specific request that describes project purpose, use, and methodology.

CDC plans to request OMB approval to extend the MTTCA clearance, with changes, for three years. The Revision information collection request (ICR) will propose further increases in the annualized estimated number of respondents and the annualized estimated burden hours. These increases are needed to support CDC's planned information collections and to accommodate additional needs that CDC may identify during the next three years. For example, the MTTCA generic clearance may be used to facilitate the development of tobacco-related health communications of interest for CDC's collaborative efforts with other federal partners including, but not limited to, the Food and Drug Administration (FDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Health (NIH), and the National Cancer Institute (NCI). At this time the MTTCA clearance is expected to be sufficient to test tobacco related messages developed by CDC. However, the MTTCA clearance should not replace the need for additional generic clearance mechanisms HHS and other federal partners may need to test tobacco messages related to their campaigns and initiatives.

CDC's revised MTTCA clearance will also describe expansion of the target audience(s) that may be involved in message testing, such as youth ages 13–17 years. The 2014 Surgeon General's Report concluded that there is already sufficient evidence to caution youth against the use of electronic cigarettes. Tobacco and electronic cigarette advertising and promotional activities can prompt smoking initiation, especially among youth. Recent studies have found that 90.7% of middle school students and 92.9% of high school students have been exposed to pro-tobacco advertisements in stores, magazines and on the internet. Media campaigns have been shown to be effective as part of a comprehensive tobacco control program to decrease the initiation of tobacco use among youths and young adults. A coordinated series of health message testing activities will be required to support future development of effective, audience-specific and channel-specific messages for CDC's ACA-funded campaign.

Finally, there may be a need to test prevention and cessation messages related to products that are not currently regulated, including non-combustible tobacco products (electronic nicotine delivery systems such as electronic cigarettes or e-cigarettes) and some combustible products (such as cigars/little cigars and cigarillos). In the event that the FDA receives authority to regulate these products and decides to do a campaign about them, CDC will work closely with FDA to avoid duplication. Additionally, CDC will share with FDA the findings from any formative work related to the youth audience.

CDC will continue to use the MTTCA clearance to develop and test messages and materials for current and future phases of the ACA-funded media campaign, OSH's ongoing programmatic initiatives including, but not limited to, the Media Campaign Resource Center, reports from the Office of the Surgeon General, and other communication efforts and materials. Participation is voluntary and there are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
General Public and Special Populations.	Screening and Recruitment	20,000	1	2/60	667
	In-depth Interviews (In Person, telephone, etc.)	96	1	1	96
	Focus Groups (In Person)	160	1	1.5	240
	Focus Groups (Online)	120	1	1	120
	Short Surveys/information needed to screen individuals being considered for inclusion in campaign ads (Online, Bulletin Board, etc.).	9,800	1	10/60	1,633
	Medium Surveys (Online)	9,940	1	25/60	4,142
	In-depth Surveys (Online)	4,100	1	1	4,100
Total		44,216			10,998

Leroy Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2014–18902 Filed 8–8–14; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3300–NC]

RIN 0938–ZB15

Medicare Program; Evaluation Criteria and Standards for Quality Improvement Networks Quality Improvement Program Contracts [Base and Task Order(s)]

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

ACTION: Notice with comment period.

SUMMARY: This notice with comment period describes the general criteria we intend to use to evaluate the effectiveness and efficiency of the Quality Innovation Network (QIN) Quality Improvement Organizations (QIOs) that will enter into contracts with CMS under the Quality Innovation Network Quality Improvement Organizations (Solicitation Number: HHSM–500–2014–RFP–QIN–QIO) Statement of Work (SOW) on August 1, 2014. The evaluation of a QIN–QIO's performance related to their SOW will be based on evaluation criteria specified for the tasks and subtasks set forth in

Sections C.5, G.22 and G.29 of the QIN–QIO Base Contract and Attachment J–1(b) of the Base Contract; Attachment J–1 is QIN–QIO Task Order No. 001.

DATES: *Effective Date:* August 1, 2014 to July 31, 2019 for the QIN–QIO contract.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 10, 2014.

ADDRESSES: In commenting, refer to file code CMS–3300–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address only:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS–3300–NC,
P.O. Box 8010,
Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS–3300–NC,
Mail Stop C4–26–05,
7500 Security Boulevard,
Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses:

a. For delivery in Washington, DC—
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445–G, Hubert H. Humphrey Building,
200 Independence Avenue SW.,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members. Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT: Alfreda Staton, (410) 786–4194.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Section 1153(h)(2) of the Social Security Act (the Act) requires the Secretary of the Department of Health and Human Services (the Secretary) to publish in the **Federal Register** the general criteria and standards that will be used to evaluate the effective and efficient performance of contract obligations by the Quality Improvement Organizations (QIOs), and to provide the opportunity for public comment with respect to these criteria and standards. This notice describes the general criteria that will be used to evaluate performance of the Quality Innovation Network (QIN)—QIOs under the QIN–QIO 11th Statement of Work (SOW) contract beginning August 1, 2014.

II. Provisions of the Notice With Comment Period

The QIN–QIO contract supports our efforts to improve health and healthcare for all Medicare beneficiaries, including those who are eligible for both the Medicare and Medicaid programs, and promote quality of care to ensure the right care at the right time, every time. The QIN–QIO SOW is structured so that QIN–QIOs perform under the base contract and task orders. Task Order 001 outlines several tasks for the QIN–QIOs as well as a mechanism for the proposal and adoption of additional tasks known as ''Special Innovation Projects'' (SIPs). Specifically, SIPs are initiatives, efforts, and programs rooted in the QIN–QIO area. SIPs are recommended to the Centers for Medicare & Medicaid Services (CMS), through the QIN–QIO, by community advocates, organizers, and groups engaged with local health issues. The SIP is intended to either address a health issue the community finds acute but is less visible to high-level federal analytics or to respond to health issues, local or national, that are discovered during the course of the contract. In addition to the SIPs, QIOs are responsible for completing the requirements for the following Tasks as part of Task Order 001:

- Improving Cardiac Health and Reducing Cardiac Healthcare Disparities;
- Reducing Disparities in Diabetes Care;
- Improving Prevention Coordination through Meaningful Use of Health Information Technology (HIT) and Collaborating with Regional Extension Centers (RECs);
- Reducing Healthcare-Associated Infections in Hospitals;
- Reducing Healthcare-Acquired Conditions in Nursing Homes;
- Improving Coordination of Care;
- Quality Improvement through Value-Based Payment, Quality Reporting, and the Physician Feedback Reporting Program; and
- Quality Improvement Initiatives.

(Detailed information for each Task may be found in sections B.1 through E.1 in Attachment J.1 posted on December 5, 2013 of Solicitation Number: HHSM–500–2014–RFP–QIN–QIO, posted at the *http://www.fedbizopps.gov* Web site: *https://www.fbo.gov/index?s=opportunity&mode=form&id=dff522bababb 6b9859bb783 c08db6074.*) References in this Notice to ''Attachments'' are to attachments of the RFP and SOW.

QIN–QIO Tasks

Improving Cardiac Health and Reducing Cardiac Healthcare Disparities (See Section B.1 of Attachment J.1, QIN–QIO Task Order No. 001)

The purpose of this task is for the QIN–QIOs to work with providers and beneficiaries in collaboration with key partners and stakeholders, including RECs, to implement evidence-based practices to improve cardiovascular health, reduce cardiovascular healthcare disparities, and support the Department of Health and Human Services' Million Hearts® initiative's goal to prevent one million heart attacks and strokes. The Million Hearts® Web site is found at *www.millionhearts.hhs.gov.* While the QIN–QIO's work targets Medicare beneficiaries of all races and ethnicities, the QIN–QIO shall also propose the number of clinicians, practitioners, and providers, (as defined in section 1861(u) of the Act (42 U.S.C. 1395)), it will recruit to voluntarily participate in this initiative. Focus will be on those clinicians and provider that provide healthcare services to African American, Hispanic, and other racial and ethnic minority Medicare beneficiaries. Goals and targets will be monitored for improvement in promoting the use of Aspirin therapy when appropriate; Blood pressure (BP) control; Cholesterol management; and Smoking assessment and cessation (ABCS).

Reducing Disparities in Diabetes Care: Everyone With Diabetes Counts (EDC) (See Section B.2 in Attachment J.1, QIN–QIO Task Order No. 001)

The purpose of this Task is to improve the quality of the lives for persons with diabetes, and to prevent or lessen the severity of complications resulting from diabetes. The QIN–QIOs will promote diabetes self-management education (DSME) for empowering Medicare beneficiaries with diabetes to take an active role in controlling their disease and improve clinical outcomes. The QIN–QIOs will work with healthcare providers, practitioners, certified diabetes educators, and community health workers to cultivate the knowledge and skills necessary to improve the quality of the lives for persons with diabetes. The QIN–QIOs will also work with stakeholders on preventing or lessening the severity of complications resulting from diabetes such as kidney failure, amputations, loss of vision, heart failure, and stroke.

Improving Prevention Coordination Through Meaningful Use of HIT and Collaborating With Regional Extension Centers (See Section B.4 in Attachment J.1, QIN–QIO Task Order No. 001)

The purpose of this Task is to support physician and other clinician practices to improve care and outcomes for their population of patients through meaningful use of interoperable health IT in collaboration with RECs. The QIN–QIOs will collaborate with RECs to improve the quality of care and transitions in care through interoperable health IT in connection with the Medicare program. The QIN–QIOs will provide targeted technical assistance to Eligible Professionals (EP), Eligible Hospitals (EH) and Critical Access Hospitals (CAH) that are most challenged to successfully meet the requirements of the Medicare Electronic Health Record (EHR) Incentive Programs and utilizing EHR functionality for quality improvement.

Reducing Healthcare-Associated Infections in Hospitals (See Section C.1 in Attachment J.1 of the QIN–QIO Task Order)

The purpose of this Task is to improve beneficiary safety by reducing the incidence of patient harm in the areas of healthcare-associated infections (HAIs) in hospital settings. The QIN–QIO will use evidence-based strategies and data to decrease and prevent HAIs in the hospital setting to improve patient care. The QIO will work to decrease Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI) and Clostridium Difficile Infection (CDI) Standardized Infection Ratios (SIRs) and improve Urinary Catheter Utilization in hospital acute care settings for Medicare beneficiaries.

Reducing Healthcare-Acquired Conditions in Nursing Homes (See Section C.2 in Attachment J.1, QIN–QIO Task Order No. 001)

The purpose of this Task is to improve beneficiary safety by reducing the incidence of healthcare-acquired conditions in nursing home provider settings. The QIN–QIO will improve the quality of care for Medicare beneficiaries in Nursing Homes by achieving improvement in the Collaborative Quality Measure Composite Score composed of 13 NQF-endorsed quality of care measures as listed in Attachment J.1—Task Order 001, Task C.2. Appendix 4; decrease the percentage of residents who received antipsychotic medications; and improve mobility of long-stay residents. The QIN–QIO will work to support the creation of National Nursing Home Quality Care Collaboratives (NNHQCC) to ''instill quality and performance improvement practices, eliminate healthcare acquired conditions, and improve resident satisfaction.'' The QIN–QIO will work with participating nursing homes, beneficiaries, beneficiary family members and/or beneficiary advocates/representatives, and in collaboration with key partners and stakeholders to accomplish these objectives.

Coordination of Care (See Section C.3 in Attachment J.1,QIN–QIO Task Order No. 001)

The purpose of this Task is to improve hospital admission and/or readmission rates, and adverse drug event rates by improving effective communication and the continuity and coordination of patient care using methods such as interoperable health IT. The QIN–QIO will improve the quality of care for Medicare beneficiaries who transition among care settings including home through a comprehensive community effort. These efforts aim to reduce readmissions following hospitalization and to yield sustainable and replicable strategies to achieve high-value health care, particularly for chronically ill and disabled Medicare beneficiaries. The QIN–QIOs will support the development of community coalitions for improving communication and the coordination of clinical decisions.

Quality Improvement Through Value-Based Payment, Quality Reporting, and the Physician Feedback Reporting Program (See Section D.1 in Attachment J.1, QIN–QIO Task Order No. 001)

The purpose of this Task is to improve quality care to beneficiaries in physician settings by supporting provider use of and participation in the CMS physician value modifier program and coordinating community driven projects that advance efforts to achieve better care at lower costs. The QIN–QIOs will improve healthcare by identifying gaps and opportunities for improvement in quality, efficiency, and care coordination. The QIOs shall be called upon to assist hospitals, PPS-exempt Cancer Hospitals (PCHs), Inpatient Psychiatric Facilities (IPFs), Ambulatory Surgical Centers (ASCs) and physicians (as defined in section 1861(r) of the Act) in improving the quality and efficiency of care through outreach and education about CMS' hospital and physician value based payment programs, quality reporting

programs, Physician Feedback Reporting Program, and the use of the quality and cost measure information contained in the confidential quality and resource use reports.

QIN–QIO-Proposed Projects That Advance Efforts for Better Care at Lower Cost (See Section D.2 in Attachment J.1, QIN–QIO Task Order No. 001)

We will use SIPs to support QIN–QIOs in their respective services areas to work with communities to improve healthcare quality and efficiencies. Specifically, SIPs are initiatives, efforts, and programs rooted in the QIN–QIO area. SIPs are recommended to us, through the QIN–QIO, by community advocates, organizers, and groups engaged with local health issues. The SIP is intended to address health issues that the community finds acute but is less visible at a national-level. Evaluation criteria and standards will be developed for each SIP.

Quality Improvement Initiatives (See Section E.1 in Attachment J.1, QIN–QIO Task Order No. 001)

The purpose of this Task is to improve the quality of health care for Medicare beneficiaries by providing technical assistance to providers and practitioners. The QIN–QIO will improve healthcare quality by assisting providers and/or practitioners in identifying the root cause of a concern, developing a framework in which to address the concern, and improving a process or system based on their analyses. A Quality Improvement Initiative (QII) is any formal activity designed to serve as a catalyst and support for quality improvement that uses proven methodologies to achieve these improvements. The improvements may relate to safety, healthcare, health and value and involve providers, practitioners, beneficiaries, and/or communities. A QII may consist of system-wide and/or non-system-wide changes and may be based on a single, confirmed concern or multiple confirmed concerns. Additionally, the QIN–QIO will collaborate with the Beneficiary and Family Centered Care-QIO to improve Beneficiary (''Patient'') and Family Engagement in healthcare quality improvement efforts and actively supporting projects aimed at shared decision-making with beneficiaries, families, and caregivers and families. QIIs may also be based upon or responsive to referrals made by other contractors in the QIO Program.

III. Evaluation of the Tasks

The QIN–QIO's performance will be evaluated based on achievement associated with the Tasks in each awarded Task Order and as described in Sections C.5, G.22 and G.29 of the QIN–QIO Base Contract and the QIN–QIO Statement of Work (including Attachments J.1 and other Attachments for measures and targets).

If a QIN–QIO is not tasked to work on a specific Task or an area under a Task, the QIN–QIO will not be evaluated under that particular area. Any Special Innovation Project that the QIN–QIO may carry out will be evaluated separately and will not be considered in the overall performance evaluation criteria.

We will conduct monitoring activities throughout the course of the contract and will act upon findings as necessary. We will monitor, at least quarterly, the QIN–QIO's performance relative to contract requirements and targets as well as milestones and progress toward successfully implementing plans and programs for each of the individual states/territories of the QIN–QIO's service area, as well as the aggregate, in the Task Award.

Information used for these monitoring purposes includes but is not limited to:

- Deliverables submitted by the QIN–QIO to CMS in accordance with the Schedule of Deliverables;
- Data for measures indicated in Attachment J.1(b);
- Data from the QIN–QIO's Continuous Internal Quality Improvement Program;
- Other data submitted by QIN–QIOs as required by CMS;
- Additional information gathered by email, telephone, video, or in-person visits.

Plans and programs against which progress will be monitored include but are not limited to:

PLAN & PROGRAM MONITORING

Base contract or task order 001	Section(s)	Brief description
Base Contract	C.6.1.1	Comprehensive Strategic Plan.
Task Order 001	A.1.1	Comprehensive Strategic Plan.
Base Contract	C.6.1.2	Integrated Communications Plan.
Task Order 001	A.1.3	Integrated Communications Plan.
Base Contract	C.6.1.3	Task Order Work Plan.
Base Contract	C.6.4.2	Recruitment.
Base Contract	C.6.4.3	Provider and Practitioner Recruitment.
Base Contract	C.6.4.4	Beneficiary (''Patient'') and Family Engagement.
Base Contract	C.6.4.5	Partner and Stakeholder Recruitment and Collaboration.
Base Contract	C.6.4.6	Sustainability Plan.
Task Order 001	A.1.2	Management Plan.
Task Order 001	A.1.6	Continuous Internal Quality Improvement Program.
All Task Orders from Task 001 forward	All Sections	Task Order 001, Excellence in Operations and Quality Improvement and all subsequent Task Orders as specified.

QIN–QIOs shall cooperate with the Contracting Officer Representative (COR) on all our monitoring processes and address any concerns identified by the COR. We will take appropriate contract action (for example, providing warning for the need for adjustment, instituting a formal correction plan, terminating an activity, or recommending early termination of a contract because of failure to meet contract timelines or performance as specified in the contract). This means that the QIO shall comply with the Base Contract, all Task Orders, Schedules of Deliverables, Evaluation Measures Tables, and any subsequent modifications (including HCQIS Memorandums) issued by CMS.

Additionally, there will be multiple periods of evaluation under this contract. The first evaluation will occur at the end of the 12th month of the contract. Subsequent evaluations will

occur at the end of the 24, 36, 48 and 54th months of the contract. The evaluations will be based on the most recent data available to us. The performance results of the evaluation at each evaluation period (that is, 12, 24, 36, 48 and 54th months) will be used, in addition to ongoing monitoring activities, to determine the QIO's performance on the overall contract.

Annual and 54th Month Evaluation

Annual and the 54th month contract evaluation will determine if the QIN–QIO has met the performance evaluation criteria as specified in the Task areas of the Base Contract. The annual and 54th month evaluation criteria are found in Section J, Attachment J.1(b), Evaluation Measures Table of the QIN–QIO SOW. Attachment J.1(b) includes the following measures, by Task:

- B.1. Improving Cardiac Health
  - Percentage of patients whose blood pressure was adequately controlled.
  - Percentage of patients who are screened about tobacco use at least one time within 24 months.
  - Percentage of patients identified as tobacco users who are provided with cessation counseling intervention.
- B.2. Everyone with Diabetes Counts
  - Percentage of clinical outcome data for Medicare beneficiaries who complete DSME classes through EDC. Clinical outcomes are: HbA1c, Lipids, Eye Exam, Blood Pressure and Weight.
  - Percentage of physician practices recruited to participate in EDC.
  - Percentage of New Beneficiaries Completing DSME.
- B.3. (Reserved)
- B.4. Meaningful Use of HIT and Collaborating With RECs
  - Percentage of recruited EPs, EHs and CAHs using certified EHR technology (CEHRT) with signed agreements within each state or territory.
  - Percentage of recruited EPs, EHs and CAHs using CEHRT receiving technical assistance within each state or territory.
  - Percentage of recruited practitioners/providers attending QIO's educational sessions and the Learning and Action Network.
  - Percentage of recruited EPs, EHs and CAHs that received Technical Assistance (TA) that meet EHR Incentive Programs clinical quality measures reporting requirements post TA within each state or territory.
  - Percentage of recruited practitioners/providers working to establish an electronic connection with beneficiaries/family representative.
- C.1. Reducing Healthcare-Acquired Infections (HAIs) in Hospitals
  - CLABSI Standardized Infection Ratio.
  - CAUTI Standardized Infection Ratio.
  - Urinary Catheter Utilization Rate.
  - CDI Standardized Infection Rate.
  - Recruitment of non-ICU and ICU units in acute care facilities to participate in HAI projects.
- C.2. Reducing Healthcare-Acquired Conditions in Nursing Homes
  - Rate of reduction in percentage of residents who received antipsychotic medications.
  - Percentage of long-stay residents with improved mobility.
  - Percentage of One-Star Category Target Number recruited for Collaborative I.
  - Sum of Percentages of One-Star Category Target Number recruited for Collaboratives I and II.
  - Percentage of Recruitment Target Number recruited for Collaborative I.
  - Sum of percentages of Recruitment Target Number recruited for Collaboratives I and II.
  - NNHQCC Quality Composite Measure Score.
- C.3. Coordination of Care
  - Percentage of interventions implemented (for a minimum of 6 months) that show improvement (for a minimum of 5 interventions across the region annually).
  - Percentage of 30-day readmissions per 1,000 Fee-for-Service (FFS) beneficiaries in region-wide coalition.
  - Percentage of admissions per 1,000 FFS beneficiaries in region-wide coalition.
  - Percentage of region-wide readmissions per 1,000 FFS beneficiaries.
  - Percentage of adverse drug events per 1,000 screened beneficiaries.
  - Increased community tenure in region-wide coalition. ''Community tenure'' is defined as the number of days beneficiaries spend in their home setting.
- D.1. Quality Improvement through Physician Value-Based Modifiers
  - Percentage of eligible physicians/physician groups attending QIO-convened forums related to the Value Modifier (VM) Program.
  - Percentage of eligible physicians/physician groups that demonstrate improvement in quality-of-care measures (per Quality and Resource Use Reports) after receiving TA from QIOs.
  - Percentage of eligible ASCs that demonstrate improvement in quality-of-care measures (per Ambulatory Surgical Center Quality Reporting) after receiving TA from QIOs.
  - Percentage of eligible IPFs that demonstrate improvement in quality-of-care measures (per Inpatient Psychiatric Facility Quality Reporting) after receiving TA from QIOs.
  - Percentage of eligible CAHs that demonstrate improvement in quality-of-care measures (per Inpatient Quality Reporting or Outpatient Quality Reporting (OQR)) after receiving TA from QIOs.
  - Percentage of eligible PCHs that demonstrate improvement in quality-of-care measures (per PPS-Exempt Cancer Hospital Quality Reporting) after receiving TA from QIOs.
  - Performance period median national measure rate on OQR measure as posted on Hospital Compare.
  - Percentage of eligible physicians/physician groups actively participating in VM that require technical assistance for electronic submission (Physician Quality Reporting System) and are successful in subsequent submissions.
  - Percentage of eligible physicians/eligible physician groups receiving payment adjustments through VM.
- E.1. Technical Assistance—Quality Improvement Initiatives (QIIs)
  - Percentage of QIIs initiated within 30 days of the receipt of the applicable referral or request for QII technical assistance.
  - Percentage of QIIs successfully resolved.

Achievement within each of the Tasks for each Task Order will be evaluated on an individual basis for appropriate contract action. Though, in general, evaluation of each Task will relate only to that area, we reserve the right to take appropriate contract action in the event of failure in multiple Task areas.

Overall Contract Evaluation

The results of the annual (12, 24, 36, 48th month) and 54th month evaluation periods, in addition to ongoing monitoring activities, will be used to determine how each QIN–QIO performed on the overall contract. Annual and 54th Month Evaluation Criteria are specifically defined in Attachment J–1(b) of the QIN–QIO SOW; the criteria for evaluating each deliverable under the contract and Task

Order No. 001 are identified in Attachment J.1(a) Schedule of Deliverables of the 11th SOW. Further, as indicated in Sections G.22 and G.29, the Contracting Officer will use the Contractor Performance Assessment Reporting System (CPARS) criteria in performing evaluations: Quality, Schedule/Timeliness, Cost/Price Control, Business Relations, Management, and Small Business. Performance on the evaluation criteria defined in Attachment J–1(b) will be considered for assessment of the Quality sub-factor for the CPARS assessment.

If we choose, we may notify the QIN–QIO of the intention not to renew the QIN–QIO contract, and inform the QIN–QIO of the QIN–QIO's rights under the current statute. Any failure at one or more of the annual or 54th month evaluations for any Task may result in the QIN–QIO receiving an adverse performance evaluation. Further, failure may impact on the QIN–QIO's ability to continue similar work in or eligibility for future QIO Program awards.

We reserve the right at any point, prior to the notification of our intention not to continue the option for a Task and/or to renew the contract, to revise measures or adjust the expected minimum thresholds for satisfactory performance or remove criteria from a Task evaluation protocol for any reason, including, but not limited to, data gathered based on experience with the amount of improvement achieved during the contract cycle or in pilot projects currently in progress, information gathered through evaluation of the QIN–QIO performance overall, or any unforeseen circumstances. Further, in accordance with standard contract procedures, we reserve the right at any time to discontinue all or part of one or more tasks for one or more states or territories in the QIN area or any other part of this contract regardless of QIN–QIO performance on the Task.

Rounding Rules

The rounding of results to assess the minimum performance criteria indicated in Section J, Attachment J.1(b) uses the following rules.

1. Interim Calculations

We will not round the interim results of calculations used to produce results. (For example, we will not round the results from steps used to calculate the criteria or result). For example, we will not first round baseline and re-measurement rates for the calculation of relative improvement.

2. Percentages/Proportions/Rates

Use conventional rounding ''round half up.'' For example, to round from the hundredth to the tenth digit, round using the tie-break rule of ''half-up.'' 5.45 will become 5.5 whereas 5.44 will become 5.4. Apply conventional rounding to one digit beyond that used to specify the criteria (for example, for whole numbers, to the tenths place). For example, for a criterion expressed as 5 percent, 4.46 percent rounds to 4.5 percent and 4.44 percent rounds to 4.4 percent.

3. Integers

For discrete numbers of units required for improvement, round to the more favorable (typically lower) integer with a minimum of one. We note that this method is applied selectively to special cases as indicated in Section J, Attachment J.1(b). This method is more than a rounding rule. We calculate a minimum performance target using the minimum performance criteria and the size of the re-measurement criteria. For example, for a minimum criteria of 95 percent and a re-measurement denominator of 10, $10 \times 0.95 = 9.5$, which is rounded down (the more favorable direction) to 9. For this example, if CMS specified use of the integer rounding rule for this measure, the minimum performance criteria of 95 percent would be met by achieving at least 9 cases given a re-measurement denominator count of size 10. If we do not specifically indicate that the integer rounding rule applied to this measure, the percentage rounding rule would be used.

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by the Office of Management and Budget.

Dated: June 3, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–18901 Filed 8–8–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects:

Title: Annual Report/ACF 204 (State MOE)—1 collection.

OMB No.: 0970–0248.

Description: The Administration for Children and Families (ACF) is requesting a three-year extension of the ACF–204 (Annual MOE Report). The report is used to collect descriptive program characteristics information on the programs operated by States and Territories in association with their Temporary Assistance for Needy Families (TANF) programs. All State and Territory expenditures claimed toward States and Territories MOE requirements must be appropriate, i.e., meet all applicable MOE requirements. The Annual MOE Report provides the ability to learn about and to monitor the nature of State and Territory expenditures used to meet States and Territories MOE requirements, and it is an important source of information about the different ways that States and Territories are using their resources to help families attain and maintain self-sufficiency. In addition, the report is used to obtain State and Territory program characteristics for ACFs annual report to Congress, and the report serves as a useful resource to use in Congressional hearings about how TANF programs are evolving, in assessing State the Territory MOE expenditures, and in assessing the need for legislative changes.

Respondents: The 50 States of the United States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.