Performance Green Buildings and provides advice regarding how the Office can accomplish its mission most effectively.

The *Portfolio Prioritization* task group is pursuing the motion of two committee members to ''propose a process for Federal agencies to consistently incorporate green building and resilience requirements into their capital investment criteria and strategies.'' The *Energy Use Index* task group is pursuing the motion of a committee member to ''develop guidelines for creating a new energy intensity metric [to reflect impacts of] densified facilities, centrally located workplace sites . . . and expansion of telework and hoteling.''

Both groups have met previously and had their work endorsed by the full Committee at its April 23, 2015 meeting. The conference calls will focus on how the task groups can further refine these motions into final consensus recommendations of each group to the full Committee, which will in turn decide whether to proceed with formal advice to GSA based upon these recommendations. Additional background information and updates will be posted on GSA's Web site at *http://www.gsa.gov/gbac.*

Dated: May 14, 2015.

Kevin Kampschroer,

Federal Director, Office of Federal High-Performance Green Buildings, General Services Administration.

[FR Doc. 2015–12210 Filed 5–19–15; 8:45 am]

BILLING CODE 6820–14–P

GOVERNMENT ACCOUNTABILITY OFFICE

Appointment to the Methodology Committee of the Patient-Centered Outcomes Research Institute (PCORI)

AGENCY: Government Accountability Office (GAO).

ACTION: Notice of appointment.

SUMMARY: The Methodology Committee assists PCORI in developing and updating methodological standards and guidance for comparative clinical effectiveness research. The Patient Protection and Affordable Care Act directs the Comptroller General to appoint up to 15 members to PCORI's Methodology Committee. This notice announces the appointment of a new member, Adam Wilcox, Ph.D., Director of Medical Informatics at Intermountain Healthcare in Salt Lake City, Utah.

DATES: The appointment is effective May 2015.

ADDRESSES: GAO: 441 G Street NW., Washington, DC 20548.

PCORI: 1828 L Street NW., Suite 900, Washington, DC 20036.

FOR MORE INFORMATION CONTACT: GAO: Office of Public Affairs, (202) 512–4800.

PCORI: Joe Selby, MD, MPH, (202) 827–7700.

[Sec. 6301, Pub. L. 111–148].

Gene L. Dodaro,

Comptroller General of the United States.

[FR Doc. 2015–11955 Filed 5–19–15; 8:45 am]

BILLING CODE 1610–02–M

GOVERNMENT ACCOUNTABILITY OFFICE

Appointments to the Health Information Technology (HIT) Policy Committee

AGENCY: Government Accountability Office (GAO).

ACTION: Notice of appointments.

SUMMARY: The American Recovery and Reinvestment Act requires the Comptroller General of the United States to appoint 13 of 20 members to the HIT Policy Committee. As of April 2015, new appointees to the HIT Policy Committee are Kathleen Blake, MD, MPH, an expert in health care quality measurement and reporting; Donna Cryer, JD, an advocate for patients or consumers; and Brent Snyder, Esq., a representative of health care providers.

DATES: Appointments are effective as of April 2015.

ADDRESSES: GAO: 441 G Street NW., Washington, DC 20548.

FOR MORE INFORMATION CONTACT: GAO: Office of Public Affairs, (202) 512–4800.

SUPPLEMENTARY INFORMATION:

More information about the new appointees is provided below. Kathleen Blake, MD, MPH, is Vice President for Performance Improvement at the American Medical Association (AMA) and resides in Chicago, Illinois, and Santa Fe, New Mexico. She was appointed to fill the health care quality measurement and reporting opening.

Donna Cryer, JD, is Founder and President of the Global Liver Institute in Washington, DC, which facilitates collaboration among patient advocates, policymakers, regulators, health systems, and payers to solve challenges to advancing liver health and treating liver diseases. She was appointed to fill the patients or consumers advocate opening.

Brent Snyder, Esq. is Chief Information Officer at Adventist Health System (AHS) and lives in Springfield, Tennessee. He was appointed to fill the representative of health care providers opening.

42 U.S.C. 300jj-12.

Gene L. Dodaro,

Comptroller General of the United States.

[FR Doc. 2015–11957 Filed 5–19–15; 8:45 am]

BILLING CODE 1610–02–M

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 changes to the currently approved information collection project: *''Medical Expenditure Panel Survey (MEPS) Household Component and the MEPS Medical Provider Component.''* 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 July 20, 2015.

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

Medical Expenditure Panel Survey (MEPS) Household Component (HC)

For over thirty years, results from the MEPS and its predecessor surveys (the 1977 National Medical Care Expenditure Survey, the 1980 National Medical Care Utilization and Expenditure Survey and the 1987 National Medical Expenditure Survey) have been used by OMB, DHHS, Congress and a wide number of health services researchers to analyze health care use, expenses and health policy.

Major changes continue to take place in the health care delivery system. The MEPS is needed to provide information about the current state of the health care system as well as to track changes over time. The MEPS permits annual estimates of use of health care and expenditures and sources of payment for that health care. It also permits tracking individual change in employment, income, health insurance and health status over two years. The use of the National Health Interview Survey (NHIS) as a sampling frame expands the MEPS analytic capacity by providing another data point for comparisons over time.

Households selected for participation in the MEPS–HC are interviewed five times in person. These rounds of interviewing are spaced about 5 months apart. The interview will take place with a family respondent who will report for him or herself and for other family members.

The goal of MEPS–HC is to provide nationally representative estimates for the U.S. civilian noninstitutionalized population for health care use, expenditures, sources of payment and health insurance coverage

Medical Expenditure Panel Survey (MEPS) Medical Provider Component (MPC)

The MEPS–MPC will contact medical providers (hospitals, physicians, home health agencies and institutions) identified by household respondents in the MEPS–HC as sources of medical care for the time period covered by the interview, and all pharmacies providing prescription drugs to household members during the covered time period. The MEPS–MPC is not designed to yield national estimates as a stand-alone survey. The sample is designed to target the types of individuals and providers for whom household reported expenditure data was expected to be insufficient. For example, Medicaid enrollees are targeted for inclusion in the MEPS–MPC because this group is expected to have limited information about payments for their medical care.

There is one addition to the MEPS–MPC being implemented in this renewal request, the MEPS MPC Medical Organizations Survey (MOS). The MEPS MOS will expand current MPC data collection activities to include information on the organization of the practices of office-based care providers identified as a usual source of care in the MEPS MPC. This additional data collection will be for a subset of office-based care providers already included in the MEPS MPC sample. In the MEPS MPC sample, for a nationally representative sample of adults, primary location for individual's office-based usual sources of care will be identified. The MEPS MPC will contact these places where medical care is provided, determine the appropriate respondent and administer a MEPS MOS. The design of the survey will be multimodal including some telephone contact. Additional data collection methods may include phone, fax, mail, self-administration, electronic transmission, and the Web. The data collection method chosen for a provider shall be the method that results in the most complete and accurate data with least burden to the provider.

The MEPS–MPC collects event level data about medical care received by sampled persons during the relevant time period. The data collected from medical providers include:

- Dates on which medical encounters during the reference period occurred
- Data on the medical content of each encounter, including ICD–9 (or ICD–10) and CPT–4 codes
- Data on the charges associated with each encounter, the sources paying for the medical care. including the patient/family, public sources, and private insurance, and amounts paid by each source

Data collected from pharmacies include:

- Date of prescription fill.
- National drug code (NDC) or prescription name, strength and form.
- Quantity.
- Payments, by source.

The MEPS–MPC has the following goal:

- To serve as an imputation source for and to supplement/replace household reported expenditure and source of payment information. This data will supplement, replace and verify information provided by household respondents about the charges, payments, and sources of payment associated with specific health care encounters.

This study is being conducted by AHRQ through its contractors, Westat and RTI International, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the delivery of such care, including activities with respect to the cost and use of health care services and with respect to health statistics and surveys. 42 U.S.C. 299a(a)(3) and (8); 42 U.S.C. 299b–2.

Method of Collection

To achieve the goals of the MEPS–HC the following data collections are implemented:

1. Household Component Core Instrument. The core instrument collects data about persons in sample households. Topical areas asked in each round of interviewing include condition enumeration, health status, health care utilization including prescribed medicines, expense and payment, employment, and health insurance. Other topical areas that are asked only once a year include access to care, income, assets, satisfaction with health plans and providers, children's health, and adult preventive care. While many of the questions are asked about the entire reporting unit (RU), which is typically a family, only one person normally provides this information. All sections of the current core instrument are available on the AHRQ Web site at *http://meps.ahrq.gov/mepsweb/survey_comp/survey_questionnaires.jsp.*

2. Adult Self-Administered Questionnaire. A brief self-administered questionnaire will be used to collect self-reported (rather than through household proxy) information on health status, health opinions and satisfaction with health care for adults 18 and older (see *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#supplemental*). The satisfaction with health care items are a subset of items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The health status items are from the Short Form 12 Version 2 (SF–12 version 2), which has been widely used as a measure of self-reported health status in the United States, the Kessler Index (K6) of non-specific psychological distress, and the Patient Health Questionnaire (PHQ–2). This questionnaire is unchanged from the previous OMB clearance.

3. Diabetes Care Self Administered Questionnaire. A brief self-administered paper-and-pencil questionnaire on the quality of diabetes care is administered once a year (during round 3 and 5) to persons identified as having diabetes. Included are questions about the number of times the respondent reported having a hemoglobin A1c blood test, whether the respondent reported having his or her feet checked for sores or irritations, whether the respondent reported having an eye exam in which the pupils were dilated, the last time the respondent had his or her blood cholesterol checked and whether the diabetes has caused kidney or eye problems. Respondents are also asked if their diabetes is being treated with diet, oral medications or insulin. This questionnaire is unchanged from the previous OMB clearance. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#supplemental.*

4. Authorization forms for the MEPS–MPC Provider and Pharmacy Survey. As in previous panels of the MEPS, we will ask respondents for authorization to obtain supplemental information from their medical providers (hospitals, physicians, home health agencies and institutions) and pharmacies. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC_AF* for the pharmacy and provider authorization forms.

5. MEPS Validation Interview. Each interviewer is required to have at least 15 percent of his/her caseload validated to insure that computer-assisted personal interview (CAPI) questionnaire content was asked appropriately and procedures followed, for example the use of show cards. Validation flags are set programmatically for cases pre-selected by data processing staff before each round of interviewing. Home office and field management may also request that other cases be validated throughout the field period. When an interviewer fails a validation all their work is subject to 100 percent validation. Additionally, any case completed in less than 30 minutes is validated. A validation abstract form containing selected data collected in the CAPI interview is generated and used by the validator to guide the validation interview.

To achieve the goal of the MEPS–MPC the following data collections are implemented:

1. MPC Contact Guide/Screening Call. An initial screening call is placed to determine the type of facility, whether the practice or facility is in scope for the MEPS–MPC, the appropriate MEPS–MPC respondent and some details about the organization and availability of medical records and billing at the practice/facility. All hospitals, physician offices, home health agencies, institutions and pharmacies are screened by telephone. A unique screening instrument is used for each of these seven provider types in the MEPS–MPC, except for the two home care provider types which use the same screening form; see *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC_CG.*

2. Home Care Provider Questionnaire for Health Care Providers. This questionnaire is used to collect data from home health care agencies which provide medical care services to household respondents. Information collected includes type of personnel providing care, hours or visits provided per month, and the charges and payments for services received. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

3. Home Care Provider Questionnaire for Non-Health Care Providers. This questionnaire is used to collect information about services provided in the home by non-health care workers to household respondents because of a medical condition; for example, cleaning or yard work, transportation, shopping, or child care. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

4. Medical Event Questionnaire for Office-Based Providers. This questionnaire is for office-based physicians, including doctors of medicine (MDs) and osteopathy (DOs), as well as providers practicing under the direction or supervision of an MD or DO (*e.g.,* physician assistants and nurse practitioners working in clinics). Providers of care in private offices as well as staff model HMOs are included. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

5. Medical Event Questionnaire for Separately Billing Doctors. This questionnaire collects information from physicians identified by hospitals (during the Hospital Event data collection) as providing care to sampled persons during the course of inpatient, outpatient department or emergency room care, but who bill separately from the hospital. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

6. Hospital Event Questionnaire. This questionnaire is used to collect information about hospital events, including inpatient stays, outpatient department, and emergency room visits. Hospital data are collected not only from the billing department, but from medical records and administrative records departments as well. Medical records departments are contacted to determine the names of all the doctors who treated the patient during a stay or visit. In many cases, the hospital administrative office also has to be contacted to determine whether the doctors identified by medical records billed separately from the hospital itself; the doctors that do bill separately from the hospital will be contacted as part of the Medical Event Questionnaire for Separately Billing Doctors. HMOs are included in this provider type. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

7. Institutions Event Questionnaire. This questionnaire is used to collect information about institution events, including nursing homes, rehabilitation facilities and skilled nursing facilities. Institution data are collected not only from the billing department, but from medical records and administrative records departments as well. Medical records departments are contacted to determine the names of all the doctors who treated the patient during a stay. In many cases, the institution administrative office also has to be contacted to determine whether the doctors identified by medical records billed separately from the institution itself. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC*).

8. Pharmacy Data Collection Questionnaire. This questionnaire requests the national drug code (NDC) and when that is not available the prescription name, date prescription was filled, payments by source, prescription strength and form (when the NDC is not available), quantity, and person for whom the prescription was filled. When the NDC is available, we do not ask for prescription name, strength or form because that information is embedded in the NDC; this reduces burden on the respondent. Most pharmacies have the requested information available in electronic format and respond by providing a computer generated printout of the patient's prescription information. If the computerized form is unavailable, the pharmacy can report their data to a telephone interviewer. Pharmacies are also able to provide a CD–ROM with the requested information if that is preferred. HMOs are included in this provider type. See *http://meps.ahrq.gov/mepsweb/survey_comp/survey.jsp#MPC.*

9. Medical Organizations Survey Questionnaire. This questionnaire will collect essential information on important features of the staffing, organization, policies, and financing for identified usual source of office based care providers. This additional data collection will be a subset of office based care providers already included in the MEPS MPC sample and will be a nationally representative sample of adults' primary location for individuals office based usual sources of care.

Dentists, optometrists, psychologists, podiatrists, chiropractors, and others not providing care under the supervision of a MD or DO are considered out of scope for the MEPS–MPC.

The MEPS is a multi-purpose survey. In addition to collecting data to yield annual estimates for a variety of measures related to health care use and expenditures, MEPS also provides estimates of measures related to health status, consumer assessment of health care, health insurance coverage, demographic characteristics, employment and access to health care indicators. Estimates can be provided

for individuals, families and population subgroups of interest. Data obtained in this study are used to provide, among others, the following national estimates:

- Annual estimates of health care use and expenditures for persons and families.
- Annual estimates of sources of payment for health care utilizations, including public programs such as Medicare and Medicaid, private insurance, and out of pocket payments.
- Annual estimates of health care use, expenditures and sources of payment of persons and families by type of utilization including inpatient stay, ambulatory care, home health, dental care and prescribed medications.
- The number and characteristics of the population eligible for public programs including the use of services and expenditures of the population(s) eligible for benefits under Medicare and Medicaid.
- The number, characteristics, and use of services and expenditures of persons and families with various forms of insurance.
- Annual estimates of consumer satisfaction with health care, and indicators of health care quality for key conditions.
- Annual estimates to track disparities in health care use and access.

In addition to national estimates, data collected in this ongoing, longitudinal study are used to study the determinants of the use of services and expenditures, and changes in the access to and the provision of health care in relation to:

- Socio-economic and demographic factors such as employment or income.
- The health status and satisfaction with health care of individuals and families.
- The health needs and circumstances of specific subpopulation groups such as the elderly and children.

To meet the need for national data on health care use, access, cost and quality, MEPS–HC collects information on:

- Access to care and barriers to receiving needed care.
- Satisfaction with usual providers.
- Health status and limitations in activities.
- Medical conditions for which health care was used.
- Use, expense and payment (as well as insurance status of person receiving care) for health services.

Given the twin problems of nonresponse and response error of some household reported data, information is collected directly from medical providers in the MEPS–MPC to improve the accuracy of expenditure estimates derived from the MEPS–HC. Because of their greater level of precision and detail, we also use MEPS–MPC data as the main source of imputations of missing expenditure data. Thus, the MEPS–MPC is designed to satisfy the following analytical objectives:

- Serve as source data for household reported events with missing expenditure information.
- Serve as an imputation source to reduce the level of bias in survey estimates of medical expenditures due to item nonresponse and less complete and less accurate household data.
- Serve as the primary data source for expenditure estimates of medical care provided by separately billing doctors in hospitals, emergency rooms, and outpatient departments, Medicaid recipients and expenditure estimates for pharmacies.
- Allow for an examination of the level of agreement in reported expenditures from household respondents and medical providers.

Data from the MEPS, both the HC and MPC components, are intended for a number of annual reports produced by AHRQ, including the National Healthcare Quality and Disparities Report.

The MEPS MPC MOS data will be used to create a database that will be unique in providing an internally consistent source of information both on individuals' characteristics and health care utilization and expenditures, and on the characteristics of the providers they use. The following areas will be addressed in the MOS as they potentially affect individuals' access to, use of and affordability of health care services:

- Organizational characteristics, *e.g.,* size, specialties covered, practice rules and procedures, patient mix and scope of care provided, membership in an ACO, certification as a primary care medical home.
- Use of health information technology.
- Policies and practices related to the ACA.
- Financial arrangements, *e.g.,* reimbursement methods, number and types of insurance contracts, compensation arrangements within the practice.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondents' time to participate in the MEPS–HC and the MEPS–MPC. The MEPS–HC Core Interview will be completed by 15,093 * (see note below Exhibit 1) ''family level'' respondents, also referred to as RU respondents. Since the MEPS–HC consists of 5 rounds of interviewing covering a full two years of data, the annual average number of responses per respondent is 2.5 responses per year. The MEPS–HC core requires an average response time of 92 minutes to administer. The Adult SAQ will be completed once a year by each person in the RU that is 18 years old and older, an estimated 28,254 persons. The Adult SAQ requires an average of 7 minutes to complete. The Diabetes care SAQ will be completed once a year by each person in the RU identified as having diabetes, an estimated 2,345 persons, and takes about 3 minutes to complete. The authorization form for the MEPS–MPC Provider Survey will be completed once for each medical provider seen by any RU member. The 14,489 RUs in the MEPS–HC will complete an average of 5.4 forms, which require about 3minutes each to complete. The authorization form for the MEPS–MPC Pharmacy Survey will be completed once for each pharmacy for any RU member who has obtained a prescription medication. RUs will complete an average of 3.1 forms, which take about 3 minutes to complete. About one third of all interviewed RUs will complete a validation interview as part of the MEPS–HC quality control, which takes an average of 5 minutes to complete. The total annual burden hours for the MEPS–HC are estimated to be 67,826 hours.

All medical providers and pharmacies included in the MEPS–MPC will receive a screening call and the MEPS–MPC uses 7 different questionnaires; 6 for medical providers and 1 for pharmacies. Each questionnaire is relatively short and requires 2 to 19 minutes to complete. The total annual burden hours for the MEPS–MPC are estimated to be 18,876 hours. The total annual burden for the MEPS–HC and MPC is estimated to be 86,702 hours.

Exhibit 2 shows the estimated annual cost burden associated with the respondents' time to participate in this information collection. The annual cost burden for the MEPS–HC is estimated to be $1,680,727; the annual cost burden for the MEPS–MPC is estimated to be $299,477. The total annual cost burden for the MEPS–HC and MPC is estimated to be $1,980,204.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
MEPS–HC				
MEPS–HC Core Interview	*15,093	2.5	92/60	57,857
Adult SAQ	28,254	1	7/60	3,296
Diabetes care SAQ	2,345	1	3/60	117
Authorization form for the MEPS–MPC Provider Survey	14,489	5.4	3/60	3,912
Authorization form for the MEPS–MPC Pharmacy Survey	14,489	3.1	3/60	2,246
MEPS–HC Validation Interview	4,781	1	5/60	398
Subtotal for the MEPS–HC	79,451	Na	na	67,826
MEPS–MPC/MOS				
MPC Contact Guide/Screening Call**	35,222	1	2/60	1,174
Home care for health care providers questionnaire	532	1.49	9/60	119
Home care for non-health care providers questionnaire	25	1	11/60	5
Office-based providers questionnaire	11,785	1.44	10/60	2,828
Separately billing doctors questionnaire	12,693	3.43	13/60	9,433
Hospitals questionnaire	5,077	3.51	9/60	2,673
Institutions (non-hospital) questionnaire	117	2.03	9/60	36
Pharmacies questionnaire	4,993	4.44	3/60	1,108
Medical Organizations Survey questionnaire	6,000	1	15/60	1,500
Subtotal for the MEPS–MPC	76,444	na	na	18,876
Grand Total	155,895	na	na	86,702

*While the expected number of responding units for the annual estimates is 14,489, it is necessary to adjust for survey attrition of initial respondents by a factor of 0.96 (15,093 = 14,489/0.96).

**There are 6 different contact guides; one for office based, separately billing doctor, hospital, institution, and pharmacy provider types, and the two home care provider types use the same contact guide.

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate	Total cost burden
MEPS–HC				
MEPS–HC Core Interview	15,093	57,857	*$24.78	1,433,696
Adult SAQ	28,254	3,296	24.78	81,675
Diabetes care SAQ	2,345	117	24.78	2,899
Authorization forms for the MEPS–MPC Provider Survey	14,489	3,912	24.78	96,939
Authorization form for the MEPS–MPC Pharmacy Survey	14,489	2,246	24.78	55,656
MEPS–HC Validation Interview	4,781	398	24.78	9,862
Subtotal for the MEPS–HC	79,451	67,826	Na	$1,680,727
MEPS–MPC/MOS				
MPC Contact Guide/Screening Call	35,222	1,174	**$15.93	18,702
Home care for health care providers questionnaire	532	119	**$15.93	1,896
Home care for non-health care providers questionnaire	25	5	**$15.93	$80
Office-based providers questionnaire	11,785	2,828	**$15.93	$45,050
Separately billing doctors questionnaire	12,693	9,433	**$15.93	$150,268
Hospitals questionnaire	5,077	2,673	**$15.93	$42,581
Institutions (non-hospital) questionnaire	117	36	**15.93	$573
Pharmacies questionnaire	4,993	1,108	**14.83*	$16,432
Medical Organizations Survey questionnaire	6,000	1,500	**15.93	$23,895
Subtotal for the MEPS–MPC	76,444	18,876	na	$299,477
Grand Total	155,895	86,073	na	$1,980,204

*Mean hourly wage for All Occupations (00–0000).
**Mean hourly wage for Medical Secretaries (43–6013).
***Mean hourly wage for Pharmacy Technicians (29–2052).

Occupational Employment Statistics, May 2013 National Occupational Employment and Wage Estimates United States, U.S. Department of Labor, Bureau of Labor Statistics. *http://www.bls.gov/oes/current/oes_nat.htm#b29-0000.*

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 health care research and health care 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.

Sharon B. Arnold,

Deputy Director.

[FR Doc. 2015–12229 Filed 5–19–15; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Docket No. CDC–2015–0016]

Proposed Revised Vaccine Information Materials for Seasonal Influenza Vaccines

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice with comment period.

SUMMARY: Under the National Childhood Vaccine Injury Act (NCVIA) (42 U.S.C. 300aa–26), the Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services (HHS) develops vaccine information materials that all health care providers are required to give to patients/parents prior to administration of specific vaccines. HHS/CDC seeks written comment on the proposed updated vaccine information statements for inactivated and live attenuated influenza vaccines.

DATES: Written comments must be received on or before July 20, 2015.

ADDRESSES: You may submit comments, identified by Docket No. CDC–2015–0016, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Written comments should be addressed to Suzanne Johnson-DeLeon (*msj1@cdc.gov*), National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, Mailstop A–19, 1600 Clifton Road NE., Atlanta, Georgia 30329.

Instructions: All submissions received must include the agency name and docket number. All relevant comments received will be posted without change to *http://regulations.gov,* including any personal information provided. For access to the docket to read background documents or comments received, go to *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Skip Wolfe (*crw4@cdc.gov*), National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, Mailstop A–19, 1600 Clifton Road NE., Atlanta, Georgia 30329.

SUPPLEMENTARY INFORMATION: The National Childhood Vaccine Injury Act of 1986 (Pub. L. 99–660), as amended by section 708 of Public Law 103–183, added section 2126 to the Public Health Service Act. Section 2126, codified at 42 U.S.C. 300aa-26, requires the Secretary of Health and Human Services to develop and disseminate vaccine information materials for distribution by all health care providers in the United States to any patient (or to the parent or legal representative in the case of a child) receiving vaccines covered under the National Vaccine Injury Compensation Program (VICP).

Development and revision of the vaccine information materials, also known as Vaccine Information Statements (VIS), have been delegated by the Secretary to the Centers for Disease Control and Prevention (CDC). Section 2126 requires that the materials be developed, or revised, after notice to the public, with a 60-day comment period, and in consultation with the Advisory Commission on Childhood Vaccines, appropriate health care provider and parent organizations, and the Food and Drug Administration. The law also requires that the information contained in the materials be based on available data and information, be presented in understandable terms, and include:

(1) A concise description of the benefits of the vaccine,

(2) A concise description of the risks associated with the vaccine,

(3) A statement of the availability of the National Vaccine Injury Compensation Program, and

(4) Such other relevant information as may be determined by the Secretary.

The vaccines initially covered under the National Vaccine Injury Compensation Program were diphtheria, tetanus, pertussis, measles, mumps, rubella and poliomyelitis vaccines. Since April 15, 1992, any health care provider in the United States who intends to administer one of these covered vaccines is required to provide copies of the relevant vaccine information materials prior to administration of any of these vaccines. Since then, the following vaccines have been added to the National Vaccine Injury Compensation Program, requiring use of vaccine information materials for them as well: Hepatitis B, *Haemophilus influenzae* type b (Hib), varicella (chickenpox), pneumococcal conjugate, rotavirus, hepatitis A, meningococcal, human papillomavirus (HPV), and seasonal influenza vaccines. Instructions for use of the vaccine information materials are found on the CDC Web site at: *http://www.cdc.gov/vaccines/hcp/vis/index.html.*

HHS/CDC is proposing updated versions of the inactivated and live attenuated seasonal influenza vaccine information statements.

The vaccine information materials referenced in this notice are being developed in consultation with the Advisory Commission on Childhood Vaccines, the Food and Drug Administration, and parent and health care provider groups.

We invite written comment on the proposed vaccine information materials entitled ''Influenza (Flu) Vaccine (Inactivated or Recombinant): What you need to know'' and ''Influenza (Flu) Vaccine (Live, Intranasal): What you need to know.'' Copies of the proposed vaccine information materials are available at *http://www.regulations.gov* (see Docket Number CDC–2015–0016). Comments submitted will be considered in finalizing these materials. When the final materials are published in the **Federal Register**, the notice will include an effective date for their mandatory use.

Dated: May 14, 2015.

Ron A. Otten,

Acting Deputy Associate Director for Science, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Docket No. CDC–2015–0014]

Proposed Revised Vaccine Information Materials for Pneumococcal Conjugate Vaccine (PCV13)

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice with comment period.

SUMMARY: Under the National Childhood Vaccine Injury Act (NCVIA) (42 U.S.C. 300aa–26), the Centers for