• Which of the services listed were covered by the plan? Routine vision care for children, Routine dental care for children, Mental health care, and Substance abuse treatment will be added Routine vision care for adults and Routine dental care for adults will replace Routine vision care and Routine dental care respectively. Chiropractic care remains unchanged.

• Is this a Grandfathered health plan as defined by the Affordable Care Act? Yes/No/Don't know

Deletions

• How many different pricing categories or tiers of prescription drug coverage were there for this plan? Number of tiers _____ or Don't know

• What was the MAXIMUM amount this plan would have paid for an enrollee in ONE YEAR? $_____ or No annual maximum

• An employer can offer a Health Reimbursement Arrangement (HRA) by setting up an account to reimburse employees for medical expenses not covered by health insurance. Did your organization offer an HRA associated with this plan in 2013? HRAs are NOT Flexible Spending Accounts (FSAs) or Health Savings Accounts (HSAs). Yes/No/Don't Know

The MEPS Definitions form—MEPS–20(D)—will also be updated with new definitions for terms used in these new questions (and the deletion of terms used only in the deleted questions).

There are no changes to the 2013 MEPS–IC survey estimates of cost and hour burdens due to these proposed question changes. The response rate for the MEPS–IC survey also is not expected to change due to these proposed changes.

The MEPS–IC is conducted pursuant to AHRQ's statutory authority to conduct surveys to collect data on the cost, use and quality of health care, including the types and costs of private health insurance. 42 U.S.C. 299b–2(a).

Method of Collection

There are no changes to the current data collection methods.

Estimated Annual Respondent Burden

There are no changes to the current burden estimates.

Estimated Annual Costs to the Federal Government

There are no changes to the current cost estimates.

Request for Comments

In accordance with the Paperwork Reduction Act, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of AHRQ healthcare research and healthcare information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) 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 upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: December 13, 2012.

Carolyn M. Clancy,

Director.

[FR Doc. 2012–30631 Filed 12–21–12; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30-Day-13–0612]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 639–7570 or send an email to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Reporting System (OMB #0920–0612, exp. 3/31/2013)—Extension—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The WISEWOMAN program (Well-Integrated Screening and Evaluation for Women Across the Nation), administered by the Centers for Disease Control and Prevention (CDC), was established to examine ways to improve the delivery of services for women who have limited access to health care and elevated risk factors for cardiovascular disease (CVD). The program focuses on reducing CVD risk factors and provides screening services for select risk factors such as elevated blood cholesterol, hypertension and abnormal blood glucose levels. The program also provides lifestyle interventions and medical referrals. On an annual basis, 21 grantees funded through the WISEWOMAN program have provided services to approximately 30,000 women who are already participating in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), also administered by CDC.

CDC seeks a one-year extension of OMB approval to collect information about WISEWOMAN grantee activities in the final year of the five-year cooperative agreement. There are no changes to the number of respondents, the data items reported to CDC, the estimated burden per response, or the total estimated annualized burden. All information will continue to be collected twice per year.

Information reported to CDC includes baseline and follow-up data (12 months post enrollment) for all women served through the WISEWOMAN program. These data, called the minimum data elements (MDE), include data elements that describe risk factors for the women served in each program and data elements that describe the number and type of intervention sessions attended. Funded grantees compile the data from their existing databases and report the MDE to CDC electronically. The estimated burden per response for Screening and Assessment MDE is 16 hours, and the estimated burden per response for Lifestyle Intervention MDE is 8 hours.

WISEWOMAN grantees also submit semi-annual progress reports that describe programmatic activities, public education and outreach, professional education, and the delivery of services. Progress reports will continue to be submitted to CDC in hardcopy format. The estimated burden per response for each progress report is 16 hours.

The information collection is designed to support continuous program monitoring and improvement. CDC uses the MDE data to assess the effectiveness of the WISEWOMAN program in

reducing the burden of cardiovascular disease risk factors among women who utilize program services. CDC uses the information submitted through progress reports to assess each grantee's progress toward meeting stated program objectives. Participation in the information collection is required under the terms of the WISEWOMAN cooperative agreement.

OMB approval is requested for one year. The total estimated annualized burden hours are 1,680.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hr)
WISEWOMAN Grantees	Screening and Assessment MDE	21	2	16
	Lifestyle Intervention MDE	21	2	8
	Progress Report	21	2	16

Dated: December 18, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity (OSI), Office of the Associate Director for Science (OADS), Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2012–30929 Filed 12–21–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-13–0573]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call (404) 639–7570 or send an email to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC 20503 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

The National HIV Surveillance System (NHSS) (OMB No. 0920–0573, Expiration 01/31/2013)-Revision-National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC). This title is being changed from the previously approved title *Adult and Pediatric HIV/AIDS Confidential Case Reports for National HIV/AIDS Surveillance* in 2009.

Background and Brief Description

The purpose of HIV surveillance is to monitor trends in HIV and describe the characteristics of infected persons (e.g., demographics, modes of exposure to HIV, clinical and laboratory markers of HIV disease, manifestations of severe HIV disease, and deaths among persons with HIV). HIV surveillance data are widely used at all government levels to assess the impact of HIV infection on morbidity and mortality, to allocate medical care resources and services, and to guide prevention and disease control activities.

CDC, in collaboration with health departments in the 50 states, the District of Columbia, and U.S. dependent areas, conduct national surveillance for cases of HIV infection. National surveillance includes tracking critical data across the spectrum of HIV disease from HIV diagnosis, to AIDS, the end-stage disease caused by infection with HIV, and death. In addition, this national system provides essential data to estimate HIV incidence and monitor patterns in viral resistance and HIV–1 subtypes, as well as provide information on perinatal exposures in the U.S.

The CDC surveillance case definition has been modified periodically to accurately monitor disease in adults, adolescents and children and reflect use of new testing technologies and changes in HIV treatment. Information is then updated in the case report forms and reporting software as needed. In 2012, CDC convened an expert consultation to consider revisions of various aspects of the case definition including criteria for reporting a potential case, criteria for reporting a confirmed case, and case classification (disease staging system). Recommendations for revisions in the case definition were adopted by the Council of State and Territorial Epidemiologists in June 2012 and the final case definition revision is planned for implementation in 2013 after publication.

The revisions requested include modifications to currently collected data elements and forms to align with anticipated changes in the case definitions for HIV surveillance to be published in 2012 and continuation of HIV surveillance activities funded under the new funding opportunity announcement CDC–RFA–PS13–1302 National HIV Surveillance System (NHSS). These include minor modifications of testing categories to accommodate new testing algorithms and modifications to staging criteria and non-substantial editorial changes aimed at improving the format and usability of the forms such as improved wording of terms and changes in the format of some response options. In addition, the number of data elements from the former enhanced perinatal surveillance (EPS) was reduced and the form modified for continuation in 2013 as Perinatal HIV Exposure Reporting (PHER). Surveillance data collection on variant and atypical strains (formerly variant, atypical and resistant HIV surveillance (VARHS)) will be continued as Molecular HIV Surveillance (MHS) with a reduced number of data elements previously approved under VARHS.

CDC provides funding for 59 jurisdictions to conduct adult and pediatric HIV case surveillance. Health department staffs compile information from laboratories, physicians, hospitals, clinics and other health care providers in order to complete the HIV and pediatric case reports. Updates to case reports are also entered into enhanced HIV/AIDS Reporting system (eHARS) by health departments, as additional information may be received from laboratories, vital statistics offices, or additional providers. Evaluations are also conducted by health departments on a subset of case reports (e.g. including re-abstraction/validation activities and routine interstate de-duplication) in all jurisdictions.

Supplemental surveillance data are collected in a subset of areas to provide additional information necessary to estimate HIV incidence, to better describe the extent of HIV viral