public comments. If individuals in making a statement reveal personal information (*e.g.,* medical information) about themselves, that information will not usually be redacted. The CDC Freedom of Information Act coordinator will, however, review such revelations in accordance with the Freedom of Information Act and if deemed appropriate, will redact such information. Disclosures of information concerning third parties will be redacted.

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: February 7, 2011.

Elaine L. Baker,

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

[FR Doc. 2011–3089 Filed 2–10–11; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–222, CMS–1771, CMS–10008, CMS–10368, and CMS–R–21]

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:* Extension of currently approved collection; *Title of Information Collection:* Independent Rural Health Center/Freestanding Federally Qualified Health Center Cost Report and Supporting Regulations 42 CFR 413.20 and 42 CFR 413.24; Use: Providers of service in the Medicare program are required to submit annual information to achieve reimbursement for health care services rendered to Medicare beneficiaries. The Form CMS–222 cost report is needed to determine the amount of reasonable cost due to the providers for furnishing medical services to Medicare beneficiaries; *Form Number:* CMS–222 (OMB# 0938–0107); *Frequency:* Yearly; *Affected Public:* Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 5812; *Total Annual Responses:* 5812; *Total Annual Hours:* 290,600.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Attending Physicians Statement and Documentation of Medicare Emergency and Supporting Regulations in 42 CFR 424.103; *Use:* 42 CFR 424.103(b) requires that before a nonparticipating hospital may be paid for emergency services rendered to a Medicare beneficiary, a statement must be submitted that is sufficiently comprehensive to support that an emergency existed. Form CMS–1771 contains a series of questions relating to the medical necessity of the emergency. The attending physician must attest that the hospitalization was required under the regulatory emergency definition (42 CFR 424.101) and give clinical documentation to support the claim. *Form Number:* CMS–1771 (OMB# 0938–0023); *Frequency:* Yearly; *Affected Public:* Private sector—business or other for-profit and not-for-profit institutions; *Number of Respondents:* 100; *Total Annual Responses:* 200; *Total Annual Hours:* 50.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Process and Information Required to Determine Eligibility of Drugs, Biologicals, and Radiopharmaceutical Agents for Transitional Pass-Through Status Under the Hospital Outpatient Prospective Payment System (OPPS); *Use:* Section 1833(t)(6) of the Social Security Act provides for temporary additional payments or "transitional pass-through payments" for certain drugs and biological agents. Interested parties such as hospitals, pharmaceutical companies, and physicians can apply for transitional pass-through payment for drugs and biologicals used with services covered under the OPPS. CMS uses this information to determine if the criteria for making a transitional pass-through payment are met and if an interim Healthcare Common Procedure Coding System (HCPCS) code for a new drug or biological is necessary. *Form Number:* CMS–10008 (OMB#: 0938–0802); *Frequency:* Once; *Affected Public:* Private sector—business or other for-profit; *Number of Respondents:* 30; *Total Annual Responses:* 480; Total Annual Hours: 480.

4. *Type of Information Collection Request:* New collection (request for a new OMB control number); *Title of Information Collection:* Dental Action Plan Template for Medicaid and CHIP Programs; *Form No.:* CMS–10368 (OMB#: 0938–NEW); *Use:* CMS is responsible for administering the Federal Medicaid program and the Children's Health Insurance Program (CHIP). As part of the Federal Medicaid program, CMS oversees the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit to assure that all requirements are met. The provision of dental services to EPSDT-eligible individuals is required under section 1905(r)(3) of the Social Security Act. In addition, section 1902(a)(43)(D)(iii) requires that CMS collect information on dental services furnished to eligible individuals. Section 501(e) of CHIPRA imposed new data reporting requirements for the CHIP program by requiring certain dental data to be reported in 2011 on the CHIP annual report. Dental data for CHIP is unavailable as the requirement to report this data is new for CHIP programs. CMS intends to use the information provided in the template to help inform us of the States activities undertaken to achieve the national oral health goals for Medicaid and CHIP. CMS will use the information to routinely follow-up with States on the achievement of their goals and activities and will share that information with other States; *Frequency:* Once; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 69; *Total Annual Responses:* 69; *Total Annual Hours:* 4,485. (For policy questions regarding this collection contact Cindy Ruff at 410–786–5916. For all other issues call 410–786–1326.)

5. *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 (Pub. L. 97–35) provides CMS with the authority to withhold Federal 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 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 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 *April 12, 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.

Martique Jones,

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

[FR Doc. 2011–3057 Filed 2–10–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–437, CMS–10358 and CMS–10360]

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 currently approved collection; *Title of Information Collection:* Psychiatric Unit Criteria Work Sheet and Supporting Regulations 412.25 and 412.27; *Use:* A limited number of hospitals and special hospital units are excluded from the Medicare Prospective Payment System (PPS) which determines Medicare payment for operating costs and capital-related costs of inpatient hospital services. 42 CFR 412.25 and 42 CFR 412.27 describes the criteria under which these facilities are excluded. Excluded units are paid on the basis of reasonable costs subject to target rate ceilings (provided for by Section 1886(b) of the Social Security Act). State survey agencies (SAs) are required to conduct initial onsite surveys of these units to verify that they continue to meet PPS-exclusion criteria. CMS proposes to continue to use the Criteria Worksheet, Forms CMS–437 for verifying first-time exclusions from the PPS, for complaint surveys, for its annual 5 percent validation sample, and for facility self-attestation. These forms are related to the survey and certification and Medicare approval of the PPS-excluded units; *Form Number:* CMS–437 (OMB#: 0938–0358); *Frequency:* Annually; *Affected Public:* Private sector businesses or other for-profits; *Number of Respondents:* 1,333; *Total Annual Responses:* 1,333; *Total Annual Hours:* 333. (For policy questions regarding this collection contact Kelley Leonette at 410–786–6664. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* MMIS APD Template for Use by States When Implementing the Mandatory National Correct Coding Initiative in Medicaid, SMD Letter #10–017 dated September 1, 2010. *Use;* The Patient Protection and Affordable Care Act (Affordable Care Act) requires implementation of Section 6507, Mandatory State Use of National Correct Coding Initiative. A State Medicaid Director letter, #10–017 dated September 1, 2010 was published with implementation requirements for provision 6507. Within this SMD letter, CMS states that a Medicaid Management Information System (MMIS) Advanced Planning Document (APD) template is required for States to request Federal financial participation (FFP) funding for implementing the provision and is also the tool for requesting deactivation of edits, due to direct conflicts with State laws, regulations, administrative rules, or payment policies. CMS has developed an MMIS–APD template specific to NCCI for State convenience. The MMIS APD template supporting implementation of the National Correct Coding Initiative in Medicaid will be submitted by States to the Regional Offices for review and to CMS Central Office for review and approval. The information requested on the MMIS APD template for NCCI will be used to determine and approve FFP to States. *Form Number:* CMS–10358 (OMB#: 0938–New); *Frequency:* Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 55; *Total Annual Responses:* 56; *Total Annual Hours:* 56. (For policy questions regarding this collection contact Richard Friedman at 410–786–4451. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* New collection; *Title of*