Agency and its customers and stakeholders. It will also allow feedback to contribute directly to the improvement of program management.

Collecting voluntary customer feedback is the least burdensome, most effective way for the Agency to determine whether or not its public Web sites are useful to and used by its customers. Generic clearance is needed to ensure that the Agency can continuously improve its Web sites though regular surveys developed from these pre-defined questions. Surveying the Agency Web sites on a regular, ongoing basis will help ensure that users have an effective, efficient, and satisfying experience on any of the Web sites, maximizing the impact of the information and resulting in optimum benefit for the public. The surveys will ensure that this communication channel meets customer and partner priorities, builds the Agency's brands, and contributes to the Agency's health and human services impact goals. *Form Number:* CMS–10415 (OCN 0938—New); *Frequency:* Occasionally; *Affected Public:* Individuals and Households, Business or other for-profits and Not-for-profit institutions, State, Local or Tribal Governments; *Number of Respondents:* 1,000,000; *Total Annual Responses:* 1,000,000; *Total Annual Hours:* 67,000. (For policy questions regarding this collection contact John Booth at 410–786–6577. 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 28, 2012. OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, Email: *OIRA_submission@omb.eop.gov*.

Dated: May 22, 2012.

Martique Jones,

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

[FR Doc. 2012–12811 Filed 5–25–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services (CMS)

[CMS–2382–N]

Medicaid Program; Announcement of Requirements and Registration for CMS Provider Screening Innovator Challenge

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

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS), is announcing the launch of the ''CMS Provider Screening Innovator Challenge.'' This Challenge is sponsored by CMS and is presented as part of the Partnership for Program Integrity Innovation program, and will be administered by the National Aeronautic and Space Administration's (NASA) Federal Center of Excellence for Collaborative Innovation. This Challenge addresses our goals of improving our abilities to streamline operations, screen providers, and reduce fraud and abuse. Specifically, the challenge is an innovation competition to develop a multi-State, multi-program provider screening software application which would be capable of risk scoring, credentialing validation, identity authentication, and sanction checks, while lowering burden on providers and reducing administrative and infrastructure expenses for States and Federal programs. More information pertaining to the Medicaid and CHIP programs can be found at *www.medicaid.gov.*

DATES: Important dates concerning the Challenge include the following:

Challenge Competition Begin: 6:00 p.m., e.d.t., May 30, 2012.

Challenge Competition End: To be determined, but expected to be completed by October/November 2012 timeframe.

FOR FURTHER INFORMATION CONTACT: John ''Chip'' Garner, 410–786–3012.

SUPPLEMENTARY INFORMATION:

Subject of Challenge Competition

Entrants are asked to develop artifacts and components of software applications that can be integrated into an open source solution that can deliver a reliable, scalable, and cost-effective provider-screening capability for multiple States (or for the nation).

We expect the winning entry to exhibit the following characteristics:

1. Reduced processing and transaction time for submitting and receiving queries to authoritative data sources regarding provider credentials and sanctions.

2. Reductions in time needed by providers to submit information and resolve discrepancies.

3. Administrative/infrastructure savings from a multi-tenant provider screening solution.

4. Improved availability of key provider data relevant for program participation and oversight.

5. Improved timeliness and accuracy in provider participation, oversight, and enrollment decisions.

6. Improved ability to implement sections 1902(a)(39) and 1902(a)(77) of the Social Security Act, as amended by the Patient Protection and Affordable Care Act (Pub. L. 111–148 and 111–152) subsections 6401(b) and (c) (Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid, and CHIP), and section 6501 (Termination of Provider Participation Under Medicaid if Terminated by Medicare or Other State Plan).

7. Assist in better driving alignment of the Medicaid Information Technology Architecture (MITA) 3.0 framework to the Information and Technology Architecture levels. More information pertaining to MITA can be found at the following Web site: *www.medicaid.gov/Medicaid-CHIP–Program-Information/By-Topics/Data-and-Systems/Medicaid-Information-Technology-Architecture-MITA.html.*

General Eligibility Rules for Participating in the Competition

To be eligible to win a prize under this Challenge, an individual or entity must comply with all the requirements under this section.

An individual or entity shall not be deemed ineligible solely because the individual or entity used Federal facilities or consulted with Federal employees during a competition if such facilities and employees are made available to all individuals and entities participating in the competition on an equitable basis.

A Federal entity or Federal employee acting within the scope of his or her employment is not eligible to participate. A Federal employee seeking to participate in this competition outside the scope of his/her employment should consult his/her ethics official prior to developing the submission. Employees of CMS, the Challenge judges, and employees of any other company or individual involved with the design, production, execution, or distribution of the Challenge, along with such employees' or judges' immediate families (spouse, parents and

step-parents, siblings and step-siblings, and children and step-children) and household members (people who share the same residence at least three (3) months out of the year) are not eligible to participate.

Regarding Registration Process for Participants, interested persons should read the Official Rules and register at the Center of Excellence for Collaborative Innovation Challenge portal: *http://community.topcoder.com/coeci/.* Registration is free and can be completed at any time before an entry is submitted in response to a particular competition.

Amount of the Prize

Based on our current assumptions, we estimate that the total prize amount for the competitions conducted as part of this Challenge will fall between $500,000 and $600,000.

Basis Upon Which Winner Will Be Selected

Challenge competition entries will be judged by an expert panel composed of CMS program staff. Judges shall be named after commencement of the Challenge. Competitions will be judged based upon both subjective and objective criteria. Should the highest-scoring submitted solution be missing requirements or otherwise need modification, it will enter a remediation/fix phase. Projects are posted and administered through a personalized, web-based administration tool. All projects progress, with some variance, through a sequence of phases from Registration to Submission to Screening to Review to Final Fixes. Submissions will be screened to ensure they meet minimum requirements for the project and do not include forbidden material. Competition submissions with subjectively evaluated components (for example, graphical design, workflow, GUI layout, etc.) are anonymized and evaluated by the Judges. Submissions with objectively scored components, such as projects (for example, architecture, development, etc.) are scored by the Judges by their fidelity to exact, enumerated requirements.

Overall, the solution must, at a minimum, meet the following criteria:

1. Capability to Conduct Identity Verification.

a. Capability to link individuals to their organizations and vice versa.

b. Capability to match on multiple variations of an individual's or organization's name to ensure that the correct entity is verified.

c. Ability to apply a range of screening rules to cross check data elements within the enrollment application.

d. Ability to apply a range of screening rules to cross check data elements against authoritative external sources for consistency.

e. Capability to establish and employ a graded screening methodology that escalates the intensity of screening for providers that are flagged as higher risk (that is, Report Card Methodology).

2. Capability to Build Provider Profiles.

a. Capability to retain screening and enrollment information and results, and compare against past and future screening results.

b. Capability to create a watch list to ensure that providers that are suspected or known to be fraudulent are flagged at the time of screening.

c. Capability to track re-enrollment attempts to ensure that slight changes to provider information are not considered a new enrollment.

d. Capability to revalidate periodically to ensure that changes in provider profiles are updated on a regular basis.

e. Capability to leverage public Web sites to conduct link analysis through which provider associations could be explored, and alerts posted on similar Web sites could be considered.

f. Capability to capture critical attributes

- Collection of application fees status.
- Exception waiver approved status.
- Incorporating enhanced screening data, including the results of site visits, criminal background checks, and finger printing.
- Capturing licensing information, financial data, and any other data attributes which could impact a risk lever.
- Other critical attributes.

g. Capability to achieve real time screening, scoring, and system outputs (queries/reports).

3. Capability to Evaluate and Maintain the Integrity of the Results.

a. Capability to persist data sources scores to determine the most reliable source for each data element.

b. Capability to evaluate data sources for reliability and accuracy.

c. Capability to create a learning system to ensure that observed negative trends factor back into screening rules so as to flag suspicious enrollments early in the screening process, ensuring the ability to detect and reduce/eliminate the incidence of false positives.

d. Capability to create system outputs to assign reasons/explanations to each code or score used.

e. Capability to build processes to allow for appropriate interpretation and action on screening and scoring results.

f. Capability to ensure that each rule is tested and its impact is evaluated prior to implementing.

4. Improves Efficiency.

a. Capability to allow searches to find specific provider information with minimal search attempts.

b. Capability to identify applicants, including individual providers and owners of institutional providers.

c. Capability to verify identity and prior history of problems with Medicaid/CHIP or Medicare programs.

d. Capability to identify and schedule revalidation process.

5. Meets Architectural Guidelines.

a. Adheres to the Architectural Guidance and meets the seven conditions and standards detailed in the Guidance for Exchange and Medicaid IT Systems, Version 2.0, located at: *http://www.medicaid.gov/Medicaid-CHIP–Program-Information/By-Topics/Data-and-Systems/Downloads/exchangemedicaiditguidance.pdf.*

b. Integrates into the MITA Framework—Is MITA Compliant. Information regarding MITA can be found at: *http://www.cms.gov/MedicaidInfoTechArch/.*

6. Accurate, Cost Effective, and Timely.

a. Turnaround time for performing automated checks typical for a web-based system.

b. Comprehensive verification of all data fields for all providers enrolled.

c. Efficiency of the Screening Solution in terms of cost and schedule to actually implement: Potential extra costs (for example, licenses, etc.) are documented.

d. Effectiveness of the risk-screening model in detecting fraud based issues.

e. Technical soundness of risk-scoring in flagging potential fraudulent patterns and tendencies.

Additional Information

CMS is one of the principal agencies dedicated to protecting the health of citizens by making our world healthier, safer, and better for all Americans. For more information, see *www.cms.gov.*

General Conditions

CMS reserves the right to cancel, suspend, and/or modify the Competition, or any part of it, for any reason, at CMS' sole discretion.

Authority: This competition is administrated by the Federal Center of Excellence for Collaborative Innovation through a partnership between CMS and NASA. The partnership is in accordance with the National Aeronautics and Space Act (51 U.S.C. 20113(e)) and The Economy Act (31 U.S.C. 1535).

Dated: May 4, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012–12633 Filed 5–25–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1441–N]

Medicare Program; Public Meeting in Calendar Year 2012 for New Clinical Laboratory Tests Payment Determinations

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

ACTION: Notice.

SUMMARY: This notice announces a public meeting to receive comments and recommendations from the public on the appropriate basis for establishing payment amounts for new or substantially revised Healthcare Common Procedure Coding System (HCPCS) codes being considered for Medicare payment under the clinical laboratory fee schedule (CLFS) for calendar year (CY) 2013.

DATES: *Meeting Dates:* The public meeting is scheduled for Monday, July 16, 2012, from 9:00 a.m. to 5:00 p.m., and Tuesday, July 17, 2012, from 9:00 a.m. to 12:00 p.m. All times are Eastern Daylight Savings Time.

Deadline for Registration of Presenters: All presenters for the public meeting must register by July 6, 2012.

Deadline for Written/Electronic Presentations: Written presentations must also be electronically submitted to on or before July 6, 2012.

Deadline for Submitting Requests for Special Accommodations: Requests for special accommodations must be received no later than 5:00 p.m., on July 6, 2012.

Deadline for Submission of Written Comments: Interested parties may submit written comments on the proposed payment determinations by September 28, 2012, to the address specified in the **ADDRESSES** section of this notice.

ADDRESSES: The public meeting will be held in the main auditorium of the central building of the Centers for Medicare & Medicaid Services (CMS), 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

FOR FURTHER INFORMATION CONTACT: Glenn McGuirk, (410) 786–5723.

SUPPLEMENTARY INFORMATION:

I. Background

Section 531(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) requires the Secretary to establish procedures for coding and payment determinations for new clinical diagnostic laboratory tests under Part B of title XVIII of the Social Security Act (the Act) that permit public consultation in a manner consistent with the procedures established for implementing coding modifications for International Classification of Diseases (ICD–9–CM). The procedures and public meeting announced in this notice for new tests are in accordance with the procedures published in the **Federal Register** on November 23, 2001 (66 FR 58743), to implement section 531(b) of BIPA.

Section 942(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) added section 1833(h)(8) of the Act. Section 1833(h)(8)(A) of the Act requires the Secretary to ''establish by regulation procedures for determining the basis for, and amount of, payment for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005'' (hereinafter referred to as, ''new test''). A code is considered to be ''substantially revised'' if ''there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).'' (See section 1833(h)(8)(E)(ii) of the Act.)

Section 1833(h)(8)(B) of the Act sets forth the process for determining the basis for, and the amount of, payment for new tests. Section 1833(h)(8)(B)(i) and (ii) of the Act requires the Secretary to—(1) ''make available to the public (through an Internet Web site and other appropriate mechanisms)a list that includes any such test for which establishment of a payment amount is being considered for a year''; and (2) ''on the same day such list is made available, causes to have published in the **Federal Register** notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis * * * for establishing payment amounts for the tests on such list.'' The list of codes for which the establishment of a payment amount under the CLFS is being considered for CY 2013 is posted on our Web site at *http://www.cms.hhs.gov/ClinicalLabFeeSched*.

Section 1833(h)(8)(B)(iii) of the Act requires that we convene a public meeting not less than 30 days after publication of the notice in the **Federal Register**. These requirements are codified at 42 CFR part 414, subpart G.

Two methods are used to establish payment amounts for new tests. The first method called ''crosswalking'' is used when a new test is determined to be comparable to an existing test, multiple existing test codes, or a portion of an existing test code. The new test code is assigned to the local fee schedule amounts and the national limitation amount of the existing test. Payment for the new test is made at the lesser of the local fee schedule amount or the national limitation amount. (See § 414.508(a).)

The second method called ''gapfilling'' is used when no comparable existing test is available. When using this method, instructions are provided to each Medicare carrier or Part A and Part B Medicare Administrative Contractor (MAC) to determine a payment amount for its carrier geographic area(s) for use in the first year. The carrier-specific amounts are established for the new test code using the following sources of information, if available: charges for the test and routine discounts to charges; resources required to perform the test; payment amounts determined by other payers; and charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant. In the second year, the test code is paid at the national limitation amount, which is the median of the carrier-specific amounts. (See § 414.508(b).)

II. Proposals in the CY 2013 Physician Fee Schedule Proposed Rule

We are following our process to determine the appropriate basis and payment amount for new test codes under the CLFS for CY 2013. Some of these tests are molecular pathology tests. Stakeholders in the molecular pathology community continue to debate whether Medicare should pay for molecular pathology tests under the CLFS or the physician fee schedule (PFS). Medicare pays for clinical diagnostic laboratory tests through the CLFS and for services that ordinarily require physician work through the PFS. We believe that we would benefit from additional public comments on whether these tests are clinical diagnostic laboratory tests or whether they are services that should be paid under the PFS. Therefore, we intend to solicit public comments on this issue in the CY 2013 PFS proposed rule as well as