Atlanta, Georgia 30333, *Telephone:* (404) 498–2733.

The Director, Management Analysis and Services Office, has been delegated the authority to sign Federal Register notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: March 7, 2011.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2011–5623 Filed 3–10–11; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10367]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the Agency's function; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* New collection (Request for a new OMB Control Number); *Title of Information Collection:* Medicaid State Plan Preprint for Use by States When Implementing Section 6505 of the [Patient Protection and] Affordable Care Act; *Use:* CMS has developed a Medicaid State Plan Preprint for use by States and specifically to support the January 1, 2011, mandate of the prohibition on payments outside of the United States. The preprint follows the format and requested information from prior preprints provided to the States by CMS and provides a placeholder and assurance of compliance with section 1902(a) of the Social Security Act; *Form Number:* CMS–10367 (OMB#: 0938–NEW); *Frequency:* Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 5. (For policy questions regarding this collection contact Carla Ausby at 410–786–2153. 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 E-mail 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 April 11, 2011: OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, E-mail: *OIRA_submission@omb.eop.gov*.

Dated: March 4, 2011.

Martique Jones,

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

[FR Doc. 2011–5685 Filed 3–10–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–2540–10, CMS–10115, CMS–10136, CMS–10260, CMS–10320, CMS–10381, CMS–855(S), CMS–855(A, B, I, R) and CMS–855(O)]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS) is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Cost Report. *Use:* Form CMS 2540–10 is used by Skilled Nursing Facilities (SNFs) and Skilled Nursing Facility Complexes participating in the Medicare program to report the health care costs to determine the amount of reimbursable costs for services rendered to Medicare beneficiaries. It is required under sections 1815(a), 1833(e) and 1861(v)(1)(A) of the Social Security Act (42 U.S.C. 1395g) to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. The revision is due to new reporting requirements as mandated by the Patient Protection and Affordability Act section 6104. The Patient Protection and Affordable Care Act, § 6104(1) of Public Law 111–148 amended § 1888(f) of the Social Security Act ("Reporting of Direct Care Expenditures"), requires SNFs to separately report expenditures for wages and benefits for direct care staff (registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff). In implementing these changes Worksheet S–3, part V was added. With the addition of this worksheet the average record keeping time for each provider will be increased by 5 hours and the average reporting time by 1 hour. *Form Number:* CMS–2540–10 (OMB#: 0938–0463); *Frequency:* Yearly; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 15,071; *Total Annual Responses:* 15,071; *Total Annual Hours:* 3,171,602 (For policy questions regarding this collection contact Amelia Citerone at 410–786–3901. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Extension of currently approved collection; *Title of*

Information Collection: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens (Sections 1011) Provider Enrollment Application; *Use:* Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, provides that the Secretary will establish a process (*i.e.,* enrollment and claims payment) for eligible providers to request payment. The Secretary must directly pay hospitals, physicians and ambulance providers (including Indian Health Service, Indian Tribe and Tribal organizations) for their otherwise un-reimbursed costs of providing services required by section 1867 of the Social Security Act (EMTALA) and related hospital inpatient, outpatient and ambulance services. CMS will use the application information to administer this health services program and establish an audit process. The Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens (Sections 1011) Provider Enrollment Application has been revised. For a list of these revisions, refer to the summary of changes document.

Form Number: CMS–10115 (OMB# 0938–0929); *Frequency:* On occasion; *Affected Public:* Private sector—Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 5,000; *Total Annual Responses:* 5,000; *Total Annual Hours:* 2,999.

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Demonstration Ambulatory Care Quality Measure Performance Assessment Tool ("PAT"); *Use:* This request is to cover a modification of an existing, approved data collection effort with a new secure Web based system. This system will also provide a platform for developing tools to collect clinical quality data for future demonstrations and programs. There is no increase in burden. In fact, because all of the practices submitting data will have Electronic Health Records (EHRs), it is likely that the originally estimated burden will decrease over the coming years of the demonstration. CMS is requesting an extension of the currently approved tool for the collection of ambulatory care clinical performance measure data.

The data will be used to continue implementation of two Congressionally mandated demonstration projects (the Physician Group Practice (PGP) Demonstration and the Medicare Care Management Performance (MCMP) Demonstration); also the support data collection under the new EHR Demonstration. Each of these demonstrations, test new payment methods for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries, especially those with chronic conditions that account for a disproportionate share of Medicare expenditures. In addition, the MCMP and EHR demonstration specifically encourage the adoption of electronic health records systems as a vehicle for improving how health care is delivered.

4. *Type of Information Collection Request:* Extension without change; *Title of Information Collection:* Medicare Advantage and Prescription Drug Program: Final Marketing Provisions CFR 422.111(a)(3) and 423.128 (a)(3). *Use:* Medicare Advantage (MA) plans must provide notice to plan members of impending changes to plan benefits, premiums and copays in the coming year so that members will be in the best position to make an informed choice on continued enrollment or disenrollment from that plan at least 15 days before the Annual Election Period (AEP). Beginning 2009, organizations will be required to notify plan members of the coming year changes using a combined standardized document at the time of enrollment and annually thereafter.

Section 422.111 requires, to the extent that a MA plan has a Web site, annual notification through the Web site of written, hard copy notification sent to the beneficiaries. Section 423.128 requires that a part D plan have mechanisms for providing specific information on a timely basis to current and prospective enrollees upon request.

These mechanisms include, Internet Web site that includes information on part D plan description. MA organizations (formerly M+C organizations) and Prescription Drug Plan Sponsors use the information to comply with the eligibility requirements and the MA and part D contract requirements. CMS will use this information to ensure that correct information is disclosed to Medicare beneficiaries, both potential enrollees and enrollees. *Form Number:* CMS–10260 (OMB#: 0938–1051); *Frequency:* Reporting—Yearly; *Affected Public:* Business or other for-profits; *Number of Respondents:* 790; *Total Annual Responses:* 790; *Total Annual Hours:* 9,480. (For policy questions regarding this collection contact Camille Brown at 410–786–0274. For all other issues call 410–786–1326.)

5. *Type of Information Collection Request:* Reinstatement of previously approved collection; *Title of Information Collection:* Health Care Reform Insurance Web Portal Requirements 45 CFR part 159; *Use:* In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, Department of Health and Human Services, is publishing the following summary of a proposed information collection request for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

This information collection is mandated by Sections 1103 and 10102 of The Patient Protection and Affordability Care Act, Public Law 111–148 (ACA). Once all of the information is collected from insurance issuers of major medical health insurance (hereon referred to as issuers) and other affected parties, it will be processed for will display at *http://www.healthcare.gov* with quarterly refreshes. The information that is provided will help the general public make educated decisions about organizations providing private health care insurance.

In accordance with the provisions of the ACA referenced above, the U.S. Department of Health and Human Services created a Web site called healthcare.gov to meet these and other provisions of the law, and data collection was conducted for six months based upon an emergency information collection request. The interim final rule published on May 5, 2010 served as the emergency **Federal Register** Notice for the prior Information Collection Request (ICR). The Office of Management and Budget (OMB) reviewed this ICR under emergency processing and approved the ICR on April 30, 2010. The CCIIO will be submitting a new ICR to OMB for review and approval in accordance with the Paperwork Reduction Act of 1995. The proposed information collection is published to obtain comments from the public and affected agencies.

CCIIO is currently updating a system (hereon referred to as Web portal) where State Departments of Insurance and issuers will log in to using a custom user ID and password validation. The

States will be tasked to provide information on issuers in their State and various Web sites maintained for consumers. The issuers will be tasked to provide information on their major medical insurance products and plans. They will ultimately be given the choice to download a basic information template to enter data then upload into the Web portal; to manually enter data within the Web portal itself; or to submit xml files containing their information. Once the States and issuers submit their data, they will receive an e-mail notifying them of any errors, and that their submission was received.

CCIIO is mandating the issuers verify and update their information on a quarterly basis and is requesting the States to verify State submitted information on an annual basis. In the event that an issuer enhances its existing plans, proposes new plans, or deactivates plans, the organization would be required to update the information in the Web portal. Changes occurring during the three month quarterly periods will be allowed utilizing effective dates for both the plans and rates associated with the plans. Information that is to be collected from State high risk pools will be collected from The National Association of State Comprehensive Health Insurance Plans (NASCHIP) at this time. Updates to this information may be submitted voluntarily.

The estimated hour burden on issuers for the Plan Finder data collection in the first year is estimated as 84,600 total burden hours, or 113 hours per organization. This estimate is based on an assumed average of 450 individual plan issuers and 700 small group plan issuers per each of the four quarterly collections. It includes 30 hours per organization for training and communication. Additionally, for each of the issuers it includes 10 hours of preparation time, one hour of login and upload time, two hours of troubleshooting and data review and one half hour for attestation per organization per quarterly refresh.

The estimated hour burden on the States is informed by the fact that they have already submitted the data once and only need to update. The overall hours estimate is 575, or 11.5 per Department of Insurance. This is premised on 2 hours of training and communication, 8 hours for data collection, and one half hour of submission. *Form Number:* CMS–10320 (OMB#: 0938–1086); *Frequency:* Reporting—Annually/Quarterly; *Affected Public:* Business or other for-profits and States; *Number of Respondents:* 801; *Total Annual Responses:* 3,051; *Total Annual Hours:* 85,175. (For policy questions regarding this collection contact Beth Liu at 301–492–4268. For all other issues call 410–786–1326.)

6. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Version 5010/ICD–10 Industry Readiness Assessment *Use:* The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Secretary of HHS to adopt transaction standards that covered entities are required to use when electronically conducting certain health care administrative transactions, such as claims, remittance, eligibility and claims status requests and responses. Accordingly, on January 16, 2009, HHS published final rules adopting by regulation two sets of standards for HIPAA transactions: Version 5010 standards for eight types of electronic health care transactions (claims, eligibility inquiries, remittance advices, *etc.*) and ICD–10 code set standards. The final rules set compliance dates of January 1, 2012 for Version 5010 standards and October 1, 2013 for ICD–10 standards. HIPAA transactions not meeting the standards by those dates will be rejected. The final rules also outlined interim milestones that organizations should meet in order to achieve compliance by the required dates. For Version 5010, these interim milestones include completing internal testing and being able to send and receive compliant transactions by December 2010, commencing external testing with trading partners by January 2011, and completing that testing and moving into production by the compliance date of January 1, 2012. Entities cannot implement ICD–10 standards until they are in compliance with Version 5010; the interim milestone for ICD–10 is to begin compliance activities (gap analysis, design, development, internal testing) by January 2011.

CMS has developed an education and communication campaign to support the adoption of and transition to Version 5010 and ICD–10. The education and communication activities will be targeted towards the millions of professionals across the health care industry who must take steps to prepare for the implementation of the new codes and transaction standards. CMS is requesting Office of Management and Budget (OMB) approval to conduct survey research to monitor the health care industry's awareness of, and preparation for, the transition to Version 5010 and ICD–10. The aggregated data obtained through the survey will help inform CMS outreach and education efforts to help affected entities (health care providers, health plans, clearinghouses, and then vendors who service them) meet interim milestones and achieve timely compliance so that they can continue to process HIPAA transactions without interruption.

CMS has contracted to conduct a tracking survey of populations charged with implementing Version 5010 and ICD–10 electronic transaction processing, specifically payers (health insurance plans and managed care organizations), providers (hospitals and primary care providers), and vendors (software providers, third-party billers and clearinghouses). A self-administered Web-based survey will be the data collection. The data collection field period is expected to be four weeks in Summer 2011. *Form Number:* CMS–10381 (OMB#: 0938–NEW); *Frequency:* Once; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 600; *Total Annual Responses:* 600; *Total Annual Hours:* 150. (For policy questions regarding this collection contact Rosali Topper at 410–786–7260. For all other issues call 410–786–1326.)

7. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Durable Medical Equipment Supplier Enrollment Application *Use:* The primary function of the CMS 855S DMEPOS supplier enrollment application is to gather information from a supplier that tells us who it is, whether it meets certain qualifications to be a health care supplier, where it renders its services or supplies, the identity of the owners of the enrolling entity, and information necessary to establish the correct claims payment. The goal of evaluating and revising the CMS 855S DMEPOS supplier enrollment application is to simplify and clarify the information collection without jeopardizing our need to collect specific information. Additionally, periodic revisions are necessary to incorporate new regulatory requirements. The goal of this revision of the CMS 855S is to incorporate new regulatory provisions found at 42 CFR 424.57(c) (1 through 30) and 42 CFR 424.58. These revisions will allow CMS to be in compliance with the above stated regulations implementing new quality standards for DMEPOS suppliers, including accreditation requirements. This revision will also incorporate new supplier standard regulations found in the final regulation that published on August 27, 2010 (75 FR 52629–52649). *Form Number:* CMS–855(S) (OMB#: 0938–1056); *Frequency:*

Yearly; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 140,290; *Total Annual Responses:* 140,290; *Total Annual Hours:* (For policy questions regarding this collection contact Kim McPhillips at 410–786–5374. For all other issues call 410–786–1326.)

8. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Enrollment Application *Use:* The primary function of the CMS–855 Medicare enrollment application is to gather information from a provider or supplier that tells us who it is, whether it meets certain qualifications to be a health care provider or supplier, where it practices or renders its services, the identity of the owners of the enrolling entity, and other information necessary to establish correct claims payments. The goal of this submission is to address the following issues. The CMS–855A enrollment form currently captures ownership/managerial information on providers. The data required under sections 6401 and 6001, however, is more specific than that currently obtained on the CMS–855A. CMS will therefore create four attachments to the CMS–855A—two for SNFs and the other two for physician-owned hospitals—to secure this information. In addition to the application changes triggered by ACA, CMS is making other revisions to the forms as well. *Form Number:* CMS–855 (A, B, I, R) (OMB#: 0938–0685); *Frequency:* Yearly; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 440,450; *Total Annual Responses:* 440,450; *Total Annual Hours:* 842,810 (For policy questions regarding this collection contact Kim McPhillips at 410–786–5374. For all other issues call 410–786–1326.)

9. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Medicare Enrollment Application for Eligible Ordering and Referring Physicians and Non-physician Practices *Use:* CMS is adding a new CMS–855 Medicare Enrollment Application (CMS 855O—Medicare Enrollment Application for Ordering and Referring Physicians only). CMS has found that many providers and suppliers who are not enrolled in Medicare are ordering and referring physicians for Medicare enrolled providers and suppliers. The ordering and referring data field on the CMS 1500 claims submission form requires an ordering or referring physician to have a Medicare identification number. Without an ordering or referring physician, specific types of claims submitted by Medicare approved providers and suppliers are rejected by Medicare Administrative Contractors (MAC) as required by Medicare regulation. Therefore, if an ordering or referring physician does not participate in the Medicare program, but orders or refers his/her patients to a Medicare provider or supplier, the claim submitted by the Medicare provider or supplier for the given ordered or referred service is automatically rejected by the MAC. The CMS 855O allows a physician to receive a Medicare identification number (without being approved for billing privileges) for the sole purpose of ordering and referring beneficiaries to Medicare approved providers and suppliers. This new Medicare application form allows physicians who do not provide services to Medicare beneficiaries to be given a Medicare identification number without having to supply all the data required for the submission of Medicare claims. It also allows the Medicare program to identify ordering and referring physicians without having to validate the amount of data necessary to determine claims payment eligibility (such as banking information), while continuing to identify the physician's credentials as valid for ordering and referring purposes. *Form Number:* CMS–855(O) (OMB#: 0938–NEW0685); *Frequency:* Yearly; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 48,000; *Total Annual Responses:* 48,000; *Total Annual Hours:* 46,000 (For policy questions regarding this collection contact Kim McPhillips at 410–786–5374. 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 at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office at 410–786–1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by *May 10, 2011:*

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov*. Follow the instructions for "Comment or Submission" or "More Search Options" to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: March 4, 2011.

Martique Jones,

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

[FR Doc. 2011–5684 Filed 3–10–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3246–N]

Medicare Program; Meeting of the Medicare Evidence Development and Coverage Advisory Committee, May 11, 2011

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

ACTION: Notice of meeting.

SUMMARY: This notice announces that a public meeting of the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) ("Committee"). The Committee generally provides advice and recommendations concerning the adequacy of scientific evidence needed to determine whether certain medical items and services can be covered under the Medicare statute. This meeting will focus on the currently available evidence regarding the outcomes associated with the use of unilateral and bilateral cochlear implant technology for hearing loss. This meeting is open to the public in accordance with the Federal Advisory Committee Act (5 U.S.C. App. 2, section 10(a)).

DATES: *Meeting Date:* The public meeting will be held on Wednesday, May 11, 2011 from 7:30 a.m. until 4:30 p.m., eastern daylight time (e.d.t.).

Deadline for Submission of Written Comments: Written comments must be received at the address specified in the **ADDRESSES** section of this notice by 5 p.m. e.d.t., Monday, April 11, 2011. Once submitted, all comments are final.

Deadlines for Speaker Registration and Presentation Materials: The