criteria outlined in section 3.2.2 would be a minimal requirement, but HHS would consider additional criteria that further distinguish models with greater and lesser support in evidence. HHS is committed to ensuring that these criteria are transparent, methodologically sound, and increase the likelihood that federal funds will contribute to improved outcomes for at-risk children and families.

There are a number of different ways that such a system could be structured. We invite comments on the proposal to distinguish among evidence-based models based on a rubric that weighs factors relating to research quality and findings. For example, one relatively simple approach would rate models using an index constructed by weighting several factors equally. Models might be given points for meeting each of the following criteria: Favorable impacts sustained at least one year after program completion, favorable impacts replicated in distinct samples, favorable impacts in studies conducted by independent evaluators, quality and relevance of outcome measures; and balance between favorable and unfavorable and null findings. Additional factors which might be considered could include further indicia of the quality of the research design and implementation (as reflected in randomization, sample size, attrition, and baseline equivalence). We invite comments on HHS' proposal to use evidence for program models as a factor in determining allocations of additional funds, how various factors should be weighed in assessing the evidence of effectiveness, how to define these categories, and any other role distinctions related to the strength of the evidence should play in funding allocation. As noted above, strength of evidence is proposed to be only one factor in the evaluation of the strength of States' applications, and we invite comments on other appropriate factors as well.

8.0 Future Considerations

We invite comment on the following:

- HHS anticipates the criteria for evidence-based models will likely need to be altered over time as the state of the field changes. If HHS believes the criteria need to be changed in future years, it is anticipated the public will have an opportunity to comment on the proposed revisions.

- HHS intends to review the evidence base for home visiting models on an ongoing basis to ensure that new evidence is incorporated.

9.0 Submission of Comments

Comments may be submitted until August 17, 2010 by e-mail to: *HVEE@mathematica-mpr.com*.

Dated: July 19, 2010.

Mary K. Wakefield,

Administrator, Health Resources and Services Administration.

Carmen R. Nazario,

Assistant Secretary, Administration for Children and Families.

[FR Doc. 2010–18013 Filed 7–22–10; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1354–NC]

Medicare and Medicaid Programs; Announcement of an Application From a Hospital Requesting Waiver for Organ Procurement Service Area

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

ACTION: Notice with comment period.

SUMMARY: A hospital has requested a waiver of statutory requirements that would otherwise require the hospital to enter into an agreement with its designated Organ Procurement Organization (OPO). The request was made in accordance with section 1138(a)(2) of the Social Security Act (the Act). This notice requests comments from OPOs and the general public for our consideration in determining whether we should grant the requested waiver.

DATES: *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 21, 2010.

ADDRESSES: In commenting, please refer to file code CMS–1354–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 instructions under the "More Search Options" tab.

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–1354–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:

Department of Health and Human Services, Attention: CMS–1354–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of 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, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Mark A. Horney, (410) 786–4554.

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

Organ Procurement Organizations (OPOs) are not-for-profit organizations that are responsible for the procurement, preservation, and transport of transplantable organs to transplant centers throughout the country. Qualified OPOs are designated by the Centers for Medicare & Medicaid Services (CMS) to recover or procure organs in CMS-defined exclusive geographic service areas, pursuant to section 371(b)(1) of the Public Health Service Act (42 U.S.C. 273(b)(1)) and our regulations at 42 CFR 486.306. Once an OPO has been designated for an area, hospitals in that area that participate in Medicare and Medicaid are required to work with that OPO in providing organs for transplant, pursuant to section 1138(a)(1)(C) of the Social Security Act (the Act) and our regulations at 42 CFR 482.45.

Section 1138(a)(1)(A)(iii) of the Act provides that a hospital must notify the designated OPO (for the service area in which it is located) of potential organ donors. Under section 1138(a)(1)(C) of the Act, every participating hospital must have an agreement to identify potential donors only with its designated OPO.

However, section 1138(a)(2)(A) of the Act provides that a hospital may obtain a waiver of the above requirements from the Secretary under certain specified conditions. A waiver allows the hospital to have an agreement with an OPO other than the one initially designated by CMS, if the hospital meets certain conditions specified in section 1138(a)(2)(A) of the Act. In addition, the Secretary may review additional criteria described in section 1138(a)(2)(B) of the Act to evaluate the hospital's request for a waiver.

Section 1138(a)(2)(A) of the Act states that in granting a waiver, the Secretary must determine that the waiver—(1) is expected to increase organ donations; and (2) will ensure equitable treatment of patients referred for transplants within the service area served by the designated OPO and within the service area served by the OPO with which the hospital seeks to enter into an agreement under the waiver. In making a waiver determination, section 1138(a)(2)(B) of the Act provides that the Secretary may consider, among other factors: (1) Cost-effectiveness; (2) improvements in quality; (3) whether there has been any change in a hospital's designated OPO due to the changes made in definitions for metropolitan statistical areas; and (4) the length and continuity of a hospital's relationship with an OPO other than the hospital's designated OPO. Under section 1138(a)(2)(D) of the Act, the Secretary is required to publish a notice of any waiver application received from a hospital within 30 days of receiving the application, and to offer interested parties an opportunity to comment in writing during the 60-day period beginning on the publication date in the **Federal Register**.

The criteria that the Secretary uses to evaluate the waiver in these cases are the same as those described above under sections 1138(a)(2)(A) and (B) of the Act and have been incorporated into the regulations at § 486.308(e) and (f).

II. Waiver Request Procedures

In October 1995, we issued a Program Memorandum (Transmittal No. A–95–11) detailing the waiver process and discussing the information hospitals must provide in requesting a waiver. We indicated that upon receipt of a waiver request, we would publish a **Federal Register** notice to solicit public comments, as required by section 1138(a)(2)(D) of the Act.

According to these requirements, we will review the request and comments received. During the review process, we may consult on an as-needed basis with the Health Resources and Services Administration's Division of Transplantation, the United Network for Organ Sharing, and our regional offices. If necessary, we may request additional clarifying information from the applying hospital or others. We will then make a final determination on the waiver request and notify the hospital and the designated and requested OPOs.

III. Hospital Waiver Requests

As permitted by § 486.308(e), the following hospital has requested a waiver in order to enter into an agreement with a designated OPO other than the OPO designated for the service area in which the hospital is located:

Stafford Hospital (Medicare provider number 49–0140), of Stafford, Virginia, is requesting a waiver to work with:

LifeNet Health, 1864 Concert Drive, Virginia Beach, VA 23453.

The Hospital's Designated OPO is:

Washington Regional Transplant Consortium, 7619 Little River Turnpike, Suite 900, Annandale, VA 22002.

IV. 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 (44 U.S.C. 35).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; Program No. 93.774, Medicare—Supplementary Medical Insurance, and Program No. 93.778, Medical Assistance Program)

Dated: July 15, 2010.

Marilyn Tavenner,

Principal Deputy Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services.

[FR Doc. 2010–18137 Filed 7–22–10; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5047–N]

Medicare Program; Solicitation for Proposals for the Medicare Imaging Demonstration

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

ACTION: Notice.

SUMMARY: This notice informs interested parties (here in there after referred to as conveners) of an opportunity to apply to participate in the Medicare Imaging Demonstration (MID) that was authorized by section 135(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The goal of the MID is to collect data regarding physician compliance with appropriateness criteria selected by the Secretary under the terms of the statute in order to determine the appropriateness of advanced diagnostic imaging services furnished to Medicare beneficiaries.

DATES: Proposals will be considered timely if they are received on or before 5 p.m., Eastern Standard Time (E.S.T.) on September 21, 2010.