ESTIMATED ANNUALIZED BURDEN TABLE

Form	Number of respondents	Number of responses per respondent	Average burden hours per response (in hrs.)	Total burden hours
Survey	48,000	1	12/60	9,600

Alice Bettencourt,

Office of the Secretary, Paperwork Reduction Act Reports Clearance Officer.

[FR Doc. E7–19724 Filed 10–4–07; 8:45 am]

BILLING CODE 4150–25–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10218 and CMS–10250]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, Department of Health and Human Services.

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:* Survey for the Evaluation of the Low Vision Rehabilitation Demonstration; *Use:* This information collection request relates to the collection of health status indicators for the Low Vision Rehabilitation Demonstration through the beneficiary survey. The survey will be conducted among Medicare beneficiaries with vision problems who have received vision services. CMS intends to administer the Low Vision Survey (LVS) for approximately eighteen months. Data on the process of implementing the demonstration will also be collected through telephone interviews with physicians and beneficiaries who receive low vision services. Focus groups will be conducted with low vision rehabilitation specialists. *Form Numbers:* CMS–10218 (OMB#: 0938–NEW); *Frequency:* Reporting—Once and Yearly; *Affected Public:* Individuals and households; *Number of Respondents:* 2131; *Total Annual Responses:* 2131; *Total Annual Hours:* 1059.

2. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Submission of Information for the Hospital Outpatient Quality Data Program; *Use:* The submission of outpatient hospital quality of care information builds on the requirement to submit such data for inpatient hospital care as required under 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108–173). The requirement to submit hospital quality of care information is intended to empower consumers with quality of care information to make more informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of care. This information is used by CMS to direct its contractor, including Quality Improvement Organizations (QIOs), to focus on particular areas of improvement, and to develop quality improvement initiatives. The information will be made available to hospitals for their use in internal quality improvement initiatives. Most importantly, this information is available to beneficiaries, as well as to the public in general, to provide hospital information to assist them in making decisions about their health care. *Form Numbers:* CMS–10250 (OMB#: 0938-NEW); *Frequency:* Reporting—quarterly; *Affected Public:* Private Sector—For-profit and not-for-profit institutions; *Number of Respondents:* 3,500; *Total Annual Responses:* 17,500; *Total Annual Hours:* 914,000.

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 December 4, 2007.

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

Dated: September 27, 2007.

Michelle Shortt,

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

[FR Doc. E7–19505 Filed 10–4–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10052, CMS–R–249 and CMS–10047]

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

AGENCY: Centers for Medicare & Medicaid Services, Department of Health and Human Services.

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:* Recognition of pass-through payment for additional (new) categories of devices under the Outpatient Prospective Payment System and Supporting Regulations in 42 CFR, Part 4 19; *Use:* Section 20 1 (b) of the Balanced Budget Act of 1999 amended section 1833(t) of the Social Security Act (the Act) by adding new section 1833(t)(6). This provision requires the Secretary to make additional payments to hospitals for a period of 2 to 3 years for certain drugs, radiopharmaceuticals, biological agents, medical devices and brachytherapy devices. Section 1833(t)(6)(A)(iv) establishes the criteria for determining the application of this provision to new items. Section 1833(t)(6)(C)(ii) provides that the additional payment for medical devices be the amount by which the hospital's charges for the device, adjusted to cost, exceed the portion of the otherwise applicable hospital outpatient department fee schedule amount determined by the Secretary to be associated with the device. Section 402 of the Benefits Improvement and Protection Act of 2000 made changes to the transitional pass-through provision for medical devices. The most significant change is the required use of categories as the basis for determining transitional pass-through eligibility for medical devices, through the addition of section 1833(t)(6)(B) of the Act.

Interested parties such as hospitals, device manufacturers, pharmaceutical companies, and physicians apply for transitional pass-through payment for certain items used with services covered in the outpatient prospective payment system. After CMS receives all requested information, CMS will evaluate the information to determine if the creation of an additional category of medical devices for transitional pass-through payments is justified. *Form Number:* CMS–10052 (OMB#: 0938–0857); *Frequency:* Reporting: Yearly; *Affected Public:* Business or other for-profit; *Number of Respondents:* 10; *Total Annual Responses:* 10; *Total Annual Hours:* 160.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Hospice Cost and Data Report and supporting regulations 42 CFR 413.20 and 42 CFR 413.24; *Use:* In accordance with sections 1815(a), 1833(e), 1861(v)(A)(ii) and 1881 (b)(2)(B) of the Social Security Act, providers of services in the Medicare program are required to submit annual information to receive reimbursement for health care services provided to Medicare beneficiaries. In addition, 42 CFR 413.20(b) requires that cost reports be filed with the provider's fiscal intermediary/Medicare Administrative Contractor (FI/MAC). The functions of the FI/MAC are described in section 1816 of the Social Security Act. The Center for Medicare and Medicaid Services will use the information from providers for rate evaluations for the Prospective Payment System. *Form Number:* CMS–R–249 (OMB#: 0938–0758); *Frequency:* Reporting: Yearly; *Affected Public:* Business or other for-profit; *Number of Respondents:* 1938; *Total Annual Responses:* 1938; *Total Annual Hours:* 341,088.

3. *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; *Use:* The collection of information contained in 42 CFR sections 411.352(d), 411.354(d), 411.355(e), 411.357(a), (b), (d), (e), (h), (l), (p), and (s), and 411.361 is necessary to allow CMS to implement section 1877 of the Social Security Act. This collection has been revised to eliminate the requirement in section 411.357(s) to notify insurance companies that an entity has a professional courtesy policy. CMS issued these regulations to comply with the provisions of section 1877 of the Social Security Act that prohibit a physician from referring a patient to an entity for a designated health service for which Medicare might otherwise pay, if the physician or an immediate family member has a financial relationship with the entity, unless an exception applies. *Form Number:* CMS–10047 (OMB#: 0938–0846); *Frequency:* Yearly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 154,404 *Total Annual Responses:* 154,404; *Total Annual Hours:* 116,035.

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 by the OMB desk officer at the address below, no later than 5 p.m. on November 5, 2007.

OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: September 27, 2007.

Michelle Shortt,

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

[FR Doc. E7–19506 Filed 10–4–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8032–N]

RIN 0938–AO61

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for Calendar Year 2008

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

ACTION: Notice.

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year (CY) 2008 under Medicare's Hospital Insurance program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts.

For CY 2008, the inpatient hospital deductible will be $1024. The daily coinsurance amounts for CY 2008 will be: (a) $256 for the 61st through 90th day of hospitalization in a benefit period; (b) $512 for lifetime reserve days; and (c) $128 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

DATES: *Effective Date:* This notice is effective on January 1, 2008.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786–6390. For case-mix analysis: Gregory J. Savord, (410) 786–1521.

SUPPLEMENTARY INFORMATION: