

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services**

[CMS-3254-N]

Medicare Program; Request for Nominations for Members for the Medicare Evidence Development & Coverage Advisory Committee**AGENCY:** Centers for Medicare & Medicaid Services, HHS.**ACTION:** Notice.

SUMMARY: This notice announces the request for nominations for membership on the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). Among other duties, the MEDCAC provides advice and guidance to the Secretary of the Department of Health and Human Services (the Secretary) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) concerning the adequacy of scientific evidence available to CMS for “reasonable and necessary” determinations under Medicare.

We are requesting nominations for both voting and nonvoting members to serve on the MEDCAC. Nominees are selected based upon their individual qualifications and not as representatives of professional associations or societies. We wish to ensure adequate representation of the interests of both women and men, members of all ethnic groups and physically challenged individuals. Therefore we encourage nominations of qualified candidates who can represent these interests.

The MEDCAC reviews and evaluates medical literature, technology assessments, and hears public testimony on the evidence available to address the impact of medical items and services on health outcomes of Medicare beneficiaries.

DATES: Nominations will be considered if postmarked by Monday, January 30, 2012 and mailed to the address specified in the **ADDRESSES** section of this notice.

ADDRESSES: You may mail nominations for membership to the following address: Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality, *Attention:* Maria Ellis, 7500 Security Boulevard, Mail Stop: South Building 3-02-01, Baltimore, MD 21244.

FOR FURTHER INFORMATION CONTACT: Maria Ellis, Executive Secretary for the MEDCAC, Centers for Medicare & Medicaid Services, Office of Clinical

Standards and Quality, Coverage and Analysis Group, S3-02-01, 7500 Security Boulevard, Baltimore, MD 21244 or contact Ms. Ellis by phone (410) 786-0309 or via email at *Maria.Ellis@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:**I. Background**

The Secretary signed the initial charter for the Medicare Coverage Advisory Committee (MCAC) on November 24, 1998. A notice in the **Federal Register** (63 FR 68780) announcing establishment of the MCAC was published on December 14, 1998. The MCAC name was updated to more accurately reflect the purpose of the committee and on January 26, 2007, the Secretary published a notice in the **Federal Register** (72 FR 3853), announcing that the Committee’s name changed to the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). The charter for the committee was renewed by the Secretary on November 24, 2010. The current charter is effective for 2 years.

The MEDCAC is governed by provisions of the Federal Advisory Committee Act, Pub. L. 92-463, as amended (5 U.S.C. App. 2), which sets forth standards for the formulation and use of advisory committees, and is authorized by section 222 of the Public Health Service Act as amended (42 U.S.C. 217A).

The MEDCAC consists of a pool of 100 appointed members including: 94 voting members of whom 6 are designated patient advocates, and 6 nonvoting representatives of industry interests. Members generally are recognized authorities in clinical medicine including subspecialties, administrative medicine, public health, biological and physical sciences, epidemiology and biostatistics, clinical trial design, health care data management and analysis, patient advocacy, health care economics, medical ethics, or other relevant professions.

The MEDCAC works from an agenda provided by the Designated Federal Official. The MEDCAC reviews and evaluates medical literature, technology assessments, and hears public testimony on the evidence available to address the impact of medical items and services on health outcomes of Medicare beneficiaries. The MEDCAC may also advise CMS as part of Medicare’s “coverage with evidence development” initiative.

II. Provisions of the Notice

As of June 2012, there will be 30 membership terms expiring. Of the 30

memberships expiring, 1 is a nonvoting industry representative, 4 are voting patient advocates and the remaining 25 membership openings are for the general MEDCAC voting membership.

Accordingly, we are requesting nominations for both voting and nonvoting members to serve on the MEDCAC. Nominees are selected based upon their individual qualifications and not as representatives of professional associations or societies. We wish to ensure adequate representation of the interests of both women and men, members of all ethnic groups and physically challenged individuals. Therefore, we encourage nominations of qualified candidates from these groups.

All nominations must be accompanied by curricula vitae. Nomination packages must be sent to Maria Ellis at the address listed in the **ADDRESSES** section of this notice. Nominees for voting membership must also have expertise and experience in one or more of the following fields:

- Clinical medicine including subspecialties
- Administrative medicine
- Public health
- Biological and physical sciences
- Epidemiology and biostatistics
- Clinical trial design
- Health care data management and analysis
- Patient advocacy
- Health care economics
- Medical ethics
- Other relevant professions

We are looking for experts in a number of fields. Our most critical needs are for experts in hematology; genomics; Bayesian statistics; clinical epidemiology; clinical trial methodology; knee, hip, and other joint replacement surgery; ophthalmology; psychopharmacology; rheumatology; screening and diagnostic testing analysis; and vascular surgery. We also need experts in biostatistics in clinical settings, cardiovascular epidemiology, dementia, endocrinology, geriatrics, gynecology, minority health, observational research design, stroke epidemiology, and women’s health.

The nomination letter must include a statement that the nominee is willing to serve as a member of the MEDCAC and appears to have no conflict of interest that would preclude membership. We are requesting that all curricula vitae include the following:

- Date of birth
- Place of birth
- Social Security number
- Title and current position
- Professional affiliation
- Home and business address
- Telephone and fax numbers

- Email address
- List of areas of expertise

In the nomination letter, we are requesting that the nominee specify whether they are applying for a voting patient advocate position, for another voting position, or as a nonvoting industry representative. Potential candidates will be asked to provide detailed information concerning such matters as financial holdings, consultancies, and research grants or contracts in order to permit evaluation of possible sources of conflict of interest.

Members are invited to serve for overlapping 2-year terms. A member may serve after the expiration of the member's term until a successor is named. Any interested person may nominate one or more qualified persons. Self-nominations are also accepted.

The current Secretary's Charter for the MEDCAC is available on the CMS Web site at: <http://www.cms.hhs.gov/FACA/Downloads/medcaccharter.pdf>, or you may obtain a copy of the charter by submitting a request to the contact listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice.

Authority: 5 U.S.C. App. 2, section 10(a)(1) and (a)(2).
(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program.)

Dated: October 18, 2011.

Patrick Conway,

CMS Chief Medical Officer and Director, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Regional Partnership Grant (RPG) Program Data Collection.
OMB No.: 0970-0353.

Description

On September 30, 2007, the Administration for Children and Families (ACF), Children's Bureau awarded multi-year grants to 53 regional partnerships grantees (RPGs) to improve the safety, permanency and well-being of children affected by methamphetamine or other substance abuse who have been removed or are at risk of removal from their home. The Child and Family Services Improvement Act of 2006, the authorizing legislation for the RPG program, required that a set of performance indicators be established to periodically assess the grantees' outcomes. The legislation mandated that these performance indicators be developed through a consultative process involving ACF, the Substance Abuse and Mental Health Services Administration (SAMHSA), and representatives of the State or Tribal agencies who are members of the regional partnerships. The legislation also requires the Secretary of the Department of Health and Human services to submit annually to Congress a report that includes the performance indicators established under this grant program.

The final set of RPG performance indicators was approved by ACF and disseminated to the funded grantees in January 2008. It includes a total of 23 indicators across four outcome domains: Child/youth (9 indicators), adult (7 indicators), family/relationship (5 indicators), and regional partnership/service capacity (2 indicators). It also includes a core set of child and adult demographic elements that will provide important context needed to properly analyze, explain and understand the outcomes. No other national data collection measures these critical child, adult, family, and RPG outcomes specifically for these children and families. The data also will have significant implications for policy and program development for child well-being programs nationwide.

The purpose of this request is to obtain OMB approval for an extension of the original three year request which was approved on March 31, 2009. Forty-three of the original 53 grantees were

awarded for a five-year grant period, thus necessitating an extension of the original request in order to continue data collection for the remainder of the grant period. The first submission of RPG grantee data to the RPG data collection system occurred in December, 2008, and every six months thereafter. Data collection will be conducted for the fifth year of the grant period, ending September 30, 2012, with data submission by January 2013. Data collection may be extended for one year until January 2014 should grantees request and be granted no-cost extensions.

To minimize grantee data collection and reporting burden, many of the data elements are already being collected by counties and States in order to report Federally-mandated data to the Adoption and Foster Care Analysis and Reporting System (AFCARS), the Treatment Episode Data Set (TEDS) and the National Outcome Measures (NOMS); in addition, all States voluntarily submit data for the Federal National Child Abuse and Neglect Data System (NCANDS). Therefore, most child welfare data elements included in the RPG performance measures can be found in a State's automated case management system, which is often a Federally-funded Statewide Automated Child Welfare Information System (SACWIS). TEDS admission and discharge data are collected by State substance abuse agencies according to their own information systems for monitoring substance abuse treatment admissions and transmitted monthly or quarterly to the SAMHSA contractor. As a result of prior Federal government reporting requirements, States are already collecting several data elements needed by the RPGs. The RPGs lead agency or their state or local partners are able to download information from these existing State child welfare and substance abuse treatment data systems to obtain data to monitor their RPG program outcomes, thereby reducing the amount of primary data collection needed.

Respondents

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Private Sector	17	2	175.5	5,967
State, Local, or Tribal Government	26	2	175.5	9,126