FR 28471–72) soliciting public comments on a proposal to introduce a cost sharing requirement for the HPP program. Twenty-eight comments were received from hospitals, hospital associations, State Health Officials, and professional organizations. The comments received included concerns about finding the resources needed to cost share, additional administrative recordkeeping related to cost sharing, and overall decreased participation in the HPP. In response, HHS believes the concerns that were raised about awardees finding the resources needed to cost share, additional administrative recordkeeping, and a potential for decreased participation in the HPP are outweighed by the benefits a cost sharing requirement will bring to HPP. The cost sharing requirement will be a concrete way of solidifying collaboration between States and the Federal government in assuring this program will achieve enhanced sustainability in healthcare system preparedness during and after the project period has ended.

Thus, HPP cooperative agreement recipients will be required to contribute non-Federal matching funds starting with the FY 2009 funding cycle and each year thereafter. Awardees will be required to make available, either directly or through donations from public or private entities, non-Federal contributions in an amount equal to five percent of the award amount in FY 2009 and ten percent of the award amount in FY 2010 and each successive year for the duration of the program. Non-Federal contributions will be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment or services. Amounts provided by the Federal government, or services assisted or subsidized to any significant extent by the Federal government, may not be included in determining the amount of such non-Federal contributions.

The cost sharing requirement will apply to the entire award amount received by the awardee from the U.S. Department of Health and Human Services through the HPP.

The cost sharing requirement will be enforced as a term and condition of the HPP award.

Dated: May 8, 2009.

William C. Vanderwagen,

Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.

[FR Doc. E9–11307 Filed 5–14–09; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–276, CMS–43, CMS–1763, CMS–R–194, CMS–R–232, and CMS–R–296]

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 of a currently approved collection; *Title of Information Collection:* Prepaid Health Plan Cost Report; *Use:* Health Maintenance Organizations and Competitive Medical Plans (HMO/CMPs) contracting with the Secretary under Section 1876 of the Social Security Act are required to submit a budget and enrollment forecast, four quarterly reports and a final certified cost report. Health Care Prepayment Plans (HCPPs) contracting with the Secretary under Section 1833 of the Social Security Act are required to submit a budget and enrollment forecast, mid-year report, and final cost report. An HMO/CMP is a health care delivery system that furnishes directly or arranges for the delivery of the full spectrum of health services to an enrolled population. A HCPP is a health care delivery system that furnishes directly or arranges for the delivery of certain physician and diagnostics services up to the full spectrum of non-provider Part B health services to an enrolled population. These reports will be used to establish the reasonable cost of delivering covered services furnished to Medicare enrollees by an HMO/CMP or HCPP.; Form Numbers: CMS–276 (OMB #: 0938–0165); *Frequency:* Recordkeeping, Reporting—Quarterly and Annually; Affected Public: Business or other for-profit; *Number of Respondents:* 35; *Total Annual Responses:* 128; *Total Annual Hours:* 5,285. (For policy questions regarding this collection contact Temeshia Johnson at 410–786–8692. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Application for Hospital Insurance Benefits for Individuals with End Stage Renal Disease: *Use:* Effective July 1, 1973, individuals with End Stage Renal Disease (ESRD) became entitled to Medicare. Because this entitlement has a different set of requirements, the existing applications for Medicare were not sufficient to capture the information needed to determine Medicare entitlement under the ESRD provisions of the law. The Application for Hospital Insurance Benefits for Individuals with End Stage Renal Disease, was designed to capture all the information needed to make a Medicare entitlement determination; Form Numbers: CMS–43 (OMB #: 0938–0800; *Frequency:* Reporting—Once; Affected Public: Individuals or households; *Number of Respondents:* 60,000; *Total Annual Responses:* 60,000; *Total Annual Hours:* 25989. (For policy questions regarding this collection contact Naomi Rappaport at 410–786–2175. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Request for Termination of Premium Hospital and/or Supplementary Medical Insurance: *Use:* The Social Security Act (the Act) allows a Medicare enrollee to voluntarily terminate Supplementary Medical Insurance (Part B) and/or the premium Hospital Insurance (premium—Part A) coverage by filing a written request with CMS or the Social Security Administration (SSA). The Act also stipulates when coverage will end based upon the date the request was filed. Because Medicare is recognized as a valuable protection against the high cost of medical and hospital bills, when an individual wishes to voluntarily terminate Part B and/or premium Part A, CMS and SSA requests the reason that an individual wishes to terminate coverage to ensure that the individual understands the ramifications of the decision. The Request for Termination of Premium Hospital and/or

Supplementary Medical Insurance, provides a standardized form to satisfy the requirements of law as well as allowing both agencies to protect the individual from an inappropriate decision; Form Numbers: CMS–1763 (OMB #: 0938–0025; *Frequency:* Reporting—Once; Affected Public: Individuals or households; *Number of Respondents:* 14,000; *Total Annual Responses:* 14,000; *Total Annual Hours:* 5,831. (For policy questions regarding this collection contact Naomi Rappaport at 410–786–2175. For all other issues call 410–786–1326.)

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Disproportionate Share Adjustment Procedures and Criteria and Supporting Regulations in 42 CFR 412.106: *Use:* Section 1886(d)(5)(F) of the Social Security Act established the Medicare disproportionate share adjustment (DSH) for hospitals, which provides additional payment to hospitals that serve a disproportionate share of the indigent patient population. This payment is an add-on to the set amount per case CMS pays to hospitals under the Medicare Inpatient Prospective Payment System (IPPS).

Under current regulations at 42 CFR 412.106, in order to meet the qualifying criteria for this additional DSH payment, a hospital must prove that a disproportionate percentage of its patients are low income using Supplemental Security Income (SSI) and Medicaid as proxies for this determination. This percentage includes two computations: (1) the ''Medicare fraction'' or the ''SSI ratio'' which is the percent of patient days for beneficiaries who are eligible for Medicare Part A and SSI and (2) the ''Medicaid fraction'' which is the percent of patient days for patients who are eligible for Medicaid but not Medicare. Once a hospital qualifies for this DSH payment, CMS also determines a hospital's payment adjustment; Form Numbers: CMS–R–194 (OMB #: 0938–0691; *Frequency:* Reporting—Occasionally; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 800; *Total Annual Responses:* 800; *Total Annual Hours:* 400. (For policy questions regarding this collection contact JoAnn Cerne at 410–786–4530. For all other issues call 410–786–1326.)

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Integrity Program Organizational Conflict of Interest Disclosure Certificate and Supporting Regulations at 42 CFR 421.300–421.316; *Use:* Section 1893(d)(1) of the Social Security Act requires CMS to establish a process for identifying, evaluating, and resolving conflicts of interest. CMS proposed a process in Section 421.310 to mandate submission of pertinent information regarding conflicts of interest. The entities providing the information will be organizations that have been awarded, or seek award of, a Medicare Integrity Program contract. CMS needs this information to assess whether contractors who perform, or who seek to perform, Medicare Integrity Program functions, such as medical review, fraud review or cost audits, have organizational conflicts of interest and whether any conflicts have been resolved. *Form Number:* CMS–R–232 (OMB #: 0938–0723); *Frequency:* Reporting—On occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 11; *Total Annual Responses:* 44; Total Annual Hours: 2,200. (For policy questions regarding this collection contact Joe Strazzire at 410–786–2775. For all other issues call 410–786–1326.)

6. *Type of Information Collection Request:* Revision of a currently approved Collection; *Title of Information Collection:* Home Health Advance Beneficiary Notice (HHABN); *Use:* Home health agencies (HHAs) are required to provide written notice to Medicare beneficiaries under various circumstances involving the initiation, reduction, or termination of services. The vehicle used in these situations is the Home Health Advance Beneficiary Notice (HHABN). The notice is designed to ensure that beneficiaries receive complete and useful information regarding potential financial liability or any changes made to their plan of care (POC) to enable them to make informed consumer decisions. The notice must provide clear and accurate information about the specified services and, when applicable, the cost of services when Medicare denial of payment is expected by the HHA. *Form Number:* CMS–R–296 (OMB #: 0938–0781); *Frequency:* Reporting—Hourly, Daily, Weekly, Monthly, Yearly, Quarterly, Semi-annually, Biennially, Once and Occasionally; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 9024; *Total Annual Responses:* 12,349,787; *Total Annual Hours:* 1,028,737. (For policy questions regarding this collection contact Evelyn Blaemire at 410–786–1803. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site 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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by July 14, 2009:

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number (CMS–10283), Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: May 7, 2009.

Michelle Shortt,

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

[FR Doc. E9–11422 Filed 5–14–09; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10237 and 10214, and CMS–10171]

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