programs; and be consistent with the beginning of the new fiscal year for Federal agencies. Given the imminence of the current effective date, seeking prior public comment on this temporary delay would be impractical. Further, given the risk of inconsistency and confusion from the imposition of divergent requirements across federal agencies, it has been determined that seeking prior comment on this temporary delay would be contrary to the public interest. The imminence of the effective date is also good cause for making this rule effective immediately upon publication.

DOT's rule is expected to issue in time to go into effect by October 1, 2010; however, should it later appear that DOT regulations may not issue in time for an October 1, 2010 implementation, SAMHSA will undertake notice and comment rulemaking to delay the effective date further.

No other changes to the Mandatory Guidelines have been made. The new effective date for the revisions to the HHS Mandatory Guidelines is October 1, 2010.

Dated: April 26, 2010.

Pamela S. Hyde,

Administrator, Substance Abuse and Mental Health Services Administration.

Kathleen Sebelius,

Secretary.

[FR Doc. 2010–10118 Filed 4–29–10; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–2552–10]

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:* Revision of a currently approved collection; *Title of Information Collection:* Hospital and Health Care Complexes Cost Report and supporting Regulations in 42 CFR 413.20 and 413.24; *Use:* Part A institutional providers must provide adequate cost data to receive Medicare reimbursement (42 CFR 413.24(a)). Providers must submit the cost data to their Medicare Fiscal Intermediary (FI)/ Medicare Administrative Contractor (MAC) through the Medicare cost report (MCR). The primary function of the cost report is to determine the reimbursement of providers for services rendered to program beneficiaries. The FI/MAC uses the cost report to make settlement with the provider for the fiscal period covered by the cost report. Furthermore, the FI/MAC uses the cost report to determine the necessity and scope of an audit of the records of the provider. CMS uses the data collected on the MCR to project future Medicare expenditures, determine adequate deductibles and premiums, and develop and update provider market baskets mandated for use in updating Medicare payment rates. CMS also uses the data to offer public use data files. Revisions made to update the forms currently in use are incorporated within this request for approval. *Form Number:* CMS–2552–10 (OMB#: 0938–0050); *Frequency:* Yearly; *Affected Public:* Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 6,174; *Total Annual Responses:* 6,174; *Total Annual Hours:* 4,155,102. (For policy questions regarding this collection contact Nadia Massuda at 410–786–5834. 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 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 *June 1, 2010.*

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer.
Fax Number: (202) 395–6974.
E-mail: *OIRA_submission@omb.eop.gov*.

Dated: April 23, 2010.

Michelle Shortt,

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

[FR Doc. 2010–10041 Filed 4–29–10; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10165, CMS–10095 and CMS–10003]

Agency Information Collection Activities: Proposed Collection; 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 & 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:* Revision of a currently approved collection; *Title of Information Collection:* Electronic Health Records Demonstration System (EHRDS)—practice application and profile update system; *Use:* In 2008, the Secretary of the Department of Health and Human Services directed the Centers for Medicare & Medicaid Services to develop a new demonstration initiative using Medicare waiver authority to reward the delivery of high-quality care supported by the

adoption and use of electronic health records (EHRs). This continues to be a critical priority under the current administration. The goal of this demonstration is to foster the implementation and adoption of EHRs and health information technology (HIT) more broadly as effective vehicles to improve the quality of care provided and transform the way medicine is practiced and delivered. Adoption of HIT has the potential to provide significant savings to the Medicare program and improve the quality of care rendered to Medicare beneficiaries.

The new electronic EHR demonstration system was first developed with the intention of having practices applying to participate in Phase 2 of the demonstration use an on-line application form, rather than the currently approved paper application form that was used for Phase 1. However, with the cancellation of Phase 2, the system will not be used to collect new applications at this time. Instead, existing data on Phase 1 applications that was collected through the paper form and manually keyed into a PC based Access database will be transferred to the new system. Practices participating in Phase 1 of the demonstration will be requested to use the new system to provide periodic updates to their practice information. The EHR demonstration system will enable practices to update critical demonstration information on line in a secure, Web-enabled environment, thereby facilitating timely and more accurate updates and processing of information. Thus, the EHR demonstration system (EHRDS) does not reflect a request for new or additional data beyond what practices are already providing to CMS and its contractors. Rather it represents an effort to streamline and improve what has been a more 'ad hoc' process for providing the same information. *Form Number:* CMS–10165 (OMB#: 0938–0965); *Frequency:* Occasionally; *Affected Public:* Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 400; *Total Annual Responses:* 313; *Total Annual Hours:* 52.3 (For policy questions regarding this collection contact Jody Blatt at 410–786–6921. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Detailed Explanation of Non-Coverage (42 CFR 422.626(e)(1)), and Notice of Medicare Non-Coverage (42 CFR 422.624(b)(1)); *Use:* Under section 42 CFR 422.624(b)(1), skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs) must deliver to Medicare health plan enrollees a 2-day advance notice of termination of services. Per requirements at 42 CFR 422.626(e)(1), plans must deliver detailed notices to the Quality Improvement Organization (QIO) and enrollees whenever an enrollee appeals a termination of services. The Notice of Medicare Non-Coverage (NOMNC) and the Detailed Explanation of Non-Coverage (DENC) fulfill these regulatory requirements. Additionally, 42 CFR 417.600(b) provides that cost plans must follow these same fast track appeal notification procedures for their enrollees in SNFs, HHAs and CORFs. Refer to the crosswalk document for a list of changes. *Form Number:* CMS–10095 (OMB#: 0938–0910); *Frequency:* Yearly; *Affected Public:* Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 25,655; *Total Annual Responses:* 100,785; *Total Annual Hours:* 45,353.25 (For policy questions regarding this collection contact Stephanie Simons at 206–615–2420. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Notice of Denial of Medical Coverage (NDMC) and Notice of Denial of Payment (NDP)—42 CFR 422.568; *Use:* Medicare health plans, including Medicare Advantage plans, cost plans, and Health Care Prepayment Plans (HCPPs), are required to issue the NDMC and NDP when a request for either a medical service or payment is denied in whole or in part. Additionally, the notices inform Medicare enrollees of their right to file an appeal. All Medicare health plans are required to use these standardized notices. Medicare health plans provide an NDMC to enrollees upon denial, in whole or in part, of an enrollee's coverage request. This denial may be subject to a series of administrative review levels, involving defined steps and timeframes. The NDMC was developed to ensure Medicare enrollees have access to information needed to navigate the Medicare beneficiary appeals process. The NDMC meets requirements for both Medicare's standard and expedited appeals processes.

Medicare health plans provide an NDP to enrollees upon denial, in whole or in part, of payment for a service or item that the enrollee received. This denial may be subject to a series of administrative review levels, involving defined steps and timeframes. The NDP was developed to ensure Medicare enrollees have access to information needed to navigate the Medicare beneficiary appeals process. The NDP meets requirements for Medicare's standard appeals process. *Form Number:* CMS–10003 (OMB#: 0938–0829); *Frequency:* Yearly; *Affected Public:* Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 740; *Total Annual Responses:* 1,168,368; *Total Annual Hours:* 194,728 (For policy questions regarding this collection contact Stephanie Simons at 206–615–2420. 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 June 29, 2010:

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, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: April 23, 2010.

Michelle Shortt,

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

[FR Doc. 2010–10038 Filed 4–29–10; 8:45 am]

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