Form	Type of respondent	Number of respondents	Number of responses per respondent	Avg. burden per response (in hrs)	Total burden hours
CJD	Epidemiologist	20	2	20/60	13
Cyclosporiasis	Epidemiologist	55	10	15/60	138
Dengue	Epidemiologist	55	182	15/60	2,503
Hantavirus	Epidemiologist	40	3	20/60	40
Kawasaki Syndrome	Epidemiologist	55	8	15/60	110
Legionellosis	Epidemiologist	23	12	20/60	92
Lyme Disease	Epidemiologist	52	385	10/60	3,337
Malaria	Epidemiologist	55	20	15/60	275
Plague	Epidemiologist	11	1	20/60	4
Q Fever	Epidemiologist	55	1	10/60	9
Reye Syndrome	Epidemiologist	50	1	20/60	17
Tick-borne Rickettsia	Epidemiologist	55	18	10/60	165
Trichinosis	Epidemiologist	25	1	20/60	8
Tularemia	Epidemiologist	55	2	20/60	37
Typhoid Fever	Epidemiologist	55	6	20/60	110
Viral hepatitis	Epidemiologist	55	200	25/60	4,583
Total					11,441

Kimberly S. Lane,

Deputy Director, Office of Scientific Integrity, Office of the Associate Director for Science Office of the Director Centers for Disease Control and Prevention.

[FR Doc. 2012–30021 Filed 12–11–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10280 and CMS–R–131]

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:* New collection; *Title:* Home Health Change of Care Notice (HHCCN); *Use:* Home health agencies (HHAs) are required to provide written notice to original Medicare beneficiaries under various circumstances involving the initiation, reduction, or termination of services. The notice used in these situations has been the Home Health Advance Beneficiary Notice (HHABN), CMS–R–296.

The HHABN, originally a liability notice specifically for HHA issuance, was first approved for use and implementation in 2000 with the home health prospective payment system transition. In 2006, the notice underwent significant modifications subsequent to the decision of the U.S. Court of Appeals (2nd Circuit) in *Lutwin* v. *Thompson.* HHABN content and formatting were revised so that it could be used to provide beneficiaries with change of care notification consistent with HHA Conditions of Participation (COPs) in addition to its liability notice function. Three interchangeable option boxes were introduced to the HHABN to support the added notification purposes. Option Box 1 addressed liability, Option Box 2 addressed change of care for agency reasons, and Option Box 3 addressed change of care due to provider orders. HHABN Collection 0938–0781 last received PRA approval in 2009 following minor notice changes such as accessibility reformatting for compliance with Section 508 of the Rehabilitation Act of 1973, as amended in 1998, and removal of the beneficiary's health insurance claim number (HICN).

In an effort to streamline, reduce, and simplify notices issued to Medicare beneficiaries, HHABN Option Box 1, the liability notice portion, will be replaced by the existing Advanced Beneficiary Notice of Noncoverage (ABN) which is approved by OMB (0938–0566), for conveying information on beneficiary liability. Written notices to inform beneficiaries of their liability under specific conditions have been available since the ''limitation on liability'' provisions in section 1879 of the Social Security Act were enacted in 1972 (Pub. L. 92–603). The ABN (CMS–R–131) is presently used by providers and suppliers other than HHAs to inform fee for service (FFS) Medicare beneficiaries of potential liability for certain items/services that might be billed to Medicare. The HHABN was developed specifically as the liability notice for HHA issuance. Since 2006, the HHABN has evolved to serve both liability and change of care notification purposes. Pursuant to a separate PRA package revising the use of the ABN, HHAs will now use the ABN for liability notification, and the HHCCN will be introduced as a separate, distinct document to give change of care notice in compliance with HHA conditions of participation. The HHCCN will replace both Option Box 2 and Option Box 3 formats of the HHABN. The single page format of the HHCCN is designed to specify whether the change of care is due to agency reasons or provider orders. *Form Number:* CMS–10280 (OCN: 0938–New); *Frequency:* Occasionally; *Affected Public:* Private Sector—Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 10,914; *Total Annual Responses:* 14,126,428; *Total Annual Hours:* 941,385. (For policy questions regarding this collection contact Evelyn Blaemire at 410–786–1803. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Advance Beneficiary Notice of Noncoverage (ABN); *Use:* The use of written notices to inform beneficiaries of their liability under specific conditions has been available since Title XVIII of the Social Security Act (the Act), section 1879, Limitation on Liability, was enacted in 1972 (Pub. L. 92–603). Similar required notification and liability protections are available under other sections of the Act: Section 1834(a)(18) refund requirements for certain items when unsolicited telephone contacts are made, section 1834(j)(4) for the same types of items when there is neither a required advance coverage determination nor required supplier number; 1834(a)(15) also for advance determinations for these items and section 1842(l) applicable to physicians not accepting assignment. Implementing regulations are found at 42 CFR 411.404(b) and (c), and 411.408(d)(2) and (f), on written notice requirements. These statutory requirements apply only to Original Medicare, not Medicare Advantage plans.

Under section 1879 of the Act, Medicare beneficiaries may be held financially responsible for items or services usually covered under Medicare, but denied in an individual case under specific statutory exclusions, if the beneficiary is informed prior to furnishing the issues or services that Medicare is likely to deny payment.

When required, the ABN is delivered by Part B paid physicians, providers (including institutional providers like outpatient hospitals) practitioners (such as chiropractors), and suppliers, as well as hospice providers and Religious Non-medical Health Care Institutions paid under Part A. Other Medicare institutional providers paid under Part A use other approved notice for this purpose.

The revised ABN in this information collection request incorporates expanded use by Home Health Agencies (HHAs). There have been no substantive changes to the form. There are no changes that will affect existing ABN users. *Form Number:* CMS–R–131 (OMB#: 0938–0566); *Frequency:* Reporting—Occasionally; *Affected Public:* Private Sector—Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 1,288,837; *Total Annual Responses:* 52,967,771; *Total Annual Hours:* 6,177,101. (For policy questions regarding this collection contact Evelyn Blaemire at 410–786–1803. 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 *February 11, 2013:*

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 7, 2012.

Martique Jones,

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

[FR Doc. 2012–29951 Filed 12–11–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS–10451]

Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB); Correction

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Correction of notice.

SUMMARY: This document corrects a technical error in the notice [Document Identifier: CMS–10451] entitled ''Evaluation and Development of Outcome Measures for Quality Assessment in Medicare Advantage and Special Needs Plans'' that was published in the October 26, 2012 (77 FR 65391) **Federal Register**.

FOR FURTHER INFORMATION CONTACT: William Parham, (410) 786–4669.

SUPPLEMENTARY INFORMATION:

I. Background

In the FR Doc. 2012–16514 of October 26, 2012 (77 FR 65391), we published a Paperwork Reduction Act notice requesting a 60-day public comment period for the document entitled ''Evaluation and Development of Outcome Measures for Quality Assessment in Medicare Advantage and Special Needs Plans.''

There were technical delays with making the information collection request publicly available; therefore, in this notice we are extending the comment period from the date originally listed in the October 26, 2012 notice.

II. Correction of Error

In FR Doc. 2012–26380 of October 26, 2012 (77 FR 65391), make the following correction:

On page 65391, second column, third full paragraph, fourth line, the sentence, ''To be assured consideration, comments and recommendations must be submitted in one of the following ways by December 26, 2012:'' is corrected to read ''To be assured consideration, comments and recommendations must be submitted in one of the following ways by January 2, 2012:''.

Dated: December 7, 2012.

Martique Jones,

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

[FR Doc. 2012–29956 Filed 12–11–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Office of Child Support Enforcement; Privacy Act of 1974; Computer Matching Agreement

AGENCY: Office of Child Support Enforcement (OCSE), ACF, HHS.

ACTION: Notice of a Computer Matching Program.

SUMMARY: In accordance with the Privacy Act of 1974 (5 U.S.C. 522a), as amended, OCSE is publishing notice of a computer matching program between OCSE and state agencies administering the Temporary Assistance for Needy Families (TANF) program.

DATES: HHS invites interested parties to review, submit written data, comments,