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 function; (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. *Title of Information Collection:* Initial Plan Data Collection to Support Qualified Health Plan (QHP) Certification and Other Financial Management and Exchange Operations; *Type of Information Collection Request:* New information collection; *Use:* As required by the CMS–9989–F (77 CFR 18310, March 27, 2012): Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (Exchange rule), each Exchange must assume responsibilities related to the certification and offering of Qualified Health Plans (QHPs). To offer insurance through an Exchange, a health insurance issuer must have its health plans certified as QHPs by the Exchange. A QHP must meet certain minimum certification standards, such as essential community providers, essential health benefits, and actuarial value. In order to meet those standards, the Exchange is responsible for collecting data and validating that QHPs meet these minimum requirements as described in the Exchange rule under 45 CFR 155 and 156, based on the Affordable Care Act, as well as other requirements determined by the Exchange. In addition to data collection for the certification of QHPs, the reinsurance and risk adjustment programs outlined by the Affordable Care Act, detailed in 45 CFR 153, CMS–9975–F(77 FR 17220, March 23, 2012): Standards for Reinsurance, Risk Corridors, and Risk Adjustment, have general information reporting requirements that apply to non-QHPs outside of the Exchanges.

The original 60-day comment period began on July 6, 2012 (77 FR 40061). We received a number of public comments which addressed multiple issues. Some of the commenters were concerned with duplicate data collection. CMS is working with States to minimize any required document submission to streamline and reduce duplication, especially in future years. CMS has oversight and enforcement responsibilities unique to Exchanges that may require more than verification from a state. CMS has also aligned the data collection for SBCs, healthcare.gov, and EHB. Other commenters asked for more clarification on the data elements we are collection. We have included those data elements in this data collection. Furthermore, CMS will provide greater clarification on its process associated with QHP certification, essential community providers, and network adequacy among other QHP certification requirements. We have taken into consideration all of the proposed suggestions and have made changes to this collection of information. In addition, CMS is increasing the estimated burden by 21 hours.

Form Number: CMS–10433; *Frequency:* Annually; *Affected Public:* States and Private Sector: Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 3490; *Number of Responses:* 3490; *Total Annual Hours:* 242,190 hours in year one and 184,110 hours in years two and three. (For policy questions regarding the QHP Certification data collection, contact Gina Zdanowicz at (301) 492–4451. For policy questions regarding risk adjustment and reinsurance data collection, contact Milan Shah at (301) 492–4427. 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 December 21, 2012. OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, Email: *OIRA_submission@omb.eop.gov.*

Dated: November 16, 2012.

Martique Jones,

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

[FR Doc. 2012–28379 Filed 11–20–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10451 and CMS–10455]

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 Uniform Institutional Provider Bill and Supporting Regulations in 42 CFR 424.5; *Use:* Section 42 CFR 424.5(a)(5) requires providers of services to submit a claim for payment prior to any Medicare reimbursement. Charges billed are coded by revenue codes. The bill specifies diagnoses according to the International Classification of Diseases, Ninth Edition (ICD–9–CM) code. Inpatient procedures are identified by ICD–9–CM codes, and outpatient procedures are described using the CMS Common Procedure Coding System (HCPCS). These are standard systems of identification for all major health insurance claims payers. Submission of information on the CMS–1450 permits Medicare intermediaries to receive consistent data for proper payment. *Form Numbers:* CMS–1450 (UB–04) (OMB#: 0938–0997); *Frequency:* Reporting—On occasion; *Affected Public:* Not-for-profit institutions, business or other for-profit; *Number of Respondents:* 53,111; *Total Annual Responses:* 181,909,654; *Total Annual Hours:* 1,567,455. (For policy questions

regarding this collection contact Matt Klischer at 410–786–7488. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Report of a Hospital Death Associated with Restraint or Seclusion; *Use:* Executive Order 13563, Improving Regulation and Regulatory Review, was signed on January 18, 2011. The order recognized the importance of a streamlined, effective, and efficient regulatory framework designed to promote economic growth, innovation, job creation, and competitiveness. Each agency was directed to establish an ongoing plan to reduce or eliminate burdensome, obsolete, or unnecessary regulations to create a more efficient and flexible structure.

The regulation that was published on May, 16, 2012 (77 FR 29034) included a reduction in the reporting requirement related to hospital deaths associated with the use of restraint or seclusion, § 482.13(g). Hospitals are no longer required to report to CMS those deaths where there was no use of seclusion and the only restraint was 2-point soft wrist restraints. It is estimated that this will reduce the volume of reports that must be submitted by 90 percent for hospitals. In addition, the final rule replaced the previous requirement for reporting via telephone to CMS, which proved to be cumbersome for both CMS and hospitals, with a requirement that allows submission of reports via telephone, facsimile or electronically, as determined by CMS. Finally, the amount of information that CMS needs for each death report in order for CMS to determine whether further on-site investigation is needed has been reduced.

The Child Health Act (CHA) of 2000 established in Title V, Part H, Section 591 of the Public Health Service Act (PHSA) minimum requirements concerning the use of restraints and seclusion in facilities that receive support with funds appropriated to any Federal department or agency. In addition, the CHA enacted Section 592 of the PHSA, which establishes minimum mandatory reporting requirements for deaths in such facilities associated with use of restraint or seclusion. Provisions implementing this statutory reporting requirement for hospitals participating in Medicare are found at 42 CFR 482.13(g), as revised in the final rule that published on May 16, 2012 (77 FR 29034). *Form Number:* CMS–10455 (OCN: 0938–New); *Frequency:* Occasionally; *Affected Public:* Private Sector. *Number of Respondents:* 4,900. *Number of Responses:* 24,500. *Total Annual Hours:* 8,085. (For policy questions regarding this collection contact Danielle Miller at 410–786–8818. 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 *January 22, 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: November 16, 2012.

Martique Jones,

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

[FR Doc. 2012–28381 Filed 11–20–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8046–N]

RIN 0938–AR14

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for CY 2013

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

ACTION: Notice.

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year (CY) 2013 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2013, the inpatient hospital deductible will be $1,184. The daily coinsurance amounts for CY 2013 will be: $296 for the 61st through 90th day of hospitalization in a benefit period; $592 for lifetime reserve days; and $148 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

DATES: This notice is effective on January 1, 2013.

FOR FURTHER INFORMATION CONTACT:

Clare McFarland, (410) 786–6390 for general information.

Gregory J. Savord, (410) 786–1521 for case-mix analysis.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires us to determine and publish each year the amount of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts applicable for services furnished in the following calendar year (CY).

II. Computing the Inpatient Hospital Deductible for CY 2013

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding CY, adjusted by our best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act) used for updating the payment rates to hospitals for discharges in the fiscal year (FY) that begins on October 1 of the same preceding CY, and adjusted to reflect changes in real case-mix. The adjustment to reflect real case-mix is determined on the basis of the most recent case-mix data available. The amount determined under this formula is rounded to the nearest multiple of $4