The survey questionnaire was developed by DBS in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) and state public health and mental health departments from Louisiana, Mississippi, Alabama, and Florida, where the survey is being conducted.

Coastal counties within 32 miles of an area where fishing was closed due to the Deepwater Horizon Event were selected for inclusion. These include the following Gulf coast counties:

Louisiana: Assumption Parish, Calcasieu Parish, Cameron Parish, Iberia Parish, Jefferson Parish, Jefferson Davis Parish, Lafourche Parish, Orleans Parish, Plaquemines Parish, St. Bernard Parish, St. Charles Parish, St. Mary Parish, St. Tammany Parish, Tangipahoa Parish, Terrebonne Parish, Vermilion Parish.

Mississippi: Hancock County, Harrison County, Jackson County.

Alabama: Baldwin County, Mobile County.

Florida: Escambia County, Okaloosa County, Santa Rosa County, Walton County.

The objective of the survey is to provide state health and mental health departments, SAMHSA, and other appropriate organizations data they need to assess the need for mental and behavioral health services in the selected counties and to inform the provision of those services.

The telephone survey will collect data from a random sample of households with land-line telephones in the selected counties. Approximately 2,500 interviews will be completed each month. Adults 18 years or older will be asked to take part in the survey, but only one adult per household will be interviewed. Potential respondents will be notified through an introductory script that participation is voluntary and they will not be compensated for participating. For those who agree to participate, interviews should last approximately 20–25 minutes.

Since the OMB emergency clearance for the DBS Gulf States Population Survey expires April 30, 2011, DBS is submitting an information collection request (ICR) for the portion of the data collection (May–December, 2011) that is not covered by the OMB emergency clearance approval.

Preliminary data from the survey will be available to SAMHSA and participating states monthly (pending sample size). The final dataset and analyses will be provided to SAMHSA and participating states in January 2012.

There is no cost to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number responses per respondent	Average burden per response (in hours)	Total burden hours
Individuals/telephone interviews	30,000	1	.5	15,000

Catina Conner,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–11–11BJ]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–5960 or send comments to Carol Walker, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS D–74, Atlanta, GA 30333 or send an e-mail to *omb@cdc.gov.*

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

CDC Diabetes Prevention Recognition Program (DPRP)—New—Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Evidence from efficacy and effectiveness research studies has shown that lifestyle modifications leading to weight loss and increased physical activity can prevent or delay type 2 diabetes in individuals with prediabetes or those at high risk of developing diabetes. To translate these research findings into practice, lifestyle programs that are effective and affordable need to be widely available and delivered on an ongoing basis.

The Centers for Disease Control and Prevention (CDC) is working to ensure that effective diabetes prevention programs are scalable, sustainable and affordable. To fullfill this mission, CDC is establishing the CDC Diabetes Prevention Recognition Program (DPRP) as an activity of the National Diabetes Prevention Program, housed in the Division of Diabetes Translation. The DPRP will provide a mechanism for recognizing organizations that deliver effective, community-based type 2 diabetes prevention programs. Information about program recognition status will be available to people at high risk of type 2 diabetes, their health care providers, and health payers. The Diabetes Prevention Recognition Program is authorized under section 399V–3 of Public Law 111–148, which directs CDC "to determine eligibility of entities to deliver community-based type 2 diabetes prevention services," monitor and evaluate the services, and provide technical assistance.

Organizations may apply for recognition through the DPRP by completing a one-time, on-line

application form. To qualify, programs must meet the minimum eligibility requirements set forth in CDC's "DPRP Draft Recognition Standards and Operating Procedures." Criteria for recognition include, but are not limited to: (1) Following an evidence-based curriculum that has been proven effective in research and demonstration projects, and (2) submitting de-identified participant process and outcome data to CDC every six months. CDC will use the process and outcome data to monitor and evaluate program effectiveness and to provide targeted technical assistance to applicant organizations. Three levels of recognition will be provided: *Pending* recognition for new applicants that have submitted an application and meet eligibility criteria defined by DPRP standards and operating procedures; *Full* recognition for programs that have demonstrated effectiveness according to DPRP standards; and *Probationary* recognition for programs that are working towards full attainment of the standards.

Each organization that seeks recognition through the DPRP will submit an initial, online application form to CDC. There is no application deadline. The de-identified process and outcome data necessary for assessing program performance will be submitted to CDC electronically twice per year. The due dates for these submissions will be determined by the date of the organization's initial application. CDC estimates that burden to respondents will be modest since the information requested for DPRP recognition is routinely collected by organizations that deliver lifestyle programs. To further minimize burden to respondents, CDC will accept process and outcome data submitted using any electronic format, software or method that meets the requirements established by DPRP standards and operating procedures.

OMB approval is requested for three years. CDC anticipates seeking continued OMB approval throughout the lifetime of the DPRP. Respondents will be organizational entities that offer diabetes prevention services. Participation in the DPRP is voluntary, and there are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hr)	Total burden (in hr)
Applicants for Recognition through the DPRP.	Application Form	67	1	3/60	3
	Process and Outcome Data	67	2	5/60	11
Total					14

Thelma Sims,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of California State Plan Amendments (SPAs) 08–009A; 08–009B1; 08–009B2; 08–009D; and 08–019

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing to be held on February 10, 2011, at the CMS San Francisco Regional Office, 90 7th Street, #5–300 (5W), San Francisco, California 94103 to reconsider CMS' decision to disapprove California SPAs 08–009A; 08–009B1; 08–009B2; 08–009D; and 08–019.

CLOSING DATE: Requests to participate in the hearing as a party must be received by the presiding officer by January 5, 2011.

FOR FURTHER INFORMATION CONTACT: Benjamin Cohen, Presiding Officer, CMS, 2520 Lord Baltimore Drive, Suite L, Baltimore, Maryland 21244. Telephone: (410) 786–3169.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider the decision of the Centers for Medicare & Medicaid Services (CMS) to disapprove California State plan amendments (SPAs) 08–009A; 08–009B1; 08–009B2; 08–009D; and 08–019 which were submitted on December 31, 2008, and disapproved on November 18, 2010. The SPAs proposed to reduce the reimbursement rates for certain services furnished under the approved State plan.

In the initial determination, CMS determined, after consulting with the Secretary, that it is unable to approve these SPAs because California has not demonstrated that it would meet the conditions set out in section 1902(a)(30)(A) of the Social Security Act (Act).

Section 1902(a)(30)(A) of the Act requires that State plans assure that "payments [to providers] * * * are sufficient to enlist enough providers so that care and services are available under the [State's Medicaid] plan [to recipients] at least to the extent that such care and services are available to the general population in the geographic area."

When the SPAs were initially submitted, the State did not provide information concerning the impact of the proposed reimbursement reductions on beneficiary access to services, even though available national data indicate that this may be an issue for California. In the Requests for Additional Information (RAI) for SPAs TN 08–009A, TN 08–009B–1, TN 08–009D, (sent to the State in December 2008), and 08–019 (sent to the State in March, 2009), CMS requested information about beneficiary access to services, but California did not respond. As indicated in a January 2, 2001, letter to State Medicaid Directors, to the extent that responses to such RAIs are not received within 90 days, CMS may initiate disapproval action. In this instance, in addition, CMS had concerns that, given the time that has elapsed since these SPAs were submitted but not implemented, the cumulative effect of a retroactively effective approval of these reimbursement reductions would only serve to exacerbate beneficiary access concerns.

For these reasons, and after consulting with the Secretary as required by Federal regulations at 42 CFR 430.15(c)(2), these SPAs were disapproved.