TABLE 2—DISASTER-RECOVERY ADJUSTED FMAP RATES
FISCAL YEAR 2013 REVISED DISASTER-RECOVERY ADJUSTED FMAP RATES

A	B	C	D	E	F
State	FY13 FMAP	FY12 disaster recovery adjusted FMAP	Decrease in FMAP	Disaster recovery adjustment increase	Disaster recovery adjusted FMAP FY13
			Col C – B	50% × Col D*	Col B + E
Louisiana	61.24	69.78	8.54	4.27	65.51

* Percentage determined in accordance with section 1905(aa)(1)(A) of the Social Security Act.

FISCAL YEAR 2014 DISASTER-RECOVERY ADJUSTED FMAP RATES

A	B	C	D	E	F
State	FY14 FMAP	FY13 disaster recovery adjusted FMAP	Decrease in FMAP	Disaster recovery adjustment increase	Disaster recovery adjusted FMAP FY14
			Col C – B	25% × Col D*	Col B + E
Louisiana	60.98	65.51	4.53	1.13	62.11

* Percentage determined in accordance with section 1905(aa)(1)(B) of the Social Security Act.

[FR Doc. 2012–29035 Filed 11–29–12; 8:45 am]
BILLING CODE 4150–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Announcement of Intent To Establish the 2015 Dietary Guidelines Advisory Committee and Solicitation of Nominations for Appointment to the Committee Membership; Amendment

AGENCY: Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services.

ACTION: Notice; amendment.

SUMMARY: A notice was published in the **Federal Register** of Friday, October 26, 2012, Vol. 77, No. 208, to announce the intent to establish the 2015 Dietary Guidelines Advisory Committee and solicit nominations of individuals who are interested in being appointed to the Committee membership. This notice is being amended to extend the solicitation period to allow additional time for nominations to be received. The new due date for all nominations to be received is no later than close of business on December 11, 2012.

FOR FURTHER INFORMATION CONTACT: Designated Federal Officer, 2015 DGAC: Richard D. Olson and/or Alternate Designated Federal Officer, 2015 DGAC: Kellie (O'Connell) Casavale, Ph.D., R.D.; Office of Disease Prevention and Health Promotion, OASH/DHHS; 1101 Wootton Parkway, Suite LL 100 Tower Building; Rockville, MD 20852; Telephone: (240) 453–8280; Fax: (240) 453–8281. Lead USDA Co-Executive Secretary: Colette I. Rihane, M.S., R.D., Director, Nutrition Guidance and Analysis Division; Center for Nutrition Policy and Promotion; U.S. Department of Agriculture; 3101 Park Center Drive, Room 1034; Alexandria, VA 22302; Telephone: (703) 305–7600; Fax: (703) 305–3300. USDA Co-Executive Secretary, Shanthy A. Bowman, Ph.D., Nutritionist, Food Surveys Research Group; Beltsville Human Nutrition Research Center, Agricultural Research Service, USDA; 10300 Baltimore Avenue, BARC-West Building 005, Room 125; Beltsville, MD 20705–2350; Telephone: (301) 504–0619. Additional information about the 2015 DGAC is available on the Internet at *www.dietary guidelines.gov.*

Dated: November 26, 2012.

Howard K. Koh,

Assistant Secretary for Health.

[FR Doc. 2012–28928 Filed 11–29–12; 8:45 am]
BILLING CODE 4150–32–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6044–N]

Medicare, Medicaid, and Children's Health Insurance Programs; Provider Enrollment Application Fee Amount for Calendar Year 2013

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

ACTION: Notice.

SUMMARY: This notice announces a $532.00 calendar year (CY) 2013 application fee for institutional providers that are initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP); revalidating their Medicare, Medicaid or CHIP enrollment; or adding a new Medicare practice location. This fee is required with any enrollment application submitted on or after January 1, 2013 and on or before December 31, 2013.

DATES: *Effective Date:* This notice is effective on January 1, 2013.

FOR FURTHER INFORMATION CONTACT: Frank Whelan, (410) 786–1302 for Medicare enrollment issues. Claudia Simonson, (312) 353–2115 for Medicaid and CHIP enrollment issues.

SUPPLEMENTARY INFORMATION:

I. Background

In the February 2, 2011 **Federal Register** (76 FR 5862), we published a final rule with comment period entitled: ''Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers.'' This rule finalized, among other things, provisions related to the submission of application fees as part of the Medicare, Medicaid, and CHIP provider enrollment processes. As stated in 42 CFR 424.514, ''institutional providers'' that are initially enrolling in the Medicare, Medicaid or CHIP program, revalidating their enrollment, or adding a new Medicare practice location are required to submit a fee with their enrollment application. An ''institutional provider'' is defined at 42 CFR 424.502 as ''(a)ny provider or supplier that submits a paper Medicare enrollment application using the CMS–855A, CMS–855B (not including physician and non-physician practitioner organizations), CMS–855S or associated Internet-based PECOS enrollment application.''

As indicated in 42 CFR 424.514 and 455.460, the application fee is not required for either of the following:

- A Medicare physician or non-physician practitioner submitting a CMS–855I.
- A prospective or re-enrolling Medicaid or CHIP provider—

++ Who is an individual physician or non-physician practitioner; or

++ That is enrolled in Title XVIII of the Act or another state's title XIX or XXI plan and has paid the application fee to a Medicare contractor or another state.

In the March 23, 2011 **Federal Register** (76 FR 16422), we published a notice entitled ''Medicare, Medicaid, and Children's Health Insurance Programs; Provider Enrollment Application Fee Amount for Calendar Year 2012''. This notice announced the following:

- A CY 2011 application fee of $505 for institutional providers that were initially enrolling in the Medicare, Medicaid, or CHIP program; revalidating their enrollment; or adding a new Medicare practice location.
- That institutional providers were required to submit the $505 fee with enrollment applications submitted on or after March 25, 2011 and on or before December 31, 2011.
- That prospective or re-enrolling Medicaid or CHIP providers must submit the application fee unless: (1) The provider is an individual physician or non-physician practitioner; or (2) the provider is enrolled in Title XVIII of the Act or another state's title XIX or XXI plan and has paid the application fee to a Medicare contractor or another state.

II. Provisions of the Notice

A. CY 2012 Fee Amount

In the November 2, 2011 **Federal Register** (76 FR 67743), we published a notice announcing a fee amount for the period of January 1, 2012 through December 31, 2012 of $523.00. This figure was calculated as follows:

- Section 1866(j)(2)(C)(i)(I) of the Social Security Act (the Act) established a $500 application fee for institutional providers in CY 2010.
- Consistent with section 1866(j)(2)(C)(i)(II) of the Act, 42 CFR § 424.514(d)(2) states that for CY 2011 and subsequent years, the fee will be adjusted by the percentage change in the consumer price index (CPI) for all urban consumers (all items; United States city average) for the 12-month period ending in June of the previous year.
- The CPI increase for CY 2011, which was calculated to be 1.0 percent, was based on data obtained from the Bureau of Labor Statistics. This resulted in an application fee for CY 2011 of $505 (or $500 × 1.01). (For more detailed information on the CPI and how the $505 application fee was calculated, see the February 2, 2011 final rule with comment period (76 FR 5955) and the March 23, 2011 notice (76 FR 16423)).
- The CPI increase for the period of July 2010 through June 2011 was 3.54 percent, based on data obtained from the Bureau of Labor Statistics. This resulted in an application fee amount for the period of January 1, 2012 through December 31, 2012 of $522.87 ($505 × 1.0354). In the February 2, 2011 final rule with comment period (76 FR 5907), we stated that if the adjustment sets the fee at an uneven dollar amount, we would round the fee to the nearest whole dollar amount. Accordingly, the application fee amount for CY 2012 was rounded to the nearest whole dollar amount, which was $523.00.

B. CY 2013 Fee Amount

Using data obtained from the Bureau of Labor Statistics, the CPI increase for the 12-month period ending on June 30, 2012 was 1.664 percent, a figure lower than the 2.0 percent CPI increase we estimated for CY 2013 in the February 2, 2011 final rule with comment period (76 FR 5953). This results in an application fee amount for the period of January 1, 2013 through December 31, 2013 of $531.70 ($523 × 1.01664). As prescribed in the February 2, 2011 final rule with comment period (76 FR 5909), we must round this figure to the nearest whole dollar amount. The application fee amount for CY 2013 is therefore $532.00. This represents a $7.00 difference from the $525 fee that we had originally projected for CY 2013 in the February 2, 2011 final rule with comment period (76 FR 5958).

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). However, it does reference previously approved information collections. The forms CMS–855A, CMS–855B, and CMS–855I are approved under OMB control number 0938–0685; the CMS–855S is approved under OMB control number 0938–1056.

IV. Regulatory Impact Statement

A. Introduction

We have examined the impact of this notice as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits, including potential economic, environmental, public health and safety effects, distributive impacts, and equity. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). As explained in section of the notice (section IV.), we estimate that the total cost of the increase in the application fee will not exceed $100 million. This notice therefore does not reach the $100 million economic threshold and is not considered a major notice.

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]

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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,