Capital, LLC, Atlanta, Georgia, and thereby indirectly acquire FAS Capital, LLC, Atlanta, Georgia, and thereby engage in engage in lending activities pursuant to section 225.28(b)(1) of Regulation Y.

Board of Governors of the Federal Reserve System, December 28, 2011.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 2011–33700 Filed 1–3–12; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

[CMS–2420–FN]

Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults

AGENCY: Office of the Secretary, HHS.

ACTION: Final notice.

SUMMARY: This final notice announces the initial core set of health care quality measures for Medicaid-eligible adults, as required by section 2701 of the Affordable Care Act, for voluntary use by State programs administered under title XIX of the Social Security Act, health insurance issuers and managed care entities that enter into contracts with Medicaid, and providers of items and services under these programs.

FOR FURTHER INFORMATION CONTACT: Karen Llanos, Centers for Medicare & Medicaid Services, (410) 786–9071.

SUPPLEMENTARY INFORMATION:

I. Background

Section 2701 of the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. 111–148) added new section 1139B to the Social Security Act (the Act). Section 1139B(a) of the Act directs the Secretary of Health and Human Services (HHS) to identify and publish for public comment a recommended initial core set of health care quality measures for Medicaid-eligible adults, and section 1139B(b)(1) of the Act requires that an initial core set be published by January 1, 2012. Additionally, the statute requires the initial core set recommendation to consist of existing adult health care quality measures in use under public and privately sponsored health care coverage arrangements or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time and that may be applicable to Medicaid-eligible adults.

Section 1139B of the Act also requires the Secretary to complete the following actions:

—By January 1, 2012:

• Establish a Medicaid Quality Measurement Program to fund development, testing, and validation of emerging and innovative evidence-based measures.

—By January 1, 2013:

• Develop a standardized reporting format for the core set of adult quality measures and procedures to encourage voluntary reporting by the States.

—By January 1, 2014:

• Annually publish recommended changes to the initial core set that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

• Include in the report to Congress mandated under section 1139A(a)(6) of the Act on the quality of health care of children in Medicaid and the Children's Health Insurance Program (CHIP) similar information for adult health quality with respect to measures established under section 1139B of the Act. This report must be published every 3 years thereafter in accordance with the statute.

—By September 30, 2014:

• Collect, analyze, and make publicly available the information reported by the States as required in section 1139B(d)(1) of the Act.

Identification of the initial core set of measures for Medicaid-eligible adults is an important first step in an overall strategy to encourage and enhance quality improvement. States that chose to collect the initial core set will be better positioned to measure their performance and develop action plans to achieve the three part aims of better care, healthier people, and affordable care as identified in HHS' National Strategy for Quality Improvement in Health Care. Additional information about the National Quality Strategy can be found at: *http://www.ahrq.gov/workingforquality/nqs/.*

The initial core set of quality measures for voluntary annual reporting by States has been determined based on recommendations from the Agency for Healthcare Research and Quality's Subcommittee to the National Advisory Council for Healthcare Research and Quality, as well as public comments, before being finalized by the Secretary. These core set measures will support HHS and its State partners in developing a quality-driven, evidence-based, national system for measuring the quality of health care provided to Medicaid-eligible adults.

Over the next year, CMS will phase in components of the Medicaid Adult Quality Measures Program that will help to further identify measurement gap areas and begin testing the collection of some of the initial core measures. The Medicaid Adult Quality Measures Program will focus on developing and refining measures, where needed, so that future updates to the initial core set can meet a wider range of States' health care quality measurement needs. By September 2012, CMS will release technical specifications as a resource for States that seek to voluntarily collect and report the initial core set of health care quality measures for Medicaid-eligible adults. Additionally, as required in statute, by January 1, 2013, CMS will issue guidance for submitting the initial core set to CMS in a standardized format. Lastly, much like activities conducted under section 1139A of the Act for the initial core child health care quality measures, the Secretary will launch a Technical Assistance and Analytic Support Program to help States collect, report, and use the voluntary core set of adult measures.

II. Method for Determining the Initial Set of Health Care Quality Measures for Medicaid-Eligible Adults

The Affordable Care Act requires the development of a core set of health quality measures for adults eligible for benefits under Medicaid. The statute parallels the requirement under section 1139A of the Act to identify and publish a recommended initial core set of quality measures for children in Medicaid and the CHIP. HHS used a similar process to identify the initial set of health care quality measures for Medicaid-eligible adults.

The Centers for Medicare & Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ) to collaborate on the identification of the initial core set of health care quality measures for adults. Working through its National Advisory Council for Healthcare Research and Quality, which provides advice and recommendations to the Director of AHRQ and to the Secretary of HHS on priorities for a national health services research agenda, AHRQ created a Subcommittee in the fall of 2010 to evaluate candidate measures for the initial core set. The Subcommittee consisted of State Medicaid representatives, health care quality experts, and representatives of health professional organizations and associations, and was charged with considering the health care quality needs of adults (ages 18 and older) enrolled in Medicaid in its

recommendation for an initial core set of measures to HHS. The Subcommittee reviewed and evaluated measures from nationally recognized sources, including measures endorsed by the National Quality Forum (NQF), measures submitted by Medicaid medical directors, measures currently in use by CMS, and measures suggested by the Co-chairs and members of the Subcommittee. Starting from approximately 1,000 measures, a total of 51 measures were recommended and posted for public comment. A report detailing the initial convening of the Subcommittee may be found on the AHRQ Web site: *http://www.ahrq.gov/about/nacqm/.*

The measures were posted for public comment through a **Federal Register** (75 FR 82397) notice published on December 30, 2010, with comments due by March 1, 2011. The public submitted 100 comments. Public comments suggested concern about the large size of the proposed set, with many requesting alignment to the extent possible with existing Federal initiatives. An additional 43 measures were suggested through public comment. See discussion in section III of this final notice for a more detailed discussion.

To be responsive to the public comments, the Subcommittee sought to identify measures that ensured comprehensive representation of variables affecting Medicaid-eligible adults while considering ways to decrease the number of measures in the set. AHRQ and CMS identified five criteria against which to evaluate the proposed core measures: importance; scientific evidence supporting the measure; scientific soundness of the measure; current use in and alignment with existing Federal programs; and feasibility for State reporting (a background report detailing the selection criteria and Subcommittee process can be found at: *http://www.ahrq.gov*). The criteria represented attributes desired of State-level measures that would represent Medicaid-eligible adults. In particular, those criteria regarding current use in and alignment with existing Federal programs and feasibility for State reporting were given particular emphasis, since those were attributes identified repeatedly in the public comments. Documented use of or alignment with existing Federal programs such as the National Quality Strategy's six priorities, the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, and Physician Quality Reporting was taken into consideration as the Subcommittee reviewed each measure.

As in the initial meeting, the Subcommittee broke into workgroups focusing on four dimensions of health care related to adults in Medicaid: Adult Health, Maternal/Reproductive Health, Complex Health Care Needs, and Mental Health and Substance Use. Workgroups were assigned two sets of measures that related to their specific areas: originally recommended measures and measures proposed in public comment. To assess how each measure fared against the five criteria, the Subcommittee reviewed background information (including numerator, denominator, exclusions, prevalence, clinical guidelines, past performance rates, etc.) on each measure from the measure owners, developers, or stewards.

A. Adult Health

The workgroup prioritized 10 of the original measures to be included in the final set, dropping five measures that were duplicative of other measures. The workgroup brought forward one measure that was suggested in public comment, *Adult Body Mass Index (BMI) Assessment,* replacing a similar BMI measure that had been originally recommended for the core set, *Preventive Care and Screening: BMI Screening and Follow-Up.* The workgroup did not recommend including the remaining 16 newly suggested measures received from the public comment period.

B. Maternal/Reproductive Health

After evaluating the measures against the criteria, the Maternal/Reproductive Health workgroup recommended keeping each of the five measures originally posed for the core set, noting that these measures addressed areas of high importance to women and reproductive health, were feasible to report and aligned well with current programs (including the initial core set of children's health care quality measures [1]). The workgroup noted that, while future measures should tie screenings to outcomes and assess additional issues outside of pregnancy that affect women (for example, access to care, incontinence due to multiple pregnancies), the measures being recommended for the core set were an important first step of using performance measures for quality improvement. Of the measures newly suggested through public comment, the workgroup recommended bringing one measure forward to a Subcommittee vote: *Chlamydia Screening in Women.* The workgroup rated this measure high on each criterion and noted its alignment with the initial core set of children's health care quality measures (the initial core set of children's measures specified only the lower age group of this measure; adding the higher age range means the measure now would be reported in full).

C. Complex Health Care Needs

The Complex Health Care Needs workgroup recommended nine of the 18 measures originally posed for inclusion in the draft core set. Although the topic areas represented in the measures suggested through public comment were important to Medicaid, many of the measures scored low on multiple criteria (for example, scientific soundness and feasibility for State reporting) and thus were deemed not ready for wide-scale implementation. Further, although several of the proposed measures assessed the very important topic of care coordination for patients who are hospitalized or transferred across multiple facilities, the workgroup noted that many of these measures were challenged by complex requirements for data collection and excluded target populations (for example, dually eligible beneficiaries and individuals with long-term care services and supports needs). Many of the measures, for example, required medical record review across time or at more than one site (for example, *Change in Basic Mobility as Measured by the AM–PAC* and *Medication Reconciliation Post-Discharge*). The workgroup concluded that the remaining measures suggested in public comment, though relevant to people with complex health care needs, addressed very narrow clinical conditions, excluded key populations, were difficult to collect at the State level, or were duplicative of other, more highly-rated measures.

D. Mental Health and Substance Use

After discussing how well the 13 measures originally proposed fared against the selection criteria, the Mental Health and Substance Use workgroup recommended nine measures for inclusion in the draft core set and decided against bringing forward any of the additional measures suggested in public comment. In general, the workgroup prioritized measures that were broadly applicable to the Medicaid population or to primary care settings. For example, the workgroup included measures that assessed conditions that may be prevalent in a low-income population, including depression, schizophrenia, and substance use, in

[1] Initial Core Set of Children's Health Care Quality Measures *https://www.cms.gov/MedicaidCHIPQualPrac/Downloads/CHIPRACoreSetTechManual.pdf.*

addition to measures that assessed utilization of general mental health services. The workgroup did not recommend including any of the five measures suggested in public comment, as they concluded that these measures addressed similar content areas as other higher-rated measures or were rated very low in feasibility for State collection and reporting.

E. Summary

A total of 35 measures received a majority vote from the full Subcommittee. The measures voted upon by the Subcommittee included recommendations from each workgroup that were based on the original 51 measures as well as new measures identified through public comment that were brought forth by each workgroup. The Adult Health work group recommended eleven measures for inclusion in the initial core set. The Maternal/Reproductive Health work group recommended six measures. The Complex Health Care Needs work group recommended nine measures and the Mental Health and Substance Use recommended nine measures.

The Subcommittee discussed how these measures represented conditions and populations relevant to Medicaid, and examined each measure's data source and use in existing programs. In the final round of voting, 24 [2] measures ultimately received a majority vote by Subcommittee members. In order to ensure priority populations were fully represented and that the goals of planned initiatives could be monitored, we then added two measures originally proposed for the draft core set (*PC–01 Elective Delivery* and *Timely Transmission of Transition Record*). The Subcommittee deferred the decision to CMS and AHRQ on which of the two HIV-related measures under consideration (*HIV/AIDS Screening: Members at High Risk of HIV/AIDS* and *HIV/AIDS: Medical Visits*) would be included in the core set. Upon discussion with colleagues from the Centers for Disease Control and Prevention and the Health Resources and Services Administration, the decision was made to include the measure originally proposed for the core set, *HIV/AIDS: Medical Visit.* A total of 26 are included in the initial core set.

[2] The CAHPS Health Plan Survey v 4.0—Adult Questionnaire and the CAHPS Health Plan Survey v 4.0H—NCQA Supplemental Items for CAHPS are counted as one measure.

III. Analysis of and Responses to Public Comments on the Notice of Comment Period

In response to the publication of the December 30, 2010 notice with comment period, we received 100 timely public comments. The following are a summary of the public comments that we received related to that notice, and our responses to the comments:

Comment: About a third of the comments specifically noted that the draft core set published in the **Federal Register** on December 30, 2010, was too large or raised the burden of reporting by States as a concern. Commenters also suggested reducing the measures to two measures per category or considering a phase-in approach.

Response: To address these concerns, the size of the core set was reduced by almost half (from 51 measures in the draft core set to 26 measures in the initial core set). Although the numbers of measures was reduced, we believe that this initial core set still reflects the health care needs of Medicaid-eligible adults. In addition to reducing the size of the initial core set, to support States in collecting and reporting these measures, CMS will provide technical assistance as well as additional guidance and tools to increase the feasibility of voluntary reporting.

Comment: Numerous comments suggested avoiding measures for inclusion in the initial core set that require medical record review.

Response: To the degree possible, measures that require medical record review were excluded in large-scale from the initial core set. However, in order to address aspects of health care quality important to the adult Medicaid population and to align with existing measurement programs (for example, the Medicare & Medicaid EHR Incentive Programs) a few measures that require medical record review (for example, controlling high blood pressure) were included in the initial core set.

Comment: Many comments suggested aligning measures with existing reporting programs, such as the Medicare and Medicaid EHR Incentive Programs and the Inpatient Hospital Quality Reporting program, as a way to decrease burden.

Response: We agree with these comments. To the degree possible, the initial core set aligns with existing Federal reporting programs. Seventeen measures from the initial core set are used in other CMS programs (refer to table at the end of Notice). Alignment was a key criterion employed in the review, based in part, on the strength of related public comments. At the same time, the areas addressed by the measures in the initial core set, however, must reflect the requirements of the statute to provide an overall assessment of the quality of care received by adults in Medicaid. As such, the types of quality measures included in other reporting programs may not fully represent the health care measurement needs of Medicaid-eligible adults.

Comment: Several commenters suggested using only measures endorsed by the National Quality Forum or National Committee for Quality Assurance Health Employer Data and Information Set (HEDIS®) measures. Many comments also emphasized the importance of ensuring the initial core set measures met thresholds for evidence, validity, reliability and feasibility.

Response: A key priority used in selecting the initial core set measures was whether or not the measure was relevant to the Medicaid population. While NQF endorsement signifies that measures have been deemed as meeting certain criteria for scientific soundness, validity and reliability, requiring NQF endorsement would have eliminated inclusion of measures in the initial core set that are relevant for assessing important aspects of care for the Medicaid population. Similarly, selecting only HEDIS measures, which were originally developed for health plan use, would have limited the initial core set's ability to address the range of care settings and conditions relevant to the Medicaid population.

Comment: Public comments questioned the appropriateness of some proposed measures.

Response: These comments are appreciated and helped us narrow the list. Each measure included in the initial core set has been compared against five criteria—importance, scientific evidence, scientific soundness, alignment with existing programs and feasibility for State reporting. Public comments related to specific measures were also reviewed and considered. To aid in assessing each measure for inclusion in the initial core set, specific information was collected for each measure, including:

- Measure description, numerator, denominator and exclusions.
- Data sources (for example, claims, medical records, electronic health records).
- Description of health importance, prevalence, financial importance and opportunity for improvement, including what is known about gaps in care and health care disparities.

• Brief description of the scientific literature, including what is known about effectiveness of the intervention being addressed, and what is known about management and follow-up.
• Published clinical guidelines relevant to the measure.
• Validity and reliability of results, including a description of the study sample and methods used.
• Performance rates (most recent and two years prior).

Comment: Two comments requested clarification on whether the initial core measures would be applied to Medicaid fee-for-service, Medicaid managed care or both types of health care delivery systems. Other commenters requested clarification on the target Medicaid population, particularly since NCQA measures included in the draft measures list had varying age ranges.

Response: The initial core set will be used by States to assess the quality of health care provided in their Medicaid programs for adults (ages 18 years and older) and across all health care delivery systems (for example, fee-for-service, managed care, primary care case management). We understand that some of the measures are currently specified only for a particular delivery system (for example, managed care). However, additional guidance will be provided to States so that these measures can be used across delivery systems and Medicaid funded programs targeting adults, including long-term services and supports.

Comment: Multiple comments suggested including measures related to patient safety and rehabilitation services. Specifically, commenters noted the need for measures that address a range of disabilities present among Medicaid beneficiaries and those receiving home and community-based services. The need for outcome measures for management of chronic conditions and care coordination measures was also noted.

Response: The measurement topic areas identified in these public comments are ones that CMS recognizes as important to assessing the health care quality of all adults enrolled in Medicaid, and we agree on the importance of measurement for chronic conditions and care coordination as well as for those receiving home and community-based services. However, the Subcommittee did not identify any existing measures in these areas that met the criteria for scientific soundness. As such, these topics will be considered measurement gap areas and will be prioritized for new measure development as part of the Medicaid Adult Quality Measures Program required under this statute.

Comment: In addition to public comments received about each of the proposed measures, 43 measures were suggested by the public.

Response: We appreciate these suggestions. Forty-two of the 43 measures had been previously considered by the Subcommittee and CMS for inclusion in the draft core measures set. The one measure that had not been considered was a newly developed measure that had not appeared in the original inventory of candidate measures (Healthy Term Newborn). The Subcommittee reviewed all 43 of these measures again and evaluated them based on the established selection criteria. The Healthy Term Newborn measure did not rate highly when compared against the selection criteria and the Subcommittee felt the measure would be more effective if paired with a process of care measure.

For additional information on consideration of the public comments and the finalization of the initial core set of health care quality measures for Medicaid-eligible adults, a background report can be found at: *http://www.ahrq.gov/.*

IV. Collection of Information Requirements

This final notice announces the initial core set of health care quality measures for Medicaid-eligible adults for voluntary use by State Medicaid programs. As required in statute, by January 1, 2013, CMS will issue guidance for submitting the initial core set to CMS in a standardized format. States choosing to collect the initial core set of measures will use that reporting template to submit data to CMS. Voluntary reporting will not begin until December 2013.

The guidance, core measures, and template are subject to the Paperwork Reduction Act and will be submitted to the Office of Management and Budget (OMB) for their review and approval at a later time. No persons are required to respond to a collection of information (whether voluntary or mandatory) unless it displays a valid OMB control number issued by OMB.

V. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

Authority: Sections XIX and XXI of the Social Security Act (42 U.S.C. 13206 through 9a).

Dated: November 16, 2011.

Marilyn B. Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: December 21, 2011.

Kathleen Sebelius,

Secretary, Health and Human Services.

Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults

This table of the initial core set of health care quality measures for Medicaid-eligible adults includes National Quality Forum (NQF) identifying numbers for measures that have been endorsed, provides the measure stewards and indicates those measures which are used in various Federal and public sector programs including: Initial Core Set of Children's Health Care Quality Measures; the Medicare & Medicaid EHR Incentive Programs for eligible health care professionals and hospitals that adopt certified Electronic Health Record technology under the Final Rule published in the July 28, 2010 **Federal Register** (75 FR 44314); the Medicare Physician Quality Reporting System (PQRS); Health Employer Data and Information Set (HEDIS); National Committee for Quality Assurance Accreditation; The Joint Commission's ORYX® Performance Measurement Initiative and other national programs.

	NQF No. †	Measure Steward‡	Measure name	Programs in which the measure is currently used¥
Prevention & Health Promotion	0039	NCQA	Flu Shots for Adults Ages 50–64 (Collected as part of HEDIS CAHPS Supplemental Survey).	HEDIS®, NCQA Accreditation.
	N/A	NCQA	Adult BMI Assessment	HEDIS®, Health Homes Core.
	0031	NCQA	Breast Cancer Screening	MU1, HEDIS®, NCQA Accreditation, PQRS GPRO, Shared Savings Program.

	NQF No. †	Measure Steward‡	Measure name	Programs in which the measure is currently used¥
	0032	NCQA	Cervical Cancer Screening	MU1, HEDIS®, NCQA Accreditation.
	0027	NCQA	Medical Assistance With Smoking and Tobacco Use Cessation (Collected as part of HEDIS CAHPS Supplemental Survey).	MU1, HEDIS®, Medicare, NCQA Accreditation.
	0418	CMS	Screening for Clinical Depression and Follow-Up Plan.	PQRS, CMS QIP, Health Homes Core, Shared Savings Program.
	N/A	NCQA	Plan All-Cause Readmission	HEDIS®.
	0272	AHRQ	PQI 01: Diabetes, Short-Term Complications Admission Rate.	
	0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate.	Shared Savings Program.
	0277	AHRQ	PQI 08: Congestive Heart Failure Admission Rate.	Shared Savings Program.
	0283	AHRQ	PQI 15: Adult Asthma Admission Rate.	
	0033	NCQA	Chlamydia Screening in Women Ages 21–24 (same as CHIPRA core measure, however, the State would report on the adult age group).	MU1, HEDIS®, NCQA Accreditation, CHIPRA Core.
Management of Acute Conditions	0576	NCQA	Follow-Up After Hospitalization for Mental Illness.	HEDIS®, NCQA Accreditation, CHIPRA Core, Health Home Core.
	0469	HCA, TJC	PC–01: Elective Delivery	HIP QDRP, TJC's ORYX Performance Measurement Program.
	0476	Prov/CWISH/NPIC/QAS/TJC.	PC–03 Antenatal Steroids	TJC's ORYX Performance Measurement Program.
Management of Chronic Conditions	0403	NCQA	Annual HIV/AIDS Medical Visit	
	0018	NCQA	Controlling High Blood Pressure	MU1, HEDIS®, NCQA Accreditation, PQRS GPRO, Shared Savings Program.
	0063	NCQA	Comprehensive Diabetes Care: LDL–C Screening.	MU1, HEDIS®, NCQA Accreditation, PQRS.
	0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c Testing.	MU1, HEDIS®, NCQA Accreditation, PQRS.
	0105	NCQA	Antidepressant Medication Management.	MU1, HEDIS®, NCQA Accreditation.
	N/A	CMS–QMHAG.	Adherence to Antipsychotics for Individuals with Schizophrenia.	VHA.
	0021	NCQA	Annual Monitoring for Patients on Persistent Medications.	HEDIS®, NCQA Accreditation.
Family Experiences of Care	0006 & 0007	AHRQ & NCQA.	CAHPS Health Plan Survey v 4.0—Adult Questionnaire with CAHPS Health Plan Survey v 4.0H—NCQA Supplemental.	HEDIS®, NCQA Accreditation, Shared Savings Program (NQF#0006).
Care Coordination	648	AMA–PCPI	Care Transition—Transition Record Transmitted to Health Care Professional.	Health Homes Core.
Availability	0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.	MU1, HEDIS®, Health Homes Core.
	1391	NCQA	Prenatal and Postpartum Care: Postpartum Care Rate (second component to CHIPRA core measure "Timeliness of Prenatal Care," State would now report 2/2 components instead of 1).	HEDIS®.

† NQF ID National Quality Forum identification numbers are used for measures that are NQF-endorsed; otherwise, NA is used.
‡ Measure Steward:
AHRQ—Agency for Healthcare Research and Quality.
CMS—Centers for Medicare & Medicaid Services.
CMS–QMHAG—Centers for Medicare & Medicaid Services, Quality Measurement and Health Assessment Group.
HCA, TJC—Hospital Corporation of America-Women's and Children's Clinical Services, The Joint Commission.
NCQA—National Committee for Quality Assurance.
Prov/CWISH/NPIC/QAS/TJC—Providence St. Vincent Medical Center/Council of Women's and Infant's Specialty Hospitals/National Perinatal Information Center/Quality Analytic Services/The Joint Commission.
TJC—The Joint Commission.
¥ Programs in which Measures are Currently in Use:
CHIPRA Core—Children's Health Insurance Program Reauthorization Act—Initial Core Set.
CMS QIP—CMS Quality Incentive Program.

HIP QDRP—Hospital Inpatient Quality Data Reporting Program.
Health Homes Core—CMS Health Homes Core Measures.
MU1—Meaningful Use Stage 1 of the Medicare & Medicaid Electronic Health Record Incentive Programs.
PQRS—Physician Quality Reporting Program Group Practice Reporting Option.
Shared Savings Program—Medicare Shared Savings Program.
VHA—Veterans Health Administration.

[FR Doc. 2011–33756 Filed 12–30–11; 4:15 pm]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Initial Review

The meeting announced below concerns National HIV Behavioral Surveillance For Young Men Who Have Sex With Men, Funding Opportunity Announcement (FOA), PS11–0010201SUPP12, initial review.

Correction: The notice was published in the **Federal Register** on November 18, 2011, Volume 76, Number 223, Page 71568. The time and date should read as follows:

Time and Date: 1 p.m.–5 p.m., February 29, 2012 (Closed).

Contact Person For More Information: Amy Yang, Ph.D., Scientific Review Officer, CDC, 1600 Clifton Road NE., Mailstop E60, Atlanta, Georgia 30333, Telephone: (404) 718–8836.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: December 20, 2011.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2011–33731 Filed 1–3–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Initial Review

The meeting announced below concerns Formative Research on Use of Mobile Applications (''app'') to Increase HIV Testing Behavior and HIV Prevention with Positive Persons, Funding Opportunity Announcement (FOA), PS12–001, initial review.

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting:

Time and Date: 8 a.m.–5 p.m., February 28, 2012 (Closed).

Place: Sheraton Gateway Hotel Atlanta Airport, 1900 Sullivan Road, Atlanta, Georgia 30337, Telephone: (770) 997–1100.

Status: The meeting will be closed to the public in accordance with provisions set forth in Section 552b(c) (4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters To Be Discussed: The meeting will include the initial review, discussion, and evaluation of applications received in response to ''Formative Research on Use of Mobile Applications (''app'') to Increase HIV Testing Behavior and HIV Prevention with Positive Persons, FOA PS12–001.''

Contact Person for More Information: Gregory Anderson, M.S., M.P.H., Scientific Review Officer, CDC, 1600 Clifton Road NE., Mailstop E60, Atlanta, Georgia 30333, Telephone: (404) 718–8833.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: December 20, 2011.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2011–33730 Filed 1–3–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–74 and CMS–10338]

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:* Extension without change of a currently approved collection; *Title of Information Collection:* Income and Eligibility Verification System (IEVS) Reporting and Supporting Regulations Contained in 42 CFR 431.17, 431.306, 435.910, 435.920, and 435.940–960; *Use:* The information collected is used to verify the income and eligibility of Medicaid applicants and recipients, as required by Section 1137 of the Social Security Act. Final regulations to implement Section 1137 of the Act were published February 28, 1986. Subsequent final amendments to the regulations were published on February 27, 1987; March 2, 1989; October 7, 1992; and January 31, 1994. These regulations provide the standards States use to determine which recipient and applicant records to match, the frequency of the match, due process protections for individuals whose records are matched, and those