Dated: March 8, 2007.

Michelle Shortt,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10095]

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:* Detailed Explanation of Non-Coverage and Notice of Medicare Non-Coverage and Supporting Regulations in 42 CFR 422.624 and 42 CFR 422.626; *Use:* Providers will deliver a Notice of Medicare Non-Coverage to enrollees at least two days prior to the end of covered services in skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities. Enrollees will use this information to determine whether they wish to appeal the service termination to the Quality Improvement Organization (QIO) in their State. If the enrollee decides to appeal, the Medicare Health organization will send the QIO and the enrollee a Detailed Explanation of Non-Coverage detailing the rationale for the termination decision. *Form Number*: CMS–10095 (OMB#: 0938–0910); *Frequency:* Reporting: Yearly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 454; *Total Annual Responses:* 47,558; *Total Annual Hours:* 23,780.52.

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.

Written comments and recommendations for the proposed information collections must be mailed or faxed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: March 16, 2007.

Michelle Shortt,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10216, CMS–R–0053, CMS–179, CMS–10137, CMS–10069 and CMS–R–246]

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:* Alternative Benefits State Plan Amendment Health Opportunity Accounts (HOA) Demonstration Program; *Use:* The DRA provides States with numerous flexibilities in operating their State Medicaid programs. For example, Section 6082 of the DRA allows up to 10 States to operate Medicaid demonstrations to test alternative systems for delivering their Medicaid benefits. Under these demonstrations, States would have the flexibility to deliver their Medicaid benefits to volunteer beneficiaries through a program that is comprised of an HOA and a High Deductible Health Plan (HDHP). Under the DRA, States can submit a State Plan Pre-print to CMS to effectuate this change to their Medicaid programs. CMS will provide a State Medicaid Director letter providing guidance on this provision and the implementation of the DRA and the associated State Plan Amendment template for use by States to modify their Medicaid State Plans if they choose to implement this flexibility; Form Number: CMS–10216 (OMB#: 0938–1007); *Frequency:* Reporting: One-time; *Affected Public:* State, Local or tribal Government; *Number of Respondents:* 56; *Total Annual Responses:* 10; *Total Annual Hours:* 10.

2. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Imposition of Cost Sharing Charges Under Medicare and Supporting Regulations Contained in 42 CFR 447.53; *Use:* The purpose of this collection is to ensure that States impose nominal cost sharing charges upon categorically and medically needy individuals as allowed by law and implementing regulations. States must identify in their State plan the following: (1) The service for which the charge is made; (2) The amount of the charge; (3) The basis for determining the charge; (4) The method used to collect the charge; (5) The basis for determining whether an individual is unable to pay the charge and the way in which the individual will be identified to providers; and, (6) The procedures for implementing and enforcing the exclusions from cost sharing; *Form*

Number: CMS–R–0053 (OMB#: 0938–0429); *Frequency:* Reporting: Occasionally; *Affected Public:* State, Local or tribal Government; *Number of Respondents:* 56; *Total Annual Responses:* 2; *Total Annual Hours:* 20.

3. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Transmittal and Notice of Approval of State Plan Material and Supporting Regulations in 42 CFR 430.10–430.20 and 440.167; *Use:* The CMS–179 is used by State agencies to transmit State plan material to the Centers for Medicare & Medicaid Services (CMS) for approval prior to amending their State plan. The State plan is the method in which States inform staff of State policies, standards, procedures and instructions. The CMS–179 is currently used by State agencies administering the Medicaid program and CMS regional offices (RO). State agencies use the form to submit State plan amendments (SPAs) (including supporting documentation) to the CMS RO for review and approval prior to amending their plan in accordance with 42 CFR 430.10–430.20. The CMS–179 includes instructions for completing the form. The inclusion of instructions is to assist State agencies in completing the form, thereby ensuring a more uniform and timely plan amendment approval process. The CMS–179 is the only source available to State agencies for submittal/approval of SPAs. This plan amendment approval process is necessary to ensure the State plan continues to meet statutory and regulatory requirements and thereby ensure the State's eligibility for Federal financial participation. CMS will use this information to track the estimated Federal budget impact associated with the SPAs. This information may result in more accurate Federal Medicaid expenditure estimates; *Form Number:* CMS–179 (OMB#: 0938–0193); *Frequency:* Reporting: Occasionally; *Affected Public:* State, Local or tribal Government; *Number of Respondents:* 56; *Total Annual Responses:* 10; *Total Annual Hours:* 560.

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Application for Prescription Drug Plans (PDP); Application for Medicare Advantage Prescription Drug (MA–PD); Application for Cost Plans To Offer Qualified Prescription Drug Coverage; Application for Employer Group Waiver Plans To Offer Prescription Drug Coverage; Service Area Expansion Application for Prescription Drug Coverage; *Use:* Collection of this information is mandated in Part D of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The application requirements are codified in Subpart K of 42 CFR part 423. Coverage for the prescription drug benefit is provided through prescription drug plans (PDPs) that offer drug-only coverage, or through Medicare Advantage (MA) organizations that offer integrated prescription drug and health care coverage (MA–PD plans). PDPs must offer a basic drug benefit. Medicare Advantage Coordinated Care Plans (MA–CCPs) must offer either a basic benefit or may offer broader coverage for no additional cost. Medicare Advantage Private Fee for Service Plans (MA–PFFS) may choose to offer a Part D benefit. Cost Plans that are regulated under Section 1876 of the Social Security Act, and Employer Group Plans may also provide a Part D benefit. If any of the contracting organizations meet basic requirements, they may also offer supplemental benefits through enhanced alternative coverage for an additional premium.

The information will be collected under the solicitation of proposals from PDP, MA–PD, Cost Plan, and Employer Group Waiver Plans applicants. The collected information will be used by CMS to: (1) Insure that applicants meet CMS requirements, and (2) support the determination of contract awards.

The major program change that has occurred in Part D applications was that CMS removed several attestations related to Health Insurance Portability and Accountability Act (HIPAA), bids and privacy; *Form Number:* CMS–10137 (OMB#: 0938–0936); *Frequency:* Reporting: Once; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 857; *Total Annual Responses:* 857; *Total Annual Hours:* 28,122.

5. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Medicare Waiver Demonstration Application; *Use:* The Medicare Waiver Demonstration Application will be used to collect standard information needed to implement congressionally mandated and administration high priority demonstrations. The application will be used to gather information about the characteristics of the applicant's organization, benefits, and services they propose to offer, success in operating the model, and evidence that the model is likely to be successful in the Medicare program. The standard application will be used for all waiver demonstrations and will reduce the burden on applicants, provide for consistent and timely information collections across demonstrations, and provide a user-friendly format for respondents; *Form Number:* CMS–10069 (OMB#: 0938–0880); *Frequency:* Reporting: Once; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 75; *Total Annual Responses:* 75; *Total Annual Hours:* 6000.

6. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Medicare CAHPS Survey; *Use:* The collection of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey measures is necessary to hold health and prescription drug plans accountable for the quality of care and services they deliver. This requirement will allow CMS to obtain information for the proper oversight of the program. This information is used to help beneficiaries choose among plans, contribute to improved quality of care through identification of quality improvement opportunities, and assist CMS in carrying out its responsibilities; *Form Number:* CMS–R–246 (OMB#: 0938–0732); *Frequency:* Reporting: Yearly; *Affected Public:* Individuals or households; *Number of Respondents:* 660,000; *Total Annual Responses:* 660,000; *Total Annual Hours:* 217,800.

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 at the address below, no later than 5 p.m. on May 22, 2007.

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—A, Attention: Melissa Musotto, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: March 16, 2007.

Michelle Shortt,

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

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