Medicare under the Act must meet specific requirements. These requirements are presented as Condition of Participation. State agencies can determine compliance with these conditions through the use of this worksheet form; *Frequency:* Other: 3–5 years; *Affected Public:* State, Local, or Tribal Government, Business or other for-profit, Not-for-profit institutions; *Number of Respondents:* 3323; *Total Annual Responses:* 3323; *Total Annual Hours:* 553.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Health Plan Employer Data and Information Set (HEDIS) and Health Outcome Survey (HOS) and supporting regulations at 42 CFR 422.152; *Form No.:* CMS–R–200 (OMB #0938–0701); *Use:* The Centers for Medicare and Medicaid Services (formerly HCFA) 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 informed choice. It is critical to CMS's 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; *Frequency:* Annually; *Affected Public:* Business or other for-profit, Not-for-profit institutions, and Individuals or Households; *Number of Respondents:* 166,709; *Total Annual Responses:* 70,992; *Total Annual Hours:* 498,436.

3. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Evaluation of the Medicaid Health Reform Demonstrations; *Form No.:* CMS–10094 (OMB #0938–NEW); *Use:* This survey is part of an evaluation of the State of Vermont's pharmacy assistance programs, which principally serve low income Medicare beneficiaries who do not have other coverage for prescription drugs. The surveys will explore the issues of self-selection into the pharmacy programs, motivations for joining or not joining, the extent of pharmacy coverage among low income Medicare beneficiaries who are not enrolled and the impact of coverage on Medicare spending. The Vermont evaluation is part of a larger evaluation of Section 1115 Medicaid demonstration programs in five states. (The other states are California, Kentucky, Minnesota, and New York. The survey will take place only in Vermont); *Frequency:* Other: One-time; *Affected Public:* Individuals or Households; *Number of Respondents:* 11,310; *Total Annual Responses:* 11,310; *Total Annual Hours:* 1,087.

4. *Type of Information Collection Request:* Reinstatement, without change, of a previously approved collection; *Title of Information Collection:* Expanded Coverage for Diabetes Outpatient Self-Management Training Services and Supporting Regulations Contained in 42 CFR 410.141–410.146 and 414.63; *Form No.:* CMS–R–247 (OMB #0938–0818); *Use:* 42 CFR 410.141–410.146 and 414.63 provide for uniform coverage of diabetes outpatient self-management training services. These services include educational and training services furnished to a beneficiary with diabetes by an entity approved to furnish the services. The physician or qualified nonphysician practitioner treating the beneficiary's diabetes certifies that these services are needed as part of a comprehensive plan of care. The regulations set forth the quality standards that an entity is required to meet in order to participate in furnishing diabetes outpatient self-management training services; *Frequency:* On occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 1,708; *Total Annual Responses:* 6,832; *Total Annual Hours:* 53,013.5.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS's Web Site address at *http://cms.hhs.gov/regulations/pra/default.asp,* or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.gov,* or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Brenda Aguilar, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: August 21, 2003.

Dawn Willinghan,

Acting Paperwork Reduction Act Team Leader, CMS Reports Clearance Officer, Office of Strategic Operations and Strategic Affairs, Division of Regulations Development and Issuances.

[FR Doc. 03–22076 Filed 8–28–03; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–372]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare and Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare and Medicaid Services (CMS)(formerly known as the Health Care Financing Administration (HCFA)), 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 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.

Type of Information Collection Request: Extension of a currently approved collection; *Title of Information Collection:* Annual Report on Home and Community Based Services Waivers and Supporting Regulations in 42 CFR 440.180 and 441.300–.310; *Form No.:* CMS–372 (OMB# 0938–0272); *Use:* States request waivers in order for beneficiaries to have the option of receiving hospital services in their homes. States with an approved waiver under section 1915(c) of the Act are required to submit the CMS–372 or CMS–372(S) annually in order for CMS to: (1) Verify that State assurances regarding waiver-cost-neutrality are met, and (2) determine the waiver's impact on the type, amount and cost of services provided under the State plan and health and welfare of recipients; *Frequency:* Annually; *Affected Public:* State, local or tribal government; *Number of Respondents;* 50; *Total Annual Responses:* 277; *Total Annual Hours:* 20,775. To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS's Web Site address at *http:/*

/cms.hhs.gov/regulations/pra/default.asp, or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hefa.gov,* or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the CMS Paperwork Clearance Officer designated at the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances, Attention: Dawn Willinghan, Room CS–14–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: August 21, 2003.

Dawn Willinghan,

Acting, CMS Reports Clearance Officer, Office of Strategic Operations and Strategic Affairs, Division of Regulations Development and Issuances.

[FR Doc. 03–22077 Filed 8–28–03; 8:45 am]

BILLING CODE 4120–03–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Oklahoma Medicaid State Plan Amendment (SPA) 02–14

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing on October 7, 2003, 10 a.m.; Room 714, 1301 Young Street; CMS Dallas Regional Office; Dallas, Texas 75202 to reconsider our decision to disapprove Oklahoma State Plan Amendment 02–14.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by September 15, 2003.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS, 2520 Lord Baltimore Drive, Suite L, Baltimore, Maryland 21244, Telephone: (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider the decision dated May 28, 2003, to disapprove Oklahoma Medicaid State Plan Amendment (SPA) 02–14.

Oklahoma submitted SPA 02–14 on October 22, 2002, and revised it on May 14, 2003. On May 28, 2003, CMS disapproved SPA 02–14, after consultation with the Secretary as required under 42 CFR 430.15(c)(2). The State requested reconsideration by letter dated July 25, 2003.

At issue is whether the proposed supplemental payment methodology contained in the SPA complies with the requirement at section 1902(a)(30)(A) of the Social Security Act (the Act) that payment methodologies must assure that ''payments are consistent with efficiency, economy and quality of care.'' The proposed payment methodology would provide supplemental payment for services rendered by doctors of medicine, osteopathy, and dentists who are State employees. The State asserted that increased payment was warranted because of the specialized services provided by these State employees. The State failed to demonstrate, however, that delivering Medicaid services through State employees generated significantly higher costs sufficient to justify the requested supplemental payment. Moreover, the supplemental payment methodology proposed by the State is not a customary method for paying physicians and other health professionals. The methodology would make it difficult to track payments for specific services and would complicate auditing processes. In sum, at issue is whether it is consistent with efficiency, economy, and quality of care to use a methodology that: (1) Is not justified by any increased costs to the State to ensure access to services for Medicaid beneficiaries; (2) is not a usual and customary payment methodology; and (3) would unduly complicate tracking and audit processes.

Section 1116 of the Act and 42 CFR part 430 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a State plan or plan amendment. The CMS is required to publish a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing and the issues to be considered. If we subsequently notify the agency of additional issues that will be considered at the hearing, we will also publish that notice.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

The notice to Oklahoma announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Mr. Jim Hancock, Director
Health Policy Division
Oklahoma Health Authority
4545 North Lincoln Boulevard, Suite 124
Oklahoma City, OK 73105

Dear Mr. Hancock: I am responding to your request for reconsideration of the decision to disapprove Oklahoma State Plan Amendment (SPA) 02–14.

Oklahoma submitted SPA 02–14 on October 22, 2002, and revised it on May 14, 2003. On May 28, 2003, I disapproved SPA 02–14, after consultation with the Secretary as required under 42 CFR 430.15(c)(2). You requested reconsideration by letter dated July 25, 2003.

At issue is whether the proposed supplemental payment methodology contained in the SPA complies with the requirement at section 1902(a)(30)(A) of the Social Security Act that payment methodologies must assure that ''payments are consistent with efficiency, economy and quality of care.'' The proposed payment methodology would provide supplemental payment for services rendered by doctors of medicine, osteopathy, and dentists who are State employees. The State asserted that increased payment was warranted because of the specialized services provided by these State employees. The State failed to demonstrate, however, that delivering Medicaid services through State employees generated significantly higher costs sufficient to justify the requested supplemental payment. Moreover, the supplemental payment methodology proposed by the State is not a customary method for paying physicians and other health professionals. The methodology would make it difficult to track payments for specific services and would complicate auditing processes. In sum, at issue is whether it is consistent with efficiency, economy, and quality of care to use a methodology that: (1) Is not justified by any increased costs to the State to ensure access to services for Medicaid beneficiaries; (2) is not a usual and customary payment methodology; and (3) would unduly complicate tracking and audit processes. For the above stated reasons, and after consulting with the Secretary as required by 42 CFR 430.15(c)(2), the Centers for Medicare & Medicaid Services (CMS) disapproved Oklahoma SPA 02–14.

I am scheduling a hearing on your request for reconsideration to be held on October 7, 2003, at 10 a.m., 1301 Young Street, Room 714, CMS Dallas Regional Office, Dallas, Texas 75202. If this date is not acceptable, we would be glad to set another date that is mutually agreeable to the parties. The hearing will be governed by the procedures prescribed at 42 CFR, part 430.

I am designating Ms. Kathleen Scully-Hayes as the presiding officer. If these arrangements present any problems, please contact the presiding officer. In order to