

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.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, e-mail your request, including your address, phone number, OMB number, and OS document identifier, to Sherette.funncoleman@hhs.gov, or call the Reports Clearance Office on (202) 690-5683. Send written comments and

recommendations for the proposed information collections within 30 days of this notice directly to the OS OMB Desk Officer; faxed to OMB at 202-395-5806.

Proposed Project: Adolescent Family Life Care and Prevention End of Year Report Templates (Revision) OMB No. 0990-0299, Office of Adolescent Pregnancy Programs (OAPP).

Abstract: OAPP is proposing to revise the current OMB approved Adolescent Family Life Care and Prevention End of Year Report Templates. The current OMB approval is applicable through May 31, 2009. All AFL grantees are required by their Notice of Grant Awards to submit an end of year report once per year. The current End of Year Report templates provide a degree of

standardization across the AFL grantees, allowing for more complete data collection by OAPP for program assessment.

OAPP is also proposing to consolidate 0990-0300—AFL Prevention Project End of Year Report Template ICR and 0990-0299—AFL Care and Prevention End of Year Report Templates ICR. After the approval by OMB on 0990-0299 ICR, OAPP will eliminate 0990-0300. This action will reduce the redundancy across ICRs and lessen the number of burden hours reported by including both templates under one ICR (0990-0299).

The original title will be changed to Adolescent Family Life End of the Year Report Template.

ESTIMATED ANNUALIZED BURDEN TABLE

Type of respondent	Form name	Number of respondents	Number of responses/ respondent	Average burden/ response (hours)	Total burden (hours)
Care demonstration projects.	Adolescent Family Life Care and Prevention Template.	31	1	65	2,015
Prevention demonstration projects.	Adolescent Family Life Care and Prevention Template.	35	1	65	2,275

Seleda Perryman,

Office of the Secretary, Paperwork Reduction Act Reports Clearance Officer.

[FR Doc. E9-20795 Filed 8-27-09; 8:45 am]

BILLING CODE 4150-30-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS-1515/1572, CMS-301, CMS-317, CMS-319, CMS-1957 and CMS-10296]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS) is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate 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.

1. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Home Health Agency Survey and Deficiencies Report, Home Health Functional Assessment Instrument and Supporting Regulations in 42 CFR 488.26 and 442.30. *Use:* In order to participate in the Medicare Program as a Home Health Agency (HHA) provider, the HHA must meet Federal Standards. These forms are used to record information and patients' health and provider compliance with requirements and to report the information to the Federal Government. *Form Number:* CMS-1515/1572 (OMB#: 0938-0355); *Frequency:* Reporting—Yearly; *Affected Public:* Health Care Services; *Number of Respondents:* 10,078; *Total Annual Responses:* 5,614; *Total Annual Hours:* 9,821. (For policy questions regarding this collection contact Patricia Sevast at 410-786-8135. For all other issues call 410-786-1326.)

2. *Type of Information Collection Request:* Revision of a currently

approved collection; *Title of Information Collection:* Certification of Medicaid Eligibility Quality Control Payment Error Rates and Supporting Regulations Contained in 42 CFR 431.816. *Use:* Under the MEQC program, States can operate the traditional MEQC sample-and-review program or States can elect to study targeted areas of eligibility or program administration that are error-prone or that will help to prevent or reduce erroneous or misspent funds. These alternative MEQC programs are called MEQC pilots. Some States operate alternative MEQC programs as part of their research and demonstration waivers under Section 1115 of the Social Security Act. The majority of States operate some form of alternative MEQC program. However, since the number of States that conduct traditional MEQC programs and alternative MEQC programs can fluctuate at any time, we have assessed the burden and costs associated with submitting the Payment Error Rate form as if all States were reporting this information.

State agencies are required to submit the Payment Error Rate form to their respective CMS Regional Offices. Regional Office staff will review these forms for completeness and will forward these forms to the Central Office for compilation of error rate charts for

projected quarterly withholdings and/or fiscal disallowances. The collection of information is also necessary to implement provisions from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3) with regard to the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs. *Form Number:* CMS-301 (OMB#: 0938-0246); *Frequency:* Reporting and Recordkeeping—Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 51; *Total Annual Responses:* 102; *Total Annual Hours:* 16,446. (For policy questions regarding this collection contact Jessica Woodard at 410-786-9249. For all other issues call 410-786-1326.)

3. Type of Information Collection
Request: Extension of a currently approved collection; *Title of Information Collection:* State Medicaid Eligibility Quality Control Sampling Plan and Supporting Regulations in 42 CFR 431.800-431.865; *Use:* The Medicaid Eligibility Quality Control (MEQC) System is operated by the State Title XIX agency to monitor and improve the administration of its Medicaid system. The MEQC system is based on monthly State reviews of Medicaid cases by States performing the traditional sampling process identified through statistically reliable statewide samples of cases selected from the eligibility files. These reviews are conducted to determine whether or not the sampled cases meet applicable State Title XIX eligibility requirements. The reviews are also used to assess beneficiary liability, if any, and to determine the amounts paid to provide Medicaid services for these cases.; *Form Number:* CMS-317 (OMB#: 0938-0146); *Frequency:* Recordkeeping and Reporting—Semi-annually; *Affected Public:* State, Local or Tribal governments; *Number of Respondents:* 10; *Total Annual Responses:* 20; *Total Annual Hours:* 480. (For policy questions regarding this collection contact Jessica Woodard at 410-786-9249. For all other issues call 410-786-1326.)

4. Type of Information Collection
Request: Revision of the currently approved collection; *Title of Information Collection:* State Medicaid Eligibility Quality Control (MEQC) Sample Selection Lists and Supporting Regulations in 42 CFR 431.800-431.865; *Use:* State Medicaid Eligibility Quality Control (MEQC) is operated by the State Title XIX agency to monitor and improve the administration of its Medicaid system. The MEQC system is

based on State reviews of Medicaid beneficiaries identified through statistically reliable statewide samples of cases selected from the eligibility files. These reviews are conducted to determine whether or not the sampled cases meet applicable State Title XIX eligibility requirements by States performing the traditional sample process. The reviews are also used to assess beneficiary liability, if any, and to determine the amounts paid to provide Medicaid services for these cases. At the beginning of each month, State agencies still performing the traditional sample are required to submit sample selection lists which identify all of the cases selected for review in the States' samples. The sample selection lists contain identifying information on Medicaid beneficiaries such as: State agency review number; beneficiary's name and address; the name of the county where beneficiary resides; Medicaid case number, *etc.* The submittal of the sample selection lists is necessary for regional office (RO) validation of State reviews. Without these lists, the integrity of the sampling results would be suspect and the ROs would have no data on the adequacy of the States' monthly sample draw or review completion status.; *Form Number:* CMS-319 (OMB#: 0938-0147); *Frequency:* Reporting—Monthly; *Affected Public:* State, Local or Tribal governments; *Number of Respondents:* 10; *Total Annual Responses:* 120; *Total Annual Hours:* 960. (For policy questions regarding this collection contact Jessica Woodard at 410-786-9249. For all other issues call 410-786-1326.)

5. Type of Information Collection
Request: Reinstatement without change of a previously approved collection; *Title of Information Collection:* SSO Report of State Buy-in Problem and Supporting Regulations in 42 CFR 407.40; *Use:* Under the State Buy-In program, States enroll certain groups of needy people under the Part B Supplementary Medical Insurance (SMI) Program and pay their premiums. The purpose of the "buy-in" is to allow the States to provide SMI protection to certain groups of needy individuals as part of its total assistance plan. Generally, States "buy-in" for individuals who are categorically needy under Medicaid and meet the eligibility requirements for Medicare Part B. States can also include in their buy-in agreement those eligible for medical assistance only. The CMS-1957 is used in the resolution of beneficiary complaints regarding State buy-in. This form facilitates the coordination of

efforts between the SSO, State Medicaid Agencies, and CMS in the resolution of a beneficiary's State buy-in problem. *Form Number:* CMS-1957 (OMB#: 0938-0035); *Frequency:* Reporting—On occasion; *Affected Public:* Federal government, Individuals or Households, and State, Local, and Tribal governments; *Number of Respondents:* 5,600; *Total Annual Responses:* 5,600; *Total Annual Hours:* 1,816. (For policy questions regarding this collection contact Lucia Diaz-Robinson at 410-786-0598. For all other issues call 410-786-1326.)

6. Type of Information Collection
Request: New collection; *Title of Information Collection:* Electronic Health Records (EHR) Testing; *Use:* The Centers for Medicare and Medicaid Services (CMS) has indicated through statements in proposed and final rulemaking for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program that it is actively seeking to pursue quality measurement based on alternative sources of data that do not require manual chart abstraction or that utilize data already being reported by many hospitals for other programs, as doing so would potentially reduce the burden associated with the collection and reporting of measures for the program. Over the years, we have encouraged hospitals to take steps toward the adoption of electronic health records (EHRs) that would allow for reporting of clinical quality data from the EHRs directly to a CMS data repository beginning with the FY 2006 Inpatient Prospective Payment System (IPPS) Rule (70 FR 47420 through 47421). We have also encouraged hospitals that are implementing, upgrading, or developing EHR systems to ensure that the technology obtained, upgraded, or developed conforms to standards adopted by the Department of Health and Human Services (HHS).

In the IPPS 2010 proposed rule (74 FR 24182), we described our intent to begin a voluntary testing program for the submission to CMS of standardized data elements needed to calculate inpatient hospital quality measures on the topics of Stroke, Venous thromboembolism, and Emergency department throughput. These measures have not been adopted for the Reporting Hospital Quality for Annual Payment Update (RHQDAPU) program, and participation in this voluntary EHR-testing program will not substitute for submission of data elements required under the RHQDAPU program in a time, form and manner specified by the Secretary. Similarly, non-participation in this voluntary program will not incur any penalties.

The results of this voluntary testing process will enable CMS to assess the feasibility of collecting data elements via electronic health records as a future alternative to submission of manually abstracted chart data elements by hospitals, thereby potentially reducing the administrative burden associated with submission of quality measures for the RHQDAPU program. *Form Number:* CMS-10296 (OMB#: 0938-New); *Frequency:* Reporting—Once; *Affected Public:* Private Sector—Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 55; *Total Annual Responses:* 55; *Total Annual Hours:* 28,655. (For policy questions regarding this collection contact Shaheen Halim at 410-786-0641. For all other issues call 410-786-1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site at <http://www.cms.hhs.gov/PaperworkReductionActof1995>, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by *October 27, 2009*:

1. *Electronically.* You may submit 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) 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.

Dated: August 21, 2009.

Michelle Shortt,

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

[FR Doc. E9-20845 Filed 8-27-09; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS-10080, CMS-R-70, CMS-R-38 and CMS-846-849, 854, 10125, 10126, 10269]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate 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 function; (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.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Publication Usage Survey; *Use:* The Publication Usage survey was developed to gather information from people who request or access Medicare publications, to ensure comprehension, usability, and use of the publications. CMS is seeking understanding about whether publications have been effective in informing members of the Medicare audience regarding policy and benefits. Included in the survey are questions regarding the satisfaction of publication users with specific publications and whether the information they received informed them about the Medicare program. Information gathered in this survey will be used only for purposes of targeting and improving communications with Medicare beneficiaries, caregivers, partners, and community organizations. *Form Number:* CMS-10080 (OMB#: 0938-0892); *Frequency:* Reporting—On occasion; *Affected Public:* Individuals or Households; *Number of Respondents:* 3,800; *Total Annual Responses:* 3,800;

Total Annual Hours: 950. (For policy questions regarding this collection contact Renee Clarke at 410-786-0006. For all other issues call 410-786-1326.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Information Collection Requirements in HSQ-110, Acquisition, Protection and Disclosure of Peer review Organization Information and Supporting Regulations in 42 CFR, Sections 480.104, 480.105, 480.116, and 480.134; *Use:* The Peer Review Improvement Act of 1982 authorizes quality improvement organizations (QIOs), formally known as peer review organizations (PROs), to acquire information necessary to fulfill their duties and functions and places limits on disclosure of the information. The QIOs are required to provide notices to the affected parties when disclosing information about them. These requirements serve to protect the rights of the affected parties. The information provided in these notices is used by the patients, practitioners and providers to: obtain access to the data maintained and collected on them by the QIOs; add additional data or make changes to existing QIO data; and reflect in the QIO's record the reasons for the QIO's disagreeing with an individual's or provider's request for amendment.: *Form Number:* CMS-R-70 (OMB#: 0938-0426); *Frequency:* Reporting—On occasion; *Affected Public:* Business or other for-profits; *Number of Respondents:* 362; *Total Annual Responses:* 3729; *Total Annual Hours:* 60,919. (For policy questions regarding this collection contact Tom Kessler at 410-786-1991. For all other issues call 410-786-1326.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Conditions of Certification for Rural Health Clinics and Supporting Regulations in 42 CFR 491.9, 491.10, 491.11; *Use:* The Rural Health Clinic (RHC) conditions of certification are based on criteria prescribed in law and are designed to ensure that each facility has a properly trained staff to provide appropriate care and to assure a safe physical environment for patients. The Centers for Medicare and Medicaid Services (CMS) uses these conditions of participation to certify RHCs wishing to participate in the Medicare program. These requirements are similar in intent to standards developed by industry organizations such as the Joint Commission on Accreditation of Hospitals, and the National League of Nursing/American Public Association