Public: Business or other for-profit, Not-for-profit institutions, and State, local or tribal governments; *Number of Respondents:* 100,000; *Total Annual Responses:* 100,000; *Total Annual Hours:* 100,000.

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.

Written comments and recommendations for the proposed information collections must be mailed or faxed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503. Fax Number: (202) 395–6974.

Dated: July 14, 2006.

Michelle Shortt,

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

[FR Doc. E6–11576 Filed 7–20–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10179]

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:* New Collection; *Title of Information Collection:* Requests by Hospitals for an Alternative Cost-to-Charge Ration Instead of the Statewide Average Cost-to-Charge Ratio; *Use:* Because of the extensive gaming of outlier payments, CMS implemented new regulations in 42 CFR 412.84(i)(2) for inpatient hospitals and 42 CFR 412.525(a)(4)(ii) and 412.529(c)(5)(ii) for Long Term Care Hospitals (LTCH) to allow a hospital to contact its fiscal intermediaries to request that its cost-to-charge ratio (CCR) (operating and/or capital CCR for inpatient hospitals or the total (combined operating and capital) CCR for LTCHs), otherwise applicable, be changed if the hospital presents substantial evidence that the ratios are inaccurate for inpatient hospitals. Any such requests would have to be approved by the CMS Regional Office with jurisdiction over that FI. *Form Number:* CMS–10179 (OMB#: 0938–NEW); *Frequency:* Reporting—On occasion; *Affected Public:* Individuals or Households and Federal Government; *Number of Respondents:* 18; *Total Annual Responses:* 18; *Total Annual Hours:* 144.

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 19, 2006.

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 14, 2006.

Michelle Shortt,

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

[FR Doc. E6–11582 Filed 7–20–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Alaska State Plan Amendment 05–06

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing to be held on August 29, 2006, at the Blanchard Plaza Building, 2201 Sixth Avenue, 11th Floor Conference Room, Seattle, WA 98121, to reconsider CMS' decision to disapprove Alaska State plan amendment 05–06.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by August 7, 2006.

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 Alaska State plan amendment (SPA) 05–06, which was submitted on August 1, 2005. This SPA was disapproved on April 21, 2006. Under SPA 05–06, Alaska proposed to add certain school-based behavioral health services under the rehabilitation services benefit.

This amendment was disapproved because it did not comport with the requirements of section 1902(a) of the Social Security Act (the Act) and implementing regulations. Specifically, the following issues will be considered on reconsideration: (1) Whether the State demonstrated that the proposed services would be within the scope of ''medical assistance'' under the State plan pursuant to section 1902(a)(10) of the Act, as defined at section 1905(a) of the Act; (2) whether the State has assured that there is non-Federal funding as required under section 1902(a)(2) to support expenditures that would be claimed under the State plan as the basis for Federal matching funding in light of financial arrangements that do not appear to result in net expenditures; (3) whether the proposed payment rates meet the requirements of section 1902(a)(30)(A) of the Act to be consistent with efficiency, economy, and quality of care, in light of financial arrangements under which the providers do not retain

Medicaid payments; and (4) whether the State plan complied with the requirements of section 1902(a) generally, and implementing Federal regulations at 42 CFR 430.10, to include all information necessary to serve as the basis for Federal financial participation. We describe each of these issues in detail below.

Section 1902(a)(10) of the Act requires that the State plan provide for making medical assistance available to eligible beneficiaries. The State did not establish that the proposed ''school-based rehabilitative services'' are within the scope of ''medical assistance,'' which is defined in section 1905(a) of the Act. While we understand the State has placed the proposed services under the rehabilitative services benefit in the State plan, the State has provided no clear definition of the proposed services so that CMS can determine whether they are, indeed, within the scope of the rehabilitation benefit. After repeated requests for further information, the State did not provide any description of what elements the ''behavioral health services (including medication services)'' encompass, and how they are different (or the same) as services in the currently approved State plan. It is not clear whether this is an expansion of coverage or a different payment methodology for school providers. Absent such information, SPA 05–06 did not comply with the requirements of section 1902(a)(10) of the Act to provide for medical assistance as defined in section 1905(a) of the Act.

Section 1902(a)(2) of the Act provides that the State plan must assure adequate funding for the non-Federal share of expenditures from State or local sources for the amount, duration, scope, or quality of care and services available under the plan. Section 1902(a)(30)(A) of the Act requires that State plans provide for payment for care and services available under the plan that is ''consistent with economy, efficiency, and quality of care.'' In order to assess compliance with these provisions, State officials were asked to provide information related to Alaska's funding mechanisms for payments, and the net State and local expenditures that are incurred. Nor did Alaska respond to requests for descriptions of any transfers of funds between providers and State or local governments, and information as to whether the providers keep 100 percent of the total computable funds given as Medicaid payments.

According to a flow chart provided by the State, the Medicaid agency pays the schools 100 percent of the claimed amount. A quarterly bill for the State match is then submitted to school providers who transfer to the Medicaid agency the State share of the services provided. This transfer of funds is made after the schools have been reimbursed for the services they provide, and is effectively a refund by the schools for part of their Medicaid payments. As a result of this refund, the net expenditure by the State Medicaid agency is wholly federally funded. In light of this refund arrangement, we cannot conclude that the proposed payment rate reflects the net expenditure by the State for Medicaid services provided by schools, and that the net non-Federal share meets the requirements of section 1902(a)(2) of the Act. Moreover, the refund is an indication that the full payment amount is not required to ensure Medicaid beneficiaries' access to the providers' services. The result is that proposed payments under this section of the plan would not be in compliance with the requirement under section 1902(a)(30)(A) of the Act that payment rates must be consistent with economy, efficiency, and quality of care.

Finally, the proposed SPA does not comply with the general provisions of section 1902(a), including section 1902(a)(4) of the Act, as implemented in part by Federal regulations at 42 CFR 430.10. This regulation requires that States include in their State plans all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation. There is absent information that would more precisely identify the covered services. Therefore, the proposed SPA does not comply with this requirement.

For the reasons cited above, and after consultation with the Secretary, as required by Federal regulations at 42 CFR 430.15(c)(2), Alaska SPA 05–06 was disapproved.

Section 1116 of the Act, and Federal regulations at 42 CFR part 430, 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.

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 in Federal regulations 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 in Federal regulations at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

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

Mr. Jerry Fuller, Medicaid Director, State of Alaska, Department of Health and Social Services, Office of the Commissioner, P.O. Box 110601, Juneau, AK 99811–0601.

Dear Mr. Fuller: I am responding to your request for reconsideration of the decision to disapprove the Alaska State plan amendment (SPA) 05–06, which was submitted on August 1, 2005, and disapproved on April 21, 2006. Under SPA 05–06, Alaska was proposing to add certain school-based behavioral health services under the rehabilitation services benefit. This amendment was disapproved because it did not comport with the requirements of section 1902(a) of the Social Security Act (the Act) and implementing regulations, as discussed in more detail below.

Specifically, the following issues will be considered on reconsideration: (1) Whether the State demonstrated that the proposed services would be within the scope of ''medical assistance'' under the State plan pursuant to section 1902(a)(10) of the Act, as defined at section 1905(a) of the Act; (2) whether the State has assured that there is non-Federal funding as required under section 1902(a)(2) of the Act to support expenditures that would be claimed under the State plan as the basis for Federal matching funding in light of financial arrangements that do not appear to result in net expenditures; (3) whether the proposed payment rates meet the requirements of section 1902(a)(30)(A) of the Act to be consistent with efficiency, economy, and quality of care, in light of financial arrangements under which the providers do not retain Medicaid payments; and (4) whether the State plan complied with the requirements of section 1902(a) of the Act generally, and implementing Federal regulations at 42 CFR 430.10, to include all information necessary to serve as the basis for Federal financial participation. We describe each of these issues in detail below.

Section 1902(a)(10) of the Act requires that the State plan provide for making medical assistance available to eligible beneficiaries. The State did not establish that the proposed ''school-based rehabilitative services'' are within the scope of ''medical assistance,'' which is defined in section 1905(a) of the Act. While we understand the State has placed the proposed services under the rehabilitative services benefit in the State plan, the State has provided no clear definition of the proposed services so that the Centers for Medicare & Medicaid Services (CMS) can determine whether they are, indeed, within the scope of the rehabilitation benefit. After repeated requests for further information, the State provided no

description of what elements the ''behavioral health services (including medication services)'' encompass, and how they are different (or the same) as services in the currently approved State plan. It is not clear whether this is an expansion of coverage or a different payment methodology for school providers. Absent such information, SPA 05–06 did not comply with the requirements of section 1902(a)(10) of the Act to provide for medical assistance as defined in section 1905(a) of the Act.

Section 1902(a)(2) of the Act provides that the State plan must assure adequate funding for the non-Federal share of expenditures from State or local sources for the amount, duration, scope, or quality of care and services available under the plan. Section 1902(a)(30)(A) of the Act requires that State plans provide for payment for care and services available under the plan that is ''consistent with economy, efficiency, and quality of care.'' In order to assess compliance with these provisions, State officials were asked to provide information related to Alaska's funding mechanisms for payments, and the net State and local expenditures that are incurred. Nor did Alaska respond to requests for any transfers of funds between providers and State or local governments, and information as to whether the providers keep 100 percent of the total computable funds given as Medicaid payments.

According to a flow chart provided by the State, the Medicaid agency pays the schools 100 percent of the claimed amount. A quarterly bill for the State match is then submitted to school providers who transfer to the Medicaid agency the State share of the services provided. This transfer of funds is made after the schools have been reimbursed for the services they provide, and is effectively a refund by the schools for part of their Medicaid payments. As a result of this refund, the net expenditure by the State Medicaid agency is wholly federally funded. In light of this refund arrangement, we cannot conclude that the proposed payment rate reflects the net expenditure by the State for Medicaid services provided by schools, and that the net non-Federal share meets the requirements of section 1902(a)(2) of the Act. Moreover, the refund is an indication that the full payment amount is not required to ensure Medicaid beneficiaries' access to the providers' services. The result is that proposed payments under this section of the plan would not be in compliance with the requirement under section 1902(a)(30)(A) of the Act that payment rates must be consistent with economy, efficiency, and quality of care.

Finally, the proposed SPA does not comply with the general provisions of section 1902(a), including section 1902(a)(4) of the Act, as implemented in part by Federal regulations at 42 CFR section 430.10. This regulation requires that States include in their State plans all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation. As discussed above, Alaska did not provide information that would more precisely identify the covered services or the non-Federal funding source. Therefore the proposed SPA does not comply with this requirement.

For the reasons cited above, and after consultation with the Secretary, as required by Federal regulations at 42 CFR 430.15(c)(2), Alaska SPA 05–06 was disapproved.

I am scheduling a hearing on your request for reconsideration to be held on August 29, 2006, at the Blanchard Plaza Building, 2201 Sixth Avenue, 11th Floor Conference Room, Seattle, WA 98121, to reconsider the decision to disapprove SPA 05–06. 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 by Federal regulations 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 at (410) 786–2055. In order to facilitate any communication which may be necessary between the parties to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled, and provide names of the individuals who will represent the State at the hearing.

Sincerely,
Mark B. McClellan, M.D., PhD.

Section 1116 of the Social Security Act (42 U.S.C. 1316; 42 CFR 430.18)

(Catalog of Federal Domestic Assistance Program No. 13.714, Medicaid Assistance Program)

Dated: July 14, 2006.

Mark B. McClellan,
Administrator.

[FR Doc. E6–11577 Filed 7–20–06; 8:45 am]
BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of a New System of Records

AGENCY: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS).

ACTION: Notice of a New System of Records (SOR).

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, we are proposing to establish a new system titled, ''Medicare Chiropractic Coverage Demonstration and Evaluation (MCCDE), System No. 09–70–0577.'' The demonstration entitled, ''Expansion of Coverage of Chiropractic Services Demonstration'' was established under provisions of Section 651 (d) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law (Pub. L.) 108–173). The MCCDE will focus on selected beneficiaries, residing within the four demonstration regions or their respective control regions, who have Medicare chiropractic-eligible diagnoses [i.e., neuromusculoskeletal conditions (NMS)]. The system will contain: Demographic information from Medicare enrollment files; Medicare claims data on utilization of NMS-related Medicare services with associated costs, for demonstration participants and their matched, non-participant controls; and participant satisfaction survey data for the subset randomly surveyed. The MCCDE has four goals: (1) To determine whether eligible beneficiaries who use chiropractic services under the demonstration use a lesser overall amount of items and services for which payment is made under the Medicare program than eligible beneficiaries who do not use such services; (2) to determine the cost of providing payment for chiropractic services under the Medicare program; (3) to further determine whether the demonstration achieves budget neutrality, and if not, the amount of any cost excess to be recouped by Medicare from the chiropractic profession; and (4) finally, to ascertain the satisfaction of eligible beneficiaries participating in the demonstration projects and their perceived quality of care received.

The primary purpose of the system is to collect and maintain individually identifiable information on beneficiaries, physicians, participating chiropractors, and providers of service participating in the demonstration and evaluation program. Information retrieved from this system may be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, consultant or grantee; (2) assist another Federal or state agency with information to contribute to the accuracy of CMS's proper payment of Medicare benefits, enable such agency to administer a Federal health benefits program, or to enable such agency to fulfill a requirement of Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds; (3) support an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects; (4) support litigation involving the agency; and (5) combat fraud and abuse in certain Federally-funded health benefits programs. We have provided background information about the new system in the