work on the contract were residents of a Gulf Coast state.

(2) If the cognizant contracting officer confirms in writing that the contractor has satisfied the requirements of section (1) above, then subject to any applicable appropriations laws the contractor will be entitled to receive an award (''Local Hiring Incentive Award'') equal to [percent] of the contract amount earned during the contract's performance period.

Will D. Spoon,

Program Analyst, Gulf Coast Ecosystem Restoration Council.

[FR Doc. 2016–17328 Filed 7–21–16; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–317, CMS–319, CMS–10166, CMS–10178, and CMS–10184]

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

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the 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.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by August 22, 2016.

ADDRESSES: When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be received by the OMB desk officer via one of the following transmissions: OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–5806 *OR* Email: *OIRA_submission@omb.eop.gov.*

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995.*

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov.*

3. Call the Reports Clearance Office at (410) 786–1326.

FOR FURTHER INFORMATION CONTACT: Reports Clearance Office at (410) 786–1326.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* State Medicaid Eligibility Quality Control Sample Plans; *Use:* The Medicaid Eligibility Quality Control (MEQC) system is based on monthly State reviews of Medicaid and Medicaid expansion under Title XXI 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 or XXI eligibility requirements when applicable. The reviews are also used to assess beneficiary liability, if any, and to determine the amounts paid to provide Medicaid services for these cases. In the MEQC system, sampling is the only practical method of validating eligibility of the total caseload and determining the dollar value of eligibility liability errors. Any attempt to make such validations and determinations by reviewing every case would be an enormous and unwieldy undertaking. In 1993, CMS implemented MEQC pilots in which States could focus on special studies, targeted populations, geographic areas or other forms of oversight with CMS approval. States must submit a sampling plan, or pilot proposal to be approved by CMS before implementing their pilot program. The Children's Health Insurance Program Reauthorization Act (CHIPRA) was enacted February 4, 2009. Sections 203 and 601 of the CHIPRA relate to MEQC. Section 203 of the CHIPRA establishes an error rate measurement with respect to the enrollment of children under the express lane eligibility option. The law directs States not to include children enrolled using the express lane eligibility option in data or samples used for purposes of complying with the MEQC requirements. Section 601 of the CHIPRA, among other things, requires a new final rule for the Payment Error Rate Measurement (PERM) program and aims to harmonize the PERM and MEQC programs and provides States with the option to apply PERM data resulting from its eligibility reviews for meeting MEQC requirements and vice versa, with certain conditions. We review, either directly or through its contractors, of the sampling plans helps to ensure States are using valid statistical methods for sample selection. 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–317 (OMB control number: 0938–0146); *Frequency:* 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 Bridgett Rider at 410–786–2602.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* State Medicaid Eligibility Quality Control Sample Selection Lists; *Use:* The Medicaid Eligibility Quality Control (MEQC) system is based on monthly State reviews of Medicaid and Medicaid expansion under Title XXI 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 or XXI eligibility requirements when applicable. The reviews are also used to assess beneficiary liability, if any, and to determine the amounts paid to provide Medicaid services for these cases. In the MEQC system, sampling is the only practical method of validating eligibility of the total caseload and determining the dollar value of eligibility liability errors. Any attempt to make such validations and determinations by reviewing every case would be an enormous and unwieldy undertaking. 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 the beneficiary resides, Medicaid case number, etc. The submittal of the sample selection lists is necessary for Regional Office validation of State reviews. Without these lists, the integrity of the sampling results would be suspect and the Regional Offices would have no data on the adequacy of the States' monthly sample draw or review completion status. The authority for collecting this information is Section 1903(u) of the Social Security Act. The specific requirement for submitting sample selection lists is described in regulations at 42 CFR 431.814(h). Regional Office staff review the sample selection lists to determine that States are sampling a sufficient number of cases for review. *Form Number:* CMS–319 (OMB control number: 0938–0147); *Frequency:* 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 Bridgett Rider at 410–786–2602.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Payment Error Rate Measurement in Medicaid & Children's Health Insurance Program (CHIP); *Use:* The Improper Payments Information Act (IPIA) of 2002 as amended by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012 requires CMS to produce national error rates for Medicaid and Children's Health Insurance Program (CHIP). To comply with the IPIA, CMS will engage a Federal contractor to produce the error rates in Medicaid and CHIP. The error rates for Medicaid and CHIP are calculated based on the reviews on three components of both Medicaid and CHIP program. They are: Fee-for-service claims medical reviews and data processing reviews, managed care claims data-processing reviews, and eligibility reviews. Each of the review components collects different types of information, and the state-specific error rates for each of the review components will be used to calculate an overall state-specific error rate, and the individual state-specific error rates will be used to produce a national error rate for Medicaid and CHIP. The states will be requested to submit, at their option, test data which include full claims details to the contractor prior to the quarterly submissions to detect potential problems in the dataset to and ensure the quality of the data. These states will be required to submit quarterly claims data to the contractor who will pull a statistically valid random sample, each quarter, by strata, so that medical and data processing reviews can be performed. State-specific error rates will be based on these review results. We need to collect the fee-for-service claims data, medical policies, and other information from states as well as medical records from providers in order for the contractor to sample and review adjudicated claims in those states selected for medical reviews and data processing reviews. Based on the reviews, state-specific error rates will be calculated which will serve as part of the basis for calculating national Medicaid and CHIP error rates. *Form Number:* CMS–10166 (OMB control number: 0938–0974); *Frequency:* Annually, Quarterly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 34; *Total Annual Responses:* 34; *Total Annual Hours:* 56,100. (For policy questions regarding this collection contact Bridgett Rider at 410–786–2602.)

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicaid and State Children's Health Insurance Plan (SCHIP) Managed Care; *Use:* The Payment Error Rate Measurement (PERM) program measures improper payments for Medicaid and the State Children's Health Insurance Program (SCHIP). The program was designed to comply with the Improper Payments Information Act (IPIA) of 2002 and the Office of Management and Budget (OMB) guidance. Although OMB guidance requires error rate measurement for SCHIP, 2009 SCHIP legislation temporarily suspended PERM measurement for this program and changed to Children's Health Insurance Program (CHIP) effective April 01, 2009. See Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Public Law 111–3 for more details. There are two phases of the PERM program, the measurement phase and the corrective action phase. The PERM measures improper payments in Medicaid and CHIP and produces State and national-level error rates for each program. The error rates are based on reviews of Medicaid and CHIP fee-for-service (FFS) and managed care payments made in the Federal fiscal year under review. States conduct eligibility reviews and report eligibility related payment error rates also used in the national error rate calculation. We created a 17 State rotation cycle so that each State will participate in PERM once every three years. Following is the list of States in which we will measure improper payments over the next three years in Medicaid. We need to collect capitation payment information from the selected States so that the federal contractor can draw a sample and review the managed care capitation payments. We will also collect State managed care contracts, rate schedules and updates to the contracts and rate schedules. This information will be used by the Federal contractor when conducting the managed care claims reviews. Sections 1902(a)(6) and 2107(b)(1) of the Social Security Act grants CMS authority to collect information from the States. The IPIA requires us to produce national error rates in Medicaid and CHIP fee-for-service, including the managed care component. The State-specific Medicaid managed care and CHIP managed care error rates will be based on reviews of managed care capitation payments in each program and will be used to produce national Medicaid managed care and CHIP managed care error rates.

Form Number: CMS–10178 (OMB control number: 0938–0994); *Frequency:* Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 34; *Total Annual Responses:* 28,050; *Total Annual Hours:* 28,050. (For policy questions regarding this collection contact Bridgett Rider at 410–786–2602.)

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Payment Error Rate Measurement—State Medicaid and SCHIP Eligibility; *Use:* The Improper Payments Information Act (IPIA) of 2002 requires CMS to produce national error rates for Medicaid and the Children's Health Insurance Program (CHIP). To comply with the IPIA, CMS will use a national contracting strategy to produce error rates for Medicaid and CHIP fee-for-service and managed care improper payments. The Federal contractor will review States on a rotational basis so that each State will be measured for improper payments, in each program, once and only once every three years. Subsequent to the first publication, we determined that we will measure Medicaid and CHIP in the same State. Therefore, States will measure Medicaid and CHIP eligibility in the same year measured for fee-for-service and managed care. We believe this approach will advantage States through economies of scale (*e.g.,* administrative ease and shared staffing for both programs reviews). We also determined that interim case completion timeframes and reporting are critical to the integrity of the reviews and to keep the reviews on schedule to produce a timely error rate. Lastly, the sample sizes were increased slightly in order to produce an equal sample size per strata each month. Periodically, CMS will conduct Federal re-reviews of States' PERM files to ensure the accuracy of States' review findings and the validity of the review process. CMS will select a random subsample of Medicaid and CHIP cases from the sample selection lists provided by each State. States will submit all pertinent information related to the review of each sampled case that is selected by CMS. *Form Number:* CMS–10184 (OMB control number: 0938–1012); *Frequency:* Annually, Quarterly *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 34; *Total Annual Responses:* 1,583; *Total Annual Hours:* 946,164. (For policy questions regarding this collection contact Bridgett Rider at 410–786–2602.)

Dated: July 18, 2016.

Martique Jones,

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

[FR Doc. 2016–17251 Filed 7–21–16; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–R–70, CMS–R–72, CMS–R–247, CMS–10151, CMS–10268, CMS–R–5, CMS–10615, and CMS–10062]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (the PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information (including each proposed extension or reinstatement of an existing collection of information) and to allow 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates 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.

DATES: Comments must be received by September 20, 2016.

ADDRESSES: When commenting, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send 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) that are 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.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995.*

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov.*

3. Call the Reports Clearance Office at (410) 786–1326.

FOR FURTHER INFORMATION CONTACT: Reports Clearance Office at (410) 786–1326.

SUPPLEMENTARY INFORMATION:

Contents

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS–R–70 Information Collection Requirements in HSQ–110, Acquisition, Protection and Disclosure of Peer review Organization Information and Supporting Regulations

CMS–R–72 Information Collection Requirements in 42 CFR 478.18, 478.34, 478.36, 478.42, QIO Reconsiderations and Appeals

CMS–R–247 Expanded Coverage for Diabetes Outpatient Self-Management Training Services and Supporting Regulations

CMS–10151 Data Collection for Medicare Beneficiaries Receiving Implantable Cardioverter-Defibrillators for Primary Prevention of Sudden Cardiac Death

CMS–10268 Consolidated Renal Operations in a Web Enabled Network (CROWNWeb) Third-party Submission Authorization Form

CMS–R–5 Physician Certification/Recertification in Skilled Nursing Facilities (SNFs) Manual Instructions

CMS–10615 Healthy Indiana Program (HIP) 2.0 Beneficiaries Survey, Focus Groups, and Informational Interviews

CMS–10062 Collection of Diagnostic Data from Medicare Advantage Organizations for Risk Adjusted Payments

Under the PRA (44 U.S.C. 3501–3520), federal agencies must obtain