Reporting: Yearly and Semi-annually *Affected Public:* Business or other for-profit, Not-for-profit institutions and Federal, State, local or tribal government; *Number of Respondents:* 450,160; *Total Annual Responses:* 1,225,173; *Total Annual Hours:* 522,204.

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Mail Survey of Medicare Advantage Special Needs Plans (SNPs)/Focus Groups with Enrollees of Medicare Advantage SNPs; *Use:* CMS is conducting an evaluation of Medicare Advantage Special Needs Plans (SNPs), which includes developing profiles of all SNPs that describe the structure and operation of these plans. A one-time short mail questionnaire will gather information about SNPs that is not available from other sources, such as reason for becoming a SNP, and information on care coordination. One-time 90-minute focus groups conducted during site visits to 15 SNPs will provide information on beneficiary experiences in SNPs, including decision to enroll and use of special services. *Form Number:* CMS–10194 (OMB#: 0938–NEW); *Frequency:* Reporting—One-time; *Affected Public:* Business or other for-profit, Not-for-profit institutions; *Number of Respondents:* 350; *Total Annual Responses:* 350; *Total Annual Hours:* 395.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Proper Claim Not Filed and Supporting Regulation in 42 CFR 411.32(c); *Use:* Section 411.32(c) requires physicians, providers, other suppliers, and beneficiaries, in case where they failed to submit a proper claim with a third party payer to report these situations on the current Medicare forms. The primary payer will notify the physician, provider, other supplier, or beneficiary of the amount normally payable, the amount of the reduction payable because the claim was not filed properly, and the amount the physician, provider, other supplier, or beneficiary is being paid under the ''primary plan'' due to the reduction. The information is transmitted on an explanation of benefits or remittance advice determination that third party payers provide to all covered individuals and physicians, providers and other suppliers as part of an industry practice. The information contained in this explanation, whether or not it concerns improperly filed claims, is submitted to Medicare as part of the claims process. *Form Number:* CMS–R–136 (OMB#: 0938–0564); *Frequency:* Reporting—On occasion; *Affected Public:* Business or other for-profit, Not-for-profit institutions, and Individuals or Households; *Number of Respondents:* 1,129,000; *Total Annual Responses:* 1,129,000; *Total Annual Hours:* 1.

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Part D Reporting Requirements and Supporting Regulations under 42 CFR 423.505; *Use:* Data collected via Medicare Part D Reporting Requirements will be an integral resource for oversight, monitoring, compliance and auditing activities necessary to ensure quality provision of the Medicare Prescription Drug Benefit to beneficiaries. Data will be validated, analyzed, and utilized for trend reporting by CMS. If outliers or other data anomalies are detected, CMS will work in collaboration with other CMS divisions for follow-up and resolution. *Form Number:* CMS–10185 (OMB#: 0938–0992); *Frequency:* Reporting: Quarterly and Semi-annually; *Affected Public:* Business or other for-profit; *Number of Respondents:* 3,203; *Total Annual Responses:* 179,368; *Total Annual Hours:* 122,902.

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: September 15, 2006.

Michelle Shortt,

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

[FR Doc. 06–8072 Filed 9–21–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–282, CMS–R–240, CMS–10204 and CMS 10209]

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:* Medicare Health Plan Appeals and Grievance Data Collection and Reporting Requirements, Data Disclosure Requirements § 422.111; *Use:* Medicare Advantage (MA) organizations and demonstrations are required to disclose information pertaining to the number of disputes, and their disposition in the aggregate. Organizations provide appeals and grievance information to individuals eligible to elect an MA organization, or persons or entities making the request on behalf of the individuals who request this information. MA eligible individuals will use this information to help them make informed decisions about their organization's performance in the area of appeals and grievances. *Form Number:* CMS–R–0282 (OMB#: 0938–0778); *Frequency:* Recordkeeping, Third Party Disclosure and Reporting—Semi-annually; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 434; *Total Annual Responses:* 868; *Total Annual Hours:* 876.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Provider-based Status Regulations in 42 CFR 413.24 and 413.65; *Use:* Section 1833(t) of the Social Security Act (of the Act), as amended by section 4523 of the Balanced Budget Act of 1997 (the BBA) requires the Secretary to establish a prospective payment system (PPS) for hospital outpatient services. Successful implementation of an outpatient PPS requires that CMS distinguish facilities or organizations that function as departments of hospitals from those that are freestanding, so that CMS can determine which services should be paid under the PPS. Regulations found at 42 CFR 413.65(b)(3) and (c) require the submission of the information CMS needs to make the determination of whether an organization functions as a department of a hospital or functions as a freestanding facility. In addition, section 1866(b)(2) of the Act authorizes hospitals and other providers to impose deductible and coinsurance charges for facility services, but does not allow such charges by facilities or organizations which are not provider-based. Implementation of this provision requires that CMS have information from the required reports, so it can determine which facilities are provider-based. *Form Number:* CMS–R–240 (OMB#: 0938–0798); *Frequency:* Recordkeeping—On occasion; *Affected Public:* Business or other for-profit, Not-for-profit institutions; *Number of Respondents:* 750; *Total Annual Responses:* 872; *Total Annual Hours:* 26,063.

3. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Evaluation of the Medical Adult Day-Care Services Demonstration, Phase I; *Use:* This request seeks Office of Management and Budget's (OMB) approval of (1) collection of enrollment data by demonstration sites and (2) face-to-face interviews with Medicare beneficiaries (not to exceed 45 minutes in length). These data collection and interviews are to be completed during Phase I of the Evaluation of the Medical Adult Day-Care Services Demonstration (Contract Number 500–00–0038/5).

Section 703 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108–173) authorizes a three-year demonstration to assess the clinical and cost-effectiveness of providing medical adult day-care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home. Under this authority, the Centers for Medicare & Medicaid Services (CMS), through its Office of Research, Development and Information (ORDI), is conducting the Medical Adult Day-Care Services Demonstration. Five Medicare certified home health agencies were selected by CMS through a competitive process to participate in the demonstration. These five demonstration sites are Aurora Visiting Nurse Association (Milwaukee, Wisconsin), Doctor's Care Home Health (McAllen, Texas), Landmark Home Health Care Services (Allison Park, Pennsylvania), Metropolitan Jewish Health System (Brooklyn, New York) and Neighborly Care Network (St. Petersburg, Florida). *Form Number:* CMS–10204 (OMB#: 0938–NEW); *Frequency:* Reporting—One-time; *Affected Public:* Individuals and Households, Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 55; *Total Annual Responses:* 110; *Total Annual Hours:* 297.5.

4. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Chronic Care Improvement Program (CCIP) and Medicare Advantage Quality Improvement Project (QIP); *Use:* 42 CFR 422.152 requires each Medicare Advantage Organization (MAOs) (other than Medicare Advantage (MA) private fee for service and MSA plans) that offers one or more MA plan to have an ongoing quality assessment and performance improvement program. Information collected in the QIP and CCIP Reporting Templates will be an integral resource for oversight, monitoring compliance and auditing activities necessary to ensure high quality provision of general health services and chronic care services to Medicare beneficiaries. *Form Number:* CMS–10209 (OMB#: 0938–New); *Frequency:* Recordkeeping, and Reporting—Annually; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 426; *Total Annual Responses:* 852; *Total Annual Hours:* 38,050.

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 November 21, 2006. 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: September 15, 2006.

Michelle Shortt,

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

[FR Doc. 06–8073 Filed 9–21–06; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8030–CN]

RIN 0938–AO23

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rates, and Annual Deductible for Calendar Year 2007; Correction

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

ACTION: Correction of notice.

SUMMARY: This document corrects a technical error in the notice that appeared in the **Federal Register** on September 18, 2006 entitled ''Medicare Part B Monthly Actuarial Rates, Premium Rates, and Annual Deductible for Calendar Year 2007.''

Effective Date: January 1, 2007.

FOR FURTHER INFORMATION CONTACT: M. Kent Clemens, (410) 786–6391.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 06–7709 of September 18, 2006 (71 FR 54665), there was a technical error in the calculation of the income-related monthly adjustment amounts. This error is identified and corrected in the Correction of Errors section below. The provisions of this correction notice are effective as if they had been included in the document that appeared in the **Federal Register** on September 18, 2006. Accordingly, the corrections are effective January 1, 2007.

Under section 5111 of the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA), in 2007 beneficiaries will be responsible for 33 percent of any applicable income-related monthly adjustment to the Part B premium. In the earlier notice, we inadvertently stated that beneficiaries would only be