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: April 15, 2011.

Elaine L. Baker,

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

[FR Doc. 2011–9879 Filed 4–21–11; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS–R–21]

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:* Extension of a currently approved collection; *Title of Information Collection:* Withholding Medicare Payments to Recover Medicaid Overpayments and Supporting Regulations in 42 CFR 447.31; *Form No.:* CMS–R–21 (OMB#: 0938–0287); *Use:* Section 2104 of the Omnibus Reconciliation Act of 1981 provides CMS with the authority to withhold Medicare payments to recover Medicaid overpayments that the Medicaid State Agency has been unable to recover. When the CMS Regional Office (RO) receives an overpayment case from a State Agency, the case file is examined to determine whether the conditions for withholding Medicare payments have been met. If the RO determines that the case is appropriate for withholding Medicare payments, the RO will contact the institution's intermediary or individual's carrier to determine the amount of Medicare payments to which the entity would otherwise be entitled. The RO will then give notice to the intermediary/carrier to withhold the entity's Medicare payment; *Frequency:* Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 54; *Total Annual Responses:* 27; *Total Annual Hours:* 81. (For policy questions regarding this collection contact Rory Howe at 410–786–4878. For all other issues call 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 *May 23, 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: April 19, 2011.

Martique Jones,

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

[FR Doc. 2011–9846 Filed 4–21–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2332–FN]

Medicare and Medicaid Programs; Approval of the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. for Deeming Authority for Organizations That Provide Outpatient Physical Therapy and Speech-Language Pathology Services

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

ACTION: Final notice.

SUMMARY: This notice announces our decision to approve the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) for recognition as a national accreditation program for organizations that provide outpatient physical therapy and speech-language pathology services seeking to participate in the Medicare or Medicaid programs.

DATES: *Effective Date:* This final notice is effective April 22, 2011 through April 22, 2015.

FOR FURTHER INFORMATION CONTACT: Alexis Prete, (410) 786–0375. Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive outpatient physical therapy and speech language pathology covered services from a provider of services, a clinic, a rehabilitation agency, a public health agency, or by others under an arrangement with and under the supervision of such provider, clinic, rehabilitation agency, or public health agency (collectively, "organizations"), provided certain requirements are met. Section 1861(p)(4) of the Social Security Act (the Act) establishes distinct criteria for organizations seeking approval to provide outpatient physical therapy and speech language pathology services. The regulations at 42 CFR part 485, subpart H specify, among other things, the conditions that an organization providing outpatient physical therapy and speech-language pathology services must meet to participate in the Medicare program. Regulations concerning provider agreements are located at 42 CFR part 489 (Provider Agreements and Supplier Approval) and those pertaining to survey and certification of facilities at 42 CFR part 488.

Generally, in order to enter into a provider agreement, an organization offering outpatient physical therapy and speech language pathology services must first be certified by a State survey agency as complying with the conditions or requirements set forth in section 1861(p)(4) of the Act, and 42 CFR part 485, subpart H. Thereafter, the organization is subject to ongoing review by a State survey agency to determine whether it continues to meet the Medicare requirements. There is an alternative, however, to State compliance surveys. Accreditation by a nationally-recognized accreditation program can substitute for ongoing State review.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accreditation organization (AO) that all applicable Medicare conditions are met or exceeded, we may "deem" that provider entity as having met the requirements. Accreditation by an accreditation organization is voluntary and is not required for Medicare