contact Kim McPhillips at 410–786–5374. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web Site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on *August 23, 2012.*

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

Dated: July 18, 2012.

Martique Jones,

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

[FR Doc. 2012–17924 Filed 7–23–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10305]

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:* Revision of a currently approved collection; *Title:* Medicare Part C and Part D Data Validation (42 CFR 422.516g and 423.514g); *Use:* The Centers for Medicare and Medicaid Services (CMS) established reporting requirements for Medicare Part C and Part D sponsoring organizations (Medicare Advantage Organizations [MAOs], Cost Plans, and Medicare Part D sponsors) under the authority described in 42 CFR 422.516(a) and 423.514(a), respectively. Under these reporting requirements, each sponsoring organization must submit Medicare Part C, Medicare Part D, or Medicare Part C and Part D data (depending on the type of contracts they have in place with CMS). In order for the reported data to be useful for monitoring and performance measurement, it must be reliable, valid, complete, and comparable among sponsoring organizations. In 2009, CMS developed the data validation program as a mechanism to verify the data reported are accurate, valid, and reliable. To maintain the independence of the validation process, sponsoring organizations do not use their own staff to conduct the data validation. Instead, sponsoring organizations are responsible for hiring external, independent data validation contractors (DVCs) who meet a minimum set of qualifications and credentials.

CMS developed standards and data validation criteria for specific Medicare Part C and Part D reporting requirements that the DVCs use in validating the sponsoring organizations' data.[1] These standards and criteria are described in Appendix 1 ''Data Validation Standards.'' The data validation standards for each measure include standard instructions relating to the types of information that should be reviewed, and measure-specific criteria (MSC) that are aligned with the ''Medicare Part C and Part D Reporting Requirement Technical Specifications.,, Furthermore, the standards and criteria describe how the DVCs should validate the sponsoring organizations' compilations of reported data, taking into account appropriate data exclusions, and verifying calculations, source code, and algorithms. The data validation reviews are conducted at the contract level given that the Medicare Part C and Part D data are generally available at the contract level and the contract is the basis of any legal and accountability issues concerning the rendering of services.

The review is conducted over a three-month period following the final submission of data by the sponsoring organizations. In addition to the ''Data Validation Standards'' described in Appendix 1, the DVCs employ a set of information collection tools when performing their reviews, which are included in the appendices described below:

Appendix 2: Organizational Assessment Instrument
Appendix 3: Data Extraction and Sampling Instructions
Appendix 4: Instructions for the Findings Data Collection Form
Appendix 5: Findings Data Collection Form (FDCF)

Data collected via ''Medicare Part C and Part D Reporting Requirements'' is an integral resource for oversight, monitoring, compliance and auditing activities necessary to ensure quality provision of the Medicare benefits to beneficiaries. CMS uses the data collected through the Medicare data validation program to substantiate the data collected via Medicare Part C and Part D Reporting Requirements. If CMS detects data anomalies, the CMS division with primary responsibility for the applicable reporting requirement assists with determining a resolution. The hour burden on industry is estimated at 179,301 total hours, or 879 hours for one contract within one organization reporting both Part C and Part D measures. The validation would require 378 hours from the sponsoring organization and 501 from the data validation contractors. The estimates are based on the total number of Part C and/or Part D measures, the average number of sponsors, and the average number of contracts by type (Part C, Part D, Part C/D) being validated as well as a level of effort associated with the individual activities associated with the data validation process. *Form Number:* CMS–10305 (OCN: 0938–1115); *Frequency:* Reporting—Annually; *Affected Public:* Private sector—Business or other for-profits; *Number of Respondents:* 135; *Total Annual Responses:* 657; *Total Annual Hours:* 179,301. (For policy questions regarding this collection contact Terry Lied at 410–786–8973. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site address at *http://www.cms.hhs.gov/*

[1] CMS determines annually which Medicare Part C and Part D measures are included in the data validation program.

PaperworkReductionActof1995, or Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by September 24, 2012:

1. *Electronically.* You may submit 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) 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.

Dated: July 18, 2012.

Martique Jones,

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

[FR Doc. 2012–17926 Filed 7–23–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2383–N]

RIN 0938–AR45

Children's Health Insurance Program (CHIP); Final Allotments to States, the District of Columbia, and U.S. Territories and Commonwealths for Fiscal Year 2012

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

ACTION: Notice.

SUMMARY: This notice sets forth the final allotments of Federal funding available to each State, the District of Columbia, and each U.S. Territory and Commonwealth for fiscal year 2012 (with the qualification that potential increases in such allotments may be available for certain States). Title XXI of the Social Security Act (the Act) authorizes payment of Federal matching funds to States, the District of Columbia, and the U.S. Territories and Commonwealths to initiate and expand health insurance coverage to uninsured, low-income children under the Children's Health Insurance Program (CHIP). The fiscal year allotments contained in this notice were determined in accordance with the funding provisions and final regulations published in the February 17, 2011 **Federal Register**.

DATES: This notice is effective on August 23, 2012. Final allotments may be available for expenditure by States beginning with October 1, 2011.

FOR FURTHER INFORMATION CONTACT: Richard Strauss, (410) 786–2019.

SUPPLEMENTARY INFORMATION:

I. Purpose of This Notice

This notice sets forth the allotments available to each State, the District of Columbia, and each U.S. Territory and Commonwealth for fiscal year (FY) 2012 under title XXI of the Social Security Act (the Act). States may implement Children's Health Insurance Program (CHIP) through a separate State program under title XXI of the Act, an expansion of a State Medicaid program under title XIX of the Act, or a combination of both. CHIP allotments for FY 2009 and subsequent fiscal years are available to match expenditures under an approved State child health plan for 2 fiscal years, including the year for which the allotments were provided. As specified by the Act, the allotments are available to States for FY 2012, and the unexpended amounts of such allotments for a State may be carried over to FY 2013 for use by the State. Federal funds appropriated for title XXI of the Act are limited, and the law specifies a methodology to divide the total fiscal year appropriation into individual allotments available for each State, the District of Columbia, and each U.S. Territory and Commonwealth with an approved child health plan.

Section 2104(b) of the Act requires States, the District of Columbia, and U.S. Territories and Commonwealths to have an approved child health plan for the fiscal year in order for the Secretary to provide an allotment for that fiscal year. All States, the District of Columbia, and U.S. Territories and Commonwealths have approved plans for FY 2012. Therefore, the FY 2012 allotments contained in this notice pertain to all States, the District of Columbia, and U.S. Territories and Commonwealths.

In general, funding is appropriated under section 2104(a) of the Act for purposes of providing allotments to States under CHIP for each fiscal year. However, title XXI of the Act as amended by section 10203(d)(1) of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148, enacted on March 23, 2010) (the Affordable Care Act) appropriates funding for CHIP fiscal year allotments through FY 2015.

II. Methodology for Determining CHIP Fiscal Year Allotments for the 50 States, the District of Columbia, and the U.S. Territories and Commonwealths

A. Funding Authority for the CHIP Fiscal Year Allotments

Section 2104(a)(1) through (18) of the Act appropriates Federal funds for providing States' allotments for FYs 2009 through 2015. In particular, the appropriated amounts available for allotments for FYs 2009 through 2015, are as follows: $10,562,000,000 for FY 2009; 12,520,000,000 for FY 2010; $13,459,000,000 for FY 2011; $14,982,000,000 for FY 2012; $17,406,000,000 for FY 2013, $19,147,000,000 for FY 2014, and $2,850,000,000 for each of the first and second half of FY 2015. Also, section 108 of the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3, enacted on February 4, 2009) (CHIPRA), as amended by section 10203(d) of the Affordable Care Act, provides for a one-time appropriation of $15,361,000,000 for allotments for the first half of FY 2015. Therefore, the total appropriation for providing allotments during FY 2015 is $21,061,000,000 (determined as the sum of $2,850,000,000, $15,361,000,000, and $2,850,000,000).

B. Methodology For Determining State's Fiscal Year Allotments

1. General

Section 2104(m) of the Act sets forth the methodology for determining States' CHIP allotments for each of FYs 2009 through 2015. In general, the States' fiscal year allotments are provided from the appropriation for the respective fiscal year allotment, subject to a proration adjustment described in section II.B.7. of this notice.

2. FY 2009 Through FY 2011 Allotments

On February 17, 2011 we published a final rule in the **Federal Register** (76 FR 9233), that set forth the methodologies and procedures to determine the fiscal year allotments of Federal funds under title XXI of the Act. In particular, the methodologies for determining the CHIP allotments for fiscal year FY 2009 through FY 2011 were contained in the final regulations published in that **Federal Register** publication.