Facility: BWX Technologies, Inc.

Location: Lynchburg, Virginia.

Job Titles and/or Job Duties: All Atomic Weapons Employer employees.

Period of Employment: January 1, 1985 through November 30, 1994.

FOR FURTHER INFORMATION CONTACT: Stuart L. Hinnefeld, Interim Director, Division of Compensation Analysis and Support, National Institute for Occupational Safety and Health (NIOSH), 4676 Columbia Parkway, MS C–46, Cincinnati, OH 45226, Telephone 877–222–7570. Information requests can also be submitted by e-mail to *DCAS@CDC.GOV.*

John Howard,

Director, National Institute for Occupational Safety and Health.

[FR Doc. 2010–26558 Filed 10–21–10; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–2088–92, CMS–10054, CMS–10102 and CMS–10358]

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:* 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.)

2. *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.)

3. *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. The HCAHPS 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.)

4. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Medicaid Management Information System Advanced Planning Document 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 (NCCI). A State Medicaid Director letter, #10–017 dated September 1, 2010 was published with implementation requirements for provision 6507. The letter stated 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 NCCI in the Medicaid program 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#: 0938–0New); *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.)

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 on (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 *December 21, 2010:*

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: October 18, 2010.

Martique Jones,

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

[FR Doc. 2010–26519 Filed 10–21–10; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: Affordable Care Act Tribal Maternal, Infant, and Early Childhood Home Visiting Program Needs Assessment and Plan for Responding to Identified Needs.

OMB No.: New Collection.

Description: Section 511(h)(2)(A) of Title V of the Social Security Act, as added by Section 2951 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148, Affordable Care Act or ACA), authorizes the Secretary of HHS to award grants to Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to conduct an early childhood home visiting program. The legislation sets aside 3 percent of the total ACA Maternal, Infant, and Early Childhood Home Visiting Program appropriation (authorized in Section 511(j)) for grants to Tribal entities and requires that the Tribal grants, to the greatest extent practicable, be consistent with the requirements of the Maternal, Infant, and Early Childhood Home Visiting Program grants to States and territories (authorized in Section 511(c)), and include conducting a needs assessment and establishing benchmarks.

The Administration for Children and Families, Office of Child Care, in collaboration with the Health Resources and Services Administration, Maternal and Child Health Bureau, recently awarded grants for the Tribal Maternal, Infant, and Early Childhood Home Visiting Program (Tribal Home Visiting). The Tribal Home Visiting grant awards will support 5-year cooperative agreements to conduct community needs assessments, plan for and implement high-quality, culturally-relevant, evidence-based home visiting programs in at-risk Tribal communities, and participate in research and evaluation activities to build the knowledge base on home visiting among Native populations.

In Phase 1 (Year 1) of the cooperative agreement, grantees must (1) conduct a comprehensive community needs assessment and (2) develop a plan and begin to build capacity to respond to identified needs. Grantees will be expected to submit the needs assessment and plan for responding to identified needs through an evidence-based home visiting program within 10 months of the Year 1 award date. Grantees may engage in needs assessment, planning, and capacity-building activities during Phase 1, but will not fully implement their plan and/or begin serving children and families through high-quality, evidence-based home visiting programs. Pending successful Phase 1 activities and submission (within 10 months of Year 1 award date) of a non-competing continuation application that includes a needs assessment and approvable plan for responding to identified needs, funds will be provided for Phase 2 (Implementation Phase, Years 2–5).

Respondents: Affordable Care Act Tribal Maternal, Infant, and Early Childhood Home Visiting Program Year 1 Grantees.