each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS–21 and –21B CMS–21 (Quarterly Children's Health Insurance Program (CHIP) Statement of Expenditures for the Title XXI Program) and CMS–21B (State Children's Health Insurance Program Budget Report for the Title XXI Program State Plan Expenditures)

Under the PRA (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA requires federal agencies to publish a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice.

Information Collection

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Quarterly Children's Health Insurance Program (CHIP) Statement of Expenditures for the Title XXI Program (CMS–21) and State Children's Health Insurance Program Budget Report for the Title XXI Program State Plan Expenditures (CMS–21B); *Use:* Forms CMS–21 and –21B provide CMS with the information necessary to issue quarterly grant awards, monitor current year expenditure levels, determine the allowability of state claims for reimbursement, develop CHIP financial management information, provide for state reporting of waiver expenditures, and ensure that the federally established allotment is not exceeded. Further, these forms are necessary in the redistribution and reallocation of unspent funds over the federally mandated timeframes. *Form Number:* CMS–21 and CMS–21B (OCN: 0938–0731); *Frequency:* Quarterly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 448; *Total Annual Hours:* 7,840. (For policy questions regarding this collection contact Abraham John at 410–786–4519).

Dated: February 11, 2014.

Martique Jones,

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

[FR Doc. 2014–03293 Filed 2–13–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–18F5, CMS–10120, and CMS–10512]

Agency Information Collection Activities: Submission for OMB Review; Comment Request and Correction

ACTION: Notice; correction.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the 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.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by *March 17, 2014.*

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

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

1. Access CMS' Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995.*

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov.*

3. Call the Reports Clearance Office at (410) 786–1326.

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

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

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Application for Hospital Insurance and Supporting Regulations; *Use:* Regulations at 42 CFR 406.6 specify the individuals who must file an application for Medicare Hospital Insurance (Part A) and those who need not file an application for Part A. Section 406.7 lists CMS–18F5 as the application form. The form elicits information that the Social Security Administration and CMS need to determine entitlement to Part A and Supplementary Medical Insurance (Part B); *Form Number:* CMS–18F5 (OCN: 0938–0251); *Frequency:* Once; *Affected Public:* Individuals or households; *Number of Respondents:* 50,000; *Total Annual Responses:* 50,000; *Total Annual Hours:* 12,500. (For policy questions regarding this collection contact Naomi Rappaport at 410–786–2175).

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* 1932(a) State Plan Amendment Template, State Plan Requirements and Supporting Regulations; *Use:* Section 1932(a)(1)(A) of the Social Security Act (the Act) grants states the authority to enroll Medicaid beneficiaries on a mandatory basis into managed care entities and primary care case managers. Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on state-wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). The template may be used by states to easily modify their state plans if they choose to implement the provisions of section 1932(a)(1)(A); *Form Number:* CMS–10120 (OCN: 0938–0933); *Frequency:* Once and occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 15; *Total Annual Hours:* 65. (For policy questions regarding this collection contact Camille Dobson at 410–786–7062).

3. *Title of Information Collection:* Direct Service Workforce (DSW) Resource Center (RC) Core Competencies (CC) Survey Instrument. *Form Number:* CMS–10512 (OCN: 0938—New).

The 30-day PRA notice published in the **Federal Register** on February 7, 2014, as a correction. While the requirements, burden estimates, and public comment information that were set out in that notice and in the associated supporting materials were correct, the notice inadvertently published as a correction.

Correction

In the **Federal Register** of February 7, 2014, in FR Doc. 2014–02630, on page 7462, in the first column, correct the document as follows:

a. Correct the subject heading to read: Agency Information Collection Activities: Submission for OMB Review; Comment Request

b. Correct the ''Action'' caption to read: **ACTION:** Notice.

Dated: February 11, 2014.

Martique Jones,

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

[FR Doc. 2014–03290 Filed 2–13–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5504–N4]

Medicare Program; Bundled Payments for Care Improvement Models 2, 3, and 4 2014 Winter 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 Models 2, 3, and 4 of the Bundled Payments for Care Improvement initiative.

DATES: *Submission Deadline:* Models 2, 3, and 4 Open Period intake forms must be submitted by April 18, 2014.

ADDRESSES: Interested organizations must submit their Models 2, 3, and 4 Open Period intake forms via email at *BundledPayments@cms.hhs.gov.* All forms must be in a searchable word or PDF format.

FOR FURTHER INFORMATION CONTACT: For questions regarding Models 2, 3, and 4 of the Bundled Payments for Care Improvement initiative send an email to *BundledPayments@cms.hhs.gov.* For additional information on this initiative go to the CMS Center for Medicare and Medicaid Innovation (Innovation Center) Web site at *http://innovation.cms.gov/initiatives/Bundled-Payments/Models2-4OpenPeriod.html.*

SUPPLEMENTARY INFORMATION:

I. Background

Section 1115A of the Social Security Act (the Act), as added by section 3021 of the Affordable Care Act, authorized the Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models that reduce spending under Medicare, Medicaid, or CHIP, while preserving or enhancing the quality of care. Consistent with that authority, we seek to achieve the following goals:

- 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 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 for a particular ''episode'' of care are potential mechanisms for developing these partnerships.

The Innovation Center is testing four episode payment models through the Bundled Payments for Care Improvement initiative. The current participants in the initiative were selected following a review of the applications submitted in response to a Request for Application, *http://innovation.cms.gov/Files/x/Bundled-Payment-Request-for-Application.pdf* released by the Innovation Center in August 2011. On January 31, 2013, the first set of BPCI Phase 1 participants were announced. Phase 2 began either on October 1, 2013 or January 1, 2014 for Awardees that have entered into Model 2 Awardee Agreements with CMS, at which point Awardees began the risk-bearing phase for some or all of their episodes. The complete transition of all episodes for all episode initiators to Phase 2 will be completed by October 2014. During the transition period, Awardees may transition episodes and/or Episode Initiators that have remained in Phase 1 to Phase 2 on a quarterly basis.

We began testing Model 1 of the initiative in April 2013. Model 1 is a retrospective payment model for the acute inpatient hospital stay. In the May 17, 2013 **Federal Register** (78 FR 29139), we published a notice announcing an open period for additional organizations to be considered for participation in Model 1 of the initiative.

Phase 2 of Models 2 through 4 began testing in October 2013. Models 2, 3, and 4 are described as follows:

- Model 2—Retrospective bundled payment models for hospitals,