In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention, NCEH/ATSDR announces the following teleconference meeting of the aforementioned subcommittee:

Times and Dates: 12:30 p.m.–2 p.m., March 19, 2007.

Place: Century Center, 1825 Century Boulevard, Atlanta, Georgia 30345.

Status: Open to the public, teleconference access limited only by availability of telephone ports.

Purpose: Under the charge of the Board of Scientific Counselors, NCEH/ATSDR the Health Department Subcommittee will provide the BSC, NCEH/ATSDR with advice and recommendations on local and State health department issues and concerns that pertain to the mandates and mission of NCEH/ATSDR.

Matters to be Discussed: The meeting will include a review of the agenda; approval of minutes from the last conference call; a discussion on identifying State and Local government issues; a discussion on bridging NCEH/ATSDR programs; public comment and the next steps for the Health Department Subcommittee.

Items are subject to change as priorities dictate.

Supplementary Information: This teleconference meeting is scheduled to begin at 12:30 p.m. Eastern Daylight Savings Time. To participate, please dial 877/315–6535 and enter conference code 383520. The public comment period is scheduled from 1:30 p.m.–1:40 p.m.

Contact Person for More Information: Shirley D. Little, Committee Management Specialist, NCEH/ATSDR, 1600 Clifton Road, Mail Stop E–28, Atlanta, GA 30303; telephone 404/498–0615, fax 404/498–0059; E-mail: *slittle@cdc.gov*. The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and the ATSDR.

Dated: February 16, 2007.

Elaine L. Baker,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E7–3100 Filed 2–22–07; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–131, CMS–10219, CMS–10097, CMS–255, and CMS–437]

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:* Advance Beneficiary Notice of Noncoverage (ABN); *Use*: Under section 1879 of the Social Security Act, a physician, provider, practitioner or supplier of items or services participating in the Medicare Program, or taking a claim on assignment, may bill a Medicare beneficiary for items or services usually covered under Medicare, but denied in an individual case under specific statutory exclusions, if they inform the beneficiary, prior to furnishing the service, that Medicare is likely to deny payment. 42 CFR 411.404(b) and (c), and 411.408(d)(2) and (f), require written notice be provided to inform beneficiaries in advance of potential liability for payment.

While the basic content of the ABN remains the same, there were several changes to the notice including but not limited to the following: (1) Revised, more user friendly language; (2) combining the two versions of the ABN, the General Use ABN, form CMS–R–131–G, and CMS–R–131–L, which was used specifically for physician-ordered laboratory tests, into a single general notice meeting both needs; (3) adding the 1–800–MEDICARE number on the notice; (4) adding information about the beneficiary's right to demand Medicare be billed; (5) increasing the selection options to 3 from 2, to allow beneficiaries' the right to pay out of pocket when they desire; (6) allowing a place for other insurance information to be recorded; and (7) describing the significance of the signature; *Form Number:* CMS–R–131 (OMB#: 0938–0566); *Frequency:* Reporting: Weekly, Monthly, Yearly, Biennially and Occasionally; *Affected Public:* Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 1,270,614; *Total Annual Responses:* 40,302,506; *Total Annual Hours:* 4,701,959.

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Health Plan Employer Data And Information Set (HEDIS®); *Use:* The Centers for Medicare & Medicaid Services (CMS) collects quality performance measures in order to hold the Medicare managed care industry accountable for the care being delivered, to enable quality improvement, and to provide quality information to Medicare beneficiaries in order to promote an informed choice. It is critical to CMS' mission that we collect and disseminate information that will help beneficiaries choose among health plans, contribute to improved quality of care through identification of improvement opportunities, and assist CMS in carrying out its oversight and purchasing responsibilities.

In December 1997, OMB approved the request from CMS for the information collections under HEDIS® and assigned the agency form number CMS–R–200. The collections approved under that request included the HEDIS® collection (following the technical specifications contained in Volume 2, published by the National Committee for Quality Assurance (NCQA); the Health of Seniors/Health Outcomes Survey (HOS); and the Medicare CAHPS® survey. Since that approval there has been a change in the statutory authority as a result of the Balanced Budget Act of 1997. During the latter part of 2000, CMS instituted several policy changes regarding this collection which reduced burden substantially on the part of the managed care organizations and the process for finalizing and publishing that policy delayed the request for OMB approval. In addition, the renewal of OMB authority for the Medicare CAHPS survey was completed as a separate request. The HOS renewal was also submitted separately. This request is

solely for the approval of the HEDIS collection, which is now a stand alone collection. *Form Number:* CMS–10219 (OMB#: 0938–NEW); *Frequency:* Yearly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 705; *Total Annual Responses:* 705; *Total Annual Hours:* 33,840.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Contractor Provider Satisfaction Survey (MCPSS); *Form No.:* CMS–10097 (OMB# 0938–0915); *Use:* The Centers for Medicare & Medicaid Services will obtain feedback from Medicare providers via a survey about satisfaction, attitudes and perceptions regarding the services provided by Medicare Fee-for-Service (FFS) Carriers, Fiscal Intermediaries, Durable Medical Equipment Suppliers, and Regional Home Health Intermediaries and Medicare Administrative Contractors. The survey focuses on basic business functions provided by the Medicare Contractors such as inquiries, provider communications, claims processing, appeals, provider enrollment, medical review and provider audit and reimbursement. Providers will receive a notice requesting they use a specially constructed Web site to respond to a set of questions customized for their contractor's responsibilities. The survey will be conducted yearly and annual reports of the survey results will be available via an online reporting system for use by CMS, Medicare Contractors, and the general public.

Due to changes in CMS' reporting needs, CMS is requesting a potential increase in the number of completed surveys. This increase will allow CMS to have not only Contractor-specific, but also jurisdiction and state-specific data which, in turn, will enable Contractors to increase and implement performance improvement activities within their organizations. This increase will affect the 2008 and 2009 administrations of the survey. *Frequency:* Reporting—Annually; *Affected Public:* Business or other for-profit, not-for-profit institutions; *Number of Respondents:* 24,279; *Total Annual Responses:* 24,279; Total Annual Hours: 8,346.

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Municipal Health Services Cost Report; *Form Number:* CMS–255 (OMB# 0938–0155); *Use:* In June 1978, the Robert Wood Johnson Foundation (RWJF) and Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), agreed to collaborate in demonstrations and evaluations of new methods of delivering and reimbursing medical services in order to simultaneously increase access to primary care and decrease total health care costs per person served. The Municipal Health Services Program (MHSP) is the first of these cooperative efforts. The chief objective of the MHSP is to assist municipalities in providing health care services to medically underserved areas. By expanding existing programs of health departments and hospitals with a limited increase in a municipality's health budget, services traditionally provided by public health programs and hospital outpatient departments will be brought together in a single locality.

Participating clinics are reimbursed for all their routine costs based on the average cost per visit. Ancillary costs are paid according to 14 categories: Laboratory, x-ray, pharmacy, transportation, optometrist, dentist, audiologist, podiatrist, eyeglasses, dentures, devices, physical therapy, speech therapy, and occupational therapy. In order to determine the cost of the clinical services being provided, it is necessary to determine the direct and indirect cost incurred by the participating clinics for the routine and ancillary cost centers. For evaluation purposes, it is necessary to accurately identify the total visit count of the clinics for all patients and for Medicare patients. The MHSP CMS Form 255 cost report is the form that is being used to report the costs to the participating clinics of providing the covered services as well as to gather the data needed to properly evaluate the demonstration. *Frequency:* Recordkeeping and Reporting—Annually; *Affected Public:* Not-for-profit institutions; *Number of Respondents:* 14; *Total Annual Responses:* 14; *Total Annual Hours:* 476.

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Psychiatric Unit Criteria Worksheet and Supporting Regulations at 42 CFR 412.25 and 412.27. *Form Number:* CMS–437 (OMB# 0938–0358); *Use:* The psychiatric unit criteria worksheets are necessary to verify that these units comply and remain in compliance with the exclusion criteria for the Medicare prospective payment system. *Frequency:* Reporting—Annually; *Affected Public:* Business or other for-profit, not-for-profit institutions, and State, Local and Tribal Government; *Number of Respondents:* 1333; *Total Annual Responses:* 1333; *Total Annual Hours:* 333.

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 April 24, 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: February 13, 2007.

Michelle Shortt,

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

[FR Doc. E7–3026 Filed 2–22–07; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10148]

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