

	Name	CAS
1	Hexachlorobenzene (UPDATE)	118-74-1
2	Endosulfan (UPDATE)	115-29-7
	Endosulfan sulfate	1031-07-8
	Endosulfan-alpha	95-99-98
	Endosulfan-beta	33213-65-9
3	1,1-Dichloroethane (UPDATE)	75-34-3
4	Dinitrotoluenes (DNT) (UPDATE).	
	2,3-DNT	602-01-7
	2,4-DNT	121-14-2
	2,5-DNT	619-15-8
	2,6-DNT	606-20-2
	3,4-DNT	610-39-9
	3,5-DNT	618-85-9

Dated: June 21, 2013.

Sascha Chaney,

Acting Director, Office of Policy, Planning and Evaluation, National Center for Environmental Health/Agency for Toxic Substances and Disease Registry.

[FR Doc. 2013-15523 Filed 6-27-13; 8:45 am]

BILLING CODE 4163-70-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

World Trade Center Health Program Scientific/Technical Advisory Committee (WTCHP-STAC)

Correction: This notice was published in the **Federal Register** on June 21, 2013, Volume 78, Number 120, Page 37543. The name of the committee was inadvertently stated as Board of Scientific Counselors, National Center for Injury Prevention and Control, (BSC, NCIPC) and the name of the Committee should read World Trade Center Health Program Scientific/Technical Advisory Committee (WTCHP-STAC).

Contact Person for More Information: Paul Middendorf, Senior Health Scientist, 1600 Clifton Rd. NE., MS: E-20, Atlanta, GA 30329; telephone (404) 498-2548 (this is not a toll-free number); email: pmiddendorf@cdc.gov.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention, and Agency for Toxic Substances and Disease Registry.

Elaine L. Baker,

Director, Management Analysis and Services Office Centers for Disease Control and Prevention.

[FR Doc. 2013-15455 Filed 6-27-13; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS-10105, CMS-10467, CMS-10469, CMS-10325 and CMS-10330]

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 July 29, 2013.

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) 395-6974 *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:* Reinstatement with change of a previously approved collection; *Title of*

Information Collection: National Implementation of In-Center Hemodialysis CAHPS Survey; **Use:** Data collected in the national implementation of the In-center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey will be used to: (1) Provide a source of information from which selected measures can be publicly reported to beneficiaries as a decision aid for dialysis facility selection; (2) aid facilities with their internal quality improvement efforts and external benchmarking with other facilities; (3) provide CMS with information for monitoring and public reporting purposes; and (4) support the end-stage renal disease value-based purchasing program. In the April 19, 2013 (78 FR 23566) **Federal Register**, this information collection request was inadvertently published as a new collection under CMS-10478 (OCN: 0938-New). We will not continue seeking approval for the information collection request under CMS-10478. The CMS-10105 was discontinued in 2007, but we are now seeking to have it reinstated.

Form Number: CMS-10105 (OCN: 0938-0926).

Frequency: Occasionally;

Affected Public: Individuals or households;

Number of Respondents: 165,000;

Total Annual Responses: 165,000;

Total Annual Hours: 87,750. (For

policy questions regarding this collection contact Elizabeth Goldstein at 410-786-6665.)

2. *Type of Information Collection*

Request: New collection (Request for a new OMB control number);

Title of Information Collection: Evaluation of the Graduate Nurse Education Demonstration Program;

Use: The Graduate Nurse Education (GNE) Demonstration is mandated under Section 5509 of the Affordable Care Act (ACA) under title XVIII of the Social Security Act (42 U.S.C. 1395 *et seq.*). According to Section 5509 of the ACA, the five selected demonstration sites receive “payment for the hospital’s reasonable costs for the provision of qualified clinical training to advance practice registered nurses”. Section 5509 of the ACA also states that an evaluation of the graduate nurse education demonstration must be completed no later than October 17, 2017. This evaluation includes analysis of the following: (1) Growth in the number of advanced practice registered nurses (APRNs) with respect to a specific base year as a result of the demonstration; (2) growth for each of the following specialties: clinical nurse

specialist, nurse practitioner, certified nurse anesthetist, certified nurse-midwife; and (3) costs to the Medicare program as result of the demonstration.

Quantitative and qualitative data from primary and secondary sources will be gathered and analyzed for this evaluation. The primary data will be collected through site visits, key stakeholder interviews, small discussion groups and focus groups, telephone interviews, electronic templates for quantitative data submission, and quarterly demonstration-site reports. The secondary data will come from mandatory hospital cost reports provided to both us and several other existing secondary data sources, such as the American Association of Colleges of Nursing (AACN).

Form Number: CMS-10467 (OCN: 0938-NEW);

Frequency: Annually;

Affected Public: State, Local, or Tribal Governments, Business and other for-profit and Not-for-profit institutions;

Number of Respondents: 330;

Total Annual Responses: 330;

Total Annual Hours: 3,370. (For

policy questions regarding this collection contact Pauline Karikari-Martin at 410-786-1040.)

3. *Type of Information Collection*

Request: New collection (Request for a new OMB control number);

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 we 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 us with 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 for 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 receive a notification by email with instructions on how to inform HHS of their selection. 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.

A **Federal Register** notice was published on April 12, 2013 (78 FR 21956), providing the public with a 60-day period to submit written comments on the information collection requirements, no comments were received.

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.)

4. *Type of Information Collection Request:* Reinstatement with change of a previously approved collection of information;

Title of Information Collection: Disclosure and Recordkeeping Requirements for Grandfathered Health Plans under the Affordable Care Act;

Use: Section 1251 of the Patient Protection and Affordable Care Act, Public Law 111–148, (the Affordable Care Act) provides that certain plans and health insurance coverage in existence as of March 23, 2010, known as grandfathered health plans, are not required to comply with certain statutory provisions in the Act. To maintain its status as a grandfathered health plan, the interim final regulations titled “Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act” (75 FR 34538, June 17, 2010) require the plan to maintain records documenting the terms of the plan in

effect on March 23, 2010, and any other documents that are necessary to verify, explain or clarify status as a grandfathered health plan. The plan must make such records available for examination upon request by participants, beneficiaries, individual policy subscribers, or a State or Federal agency official. The recordkeeping requirement will allow a participant, beneficiary, or federal or state official to inspect plan documents to verify that a plan or health insurance coverage is a grandfathered health plan. A grandfathered health plan must include a statement in any plan materials provided to participants or beneficiaries (in the individual market, primary subscriber) describing the benefits provided under the plan or health insurance coverage, and that the plan or coverage is intended to be grandfathered health plan. The disclosure requirement will provide participants and beneficiaries with important information about their grandfathered health plans, such as that grandfathered plans are not required to comply with certain consumer protection provisions contained in the Act. It also will provide important contact information for participants to find out which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered to non-grandfathered health plan status. An amendment to the interim final regulations (75 FR 70114, November 17, 2010) requires a grandfathered group health plan that is changing health insurance issuers to provide the succeeding health insurance issuer (and the succeeding health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health insurance coverage sufficient to make a determination whether the standards set forth in paragraph (g)(1) of the interim final regulations are exceeded.

Form Number: CMS–10325 (OCN: 0938–1093);

Frequency: Annually;

Affected Public: State, Local, or Tribal governments and health insurance coverage issuers;

Number of Respondents: 64,552;

Number of Responses: 10,113,926;

Total Annual Hours: 85. (For policy questions regarding this collection, contact Usree Bandyopadhyay at (410) 786–6650.)

5. *Type of Information Collection Request:* Reinstatement with change of a previously approved information collection;

Title of Information Collection: Enrollment Opportunity Notice Relating to Lifetime Limits; Required Notice of Rescission of Coverage; and Disclosure Requirements for Patient Protection under the Affordable Care Act;

Use: Under section 2711 of the Public Health Services Act (PHS Act) amended by the Affordable Care Act, the enrollment opportunity notice was to be used by health plans to notify certain individuals of their right to re-enroll in their plan. The affected individuals were those whose coverage ended due to reaching a lifetime limit on the dollar value of all benefits for any individual. This notice was a one-time requirement and is being discontinued. Under section 2712 of the PHS Act as amended by the Affordable Care Act, the rescission notice will be used by health plans to provide advance notice to certain individuals that their coverage may be rescinded. The affected individuals are those who are at risk of rescission on their health insurance coverage. Under section 2719A of the PHS Act as amended by the Affordable Care Act, the patient protection notification will be used by health plans to inform certain individuals of their right to choose a primary care provider or pediatrician and to use obstetrical/gynecological services without prior authorization.

Form Number: CMS–10330 (OCN: 0938–1094);

Frequency: Occasionally;

Affected Public: State, Local, or Tribal Governments, Private Sector;

Number of Respondents: 8,382;

Number of Responses: 1,583,371;

Total Annual Hours: 2,267. (For policy questions regarding this collection, contact Usree Bandyopadhyay at 410–786–6650.)

Dated: June 25, 2013.

Martique Jones

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

[FR Doc. 2013–15539 Filed 6–27–13; 8:45 am]

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