technical amendments to better align the proposed quarterly reporting form to the reporting forms that issuers submit to the National Association of Insurance Commissioners (NAIC). We have also amended the form to create two separate, but practically identical, forms with corresponding instructions, so as to allow issuers to nationally aggregate the experience of expatriate plans and to allow issuers to separately report the experience of mini-med plans and expatriate plans. We have also supplied the instructions in a separate document rather than at the bottom of each reporting form. *Form Number:* CMS–10373 (OCN: 0938–1132); *Frequency:* Quarterly; *Affected Public:* Private Sector: Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 75; *Number of Responses:* 825; *Total Annual Hours:* 51,480. (For policy questions regarding this collection, contact Carol Jimenez at (301) 492–4109. 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.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage* or email 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 *August 16, 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: June 14, 2011.

Martique Jones,

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

[FR Doc. 2011–15072 Filed 6–16–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS–1856 and CMS–1893, CMS–10381 and CMS–10342]

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:* (CMS–1856) Request for Certification in the Medicare and/or Medicaid Program to Provide Outpatient Physical Therapy and/or Speech Pathology Services, and (CMS–1893) Outpatient Physical Therapy—Speech Pathology Survey Report; *Use:* CMS–1856 is used as an application to be completed by providers of outpatient physical therapy and/or speech-language pathology services requesting participation in the Medicare and Medicaid programs. This form initiates the process for obtaining a decision as to whether the conditions of participation are met as a provider of outpatient physical therapy and/or speech-language pathology services. It is used by the State agencies to enter new provider into the Automated Survey Process Environment (ASPEN). CMS–1893 is used by the State survey agency to record data collected during an on-site survey of a provider of outpatient physical therapy and/or speech-language pathology services, to determine compliance with the applicable conditions of participation, and to report this information to the Federal government. The form is primarily a coding worksheet designed to facilitate data reduction and retrieval into the ASPEN system. The information needed to make certification decisions is available to CMS only through the use of information abstracted from the form; *Form Numbers:* CMS–1856 and CMS–1893 (OMB#: 0938–0065); *Frequency:* Annually, occasionally; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 2,968; *Total Annual Responses*: 495; *Total Annual Hours:* 866. (For policy questions regarding this collection contact Georgia Johnson at 410–786–6859. For all other issues call 410–786–1326.)

2. *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.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Annual Limits Waiver Online Application Form; *Use:* Under section 2711(a)(2) of the Public Health Service Act, as amended by the Affordable Care Act section 1302(b), The Secretary of Health and Human Services is required to impose restrictions on the dollar value of essential benefits provided by new or existing group health plans or individual policies in the market between September 23, 2010 and January 1, 2014. The interim final regulations published June 28, 2010 (45 CFR 147.126) give the Secretary the authority to waive these restricted annual limits if compliance would result in a significant increase in premium or significant decrease in access to benefits for those already covered. CMS is in the process of evaluating applications for waivers of annual limits and seeks to publish an updated Microsoft Excel spreadsheet to standardize and simplify the data collection process. Applicants must fill out (1) spreadsheet per application. The spreadsheet is a mandatory component of each waiver application necessary to fulfill the statutory requirements under section 2711(a)(2) of the Public Health Service Act. The information collected includes applicant contact information; information about the annual limit(s) on the overall plan or policy and on essential health benefits (as defined by the Affordable Care Act section 1302(b)); information about plan design such as copayment, coinsurance, and deductibles; financial projections by enrollee tier; and a description of how a significant decrease in access to benefits would result from compliance with section 2711(a)(2) of the Affordable Care Act. This information is required to accurately and objectively assess whether compliance with the restricted annual limits would result in the aforementioned significant increase in premium or significant decrease in access to benefits, on which the grant of a waiver is conditioned in the interim final regulations. The updated spreadsheet contains a more detailed description of what values should be entered into each cell. This description should save applicants time when completing the spreadsheet initially, and it should lessen the need for applicants to go back and correct mistakes after submission. *Form Number:* CMS–10342 (OCN: 0938–1105); *Frequency:* Annually; *Affected Public:* Private Sector; *Number of Respondents:* 4,872; *Number of Responses:* 4,608,372; *Total Annual Hours:* 178,183. (For policy questions regarding this collection, contact Erika Kottenmeier at (301) 492–4170. 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 July 18, 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: June 14, 2011.

Martique Jones,

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

[FR Doc. 2011–15071 Filed 6–16–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Child and Family Services Plan (CFSP), Annual Progress and Servicers Review (ASPR), and Annual Budget Expenses Request and Estimated Expenditures (CFS–101).

OMB No.: 0980–0047.

Description

Under title IV–B, subparts 1 and 2, of the Social Security Act (the Act), States, Territories, and Tribes are required to submit a Child and Family Services Plan (CFSP). The CFSP lays the groundwork for a system of coordinated, integrated, and culturally relevant family services for the subsequent five years (45 CFR 1357.15(a)(1)). The CFSP outlines initiatives and activities the State, Tribe or territory will carry out in administering programs and services to promote the safety, permanency, and well-being of children and families. By June 30 of each year, States, Territories, and Tribes are also required to submit an Annual Progress and Services Report (APSR) and a financial report called the CFS–101. The APSR is a Yearly report that discusses progress made by a State, Territory or Tribe in accomplishing the goals and objectives cited in its CFSP (45 CFR 1357.16(a)). The APSR contains new and updated information about service needs and organizational capacities throughout the five-year plan period. The CFS–101 has three parts. Part I is an annual budget request for the upcoming fiscal year. Part II includes a summary of planned expenditures by