• Developing and implementing education and outreach programs for individuals enrolled in, or eligible for, Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

• Enhancing the federal government's effectiveness in informing Medicare, Medicaid and CHIP consumers, providers and stakeholders pursuant to education and outreach programs of issues regarding these and other health coverage programs, including the appropriate use of public-private partnerships to leverage the resources of the private sector in educating beneficiaries, providers and stakeholders.

• Expanding outreach to vulnerable and underserved communities, including racial and ethnic minorities, in the context of Medicare, Medicaid and CHIP education programs.

• Assembling and sharing an information base of ''best practices'' for helping consumers evaluate health plan options.

• Building and leveraging existing community infrastructures for information, counseling and assistance.

• Drawing the program link between outreach and education, promoting consumer understanding of health care coverage choices and facilitating consumer selection/enrollment, which in turn support the overarching goal of improved access to quality care, including prevention services, envisioned under health care reform.

The current members of the Panel are: Samantha Artiga, Principal Policy Analyst, Kaiser Family Foundation; Joseph Baker, President, Medicare Rights Center; Philip Bergquist, Manager, Health Center Operations, CHIPRA Outreach & Enrollment Project and Director, Michigan Primary Care Association; Marjorie Cadogan, Executive Deputy Commissioner, Department of Social Services; Jonathan Dauphine, Senior Vice President, AARP; Barbara Ferrer, Executive Director, Boston Public Health Commission; Shelby Gonzales, Senior Health Outreach Associate, Center on Budget & Policy Priorities; Jan Henning, Benefits Counseling & Special Projects Coordinator, North Central Texas Council of Governments' Area Agency on Aging; Warren Jones, Executive Director, Mississippi Institute for Improvement of Geographic Minority Health; Cathy Kaufmann, Administrator, Oregon Health Authority; Sandy Markwood, Chief Executive Officer, National Association of Area Agencies on Aging; Miriam Mobley-Smith, Dean, Chicago State University, College of Pharmacy; Ana Natale-Pereira, Associate Professor of Medicine, University of Medicine & Dentistry of New Jersey; Megan Padden, Vice President, Sentara Health Plans; David W. Roberts, Vice-President, Healthcare Information and Management System Society; Julie Bodën Schmidt, Associate Vice President, National Association of Community Health Centers; Alan Spielman, President & Chief Executive Officer, URAC; Winston Wong, Medical Director, Community Benefit Director, Kaiser Permanente and Darlene Yee-Melichar, Professor & Coordinator, San Francisco State University.

The agenda for the December 18, 2012 meeting will include the following:

• Welcome and Listening Session with CMS Leadership.

• Recap of the Previous (August 2, 2012) Meeting.

• Affordable Care Act Initiatives.

• Quality Initiatives.

• An Opportunity for Public Comment.

• Meeting Summary, Review of Recommendations and Next Steps.

Individuals or organizations that wish to make a 5-minute oral presentation on an agenda topic should submit a written copy of the oral presentation to the DFO at the address listed in the **ADDRESSES** section of this notice by the date listed in the **DATES** section of this notice. The number of oral presentations may be limited by the time available. Individuals not wishing to make a presentation may submit written comments to the DFO at the address listed in the **ADDRESSES** section of this notice by the date listed in the **DATES** section of this notice.

Authority: Sec. 222 of the Public Health Service Act (42 U.S.C. 217a) and sec. 10(a) of Pub. L. 92–463 (5 U.S.C. App. 2, sec. 10(a) and 41 CFR 102–3).

(Catalog of Federal Domestic Assistance Program No. 93.733, Medicare—Hospital Insurance Program; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 20, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012–28647 Filed 11–26–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9962–NC]

Request for Information Regarding Health Care Quality for Exchanges

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

ACTION: Request for Information.

SUMMARY: This notice is a request for information to seek public comments regarding health plan quality management in Affordable Insurance Exchanges.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 27, 2012.

ADDRESSES: In commenting, refer to file code CMS–9962–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9962–NC, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9962–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without

Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the ''**SUPPLEMENTARY INFORMATION**'' section.

FOR FURTHER INFORMATION CONTACT: Rebecca Zimmermann, (301) 492–4396.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Last year, the Department of Health and Human Services (HHS) adopted the National Strategy for Quality Improvement in Health Care (National Quality Strategy) to create national aims and priorities that would guide local, state, and national efforts to improve the quality of health care in the United States. The priorities of the National Quality Strategy include making care safer; ensuring person- and family-centered care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment for the leading causes of mortality, starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable.[1] As discussed in the National Quality Strategy, ''[t]he Affordable Care Act seeks to increase access to high-quality, affordable health care for all Americans.'' To that end, the Affordable Care Act contains several provisions that help to foster and support health care quality improvement across the insurance marketplace, including section 2717 of the Public Health Service Act (PHS Act). The Affordable Care Act places additional quality-related requirements on health insurance issuers offering qualified health plans (QHPs) in the new Exchange marketplace, including section 1311 which directs QHP issuers to implement quality improvement strategies, enhance patient safety through specific contracting requirements, and publicly report quality data. The Affordable Care Act also directs the Secretary of HHS to develop and administer a quality rating system and an enrollee satisfaction survey system, the results of which will be available to Exchange consumers shopping for insurance plans. In addition, section 10329 of the Affordable Care Act, which relates to plans both inside and outside the Exchange, directs the Secretary, in consultation with relevant stakeholders, to develop a methodology for calculating the value of a health plan.

HHS's strategy for establishing quality reporting requirements to ensure that quality health care is delivered through the Exchange marketplace includes the consideration of existing relevant quality measure sets and quality improvement initiatives in conjunction with other factors, such as characteristics of the Exchange population. States, employers, health insurance issuers, and other stakeholders, in addition to the Centers for Medicare and Medicaid Services (CMS) and other HHS agencies, are currently engaged in health plan quality reporting and improvement initiatives. As indicated in the National Quality Strategy, HHS is interested in promoting effective quality measurement while minimizing the burden of data collection by aligning measures across programs. These efforts would also ease comparability across plans, providers, and insurance markets, and promote delivery of high-quality and high-value health care.

As set forth in the May 2012 General Guidance on Federally-facilitated Exchanges, HHS intends to propose a phased approach to quality reporting and display standards for all Exchanges and QHP issuers. No new quality reporting standards would be in place until 2016 (other than those related to accreditation, if applicable), which allows time to develop standards appropriately matched to the Exchange enrollee population and plan offerings. Until final regulations are issued, state-based Exchanges would have the choice of adopting a similar approach or implementing their own quality reporting standards immediately and over time.[2]

In preparation for the implementation of the quality provisions affecting QHPs in the new Exchange marketplace under the Affordable Care Act, HHS is requesting information through this notice from stakeholders regarding existing quality measures and rating systems, strategies and requirements for quality improvement, purchasing strategies to promote care redesign and patient safety, as well as effective methodologies to measure health plan value. This notice also offers the opportunity to provide recommendations on the most effective ways to enhance and align the quality reporting and display requirements for QHPs starting in 2016 in conjunction with existing quality improvement initiatives, such as the National Quality Strategy. We note that this notice should not be viewed as final policy that will be adopted pursuant to rulemaking.

II. Solicitation of Comments

CMS is requesting information regarding the following:

Understanding the Current Landscape

1. What quality improvement strategies do health insurance issuers currently use to drive health care quality improvement in the following categories: (1) Improving health outcomes; (2) preventing hospital readmissions; (3) improving patient safety and reducing medical errors; (4) implementing wellness and health promotion activities; and (5) reducing health disparities?

2. What challenges exist with quality improvement strategy metrics and

[1] See *Report to Congress: National Strategy for Quality Improvement in Health Care* available at *http://www.healthcare.gov/law/resources/reports/quality03212011a.html*.

[2] See ''General Guidance on Federally-facilitated Exchanges,'' available at *http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf*.

tracking quality improvement over time (for example, measure selection criteria, data collection and reporting requirements)? What strategies (including those related to health information technology) could mitigate these challenges?

3. Describe current public reporting or transparency efforts that states and private entities use to display health care quality information.

4. How do health insurance issuers currently monitor the performance of hospitals and other providers with which they have relationships? Do health insurance issuers monitor patient safety statistics, such as hospital acquired conditions and mortality outcomes, and if so, how? Do health insurance issuers monitor care coordination activities, such as hospital discharge planning activities, and outcomes of care coordination activities, and if so, how?

Applicability to the Health Insurance Exchange Marketplace

5. What opportunities exist to further the goals of the National Quality Strategy through quality reporting requirements in the Exchange marketplace?

6. What quality measures or measure sets currently required or recognized by states, accrediting entities, or CMS are most relevant to the Exchange marketplace?

7. Are there any gaps in current clinical measure sets that may create challenges for capturing experience in the Exchange?

8. What are some issues to consider in establishing requirements for an issuer's quality improvement strategy? How might an Exchange evaluate the effectiveness of quality improvement strategies across plans and issuers? What is the value in narrative reports to assess quality improvement strategies?

9. What methods should be used to capture and display quality improvement activities? Which publicly and privately funded activities to promote data collection and transparency could be leveraged (for example, Meaningful Use Incentive Program) to inform these methods?

10. What are the priority areas for the quality rating in the Exchange marketplace? (for example, delivery of specific preventive services, health plan performance and customer service)? Should these be similar to or different from the Medicare Advantage five-star quality rating system (for example, staying healthy: screenings, tests and vaccines; managing chronic (long-term) conditions; ratings of health plan responsiveness and care; health plan members' complaints and appeals; and health plan telephone customer service)? [3]

11. What are effective ways to display quality ratings that would be meaningful for Exchange consumers and small employers, especially drawing on lessons learned from public reporting and transparency efforts that states and private entities use to display health care quality information?

12. What types of methodological challenges may exist with public reporting of quality data in an Exchange? What suggested strategies would facilitate addressing these issues?

13. Describe any strategies that states are considering to align quality reporting requirements inside and outside the Exchange marketplace, such as creating a quality rating for commercial plans offered in the non-Exchange individual market.

14. Are there methods or strategies that should be used to track the quality, impact and performance of services for those with accessibility and communication barriers, such as persons with disabilities or limited English proficiency?

15. What factors should HHS consider in designing an approach to calculate health plan value that would be meaningful to consumers? What are potential benefits and limitations of these factors? How should Exchanges align their programs with value-based purchasing and other new payment models (for example, Accountable Care Organizations) being implemented by payers?

Dated: November 6, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: November 16, 2012.

Kathleen Sebelius,

Secretary.

[FR Doc. 2012–28473 Filed 11–23–12; 11:15 am]

BILLING CODE 4120–01–P

[3] For more information on Medicare Advantage rating system domains see *http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/2013-Call-Letter.pdf; http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

National Advisory Council on Migrant Health; Cancellation of Meeting

Name: National Advisory Council on Migrant Health.

Dates and Times: December 4, 2012, 8:30 a.m. to 5:00 p.m. December 5, 2012, 8:00 a.m. to 12:00 p.m.

STATUS: The meeting of the National Advisory Council on Migrant Health, scheduled for December 4 and 5, 2012, is cancelled. This cancellation applies to all sessions of the meeting. The meeting was announced in the **Federal Register** of November 8, 2012 (77 FR 67014).

FOR FURTHER INFORMATION CONTACT: Gladys Cate, Office of Special Population Health, Bureau of Primary Health Care, Health Resources and Services Administration, 5600 Fishers Lane, Room 15–74, Rockville, Maryland 20857; telephone (301) 594–0367.

Dated: November 20, 2012.

Bahar Niakan,

Director, Division of Policy and Information Coordination.

[FR Doc. 2012–28699 Filed 11–26–12; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Government-Owned Inventions; Availability for Licensing

AGENCY: National Institutes of Health, Public Health Service, HHS.

ACTION: Notice.

SUMMARY: The inventions listed below are owned by an agency of the U.S. Government and are available for licensing in the U.S. in accordance with 35 U.S.C. 207 to achieve expeditious commercialization of results of federally-funded research and development. Foreign patent applications are filed on selected inventions to extend market coverage for companies and may also be available for licensing.

FOR FURTHER INFORMATION CONTACT: Licensing information and copies of the U.S. patent applications listed below may be obtained by writing to the indicated licensing contact at the Office of Technology Transfer, National Institutes of Health, 6011 Executive Boulevard, Suite 325, Rockville,