we attempted to obtain a balance between availability of data needed to assess the impact of the intervention, and the generalizability of the setting of care. In revisions made to the protocol we have focused on developing an intervention that could be conducted in a community pharmacy, and as such may be generalizable to community pharmacies.

Dated: May 10, 2007.

Carolyn M. Clancy,

Director.

[FR Doc. 07–2481 Filed 5–17–07; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10233, CMS–10234 and CMS–10236]

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 of Information Collection:* Regional Preferred Provider Organization (RPPO) Reconciliation Cost Report; *Form Number:* CMS–10233 (OMB#: 0938–New); *Use:* The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Title II, Subtitle C (Offering of Medicare Advantage Regional Plans; Medicare Advantage Competition) provided for the establishment of Medicare Advantage Regional Plans. Subsequently, the Regional Preferred Provider Organization (RPPO) program was developed and began contracting with Managed Care Organizations (MCOs) and enrolling beneficiaries for the 2006 contract year. Section 1858 of the Social Security Act provides for risk sharing with RPPOs to be in place for contract years 2006 and 2007. The Code of Federal Regulations at 42 CFR 422.458 provides specific direction with respect to how the Centers for Medicare and Medicaid Services (CMS) will share risk with the RPPOs. The regulations require CMS to collect Allowable Cost data, and to compare this data to Target Amounts. If the comparison demonstrates that there were either savings or losses in the contract year, the regulations provide specific risk corridors to be used in determining the Risk Sharing Reconciliation amount due to either the plan or CMS. The Risk Sharing Reconciliation cost report will be used to collect the information necessary to accurately reconcile the payments made to RPPOs for the 2006 and 2007 contract years. *Frequency:* Reporting—Annually; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 14; *Total Annual Responses:* 14; T*otal Annual Hours:* 1,120.

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* State Plan Pre-print implementing Section 6087 of the Deficit Reduction Act: Optional Self-Direction Personal Assistance Services (PAS) Program (Cash and Counseling); *Form Number:* CMS–10234 (OMB#: 0938–New); *Use:* Information submitted via the State Plan Amendment (SPA) pre-print will be used by the Centers for Medicare & Medicaid Services (CMS) Central and Regional Offices to analyze a State's proposal to implement Section 6087 of the Deficit Reduction Act (DRA). State Medicaid Agencies will complete the SPA pre-print, and submit it to CMS for a comprehensive analysis. The pre-print contains assurances, check-off items, and areas for States to describe policies and procedures for subjects such as quality assurance, risk management, and voluntary and involuntary disenrollment; *Frequency:* Reporting—Once; *Affected Public:* State, Local, or Tribal Government; *Number of Respondents:* 56; *Total Annual Responses:* 30; Total Annual Hours: 600.

3. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Disclosure of Financial Relationships Report (''DFRR''); *Form Number:* CMS–10236 (OMB#: 0938–New); *Use:* Section 1877(f) of the Social Security Act requires that each entity providing covered items or services for which payment may be made shall provide the Secretary with information concerning the entity's ownership, investment, and compensation arrangements, in such form, manner, and at such times as the Secretary shall specify. DFRR is a new collection instrument that will be used by CMS to obtain information necessary to analyze each hospital's compliance with Section 1877 of the Social Security Act (''the physician self-referral law''), and implementing regulations (42 Code of Federal Regulations, Subpart J). *Frequency:* Reporting—Once; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 500; *Total Annual Responses:* 500; *Total Annual Hours:* 2,000.

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,* 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 July 17, 2007.

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—B, Attention: William N. Parham, III, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: May 11, 2007.

Michelle Shortt,

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

[FR Doc. E7–9472 Filed 5–17–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–265–94 and CMS–460]

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:* Independent Renal Dialysis Facility Cost Report and supporting regulations 42 CFR 413.20 and 42 CFR 413.24; *Form No.:* CMS–265–94 (OMB# 0938–0236); *Use:* Providers of services participating in the Medicare program are required under sections 1815(a), 1833(e), 1861(v)(1)(A) and 1881(b)(2)(B) of the Social Security Act to submit annual information to achieve reimbursement for health care services rendered to Medicare beneficiaries. The Form CMS 265–94 cost report is needed to determine the amount of reasonable cost due to the providers for furnishing medical services to Medicare beneficiaries.

The data collected will be used for the following additional purposes: (a) Determination of reimbursement rates for renal dialysis treatments, self-dialysis training, and other reasonable and medically necessary services rendered in connection with these treatments; (b) justification of requests for adjustments or exceptions in the reimbursements rates; and, (c) accumulation of data for overall evaluation. Worksheet B, Worksheet C and Worksheet D have been modified to implement provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003. On Worksheet B, the allocation of Administrative and General cost to Separately Billable Drugs was eliminated. On Worksheet C, two columns were sub-divided to identify services before, on or after 4/1/2005. A line was added to Worksheet D to report bad debts for dual eligible beneficiaries. None of these changes request new information; rather, the changes require reporting of data in greater detail than was previously reported. *Frequency:* Reporting—Annually; *Affected Public:* Business or other for-profit, Not-for-profit institutions; *Number of Respondents:* 4,885; *Total Annual Responses:* 4,885; *Total Annual Hours:* 957,460.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Participating Physician or Supplier Agreement; *Form No.:* CMS–460 (OMB# 0938–0373); *Use:* The CMS–460 is the agreement a physician, supplier or their authorized official signs to participate in Medicare Part B. By signing the agreement to participate in Medicare, the physician, supplier or their authorized official agrees to accept the Medicare-determined payment for Medicare covered services as payment in full and to charge the Medicare Part B beneficiary no more than the applicable deductible or coinsurance for the covered services. For purposes of this explanation, the term a supplier means any person or entity that may bill Medicare for Part B services (e.g. DME supplier, nurse practitioner, supplier of diagnostic tests) except a Medicare provider of services (e.g. hospital), which must participate to be paid by Medicare for covered care.

There are additional benefits associated with payment for services paid under the Medicare fee schedule. Payments made under the Medicare fee schedule for physician services to participating physicians and suppliers are based on 100 percent of the Medicare fee schedule amount, while the Medicare fee schedule payment for physician services by nonparticipating physicians and suppliers is based on 95 percent of the fee schedule amount. Physicians and suppliers who do not participate in Medicare are subject to limits on their actual charges for unassigned claims for physician services. These limits, known as limiting charges, cannot exceed 115 percent of the non-participant fee schedule, which is set at 95 percent of the full fee schedule amount. In addition, if a physician or supplier does not accept assignment on a claim for Medicare payment, the physician or supplier must collect payment from the beneficiary. If the physician or supplier accepts assignment on the claim, Medicare pays its share of the payment directly to the physician or supplier, resulting in faster and more certain payment. *Frequency:* Reporting, Other—when starting a new business; *Affected Public:* Business or other for-profit; *Number of Respondents:* 6000; *Total Annual Responses:* 6000; *Total Annual Hours:* 1500.

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: May 10, 2007.

Michelle Shortt,

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

[FR Doc. E7–9473 Filed 5–17–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Income Withholding for Support (IWO) (*Formerly:* Order to Withhold Income for Child Support and Notice of an Order to Withhold Income for Child Support).

OMB No.: 0970–0154.

Description: Pub. L. 104–193, The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Section 324, requires the Federal Office of Child Support Enforcement (OCSE) to develop a standardized form to collect child support payments from an obligor's employer. The form, which promotes standardization and is used for title IV–D and non-IV–D cases that require income withholding, expires 5/31/2007, and the Administration for Children and Families is taking this opportunity to revise the form and its instructions.

Overall, the language and format of the form have been edited, modified, and made easier to read and comprehend. The two-page form provides a detailed legal description of the established order, support amounts, and remittance information an employer