justification for an FMAP adjustment, we cannot predetermine how much time will be required to verify the information, but will review and verify a State's submission and request for an adjustment to its FMAP as expeditiously as possible.

D. Methodology Utilized in the Calculation of the Adjustment to the Medicaid FMAP

This Final Notice announces the methodology that the U.S. Department of Health and Human Services (HHS) will use in implementing the employer contribution disregard required by Section 614 of CHIPRA. The approach reflects the absence of a Federal source of reliable and timely data on pension and insurance contributions by individual employer and State.

We will use the BEA definition of pension and insurance contributions: contributions consisting of employer payments (including payments-in-kind) to private pension and profit-sharing plans, publicly administered government employee retirement plans, private group health and life insurance plans, privately administered workers' compensation plans, and supplemental unemployment benefit plans, formerly called "other labor income".

We will identify significantly disproportionate employer pension or insurance contributions for a State by reviewing contributions identified by the State. We believe that States may have greater access to timely and relevant data on such contributions than is available from Federal data sources. We would request that any State that believes an individual employer has made a significantly disproportionate employer or insurance contribution provide data on that individual employer contribution to HHS. The State may submit official audited financial statements for the employer for the year of the contribution (starting with the year 2003) and the prior year. If the State does not submit official audited financial statements for the employer, the State may submit other evidence that the increase in the employer's contribution is likely to exceed 25 percent of the increase in the State's personal income in that year.

After a State submits written notification that such a contribution occurred, HHS will verify the State's data. As part of this verification process, HHS will search the Security Exchange Commission (SEC) filings or the Internal Revenue Service (IRS) 5500 Annual Return/Report of Employee Benefit Plan database to find the employer's contributions for the relevant two-year period. If HHS is unable to verify the State's submitted data, no FMAP adjustment will be made.

After the State's data for an employer is verified, HHS will allocate employer contributions in both years to the State according to the methodology used by the BEA. Under that methodology, employer contributions to pension and insurance funds are distributed according to State wages and salaries by the employer's industry subsector. Then, HHS will determine whether the State increase in the employer contribution exceeds the trigger of 25 percent of the increase in total State personal income.

If the employer contribution is significantly disproportionate, HHS will disregard the State-allocated contribution, *i.e.,* subtract it from the State's personal income in that year. HHS will calculate the FMAP adjustment for the State using the revised State per capita income based on the newly calculated State personal income. Since the FMAP calculation involves the average per capita income for three years, the FMAP adjustment will be calculated for each fiscal year affected by the State's revised per capita income. For instance, a significantly disproportionate employer contribution in 2003 would affect the FMAPs for FY06 (based on State per capita income for calendar years 2001, 2002, and 2003), FY07 (based on State per capita income for calendar years 2002, 2003, and 2004), and FY08 (based on State per capita income for calendar years 2003, 2004, and 2005).

States may submit data on disproportionate employer contributions made between 2003 and 2008 to HHS by the end of FY 2011. The deadline for 2009 and beyond will be the end of the second fiscal year following the year end of the employer's annual financial statement that includes the disproportionate employer contribution.

To summarize this methodology, after receipt of a State submission, HHS will verify the employer contributions from SEC filings or IRS 5500 reports for the year of the contribution and the prior year. If the employer contributions are verified, HHS will allocate the employer contributions for the State for both years and determine whether the State increase in the employer contribution exceeds the trigger of 25 percent of the increase in the State's personal income. If the employer contribution meets the definition of significantly disproportionate by exceeding the trigger, HHS will recalculate the FMAP rates for the corresponding fiscal years. The Centers for Medicare & Medicaid Services (CMS) will then calculate the changes in Federal medical assistance payments resulting from the adjusted FMAP rates for the State's applicable fiscal years. If HHS is unable to verify the State's submitted data, then no FMAP adjustment will be made.

DATES: *Effective Dates:* This final notice is effective 30 days after publication and sets forth a methodology for adjusted percentages applicable under title XIX of the Social Security Act for fiscal years 2006 and beyond, beginning October 1, 2005.

FOR FURTHER INFORMATION CONTACT: Rose Chu or Thomas Musco, Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation, Room 447D—Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, (202) 690–6870.

Dated: September 10, 2010 .

Kathleen Sebelius,

Secretary.

[FR Doc. 2010–25977 Filed 10–14–10; 8:45 am]

BILLING CODE 4210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10304 and CMS–10315]

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

AGENCY: Centers for Medicare & Medicaid Services, HHS.

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:* New collection; *Title of Information Collection:* Information

Collection Requirements and Supporting Information for Chronic Kidney Disease Surveys under the 9th Scope of Work; *Form Number:* CMS–10304 (OMB #: 0938–New); *Use:* The Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (DHHS) are requesting OMB clearance for the Chronic Kidney Disease (CKD) Partner Survey and the Chronic Kidney Disease (CKD) Provider Survey. The Prevention CKD Theme is a component of the Prevention Theme of the Quality Improvement Organization (QIO) Program's 9th Scope of Work (SOW). The statutory authority for this scope of work is found in Part B of Title XI of the Social Security Act (the Act) as amended by the Peer Review Improvement Act of 1982. The Act established the Utilization and Quality Control Peer Review Organization Program, now known as the Quality Improvement Organization (QIO) Program.

The goal of the Prevention CKD Theme is to detect the incidence, decrease the progression of CKD, and improve care among Medicare beneficiaries through provider adoption of timely and effective quality of care interventions; participation in quality incentive initiatives; beneficiary education; and key linkages and collaborations for system change at the state and local level. In addition to improving the quality of care for the elderly and frail-elderly, this Theme aims to reduce the rate of Medicare entitlement by disability through the delay and prevention of end-stage renal disease (ESRD); thus resulting in higher quality care and significant savings to the Medicare Trust Fund.

The CKD Partner Survey constitutes a new information collection to be used by CMS to obtain information on how QIO collaboration with partners facilitates systems change within the QIO's respective state. The CKD Partner Survey will be a census administered to 350 collaborative partners in the 9th SOW. The CKD Partner Survey will be administered via telephone. Responses will be entered into a pre-programmed Computer-Assisted Telephone Interviewing (CATI) interface. The results of the survey shall be used for inpatient quality indicators (IQI) by the QIO. CMS will also use the results to assess how partner organizations and their perspective of the QIO's role are implementing system change.

Similarly, the CKD Provider Survey constitutes a new information collection to be used by CMS to obtain information on how QIO collaboration with physician practices facilitates systems change within the QIO's respective state. The CKD Provider Survey will be administered via telephone and the Web. Responses collected by phone will be entered into a pre-programmed Computer-Assisted Telephone Interviewing (CATI) interface. Responses collected by Web will be housed on a secure server and database. The results of the survey shall be used for inpatient quality indicators (IQI) by the QIO. CMS will also use the results to assess how physicians' practices and their perspective of the QIO's role are implementing system change. *Frequency:* Yearly; *Affected Public:* Private Sector—Business or other for-profits and Not-for profit institutions; *Number of Respondents:* 1,350; *Total Annual Responses:* 1,350; *Total Annual Hours:* 337.5. (For policy questions regarding this collection contact Robert Kambic at 410–786–1515. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Patient Safety Survey Under the 9th Scope of Work: Nursing Home in Need (NHIN) *Use:* The Centers for Medicare & Medicaid Services (CMS) is requesting OMB clearance for the Nursing Homes in Need (NHIN) Survey. The NHIN is a component of the Patient Safety Theme of the Quality Improvement Organization (QIO) Program's 9th Scope of Work (SOW). The statutory authority for this scope of work is found in Part B of Title XI of the Social Security Act (the Act) as amended by the Peer Review Improvement Act of 1982. The Act established the Utilization and Quality Control Peer Review Organization Program, now known as the Quality Improvement Organization (QIO) Program.

The QIO in each State will provide special technical assistance to a small number of nursing homes in need of assistance with quality improvement efforts. This special technical assistance will be for the QIO to conduct a root cause analysis (RCA) with one nursing home in its state per year (three over three years). Under this component, it is expected that within the first quarter of the contract period, CMS will assign one nursing home to each QIO. The determination of which nursing homes are eligible under this component will be made by CMS. Some of these facilities may meet criteria for Special Focus Facilities (SFF). The intent of this component is that each State QIO will work with three nursing homes over the three-year contract period; these assignments are expected to be spaced out so that each State QIO will get one nursing home assigned approximately every 12 months.

The NHIN Survey is a new information collection to be used by CMS to obtain information on nursing home satisfaction with technical assistance strategies delivered as a component of the NHIN. The NHIN Survey will be a census of 53 nursing homes working with their respective QIOs. The survey will be conducted one time for each of the nursing homes assisted in the first two years under the 9th SOW and it will be conducted twice with nursing homes assisted in the third year. The information collected through this survey will allow CMS to help focus the NHIN task to maximize the benefit to participating nursing homes. The NHIN Survey will be administered via telephone by trained and experienced interviewers. Responses will be entered into a pre-programmed Computer-Assisted Telephone Interviewing (CATI) interface.

The NHIN Survey will include questions to determine if the QIO has conducted a root cause analysis and developed an action plan. These will be followed by questions about their satisfaction with the QIO and their perceived value of the QIO's assistance. The NHIN Survey will address the following:

- Background information;
- Current work—*information and assessment;*
- Satisfaction with QIOs;
- Value of QIO assistance;
- Sources of information; and
- Respondent comments.

All survey protocol and correspondence will be translated into Spanish and bi-lingual telephone interviewers will be used as needed. *Form Number:* CMS–10315 (OMB #: 0938–New); *Frequency:* Occasionally; *Affected Public:* Businesses and other for-profit and not-for-profit institutions; *Number of Respondents:* 53; *Total Annual Responses:* 106; *Total Annual Hours:* 17.5 hours (years 1 and 2), 35 hours (year 3). (For policy questions regarding this collection contact Bob Kambic 410–786–1515. 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 address 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.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on *November 15, 2010.*

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, e-mail: *OIRA_submission@omb.eop.gov.*

Dated: *October 8, 2010.*

Martique Jones,

Director, Regulations Development Division—B, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2010–25943 Filed 10–14–10; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–153 and CMS–10152]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

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:* Reinstatement with change of a previously approved collection; *Title of Information Collection:* Medicaid Drug Utilization Review (DUR) Annual Report; *Use:* The DUR program is required to assure that prescriptions are appropriate, medically necessary and are not likely to result in adverse medical results. Each State DUR program must consist of prospective drug use review, retrospective drug use review, data assessment of drug use against predetermined standards, and ongoing educational outreach activities. In addition, States are required to submit an annual DUR program report that includes a description of the nature and scope of State DUR activities as outlined in the statute and regulations. Over the years, technology has changed as has the practice of the pharmacy. Therefore, CMS has revised the old survey vehicle to more fully address the current practices and areas of concern with the Medicaid Pharmacy Programs. *Form Number:* CMS–R–153 (OMB#: 0938–0659); *Frequency:* Annually; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 51; *Total Annual Responses:* 51; *Total Annual Hours:* 20,298. (For policy questions regarding this collection contact Madlyn Kruh at 410–786–3239. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Data Collection for Medicare Beneficiaries Using NaF–18 Positron Emission Tomography (PET) to Identify Bone Metastasis in Cancer; *Use:* In Decision Memorandum # CAG–00065R, issued on February 26, 2010, the Centers for Medicare and Medicaid Services (CMS) determined that the evidence is sufficient to conclude that for Medicare beneficiaries receiving NaF–18 PET scan to identify bone metastasis in cancer is reasonable and necessary only when the provider is participating in and patients are enrolled in a clinical study designed to information at the time of the scan to assist in initial antitumor treatment planning or to guide subsequent treatment strategy by the identification, location and quantification of bone metastases in beneficiaries in whom bone metastases are strongly suspected based on clinical symptoms or the results of other diagnostic studies. Qualifying clinical studies must ensure that specific hypotheses are addressed; appropriate data elements are collected; hospitals and providers are qualified to provide the PET scan and interpret the results; participating hospitals and providers accurately report data on all Medicare enrolled patients; and all patient confidentiality, privacy, and other Federal laws must be followed. Consistent with section 1142 of the Social Security Act, the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that the CMS determines meet specified standards and address the specified research questions.

To qualify for payment, providers must prescribe certain NaF–18 PET scans for beneficiaries with a set of clinical criteria specific to each solid tumor. The statuary authority for this policy is section 1862(a)(1)(E) of the Social Security Act. The need to prospectively collect information at the time of the scan is to assist the provider in decision making for patient management. To qualify for payment, providers must prescribe certain NaF–18 PET scans for beneficiaries with a set of clinical criteria specific to each solid tumor. Data elements will be transmitted to CMS for evaluation of the short and long-term benefits of NaF–18 PET to beneficiaries and for use in future clinical decision making. *Form Number:* CMS–10152 (OMB#: 0938–0968); *Frequency:* Annually; *Affected Public:* Individuals or Households; *Number of Respondents:* 25,000; *Total Annual Responses:* 25,000; *Total Annual Hours:* 2,084. (For policy questions regarding this collection contact Stuart Caplan at 410–786–9564. 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 *December 14, 2010:*

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: October 8, 2010.

Michelle Shortt,

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

[FR Doc. 2010–25934 Filed 10–14–10; 8:45 am]

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