making it difficult to compare severity, costs, and outcomes across settings. These four provider types form a continuum of care where patients may overlap in terms of the conditions being treated, but they primarily differ in terms of the severity of the patients' medical or functional impairments. The current payment methods are designed as silos that do not recognize the potential overlap in case mix or the complimentary nature of the services across an episode, nor does it allow for standardized measures of costs across settings since each PPS was developed independently using different measurement systems and underlying assumptions.

The Post-Acute Care Payment Reform Demonstration will examine the relative costliness and outcomes of post acute cases admitted to different settings for similar conditions. The work will differ from past attempts in this area because it will use a standardized case mix tool for measuring patient severity and a standardized resource data collection tool in all four post acute settings. Specifically, the legislation requires that CMS provide information on both the fixed and variables costs for each individual treated in post acute care settings.

The CRU data collection instruments are designed to collect a provider's routine costs to specific patients because in general, nurses' and many other direct care providers' time spent on behalf of specific patients and on activities not patient-specific, is not reported. In addition, charges for therapist services reported on claims may not sufficiently measure true relative differences in therapy resource costs among patients. The data will be used, along with Medicare claims and cost report data, to examine substitution issues: How do costs and outcomes differ for post acute care patients with similar case mix acuity when treated in one of the various settings. The results will be used to provide CMS and Congress information on setting-neutral payment models, revisions to single setting payment systems, current discharge placement patterns, and patient outcomes across settings.

Form Number: CMS–10246 (OMB#: 0938–New).

Frequency: Reporting and Recordkeeping.

Affected Public: Private Sector—Business or other for-profits and not-for-profit institutions.

Number of Respondents: 138.

Total Annual Responses: 61,589.

Total Annual Hours: 28,783.

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 October 23, 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: August 17, 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–R–216, CMS–R–262, CMS–10106, and CMS–10173]

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: Issuance of Advisory Opinions Concerning Physicians' Referrals.

Use: Section 1877(g)(6) of the Social Security Act (the Act), requires that the Department of Health and Human Services issue advisory opinions concerning whether the referral of a Medicare patient by a physician for certain designated health services (other than clinical laboratory services) is prohibited under the physician referral provisions of the Social Security Act. Section 1877(g)(6) of the Act requires that the Department of Health and Human Services accept requests for advisory opinions made after November 3, 1997 and before August 21, 2000. Section 543 of the Benefits Improvement and Protection Act of 2001, Public Law 106–554, extended indefinitely the period during which the Department of Health and Human Services accepts requests for these advisory opinions. The collection of information contained in 42 CFR 411.372 and 411.373 is necessary to comply with this statutory mandate, and allow CMS to consider requests for advisory opinions and provide accurate and useful opinions.

Form Number: CMS–R–216 (OMB#: 0938–0714).

Frequency: Once.

Affected Public: Business or other for-profit and Not-for-profit institutions.

Number of Respondents: 50.

Total Annual Responses: 50.

Total Annual Hours: 1,000.

2. *Type of Information Collection Request:* Revision of a currently approved collection.

Title of Information Collection: Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP).

Use: CMS requires that MA and PDP organizations submit a completed formulary and PBP as part of the annual bidding process. During this process, organizations prepare their proposed plan benefit packages for the upcoming contract year and submit them to CMS for review and approval. To see the comprehensive list of changes from CY2007 to CY2008, please refer to the document entitled ''Appendix B—PBP-Formulary CY2008 List of Changes.''

Form Number: CMS–R–262 (OMB#: 0938–0763).

Frequency: Yearly.

Affected Public: Business or other for-profit and Not-for-profit institutions.

Number of Respondents: 450.

Total Annual Responses: 4725.

Total Annual Hours: 10,800.

3. *Type of Information Collection Request:* Extension of a currently approved collection.

Title of Information Collection: Medicare Authorization to Disclose Personal Health Information.

Form Number: CMS–10106 (OMB#: 0938–931).

Use: Unless permitted or required by law, § 164.508 of the Standards for Privacy of Individually Identifiable Health Information final rule (67 FR 53182) prohibits Medicare, a Health Insurance Portability and Accountability (HIPAA) covered entity, from disclosing an individual's protected health information without a valid authorization. In order to be valid, an authorization must include specified core elements and statements. Medicare will make available to Medicare beneficiaries a standard, valid authorization to enable beneficiaries to request the disclosure of their protected health information. This standard authorization will simplify the process of requesting information disclosure for beneficiaries and minimize the response time for Medicare. The completed authorization will allow Medicare to disclose an individual's personal health information to a third party at the individual's request.

Frequency: Reporting—On occasion.

Affected Public: Individuals or households.

Number of Respondents: 1,000,000.

Total Annual Responses: 1,000,000.

Total Annual Hours: 250,000.

4. *Type of Information Collection Request:* Extension of a currently approved collection.

Title of Information Collection: Individuals Authorized Access to the CMS Computer Services (IACS).

Form Number: CMS–10173 (OMB#: 0938–0989).

Use: The Centers for Medicare and Medicaid Services (CMS) is requesting the Office of Management and Budget (OMB) approval of the Individuals Authorized to Customer Service Application for Access to CMS Computer Systems. The IACS system provides a centralized user provisioning and administration service that supports the creation, deletion, and lifecycle management of enterprise identities. This service creates accounts, supports Role Based Access Control (RBAC), the form flow approval process and enterprise identity audit and recertification, and provides business application integration points. An application integration point allows business application owners to use the form flow process of the user provisioning service to approve or deny requests for access to business applications. The primary purpose of this system is to implement a unified framework for managing user information and access rights, for those individuals who apply for and are granted access across multiple CMS systems and business contexts. Information in this system will also be used to: (1) Support regulatory and policy functions performed within the Agency or by a contractor or consultant; (2) support constituent requests made to a Congressional representative; and (3) to support litigation involving the Agency related to this system. Although the Privacy Act requires only that the ''routine use'' portion of the system be published for comment, CMS invites comments on all portions of this notice.

Frequency: As required.

Affected Public: Individuals or households; Business or other for-profit and Not-for-profit; State, Local or Tribal governments.

Number of Respondents: 60,000,000.

Total Annual Responses: 15,000,000.

Total Annual Hours: 15,000,000.

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.

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: August 17, 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

[CMS–1542–N2]

Medicare Program; Announcement of New Members to the Advisory Panel on Ambulatory Payment Classification (APC) Groups

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (DHHS).

ACTION: Notice.

SUMMARY: This notice announces two new members selected to serve on the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel). The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary of the Department of Health and Human Services (DHHS), and the Administrator of the Centers for Medicare & Medicaid Services (CMS), concerning the clinical integrity of the APC groups and their associated weights. We will consider the Panel's advice as we prepare the annual updates of the hospital outpatient prospective payment system (OPPS).

FOR FURTHER INFORMATION CONTACT: For inquiries about the Panel, please contact the Designated Federal Official (DFO): Shirl Ackerman-Ross, DFO, CMS, CMM, HAPG, DOC, 7500 Security Boulevard, Mail Stop C4–05–17, Baltimore, MD 21244–1850, Phone (410) 786–4474.

APC Panel E-Mail Address: The E-mail address for the Panel is as follows: *CMS APCPanel@cms.hhs.gov.*

News Media Contact: News media representatives must contact our Public Affairs Office at (202) 690–6145.

CMS Advisory Committee Hotlines: The CMS Federal Advisory Committee Hotline is 1–877–449–5659 (toll free) and (410) 786–9379 (local) for additional Panel information.

Web Sites: For additional information regarding the APC Panel membership, meetings, agendas, and updates to the Panel's activities, please search our Web site at the following Uniform Resource Locator (URL): *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.*

The public may also access the following URL for the Federal Advisory Committee Act Web site to obtain APC Panel information: *https://www.fido.gov/facadatabase/logon.asp.*

A copy of the Panel's Charter and other pertinent information are on both Web sites mentioned above. You may