HIP QDRP—Hospital Inpatient Quality Data Reporting Program.
Health Homes Core—CMS Health Homes Core Measures.
MU1—Meaningful Use Stage 1 of the Medicare & Medicaid Electronic Health Record Incentive Programs.
PQRS—Physician Quality Reporting Program Group Practice Reporting Option.
Shared Savings Program—Medicare Shared Savings Program.
VHA—Veterans Health Administration.

[FR Doc. 2011–33756 Filed 12–30–11; 4:15 pm]

**BILLING CODE P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

### Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Initial Review

The meeting announced below concerns National HIV Behavioral Surveillance For Young Men Who Have Sex With Men, Funding Opportunity Announcement (FOA), PS11–0010201SUPP12, initial review.

*Correction:* The notice was published in the **Federal Register** on November 18, 2011, Volume 76, Number 223, Page 71568. The time and date should read as follows:

*Time and Date:* 1 p.m.–5 p.m., February 29, 2012 (Closed).

*Contact Person For More Information:* Amy Yang, Ph.D., Scientific Review Officer, CDC, 1600 Clifton Road NE., Mailstop E60, Atlanta, Georgia 30333, Telephone: (404) 718–8836.

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: December 20, 2011.

**Elaine L. Baker,**

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

[FR Doc. 2011–33731 Filed 1–3–12; 8:45 am]

**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

### Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Initial Review

The meeting announced below concerns Formative Research on Use of Mobile Applications (''app'') to Increase HIV Testing Behavior and HIV Prevention with Positive Persons, Funding Opportunity Announcement (FOA), PS12–001, initial review.

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting:

*Time and Date:* 8 a.m.–5 p.m., February 28, 2012 (Closed).

*Place:* Sheraton Gateway Hotel Atlanta Airport, 1900 Sullivan Road, Atlanta, Georgia 30337, Telephone: (770) 997–1100.

*Status:* The meeting will be closed to the public in accordance with provisions set forth in Section 552b(c) (4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

*Matters To Be Discussed:* The meeting will include the initial review, discussion, and evaluation of applications received in response to ''Formative Research on Use of Mobile Applications (''app'') to Increase HIV Testing Behavior and HIV Prevention with Positive Persons, FOA PS12–001.''

*Contact Person for More Information:* Gregory Anderson, M.S., M.P.H., Scientific Review Officer, CDC, 1600 Clifton Road NE., Mailstop E60, Atlanta, Georgia 30333, Telephone: (404) 718–8833.

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: December 20, 2011.

**Elaine L. Baker,**

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

[FR Doc. 2011–33730 Filed 1–3–12; 8:45 am]

**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[Document Identifier: CMS–R–74 and CMS–10338]**

### 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 without change of a currently approved collection; *Title of Information Collection:* Income and Eligibility Verification System (IEVS) Reporting and Supporting Regulations Contained in 42 CFR 431.17, 431.306, 435.910, 435.920, and 435.940–960; *Use:* The information collected is used to verify the income and eligibility of Medicaid applicants and recipients, as required by Section 1137 of the Social Security Act. Final regulations to implement Section 1137 of the Act were published February 28, 1986. Subsequent final amendments to the regulations were published on February 27, 1987; March 2, 1989; October 7, 1992; and January 31, 1994. These regulations provide the standards States use to determine which recipient and applicant records to match, the frequency of the match, due process protections for individuals whose records are matched, and those

circumstances which permit exceptions from conducting verifications; *Form Number:* CMS–R–74 (OCN 0938–0467); *Frequency:* Monthly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 50; *Total Annual Responses:* 8,520,000; *Total Annual Hours:* 124,054. (For policy questions regarding this collection contact Barbara Washington at (410) 786–9964. For all other issues call (410) 786–1326.)

2. *Type of Information Collection Request:* Type of Information Collection Request: Extension of a currently approved collection; Title of Information Collection: Affordable Care Act Internal Claims and Appeals and External Review Procedures for Non-grandfathered Group Health Plans and Issuers and Individual Market Issuers; Use: The Patient Protection and Affordable Care Act, Public Law 111–148, (the Affordable Care Act) was enacted on March 23, 2010. As part of the Act, Congress added PHS Act section 2719, which provides rules relating to internal claims and appeals and external review processes. On July 23, 2010 (75 FR 43330), interim final regulations (IFR) set forth rules implementing PHS Act section 2719 for internal claims and appeals and external review processes. With respect to internal claims and appeals processes for group health coverage, PHS Act section 2719 and our regulations provide that group health plans and health insurance issuers offering group health insurance coverage must comply with the internal claims and appeals processes set forth in 29 CFR 2560.503–1 (the DOL claims procedure regulation) and update such processes in accordance with standards established by the Secretary of Labor. The DOL claims procedure regulation requires an employee benefit plan to provide third-party notices and disclosures participants and beneficiaries of the plan. In addition, our regulations add an additional requirement that non-grandfathered group health plans and issuers of non-grandfathered health policies provide to the claimant, free of charge, any new or additional evidence considered, or generated by the plan or issuer in connection with the claim.

The IFR also requires issuers offering coverage in the individual health insurance market to also generally comply with the DOL claims procedure regulation as updated by the Secretary of HHS in the IFR for their internal claims and appeals processes.

Furthermore, PHS Act section 2719 and the IFR provide that non-grandfathered group health plans, issuers offering group health insurance coverage, and self-insured nonfederal governmental plans (through the IFR amendment dated June 24, 2011) must comply either with a State external review process or a Federal review process. The IFR provides a basis for determining when such plans and issuers must comply with an applicable State external review process and when they must comply with the Federal external review process. Plans and issuers that are required to participate in the Federal external review process must electronically elect either the HHS-administered process or the private accredited IRO process by January 1, 2012. The election requirements associated with this ICR are articulated through guidance published June 22, 2011 at *http://cciio.cms.gov/resources/files/hhs_srg_elections_06222011.pdf.* The election requirements are necessary for the Federal external review process to provide an independent external review as requested by claimants. Form Number: CMS–10338 (OCN: 0938–1099); Frequency: Occasionally; Affected Public: State, Local, Tribal Governments; Business or other for-profit; Not-for-profit institutions. Number of Respondents: 46,773; Number of Responses: 218,657,161; Total Annual Hours: 930,267. (For policy questions regarding this collection, contact Colin McVeigh at (301) 492–4263. 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 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 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 March 5, 2012:

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: December 23, 2011.

**Martique Jones,**

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

[FR Doc. 2011–33752 Filed 1–3–12; 8:45 am]

**BILLING CODE 4120–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[Document Identifier CMS–10142 and CMS–R–262]**

### 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:* Revision of a currently approved collection; *Title of Information Collection:* Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP); *Use:* Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and implementing regulations at 42 CFR, Medicare Advantage organizations (MAO) and Prescription Drug Plans (PDP) are required to submit an actuarial pricing ''bid'' for each plan offered to Medicare beneficiaries for approval by the Centers for Medicare & Medicaid Services (CMS).