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 June 3, 2013.

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

Dated: May 1, 2013.

Martique Jones,

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

[FR Doc. 2013–10681 Filed 5–3–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Kentucky State Plan Amendments (SPA) 10–007

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

ACTION: Notice of Hearing.

SUMMARY: This notice announces an administrative hearing to be held on June 27, 2013, at the CMS Atlanta Regional Office, Atlanta Federal Center, 61 Forsyth Street, South West, Atlanta, Georgia 30303–8909, to reconsider CMS' decision to disapprove Kentucky SPA 10–007.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by May 21, 2013.

FOR FURTHER INFORMATION CONTACT: Benjamin Cohen, Presiding Officer, CMS, 2520 Lord Baltimore Drive, Suite L, Baltimore, Maryland 21244, Telephone: (410) 786–3169.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider CMS's decision to disapprove Kentucky SPA 10–007 which was submitted on September 30, 2010, and disapproved on April 2, 2013. The SPA proposed a payment methodology based on actual, incurred, costs for services provided by Community Mental Health Clinics (CMHCs).

At issue in the hearing is whether the proposed cost-based Medicaid payment methodology is consistent with the requirements of section 1902(a)(30)(A) of the Social Security Act (Act) when Kentucky did not specifically document that, under the proposed methodology, non-Medicaid costs would be excluded from the Medicaid payment calculation. Specifically, it appears that the methodology would rely on a cost reporting mechanism which results in over-allocation of both indirect and direct cost to Medicaid services. Specifically, for CMHCs that function within a larger parent organization, the state proposed an inappropriate transfer of cost from the parent organization to the CMHCs. Additionally, the state did not demonstrate that it had an acceptable method of allocating practitioner cost between reimbursable and non-reimbursable activities.

Section 1902(a)(30)(A) of the Act requires that states have methods and procedures in place to ensure payments are consistent with economy, efficiency, and quality of care. Because the proposed payment methodology is based on each provider's reconciled cost, CMS requested that Kentucky document the cost-finding and provider reporting mechanisms used to determine payment. This information would allow CMS to ensure that the proposed payment would be limited to amounts economic and efficient for covered Medicaid services, and were sufficient to ensure quality of care. Upon review of Kentucky's response, CMS determined that Kentucky was not able to document that its cost reporting mechanism properly allocated cost to Medicaid covered services. Specifically, CMS was concerned that Kentucky's methodology did not demonstrate the exclusion of costs incurred outside of these clinics for non-Medicaid activities and services. CMS worked with Kentucky on its cost reporting methodology over an extended period of time; however, CMS was not able to resolve questions surrounding the issue of including non-Medicaid costs. As a result, CMS could not conclude that Kentucky's proposed plan for payment was economic and efficient, or consistent with quality of care. In the absence of this specific information, CMS could not conclude that the requirements of section 1902(a)(30)(A) were satisfied.

Section 1116 of the Act and federal regulations at 42 CFR Part 430, establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a state plan or plan amendment. CMS is required to publish a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing, and the issues to be considered. If we subsequently notify the agency of additional issues that will be considered at the hearing, we will also publish that notice.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

The notice to Kentucky announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Mr. Lawrence J. Kissner,
Commissioner,
Cabinet for Health and Family Services,
Department for Medicaid Services,
275 East Main Street, 6W–A,
Frankfort, KY 40621.

Dear Mr. Kissner:

I am responding to your request for reconsideration of the decision to disapprove the Kentucky State Plan Amendment (SPA) 10–007 which was submitted on September 30, 2010, and disapproved on April 2, 2013. The SPA proposed a payment methodology based on actual, incurred, costs for services provided by Community Mental Health Clinics (CMHCs).

I disapproved Kentucky SPA 10–007 because I could not conclude that it complied with section 1902(a)(30)(A) of the Social Security Act (the Act), which requires payments to be consistent with economy efficiency and quality of care. In order to meet this requirement, the Centers for Medicare & Medicaid Services (CMS) requested that Kentucky document the cost-finding and provider reporting mechanisms used to determine payment. Upon review of the commonwealth's response to CMS's formal Request for Additional Information (RAI), CMS determined that Kentucky had not sufficiently documented that its cost reporting mechanism properly allocated cost to Medicaid covered services by excluding non-Medicaid costs from the Medicaid payment calculation.

The CMS worked with Kentucky on its cost reporting methodology over an extended period of time; however, CMS was not able to resolve questions surrounding the issue of including non-Medicaid costs. As a result, CMS could not conclude that Kentucky's proposed plan for payment was economic and efficient, or consistent with quality of care. In the absence of this specific information, CMS could not conclude that the requirements of section 1902(a)(30)(A) of the Act were satisfied.

At issue in this appeal is whether the proposed cost-based Medicaid payment methodology is consistent with the requirements of section 1902(a)(30)(A) of the

Act when Kentucky did not specifically document that, under the proposed methodology, non-Medicaid costs would be excluded from the Medicaid payment calculation. Specifically, it appears that the methodology would rely on a cost reporting mechanism which results in over-allocation of both indirect and direct cost to Medicaid services. Specifically, for CHMCs that function within a larger central office unit, the state proposed an inappropriate transfer of cost from the larger central office unit to the CHMCs. Additionally, the state did not demonstrate that it had an acceptable method of allocating practitioner cost between reimbursable and non-reimbursable activities.

I am scheduling a hearing on your request for reconsideration to be held on June 27, 2013, at the CMS Atlanta Regional Office, Atlanta Federal Center, 61 Forsyth Street, South West, Atlanta, Georgia 30303–8909.

If this date is not acceptable, I would be glad to set another date that is mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by federal regulations at 42 CFR Part 430.

I am designating Mr. Benjamin Cohen as the presiding officer. If these arrangements present any problems, please contact Mr. Cohen at (410) 786–3169. In order to facilitate any communication that may be necessary between the parties prior to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide names of the individuals who will represent the state at the hearing.

Sincerely,

Marilyn Tavenner,

Acting Administrator.

Section 1116 of the Social Security Act (42 U.S.C. 1316; 42 CFR 430.18)

(Catalog of Federal Domestic Assistance program No. 13.714, Medicaid Assistance Program.)

Dated: April 29, 2013.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2013–10695 Filed 5–3–13; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Title: Health Profession Opportunity Grants (HPOG) program.

Omb No.: 0970–0394.

Description: The Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS) is proposing data collection activities as part of the Health Profession Opportunity Grants (HPOG) program. ACF has developed a multi-pronged research and evaluation approach for the HPOG program to better understand and assess the activities conducted and their results. The proposed data collection activities described in this notice will provide data for two evaluation components, the National Implementation Evaluation of the Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals (HPOG–NIE) and the Impact Studies of the Health Profession Opportunity Grants (HPOG-Impact).

Two data collection efforts related to HPOG research were approved by OMB, including approval of a Performance Reporting System (PRS) (approved September 2011) and for collection of additional baseline data for the HPOG-Impact study (approved October 2012). These collection activities will continue under this new request.

This 30-day notice describes the remaining data collection efforts for both HPOG–NIE and HPOG-Impact. Information collection described under 1 through 13 are included in the current OMB submission for review. Information collections 14 through 18 will be submitted in a future information collection clearance request.

The goal of HPOG–NIE is to describe and assess the implementation, systems change, and outcomes and other important information about the operations of the 27 HPOG grantees focused on TANF recipients and other low-income individuals. To achieve these goals, it is necessary to collect data about the HPOG program designs and implementation, HPOG partner and program networks and indicators of systems change, employers' perceptions of HPOG programs, the composition and intensity of HPOG services received, participant characteristics and HPOG experiences, and participant outputs and outcomes.

The goal of HPOG-Impact is to evaluate the effectiveness of approaches used by 20 of the HPOG grantees to provide TANF recipients and other low-income individuals with opportunities for education, training and advancement within the health care field. HPOG-Impact also is intended to evaluate variation in participant impact that may be attributable to different HPOG program components and models. The impact study design is a classic experiment in which eligible applicants will be randomly assigned to a treatment group that is offered participation in HPOG and a control group that is not permitted to enroll in HPOG. In approximately 13 sites, eligible applicants will be randomized into two treatment arms (a basic and an enhanced version of the intervention) and a control group. Data collected from the HPOG participants served by these 20 grantees will also be used for the HPOG–NIE study.

The new information collection activities proposed for HPOG–NIE and HPOG-Impact include: (1) The HPOG–NIE sampling questionnaire; (2) The HPOG–NIE follow-up phone protocol for the stakeholder/network survey; (3) The HPOG–NIE grantee survey; (4) The HPOG-Impact implementation interview guide for partnering employers; (5) The HPOG-Impact implementation interview guide for instructors; (6) The HPOG-Impact implementation interview guide for HPOG program management; (7) The HPOG-Impact implementation interview guide for HPOG program staff; (8) The HPOG–NIE management and staff survey; (9) The HPOG–NIE stakeholder/network survey; (10) The HPOG–NIE employer survey; (11) The HPOG-Impact 15-month participant follow-up survey; (12) The HPOG-Impact 15-month control group member follow-up survey; and (13) The HPOG–NIE 15-month participant follow-up survey.

Data collection activities to submit in a future information collection request include: (14) the HPOG–NIE follow-up stakeholder/network survey; (15) the HPOG-Impact second follow-up survey of both treatment and control group members; (16) the HPOG–NIE second supplemental participant follow-up survey; (17) HPOG-Impact follow-up data collection on children of HPOG-Impact study participants; and (18) the HPOG–NIE in-person interviews with HPOG managers and staff.

Respondents: Individuals enrolled in HPOG interventions; control group members; HPOG program managers; HPOG program staff, including instructors and case managers; representatives of partner agencies and stakeholders, including support service providers, education and vocational training providers, Workforce Investment Boards, TANF agencies, and local health care employers.