the we collect and disseminate valid and reliable information that can be used to improve quality of care through identification of quality improvement opportunities, assist us in carrying out our oversight responsibilities, and help beneficiaries make an informed choice among health plans. *Form Number:* CMS–10203 (OCN: 0938–0701); *Frequency:* Yearly; *Affected Public:* Individuals and households; *Number of Respondents:* 739,959; *Total Annual Responses:* 244,187; *Total Annual Hours:* 244,187. (For policy questions regarding this collection contact Kimberly DeMichele at 410–786–4286.)

Dated: February 24, 2014.

Martique Jones,

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

[FR Doc. 2014–04328 Filed 2–27–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10346 and CMS–10496]

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

ACTION: Notice.

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 31, 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:* Appeals of Quality Bonus Payment Determinations; *Use:* Section 1853(o) of the Social Security Act (the Act) requires us to make quality bonus payments (QBPs) QBPs to Medicare Advantage (MA) organizations that achieve performance rating scores of at least 4 stars under a five-star rating system. While we have applied a Star Rating system to MA organizations for a number of years, prior to the QBP program these Star Ratings were used only to provide additional information for beneficiaries to consider in making their Part C and D plan elections. Beginning in 2012, the Star Ratings we assign for purposes of QBPs directly affected the monthly payment amount MA organizations receive from us under their contracts. Additionally, section 1854(b)(1)(C)(v) of the Act, as added by the Affordable Care Act, also requires us to change the share of savings that MA organizations must provide to enrollees as the beneficiary rebate specified at § 422.266(a) based on the level of a sponsor's Star Rating for quality performance.

While the statute does not specify an administrative review process for appealing low QBP Star Ratings, we have implemented an appeals process in accordance with its authority to establish MA program standards by regulation at section 1856(b)(1) of the Act. Under this process, MA organizations may seek review of their QBP Star Rating determinations. This review process also applies to the determinations we made where the organization's Star Rating sets its QBP status at ineligible for rebate retention. The information collected from Medicare Advantage organizations is considered by the reconsideration official and potentially the hearing officer to review our determination of the organization's eligibility for a quality bonus payment. *Form Number:* CMS–10346 (OCN: 0938–1129; *Frequency:* Yearly; *Affected Public:* Private sector—Business or other for-profits; *Number of Respondents:* 350; *Total Annual Responses:* 25; *Total Annual Hours:* 200. (For policy questions regarding this collection contact Sarah Gaillot at 410–786–4637).

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* State Health Insurance Exchange Incident Report; *Use:* We have implemented a Computer Matching Agreement (CMA) with the State-Based Administering Entities (AEs). This agreement establishes the terms, conditions, safeguards, and procedures under which we will disclose certain information to the AEs in accordance with the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act (Pub. L. 111–152), which are referred to collectively as the Affordable Care Act (ACA),

amendments to the Social Security Act made by the ACA, and the implementing regulations. The AEs, which are state entities administering Insurance Affordability Programs, will use the data, accessed through the CMS Data Services Hub (Hub), to make Eligibility Determinations for Insurance Affordability Programs and certificates of exemption.

The AEs shall report suspected or confirmed incidents affecting loss or suspected loss of PII within one hour of discovery to their designated Center for Consumer Information and Insurance Oversight State Officer who will then notify the affected Federal agency data sources, i.e., Internal Revenue Service, Department of Defense, Department of Homeland Security, Social Security Administration, Peace Corps, Office of Personnel Management and Veterans Health Administration. Additionally, AEs shall contact the office of the appropriate Special Agent-in-Charge, Treasury Inspector General for Tax Administration (TIGTA), and the IRS Office of Safeguards within 24 hours of discovery of any potential breach, loss, or misuse of Return Information. *Form Number:* CMS–10496 (OCN: 0938–1216); *Frequency:* Occasionally; *Affected Public:* State, Local or Tribal governments; *Number of Respondents:* 18; *Total Annual Responses:* 936; *Total Annual Hours:* 234. (For policy questions regarding this collection contact Theodora Wills at 410–786–1504.)

Dated: February 24, 2014.

Martique Jones,

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

[FR Doc. 2014–04327 Filed 2–27–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2389–N]

Medicaid Program; Preliminary Disproportionate Share Hospital Allotments (DSH) for Fiscal Year (FY) 2014 and the Preliminary Institutions for Mental Diseases Disproportionate Share Hospital Limits for FY 2014

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

ACTION: Notice.

SUMMARY: This notice announces the preliminary federal share DSH allotments for FY 2014 and the preliminary federal share FY 2014 limits on aggregate DSH payments that states may make to institutions for mental diseases (IMDs) and other mental health facilities. This notice also includes additional information regarding the calculation of the FY 2014 DSH allotments and FY 2014 IMD DSH limits.

DATES: *Effective Date:* This notice is effective on March 31, 2014. The final allotments and limitations set forth in this notice are effective for the fiscal years specified.

FOR FURTHER INFORMATION CONTACT: Rory Howe, (410) 786–4878; or Richard Strauss, (410) 786–2019.

SUPPLEMENTARY INFORMATION:

I. Background

A. Fiscal Year DSH Allotments

A state's federal fiscal year (FY) disproportionate share hospital (DSH) allotment represents the aggregate limit on the federal share amount of the state's payments to DSH hospitals in the state for the FY. The amount of such allotment is determined in accordance with the provisions of section 1923(f)(3) of the Social Security Act (the Act). Under such provisions, in general a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the Consumer Price Index for all Urban Consumers (CPI–U) for the previous FY.

The Affordable Care Act amended Medicaid DSH provisions, adding section 1923(f)(7) of the Act which would have required reductions to states' FY DSH allotments beginning with FY 2014, the calculation of which was described in the Disproportionate Share Hospital Payment Reduction final rule published in the September 18, 2013 **Federal Register** (78 FR 57293). Under the DSH reduction methodology, first, each state's unreduced FY DSH allotment would have been calculated in accordance with the provisions of section 1923(f) of the Act, excluding section 1923(f)(7) of the Act; then, the reduction amount for each state would have been determined under the provisions of section 1923(f)(7) of the Act and implementing regulations at 42 CFR 447.294; and, finally, the net FY DSH allotment for each state would have been determined by subtracting the DSH reduction amount for the state from its unreduced FY 2014 DSH allotment.

The reductions under section 1923(f)(7) of the Act were delayed and modified by section 1204 of Division B (Medicare and Other Health Provisions) of the ''Pathway for SGR Reform Act of 2013'' (Pub. L. 113–67), which was enacted on December 26, 2013. The reductions of states' fiscal year DSH allotments under section 1923(f)(7) of the Act that were applicable to FY 2014 and 2015 were repealed, and the FY 2016 was increased substantially.

Because there is no reduction to DSH allotments for FY 2014 under section 1923(f)(7) of the Act, this notice contains only the state-specific FY 2014 DSH allotments, as calculated under the statute without application of the reductions that would have been imposed under the Affordable Care Act provisions beginning with FY 2014. This notice also provides information on the calculation of such FY DSH allotments, the calculation of the states' IMD DSH limits, and the amounts of states' preliminary FY 2014 IMD DSH limits.

B. Determination of Fiscal Year DSH Allotments

Generally, in accordance with the methodology specified under section 1923(f)(3) of the Act, a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the CPI–U for the previous FY. Also in accordance with section 1923(f)(3) of the Act, a state's DSH allotment for a FY is subject to the limitation that an increase to a state's DSH allotment for a FY cannot result in the DSH allotment exceeding the greater of the state's DSH allotment for the previous FY or 12 percent of the state's total medical assistance expenditures for the allotment year (this is referred to as the 12 percent limit).

Furthermore, under section 1923(h) of the Act, federal financial participation (FFP) for DSH payments to institutions for mental diseases (IMDs) and other mental health facilities is limited to state-specific aggregate amounts. Under this provision, the aggregate limit for DSH payments to IMDs and other mental health facilities is the lesser of a state's FY 1995 total computable (state and federal share) IMD and other mental health facility DSH expenditures applicable to the state's FY 1995 DSH allotment (as reported on the Form CMS–64 as of January 1, 1997), or the amount equal to the product of the state's current year total computable DSH allotment and the applicable percentage specified in section 1902(h) of the Act (the applicable percentage is the IMD share of DSH total computable expenditures as of FY 1995).

In general, we determine states' DSH allotments for a FY and the IMD DSH limits for the same FY using the most