the Government in Sunshine Act, 5 U.S.C. section 552b(c), to May 23, 2012.

DATES: The April 30, 2012, NBSB closed session by teleconference is being rescheduled to May 23, 2012, from 1 p.m. to 3:30 p.m. The agenda and time are subject to change as priorities dictate.

ADDRESSES: The closed session will occur by teleconference and will not be open to the public as stipulated under exemption 9(B) of the Government in Sunshine Act, 5 U.S.C. section 552b(c).

FOR FURTHER INFORMATION CONTACT: NBSB Mailbox, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services; Email: *NBSB@HHS.GOV.*

SUPPLEMENTARY INFORMATION: Pursuant to section 319M of the Public Health Service Act (*42 U.S.C. 247d–7f*) and section 222 of the Public Health Service Act (*42 U.S.C. 217a*), the Department of Health and Human Services established the National Biodefense Science Board. The Board shall provide expert advice and guidance to the Secretary on scientific, technical, and other matters of special interest to the Department of Health and Human Services regarding current and future chemical, biological, nuclear, and radiological agents, whether naturally occurring, accidental, or deliberate. The Board may also provide advice and guidance to the Secretary and/or the Assistant Secretary for Preparedness and Response on other matters related to public health emergency preparedness and response.

Background: The Board is being asked to review and evaluate the 2012 Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) Strategy and Implementation Plan (SIP). Until a final document is approved by the Secretary of the Department of Health and Human Services (HHS), the development of PHEMCE SIP requires consideration and discussion of procurement-sensitive information that should not be released to the public prior to the Secretary's final decision. Premature public disclosure of the draft PHEMCE SIP would limit the Secretary's decision-making ability to effectively prioritize HHS expenditures on critical medical countermeasures. Therefore, the Board's deliberations on the new task are being conducted in closed sessions in accordance with provisions set forth under exemption 9(B) of the Government in Sunshine Act, 5 U.S.C. section 552b(c), and with approval by the Assistant Secretary for Preparedness and Response.

Availability of Materials: All public materials will be posted on the NBSB Web site at *www.phe.gov/nbsb.*

Procedures for Providing Public Input: All written comments should be sent by email to *NBSB@HHS.GOV* with ''NBSB Public Comment'' as the subject line.

Dated: April 13, 2012.

Nicole Lurie,

Assistant Secretary for Preparedness and Response.

[FR Doc. 2012–9497 Filed 4–19–12; 8:45 am]

BILLING CODE 4150–37–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1442–N]

Medicare Program; Extension of Certain Wage Index Reclassifications and Special Exceptions for the Hospital Inpatient Prospective Payment Systems (PPS) for Acute Care Hospitals and the Hospital Outpatient PPS

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

ACTION: Notice.

SUMMARY: This notice announces changes to wage indices and hospital reclassifications in accordance with section 302 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) as amended by section 3001 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA). The TPTCCA and MCTRJCA extend the expiration date for certain geographic reclassifications and special exception wage indices through March 31, 2012 for the hospital inpatient prospective payment systems for acute care hospitals (IPPS). These geographic reclassifications and special exception wage indices are also extended under the hospital outpatient prospective payment system (OPPS).

DATES: *Applicability Dates:* For IPPS payments, the revised wage indices for section 508, certain nonsection 508, and special exception providers described in this notice are applicable for discharges on or after October 1, 2011 and on or before March 31, 2012. For OPPS payments, the revised wage indices for section 508 providers described in this notice are applicable for services furnished on or after October 1, 2011 and on or before March 31, 2012; and the revised wage indices for nonsection 508 and special exception providers described in this notice are applicable for services furnished on or after January 1, 2012 and on or before June 30, 2012.

FOR FURTHER INFORMATION CONTACT:
Brian Slater, (410) 786–5229, for the IPPS.
Erick Chuang (410) 786–1816, for the OPPS.

SUPPLEMENTARY INFORMATION:

I. Background

On December 23, 2011, the Temporary Payroll Tax Cut Continuation Act (TPTCCA) of 2011 (Pub. L. 112–78) was enacted. Section 302 of the TPTCCA extends section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) reclassifications and certain additional special exceptions for 2 months, through November 30, 2011. On February 22, 2012, the Middle Class Tax Relief and Job Creation Act (MCTRJCA) of 2012 (Pub. L. 112–96) was enacted. Section 3001 of the MCTRJCA amended section 302 of the TPTCCA by extending section 508 reclassifications and certain additional special exceptions for an additional 4 months, through March 31, 2012. We apply such extensions to both the hospital inpatient prospective payment systems (IPPS) (for the relevant part of fiscal year (FY) 2012) and the hospital outpatient prospective payment system (OPPS) (for the relevant parts of calendar years (CYs) 2011 and 2012) final wage index data.

II. Provisions of This Notice

A. Overview of the Section 508 Extension

Section 302 of the TPTCCA and section 3001 of the MCTRJCA, extend through March 31, 2012 wage index reclassifications under section 508 of the MMA and certain special exceptions, for example, those special exceptions contained in the final rule that appeared in the August 11, 2004 **Federal Register** (69 FR 49105 and 49107) extended under section 117 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 (Pub. L. 110–173) and further extended under section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275), section 3137(a) of the Patient Protection and Affordable Care Act (also known as the Affordable Care Act) (Pub. L. 111–148) as amended by section 10317 of Affordable Care Act, and section 102 of the Medicare and Medicaid Extenders Act of 2010, Public Law 111–309.

Under section 508 of the MMA, a qualifying hospital could appeal the

wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the State in which the hospital is located or, at the discretion of the Secretary, to an area within a contiguous State. We implemented this process through notices published in the **Federal Register** on January 6, 2004 (69 FR 661) and February 13, 2004 (69 FR 7340). Such reclassifications were applicable to discharges occurring during the 3-year period beginning April 1, 2004, and ending March 31, 2007. Section 106(a) of the Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006 (MIEA–TRHCA) extended the geographic reclassifications of hospitals that were made under section 508 of the MMA. In the March 23, 2007 **Federal Register** (72 FR 3799), we published a notice that indicated how we were implementing section 106(a) of the MIEA–TRHCA through September 30, 2007. Section 117 of the MMSEA further extended section 508 reclassifications and certain special exceptions through September 30, 2008. On February 22, 2008 in the **Federal Register** (73 FR 9807), we published a notice regarding our implementation of section 117 of the MMSEA. In the October 3, 2008 **Federal Register** (73 FR 57888), we published a notice regarding our implementation of section 124 of MIPPA, which extended section 508 reclassifications and certain special exceptions through September 30, 2009. In the June 2, 2010 **Federal Register** (75 FR 31118), we described our implementation of section 3137(a) of the Affordable Care Act, as amended by section 10317 of Affordable Care Act, which further extended section 508 reclassifications and certain special exceptions through the end of FY 2010. Section 102 of the Medicare and Medicaid Extenders Act of 2010 (MMEA) (Pub. L. 111–309) further extended section 508 reclassifications and certain special exceptions through September 30, 2011. In the April 7, 2011 **Federal Register** (76 FR 19365), we published a notice regarding our implementation of section 102 of the MMEA.

Section 302 of the TPTCCA and section 3001 of the MCTRJCA have extended the hospital reclassifications originally received under section 508 and certain special exceptions for 6 months, through March 31, 2012. Furthermore, for the 6-month period, section 302 of the TPTCCA and section 3001 of the MCTRJCA also require that in determining the wage index applicable to hospitals that qualify for reclassification, the Secretary shall remove the section 508 and special exception hospital's wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. As a result of these changes, we have recalculated certain wage index values to account for the new legislation.

When originally implementing section 508 of the MMA, we required each hospital to submit a request in writing by February 15, 2004, to the Medicare Geographic Classification Review Board (MGCRB), with a copy to CMS. We will neither require nor accept written requests for the extension required by the TPTCCA and the MCTRJCA, since these laws simply provide a 6-month continuation from October 1, 2011 through March 31, 2012 for any section 508 reclassifications and special exceptions wage indices that expired September 30, 2011.

B. Implementation of Section 508 Extension

1. Under the IPPS

The final rule setting forth the Medicare fiscal year (FY) 2012 IPPS and the long-term care hospital prospective payment system (LTCH PPS) (hereinafter referred to as the FY 2012 IPPS/LTCH PPS final rule) appeared in the August 18, 2011 **Federal Register** (76 FR 51476) and we subsequently corrected this final rule via the September 26, 2011 (76 FR 59263) and February 1, 2012 (77 FR 4908) **Federal Register**.

The FY 2012 final wage index values and geographic adjustment factors (GAF) for IPPS hospitals affected by section 302 of the TPTCCA and section 3001 of the MCTRJCA for the 6-month period beginning on October 1, 2011 and ending on March 31, 2012 are included in Tables 2, 4C, and 9B which are posted on our Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/*. Also posted, is a Table showing the hospitals that have been removed from Table 9A for the 6-month period due to the enactment of section 302 of TPTCCA and section 3001 of the MCTRJCA, Table 2 includes the final wage index values for the 6-month period for section 508, nonsection 508 and special exception hospitals affected by the extension. Table 4C lists the revised final wage index and GAF values for the 6-month period for hospitals that are reclassified. In addition, Table 9B lists hospitals that have section 508 and special exception reclassifications that have been extended until March 31, 2012. Please note that some hospitals that might otherwise qualify for an extension of their section 508 reclassification or special exception have not been so extended for FY 2012, because they are receiving a higher wage index as a result of maintaining their MGCRB reclassification or due to section 10324 of the Affordable Care Act which provides for a floor (of 1.0) on the area wage index for hospitals in Frontier States. Therefore, in keeping with our historical practice, these providers continue to receive the wage index published in the FY 2012 IPPS/LTCH PPS final rule, or subsequent correction notices (published September 26, 2011 (76 FR 59263), February 1, 2012 (77 FR 4908), respectively), and are neither removed from Table 9A nor listed in Table 9B.

2. Under the OPPS

Under the OPPS, wage indices applicable to providers reclassified under section 508 are adopted on a federal fiscal year timeframe. Table 2A at *http://www.cms.gov/HospitalOutpatientPPS/lists* section 508 providers and their applicable wage indices from October 1, 2011 through March 31, 2012. Please note these section 508 providers will revert to the previously scheduled January 1, 2012 reclassification or home area wage index from April 1, 2012 through December 31, 2012 as published in the FY 2012 IPPS/LTCH PPS final rule, or subsequent correction notices (published September 26, 2011 (76 FR 59263), February 1, 2012 (77 FR 4908), respectively) and adopted under the OPPS. The wage indices applicable to certain nonsection 508 OPPS providers and to providers that receive special exception wage indexes are adopted on a calendar year timeframe. Because the OPPS payments are based on the calendar year, the wage indices for these nonsection 508 providers and special exception providers are applied from January 1, 2012 through June 30, 2012 in order for these providers to receive the revised wage index for 6 months, the same period that applies in the IPPS. Table 2B at *http://www.cms.gov/HospitalOutpatientPPS/lists* these nonsection 508 and special exceptions providers and their wage indices that are applicable from January 1, 2012 through June 30, 2012.

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).

IV. Waiver of Proposed Rulemaking and Delay of Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 553(b) of the Administrative Procedure Act (APA) and section 1871 of the Act. In addition, in accordance with section 553(d) of the APA and section 1871(e)(1)(B)(i) of the Act, we ordinarily provide a 30 day delay to a substantive rule's effective date. For substantive rules that constitute major rules, in accordance with 5 U.S.C. 801, we ordinarily provide a 60-day delay in the effective date.

None of the processes or effective date requirements apply, however, when the rule in question is interpretive, a general statement of policy, or a rule of agency organization, procedure or practice. They also do not apply when the Congress itself has created the rules that are to be applied, leaving no discretion or gaps for an agency to fill in through rulemaking.

In addition, an agency may waive notice and comment rulemaking, as well as any delay in effective date, when the agency for good cause finds that notice and public comment on the rule as well the effective date delay are impracticable, unnecessary, or contrary to the public interest. In cases where an agency finds good cause, the agency must incorporate a statement of this finding and its reasons in the rule issued.

The policies being publicized in this notice do not constitute agency rulemaking. Rather, the Congress, in the TPTCCA and MCTRJCA, has already required that the agency make these changes, and we are simply notifying the public of certain required revisions to wage index values that are effective October 1, 2011 through March 31, 2012 for the IPPS and OPPS, and effective January 1, 2012 through June 30, 2012 for OPPS for certain nonsection 508 and special exception providers. As this notice merely informs the public of these modifications to the wage index values under the IPPS and OPPS, it is not a rule and does not require any notice and comment rulemaking. To the extent any of the policies articulated in this notice constitute interpretations of the Congress's requirements or procedures that will be used to implement the Congress's directive; they are interpretive rules, general statements of policy, and/or rules of agency procedure or practice, which are not subject to notice and comment rulemaking or a delayed effective date.

However, to the extent that notice and comment rulemaking or a delay in effective date or both would otherwise apply, we find good cause to waive such requirements. Specifically, we find it unnecessary to undertake notice and comment rulemaking in this instance as this notice does not propose to make any substantive changes to IPPS and OPPS policies or methodologies already in effect as a matter of law, but simply applies rate adjustments under the TPTCCA and MCTRJCA to these existing policies and methodologies. Therefore, we would be unable to change any of the policies governing the IPPS for FY 2012 and the OPPS for CY 2011 or 2012 in response to public comment on this notice. As the changes outlined in this notice have already taken effect, it would also be impracticable to undertake notice and comment rulemaking. For these reasons, we also find that a waiver of any delay in effective date, if it were otherwise applicable, is necessary to comply with the requirements of the TPTCCA and MCTRJCA. Therefore, we find good cause to waive notice and comment procedures as well as any delay in effective date, if such procedures or delays are required at all.

V. Regulatory Impact Analysis

A. Introduction

We have examined the impacts 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 (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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for regulatory actions with economically significant effects ($100 million or more in any 1 year). Although we do not consider this notice to constitute a substantive rule or regulatory action, the changes announced in this notice are ''economically'' significant, under section 3(f)(1) of Executive Order 12866, and therefore we have prepared a RIA, that to the best of our ability, presents the costs and benefits of this notice. In accordance with Executive Order 12866, the notice has been reviewed by the Office of Management and Budget.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. We estimate that most hospitals and most other providers and suppliers are small entities as that term is used in the RFA. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $7.5 to $34.5 million in any 1 year). (For details on the latest standard for health care providers, we refer readers to page 33 of the Table of Small Business Size Standards at the Small Business Administration's Web site at *http://www.sba.gov/services/contractingopportunities/sizestandardstopics/tableofsize/index.html.*) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that this notice will have a significant impact on small entities. Because we acknowledge that many of the affected entities are small entities, the analysis discussed in this section would fulfill any requirement for a final regulatory flexibility analysis.

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. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4) 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 2011, that threshold is approximately $136 million. This notice will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

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. This notice will not have a substantial effect on State and local governments.

Although this notice merely reflects the implementation of provisions of the TPTCCA and MCTRJCA and does not constitute a substantive rule, we are nevertheless preparing this impact analysis in the interest of ensuring that the impacts of these changes are fully understood. The following analysis, in conjunction with the remainder of this document, demonstrates that this notice is consistent with the regulatory philosophy and principles identified in Executive Order 12866 and 13563, the RFA, and section 1102(b) of the Act. The notice will positively affect payments to a substantial number of small rural hospitals and providers, as well as other classes of hospitals and providers, and the effects on some hospitals and providers may be significant. The impact analysis, which shows the affect on all payments to IPPS and OPPS hospitals and providers, is shown in Table I of this notice.

B. Statement of Need

This notice is necessary to update the IPPS final fiscal year (FY) 2012 and OPPS final calendar years (CYs) 2011 and 2012 wage indices and hospital reclassifications and other related tables to reflect changes required by or resulting from the implementation of section 302 of the TPTCCA and section 3001 of the MCTRJCA. The TPTCCA and MCTRJCA require the extension of the expiration date for certain geographic reclassifications and special exception wage indices through March 31, 2012 We note that the changes in this notice are already in effect with changes made to PRICER in February 2012. Thus, the issuance of this notice does not result in additional changes in payments.

C. Overall Impact

1. Under the IPPS

The FY 2012 IPPS final rule included an impact analysis for the changes to the IPPS included in that rule. This notice updates those impacts to the IPPS operating payment system as to reflect certain changes required by section 302 of the TPTCCA and section 3001 of the MCTRJCA. Because these provisions in the TPTCCA and the MCTRJCA were not budget neutral, the overall estimates for hospitals have changed from our estimate that was published in the FY 2012 IPPS final rule (76 FR 51814). We estimate that the changes in the FY 2012 IPPS final rule, in conjunction with the final IPPS rates and wage index included in this notice, will result in an approximate $1.22 billion increase in total operating payments relative to FY 2011. In the FY 2012 IPPS final rule (76 FR 51814), we had projected that total operating payments would increase by $1.13 billion relative to FY 2011. However, since the changes in this notice will increase operating payments by $90 million relative to what was projected in the FY 2012 IPPS final rule, these changes will result in a net increase of $1.22 billion in total operating payments, as mentioned previously. Capital payments are estimated to increase by an additional $7.6 million in FY 2012 relative to FY 2011 as a result of the changes in this notice.

2. Under the OPPS

The CY 2012 OPPS final rule included an impact analysis for the changes to the OPPS included in that rule. This notice updates those impacts to the OPPS to reflect certain changes we are announcing as a result of section 302 of the TPTCCA and section 3001 of the MCTRJCA. The overall estimates for hospitals have changed from our estimate that was published in the CY 2012 OPPS final rule (76 FR 74562). We estimate that the changes to the CY 2011 wage indexes included in this notice will increase the OPPS payments in CY 2011 by $11 million, relative to what was estimated in the CY 2012 OPPS final rule. We estimate that the changes to the CY 2012 OPPS wage indexes will increase OPPS payments by $15 million relative to what was projected in the CY 2012 OPPS final rule, resulting in a net increase of $650 million in OPPS operating payments in CY 2012 relative to CY 2011.

D. Anticipated Effects

1. Under the IPPS

In the Table I, we provide an impact analysis for changes to the IPPS operating payments in FY 2012 as a result of the changes required by section 302 of the TPTCCA and section 3001 of the MCTRJCA. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The first row of the Table I shows the overall impact on the 3,423 acute care hospitals included in the analysis. The impact analysis reflects the change in estimated operating payments in FY 2012 due to section 302 of the TPTCCA and section 3001 of the MCTRJCA relative to estimated FY 2012 operating payments published in the FY 2012 IPPS final rule (76 FR 51817). Overall, all hospitals paid under the IPPS will experience an estimated 0.1 percent increase in operating payments in FY 2012 due to these provisions in the TPTCCA and MCTRJCA compared to the previous estimates of operating payments in FY 2012 published in the FY 2012 IPPS final rule. Because section 302 of the TPTCCA and section 3001 of the MCTRJCA were not budget neutral, all hospitals, depending on whether they were affected by these provisions, will either experience no change or an increase in IPPS operating payments in FY 2012 in this notice relative to the previously published estimates. As such, hospitals located in urban areas will experience a 0.1 percent increase in payments while hospitals located in rural areas will not experience any change in payments in FY 2012 due to the provisions in this notice as compared to the estimated payments provided in the FY 2012 IPPS final rule. Among the hospitals that are subject to the changes in this notice, hospitals will experience a net effect increase in payments ranging from 0.1 percent to 0.3 percent where urban New England hospitals and urban reclassified hospitals are expected to experience the largest net increase in operating payments of 0.3 percent in FY 2012.

TABLE I—IMPACT ANALYSIS OF CHANGES FOR FY 2012 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM

	Number of hospitals	Percent net effect of all changes for FY 2012
All Hospitals	3423	0.1
By Geographic Location:		
Urban hospitals	2499	0.1
Large urban areas	1371	0.1
Other urban areas	1128	0.1
Rural hospitals	924	0
Bed Size (Urban):		
0–99 beds	633	0
100–199 beds	782	0.1
200–299 beds	449	0.1
300–499 beds	430	0.1
500 or more beds	205	0.1
Bed Size (Rural):		
0–49 beds	319	0
50–99 beds	348	0
100–149 beds	152	0
150–199 beds	58	0
200 or more beds	47	0
Urban by Region:		
New England	120	0.3
Middle Atlantic	320	0.2
South Atlantic	380	0
East North Central	401	0.2
East South Central	153	0
West North Central	169	0
West South Central	367	0
Mountain	159	0
Pacific	380	0
Puerto Rico	50	0
Rural by Region:		
New England	23	0
Middle Atlantic	69	0
South Atlantic	165	0
East North Central	120	0
East South Central	170	0
West North Central	99	0.1
West South Central	182	0
Mountain	66	0
Pacific	29	0
Puerto Rico	1	0
By Payment Classification:		
Urban hospitals	2520	0.1
Large urban areas	1384	0.1
Other urban areas	1136	0.1
Rural areas	903	0
Teaching Status:		
Nonteaching	2391	0
Fewer than 100 residents	792	0.1
100 or more residents	240	0.2
Urban DSH:		
Non-DSH	739	0.1
100 or more beds	1547	0.1
Less than 100 beds	337	0
Rural DSH:		
SCH	417	0
RRC	222	0
100 or more beds	27	0.1
Less than 100 beds	134	0.1
Urban teaching and DSH:		
Both teaching and DSH	827	0.1
Teaching and no DSH	144	0.2
No teaching and DSH	1057	0
No teaching and no DSH	492	0.1
Special Hospital Types:		
RRC	175	0
SCH	320	0
MDH	193	0
SCH and RRC	120	0

TABLE I—IMPACT ANALYSIS OF CHANGES FOR FY 2012 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of hospitals	Percent net effect of all changes for FY 2012
MDH and RRC	18	0
Type of Ownership:		
Voluntary	1985	0.1
Proprietary	870	0.1
Government	566	0
Medicare Utilization as a Percent of Inpatient Days:		
0–25	358	0
25–50	1695	0.1
50–65	1081	0.1
Over 65	198	0.1
FY 2012 Reclassifications by the Medicare Geographic Classification Review Board:		
All Reclassified Hospitals	655	0.2
Non-Reclassified Hospitals	2768	0
Urban Hospitals Reclassified	323	0.3
Urban Nonreclassified Hospitals, FY 2012	2142	0
All Rural Hospitals Reclassified FY 2012	332	0
Rural Nonreclassified Hospitals FY 2012	532	0
All Section 401 Reclassified Hospitals	40	0
Other Reclassified Hospitals (Section 1886(d)(8)(B))	62	0
Specialty Hospitals:		
Cardiac specialty Hospitals	19	0

2. Under the OPPS

In the Table II, we provide an impact analysis for changes to the OPPS payments in CYs 2011 and 2012 as a result of the changes under section 302 of the TPTCCA and section 3001 of the MCTRJCA. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The first row of Table II shows the overall impact on the 3,894 hospitals included in the analysis. The impact analysis reflects the change in estimated OPPS payments in CYs 2011 and 2012 due to section 302 of the TPTCCA and section 3001 of the MCTRJCA relative to estimated OPPS payments published in the CY 2011 OPPS final rule (75 FR 72268) and promulgated in the CY 2012 OPPS final rule. Overall, all hospitals will experience an estimated 0.0 percent increase in OPPS payments in CYs 2011 and 2012 due to these provisions compared to the previous estimates of OPPS payments published in the CY 2012 OPPS final rule. Because the changes are not budget neutral, all hospitals, depending on whether they were affected by these provisions, will either experience no change or an increase in OPPS payments in CYs 2011 and 2012 in this notice relative to the previously published estimates. As such, hospitals located in urban areas will generally not experience any change in payments while hospitals located in rural areas will generally not experience any change in payments in CY 2012 due to the provisions in this notice as compared to the estimated payments provided in the CY 2012 OPPS final rule. Among the hospitals that are subject to the changes in this notice, hospitals will experience a net effect increase in payments ranging from 0.0 percent to 0.1 percent.

TABLE II—IMPACT ANALYSIS OF CHANGES FOR CYS 2011 AND 2012 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of hospitals	Percent net effect of all changes for CY 2011	Percent net effect of all changes for CY 2012
All Hospitals (excludes hospitals held harmless and CMHCs)	3,894	0.0	0.0
Urban Hospitals	2,945	0.0	0.0
Large urban (>1 Million)	1,607	0.0	0.0
Other urban (≤1 Million)	1,338	0.0	0.0
Rural Hospitals	949	0.0	0.0
Sole Community	384	0.1	0.1
Other Rural	565	0.0	0.0
Beds (Urban)			
0–99 Beds	1,028	0.0	0.0
100–199 Beds	841	0.0	0.0
200–299 Beds	454	0.0	0.0
300–499 Beds	419	0.0	0.1
500 + Beds	203	0.0	0.0
Beds (Rural)			
0–49 Beds	349	0.0	0.0
50–100 Beds	355	0.0	0.1
101–149 Beds	140	0.0	0.0

TABLE II—IMPACT ANALYSIS OF CHANGES FOR CYS 2011 AND 2012 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

	Number of hospitals	Percent net effect of all changes for CY 2011	Percent net effect of all changes for CY 2012
150–199 Beds	57	0.0	0.0
200 + Beds	48	0.0	0.1
Volume (Urban)			
<5,000 lines	597	0.0	0.0
5,000–10,999 lines	146	0.0	0.0
11,000–20,999 lines	235	0.0	0.0
21,000–42,999 lines	477	0.0	0.0
42,999–89,999 lines	713	0.0	0.0
>89,999 lines	777	0.0	0.0
Volume (Rural)			
<5,000 lines	67	0.0	0.0
5,000–10,999 lines	71	0.0	0.0
11,000–20,999 lines	174	0.0	0.0
21,000–42,999 lines	282	0.0	0.0
>42,999 lines	355	0.0	0.0
Region (Urban)			
New England	150	0.1	0.1
Middle Atlantic	355	0.1	0.1
South Atlantic	449	0.0	0.0
East North Cent	472	0.1	0.1
East South Cent	183	0.0	0.0
West North Cent	190	0.0	0.0
West South Cent	498	0.0	0.0
Mountain	208	0.0	0.0
Pacific	394	0.0	0.0
Puerto Rico	46	0.0	0.0
Region (Rural)			
New England	25	0.0	0.0
Middle Atlantic	67	0.0	0.0
South Atlantic	162	0.0	0.0
East North Cent	128	0.1	0.1
East South Cent	170	0.0	0.0
West North Cent	101	0.1	0.1
West South Cent	200	0.0	0.0
Mountain	67	0.0	0.1
Pacific	29	0.1	0.1
Teaching Status			
Non-Teaching	2,895	0.0	0.0
Minor	708	0.0	0.0
Major	291	0.1	0.1
DSH Patient Percent			
0	11	0.0	0.0
>0–0.10	353	0.0	0.0
0.10–0.16	357	0.1	0.1
0.16–0.23	734	0.0	0.1
0.23–0.35	1,040	0.0	0.0
≥0.35	785	0.0	0.0
DSH Not Available *	614	0.0	0.0
Urban Teaching/DSH			
Teaching & DSH	903	0.0	0.1
No Teaching/DSH	1,456	0.0	0.0
No teaching/No DSH	10	0.0	0.0
DSH not Available	576	0.0	0.0
Type Of Ownership			
Voluntary	2,061	0.0	0.0
Proprietary	1,272	0.0	0.0
Government	561	0.0	0.0

** Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

E. Alternatives Considered

This notice provides descriptions of the statutory provisions that are addressed and identifies policies for implementing these provisions. Due to the prescriptive nature of the statutory provisions, no alternatives were considered.

F. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table III, we have prepared an accounting

statement showing the classification of expenditures associated with the provisions of this notice as they relate to acute care hospitals. This table provides our best estimate of the change in Medicare payments to providers as a result of the changes to the IPPS presented in this notice. All expenditures are classified as transfers from the Federal government to Medicare providers. As previously discussed, relative to what was projected in the FY 2012 IPPS final rule, the changes in this notice are projected to increase FY 2012 IPPS operating payments by $90 million and IPPS capital payments by $ 8 million. As previously discussed, relative to what was projected in the CY 2012 OPPS final rule, the changes in this notice will increase CY 2011 OPPS payments by $11 million, and will increase CY 2012 OPPS payments by $15 million. Thus, the total increase in Federal expenditures for implementing section 302 of the TPTCCA and section 3001 of the MCTRJCA under the IPPS and the OPPS is approximately $124 million.

TABLE III—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM PUBLISHED FY 2012 TO REVISED FY 2012 AND UNDER THE OPPS FROM PUBLISHED CYS 2011 AND 2012 TO REVISED CYS 2011 AND 2012

Category	Transfers
Annualized Monetized Transfers	$124 million.
From Whom to Whom	Federal Government to IPPS and OPPS Medicare Providers.
Total	$124 million.

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

Dated: March 1, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: March 23, 2012.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Tribal Personal Responsibility Education Program (Tribal PREP) Implementation Plan and PPR.

OMB No: New Collection.

Description: Description: The Patient Protection and Affordable Care Act, 2010, also known as health care reform, amends Title V of the Social Security Act (42 U.S.C. 701 *et seq.*) as amended by sections 2951 and 2952(c), by adding section 513, authorizing the Personal Responsibility Education Program (PREP). The President signed into law the Patient Protection and Affordable Care Act on March 23, 2010, Public Law 111–148, which adds the new PREP program and provisions for a 5% set-aside for Tribes and tribal organizations. The purpose of this program is to: Educate adolescents on both abstinence and contraception; to prevent pregnancy and sexually transmitted infections; and at least three adulthood preparation subjects. The PREP grant funding is authorized from FY 2010 through FY 2014.

A request is being made to solicit comments from the public on paperwork reduction as it relates to ACYF's receipt of the following documents from awardees:

Respondents: 16 Tribal PREP grantees.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Tribal PREP Implementation Plan	16	1	50	800
Performance Progress Reports	16	2	30	960

Estimated Total Annual Burden Hours: 1760.

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Planning, Research and Evaluation, 370 L'Enfant Promenade SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. Email address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, Email: *OIRA_SUBMISSION@OMB.EOP.GOV,* Attn: Desk Officer for the Administration for Children and Families.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2012–9544 Filed 4–19–12; 8:45 am]

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