of Wilmington Trust Company, both of Wilmington, Delaware.

In connection with this application, M&T Bank Corporation has applied to acquire Camden Partners Holdings, LLC; Camden Partners Private Equity Advisors, LLC, both of Baltimore, Maryland; Cramer Rosenthal McGlynn, LLC, White Plains, New York; Grant Tani Barash & Altman, LLC, Beverly Hills, California; Rodney Square Management Corp., Wilmington, Delaware; Roxbury Capital Management, LLC, Santa Monica, California; Wilmington Family Office, Inc.; Wilmington Trust Conduit Services, LLC, both of Wilmington, Delaware; Wilmington Trust FSB, Baltimore, Maryland; Wilmington Trust Fiduciary Services Company, Weehawken, New Jersey; Wilmington Trust Investment Management, LLC, Wilmington, Delaware; and thereby engage in (1) operating a savings association; (2) operating a nondepository trust company; (3) extending credit and servicing loans; (4) activities related to extending credit; (5) providing trust, fiduciary, and custody services; (6) acting as an investment advisor; (7) providing tax planning services; (8) securities brokerage services; (9) providing management consulting and employee benefits consulting services; (10) financing and investing in community development projects; and (11) selling U.S. savings bonds and issuing and selling traveler's checks pursuant to sections 225.28(b)(1), (2), (4), (5), (6), (7), (9), (12) and (13) of Regulation Y.

Board of Governors of the Federal Reserve System, January 10, 2011.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 2011–698 Filed 1–13–11; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10102, CMS–2088–92, CMS–10054, and CMS–10343]

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: National Implementation of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); *Use:* The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. Also known as the CAHPS ® Hospital Survey, it is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally and nationally.

Publicly reported HCAHPS results are based on four consecutive quarters of patient surveys. CMS publishes participating hospitals' HCAHPS results on the Hospital Compare Web site four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. Three broad goals have shaped HCAHPS. First, the survey is designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care. Third, public reporting serves to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey is credible, useful, and practical. This methodology and the information it generates are made available to the public. *Form Number:* CMS–10102 (OMB#: 0938–0981); *Frequency:* Occasionally; *Affected Public:* Private Sector: Business or other for-profits and Not-for-profit institutions; and Individuals or households; *Number of Respondents:* 2,483,775; *Total Annual Responses:* 2,480,000; *Total Annual Hours:* 289,342. (For policy questions regarding this collection, contact William Lehman at 410–786–1037. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Outpatient Rehabilitation Provider Cost Report utilized by Community Mental Health Centers; *Use:* In accordance with sections 1815, 1833 and 1861 of the Social Security Act, providers of service in the Medicare program are required to submit annual information to achieve reimbursement for health care services rendered to Medicare beneficiaries. In addition, 42 CFR 413.20(b) requires that cost reports will be required from providers on an annual basis. Such cost reports are required to be filed with the provider's Fiscal Intermediary (FI)/ Medicare Administrative Contractor (MAC).

The FI/MAC uses the cost report not only to make settlement with the provider for the fiscal period covered by the cost report, but also in deciding whether to audit the records of the provider. *Form Number:* CMS–2088–92 (OMB#: 0938–0037); *Frequency:* Yearly; *Affected Public:* Private Sector: Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 596; *Total Annual Responses:* 596; *Total Annual Hours:* 59,600. (For policy questions regarding this collection, contact Jill Keplinger at 410–786–4550. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Recognition of Payment for New Technology Ambulatory Payment Classification (APC) Groups under the Outpatient Prospective Payment System and Supporting Regulations in 42 CFR, Part 419; *Use:* In the April 7, 2000 final rule first implementing the hospital outpatient prospective payment system (OPPS), we created a set of New Technology ambulatory payment classifications (APCs) to pay for certain new technology services under the OPPS. These APCs are intended to pay

for new technology services that were not covered by the transitional pass-through payments provisions authorized by the Balanced Budget Refinement Act (BBRA) of 1999. Both the New Technology APC provision and the transitional pass-through provisions provide ways for ensuring appropriate payment for new technologies for which the use and costs are not adequately represented in the base year claims data on which the outpatient PPS is constructed.

CMS needs to keep pace with emerging new technologies and make them accessible to Medicare beneficiaries in a timely manner. It is necessary that we continue to collect appropriate information from interested parties such as hospitals, medical device manufacturers, pharmaceutical companies and others that bring to our attention specific services that they wish us to evaluate for New Technology APC payment. We are making no changes to the information that we collect. The information that we seek to continue to collect is necessary to determine whether certain new services are eligible for payment in New Technology APCs, to determine appropriate coding and to set an appropriate payment rate for the new technology service. The intent of these provisions is to ensure timely beneficiary access to new and appropriate technologies. *Form Number:* CMS–10054 (OMB#: 0938–0860); *Frequency:* Annually; *Affected Public:* Private sector business or other for-profits; *Number of Respondents:* 15; *Total Annual Responses:* 15; *Total Annual Hours:* 180. (For policy questions regarding this collection contact Christina Smith Ritter at 410–786–4636. For all other issues call 410–786–1326.)

4. *Type of Information Collection Request:* New collection; *Title of Information Collection:* State Plan Preprint for Medicaid Recovery Audit Contractors (RACs); *Use:* Under section 1902(a)(42)(B)(i) of the Social Security Act, States are required to establish programs to contract with one or more Medicaid RACs for the purpose of identifying underpayments and recouping overpayments under the State plan and any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver. Further, the statute requires States to establish programs to contract with Medicaid RACs in a manner consistent with State law, and generally in the same manner as the Secretary contracts with Medicare RACs. State programs contracted with Medicaid RACs are not required to be fully operational until after December 31, 2010. States may submit, to CMS, a State Plan Amendment (SPA) attesting that they will establish a Medicaid RAC program. States have broad discretion regarding the Medicaid RAC program design and the number of entities with which they elect to contract. Many States already have experience utilizing contingency-fee-based Third Party Liability recovery contractors; *Form Number:* CMS–10343 (OMB#: 0938–NEW); *Frequency:* Once; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 56. (For policy questions regarding this collection contact Mary Jo Cook at 410–786–3231 or Eva Tetteyfio at 410–786–3653. 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 *February 14, 2011.* OMB, Office of Information and Regulatory Affairs, *Attention:* CMS Desk Officer, *Fax Number:* (202) 395–6974, *E-mail: OIRA_submission@omb.eop.gov*.

Martique Jones,

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

[FR Doc. 2011–736 Filed 1–13–11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–268 and CMS–10328]

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 a currently approved collection; *Title of Information Collection:* CMS Survey Tool for *http://www.cms.gov* and *http://www.medicare.gov; Use:* The purpose of this submission is to continue to collect information from Internet users as they exit from the Web sites Medicare.gov and CMS.gov. To ensure that we gather information about user reactions to the Web sites, we have developed a survey tool that users can complete when they exit either site or by accessing a link on the bottom bar on the page. The responses on this survey tool will help CMS to make appropriate changes to the Web sites in the future. The survey tool contains questions about the information that visitors are seeking from the sites, the degree to which either site was useful to them, the improvements that they would like to see in the sites, and their general comments. *Form Number:* CMS–R–268 (OMB# 0938–0756); *Frequency:* Yearly; *Affected Public:* Individuals and households, Private sector—Business or other for-profit; *Number of Respondents:* 7,000; *Total Annual Responses:* 9,100; *Total Annual Hours:* 1,167. (For policy questions regarding this collection contact Matthew Aiken at 410–786–1029. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Revision of currently approved collection; *Title of Information Collection:* Medicare Self-Referral Disclosure Protocol; *Use:* Section 6409 of the ACA requires the Secretary to establish and post information on the CMS' public Internet Web site concerning a self-referral disclosure protocol (SRDP) that sets forth a process for providers of services and suppliers to self-disclose actual or potential violations of section 1877 of the Act. In addition, section 6409(b) of the ACA gives the Secretary authority to reduce