before a motion to quash must be filed. Accordingly, the IPOA recommends allowing 20 days to move to quash, which would permit parties some time to meet and confer regarding subpoena objections and possibly avoid motions practice without unduly delaying the investigation. The IPOA questions whether the removal of ''motions to limit'' from the proposed rule was intentional and intended to be subsumed into the new objections process. The IPOA also argues that the requirement for parties to show good cause for an extension of time to serve objections or to file motions to question unduly restricts an administrative law judge's ability to allow parties additional time or to permit parties to jointly agree on extensions. The IPOA suggests the following amendment to proposed rule 210.32(d)(1):

> Any objection to a subpoena shall be served in writing on the party or attorney designated in the subpoena within *the later of* 10 days after receipt of the subpoena *or within such other time as the administrative law judge may allow or the party serving the subpoena may permit.* [The administrative law judge may, for good cause shown, extend the time in which objections may be filed.]

and proposed rule 210.32(d)(2):

> Any motion to quash a subpoena shall be filed within [10] *the later of 20* days after receipt of the subpoena *or within such other time as the administrative law judge may allow.* [The administrative law judge may, for good cause shown, extend the time in which motions to quash may be filed.]

The ITCTLA states that it appreciates the Commission's efforts to bring its subpoena practice into closer conformity with the Federal Rules of Civil Procedure. The ITCTLA, however, expresses several concerns with the effect and clarity of proposed rule 210.32(d) and, in particular, the respective roles of objections and motions to quash. In particular, the ITCTLA notes that it supports the addition of a mechanism, like in Federal District Court, that permits a third party subject to a subpoena to serve objections to the subpoena. Specifically, the ITCTLA notes that proposed rule 210.32(d)(1) does not indicate the effect of filing such objections, whereas Fed. R. Civ. P. 45(d)(2)(B) provides that, if an objection is made, the party serving the subpoena may move for an order compelling compliance. The ITCTLA asserts that the proposed rule is unclear as to whether upon service of objections, the party has discharged its obligations with respect to the subpoena (thus shifting the burden to the party that requested the subpoena to move for a request for judicial enforcement) or whether the party subject to the subpoena must now simultaneously file both objections and a motion to quash if it seeks to limit a subpoena. The ITCTLA suggests that, if the intent of the proposed rule is the former, which would be more in keeping with the federal rules, the Commission amend the proposed rule as indicated below.

The ITCTLA also questions the removal of the ''motion to limit'' language, noting that if the intent is to permit the option of filing objections if a party objects in part to a subpoena and to file a motion to quash if the subpoenaed party objects in full, such is not clear from the proposed rules or the NPRM. Lastly, the ITCTLA expresses concern over the requirement of good cause shown for any extension of time beyond ten days to serve objections or file a motion to quash. The ITCTLA asserts that the proposed rule unduly limits the ability of administrative law judges to permit additional time in their ground rules or to permit parties to jointly agree on extensions for objections without the need for a motion. In view of its comments, the ITCTLA suggests the following amendments to proposed rule 210.32(d)(1):

> Any objection to a subpoena shall be served in writing on the party or attorney designated in the subpoena within the later of 10 days after receipt of the subpoena or within such time as the administrative law judge may allow or the party or attorney designated in the subpoena may permit. [The administrative law judge may, for good cause shown, extend the time in which objections may be filed.] If an objection is made, the party that requested the subpoena may move for a request for judicial enforcement.

and proposed rule 210.32(d)(2):

> Any motion to quash a subpoena shall be filed within the later of 10 days after receipt of the subpoena or within such time as the administrative law judge may allow. [The administrative law judge may, for good cause shown, extend the time in which motions to quash may be filed.]

Adduci expresses concern that the 10-day deadline in proposed rule 210.32(d)(2) for filing motions to quash, particularly in light of the proposed 10-day deadline for objections under proposed rule 210.32(d)(1), will result in unnecessary motions to quash and waste private and public resources. Adduci states that, in practice, a party served with a subpoena should first serve its objections (as proposed in rule 210.32(d)(1)), and should thereafter have an opportunity to meet and confer with the requesting party on those objections before being required to file a motion to quash. Adduci notes that parties are often able to resolve disputes over a subpoena without the need for a motion to quash. Accordingly, Adduci recommends the Commission modify the language of proposed rule 210.32(d)(2) to require that any motion to quash be filed within twenty days of receipt of the subpoena. Furthermore, Adduci suggests the rule make clear that a motion to quash may be filed only if the movant: (1) Timely served objections pursuant to proposed rule 210.32(d)(1), and (2) met and conferred with the requesting party to make a good faith effort to resolve any issues that it has with the subpoena. Adduci states that offsetting the deadlines for objections and motions to quash would

provide notice of the receiving party's objections and allow sufficient time for the parties to attempt to resolve those issues without resorting to motions practice.

Mr. Chubb notes that, in practice, motions to quash subpoenas are rarely filed within 10 days, since the parties will generally discuss the breadth of the subpoena before reaching an impasse that necessitates a motion to quash. Mr. Chubb suggests that, since it appears the Commission's intent is that the time for motions to quash ultimately be determined by the administrative law judge, proposed rule 210.32(d)(2) should state so directly by expressly giving the judge the ability to set the time for filing motions to quash in the first instance, rather than the current proposal which is directed to extension of time for such motions. Mr. Chubb suggests the following language for proposed rule 210.32(d)(2):

> Any motion to quash a subpoena shall be filed within 10 days after receipt of the subpoena or within a period of time set by the administrative law judge. The administrative law judge may, for good cause shown, extend the time in which motions to quash may be filed.

Commission Response

The Commission notes that the commenters seem to be conflating objections and motions to quash. As stated in Rule 45 of the Federal Rules of Civil Procedure, motions to quash are generally allowed only in specific circumstances. *See* FRCP 45(d)(3). The Federal Rules do not apply such strictures on the filing of objections to a subpoena. Rather, when a subpoenaed entity files an objection, the burden shifts to the requesting party, requiring the requester to file a motion to compel after notifying the subpoenaed entity. *See* FRCP 45(d)(2)(B). It is this precise burden shifting the Commission intended to capture with the proposed rule. Objections and motions to quash are generally intended to be mutually exclusive procedures though there may occasionally be overlap in how they are utilized. The Commission therefore disagrees with Adduci's assumption that motions to quash may be filed only after the failure of negotiations following an objection pursuant to proposed rule 210.32(d)(1).

The IPOA's assumption that motions to limit were intended to be subsumed into the new objections process is partially correct. The Commission's purpose is to align the Commission's practice to Rule 45, which requires the requesting party to prove that information it seeks from the subpoenaed party is relevant and not burdensome.

In keeping with the Federal rules, the Commission has determined to clarify proposed rule 210.32(d)(2) to require, akin to current rule 210.33(a), which addresses motions to compel, that after an objection is made and negotiations fail, the requesting party must provide notice before seeking judicial enforcement. With respect to the requirement that administrative law judges can extend the time for filing objections or motions to quash only for good cause, the Commission accepts the solution proposed by the commenters to allow the judges to otherwise set the time.

Based on the above discussion, the Commission has determined to adopt the amendments to rule 210.32(d) proposed by the ITCTLA, with the addition of the notice language from rule 210.33. That language indicates that the requesting party may also move for a request for judicial enforcement upon reasonable notice or as provided by the administrative law judge. For example, the administrative law judge may require that the parties meet and confer prior to the filing of the request for judicial enforcement. The Commission does not, however, accept the ITCTLA's suggestion that the party or attorney designated in the subpoena may agree on the timing of responses without the input and approval of the administrative law judge.

No comments were received concerning proposed rule 210.32(f). The Commission therefore adopts proposed rule 210. 32(f) as stated in the NPRM with a typographical correction.

Section 210.34

Section 210.34 provides for the issuance of protective orders and for the remedies and sanctions the Commission may impose in the event of a breach of a Commission-issued administrative protective order. Section 210.34(c)(1) provides that the Commission shall treat the identity of any alleged breacher as confidential business information unless the Commission determines to issue a public sanction. Section 210.34(c)(1) also requires the Commission and the administrative law judge to allow parties to make submissions concerning these matters. The NPRM proposed amending § 210.34(c)(1) to remove the provision requiring the Commission or the administrative law judge to allow the parties to make written submissions or present oral arguments bearing on the issue of violation of a protective order and the appropriate sanctions therefor. The Commission and the administrative law judge continue to have discretion to permit written submissions or oral argument bearing on administrative protective order violations and sanctions therefor. In the interest of preserving the confidentiality of the process, the Commission has decided that notification of all parties in an investigation regarding breach of a protective order may be inappropriate in many cases. Submissions from relevant persons will be requested as necessary and appropriate.

Comments

The IPOA supports the Commission and the administrative law judge having the discretion to permit parties to make written submissions or present oral arguments concerning administrative protective order violations. The IPOA contends, however, that it is unclear whether the proposed changes will affect the notice of an alleged or actual breach provided under current rule 210.34. The IPOA therefore recommends leaving current rule 210.34(c)(1) unchanged.

The ITCWG cautions against implementation of proposed rule 210.34(c), arguing that the rule and the accompanying comment in the NPRM appear inconsistent. Specifically, ITCWG notes, the comment states that ''notification of all parties in an investigation regarding breach of a protective order may be inappropriate in many cases,'' while the proposed rule refers to the initiation of a sanctions inquiry by party motion, which presumably must be served on all parties to the investigation and filed on EDIS. The ITCWG states that the Commission's comment that notice of an alleged administrative protective order breach will be provided at its discretion is at odds with the goal stated in the Strategic Plan that the Commission wishes to promote transparency and understanding in investigative proceedings. The ITCWG contends that the proposed rule appears to allow no notice to parties who are not directly involved in the alleged breach even though, the ITCWG insists, such knowledge could prove valuable in helping better secure the aggrieved party's confidential business information going forward. The ITCWG argues that the Commission's comment appears to suggest the Commission need not notify a party whose confidential business information may have been disclosed, presumably if it wasn't that party who brought the potential breach to the Commission's attention. The ITCWG cautions that, under the proposed rule, there is too much uncertainty regarding how much notice

will be provided and how the process will operate, which could make parties reluctant to produce confidential business information in an investigation.

Mr. Chubb states that he agrees with the Commission's proposal to remove the mandatory provision from § 210.34(c)(1) that currently requires the Commission or the administrative law judge to allow all parties to make written submissions or present oral arguments on alleged protective order violations and sanctions, regardless of whether they are the alleged breacher or compromised party. Mr. Chubb notes that the proposed rule provides the Commission with the flexibility to accommodate the interest other parties may have in a protective order violation dispute and permit participation to an appropriate extent.

Commission Response

The comments from IPOA and the ITCWG reflect some basic differences between administrative protective order breach investigations that occur before administrative law judges and those that occur before the Commission. Breach investigations before administrative law judges may be more adversarial in nature, with notice being provided to the parties and parties having the opportunity to file submissions. Proceedings before the Commission, however, are more limited, with information concerning potential breaches provided on a need-to-know basis. The comments appear to be relevant primarily to proceedings before administrative law judges.

As the preamble to the rule in the NPRM states, the proposed rule recognizes that notification of all parties regarding a breach investigation may not be appropriate in many cases, in particular, those initiated before the Commission. The proposed amendment, which removes the provision requiring the Commission or the administrative law judge to allow the parties to make written submissions or present oral arguments bearing on the issue of violation of a protective order and the appropriate sanctions, does not affect the ability of administrative law judges, or the Commission when deemed appropriate, to request such briefing.

ITCWG raises the concern that the proposed rule suggests the Commission need not notify a party whose confidential business information may have been breached if that party did not notify the Commission of the potential breach. The Commission is concerned with preserving the confidentiality of the alleged breacher when an investigation into a potential breach of an administrative protective order is initiated before the Commission. The Commission does not currently notify parties not directly involved in the alleged breach. However, in most situations, it is the owner of the confidential information who brings the need for an investigation to the Commission's attention. Moreover, under § 210.34(b), which remains unchanged, the alleged breacher is required to notify the submitter of the confidential information.

The Commission has therefore determined to adopt proposed rule 210.34 as stated in the NPRM.

Section 210.42

Section 210.42 provides for the issuance of initial determinations by the presiding administrative law judge concerning specific issues, including violation of section 337 under § 210.42(a)(1)(i), on motions to declassify information under § 210.42(a)(2), on issues concerning temporary relief or forfeiture of temporary relief bonds under § 210.42(b), or on other matters as specified in § 210.42(c).

The NPRM proposed adding § 210.42(a)(3), authorizing the presiding administrative law judge to issue an initial determination ruling on a potentially dispositive issue in accordance with a Commission order under new § 210.10(b)(3). In addition, the proposed rule would require the administrative law judge to certify the record to the Commission and issue the initial determination within 100 days of institution pursuant to 210.10(b)(3). The 100-day period may be extended for good cause shown. These changes are intended to provide a procedure for the early disposition of potentially dispositive issues identified by the Commission at institution of an investigation. This procedure is not intended to affect summary determination practice under § 210.18 whereby the administrative law judge may dispose of one or more issues in the investigation when there is no genuine issue as to material facts and the moving party is entitled to summary determination as a matter of law. Rather, this procedure differs from a summary determination proceeding in that the administrative law judge's ruling pursuant to this section is made following an evidentiary hearing.

The NPRM also proposed adding § 210.42(c)(3), authorizing the presiding administrative law judge to issue an initial determination severing an investigation into two or more investigations pursuant to new § 210.14(h).

In addition, § 210.42(e) provides that the Commission shall notify certain agencies of each initial determination granting a motion for termination of an investigation in whole or part on the basis of a consent order or settlement, licensing, or other agreement pursuant to § 210.21, and notice of such other initial determinations as the Commission may order. Those agencies include the U.S. Department of Health and Human Services, the U.S. Department of Justice, the Federal Trade Commission, the U.S. Customs Service (now U.S. Customs and Border Protection), and such other departments and agencies as the Commission deems appropriate. The rule further states that the indicated agencies have 10 days after service of any such initial determinations to submit comments. Currently, the Commission effects such notice through various electronic means, including posting a public version of the initial determination on its website so that paper service is unnecessary. The NPRM proposed amending § 210.42(e) to remove the explicit requirement that the Commission otherwise provide any specific notice of or directly serve any initial determinations concerning terminations under § 210.21 on the listed agencies. This change is intended to conserve Commission resources and does not relieve the Commission of its obligation under section 337(b)(2) to consult with and seek advice and information from the indicated agencies as the Commission considers appropriate during the course of a section 337 investigation. The Commission has consulted with the agencies in question and they have not requested that the Commission provide direct notice beyond its current practice.

Section 210.42(a)(3)

Comments

The IPOA, in accordance with its recommendation not to implement proposed rules 210.14(i) or 210.22, suggests the following amended language for proposed § 210.42(a)(3):

> The administrative law judge shall issue an initial determination ruling on a potentially dispositive issue in accordance with a Commission order pursuant to § 210.10(b)(3) [or an administrative law judge's order issued pursuant to § 210.14(i) or § 210.22]. The administrative law judge shall certify the record to the Commission and shall file an initial determination ruling on the potentially dispositive issue designated pursuant to § 210.42(a)(3)(i) within 100 days, or as extended for good cause shown, of when the issue is designated by the Commission pursuant to § 210.10(b)(3) [or by the administrative law judge pursuant to § 210.14(i) or § 210.22].

The IPOA also argues that the proposed rules provide no deadline for the Commission to determine whether to issue its own determination on a 100-day proceeding or to determine whether to review the administrative law judge's 100-day initial determination. The IPOA proposes to add a paragraph (h)(7) to § 210.42(h):

An initial determination filed pursuant to § 210.42(a)(3) shall become the determination of the Commission 30 days after the date of service of the initial determination, unless the Commission has ordered review of the initial determination or certain issues therein, or by order has changed the effective date of the initial determination.

Mr. Chubb notes the Commission's statement in the NPRM that proposed rule 210.42(a)(3) is not intended to affect summary determination practice. Mr. Chubb suggests the Commission confirm that motions for summary determination on any potentially dispositive issue that is the subject of a 100-day proceeding are still permitted, but that such motions should not become a basis for extending such proceedings beyond the 100 days.

Commission Response

The Commission has determined that clarification is needed regarding when an initial determination pursuant to proposed rule 210.42(a)(3) would become the Commission's final determination. Section 210.42(h) concerns the timing of when an initial determination shall become the determination of the Commission absent review. Proposed rule 210.43(d)(1) (as discussed below) states that the Commission has 30 days to determine whether to review an initial determination concerning a dispositive issue. As such, the Commission adopts the IPOA's proposed addition of § 210.42(h)(7) to specify that an initial determination issued pursuant to proposed rule 210.42(a)(3) will become the Commission's final determination within 30 days after service of the initial determination, absent review.

Regarding Mr. Chubb's comment, the Commission does not intend the 100-day procedure to affect summary determination practice during the course of a regular investigation. Therefore there is no need to change the current procedure for summary determinations as provided in § 210.18.

Because the Commission has determined not to implement proposed rule 210.14(i) allowing administrative law judges to designate potentially dispositive issues, the Commission has determined to remove all references to proposed rule 210.14(i) in the final version of rule 210.42(a)(3). As noted above, the Commission has also determined to add rule 210.42(h)(7) to specify that an initial determination issued pursuant to proposed rule 210.42(a)(3) will become the Commission's final determination within 30 days after service of the initial determination, absent review.

Section 210.42(c)(3)

With respect to proposed rule 210.14(h) regarding severance of investigations by administrative law judges, the ITCTLA recommends the Commission authorize judges to act by order rather than initial determination, rendering proposed rule 210.42(c)(3) unnecessary. Mr. Chubb, on the other hand, argues that a decision to sever should be in the form of an initial determination.

As stated above, the Commission has determined to allow administrative law judges to sever investigations by order. Accordingly, the Commission has determined not to adopt proposed rule 210.42(c)(3).

Section 210.42(e)

No comments concerning the proposed amendments to rule 210.42(e) were received. The Commission has therefore determined to adopt proposed rule 210.42(e) as stated in the NPRM.

Section 210.43

Section 210.43 provides for the process by which a party may request, and the Commission may consider, petitions for review of initial determinations on matters other than temporary relief. In particular, § 210.43(a)(1) specifies when parties must file petitions for review based on the nature of the initial determination, and § 210.43(c) specifies when parties must file responses to any petitions for review. The NPRM proposed amending § 210.43(a)(1) to specify when parties must file petitions for review of an initial determination ruling on a potentially dispositive issue pursuant to new § 210.42(a)(3). The NPRM further proposed amending § 210.43(c) to specify when the parties must file responses to any such petitions for review. Under the proposed rule, parties are required to file a petition for review within five calendar days after service of the initial determination and any responses to the petitions within three business days after service of a petition.

Section 210.43(d)(1) provides for the length of time the Commission has after service of an initial determination to determine whether to review the initial determination. The NPRM proposed amending § 210.43(d)(1) to specify that the Commission must determine whether to review initial determinations on potentially dispositive issues pursuant to new § 210.42(a)(3) within 30 days of service of the initial determination.

In addition, § 210.43(d)(3) provides that, if the Commission determines to grant a petition for review, in whole or in part, and solicits written submissions on the issues of remedy, the public interest, and bonding, the Secretary of the Commission shall serve the notice of review on all parties, the U.S. Department of Health and Human Services, the U.S. Department of Justice, the Federal Trade Commission, the U.S. Customs Service (now U.S. Customs and Border Protection), and such other departments and agencies as the Commission deems appropriate. Currently, the Commission effects such notice through various electronic means, including posting a public version of the notice on its website such that paper service is unnecessary. The NPRM proposed amending § 210.43(d)(3) to remove the explicit requirement that the Commission provide by way of direct service any such notice to the indicated agencies, thus conserving Commission resources. This change is intended to conserve Commission resources and does not relieve the Commission of its obligation under section 337(b)(2) to consult with and seek advice and information from the indicated agencies as the Commission considers appropriate during the course of a section 337 investigation.

Comments

The CCCME cautions that the time limits for filing petitions for review and petition responses under the proposed rule are too short for foreign parties. The CCCME recommends allowing seven calendar days for petitions for review and five business days for petition responses.

Adduci notes that § 201.14 states that, for any deadline less than seven days, intermediate Saturdays, Sundays, and Federal legal holidays are excluded, effectively transforming a five calendar day deadline into a five business day deadline. Adduci therefore suggests the Commission modify proposed rule 210.42(a)(3) to require parties to file petitions for review of initial determinations pursuant to proposed rule 210.42(a)(3) within five business days, rather than five calendar days, thus bringing the proposed rule into conformity with the requirements of § 201.14.

The ITCWG states that it does not support the proposed changes to rule

210.43(d)(3) that would change the method by which the Commission is required to provide notice of a grant of petition for review to the designated agencies. The ITCWG states that it does not believe the conservation of Commission resources by foregoing actual service in lieu of merely posting notice of the grant on the Commission's website outweighs the burden placed on other agencies to monitor the Commission's website for relevant notices for which they may wish to provide comment.

Commission Response

With respect to proposed rule 210.43(a)(1), Adduci suggests that the rule should require that petitions for review of an initial determination ruling on a potentially dispositive issue be filed within five business days after service of the initial determination. CCCME argues that the proposed time, *i.e.* five calendar days, is too short for foreign parties. Adduci's suggestion increases the time for filing to include any subsumed weekends, thus addressing CCCME's concern. The Commission therefore has determined to amend proposed rule 210.43(a)(1) in accordance with this suggestion.

Concerning proposed rule 210.43(c), the CCCME again argues that the proposed time for responding to such a petition, *i.e.,* three business days, is too short for foreign parties. The Commission agrees and has determined that responses to petitions for review of initial determinations issued under new rule 210.42(a)(3) are due within five (5) business days of service of such petitions. The Commission therefore has determined not to adopt the proposed amendments to § 210.43(c), as the current rule, which states that responses to petitions for review of initial determinations other than those issued under § 210.42(a)(1) are due within five(5) business days of service of such petition, is sufficient to capture this new deadline.

No comments were received regarding the proposed amendments to § 210.43(d)(1). The Commission has therefore determined to adopt proposed rule 210.43(d)(1) as stated in the NPRM.

Regarding proposed rule 210.43(d)(3), the Commission notes that this amendment is consistent with similar amendments discussed previously in this notice for which no comments were received. The Commission has consulted with the agencies in question and they have not requested that the Commission provide direct notice beyond its current practice. The Commission has therefore determined to adopt proposed rule 210.43(d)(3) as stated in the NPRM.

Section 210.47

Section 210.47 provides the procedure by which a party may petition the Commission for reconsideration of a Commission determination. The NPRM proposed amending § 210.47 to make explicit the Commission's authority to reconsider a determination on its own initiative.

No comments concerning the proposed amendments to rule 210.47 were received. The Commission has therefore determined to adopt proposed rule 210.47 as stated in the NPRM.

Section 210.50

Section 210.50, and in particular § 210.50(a)(4), requires the Commission to receive submissions from the parties to an investigation, interested persons, and other Government agencies and departments considering remedy, bonding, and the public interest. Section 210.50(a)(4) further requests the parties to submit comments concerning the public interest within 30 days of issuance of the presiding administrative law judge's recommended determination. It has come to the Commission's attention that members of the public are confused as to whether § 210.50(a)(4) applies to them since the post-recommended determination provision is stated immediately after the provision requesting comments from ''interested persons.'' The NPRM proposed amending § 210.50(a)(4) to clarify that the rule concerns post-recommended determination submissions from the parties. Given the variability of the dates for issuance of the public version of the recommended determinations and the general public's lack of familiarity with Commission rules, post-recommended determination submissions from the public are solicited via a notice published in the **Federal Register** specifying the due date for such public comments.

No comments concerning the proposed amendments to rule 210.50 were received. The Commission has therefore determined to adopt proposed rule 210.50(a)(4) as stated in the NPRM.

Section 210.75

Section 210.75 provides for the enforcement of remedial orders issued by the Commission, including exclusion orders, cease and desist orders, and consent orders. Section 210.75(a) provides for informal enforcement proceedings, which are not subject to the adjudication procedures described in § 210.75(b) for formal enforcement proceedings. In *Vastfame Camera, Ltd.* v. *Int'l Trade Comm'n,* 386 F.3d 1108, 1113 (Fed. Cir. 2004), the Federal Circuit stated that the Commission's authority to conduct enforcement proceedings stems from its original investigative authority under subsection 337(b) and its authority to issue temporary relief arises under subsection 337(e). Both subsections require that the Commission afford the parties the ''opportunity for a hearing in conformity with the provisions of subchapter II of chapter 5 of title 5.'' *Id.* at 1114–15. Section 210.75(a), which provides for informal enforcement proceedings, is therefore not in accordance with the Federal Circuit's holding in *Vastfame.* Accordingly, the NPRM proposed deleting § 210.75(a).

Section 210.75(b) currently provides that the Commission may institute a formal enforcement proceeding upon the filing of a complaint setting forth alleged violations of any exclusion order, cease and desist order, or consent order. The NPRM proposed amending § 210.75(b)(1), redesignated as 210.75(a)(1), to provide that the Commission shall determine whether to institute the requested enforcement proceeding within 30 days of the filing of the enforcement complaint, similar to the provisions recited in § 210.10(a), barring exceptional circumstances, a request for postponement of institution, or withdrawal of the enforcement complaint.

Moreover, when the Commission has found a violation of an exclusion order, the Commission has issued cease and desist orders as appropriate. The NPRM proposed amending § 210.75(b)(4), redesignated as 210.75(a)(4), to explicitly provide that the Commission may issue cease and desist orders pursuant to section 337(f) at the conclusion of a formal enforcement proceeding. The proposed rule would also amend § 210.75(b)(5), redesignated as 210.75(a)(5), to include issuance of new cease and desist orders pursuant to new § 210.75(a)(4).

Current § 210.75(a)

Comments

Mr. Chubb questions the Commission's apparent reading of *Vastfame* as prohibiting the Commission from investigating potential violations of its remedial orders without engaging in full-blown due process adjudications under the Administrative Procedure Act. Mr. Chubb argues that such a reading would defy common sense and cripple the Commission's ability to carry out its functions. Mr. Chubb contends that if only formal enforcement proceedings

under current § 210.75 were permitted, an unacceptably large proportion of potentially violative behavior would go unscrutinized, since formal enforcement proceedings would not be appropriate in every situation.

Mr. Chubb suggests that the Commission could remedy any concerns that use of the term ''enforcement proceeding'' in current rule 210.75(a) invokes *Vastfame* by using a different term such as ''preliminary investigative activity.'' Mr. Chubb notes that the Commission is specifically authorized under Section 603 of the Trade Act of 1974, 19 U.S.C. 2482, to engage in such preliminary investigations. Mr. Chubb therefore recommends the Commission retain § 210.75(a) as a vehicle for informal investigative activity, but avoid any concerns about potential conflicts with *Vastfame* by adopting the following revised language:

> Informal investigative activities may be conducted by the Commission, including through the Office of Unfair Import Investigations, with respect to any act or omission by any person in possible violation of any provision of an exclusion order, cease and desist order, or consent order. Such matters may be handled by the Commission through correspondence or conference or in any other way that the Commission deems appropriate. The Commission may issue such orders as it deems appropriate to implement and insure compliance with the terms of an exclusion order, cease and desist order, or consent order, or any part thereof. Any matter not disposed of informally may be made the subject of a formal proceeding pursuant to this subpart.

Commission Response

Current section 210.75(a) states that the Commission may issue orders as a result of the ''informal enforcement proceedings'' provided for in the rule. 19 CFR 210.75(a). However, under *Vastfame,* the Commission's investigation of a violation of remedial orders must be considered the same as an investigation under subsection 337(b) of the statute. The Commission's authority to issue a remedy for violation of remedial orders cannot be altered merely by changing the verbiage used to describe the Commission's investigative activity. 19 U.S.C. 2482 confers authority for conducing preliminary investigations before determining whether to institute either an initial investigation or an enforcement proceeding. This section of the statute does not provide authority for the Commission to conduct investigations that may potentially result in the Commission issuing a remedy.

Based on the above discussion, the Commission has determined to adopt the proposed amendment indicated in the NPRM to delete current § 210.75(a).

Redesignated § 210.75(a) (currently § 210.75(b)(1))

Comments

Mr. Chubb notes that the NPRM proposes amending redesignated § 210.75(a)(1) to impose a 30-day deadline to institute formal enforcement proceedings after a complaint for enforcement is filed. Mr. Chubb questions the necessity of a rule providing a fixed deadline for instituting formal enforcement proceedings since, as he states, the Commission has its own incentives, through internal deadlines and its Strategic Plan, to expeditiously process enforcement complaints. Mr. Chubb notes that the rules do not specify requirements for enforcement complaints as comprehensively as they do for violation complaints. Accordingly, Mr. Chubb asserts, the Commission may need to conduct more of a pre-institution investigation in many cases and seek supplementation from the complainant, making a rigid 30-day period unworkable. Additionally, Mr. Chubb contends that under the proposed 30-day rule, the Commission's ability to comply will likely be heavily dependent on the Office of Unfair Import Investigations' informal review of draft complaints. Mr. Chubb cautions that it is unclear whether enforcement complainants will take advantage of the Office of Unfair Import Investigations' ability to review draft complaints.

Moreover, Mr. Chubb warns that the 30-day institution proposal for formal enforcement proceedings is unrealistic because it fails to take into account the right of an enforcement respondent to respond to an enforcement complaint within 15 days of service. Mr. Chubb notes that, in instituting violation investigations, the Commission does not have to address such responses, which is another factor to consider in setting a deadline for institution of enforcement complaints. Mr. Chubb therefore suggests that, if the Commission intends to impose a regulatory deadline for the institution of formal enforcement proceedings, it allow at least 45 or 60 days.

Commission Response

The Commission acknowledges Mr. Chubb's concerns regarding the Commission's ability to meet the 30-day institution goal for enforcement proceedings as indicated in proposed rule (as redesignated) 210.75(a)(1). The Commission, however, has committed itself to abide by a 30-day deadline in instituting formal enforcement investigations. Moreover, the revised rule allows for extending the deadline in the case of exceptional circumstances. The Commission also notes that the Office of Unfair Import Investigations does not review enforcement complaints. Moreover, enforcement complaints are served after institution and so the Commission does not consider responses to the complaint during the pre-institution period. 19 CFR 210.75(a)(1) formerly 19 CFR 210.75(b)(1).

No comments were received concerning proposed rules (as redesignated) 210.75(a)(4) and (5). The Commission has therefore determined to adopt proposed rule (as redesignated) 210.75(a) as stated in the NPRM.

Section 210.76

Section 210.76 provides the method by which a party to a section 337 investigation may seek modification or rescission of exclusion orders, cease and desist orders, and consent orders issued by the Commission. The NPRM proposed amending § 210.76(a) to clarify that this section is in accordance with section 337(k)(1) and allows any person to request the Commission to make a determination that the conditions which led to the issuance of a remedial or consent order no longer exist. The NPRM also proposed adding § 210.76(a)(3) to require that, when the requested modification or rescission is due to a settlement agreement, the petition must include copies of the agreements, any supplemental agreements, any documents referenced in the petition or attached agreements, and a statement that there are no other agreements, consistent with rule 210.21(b)(1).

In addition, § 210.76(b) specifies that the Commission may institute such a modification or rescission proceeding by issuing a notice. The NPRM proposed amending § 210.76(b) to provide that the Commission shall determine whether to institute the requested modification or rescission proceeding within 30 days of receiving the request, similar to the provisions recited in § 210.10(a), barring exceptional circumstances, a request for postponement of institution, or withdrawal of the petition for modification or rescission. The proposed rule would further clarify that the notice of commencement of the modification or rescission proceeding may be amended by leave of the Commission. Under some circumstances, such as when settlement between the parties is the basis for

rescission or modification of issued remedial orders, institution and disposition of the rescission or modification proceeding may be in a single notice.

Comments

Mr. Chubb asserts the Commission's proposal to adopt a 30-day deadline for the institution of modification or rescission proceedings suffers from the same infirmities as the Commission's proposal to adopt a 30-day deadline for the institution of enforcement proceedings under proposed rule 210.75. Mr. Chubb suggests, consistent with his recommendations concerning proposed rule 210.75, that the Commission reject the proposed amendments to § 210.76 or, in the alternative, lengthen the proposed 30-day period to a 45 or 60-day period.

Commission Response

No comments were received concerning proposed rule 210.76(a). With respect to Mr. Chubb's comment, the Commission has committed itself to abide by a 30-day deadline in instituting modification or rescission proceedings, but the revised rule allows for extending the deadline in the case of exceptional circumstances. The Commission has therefore determined to adopt proposed rule 210.76 as stated in the NPRM.

Section 210.77

Section 210.77 provides for the Commission to take temporary emergency action pending a formal enforcement proceeding under § 210.75(b) by immediately and without hearing or notice modify or revoke the remedial order under review and, if revoked, to replace the order with an appropriate exclusion order. As noted above, the Federal Circuit held in *Vastfame* that an enforcement proceeding requires that the parties be afforded an opportunity for a hearing. 386 F.3d at 1114–15. The procedure set forth in § 210.77 for temporary emergency action pending a formal enforcement proceeding, therefore, is not in accordance with the Federal Circuit's holding in *Vastfame*. The proposed rule would, accordingly, delete § 210.77.

No comments concerning the proposed deletion of rule 210.77 were received except for Mr. Chubb's, stating his approval of the proposal and noting that the provision for ''temporary emergency action'' has seldom if ever been used by the Commission and, as noted in the NPRM, is of questionable legality in view of *Vastfame*. The Commission has therefore determined to delete rule 210.77 and reserve it for future use as stated in the NPRM.

Section 210.79

Section 210.79 provides that the Commission will, upon request, issue advisory opinions concerning whether any person's proposed course of action or conduct would violate a Commission remedial order, including an exclusion order, cease and desist order, or consent order. The NPRM proposed amending § 210.79(a) to provide that any responses to requests for advisory opinions shall be filed within 10 days of service. The NPRM also proposed amending § 210.79(a) to provide that the Commission shall institute the advisory proceeding by notice, which may be amended by leave of the Commission, and the Commission shall determine whether to institute an advisory opinion proceeding within 30 days of receiving the request barring exceptional circumstances, a request for postponement of institution, or withdrawal of the request for an advisory opinion.

Comments

Mr. Chubb asserts the Commission's proposal to adopt a 30-day deadline for the institution of advisory opinion proceedings suffers from the same infirmities as the Commission's proposal to adopt a 30-day deadline for the institution of enforcement proceedings under proposed rule 210.75. Mr. Chubb suggests, consistent with his recommendations concerning proposed rule 210.75, that the Commission reject the proposed amendments to § 210.79 or, in the alternative, lengthen the proposed 30-day period to a 45 or 60-day period.

Commission Response

The Commission again notes that it has committed itself to abide by a 30-day deadline in instituting advisory opinion proceedings, but the revised rule allows for extending the deadline in the case of exceptional circumstances. The Commission has therefore determined to adopt proposed rule 210.79 as stated in the NPRM.

List of Subjects

19 CFR Part 201

Administration practice and procedure, Reporting and record keeping requirements.

19 CFR Part 210

Administration practice and procedure, Business and industry, Customs duties and inspection, Imports, Investigations.

For the reasons stated in the preamble, the United States International Trade Commission amends 19 CFR parts 201 and 210 as follows:

PART 201—RULES OF GENERAL APPLICATION

■ 1. The authority citation for part 201 continues to read as follows:

Authority: Sec. 335 of the Tariff Act of 1930 (19 U.S.C. 1335), and sec. 603 of the Trade Act of 1974 (19 U.S.C. 2482), unless otherwise noted.

Subpart A—Miscellaneous

■ 2. Amend § 201.16 by revising paragraphs (a)(1), (a)(4), and (f) to read as follows:

§ 201.16 Service of process and other documents.

(a) * * *

(1) By mailing, delivering, or serving by electronic means a copy of the document to the person to be served, to a member of the partnership to be served, to the president, secretary, other executive officer, or member of the board of directors of the corporation, association, or other organization to be served, or, if an attorney represents any of the above before the Commission, by mailing, delivering, or serving by electronic means a copy to such attorney; or

* * * * *

(4) When service is by mail, it is complete upon mailing of the document. When service is by an express service, service is complete upon submitting the document to the express delivery service or depositing it in the appropriate container for pick-up by the express delivery service. When service is by electronic means, service is complete upon transmission of a notification that the document has been placed in an appropriate repository for retrieval by the person, organization, representative, or attorney being served, unless the Commission is notified that the notification was not received by the party served.

* * * * *

(f) *Electronic service by parties.* Parties may serve documents by electronic means in all matters before the Commission. Parties may effect such service on any party, unless that party has, upon notice to the Secretary and to all parties, stated that it does not consent to electronic service. If electronic service is used, no additional time is added to the prescribed period. However, any dispute that arises among parties regarding electronic service must

be resolved by the parties themselves, without the Commission's involvement. When a document served by electronic means contains confidential business information or business proprietary information subject to an administrative protective order, the document must be securely stored and transmitted by the serving party in a manner, including by means ordered by the presiding administrative law judge, that prevents unauthorized access and/or receipt by individuals or organizations not authorized to view the specified confidential business information.

* * * * *

PART 210—ADJUDICATION AND ENFORCEMENT

■ 3. The authority citation for part 210 continues to read as follows:

Authority: 19 U.S.C. 1333, 1335, and 1337.

Subpart B—Commencement of Preinstitution Proceedings and Investigations

■ 4. Amend § 210.10 by adding paragraph (a)(6) and revising paragraph (b) read as follows:

§ 210.10 Institution of investigation.

(a) * * *

(6) The Commission may determine to institute multiple investigations based on a single complaint where necessary to allow efficient adjudication.

(b)(1) An investigation shall be instituted by the publication of a notice in the **Federal Register**. The notice will define the scope of the investigation in such plain language as to make explicit what accused products or category of accused products provided in accordance with § 210.12(a)(12) will be the subject of the investigation, and may be amended as provided in § 210.14(b) and (c).

(2) The Commission may order the administrative law judge to take evidence and to issue a recommended determination on the public interest based generally on the submissions of the parties and the public under § 210.8(b) and (c). If the Commission orders the administrative law judge to take evidence with respect to the public interest, the administrative law judge will limit public interest discovery appropriately, with particular consideration for third parties, and will ensure that such discovery will not delay the investigation or be used improperly. Public interest issues will not be within the scope of discovery unless the administrative law judge is specifically ordered by the Commission to take evidence on these issues.

(3) The Commission may order the administrative law judge to issue an initial determination within 100 days of institution of an investigation as provided in § 210.42(a)(3) ruling on a potentially dispositive issue as set forth in the notice of investigation. The presiding administrative law judge is authorized, in accordance with § 210.36, to hold expedited hearings on any such designated issue and also has discretion to stay discovery of any remaining issues during the pendency of the 100-day proceeding.

* * * * *

■ 5. Amend § 210.11 by revising paragraph (a)(2)(i) to read as follows:

§ 210.11 Service of complaint and notice of investigation.

(a) * * *

(2) * * *

(i) Copies of the nonconfidential version of the motion for temporary relief, the nonconfidential version of the complaint, and the notice of investigation upon each respondent; and

* * * * *

Subpart C— Pleadings

■ 6. Amend § 210.12 by adding paragraph (a)(9)(xi) to read as follows:

§ 210.12 The complaint.

(a) * * *

(9) * * *

(xi) The expiration date of each patent asserted.

* * * * *

■ 7. Amend § 210.14 by adding paragraph (h) to read as follows:

§ 210.14 Amendments to pleadings and notice; supplemental submissions; counterclaims; consolidation of investigations; severance of investigations.

* * * * *

(h) *Severance of investigation.* The administrative law judge may determine to sever an investigation into two or more investigations at any time prior to or upon thirty days from institution, based upon either a motion by any party or upon the administrative law judge's own judgment that severance is necessary to allow efficient adjudication. The administrative law judge's decision will be in the form of an order. The newly severed investigation(s) shall remain with the same presiding administrative law judge unless reassigned at the discretion of the chief administrative law judge. The severed investigation(s) will be designated with new investigation numbers.

Subpart D—Motions

■ 8. Amend § 210.15 by revising paragraph (a)(2) to read as follows:

§ 210.15 Motions.

(a) * * *

(2) When an investigation or related proceeding is before the Commission, all motions shall be addressed to the Chairman of the Commission. All such motions shall be filed with the Secretary and shall be served upon each party. Motions may not be filed with the Commission during preinstitution proceedings except for motions for temporary relief pursuant to § 210.53.

* * * * *

■ 9. Amend § 210.19 by revising the first sentence to read as follows:

§ 210.19 Intervention.

Any person desiring to intervene in an investigation or a related proceeding under this part shall make a written motion after institution of the investigation or related proceeding.

* * *

■ 10. Amend section 210.21 by
■ a. Revising paragraph (b)(2);
■ b. Removing paragraph (c)(2)(i);
■ c. Redesignating paragraph (c)(2)(ii) as paragraph (c)(2) and revising it;
■ d. Revising paragraph (c)(3)(ii)(A);
■ e. Revising paragraph (c)(4)(viii);
■ f. Revising paragraph (c)(4)(x)
■ g. Redesignating paragraph (c)(4)(xi) as (c)(4)(xii); and
■ h. Adding a new paragraph (c)(4)(xi)

The revisions and additions read as follows:

§ 210.21 Termination of investigations.

* * * * *

(b) * * *

(2) The motion and agreement(s) shall be certified by the administrative law judge to the Commission with an initial determination if the motion for termination is granted. If the licensing or other agreement or the initial determination contains confidential business information, copies of the agreement and initial determination with confidential business information deleted shall be certified to the Commission simultaneously with the confidential versions of such documents. If the Commission's final disposition of the initial determination results in termination of the investigation in its entirety, a notice will be published in the **Federal Register**. Termination by settlement need not constitute a determination as to violation of section 337 of the Tariff Act of 1930.

(c) * * *

(2) *Commission disposition of consent order.* The Commission, after

considering the effect of the settlement by consent order upon the public health and welfare, competitive conditions in the U.S. economy, the production of like or directly competitive articles in the United States, and U.S. consumers, shall dispose of the initial determination according to the procedures of §§ 210.42 through 210.45. If the Commission's final disposition of the initial determination results in termination of the investigation in its entirety, a notice will be published in the **Federal Register**. Termination by consent order need not constitute a determination as to violation of section 337. Should the Commission reverse the initial determination, the parties are in no way bound by their proposal in later actions before the Commission.

(3) * * *

(ii) * * *

(A) A statement that if any asserted patent claim, copyright, trademark, mask work, boat hull design, or unfair trade practice claim has expired or is held invalid or unenforceable by a court or agency of competent jurisdiction or if any article has been found or adjudicated not to infringe the asserted right in a final decision, no longer subject to appeal, this Consent Order shall become null and void as to such expired, invalid, or unenforceable claim or as to any adjudicated article;

* * * * *

(4) * * *

(viii) A statement that Respondent and its officers, directors, employees, agents, and any entity or individual acting on its behalf and with its authority shall not seek to challenge the validity or enforceability of any asserted patent claims, copyright, trademark, mask work, boat hull design, or unfair trade practice claim in any administrative or judicial proceeding to enforce the Consent Order;

* * * * *

(x) A statement that if any asserted patent claim, copyright, trademark, mask work, boat hull design, or unfair trade practice claim is held invalid or unenforceable by a court or agency of competent jurisdiction or if any article has been found or adjudicated not to infringe the asserted right in a final decision, no longer subject to appeal, this Consent Order shall become null and void as to such invalid or unenforceable claim or adjudicated article;

(xi) An admission of all jurisdictional facts; and

* * * * *

■ 11. Amend § 210.25 by revising the first sentence of paragraph (a)(1) and paragraph (a)(2) to read as follows:

§ 210.25 Sanctions.

(a)(1) Any party may file a motion for sanctions for abuse of process under 210.4(d)(1), abuse of discovery under § 210.27(g)(3), failure to make or cooperate in discovery under § 210.33(b) or (c), or violation of a protective order under § 210.34(c). * * *

(2) The administrative law judge (when the investigation or related proceeding is before the administrative law judge) or the Commission (when the investigation or related proceeding is before it) also may raise the sanctions issue sua sponte. (See also §§ 210.4(d)(1)(ii), 210.27(g)(3), 210.33(c), and 210.34(c).)

* * * * *

Subpart E—Discovery and Compulsory Process

■ 12. Amend § 210.27 by adding paragraph (e)(5) and in paragraph (g)(3), by removing the phrase ''If without substantial justification a request, response, or objection is certified in violation of paragraph (d)(2) of this section'' and adding in its place ''If without substantial justification a request, response, or objection is certified in violation of paragraph (g)(2) of this section,''.

The addition reads as follows:

§ 210.27 General provisions governing discovery.

* * * * *

(e) * * *

(5)(i) The provisions of § 210.27(e)(1) through (4) protect drafts of expert reports, regardless of the form in which the draft is recorded.

(ii) The provisions of § 210.27(e)(1) through (4) protect communications between the party's attorney and expert witnesses concerning trial preparation, regardless of the form of the communications, except to the extent that the communications:

(A) Relate to compensation for the expert's study or testimony;

(B) Identify facts or data that the party's attorney provided and that the expert considered in forming the opinions to be expressed; or

(iii) Identify assumptions that the party's attorney provided and that the expert relied on in forming the opinions to be expressed.

* * * * *

■ 13. Amend § 210.28 by revising paragraph (h)(3)(v) and adding paragraph (h)(3)(vi) to read as follows:

§ 210.28 Depositions.

* * * * *

(h) * * *

(3) * * *

(v) Upon application and notice, that such exceptional circumstances exist as to make it desirable in the interest of justice and with due regard to the importance of presenting the oral testimony of witnesses at a hearing, to allow the deposition to be used; or

(vi) Upon agreement of the parties and within the administrative law judge's discretion, the use of designated deposition testimony in lieu of live witness testimony absent the circumstances otherwise enumerated in this paragraph is permitted.

* * * * *

■ 14. Amend § 210.32 by revising paragraphs (d) and (f)(1) to read as follows:

§ 210.32 Subpoenas.

* * * * *

(d) *Objections and motions to quash.* (1) Any objection to a subpoena shall be served in writing on the party or attorney designated in the subpoena within the later of 10 days after receipt of the subpoena or within such time as the administrative law judge may allow. If an objection is made, the party that requested the subpoena may move for a request for judicial enforcement upon reasonable notice to other parties or as otherwise provided by the administrative law judge who issued the subpoena.

(2) Any motion to quash a subpoena shall be filed within the later of 10 days after receipt of the subpoena or within such time as the administrative law judge may allow.

* * * * *

(f) * * *

(1) *Deponents and witnesses.* Any person compelled to appear in person to depose or testify in response to a subpoena shall be paid the same fees and mileage as are paid to witnesses with respect to proceedings in the courts of the United States; provided, that salaried employees of the United States summoned to depose or testify as to matters related to their public employment, irrespective of the party at whose instance they are summoned, shall be paid in accordance with the applicable Federal regulations.

* * * * *

■ 15. Amend § 210.34 by revising paragraph (c)(1) to read as follows:

§ 210.34 Protective orders; reporting requirement; sanctions and other actions.

* * * * *

(c) *Violation of protective order.* (1) The issue of whether sanctions should be imposed may be raised on a motion by a party, the administrative law judge's own motion, or the

Commission's own initiative in accordance with § 210.25(a)(2). Parties, including the party that identifies an alleged breach or makes a motion for sanctions, and the Commission shall treat the identity of the alleged breacher as confidential business information unless the Commission issues a public sanction. The identity of the alleged breacher means the name of any individual against whom allegations are made. The Commission and the administrative law judge may permit the parties to file written submissions or present oral argument on the issues of the alleged violation of the protective order and sanctions.

* * * * *

Subpart G—Determinations and Actions Taken

■ 16. Amend § 210.42 by adding paragraph (a)(3), revising paragraph (e), and adding paragraph (h)(7) to read as follows:

§ 210.42 Initial determinations.

(a) * * *

(3) *On potentially dispositive issues.* The administrative law judge shall issue an initial determination ruling on a potentially dispositive issue in accordance with a Commission order pursuant to § 210.10(b)(3). The administrative law judge shall certify the record to the Commission and shall file an initial determination ruling on the potentially dispositive issue designated pursuant to § 210.10(b)(3) within 100 days of institution, or as extended for good cause shown.

* * * * *

(e) *Notice to and advice from other departments and agencies.* Notice of such initial determinations as the Commission may order shall be provided to the U.S. Department of Health and Human Services, the U.S. Department of Justice, the Federal Trade Commission, U.S. Customs and Border Protection, and such other departments and agencies as the Commission deems appropriate by posting of such notice on the Commission's website. The Commission shall consider comments, limited to issues raised by the record, the initial determination, and the petitions for review, received from such agencies when deciding whether to initiate review or the scope of review. The Commission shall allow such agencies 10 days after the posting of such notice of an initial determination on the Commission's website to submit their comments.

* * * * *

(h) * * *

(7) An initial determination filed pursuant to § 210.42(a)(3) shall become the determination of the Commission 30 days after the date of service of the initial determination, unless the Commission has ordered review of the initial determination or certain issues therein, or by order has changed the effective date of the initial determination.

* * * * *

■ 17. Amend § 210.43 by revising paragraphs (a)(1) and (d)(1) and (3) to read as follows:

§ 210.43 Petitions for review of initial determinations on matters other than temporary relief.

(a) * * *

(1) Except as provided in paragraph (a)(2) of this section, any party to an investigation may request Commission review of an initial determination issued under § 210.42(a)(1) or (c), § 210.50(d)(3), § 210.70(c), or § 210.75(b)(3) by filing a petition with the Secretary. A petition for review of an initial determination issued under § 210.42(a)(1) must be filed within 12 days after service of the initial determination. A petition for review of an initial determination issued under § 210.42(a)(3) must be filed within five (5) business days after service of the initial determination. A petition for review of an initial determination issued under § 210.42(c) that terminates the investigation in its entirety on summary determination, or an initial determination issued under § 210.50(d)(3), § 210.70(c), or § 210.75(b)(3), must be filed within 10 days after service of the initial determination. Petitions for review of all other initial determinations under § 210.42(c) must be filed within five (5) business days after service of the initial determination. A petition for review of an initial determination issued under § 210.50(d)(3) or § 210.70(c) must be filed within 10 days after service of the initial determination.

(d) * * *

(1) The Commission shall decide whether to grant, in whole or in part, a petition for review of an initial determination filed pursuant to § 210.42(a)(2) or § 210.42(c), which grants a motion for summary determination that would terminate the investigation in its entirety if it becomes the final determination of the Commission, § 210.50(d)(3), or § 210.70(c) within 45 days after the service of the initial determination on the parties, or by such other time as the Commission may order. The Commission shall decide whether to grant, in whole or in part, a petition for review of an initial determination filed pursuant to § 210.42(a)(3) within 30 days after the service of the initial determination on the parties, or by such other time as the Commission may order. The Commission shall decide whether to grant, in whole or in part, a petition for review of an initial determination filed pursuant to § 210.42(c), except as noted above, within 30 days after the service of the initial determination on the parties, or by such other time as the Commission may order.

* * * * *

(3) The Commission shall grant a petition for review and order review of an initial determination or certain issues therein when at least one of the participating Commissioners votes for ordering review. In its notice, the Commission shall establish the scope of the review and the issues that will be considered and make provisions for filing of briefs and oral argument if deemed appropriate by the Commission.

■ 18. Amend § 210.47 by adding a sentence after the third sentence and revising the last sentence to read as follows:

§ 210.47 Petitions for reconsideration.

* * * Any party desiring to oppose such a petition shall file an answer thereto within five days after service of the petition upon such party. The Commission on its own initiative may order reconsideration of a Commission determination or any action ordered to be taken thereunder. The filing of a petition for reconsideration shall not stay the effective date of the determination or action ordered to be taken thereunder or toll the running of any statutory time period affecting such determination or action ordered to be taken thereunder unless specifically so ordered by the Commission.

■ 19. Amend § 210.50 by:

■ a. Revising paragraph (a)(4) introductory text;

■ b. Redesignating paragraph (a)(4)(i) through (iv) as paragraphs (a)(4)(ii) through (v); and

■ c. Adding new paragraph (a)(4)(i).

The revision and addition read as follows:

§ 210. 50 Commission action, the public interest, and bonding by respondents.

* * * * *

(a) * * *

(4) Receive submissions from the parties, interested persons, and other Government agencies and departments with respect to the subject matter of paragraphs (a)(1) through (3) of this section.

(i) After a recommended determination on remedy is issued by the presiding administrative law judge, the parties may submit to the Commission, within 30 days from service of the recommended determination, information relating to the public interest, including any updates to the information supplied under §§ 210.8(b) and (c) and 210.14(f). Submissions by the parties in response to the recommended determination are limited to 5 pages, inclusive of attachments. This provision does not apply to the public. Dates for submissions from the public are announced in the **Federal Register**.

* * * * *

Subpart I—Enforcement Procedures and Advisory Opinions

■ 20. Amend § 210.75 by:
■ a. Removing paragraph (a);
■ b. Redesignating paragraph (b) as paragraph (a) and:
■ i. Adding paragraphs (a)(1)(i) through (iv);
■ ii. Adding paragraph (a)(4)(iv);
■ iii. Revising newly redesignated paragraph (a)(5); and
■ c. Redesignating paragraph (c) as paragraph (b).

The additions and revisions read as follows:

§ 210.75 Proceedings to enforce exclusion orders, cease and desist orders, consent orders, and other Commission orders.

(a) * * *

(1) * * *

(i) The determination of whether to institute shall be made within 30 days after the complaint is filed, unless—

(A) Exceptional circumstances preclude adherence to a 30-day deadline;

(B) The filing party requests that the Commission postpone the determination on whether to institute an investigation; or

(C) The filing party withdraws the complaint.

(ii) If exceptional circumstances preclude Commission adherence to the 30-day deadline for determining whether to institute an investigation on the basis of the complaint, the determination will be made as soon after that deadline as possible.

(iii) If the filing party desires to have the Commission postpone making a determination on whether to institute an investigation in response to the complaint, the filing party must file a written request with the Secretary. If the request is granted, the determination will be rescheduled for whatever date is appropriate in light of the facts.

(iv) The filing party may withdraw the complaint as a matter of right at any time before the Commission votes on whether to institute an enforcement proceeding. To effect such withdrawal, the filing party must file a written notice with the Commission.

* * * * *

(4) * * *

(iv) Issue a new cease and desist order as necessary to prevent the unfair practices that were the basis for originally issuing the cease and desist order, consent order, and/or exclusion order subject to the enforcement proceeding.

(5) Prior to effecting any issuance, modification, revocation, or exclusion under this section, the Commission shall consider the effect of such action upon the public health and welfare, competitive conditions in the U.S. economy, the production of like or directly competitive articles in the United States, and U.S. consumers.

* * * * *

■ 21. Amend § 210.76 by:
■ a. Revising the section heading;
■ b. Revising paragraph (a)(1);
■ c. Adding paragraph (a)(3); and
■ d. Adding paragraphs (b)(1) through (5).

The revisions and additions read as follows:

§ 210.76 Modification or rescission of exclusion orders, cease and desist orders, consent orders, and seizure and forfeiture orders.

(a) *Petitions for modification or rescission of exclusion orders, cease and desist orders, and consent orders.* (1) Whenever any person believes that changed conditions of fact or law, or the public interest, require that an exclusion order, cease and desist order, or consent order be modified or set aside, in whole or in part, such person may request, pursuant to section 337(k)(1) of the Tariff Act of 1930, that the Commission make a determination that the conditions which led to the issuance of an exclusion order, cease and desist order, or consent order no longer exist. The Commission may also on its own initiative consider such action. The request shall state the changes desired and the changed circumstances or public interest warranting such action, shall include materials and argument in support thereof, and shall be served on all parties to the investigation in which the exclusion order, cease and desist order, or consent order was issued. Any person may file an opposition to the petition within 10 days of service of the petition. If the Commission makes such a determination, it shall notify the Secretary of the Treasury and U.S. Custom and Border Protection.

* * * * *

(3) If the petition requests modification or rescission of an order issued pursuant to section 337(d), (e), (f), (g), or (i) of the Tariff Act of 1930 on the basis of a licensing or other settlement agreement, the petition shall contain copies of the licensing or other settlement agreements, any supplemental agreements, any documents referenced in the petition or attached agreements, and a statement that there are no other agreements, written or oral, express or implied between the parties concerning the subject matter of the investigation. If the licensing or other settlement agreement contains confidential business information within the meaning of § 201.6(a) of this chapter, a copy of the agreement with such information deleted shall accompany the motion. On motion for good cause shown, the administrative law judge or the Commission may limit the service of the agreements to the settling parties and the Commission investigative attorney.

(b) * * *

(1) The determination of whether to institute shall be made within 30 days after the petition is filed, unless—

(i) Exceptional circumstances preclude adherence to a 30-day deadline;

(ii) The petitioner requests that the Commission postpone the determination on whether to institute a modification or rescission proceeding; or

(iii) The petitioner withdraws the petition.

(2) If exceptional circumstances preclude Commission adherence to the 30-day deadline for determining whether to institute a modification or rescission proceeding on the basis of the petition, the determination will be made as soon after that deadline as possible.

(3) If the petitioner desires to have the Commission postpone making a determination on whether to institute a modification or rescission proceeding in response to the petition, the petitioner must file a written request with the Secretary. If the request is granted, the determination will be rescheduled for a date that is appropriate in light of the facts.

(4) The petitioner may withdraw the complaint as a matter of right at any time before the Commission votes on whether to institute a modification or rescission proceeding. To effect such withdrawal, the petitioner must file a written notice with the Commission.

(5) The Commission shall institute a modification or rescission proceeding

by publication of a notice in the **Federal Register**. The notice will define the scope of the modification or rescission proceeding and may be amended by leave of the Commission.

* * * * *

§ 210.77 [Removed and Reserved]

■ 22. Remove and reserve § 210.77.

■ 23. Amend § 210.79 by revising paragraph (a) to read as follows:

§ 210.79 Advisory opinions.

(a) *Advisory opinions.* Upon request of any person, the Commission may, upon such investigation as it deems necessary, issue an advisory opinion as to whether any person's proposed course of action or conduct would violate a Commission exclusion order, cease and desist order, or consent order. Any responses to a request for an advisory opinion shall be filed within 10 days of service of the request. The Commission will consider whether the issuance of such an advisory opinion would facilitate the enforcement of section 337 of the Tariff Act of 1930, would be in the public interest, and would benefit consumers and competitive conditions in the United States, and whether the person has a compelling business need for the advice and has framed his request as fully and accurately as possible. Advisory opinion proceedings are not subject to sections 554, 555, 556, 557, and 702 of title 5 of the United States Code.

(1) The determination of whether to issue and advisory opinion shall be made within 30 days after the petition is filed, unless—

(i) Exceptional circumstances preclude adherence to a 30-day deadline;

(ii) The requester asks the Commission to postpone the determination on whether to institute an advisory proceeding; or

(iii) The petitioner withdraws the request.

(2) If exceptional circumstances preclude Commission adherence to the 30-day deadline for determining whether to institute an advisory proceeding on the basis of the request, the determination will be made as soon after that deadline as possible.

(3) If the requester desires that the Commission postpone making a determination on whether to institute an advisory proceeding in response to its request, the requester must file a written request with the Secretary. If the request is granted, the determination will be rescheduled for whatever date is appropriate in light of the facts.

(4) The requester may withdraw the request as a matter of right at any time before the Commission votes on whether to institute an advisory proceeding. To effect such withdrawal, the requester must file a written notice with the Commission.

(5) The Commission shall institute an advisory proceeding by publication of a notice in the **Federal Register**. The notice will define the scope of the advisory opinion and may be amended by leave of the Commission.

* * * * *

By order of the Commission.

Issued: April 26, 2018.

Lisa Barton,

Secretary to the Commission.

[FR Doc. 2018–09268 Filed 5–3–18; 4:15 pm]

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