The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7.0 million to $34.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. As we stated in the RIA for the February 2, 2011 final rule with comment period (76 FR 5952), the regulatory impact statement of the March 23, 2011 notice (76 FR 16423), and the regulatory impact statement of the November 2, 2011 notice (76 FR 67744), we do not believe that the application fee will have a significant impact on small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this notice would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold is approximately $139 million. The Agency has determined that there will be minimal impact from the costs of this notice, as the threshold is not met under the UMRA.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. Since this notice does not impose substantial direct costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

B. Estimated Costs

The costs associated with this notice involve the increase in the application fee that certain providers and suppliers must pay in CY 2013. As alluded to earlier, in the RIA for the February 2, 2011 final rule with comment period (76 FR 5955 through 5958), we estimated the total amount of application fees for CYs 2011 through 2015. For CY 2013, and based on a $525 application fee, we projected in tables 11 and 12 (76 FR 5955 and 5956) a total cost in fees of $60,913,125 ($16,380,000 + $44,533,125) for Medicare institutional providers (or 116,025 providers × $525). We also projected in tables 13 and 14 (76 FR 5957 and 5958) the total cost in CY 2013 for Medicaid providers to be $13,195,350 ($4,429,950 + $8,765,400 or 25,134 (8,438 newly enrolling + 16,696 re-enrolling) providers × $525).

Based on CY 2009 and CY 2010 data furnished by State Medicaid agencies through the annual State Program Integrity Assessment, we are increasing the estimated number of affected Medicaid providers from 25,134 to 27,859. We are also changing the Medicare provider estimate based on our ongoing program of revalidating all Medicare providers and suppliers by the end of 2015—even if the revalidation is considered ''off-cycle'' per 42 CFR 424.515(e).

1. Medicare

For purposes of this notice only, we estimate that approximately 400,000 Medicare providers and suppliers will be subject to revalidation in CY 2013. Of this total, and based on our experience, we believe that roughly 80 percent will be exempt from the application fee requirement because the provider or supplier: (1) Is of a type (for example, a physician) that is exempt from the requirement; or (2) qualifies for a hardship exception under 42 CFR 424.514(c). This leaves 80,000 revalidating providers and suppliers that will have to pay the fee.

In the February 2, 2011 final rule with comment period (76 FR 5955), we estimated that 31,200 newly-enrolling institutional providers would be subject to the application fee in CY 2013. In the first quarter of CY 2012, there were 1,030 initial enrollments that required a fee. Based on this, we must dramatically reduce our earlier estimate of 31,200 Medicare institutional providers to 4,120 (1,030 × 4) for purposes of this notice. Using a figure of 84,120 (80,000 + 4,120) institutional providers, we estimate an increase in the cost of the Medicare application fee requirement in CY 2013 of $588,840 (84,120 × $7.00) from CY 2012 estimates.

2. Medicaid and CHIP

We estimate that 27,859 (8,438 newly enrolling + 19,421 re-enrolling) Medicaid and CHIP providers would be subject to an application fee in CY 2013. Using this figure, we estimate an increase in the cost of the Medicaid and CHIP application fee requirements in CY 2013 of $195,013 (27,859 × $7.00) from CY 2012 estimates.

3. Total

Based on the foregoing, we estimate the total increase in the cost of the application fee requirement for Medicare, Medicaid, and CHIP providers and suppliers in CY 2013 to be $783,853 ($588,840 + $195,013) from CY 2012.

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by the Office of Management and Budget.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 9, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012–29003 Filed 11–29–12; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission to OMB for Review and Approval; Public Comment Request

AGENCY: Health Resources and Services Administration; HHS.

ACTION: Notice.

SUMMARY: In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35), the Health Resources and Services Administration (HRSA) will submit an Information Collection Request (ICR) to the Office of Management and Budget (OMB). Comments submitted during the first public review of this ICR will be provided to OMB. OMB will accept further comments from the public during the review and approval period. To request a copy of the clearance requests submitted to OMB for review,

email *paperwork@hrsa.gov* or call the HRSA Reports Clearance Office at (301) 443–1984.

Information Collection Request Title: Workforce Recruitment in Health Resources and Services Administration (HRSA)—Funded Health Centers (OMB No. 0915–0353)—[Extension]

This semi-annual survey is designed to collect information from HRSA-funded health centers regarding their current workforce and recent hiring efforts. The purpose of this data collection instrument is to provide data on health center workforce recruitment and identify areas for additional training or technical assistance that might be needed to support health centers in their hiring efforts. As authorized by statute, HRSA provides technical assistance to health centers to assist them in meeting the Health Center Program requirements and in providing required primary health services, the provisions of which are dependent on maintaining a high quality and effective workforce.

Ensuring that the primary care workforce is able to meet the demands of increasing patient volume is critical to the future success of health centers in serving the nation's underserved and vulnerable populations. As health centers seek to fill open positions, one growing pool of qualified candidates increasingly being recruited is returning veterans, many of whom have trained as health care providers and/or administrators during their time in the service. The information collected in this survey will help assess how health centers have filled vacancies, whether the availability of veterans to join the health center workforce is impacting their hiring efforts, and what additional efforts might improve health center recruitment.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose, or provide the information requested. This includes the time needed to review instructions, to develop, acquire, install, and utilize technology and systems for the purpose of collecting, validating, and verifying information; processing and maintaining information; and disclosing and providing information, to train personnel and to be able to respond to a collection of information, to search data sources, to complete and review the collection of information, and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

The annual estimate of burden is as follows:

Instrument	Number of respondents	Responses per respondent	Total responses	Hours per response*	Total burden hours
Health Center Work Force Survey	1,200	2	2,400	1.0	2,400
Total	1,200	2	2,400	1.0	2,400

* **Note:** This estimate includes the time for the grantee to read the survey instructions, collect the data and information requested, and to complete the online survey.

ADDRESSES: Submit your comments to the desk officer for HRSA, either by email to *OIRA_submission@omb.eop.gov* or by fax to 202–395–5806. Please direct all correspondence to the ''attention of the desk officer for HRSA.''

Deadline: Comments on this ICR should be received within 30 days of this notice.

Dated: November 26, 2012.

Bahar Niakan,

Director, Division of Policy and Information Coordination.

[FR Doc. 2012–29009 Filed 11–29–12; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Advisory Commission on Childhood Vaccines; Notice of Meeting

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Correction.

SUMMARY: The Health Resources and Services Administration published a notice in the **Federal Register**, FR 2012–28377 (77 FR 70169, November 23, 2012), announcing the meeting of the Advisory Commission on Childhood Vaccines, December 6, 2012, in the Parklawn Building (and via audio conference call), Conference Rooms 10–65, 5600 Fishers Lane, Rockville, MD 20857.

Correction

In the **Federal Register**, FR 2012–28377 (77 FR 70169, November 23, 2012), please make the following corrections:

In the Date and Time section, correct to read December 6, 2012, 1:00 p.m. to 5:00 p.m., EDT.

In the Place section, correct to read via audio conference only.

The ACCV will meet on Thursday, December 6, from 1:00 p.m. to 5:00 p.m. (EDT). The public can join the meeting via audio conference call by dialing 1–800–369–3104 on December 6 and providing the following information: Leader's Name: Dr. Vito Caserta. Password: ACCV.

Dated: November 26, 2012.

Bahar Niakan,

Director, Division of Policy and Information Coordination.

[FR Doc. 2012–29008 Filed 11–29–12; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Proposed Collection; Comment Request: Healthy Communities Study: How Communities Shape Children's Health (HCS)

SUMMARY: In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, for opportunity for public comment on proposed data collection projects, the National Heart, Lung, and Blood Institute (NHLBI), the National Institutes of Health (NIH) will publish periodic summaries of proposed projects to be submitted to the Office of Management and Budget (OMB) for review and approval.

Proposed Collection: Title: Healthy Communities Study: How Communities Shape Children's Health (HCS). *Type of Information Collection Request:* Revision—OMB# 0925–0649. *Need and Use of Information Collection:* The HCS will address the need for a cross-cutting national study of community programs and policies and their relationship to childhood obesity. The HCS is an observational study of communities that aims to (1) determine the associations