Of those nine comments, three were related to the information collection request and six were out of scope. Specifically, one commenter requested a process that would allow web-brokers to enroll people without reporting individual issuer appointments, and CMS made this revision to the registration process. We also received some questions about how the training process will work. We confirmed that agents and brokers will only need to register for the FFE once and that CMS will host the training program, as opposed to individual issuers. As a result of the comments, we modified both the registration process and simplified how agents and brokers would participate in the Exchanges to make it align more closely with how issuers, agents, and web-brokers currently do business. *Form Number:* CMS–10464 (OCN: 0938–NEW); *Frequency:* Annually; *Affected Public:* Private Sector—Business or Other For-Profit, Non-For-Profit Institutions, or Farms; *Number of Respondents:* 350,000; *Total Annual Responses:* 350,000; *Total Annual Hours:* 175,000 hours. (For policy questions regarding this collection contact Leigha Basini at 301–492–4307. For all other issues call 410–786–1326.)

6. *Type of Information Collection Request:* Revision of a currently approved collection. *Title of Information Collection:* Electronic Funds Transfers Authorization Agreement; *Use:* The primary function of the Electronic Funds Transfer Authorization Agreement (CMS 588) is to gather information from a provider/supplier to establish an electronic payment process.

The legal authority to collect this information is found in Section 1815(a) of the Social Security Act. This section provides authority for the Secretary of Health and Human Services to pay providers/suppliers of Medicare services. Under 31 U.S.C. 3332(f)(1), all federal payments, including Medicare payments to providers and suppliers, shall be made by electronic funds transfer. 31 U.S.C. 7701 (c) requires that any person or entity doing business with the federal government must provide their Tax Identification Number (TIN).

The goal of this submission is to renew the data collection. Only two minor revisions for systems requirements will be made at this time, specifically adding a street address line for the location of the financial institution and adding an additional National Provider Identification (NPI) number collection field for those providers/suppliers who have more than one NPI. *Form Number:* CMS–588 (OCN: 0938–0626); *Frequency:* Occasionally; *Affected Public:* Private Sector—Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 94,000; *Total Annual Responses:* 94,000; *Total Annual Hours:* 23,500. (For policy questions regarding this collection contact Kim McPhillips at 410–786–5374. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on June 17, 2013.

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, Email: *OIRA_submission@omb.eop.gov.*

Dated: May 14, 2013.

Martique Jones,

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

[FR Doc. 2013–11811 Filed 5–16–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10088, CMS–10265, CMS–10477 and CMS–R–13]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS) is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Notification of Fiscal Intermediaries (FIs) and CMS of Co-located Medicare Providers and Supporting Regulations in 42 CFR 412.22 and 412.532; *Use:* Many long-term care hospitals (LTCHs) are co-located with other Medicare providers (acute care hospitals, inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and psychiatric facilities), which leads to potential gaming of the Medicare system based on patient shifting. We are requiring LTCHs to notify fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and CMS of co-located providers and establish policies to limit payment abuse that will be based on FIs and MACs tracking patient movement among these co-located providers 42 CFR 412.22(e)(6) and (h)(5).

Based upon being able to identify co-located providers, FIs, MACs, and CMS will be able to track patient shifting between LTCHs and other in-patient providers which will lead to appropriate payments under § 412.532. That section limits payments to LTCHs where over 5 percent of admissions represent patients who had been sequentially discharged by the LTCH, admitted to an on-site provider, and subsequently readmitted to the LTCH. Since each discharge triggers a Medicare payment, we implemented this policy to discourage payment abuse.

Form Number: CMS–10088 (OCN: 0938–0897); *Frequency:* Occasionally; *Affected Public:* Private Sector—Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 25; *Total Annual Responses:* 25; *Total Annual Hours:* 6. (For policy questions regarding this collection contact Judy Richter at 410–786–2590. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Reinstatement with a change of a previously approved collection; *Title of Information Collection:* Mandatory Insurer Reporting Requirements of Section 111 of the Medicare, Medicaid and SCHIP Act of 2007; *Use:* Section

111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (Pub. L. 110–173) (MMSEA) amends the Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)) to provide for mandatory reporting by group health plan arrangements and by liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws and plans. The law provides that, notwithstanding any other provision of law, the Secretary of Health and Human Services may implement this provision by program instruction or otherwise. The Secretary has elected not to implement the provision through rulemaking and will implement by publishing instructions on a publicly available Web site and submitting an information collection request to OMB for review and approval of the associated information collection requirements.

Effective January 1, 2009, as required by the MMSEA, an entity serving as an insurer or third party administrator for a group health plan and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary must: (1) Secure from the plan sponsor and plan participants such information as the Secretary may specify to identify situations where the group health plan is a primary plan to Medicare; and (2) report such information to the Secretary in the form and manner (including frequency) specified by the Secretary.

Effective July 1, 2009, as required by the MMSEA, ''applicable plans,'' must: (1) Determine whether a claimant is entitled to Medicare benefits; and, if so, (2) report the identity of such claimant and provide such other information as the Secretary may require to properly coordinate Medicare benefits with respect to such insurance arrangements in the form and manner (including frequency) as the Secretary may specify after the claim is resolved through a settlement, judgment, award or other payment (regardless of whether or not there is a determination or admission of liability). Applicable plan refers to the following laws, plans or other arrangements, including the fiduciary or administrator for such law, plan or arrangement: (1) Liability insurance (including self-insurance); (2) No-fault insurance; and (3) Workers' compensation laws or plans. As indicated, the Secretary has elected to implement this provision by publishing instructions at a Web site established for such purpose. The Web site is (*http://www.cms.hhs.gov/MandatoryInsRep/*). CMS shall use this Web site to publish preliminary guidance as well as the final instructions. The Web site also advises interested parties how to comment on the preliminary guidance. *Form Number:* CMS–10265 (OCN: 0938–1074); *Frequency:* Yearly; *Affected Public:* Private Sector—Business or other for-profits and not-for-profit institutions, State, Local or Tribal Governments; *Number of Respondents:* 22,647; *Total Annual Responses:* 22,647; *Total Annual Hours:* 333,130. (For policy questions regarding this collection contact Cynthia Ginsburg at 410–786–2579. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* New Collection (Request for a new control number); *Title of Information Collection:* Medicaid Incentives for Prevention of Chronic Disease (MIPCD) Demonstration; *Use:* Under section 4108(d)(1) of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) is required to contract with an independent entity or organization to conduct an evaluation of the Medicaid Incentives for Prevention of Chronic Disease (MIPCD) demonstration. The contractor will conduct state site visits, two rounds of focus group discussions, interviews with key program stakeholders, and field a beneficiary satisfaction survey. Both the state site visits and interviews with key program stakeholders will entail one-on-one interviews; however each set will have a unique data collection form. Thus, each evaluation task listed above has a separate data collection form and this proposed information collection encompasses four data collection forms. The purpose of the evaluation and assessment includes determining the following:

- The effect of such initiatives on the use of health care services by Medicaid beneficiaries participating in the program;
- The extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;
- The level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and
- The administrative costs incurred by state agencies that are responsible for administration of the program.

Form Number: CMS–10477 (OCN: 0938–NEW); *Frequency:* Annually; *Affected Public:* Individuals and households, business and not-for-profits, State, Local or Tribal Governments; *Number of Respondents:* 4,524; *Total Annual Responses:* 4,524; *Total Annual Hours:* 1,795. (For policy questions regarding this collection contact Jean Scott at 410–786–6327. For all other issues call 410–786–1326.)

4. *Type of Information Collection Request:* Reinstatement with change of a previously approved collection; *Title of Information Collection:* Conditions of Coverage for Organ Procurement Organizations and Supporting Regulations in 42 CFR, Sections 486.301–.348; *Use:* Section 1138(b) of the Social Security Act, as added by section 9318 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509), sets forth the statutory qualifications and requirements that organ procurement organizations (OPOs) must meet in order for the costs of their services in procuring organs for transplant centers to be reimbursable under the Medicare and Medicaid programs. An OPO must be certified and designated by the Secretary as an OPO and must meet performance-related standards prescribed by the Secretary. The corresponding regulations are found at 42 CFR Part 486 (Conditions for Coverage of Specialized Services Furnished by Suppliers) under subpart G (Requirements for Certification and Designation and Conditions for Coverage: Organ Procurement Organizations).

Since each OPO has a monopoly on organ procurement within its designated service area (DSA), CMS must hold OPOs to high standards. Collection of this information is necessary for CMS to assess the effectiveness of each OPO and determine whether it should continue to be certified as an OPO and designated for a particular donation service area by the Secretary or replaced by an OPO that can more effectively procure organs within that DSA. *Form Number:* CMS–R–13 (OCN: 0938–0688); *Frequency:* Occasionally; *Affected Public:* Not-for-profit institutions; *Number of Respondents:* 58; *Total Annual Responses:* 58; *Total Annual Hours:* 14,453. (For policy questions regarding this collection contact Diane Corning at 410–786–8486. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995*, or Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office on (410) 786–1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by July 16, 2013:

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number ____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: May 14, 2013.

Martique Jones,

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

[FR Doc. 2013–11812 Filed 5–16–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5504–N3]

Medicare Program; Bundled Payments for Care Improvement Model 1 Open Period

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

ACTION: Notice.

SUMMARY: This notice announces an open period for additional organizations to be considered for participation in Model 1 of the Bundled Payments for Care Improvement initiative.

DATES: *Model 1 of the Bundled Payments for Care Improvement Deadline:* Interested organizations must submit a Model 1 Open Period Information Intake form by July 31, 2013.

FOR FURTHER INFORMATION CONTACT:

BPModel1@cms.hhs.gov for questions regarding Model 1 of the Bundled Payments for Care Improvement initiative. For additional information on this initiative go to the CMS Center for Medicare and Medicaid Innovation Web site at *http://innovation.cms.gov/initiatives/BPCI-Model-1/index.html.*

SUPPLEMENTARY INFORMATION:

I. Background

We are committed to achieving better health, better care, and lower costs through continuous improvement for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. Beneficiaries can experience improved health outcomes and encounters in the health care system when providers work in a coordinated and person-centered manner. To this end, we are interested in partnering with providers that are working to redesign care to meet these goals. Payment approaches that reward providers that assume payment accountability at the individual level for a particular ''episode'' of care are potential mechanisms for developing these partnerships.

The CMS Center for Medicare and Medicaid Innovation (Innovation Center) is testing four episode payment models. Testing of the first model, Model 1 of the Bundled Payments for Care Improvement initiative, began in April 2013 following a review of applications submitted in response to a Request for Application released by the Innovation Center in August 2011. For additional information about Model 1 of the Bundled Payments for Care Improvement initiative that began in April 2013, please visit the Innovation Center Web site as specified in the **FOR FURTHER INFORMATION CONTACT** section of this notice.

The Innovation Center is announcing an open period for additional organizations to be considered for participation in Model 1 of the Bundled Payments for Care Improvement initiative. Interested organizations can find information about the intake process, eligible organizations, and model requirements on the Web site as specified in the **FOR FURTHER INFORMATION CONTACT** section of this notice.

II. Provisions of the Notice

We seek to achieve the following goals through implementation, consistent with the authority under section 1115A of the Social Security Act (the Act), as added by section 3021 of the Affordable Care Act, to test innovative payment and service delivery models that reduce spending under Medicare, Medicaid, or CHIP, while preserving or enhancing the quality of care:

- Improve care coordination, beneficiary experience, and accountability in a person-centered manner.
- Support and encourage providers that are interested in continuously reengineering care to deliver better care and better health at lower costs through continuous improvement.
- Create a cycle that leads to continually decreasing the cost of an acute or chronic episode of care while fostering quality improvement.
- Develop and test payment models that create extended accountability for better care, better health at lower costs for the full range of health care services.
- Shorten the cycle time for adoption of evidence-based care.
- Create environments that stimulate rapid development of new evidence-based knowledge.

We are announcing an open period for additional organizations to be considered for participation in Model 1 of the Bundled Payments for Care Improvement initiative. Acute care hospitals paid under the inpatient prospective payment systems (IPPS) and organizations that wish to convene acute care hospitals in a facilitator convener role are eligible to be considered for participation in Model 1. Interested organizations must submit a Model 1 Open Period Information Intake form for a copy of the form go to the CMS Web site as specified in the **FOR FURTHER INFORMATION CONTACT** section of this notice. Once organizations submit the intake form to *BPModel1@cms.hhs.gov*, we will review the information provided and screen organizations for suitability for participation in Model 1. For information on the screening process go to the CMS Center for Medicare and Medicaid Innovation Web site as specified in the **FOR FURTHER INFORMATION CONTACT** section. We expect to offer Model 1 participation agreements to those organizations that demonstrate their fitness for participation in Model 1. More information about the participation process and model requirements can be found on the Web site as specified in the **FOR FURTHER INFORMATION CONTACT** section of this notice.

III. Collection of Information Requirements

Section 1115A(d) of the Act waives the requirements of the Paperwork Reduction Act of 1995 for purposes of testing and evaluation of new models or expansion of such models under section 1115A under this section.

Authority: Section 1115A of the Social Security Act (42 U.S.C. 1315a)
(Catalog of Federal Domestic Assistance No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)