CARE Data Set V1.01. *Form Number:* CMS–10409 (OCN: 0938–1163); *Frequency:* Occasionally; *Affected Public:* Private Sector: Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 442; *Total Annual Responses:* 403,988; *Total Annual Hours:* 212,160. (For policy questions regarding this collection contact Charles Padgett at 410–786–2811. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* New collection (request for a new OMB control number). *Title of Information Collection:* Emergency Department Patient Experience of Care Survey. *Use:* This survey supports the six national priorities for improving care from the National Quality Strategy developed by the U.S. Department of Health and Human Services (HHS) that was called for under the Affordable Care Act to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care. The priorities support a three-part aim focusing on better care, better health, and lower costs through improvement. In this regard, this survey will provide patient experiences with care data that enables making comparisons of emergency departments across the nation and promoting effective communication and coordination. *Form Number:* CMS–10461 (OCN: 0938—New). *Frequency:* Once. *Affected Public:* Individuals and households. *Number of Respondents: Total Annual Responses:* 3,360. *Total Annual Hours:* 799. (For policy questions regarding this collection contact Sai Ma at 410–786–1479. 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 May 13, 2013. OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, Email: *OIRA_submission@omb.eop.gov.*

Dated: April 9, 2013.

Martique Jones,

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

[FR Doc. 2013–08677 Filed 4–11–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–460 and CMS–10469]

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 of a currently approved collection; *Title of Information Collection:* Medicare Participating Physician or Supplier Agreement. *Use:* Section 1842(h) of the Social Security Act permits physicians and suppliers to voluntarily participate in Medicare Part B by agreeing to take assignment on all claims for services to Medicare beneficiaries. The law also requires that the Secretary provide specific benefits to the physicians, suppliers and other persons who choose to participate. The CMS–460 is the agreement by which the physician or supplier elects to participate in Medicare. The information is used by: Medicare contractors to provide the benefits the law provides for participating entities and to enable contractors to enforce the Medicare limiting charge for physicians, suppliers and other persons who do not participate; Medicare beneficiaries to assist them in locating physicians who will accept Medicare assignment on claims for services and therefore save them money; and CMS to gauge the effectiveness of our and contractors efforts to increase participation in Medicare. *Form Number:* CMS–460 (OCN: 0938–0373). *Frequency:* Yearly. *Affected Public:* Private sector (business or other for-profits). *Number of Respondents:* 120,000. *Total Annual Responses:* 120,000. *Total Annual Hours:* 30,000. (For policy questions regarding this collection contact April Billingsley at 410–786–0140. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Issuer Reporting Requirements for Selecting a Cost-Sharing Reductions Reconciliation Methodology; *Use:* Under established Department of Health and Human Services (HHS) regulations, qualified health plan (QHP) issuers will receive advance payments of the cost-sharing reductions throughout the year. Each issuer will then be subject to one of two reconciliation processes after the year to ensure that HHS reimbursed each issuer the correct advance cost-sharing amount. This information collection request establishes the data collection requirements for a QHP issuer to report to HHS which reconciliation reporting option the issuer will be subject to for a given benefit year.

On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111–148. Sections 1402 and 1412 of the Affordable Care Act provide for reductions in cost sharing on essential health benefits for low- and moderate-income enrollees in silver level qualified health plans on individual market Exchanges. It also provides for reductions in cost sharing for Indians enrolled in QHPs at any metal level. These cost-sharing reductions will help eligible individuals and families afford the out-of-pocket spending associated with health care services provided through Exchange-based QHP coverage.

The law directs QHP issuers to notify the Secretary of HHS of cost-sharing reductions made under the statute for qualified individuals, and directs the Secretary to make periodic and timely payments to the QHP issuer equal to the value of those reductions. Further, the law permits advance payment of the cost-sharing reduction amounts to QHP issuers based upon amounts specified by the Secretary.

On December 7, 2012, HHS published a proposed rule (77 FR 73118) entitled ''HHS Notice of Benefit and Payment Parameters for 2014.'' This rule proposed a payment approach under which CMS would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments after the end of the benefit year to the actual cost-sharing reduction amounts. The reconciliation process described in the rule would require that QHP issuers provide CMS the amount of cost-sharing paid by each enrollee, as well as the level of cost-sharing that enrollee would have paid under a standard plan without cost-sharing reductions. To determine the amount of cost-sharing an enrollee receiving cost-sharing reductions would have paid under a standard plan, QHP issuers would need to re-adjudicate each claim for these enrollees under a standard plan structure. HHS finalized the proposed notice of benefit and payment parameters for 2014 and this approach on March 11, 2013 (78 FR 15410).

During the comment period to the proposed rule, HHS received numerous comments suggesting that the reporting requirements of the reconciliation process for QHP issuers would be operationally challenging for some issuers. In response to these comments, HHS issued an interim final rule (CMS–9964–IFC) with comment period on March 11, 2013 (78 FR 15541) entitled ''Amendments to the HHS Notice of Benefit and Payment Parameters for 2014,'' which laid out an alternative approach that QHP issuers may elect to pursue with respect to the reporting requirements. This alternative approach would allow a QHP issuer to estimate the amount of cost-sharing an enrollee receiving cost-sharing reductions would have paid under a standard plan in the Exchange, rather than re-adjudicating each of the enrollee's claims. This approach is intended to permit a reasonable transitional period in which QHP issuers will be allowed to choose the methodology that best aligns with their operational practices, which should reduce the administrative burden on issuers in the initial years of the Exchanges. The interim final rule describes the estimation methodology in sufficient detail to allow QHP issuers to make an informed decision of which reporting approach to pursue.

Prior to the start of each coverage year, QHP issuers must notify HHS of the methodology it is selecting for the benefit year. QHP issuers will provide information on which option they choose via the Health Insurance Oversight System (HIOS), a web-based data collection system that is already being used by issuers to provide information for the healthcare.gov Web site. All submissions will be made electronically and no paper submissions are required. The QHP issuer must select the same methodology for all plan variations it offers on the Exchange for a benefit year. Moreover, as the estimated methodology is intended as a transition to the actual methodology, the QHP issuer may not select the estimated methodology if it selected the actual methodology for the prior benefit year. *Form Number:* CMS–10469 (OCN: 0938–NEW); *Frequency:* Annually; *Affected Public:* Private Sector (business or other for-profits); *Number of Respondents:* 1,200; *Total Annual Responses:* 1,200; *Total Annual Hours:* 13,200. (For policy questions regarding this collection contact Chris Weiser at 410–786–0650. 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 June 11, 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: April 9, 2013.

Martique Jones,

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

[FR Doc. 2013–08676 Filed 4–11–13; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10463]

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:* New collection; *Title of Information Collection:* Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges; *Use:* Section 1311(i) of the Affordable Care Act requires Exchanges to establish a Navigator grant program as part of its function to provide consumers with assistance when they need it. Navigators will assist consumers by providing education about and facilitating selection of qualified health plans (QHPs) within Exchanges, as well as other required duties. Section 1311(i) requires that an Exchange operating as of January 1, 2014, must establish a Navigator Program under which it awards grants to eligible individuals or entities who satisfy the requirements to be Exchange Navigators. For Federally-facilitated Exchanges (FFE) and State Partnership Exchanges (SPEs), CMS will be awarding these grants. Navigator awardees must provide quarterly, bi-annual, and an annual progress report to CMS on the activities performed during the grant period and any sub-awardees receiving funds. *Form Number:* CMS–10463 (OMB#: 0938–NEW); *Frequency:* Annually; Quarterly; *Affected Public:* Private sector *Number of Respondents:*