Paragraph II.B prohibits the Respondent from facilitating exchanges of information between health care providers concerning whether, or on what terms, to contract with a payor. Paragraph II.C bars attempts to engage in any action prohibited by Paragraph II.A or II.B, and Paragraph II.D proscribes encouraging, suggesting, advising, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs II.A through II.C.

As in other Commission orders addressing health care providers' collective bargaining with health care payors, certain kinds of agreements are excluded from the general bar on joint negotiations. Paragraph II does not preclude ABMG from engaging in conduct that is reasonably necessary to form or participate in legitimate ''qualified risk-sharing'' or ''qualified clinically-integrated'' joint arrangements, as defined in the proposed Consent Order. Also, Paragraph II would not bar agreements that only involve physicians who are part of the same medical group practice, defined in Paragraph I.B, because it is intended to reach agreements between and among independent competitors.

Paragraphs III through VI require ABMG to notify the Commission before it initiates certain contacts regarding contracts with payors. Paragraphs III and IV apply to arrangements under which ABMG would be acting as a messenger on behalf of its member physicians. Paragraphs V and VI discuss arrangements under which ABMG plans to achieve financial or clinical integration.

Paragraph VII.A requires ABMG to send a copy of the Complaint and Consent Order to its physician members, its management and staff, and any payors who communicated with ABMG, or with whom ABMG communicated, with regard to any interest in contracting for physician services, at any time since January 1, 2001.

Paragraph VII.B requires ABMG to terminate, without penalty, pre-existing payer contracts that it had entered into since 2001, at the earlier of (1) receipt by ABMG of a written request for termination by the payer; or (2) the termination date, renewal date, or anniversary date of the contract. This provision is intended to eliminate the effects of ABMG's illegal collective behavior. The payer can delay the termination for up to one year by making a written request to ABMG.

Paragraph VII.D contains three-year notification provisions relating to future contact with physicians, payors, management and staff. This provision requires ABMG to distribute a copy of the Complaint and Consent Order to each physician who begins participating in ABMG; each payor who contacts ABMG regarding the provision of physician services; and each person who becomes an officer, director, manager, or employee for five years after the date on which the Consent Order becomes final. In addition, Paragraph VII.D requires ABMG to publish a copy of the Complaint and Consent Order, annually, in any official publication that it sends to its participating physicians.

Paragraphs VII.E and VIII–IX impose various obligations on ABMG to report or to provide access to information to the Commission to facilitate monitoring its compliance with the Consent Order.

Pursuant to Paragraph X, the proposed Consent Order will expire in 20 years from the date it is issued.

By direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. E9–13956 Filed 6–12–09: 8:45 am]

BILLING CODE: 6750–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Low Income Home Energy Assistance Program LIHEAP Leveraging Report.

OMB No.: 0970–0121.

Description: The LIHEAP leveraging incentive program rewards LIHEAP grantees that have leveraged non-federal home energy resources for low-income households. The LIHEAP leveraging report is the application for leveraging incentive funds that these LIHEAP grantees submit to the Department of Health and Human Services for each fiscal year in which they leverage countable resources. Participation in the leveraging incentive program is voluntary and is described at 45 CFR 96.87. The LIHEAP leveraging report obtains information on the resources leveraged by LIHEAP grantees each fiscal year (as cash, discounts, waivers, and in-kind); the benefits provided to low-income households by these resources (for example, as fuel and payments for fuel, as home heating and cooling equipment, and as weatherization materials and installation); and the fair market value of these resources/benefits.

HHS needs this information in order to carry out statutory requirements for administering the LIHEAP leveraging incentive program, to determine countability and valuation of grantees leveraged non-federal home energy resources, and to determine grantees shares of leveraging incentive funds. HHS proposes to request a three-year extension of OMB approval for the currently approved LIHEAP leveraging report information collection.

Respondents: State, Local or Tribal Governments.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
LIHEAP Leveraging Report	70	1	38	2,660

Estimated Total Annual Burden Hours: 2,660

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. E-mail address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it

within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, Fax: 202–395–7245, Attn: Desk Officer for the Administration for Children and Families.

Dated: June 10, 2009.

Janean Chambers,

Reports Clearance Officer.

[FR Doc. E9–13985 Filed 6–12–09; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10266]

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:* New collection; *Title of Information Collection:* Conditions of Participation: Requirements for Approval and Reapproval of Transplant Centers to Perform Organ Transplants and Supporting Regulations in 42 CFR 482.74, 482.94, 482.100, 482.102, 488.61; *Use:* The Conditions of Participation and accompanying requirements specified in the regulations are used by our surveyors as a basis for determining whether a transplant center qualifies for approval or re-approval under Medicare. CMS and the healthcare industry believe that the availability to the facility of the type of records and general content of records is standard medical practice and is necessary in order to ensure the well-being and safety of patients and professional treatment accountability. *Form Number:* CMS–10266 (OMB# 0938–New); *Frequency:* Yearly; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 514; *Total Annual Responses:* 3,270; *Total Annual Hours:* 9,334.

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 *July 15, 2009.*

OMB Human Resources and Housing Branch, Attention: OMB Desk Officer, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: June 5, 2009.

Michelle Shortt,

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

[FR Doc. E9–13947 Filed 6–12–09; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–304/304a, CMS–10288, CMS–10289 and CMS–1450 (UB–04)]

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 without change of a currently approved collection; *Title of Information Collection:* Reconciliation of State Invoice and Prior Quarter Adjustment Statement; *Use:* Section 1927 of the Social Security Act requires drug manufacturers to enter into and have in effect a rebate agreement with CMS in order for States to receive funding for drugs dispensed to Medicaid recipients. Drug manufacturers must complete and submit to States the 304 form (the Reconciliation of State Invoice Form) to explain any rebate payment adjustments for the current quarter, and complete and submit the 304A form (the Prior Quarter Adjustment Statement Form) to States to explain rebate payment adjustments to any prior quarters. Both forms are used to reconcile drug rebate payments made by manufacturers with the State invoices of rebates due. *Form Number:* CMS–304/304a (OMB#: 0938–0676); *Frequency:* Reporting—Quarterly; *Affected Public:* Private Sector: Business or other for profits; *Number of Respondents:* 570; *Total Annual Responses:* 3820; *Total Annual Hours:* 141,080. (For policy questions regarding this collection contact Cindy Bergin at 410–786–1176. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* State Plan Pre-Print to Implement Required Dental Benefits Pursuant of Children's Health Insurance Program Reauthorizing Act (CHIPRA) 2009; *Use:* Section 501 of CHIPRA 2009 amends XXI and requires that ''child health assistance provide to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.'' States that provide coverage in a separate Children's Health Insurance Program may choose between two methods of providing the dental services required in Section 501. The State may define the