

Dated: March 27, 2012.

Kathleen Sebelius,
Secretary.

[FR Doc. 2012-9238 Filed 4-16-12; 11:15 am]

BILLING CODE 4150-03-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: "CHIPRA Pediatric Quality Measures Program Candidate Measure Submission Form." In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501-3521, AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by June 18, 2012.

ADDRESSES: Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by email at doris.lefkowitz@AHRQ.hhs.gov.

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT: Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427-1477, or by email at doris.lefkowitz@AHRQ.hhs.gov.

SUPPLEMENTARY INFORMATION:

Proposed Project

Pediatric Quality Measures Program

Section 401(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, amended the Social Security Act ("the Act") to enact section 1139A (42 U.S.C. 1320b-9a). Section 1139A(b) charged the Department of Health and Human Services (HHS) with improving pediatric health care quality measures. Since CHIPRA was passed, AHRQ and the Centers for Medicare & Medicaid Services (CMS) have been working together to implement selected provisions of the legislation related to children's health care quality. An initial core measure set for voluntary use by

Medicaid and Children's Health Insurance Programs (CHIP) was posted December 29, 2009 (<http://www.gpo.gov/fdsys/pkg/FR-2009-12-29/html/E9-30802.htm>). In February 2010, CMS released a State Health Official letter which outlined the initial core measures and how these measures would be reported to CMS.

Subsequently, AHRQ and CMS established the CHIPRA Pediatric Quality Measures Program (PQMP) in accordance with section 1139A(b)(1) of the Act to enhance select children's health care quality measures and develop new measures (<http://www.ahrq.gov/chipra>). The PQMP is intended to increase the portfolio of measures available to public and private purchasers of children's health care services, providers, and consumers. HHS anticipates that measures ultimately included in the Improved Core Set will also be used by public and private purchasers to measure pediatric healthcare quality. The PQMP consists of the following:

(1) Seven Centers of Excellence (CoEs) that are developing and/or enhancing children's health care quality measures through cooperative agreements with AHRQ in order to increase the portfolio of measures available to the public and private purchasers of children's health care services, providers and consumers (<http://www.ahrq.gov/chipra/pqmpfact.htm>);

(2) CHIPRA Coordinating and Technical Assistance Center (CCTAC);

(3) Two CHIPRA quality demonstration grantees (Illinois, a partner to the Florida grantee, and Massachusetts) funded by CMS to undertake new quality measure development as part of their grants http://www.insurekidsnow.gov/professionals/CHIPRA/grants_summary.html; and

(4) The Subcommittee on Children's Healthcare Quality Measures of the AHRQ National Advisory Council on Healthcare Research and Quality (SNAC) that will review measures nominated through a public call for measures, as well as measures developed or enhanced by the CoEs, and make recommendations for an improved core set of children's health care quality measures and other CHIPRA purposes (<http://www.ahrq.gov/chipra/panellist11.htm>).

Section 1139A of the Act provides that improved core sets of children's health care quality measures be identified beginning January 1, 2013, and annually thereafter, for potential voluntary use by Medicaid and CHIP programs and other CHIPRA purposes. AHRQ intends to solicit nominations for

children's health care quality measures for these purposes using a standard measure nomination form early in calendar years 2013 and 2014 through a public call for measures. These solicitations will be undertaken by AHRQ to identify children's health care quality measures for review by the SNAC.

Section 1139A(b)(2) of the Act requires that the measures in the improved core sets shall, at a minimum, be:

(A) Evidence-based and, where appropriate, risk adjusted;

(B) Designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care;

(C) Designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level;

(D) Periodically updated; and

(E) Responsive to the child health needs, services, and domains of health care quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A).

Hence, AHRQ, CMS, and PQMP developed a CHIPRA Pediatric Quality Measures Program (PQMP) Candidate Measure Submission Form (hereinafter referred to as "CHIPRA PQMP Candidate Measure Submission Form") and a Glossary of Terms. The CHIPRA PQMP Candidate Measure Submission Form and Glossary of Terms detail the measure evaluation criteria and related definitions to provide operational guidance for the minimum evaluation criteria as specified in section 1139A(b)(2) of the Act. AHRQ intends to use this CHIPRA PQMP Candidate Measure Submission Form to conduct a public call for measures early in calendar years 2013 and 2014 to solicit measures for consideration by the SNAC for the 2014 and 2015 improved core sets of children's health care quality measures for voluntary use by Medicaid and CHIP programs and for other CHIPRA purposes.

The goals of the CHIPRA PQMP Candidate Measure Form project are to:

(1) Solicit nominations for children's health care quality measures early in calendar years 2013 and 2014 through public calls for measures, using a standardized data collection form;

(2) Use the information provided through the standardized data collection form to support SNAC review of children's health care quality measures nominated by the public and measures developed by the seven CoEs; and

(3) Identify measures for improved core sets of children's health care quality measures and for other CHIPRA purposes.

The process for review of the measures developed by the seven COEs will be the same as that for measures submitted in response to calls for public nominations.

Respondents to these public calls for measures in 2013 and 2014 are expected to include pediatricians, researchers, measure developers, and measure stewards of children's health care quality measures.

This project is being conducted by AHRQ pursuant to AHRQ's statutory authority under Title IX of the Public Health Service Act to conduct and support research to improve health care quality, and to fulfill a number of requirements under Title IV of CHIPRA, including requirements to identify candidate measures for public posting of an improved core set of children's health care quality measures by January 1, 2014 and January 1, 2015.

Method of Collection

To achieve the goals of this project, AHRQ intends to solicit submission of measures from the members of the public using the CHIPRA PQMP Candidate Measure Submission Form, a standardized data collection tool. Data collection using the CHIPRA PQMP Candidate Measure Submission Form will be adequate to achieve the goals of the project. Below is an outline of the type of data collected through the CHIPRA PQMP Candidate Measure Submission Form and description of the information solicited from each nominator pursuant to section 1139A(b)(2) of the Act.

1. Basic measure information, including: measure name, measure description, denominator statement (if applicable), numerator statement (if applicable), data sources, exclusions, measure owner and/or copyright owner and any other applicable proprietary rights (e.g., patent or data rights), any confidentiality or trade secret protections, National Quality Forum (NQF) identification number (if applicable; i.e., if the measure has been endorsed by NQF), and whether part of a measure hierarchy (e.g., a collection of measures, a measure set, a measure subset as defined at <http://www.qualitymeasures.ahrq.gov/about/hierarchy.aspx>).

2. Detailed measure specifications: Description of how a measure would be calculated from appropriate data sources.

3. Importance of the measure: Description of how the measure meets one or more of the following criteria for importance, citing scientific literature and providing references: importance to Medicaid and/or CHIP program,

including the extent to which Medicaid/CHIP policies can stimulate improvement on the measure, and relevance to Early Periodic Screening, Diagnosis, and Treatment benefit; potential for quality improvement and reduction of disparities in quality; health importance/prevalence of condition; health importance/severity and burden (including impact on children, families and societies); overall cost burden to patients, families, public and private payers, or society more generally currently and over the life span of the child; association of measure topic to children's current or future health; how the underlying concept of the measure changes in meaning and manifestation (if at all) across developmental stages.

4. Settings, services, measure domains, and populations addressed by the measure. CHIPRA asks that the improved core sets cover the following domains of healthcare quality for children at a minimum: the duration of children's coverage over a 12 month time period; the availability and effectiveness of a full range of: (i) Preventive services, treatments, and services for acute conditions, including services to promote healthy birth, prevent and treat premature birth, and detect the presence or risk of physical or mental conditions that could adversely affect growth and development; (ii) treatments to correct or ameliorate the effects of physical and mental conditions, including chronic conditions, in infants, young children, school-age children, and adolescents; (iii) the availability of care in a range of ambulatory and inpatient health care settings in which such care is furnished; and, (iv) the types of measures that, taken together, can be used to estimate the overall national quality of health care for children, including children with special needs, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and healthcare for children. Nominations will need to identify all settings, services, measure domains, and populations that a measure addresses.

5. Evidence for focus of the measure: The evidence base for the focus of the measures included in the January 1, 2014 and January 1, 2015 improved core sets will be made explicit and transparent; thus, it is critical for nominations to specify the scientific evidence or other basis for the focus of the measure, including a brief description of the evidence base or rationale for the relationship between the measure and a significant structure,

process, or outcome that influences children's health and health care.

6. Scientific soundness of the measure: Explanation of methods to determine the scientific soundness of the measure itself, including results of all tests of validity and reliability, including description(s) of the study sample(s) and methods used to arrive at the results. Also, information on how characteristics of the data system/data sources may affect validity and reliability of the measure.

7. Identification of disparities: CHIPRA requires that quality measures be able to identify disparities by race, and ethnicity, and be responsive to domains of health care quality such as socioeconomic status, and special health care needs. Nominations will provide evidence (if available) from testing of measures with diverse populations (considering that diversity may include race, ethnicity, rural populations, inner city populations, special health care needs, socioeconomic status, and/or insurance source, especially Medicaid or CHIP) to assess measure's performance for disparities identification.

8. Feasibility: Description of the measure's feasibility, including: availability of data in existing data systems; opportunities/pathways for implementation; extent to which the measure has been used or is in use (or has not been used), including settings in which it has been used; data collection methods that have been used; eligible populations and results of testing in the eligible populations, including an estimation of the population size required to gain adequate numbers of observations for reliable comparisons, such as estimates of the required population sizes to gain adequate numbers for stratification by race, ethnicity, special health care need, and socioeconomic status.

9. Levels of aggregation: CHIPRA states that data used in quality measures must be collected and reported in a standard format that permits comparison (at minimum) at State, health plan, and provider levels. Nominations will provide information on all levels of aggregation at which the measure is primarily intended to apply (e.g., State (Medicaid and CHIP populations), health plan, hospital, practice, provider, patient) and at which the measure has been tested.

10. Understandability: CHIPRA states that the core set should allow purchasers, families, and health care providers to understand the quality of care for children. Nominations will include a description of the usefulness of the measure to purchasers, families,

and health care providers and present results from efforts to assess the understandability of the measure.

11. Health Information Technology: Nominations will provide information on health information technology (HIT) that has been or could be incorporated into the measure calculation.

12. Additional Disclosures and Notices: All nominations will include contact information for the measure submitter, including: (a) Name, (b) Title, (c) Organization, (d) Mailing address, (e) Telephone number, and (f) email address. Further, all nominations will include a written statement disclosing the proprietary and/or confidentiality status of the measure and full measure specifications, as described in the Basic Measure Information category. This statement must be signed by the applicable rights holder(s) or an individual authorized to act on its behalf for each submitted measure or instrument. If signed by an authorized individual, the statement must describe the basis for such authorization. Submitters are encouraged to disclose the terms under which the measure and full measure specifications are currently made available to interested parties—for

example, a standard license and/or nondisclosure agreement, or a statement describing the terms thereof. Should HHS accept the measure for the 2014 and/or 2015 Improved Core Measure Sets, full measure specifications for the accepted measure will be subject to public disclosure (e.g., on the AHRQ and/or CMS Web sites). In addition, AHRQ expects that measures and full measure specifications will be made reasonably available to all interested parties.

The information resulting from this data collection will be used to: (a) Improve and strengthen the initial core set of measures of health care quality measures established under CHIPRA in December 2009 (<http://www.gpo.gov/fdsys/pkg/FR-2009-12-29/html/E9-30802.htm>), (b) expand on existing pediatric quality measures used by public and private health care purchasers, and (c) increase the portfolio of evidence-based consensus pediatric quality measures available to public and private purchasers of children's health care services, providers, and consumers.

Each measure nominated by members of the public will be reviewed by

members of SNAC using the categories of evaluation criteria detailed in the CHIPRA PQMP Candidate Measure Submission Form. SNAC will make recommendations to NAC which in turn make recommendations to the AHRQ Director for consideration of select measures for inclusion in the public posting of an improved core set by January 1, 2014 and January 1, 2015 for voluntary use by Medicaid and CHIP programs and other CHIPRA purposes.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for members of the public who will nominate measures through use of the online CHIPRA PQMP Candidate Measure Submission Form. We anticipate a maximum of 50 nominations each year with each nomination requiring three hours. The total burden is estimated to be 150 hours annually.

Exhibit 2 shows the estimated annualized cost burden for respondents' to complete the online submission form for the public call for measures. The total cost burden is estimated to be \$11,801 annually.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Data collection	Number of nominations	Number of responses per nominations	Hours per response	Total burden hours
CHIPRA PQMP Candidate Measure Submission Form	50	1	3	150

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Data collection	Number of nominations	Total burden hours	Average hourly wage rate*	Total cost burden
CHIPRA PQMP Candidate Measure Submission Form	50	150	\$78.67	\$11,801

*Based upon the mean of the average wages for 29–1065 (Pediatricians, General), \$78.67 per hour, National Compensation Survey: Occupational wages in the United States May 2009, U.S. Department of Labor, Bureau of Labor Statistics. Although the measure nominations will be solicited from the general public, AHRQ is using the wage rate for pediatricians since our expectation is that respondents to the 2013 and 2014 public call for measures will primarily be pediatricians who will be measure developers or measure stewards of children's health care quality measures.

Estimated Annual Costs to the Federal Government

Exhibit 3 shows the estimated total and annualized cost over 3 years to the

government for conducting this project. The total cost is estimated to be \$275,270.

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST

Cost component	Total cost	Annualized cost
Project Development	\$16,205	\$5,402
Data Collection Activities	46,553	15,518
Data Processing and Analysis	43,190	14,397
Publication of Results	53,938	17,979
Project Management	22,620	7,540
Overhead	92,764	30,921

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST—Continued

Cost component	Total cost	Annualized cost
Total	275,270	91,757

Request for Comments

In accordance with the Paperwork Reduction Act, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of AHRQ healthcare research and healthcare information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: April 6, 2012.

Carolyn M. Clancy,
Director.

[FR Doc. 2012-9105 Filed 4-17-12; 8:45 am]

BILLING CODE 4160-90-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Disease Control and Prevention**

[60Day-12-12IG]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404-639-7570 and send comments to Kimberly S. Lane, at

CDC 1600 Clifton Road, MS-D74, Atlanta, GA 30333 or send an email to omb@cdc.gov.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Targeted Surveillance and Biometric Studies for Enhanced Evaluation of Community Transformation Grants—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Prevention and Public Health Fund (PPHF) of the Patient Protection and Affordable Care Act of 2010 (ACA) provides an important opportunity for states, counties, territories and tribes to advance public health across the lifespan and to reduce health disparities. The PPHF authorizes Community Transformation Grants (CTG) for the implementation, evaluation, and dissemination of evidence-based community preventive health activities. The CTG Program emphasizes five strategic directions: (1) Tobacco-free living, (2) active lifestyles and healthy eating, (3) high impact, evidence-based clinical and other preventive services, (4) social and emotional well-being, and (5) healthy and safe physical environments.

The CTG Program is administered by the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). As required by Section 4201 of the ACA, CDC is responsible for conducting a comprehensive evaluation of the CTG Program which includes assessment

over time of measures relating to each of the five strategic directions. CDC is requesting OMB approval to collect information needed for these assessments. The information collection will include population-level and targeted surveillance of high interest indicators for a range of age groups in select CTG communities, as well as enhanced evaluation studies designed to assess the potential impact of specific CTG strategies on health outcomes.

CDC plans to conduct the Adult Targeted Surveillance Survey (ATSS) in 20 CTG communities. Ten communities that have already received CTG cooperative agreements (group A) will participate in the ATSS in 2012, 2014, and 2016, and ten communities that will receive CTG funding in fiscal year 2013 (group B) will participate in the ATSS in 2013, 2015, and 2017. The ATSS will be administered by telephone to a representative sample of 1,000 adult residents in each community for an estimated annualized number of respondents of 10,000. Respondents will be asked to provide information about household practices and their personal behaviors specific to the five strategic directions (e.g., nutrition). Responses will be used to monitor changes in relevant attitudes, risk behaviors, and other behavioral factors in specific geographic areas where CTG cooperative agreement awardees are implementing interventions related to CTG strategic directions. Information from the targeted surveillance surveys will be compared with data from other local, state or national surveillance systems. During the initial three-year OMB clearance period, the ATSS will be administered to a total of 20,000 respondents in group A communities and 10,000 respondents in group B communities.

CDC's CTG Program evaluation plans also include enhanced evaluation activities and special studies fulfilling the congressional mandate to expand the evidence base of effective public health interventions across a range of settings, population subgroups, and health outcomes. These studies will include use of mixed-method approaches and observational and outcome data collection in select communities. The initial selected studies will address biometric changes specific to CTG interventions; the