formula grant program. The purpose of this program is to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections (STIs); and at least three adulthood preparation subjects. The Personal Responsibility Education grant program funding is available for fiscal years 2010 through 2014.

An emergency request is being made to solicit comments from the public on paperwork reduction as it relates to ACYF's receipt of the following documents from applicants and awardees: Application for Mandatory Formula Grant State Plan; Performance Progress Report.

Respondents: 50 States and 9 Territories, to include, District of Columbia, Puerto Rico, Virgin Islands, Guam, American Samoa, Northern Mariana Islands, the Federated States of Micronesia, the Marshall Islands and Palau

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Application, to include program narrative	59	1	24	1,416
State Plan	59	1	40	2,360
Performance Progress Reports	59	5	16	4,720

Estimated Total Annual Burden Hours: 8,496

In compliance with the requirements of Section 506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. E-mail address: *infocollection@acf.hhs.gov.* All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Dated: September 14, 2010

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2010–23200 Filed 9–16–10; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10267, CMS–10137, CMS–10237, CMS–R–240, CMS–10316 and CMS–10305]

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

AGENCY: Centers for Medicare & Medicaid Services.

In compliance with the requirement of section 3506I(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:* Revision of a currently approved collection; *Title of Information Collection:* QualityNet Identity Management System (QIMS) Account Form; *Use:* The QualityNet Identity Management System (QIMS) account registration form must be completed by any new persons needing access to Consolidated Renal Operations in a Web Enabled Network (CROWNWeb.) The 8,561 existing accounts owners will not have to reregister for new user accounts. The CROWNWeb user community is composed of CMS employees, ESRD Network Organization staff and dialysis facilities staff. The CROWNWeb system is the system used as the collection point of data necessary for entitlement of ESRD patients to Medicare benefits and Federal Government monitoring and assessing of quality and type of care provided to renal patients. The data collected in QIMS will provide the necessary security measures for creating and maintaining active CROWNWeb user accounts and collection of audit trail information required by the CMS Information Security Officers (ISSO). *Form Number:* CMS–10267 (OMB#: 0938–1050); *Frequency:* Occasionally; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 7,439; Total *Annual Responses:* 7,439; *Total Annual Hours:* 3,720. (For policy questions regarding this collection contact Michelle Tucker at 410–786–0376. For all other issues call 410–786–1326.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Application for Prescription Drug Plans (PDP); Application for Medicare Advantage Prescription Drug (MA–PD); Application for Cost Plans to Offer Qualified Prescription Drug Coverage; Application for Employer Group Waiver Plans to Offer Prescription Drug Coverage; Service Area Expansion Application for Prescription Drug Coverage; *Use:* The Applications for Part D sponsors to offer qualified prescription drug coverage are completed by entities seeking approval to offer Part D benefits under the Medicare Prescription Drug Benefit

program established by section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and is codified in section 1860D of the Social Security Act.

Effective January 1, 2006, the Part D program established an optional prescription drug benefit for individuals who are entitled to Medicare Part A or enrolled in Part B. In general, coverage for the prescription drug benefit is provided through PDPs that offer drug-only coverage, or through MA organizations that offer integrated prescription drug and health care coverage (MA–PD plans). PDPs must offer a basic drug benefit. Medicare Advantage Coordinated Care Plans (MA–CCPs) must offer either a basic benefit or may offer broader coverage for no additional cost. Medicare Advantage Private Fee for Service Plans (MA–PFFS) may choose to offer a Part D benefit. Cost Plans that are regulated under Section 1876 of the Social Security Act, and Employer Group Plans may also provide a Part D benefit. If any of the contracting organizations meet basic requirements, they may also offer supplemental benefits through enhanced alternative coverage for an additional premium.

The information will be collected under the solicitation of proposals from PDP, MA–PD, Cost Plan, PACE, and EGWP applicants. The collected information will be used by CMS to: (1) ensure that applicants meet CMS requirements, (2) support the determination of contract awards. *Form Number:* CMS–10137 (OMB#: 0938–0936); *Frequency:* Once; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 295; Total *Annual Responses:* 295; *Total Annual Hours:* 3,576. (For policy questions regarding this collection contact Linda Anders at 410–786–0459. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Part C Medicare Advantage Application and 1876 Cost Plan Expansion Application; *Use:* The Balanced Budget Act of 1997 (BBA) established a new "Part C" in the Medicare statute (sections 1851 through 1859 of the Social Security Act (the Act) which provided for a Medicare+Choice (M+C) program. Under section 1851(a)(1) of the Act, every individual entitled to Medicare Part A and enrolled under Part B, except for most individuals with end-stage renal disease (ESRD), could elect to receive benefits either through the Original Medicare Program or an M+C plan, if one was offered where he or she lived. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Benefit Program (Part D) and made revisions to the provisions of Medicare Part C, governing what is now called the Medicare Advantage (MA) program (formerly Medicare+Choice) Organizations wishing to provide healthcare services under MA and/or MA–PD plans must complete an application, file a bid, and receive final approval from CMS. Existing MA plans may expand their contracted area by completing the Service Area Expansion (SAE) application. Any current Cost Plan Contractor that wants to expand its Medicare cost-based contract with CMS under Section 1876 of the Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and subsequent legislation can complete the application. *Form Number:* CMS–10237 (OMB#: 0938–0935); *Frequency:* Yearly; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 870; Total *Annual Responses:* 870; *Total Annual Hours:* 15,696. (For policy questions regarding this collection contact Letticia Ramsey at 410–786–5262. For all other issues call 410–786–1326.)

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Prospective Payments for Hospital Outpatient Service and Supporting Regulations is 42 CFR 413.65; *Use:* Section 1833(t) of the Social Security Act (the Act) requires the Secretary to establish a prospective payment system (PPS) for hospital outpatient services. Successful implementation of an outpatient PPS requires that CMS distinguish facilities or organizations that function as departments of hospitals from those that are freestanding, so that CMS can determine which services should be paid under the outpatient prospective payment system (OPPS), the clinical laboratory fee schedule, or other payment provisions applicable to services furnished to hospital outpatients.

CMS will use the information from sections 413.65(b)(3) and (c) to determine whether a facility or organization acquired by a main provider should be treated as provider-based for Medicare certification, coverage, and payment purposes or whether a main provider has had a material change in its relationship to a provider-based facility or organization that affects the provider-based status of the facility or organization. In addition, section 1866(b)(2) of the Act authorizes hospitals and other providers to impose deductible and coinsurance charges for facility services, but does not allow such charges by facilities or organizations which are not provider-based. Implementation of this provision requires that CMS have information from the required reports, so it can determine which facilities are provider-based. *Form Number:* CMS–R–240 (OMB#: 0938–0798); *Frequency:* Occasionally; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 905; *Total Annual Responses:* 500,405; *Total Annual Hours:* 26,563 (For policy questions regarding this collection contact Daniel Schroder at 410–786–7452. For all other issues call 410–786–1326.)

5. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Medicare Prescription Drug Plan (PDP) and Medicare Advantage Prescription Drug Plan (MA–PD) Disenrollment Reasons Survey; *Use:* The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the collection and reporting performance data for Part D prescription drug plans. Specifically, the MMA under section 1860D–4 (Beneficiary Protections for Qualified Prescription Drug Coverage) requires CMS to conduct consumer satisfaction surveys regarding PDPs and MA–PDs. CMS will use the survey to obtain information regarding beneficiaries' reasons for disenrolling from their chosen Part D plan, and their expectations relative to provided benefits and services. Determining the reasons for disenrollment from Part D plans will provide important information regarding potential dissatisfaction with some aspect of the plan, such as access, service, cost, quality of care, or the benefits provided. This information can be used by CMS to improve the design and functioning of the Part D program. *Form Number:* CMS–10316 (OMB#: 0938–New); *Frequency:* Yearly; *Affected Public:* Individuals and households; *Number of Respondents:* 120,000; *Total Annual Responses:* 120,000; *Total Annual Hours:* 34,800. (For policy questions regarding this collection contact Phyllis Nagy at 410–786–6646. For all other issues call 410–786–1326.)

6. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Medicare Part C and Part D Data Validation (42 CFR 422.516g and 423.514g); *Use:* Organizations contracted to offer Medicare Part C and Part D benefits are required to report data to the Centers for

Medicare & Medicaid Services on a variety of measures. In order for the data to be useful for monitoring and performance measurement, the data must be reliable, valid, complete, and comparable among sponsoring organizations. To meet this goal, CMS is developing reporting standards and data validation specifications with respect to the Part C and Part D reporting requirements. These standards will provide a review process for Medicare Advantage Organizations (MAOs), Cost Plans, and Part D sponsors to use to conduct data validation checks on their reported Part C and Part D data. *Form Number:* CMS–10305 (OMB#: 0938–NEW); *Frequency:* Yearly; *Affected Public:* Business or other for-profit; *Number of Respondents:* 634; *Total Annual Responses:* 634; *Total Annual Hours:* 237,127. (For policy questions regarding this collection contact Terry Lied at 410–786–8973. 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 October 18, 2010. OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, E-mail: *OIRA_submission@omb.eop.gov.*

Dated: September 13, 2010.

Michelle Shortt,

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

[FR Doc. 2010–23160 Filed 9–16–10; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

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

Periodically, the Health Resources and Services Administration (HRSA) publishes abstracts of information collection requests under review by the Office of Management and Budget (OMB), in compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). To request a copy of the clearance requests submitted to OMB for review, e-mail *paperwork@hrsa.gov* or call the HRSA Reports Clearance Office on (301) 443–1129.

The following request has been submitted to the Office of Management and Budget for review under the Paperwork Reduction Act of 1995:

Proposed Project: Black Lung Clinics Program Database (OMB No. 0915–0292)—Revision

The Office of Rural Health Policy (ORHP), Health Resources and Services Administration, conducts an annual data collection of user information for the Black Lung Program. This has been ongoing with OMB approval since 2004. The purpose of the Black Lung Clinic Program is to improve the health status of coal workers by providing services to minimize the effects of respiratory and pulmonary impairments of coal miners, treatment procedures required in the management of problems associated with black lung disease which improves the quality of life or the miner and reduces economic costs associated with morbidity and mortality arising from pulmonary diseases. The purpose of collecting this data is to provide HRSA with information on how well each grantee is meeting the needs of active and retired miners in the funded communities.

Data from the annual report will provide quantitative information about the programs, specifically: (a) The characteristics of the patients they serve (gender, age, disability level, occupation type); (b) the characteristics of services provided (medical encounters, non-medical encounters, benefits counseling, or outreach); and (c) the number of patients served. The annual report will be updated to include a qualitative measure on the percent of patients that show improvement in pulmonary function. This assessment will provide data useful to the program and will enable HRSA to provide data required by Congress under the Government Performance and Results Act of 1993. It will also ensure that funds are being effectively used to provide services to meet the needs of the target population.

There has been a modification to a long term Black Lung performance measures. The new measure will be the evaluation of the quality of spirometry performed by the clinic. The evaluation of coal miners for the presence of disabling pneumoconiosis depends on well performed, valid and accurate lung function testing. There is no additional burden on the grantee to collect this information since the grantees are currently collecting this data.

The annual estimate of burden is as follows:

Instrument	Number of respondents	Responses per respondent	Total responses	Hours per response	Total burden hours
Database	15	1	1	10	150

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to the desk officer for HRSA, either by e-mail to *OIRA_submission@omb.eop.gov* or by fax to 202–395–6974. Please direct all correspondence to the "attention of the desk officer for HRSA."

Dated: September 13, 2010.

Sahira Rafiullah,

Director, Division of Policy and Information Coordination.

[FR Doc. 2010–23260 Filed 9–16–10; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: New Runaway and Homeless Youth Management Information System (NEORHYMIS)

OMB No.: 0970–0123.