

Health of People with Intellectual Disabilities.”

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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 CDC and the Agency for Toxic Substances and Disease Registry.

**Elaine L. Baker,**

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

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

[Document Identifier: CMS-10003, CMS-901A and D, CMS-9044, CMS-R-193 and CMS-10066]

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

**AGENCY:** Centers for Medicare & Medicaid Services.

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), 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:** Notice of Denial of Medical Coverage (NDMC), and the Notice of Denial of Payment (NDP) and

supporting regulations in 42 CFR 422.568; **Use:** Section 1852(g)(1)(B) of the Statute requires Medicare Health organizations (Medicare Advantage, cost, and Health Care Prepayment Plans) to provide determinations to deny coverage (*i.e.*, medical services or payment) in writing and include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes. These notices fulfill the regulatory requirement. **Form Number:** CMS-10003 (OMB#: 0938-0829); **Frequency:** Reporting: Yearly; **Affected Public:** Business or other for-profit and not-for-profit institutions; **Number of Respondents:** 454; **Total Annual Responses:** 105,138; **Total Annual Hours:** 26285.

**2. Type of Information Collection Request:** Revision of a currently approved collection; **Title of Information Collection:** CMS Application for Federal Qualification (901A); CMS Medicare Agreement Application (901D) and Supporting Regulations in 42 CFR Section 417.143 and 422.6; **Use:** Prepaid health plans must meet certain regulatory requirements to be federally qualified health maintenance organizations or to enter into a contract with CMS to provide health benefits to Medicare beneficiaries. The application forms are used by CMS to collect information about a health plan to determine their compliance with Federal regulations. **Form Number:** CMS-901A and D (OMB#: 0938-0470); **Frequency:** Reporting: Once; **Affected Public:** Business or other for-profit and not-for-profit institutions; **Number of Respondents:** 55; **Total Annual Responses:** 55; **Total Annual Hours:** 2,200.

**3. Type of Information Collection Request:** Revision of a currently approved collection; **Title of Information Collection:** Medicare ESRD Exceptions; **Use:** This information is collected in accordance with section 2145 of the Omnibus Budget Reconciliation Act of 1981 and section 623 of the Medicare Prescription Drug Improvement and Modernization Act of 2003. End Stage Renal Disease (ESRD) facilities can file for an exception to its composite payment rate. CMS uses the information submitted to determine whether an ESRD facility qualifies for a rate increase and the amount of the increase. **Form Number:** CMS-9044 (OMB#: 0938-0296); **Frequency:** Reporting: Occasionally; **Affected Public:** Business or other for-profit and not-for-profit institutions; **Number of Respondents:** 10; **Total Annual**

**Responses:** 10; **Total Annual Hours:** 400.

**4. Type of Information Collection Request:** Revision of a currently approved collection; **Title of Information Collection:** Medicare and Medicare Advantage Programs; Notification Procedures for Hospital Discharges—Important Message from Medicare **Use:** Requirements that hospitals notify beneficiaries in inpatient hospital settings of their rights as a hospital patient including their discharge appeal rights are referenced in Section 1866(a)(1)(M) of the Social Security Act (The Act). The authority for the right to an expedited determination is set forth at Section 1869(c)(3)(C)(iii)(III) of the Act. Under sections 42 CFR 405.1205 and 422.620, the hospital must deliver valid, written notice, the Important Message from Medicare (IM), of a patient's rights as a hospital patient including the discharge appeal rights, within 2 calendar days of admission. A follow-up copy of the signed IM is given again as far as possible in advance of discharge, but no more than 2 calendar days before. Follow-up notice is not required if the provision of the admission IM, falls within 2 calendar days of discharge.

Several changes are being proposed to the IM, including but not limited to the following: 1. Patient Information section: CMS removed the "Date of Notice" line. 2. Your Rights as Hospital Inpatient section: (a) There are several proposed clarifying language updates. (b) CMS added a bullet stating that the beneficiary can call the Quality Improvement Organization (QIO) for quality of care concerns based on information currently contained in the Medicare and You 2007 booklet. 3. Your Hospital Discharge and Medicare Appeal Rights section: CMS added a bullet stating that the beneficiary may call 1-800 Medicare and added supporting rationale for when to call. 4. CMS added instructions for the beneficiary or representative to both sign and date the notice and, 5. CMS added an "Additional Information" space requesting that hospitals be able to add signature lines for hospital staff documentation. **Form Number:** CMS-R-193 (OMB#: 0938-0692); **Frequency:** Reporting: Yearly; **Affected Public:** Business or other for-profit and not-for-profit institutions; **Number of Respondents:** 6000; **Total Annual Responses:** 13,000,000; **Total Annual Hours:** 3,250,000.

**5. Type of Information Collection Request:** New Collection; **Title of Information Collection:** Medicare and Medicare Advantage Programs; Notification Procedures for Hospital

Discharges—Detailed Notice of Discharge; *Use:* The authority for the right to an expedited determination is set forth at Section 1869(c)(3)(C)(iii)(III) of the Social Security Act. This collection has been revised and now pertains to sections 42 CFR 405.1206 and 42 CFR 422.622. When a Quality Improvement Organization (QIO) notifies a hospital or Medicare Advantage (MA) organization that a beneficiary/enrollee has requested an expedited determination, the hospital or MA organization must deliver a detailed notice to the beneficiary/enrollee by noon of the day after the QIO's notification. In addition, the title has been revised, and the wording of the notice has been revised to more clearly convey the purpose of the notice. This revised notice fulfills the regulatory requirement; *Form Number:* CMS-10066 (OMB#: 0938–New); *Frequency:* Yearly; *Affected Public:* Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 6057; *Total Annual Responses:* 130,000; *Total Annual Hours:* 130,000.

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](mailto: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 29, 2007.

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

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Substance Abuse and Mental Health Services Administration**

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

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276-1243.

**Proposed Project: National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program: Phase IV—(OMB No. 0930-0257)—Revision**

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center of Mental Health is responsible for the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program that will collect data on child mental health outcomes, family life, and service system development and performance.

The national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program will collect data on child mental health outcomes, family life, and service system development and performance. Data will be collected on 27 service systems, and roughly 5922 children and families. Data collection for this evaluation is conducted over a five-year period. The core of service system data will be collected every 18 months throughout the 5-year evaluation period, with a sustainability survey conducted in selected years. Service delivery and system variables of interest include the following: Maturity of system of care development, adherence to the system of care program model, and client service experience. The length of time that individual families will participate in the study ranges from 18 to 36 months depending

on when they enter the evaluation. Child and family outcomes of interest will be collected at intake and during subsequent follow-up sessions at six-month intervals. The outcome measures include the following: child symptomatology and functioning, family functioning, material resources, and caregiver strain. Time-limited studies addressing the cultural competence of services and the role of primary care providers in systems of care will be conducted at selected points during the evaluation period. Internet-based technology will be used for collecting data via Web-based surveys and for data entry and management. The average annual respondent burden is estimated below for the final three years of data collection. The estimate reflects the average number of respondents in each respondent category, the average number of responses per respondent per year, the average length of time it will take for each response, and the total average annual burden for each category of respondent, and for all categories of respondents combined.

This revision to the currently approved information collection activities includes: (1) The addition of a Primary Care Study and (2) the addition of a Treatment Effectiveness Study. The Primary Care Study seeks to investigate the role of primary health care practitioners (PCPs) in systems of care and to further understand the impact of services provided within primary care on child and family outcomes. One goal of this study is to identify strategies that help primary care and mental health care providers to work together effectively. Another is to identify ways to integrate PCPs into systems of care. The treatment effectiveness study will examine the relative impact of community-based treatments focused within system of care sites. This study will focus on a community-based practice that has not accumulated research evidence, but rather through community-based implementation has accumulated practice-based evidence.

Instrument	Respondent	Number of respondents	Total average number of responses per respondent	Hours per response	Total burden hours
<b>System of Care Assessment</b>					
Interview Guides and Data Collection Forms .....	Key site informants	1 648	2	1.000	1296
Interagency Collaboration Scale (IACS) .....	Key site informants	648	2	0.133	173
Caregiver Information Questionnaire (CIQ-IC) .....	Caregiver .....	<sup>3</sup> 5,922	1	0.283	1676
Caregiver Information Questionnaire Followup (CIQ-FC) .....	Caregiver .....	5,922	3	0.200	3553