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:* Medicare Advantage Chronic Care Improvement Program (CCIP) and Quality Improvement (QI) Project Reporting Tools; *Use:* Medicare Advantage Organizations (MAOs) are required to have an ongoing quality improvement (QI) program that meets our requirements and includes at least one chronic care improvement program (CCIP) and one QI project. Every MAO must have a QI program that monitors and identifies areas where implementing appropriate interventions would improve patient outcomes and patient safety. Information collected using the CCIP and QIP reporting tools is an integral resource for oversight, monitoring, compliance, and auditing activities necessary to ensure high quality value-based health care for Medicare beneficiaries. *Form Number:* CMS–10209 (OCN: 0938–1023); *Frequency:* Yearly; *Affected Public:* Private sector (business or other for-profits and not-for-profit institutions); *Number of Respondents:* 1,904; *Total Annual Responses:* 1,904; *Total Annual Hours:* 28,560. (For policy questions regarding this collection contact Ellen Dieujuste at 410–786–2191).

2. *Type of Information Collection Request:* Reinstatement with change of a previously approved information collection; *Title of Information Collection:* Rate Increase Disclosure and Review Reporting Requirements; *Use:* Section 1003 of the Affordable Care Act adds a new section 2794 of the PHS Act which directs the Secretary of the Department of Health and Human Services (the Secretary), in conjunction with the states, to establish a process for the annual review of ''unreasonable increases in premiums for health insurance coverage.'' The statute provides that health insurance issuers must submit to the Secretary and the applicable state justifications for unreasonable premium increases prior to the implementation of the increases. Section 2794 also specifies that beginning with plan years beginning in 2014, the Secretary, in conjunction with the states, shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

Section 2794 directs the Secretary to ensure the public disclosure of information and justification relating to unreasonable rate increases. The regulation therefore develops a process to ensure the public disclosure of all such information and justification. Section 2794 requires that health insurance issuers submit justification for an unreasonable rate increase to CMS and the relevant state prior to its implementation. Additionally, section 2794 requires that rate increases effective in 2014 (submitted for review in 2013) be monitored by the Secretary, in conjunction with the states. To those ends the regulation establishes various reporting requirements for health insurance issuers, including a Preliminary Justification for a proposed rate increase, a Final Justification for any rate increase determined by a state or CMS to be unreasonable, and a notification requirement for unreasonable rate increases which the issuer will not implement.

On November 14, 2013, CMS issued a letter to State Insurance Commissioners outlining transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. If permitted by applicable State authorities, health insurance issuers may choose to continue coverage that would otherwise be terminated or cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. Under this transitional policy, non-grandfathered health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014, and October 1, 2014, will not be considered to be out of compliance with certain market reforms if certain specific conditions are met. These transitional plans continue to be subject to the requirements of section 2794, but are not subject to 2701 (market rating rules), 2702 (guaranteed availability), 2704 (prohibition on health status rating), 2705 (prohibition on health status discrimination) and 2707 (requirements of essential health benefits) and the because the single risk pool (1311(e)) is dependent on all of the aforementioned sections (2701, 2702, 2704, 2705 and 2707), the transitional plans are also exempt from the single risk pool. The Unified Rate Review Template and system are exclusively designed for use with the single risk pool plan, and any attempt to include non-single risk pool plans in the Unified Rate Review template or system will create errors, inaccuracies and limitations on submissions that would prevent the effectiveness of reviews of both sets of non-grandfathered plans (single risk pool and transitional). For these many reasons, CMS is requiring issuers with transitional plans that experience rate increases subject to review to use the Rate Review Justification system and templates which were required and utilized prior to April 1, 2013. *Form Number:* CMS–10379 (OCN: 0938–1141); *Frequency:* Annual; *Affected Public:* Private sector, State Governments; *Number of Respondents:* 81; *Total Annual Responses:* 358; *Total Annual Hours:* 1,879. (For policy questions regarding this collection, contact Doug Pennington at (410) 786–1553.)

Dated: March 28, 2014.

Martique Jones,

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

[FR Doc. 2014–07402 Filed 4–1–14; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS–370 and CMS–377]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

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 (the 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 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates 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 must be received by June 2, 2014.

ADDRESSES: When commenting, please reference the document identifier or OMB control number (OCN). To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send 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) that are 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.

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:

Contents

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS–370 and CMS–377 Health Insurance Benefits Agreement and Ambulatory Surgical Center Request for Certification or Update of Certification Information in the Medicare Program

Under the 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 requires federal agencies to publish a 60-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.

Information Collection

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Titles of Information Collection:* Health Insurance Benefits Agreement and Ambulatory Surgical Request for Certification or Update of Certification Information in the Medicare Program; *Use:* The CMS–370 is used to establish eligibility for payment. This agreement, upon submission by the ambulatory surgical center (ASC) and acceptance for filing by the Secretary of Health & Human Services, shall be binding on both the ASC and the Secretary. The agreement may be terminated by either party in accordance with regulations. In the event of termination, payment will not be available for ASC services furnished on or after the effective date of termination.

The CMS–377 is used to collect facility-specific characteristics that facilitate CMS' oversight of ambulatory surgical centers (ASCs). The CMS–377 is submitted by ASCs when they request initial certification of compliance with the ASC conditions for coverage or to update an ASC's existing certification information. It is also used by State agencies who conduct certification surveys on CMS' behalf to maintain information on the facility's characteristics that facilitate conducting surveys, e.g., determining the size and the composition of the survey team on the basis of the number of operating and procedure rooms and the types of surgical procedures performed in the ASC. *Form Numbers:* CMS–370 and CMS–377 (OCN: 0938–0266); *Frequency:* Occasionally; *Affected Public:* Private sector—business or other for-profit and not-for-profit institutions; *Number of Respondents:* 5,449; *Total Annual Responses:* 1,833; *Total Annual Hours:* 633. (For policy questions regarding this collection contact Erin McCoy at 410–786–2337.)

Dated: March 28, 2014.

Martique Jones,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Community Living

National Legal Resource Center

SUMMARY: The Administration for Community Living (ACL) is announcing the application deadline and a single case deviation from maximum competition for the National Legal Assistance and Support grants under Section 420(a)(1) of the Older Americans Act (OAA) that constitute the National Legal Resource Center (NLRC). The NLRC program provides resource support to a national system of legal assistance and elder rights programs to improve the quality, cost effectiveness, and accessibility of legal assistance and elder rights protections provided to older people. The purpose of this deviation is to award a 4th year non-competing continuation to the NLRC project grantees with a three (3) year budget period set to expire May 31, 2014 so that: (1) Stakeholder input can be obtained on the resource support needs of legal and aging/disability service providers across the country; and (2) the current work under the NLRC can be better directed to support and advance ACL activities anticipated in FY15 in the area of elder rights and elder abuse prevention.

Program Name: National Legal Assistance and Support—National Legal Resource Center.

Award Amount: $655,462 ($143,347 to $185,693 per grantee).

Project Period: 6/1/2011 to 5/31/2015.

Award Type: Cooperative Agreement.

Statutory Authority: Title IV, Sections 420(a)(1) and 420(a)(2), of the OAA (42 U.S.C. 3032), as amended by the OAA Amendments of 2006, Public Law 109–365.

Catalog of Federal Domestic Assistance (CFDA) Number: 93.048 Discretionary Projects