patient assessment instrument designed to measure differences in patient severity, resource utilization, and outcomes for patients in acute and post-acute care settings. This tool will be used to (1) Standardize program information on Medicare beneficiaries' acuity at discharge from acute hospitals, (2) document medical severity, functional status and other factors related to outcomes and resource utilization at admission, discharge, and interim times during post acute treatment, and (3) understand the relationship between severity of illness, functional status, social support factors, and resource utilization. The CARE instrument will be used in the Post-Acute Care (PAC) Payment Reform Demonstration program mandated by Section 5008 of the Deficit Reduction Act of 2005 to develop payment groups that reflect patient severity and related cost and resource use across post acute settings. Specifically, the data collected using the CARE instrument during the Post-Acute Care Payment Demonstration will be used by CMS to develop a setting neutral post-acute care payment model as mandated by Congress. The data will be used to characterize patient severity of illness and level of function in order to predict resource use, post-acute care discharge placement, and beneficiary outcomes. CMS will use the data from the CARE instrument to examine the degree to which the items on the instrument can be used to predict beneficiary resource use and outcomes. *Form Number:* CMS–10243 (OMB#: 0938–NEW); *Frequency:* Reporting—Daily; *Affected Public:* Private Sector—Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 388; *Total Annual Responses:* 244,292; *Total Annual Hours:* 179,341.

5. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Medicaid State Program Integrity Assessment (SPIA); *Use:* Under the provisions of the Deficit Reduction Act (DRA) of 2005, Congress directed CMS to establish the Medicaid Integrity Program (MIP), CMS' first national strategy to combat Medicaid fraud, waste, and abuse. CMS has two broad responsibilities under the MIP:

(1) Reviewing the actions of individuals or entities providing services or furnishing items under Medicaid; conducting audits of claims submitted for payment; identifying overpayments; and educating providers and others on payment integrity and quality of care; and

(2) Providing effective support and assistance to States to combat Medicaid fraud, waste, and abuse.

In order to fulfill the second of these requirements, CMS plans to develop a Medicaid State Program Integrity Assessment (SPIA) system. CMS is seeking approval from the Office of Management and Budget (OMB) to collect information from the States on an annual basis for input into a national SPIA system. Through the SPIA system, CMS will identify current Medicaid program integrity (PI) information, develop profiles for each State based on these data, determine areas to provide States with technical support and assistance, and use the data to develop performance measures to assess States' performance in an ongoing manner; *Form Number:* CMS–10244 (OMB#: 0938–NEW); *Frequency:* Reporting: Yearly; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 1,400.

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 September 25, 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: July 18, 2007.

Michelle Shortt,

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

[FR Doc. 07–3647 Filed 7–26–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–312]

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:* Conflict of Interest and Ownership and Control Information *Use:* The Conflict of Interest and Ownership and Control Information Statement (COI Statement) is sent to all Medicare Fiscal Intermediaries (FIs) and Carriers to collect full and complete information on any entity's or individual's ownership interest (defined as a 5 per centum or more) in an organization that may present a potential conflict of interest in their role as a Medicare FI or Carrier.

The information gathered in the survey is used to ensure that all potential, apparent and actual conflicts of interest involving Medicare contractors are appropriately mitigated and that employees of the contractors, including officers, directors, trustees and members of their immediate families, do not utilize their positions with the contractor for their own private business interest to the detriment of the Medicare program. Information is also requested on potential organizational conflicts of interest involving Medicare contractors' ownership of other entities in the health care industry. If a response has indicated that a potential conflict of interest exists, the contractor is contacted and asked to address how the conflict can be avoided or mitigated. *Form Number:* CMS–R–312 (OMB#: 0938–0795); *Frequency:* Reporting—Annually; *Affected Public:* Private Sector—Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 37; *Total Annual Responses:* 37; *Total Annual Hours:* 11,100.

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 September 25, 2007.

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—B, Attention: William N. Parham, III, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: July 20, 2007.

Michelle Shortt,

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

[FR Doc. E7–14481 Filed 7–26–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Virginia Title XXI State Plan Amendment (SPA) No. 6

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

ACTION: Notice of Hearing.

SUMMARY: This notice announces an administrative hearing to be held on September 4, 2007, at 150 S. Independence Mall West, Suite 216, Conference Room #241, Pennsylvania Room, The Public Ledger Building, Philadelphia, PA 19106–3499, to reconsider CMS' decision to disapprove Virginia's title XXI SPA No. 6.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by (15 days after publication).

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS, Lord Baltimore Drive, Mail Stop LB–23–20, Baltimore, Maryland 21244, *Telephone:* (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider CMS' decision to disapprove Virginia's title XXI SPA No. 6, which was submitted on June 29, 2004. This SPA was disapproved on April 20, 2007.

Under this SPA, the State requested the addition of new school-based health services to the State Children's Health Insurance Program (SCHIP) Family Access to Medical Insurance Security (FAMIS) benefit package.

The amendment was disapproved because CMS found that the amendment violated the statute for reasons set forth in the disapproval letter.

The following issues are to be decided at the hearing:

(1) Whether Virginia provided all information necessary to establish that the proposed SPA, in the context of its State child health plan, conformed to all requirements of the SCHIP statute and implementing regulations, including:

(a) Information on the exact nature of the services to be covered; whether those services are within the definition of child health assistance at section 2110(a) of the Social Security Act (Act);

(b) Information on proposed provider qualifications necessary to ensure the quality and appropriateness of care pursuant to section 2102(a)(7) of the Act and ensure that services are provided in an effective manner pursuant to section 2101(a) of the Act, and;

(c) Information on the budgetary impact necessary to ensure that services are provided in an effective and efficient manner.

(2) In the absence of such information, whether a disapproval was warranted when 950 days had passed after CMS had requested that information.

The Commonwealth of Virginia's title XXI SPA No. 6 was submitted to the CMS on June 29, 2004, with a requested retroactive effective date of August 3, 2003. This amendment requested the addition of new school-based health services to the State's SCHIP FAMIS benefit package.

A request for additional information (RAI) was submitted to the State on August 18, 2004, which stopped the 90-day review period. The RAI included questions concerning the nature of the proposed services, the qualifications of the providers, and the budgetary impact of the amendment.

To date, the State has not responded to the request for additional information.

Section 1116 of the Act and Federal regulations at 42 CFR part 430, Subpart D, and section 457.203 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a State plan or plan amendment. 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 pursuant to 42 CFR 430.74(a).

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). A hearing may be rescheduled by written agreement between CMS and a State pursuant to 42 CFR 430.72(a).

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

Mr. Brian McCormick,
Department of Medical Assistance Services, Commonwealth of Virginia, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Dear Mr. McCormick: I am responding to your request for reconsideration of the decision to disapprove Virginia's title XXI State plan amendment (SPA) No. 6, which was submitted on June 29, 2004, and was disapproved on April 20, 2007.

Under this SPA, the State requested the addition of new school-based health services to the State Children's Health Insurance Program (SCHIP) Family Access to Medical Insurance Security (FAMIS) benefit package. The amendment was disapproved because the Centers for Medicare & Medicaid Services (CMS) was not certain if the amendment was in compliance with section 2106(c) of the Social Security Act (the Act) because the State did not respond to a request for additional information dated August 18, 2004. In the absence of a response, the SPA was disapproved because there was insufficient information to make the necessary determination.

The following issues are to be decided at the hearing:

(1) Whether Virginia provided all information necessary to establish that the proposed SPA, in the context of its State child health plan, conformed to all requirements of the SCHIP statute and implementing regulations, including:

(a) Information on the exact nature of the services to be covered; whether those services are within the definition of child health assistance at section 2110(a) of the Act;

(b) Information on proposed provider qualifications necessary to ensure the quality and appropriateness of care pursuant to section 2102(a)(7) of the Act and ensure that services are provided in an effective manner pursuant to section 2101(a) of the Act, and;

(c) Information on the budgetary impact necessary to ensure that services are provided in an effective and efficient manner.