be allowed to enroll Medicaid beneficiaries on a mandatory basis into managed care entities without section 1115 or 1915(b) waiver authority.; *Frequency:* On occasion; *Affected Public:* State, local, or tribal government; *Number of Respondents:* 56; *Total Annual Responses:* 10; *Total Annual Hours:* 100.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS's Web site address at *http://www.cms.hhs.gov/regulations/pra/,* or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.gov,* or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the CMS Paperwork Clearance Officer designated at the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances, Attention: Melissa Musotto, Room C5–14–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: July 14, 2004.

John P. Burke, III,

Paperwork Reduction Act Team Leader, Office of Strategic Operations and Strategic Affairs, Division of Regulations Development and Issuances.

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BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–10105, CMS–1561, CMS–10110, CMS–R–216 and CMS–10047]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare and 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 and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA), 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 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 of Information Collection:* In-Center Hemodialysis CAHPS Survey (**Note:** Significant modifications were made to this information collection since the publication of the 60-day FR notice. The title of this information collection was also changed from End Stage Renal Disease Hemodialysis Patient Experience of Care (CAHPS) Survey since its publication.; *Form No.:* CMS–10105 (OMB #0938–NEW; *Use:* The In-Center Hemodialysis CAHPS Survey follows CMS CAHPS efforts in other provider areas (Managed Care, FFS, hospital), and is intended to provide CMS with a picture of the experience of this vulnerable population who receive life sustaining dialysis therapy approximately three times per week from dialysis facilities. A variety of patient satisfaction surveys are already conducted regularly by a many dialysis organizations (although the majority of instruments have not been tested) and this tool would provide the ESRD community with a tested, standardized survey instrument that facilities could use for quality improvement and comparative purposes. It will provide information for consumer choice, data that facilities can use for internal quality improvement and external benchmarking against other facilities, and finally, information that CMS can use for public reporting and monitoring purposes.; *Frequency:* Recordkeeping; *Affected Public:* Individuals or Households; *Number of Respondents:* 3,000; *Total Annual Responses:* 3,000; *Total Annual Hours:* 1,500.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Health Insurance Benefit Agreement and Supporting Regulations in 42 CFR Section 489 and 491; *Form No.:* CMS–1561 (OMB #0938–0832); *Use:* Applicants to the Medicare program are required to agree to provide services in accordance with Federal requirements. The CMS–1561 and CMS–1561A are essential for CMS to ensure that applicants are in compliance with the requirements. Applicants are required to sign the completed forms and provide operational information to CMS to assure that they continue to meet the requirements after approval; *Frequency:* Other: as needed; *Affected Public:* Business or other for-profit, Not-for-profit institutions, and State, Local or Tribal Government; *Number of Respondents:* 3,300; *Total Annual Responses:* 3,300; *Total Annual Hours:* 175.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Manufacturer Submission of Average Sales Price (ASP) data for Medicare Part B Drugs and Biologicals and Supporting Regulations; *Form No.:* CMS–10110 (OMB #0938–0921); *Use:* This information collection implements the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 that require instructions to manufacturers on the submission of average sales price (ASP) data on Medicare Part B drugs to the Centers for Medicare and Medicaid Services (CMS). This form is the tool used by manufacturers to submit the required data.; *Frequency:* Quarterly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 120; *Total Annual Responses:* 480; *Total Annual Hours:* 15,360.

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Procedures for Advisory Opinions Concerning Physician Referrals and Supporting Regulations in 42 CFR Sections 411.370 through 411.389; *Form No.:* CMS–R–216 (OMB #0938–0714); *Use:* A request must include a complete description of the situation that is subject of the advisory opinion and must include copies of all relevant documents (or relevant portions), such as financial statements, contracts, leases, employment agreements and court documents. The submission must include the identities and addresses of all known actual and potential parties to the arrangement. A request for an advisory opinion is purely voluntary. The facts will relate to business plans and the requestor will already have collected and analyzed all or most of the information we will need to review the request; *Frequency:* On occasion; *Affected Public:* Not-for-profit institutions, Individuals or Households, and Business or other for-profit; *Number or Respondents:* 200; *Total Annual Responses:* 200; *Total Annual Hours:* 2,000.

5. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships and Supporting Regulations in 42 CFR, Sections 411.352 through 411.361; *Form No.:* CMS–10047 (OMB #0938–0846); *Use:* The final rule (HCFA–1809) incorporated into regulations the provisions in paragraphs (a), (b), (c), (d), and (h) of section 1877 of the Social Security Act. Under section 1877, if a physician or a member of a physician's immediate family has a financial relationship with a health care entity, the physician may not refer Medicare patients to that entity for the furnishing of 11 designated health services, unless an exception applies. In addition, section 1877 prohibits an entity from presenting or causing to be presented a Medicare claim or bill to any individual, third party payer, or other entity for designated health services furnished under a prohibited referral. Also, Medicare does not pay for a designated health service furnished under a prohibited referral.; *Frequency:* Annually and Other: whenever financial arrangements between entities that furnish designated health services and physicians change.; *Affected Public:* Business or other for-profit, Not-for-profit institutions, and Individuals or Households; *Number or Respondents:* 62,824; *Total Annual Responses:* 62,824; *Total Annual Hours:* 1,561,633.

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/regulations/pra/,* or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.gov,* or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Christopher Martin, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: July 14, 2004.

John P. Burke, III,

Paperwork Reduction Act Team Leader, CMS Reports Clearance Officer, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2187–N]

State Children's Health Insurance Program (SCHIP); Extended Availability of Unexpended SCHIP Funds From the Appropriation for Fiscal Years 1998 Through 2001; and Provision of Authority for Qualifying States To Use a Portion of SCHIP Funds for Medicaid Expenditures

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

ACTION: Notice.

SUMMARY: This notice describes the extension of availability to the end of Federal fiscal year (FY) 2004 of the amounts of States' unexpended FY 1998 and FY 1999 allotment funds. Additionally, this notice sets forth the amounts of States' unexpended FY 2000 allotments that remained at the end of FY 2002 that will be available under a statutory formula for each of the 50 States, the District of Columbia, and the Commonwealths and Territories through the end of a subsequent period of availability ending September 30, 2004. This notice also sets forth the amounts of States' unexpended FY 2001 allotments that remained at the end of FY 2003 that will be available under a statutory formula for each of the 50 States, the District of Columbia, and the Commonwealths and Territories through the end of a subsequent period of availability ending September 30, 2005.

Finally, this notice permits ''Qualifying States'' to elect to receive a portion of their available SCHIP allotments as increased Federal matching funding for certain expenditures in their Medicaid programs.

FOR FURTHER INFORMATION CONTACT: Richard Strauss, (410) 786–2019.

SUPPLEMENTARY INFORMATION:

I. Background

A. Extension of Availability and Redistribution of State Children's Health Insurance Program (SCHIP) Fiscal Year 1998 Through 2001 Allotments

Title XXI of the Social Security Act (the Act) sets forth the State Children's Health Insurance Program (SCHIP) to enable States, the District of Columbia, and specified Commonwealths and Territories to initiate and expand health insurance coverage to uninsured, low-income children. In this notice, unless otherwise indicated, the terms ''State'' and ''States'' refer to any or all of the 50 States, the District of Columbia, and the Commonwealths and Territories. States may implement SCHIP through a separate child health program under title XXI of the Act, an expanded program under title XIX of the Act, or a combination of both. Under section 2104 of the Act, the SCHIP allotments for a Federal fiscal year (FY) are available to match expenditures under an approved State child health plan for an initial 3-fiscal year ''period of availability,'' including the fiscal year for which the allotment was provided. After the initial period of availability, the amount of unspent allotments is subject to a subsequent period of availability. With the exception described below for the allotments made in FYs 1998 through 2001, allotments unspent in the initial 3-year period of availability would be redistributed from States that did not fully spend these allotments to States that fully spent their allotments for that fiscal year.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) enacted as part of Pub. L. 106–554 on December 21, 2000, amended title XXI of the Act, in part by establishing new requirements for a subsequent extended period of availability with respect to the amounts of States' FY 1998 and FY 1999 allotments that were unspent during the initial 3-year period of availability. Under the BIPA amendments, the subsequent period of availability for States' unspent FY 1998 and 1999 allotments was extended to the end of FY 2002.

Section 1 of Pub. L. 108–74, enacted on August 15, 2003, amended title XXI of the Act to establish new requirements for the subsequent period of availability associated with the unexpended amounts of States' FYs 1998, 1999, 2000, and 2001 allotments that were unspent during the initial 3-year period of availability relating to those fiscal years. Specifically, section 2104(g) of the Act extends the subsequent period of availability associated with the allotments and redistribution of allotments for FYs 1998 through 2000 through the end of fiscal year 2004, and through the end of fiscal year 2005 for the redistributed and extended FY 2001 allotments.

The requirements of section 2104(g) of the Act prescribe a methodology and process which includes the retention of certain amounts of unspent FY 2000 and FY 2001 allotments that would remain available to the States that did not fully expend their FY 2000 or FY 2001