DEPARTMENT OF HEALTH AND HUMAN SERVICES

Meeting of the President's Council on Fitness, Sports, and Nutrition; Correction

AGENCY: Department of Health and Human Services, Office of the Secretary, Office of the Assistant Secretary for Health, Office of the President's Council on Fitness, Sports, and Nutrition.

ACTION: Notice; correction.

SUMMARY: The Department of Health and Human Services published a notice in the **Federal Register** on April 11, 2013 to announce a meeting of the President's Council on Fitness, Sports, and Nutrition on May 7, 2013, from 10:00 a.m. to 4:30 p.m., at the Department of Health and Human Services, 200 Independence Ave., SW., Room 800; Washington, DC 20201. The meeting time has changed.

FOR FURTHER INFORMATION CONTACT: Ms. Shellie Pfohl, Executive Director, President's Council on Fitness, Sports, and Nutrition; Phone: (240) 276–9866 or (240) 276–9567.

Correction

In the **Federal Register** of April 11, 2013, FR Doc. 2013–08494 , on page 21606, in the second column, correct the **DATES** caption to read:

DATES: The meeting will be held on May 7, 2013, from 9:30 a.m. to 1:00 p.m.

Dated: April 26, 2013.

M. Shannon Feaster,

Director of Communications, President's Council on Fitness, Sports, and Nutrition.

[FR Doc. 2013–10674 Filed 5–3–13; 8:45 am]

BILLING CODE 4150–35–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10419]

Agency Information Collection Activities: Submission for OMB Review; 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), Department of Health and Human Services, 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 function; (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:* New collection (request for a new OMB control number); *Title of Information Collection:* Transparency Reports and Reporting of Physician Ownership or Investment Interests; *Use:*

Reports of Payments or Other Transfers of Value to Covered Recipients

The regulations at 42 CFR 403.904 require direct and indirect payments or other transfers of value provided by an applicable manufacturer to a covered recipient, and that direct and indirect payments or other transfers of value provided to a third party at the request of (or designated by) the applicable manufacturer on behalf of a covered recipient, be reported by the applicable manufacturer to CMS on an annual basis.

Reports of Physician Ownership and Investment Interests

Under § 403.906, each applicable manufacturer and applicable group purchasing organization must report to CMS on an annual basis all ownership and investment interests in the applicable manufacturer or applicable group purchasing organization that were held by a physician or an immediate family member of a physician during the preceding calendar year.

Data Collection

The data templates will provide detailed information about the data to be collected including the data element name, format, allowable values, required versus optional fields, and other associated rules intended to aid the applicable manufacturers and applicable group purchasing organizations as they prepare for and participate in data collection. Applicable manufacturers and applicable GPOs will engage in data collection external to CMS within their own systems or tracking tools. If we intend to make changes to the data templates, we will provide them at least 90 days prior to first day of data collection for the next reporting year. In providing revised templates, we will also comply with the requirements of the Paperwork Reduction Act to seek public comments on the proposed changes to the information collections, as required by law. This will allow applicable manufacturers and applicable GPOs to make any necessary changes to prepare for the next reporting year. This is the same time as the date by which we will publish the list of teaching hospitals.

Data Submission

Section 403.908 requires that reports must be electronically submitted to CMS by March 31, 2014, and by the 90th day of each subsequent calendar year. Additionally, applicable manufacturers and applicable group purchasing organizations may submit an entirely optional assumptions document, explaining the reasonable assumptions made and methodologies used when reporting payments or other transfers of value, or ownership or investment interests. The assumptions documents will not be made available to covered recipients, physician owners or investors, or the public.

Dispute Resolution and Corrections

There are several situations which may necessitate that data previously submitted be updated. These cases include corrections based on disputes, or corrections known by the applicable manufacturer or applicable GPO through another mechanism. For example, if an applicable manufacturer or applicable group purchasing organization discovers an error or omission in its annual report, under § 703.908(h), applicable manufacturers and applicable GPOs must notify CMS immediately upon discovering errors or omissions in their reports and must submit corrected information to CMS immediately upon confirmation of the error or omission. CMS will update the Web site at least once annually with corrected information. *Form Number:* CMS–10461 (OCN: 0938-New). *Frequency:* Annual; *Affected Public:* Private Sector (business or other for-profit and not-for-profit institutions); *Number of Respondents:* 396,414. *Total Annual Responses:* 396,414. *Total Annual Hours:* 13,327,065. (For policy questions regarding this collection contact Doug Brown at 410–786–0028. 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 June 3, 2013.

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

Dated: May 1, 2013.

Martique Jones,

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

[FR Doc. 2013–10681 Filed 5–3–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Kentucky State Plan Amendments (SPA) 10–007

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

ACTION: Notice of Hearing.

SUMMARY: This notice announces an administrative hearing to be held on June 27, 2013, at the CMS Atlanta Regional Office, Atlanta Federal Center, 61 Forsyth Street, South West, Atlanta, Georgia 30303–8909, to reconsider CMS' decision to disapprove Kentucky SPA 10–007.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by May 21, 2013.

FOR FURTHER INFORMATION CONTACT: Benjamin Cohen, Presiding Officer, CMS, 2520 Lord Baltimore Drive, Suite L, Baltimore, Maryland 21244, Telephone: (410) 786–3169.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider CMS's decision to disapprove Kentucky SPA 10–007 which was submitted on September 30, 2010, and disapproved on April 2, 2013. The SPA proposed a payment methodology based on actual, incurred, costs for services provided by Community Mental Health Clinics (CMHCs).

At issue in the hearing is whether the proposed cost-based Medicaid payment methodology is consistent with the requirements of section 1902(a)(30)(A) of the Social Security Act (Act) when Kentucky did not specifically document that, under the proposed methodology, non-Medicaid costs would be excluded from the Medicaid payment calculation. Specifically, it appears that the methodology would rely on a cost reporting mechanism which results in over-allocation of both indirect and direct cost to Medicaid services. Specifically, for CMHCs that function within a larger parent organization, the state proposed an inappropriate transfer of cost from the parent organization to the CMHCs. Additionally, the state did not demonstrate that it had an acceptable method of allocating practitioner cost between reimbursable and non-reimbursable activities.

Section 1902(a)(30)(A) of the Act requires that states have methods and procedures in place to ensure payments are consistent with economy, efficiency, and quality of care. Because the proposed payment methodology is based on each provider's reconciled cost, CMS requested that Kentucky document the cost-finding and provider reporting mechanisms used to determine payment. This information would allow CMS to ensure that the proposed payment would be limited to amounts economic and efficient for covered Medicaid services, and were sufficient to ensure quality of care. Upon review of Kentucky's response, CMS determined that Kentucky was not able to document that its cost reporting mechanism properly allocated cost to Medicaid covered services. Specifically, CMS was concerned that Kentucky's methodology did not demonstrate the exclusion of costs incurred outside of these clinics for non-Medicaid activities and services. CMS worked with Kentucky on its cost reporting methodology over an extended period of time; however, CMS was not able to resolve questions surrounding the issue of including non-Medicaid costs. As a result, CMS could not conclude that Kentucky's proposed plan for payment was economic and efficient, or consistent with quality of care. In the absence of this specific information, CMS could not conclude that the requirements of section 1902(a)(30)(A) were satisfied.

Section 1116 of the Act and federal regulations at 42 CFR Part 430, establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a state plan or plan amendment. CMS is required to publish a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing, and the issues to be considered. If we subsequently notify the agency of additional issues that will be considered at the hearing, we will also publish that notice.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

The notice to Kentucky announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Mr. Lawrence J. Kissner,
Commissioner,
Cabinet for Health and Family Services,
Department for Medicaid Services,
275 East Main Street, 6W–A,
Frankfort, KY 40621.

Dear Mr. Kissner:

I am responding to your request for reconsideration of the decision to disapprove the Kentucky State Plan Amendment (SPA) 10–007 which was submitted on September 30, 2010, and disapproved on April 2, 2013. The SPA proposed a payment methodology based on actual, incurred, costs for services provided by Community Mental Health Clinics (CMHCs).

I disapproved Kentucky SPA 10–007 because I could not conclude that it complied with section 1902(a)(30)(A) of the Social Security Act (the Act), which requires payments to be consistent with economy efficiency and quality of care. In order to meet this requirement, the Centers for Medicare & Medicaid Services (CMS) requested that Kentucky document the cost-finding and provider reporting mechanisms used to determine payment. Upon review of the commonwealth's response to CMS's formal Request for Additional Information (RAI), CMS determined that Kentucky had not sufficiently documented that its cost reporting mechanism properly allocated cost to Medicaid covered services by excluding non-Medicaid costs from the Medicaid payment calculation.

The CMS worked with Kentucky on its cost reporting methodology over an extended period of time; however, CMS was not able to resolve questions surrounding the issue of including non-Medicaid costs. As a result, CMS could not conclude that Kentucky's proposed plan for payment was economic and efficient, or consistent with quality of care. In the absence of this specific information, CMS could not conclude that the requirements of section 1902(a)(30)(A) of the Act were satisfied.

At issue in this appeal is whether the proposed cost-based Medicaid payment methodology is consistent with the requirements of section 1902(a)(30)(A) of the