Dated: August 25, 2006.

Michelle Shortt,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–143, CMS–R–247, CMS–10199, and CMS–10184]

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:* Extension of a currently approved collection.

Title of Information Collection: Medicare Physician Fee Schedule Geographic Practice Expense Index (GPCI).

Use: This information collection is a survey of State insurance commissioners and malpractice insurers to acquire premium data for use in computing the malpractice component of the geographic practice cost index, a component of the geographic cost index as set forth in the Omnibus Reconciliation Act of 1989. The data collected in this information collection request will be used by CMS staff and outside contractors to update the Medicare physician fee schedule geographic practice expense index (MGPCI), the malpractice relative value units (MRVUs), and to supplement the updating of the malpractice component of the Medicare Economic Index (MEI). The MGPCI is one of the components of the GPCI, the others being physician work (net income), employee wages, office rents, medical equipment and supplies, and miscellaneous expenses. The MRVUs are one of the three components of the fee schedule, the others being physician work RVUs and practice expense RVUs. The GPCIs and fee schedule RVUs also used by other Federal agencies such as the Veteran's Administration and the Department of Labor. Form Number: CMS–R–143 (OMB#: 0938–0575).

Frequency: Reporting—Every three years.

Affected Public: State, Local or Tribal governments, Business or other for-profit and Not-for-profit institutions.

Number of Respondents: 150.

Total Annual Responses: 50.

Total Annual Hours: 150.

2. *Type of Information Collection Request:* Extension of a currently approved collection.

Title of Information Collection: Expanded Coverage for Diabetes Outpatient Self-Management Training Services and Supporting Regulations Contained in 42 CFR 410.141, 410.142, 410.143, 410.144, 410.145, 410.146, 414.63.

Use: According to the National Health and Nutrition Examination Survey (NHANES), as many as 18.7 percent of Americans over age 65 are at risk for developing diabetes. The goals in the management of diabetes are to achieve normal metabolic control and reduce the risk of micro- and macro-vascular complications. Numerous epidemiologic and interventional studies point to the necessity of maintaining good glycemic control to reduce the risk of the complications of diabetes. In expanding the Medicare program to include diabetes outpatient self-management training services, the Congress intended to empower Medicare beneficiaries with diabetes to better manage and control their conditions. The Conference Report indicates that the conferees believed that ''this provision will provide significant Medicare savings over time due to reduced hospitalizations and complications arising from diabetes.'' (H.R. Conf. Rep. No. 105–217, at 701 (1997)).

Form Number: CMS–R–247 (OMB#: 0938–818).

Frequency: Recordkeeping and Reporting—On occasion.

Affected Public: Business or other for-profit institutions.

Number of Respondents: 2008.

Total Annual Responses: 8,032; Total Annual Hours: 88,519.

3. *Type of Information Collection Request:* New collection.

Title of Information Collection: Data Collection for Medicare Facilities Performing Carotid Artery Stenting with Embolic Protection in Patients at High Risk for Carotid Endarterectomy.

Use: CMS provides coverage for carotid artery stenting (CAS) with embolic protection for patients at high risk for carotid endarterectomy and who also have symptomatic carotid artery stenosis between 50% and 70% or have asymptomatic carotid artery stenosis ≥ 80% in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201), a trial under the CMS Clinical Trial Policy (NCD Manual § 310.1, or in accordance with the National Coverage Determination on CAS post approval studies (Medicare NCD Manual 20.7). Accordingly, CMS considers coverage for CAS reasonable and necessary {section 1862 (A)(1)(a) of the Social Security Act}. However, evidence for use of CAS with embolic protection for patients at high risk for carotid endarterectomy and who also have symptomatic carotid artery stenosis ≥ 70% who are not enrolled in a study or trial is less compelling. To encourage responsible and appropriate use of CAS with embolic protection, CMS issued a *Decision Memo for Carotid Artery Stenting* on March 17, 2005, indicating that CAS with embolic protection for patients at high risk for carotid endarterectomy and who also have symptomatic carotid artery stenosis ≥ 70% will be covered only if performed in facilities that have been determined to be competent. In accordance with this criteria CMS considers coverage for CAS reasonable and necessary (section 1862(A)(1)(a) of the Social Security Act).

Form Number: CMS–10199 (OMB#: 0938–NEW).

Frequency: Reporting—On.

Affected Public: Business or other for-profit, Not-for-profit institutions.

Number of Respondents: 1,000.

Total Annual Responses: 1,000.

Total Annual Hours: 500.

4. *Type of Information Collection Request:* New collection.

Title of Information Collection: Payment Error Rate Measurement (PERM) of Eligibility in Medicaid and the State Children's Health Insurance Program (SCHIP).

Use: The Improper Payments Information Act (IPIA) of 2002 requires CMS to produce national error rates for Medicaid and the State Children's Health Insurance Program (SCHIP). To comply with the IPIA, CMS will use a national contracting strategy in part to

produce error rates for Medicaid and SCHIP fee-for-service and managed care improper payments. The Federal contractor will review states on a rotational basis so that each state will be measured for improper payments, in each program, once and only once every three years.

Subsequent to the first publication, we determined that we will measure Medicaid and SCHIP in the same State. Therefore, states will measure Medicaid and SCHIP eligibility in the same year measured for fee-for-service and managed care. We believe this approach will advantage States through economies of scale (e.g. administrative ease and shared staffing for both programs reviews). We also determined that interim case completion timeframes and reporting are critical to the integrity of the reviews and to keep the reviews on schedule to produce a timely error rate. An additional revision is that the sample sizes were increased slightly in order to produce an equal sample size per strata each month. Finally, this information collection request does, to a certain extent, duplicate Medicaid eligibility reviews under the Medicaid Eligibility Quality Control (MEQC) as required by section 1903(u) of the Social Security Act (of the Act) and we proposed this option in the first publication of this information request.

However, CMS has not finalized its analysis of the associated legal and policy matters regarding the option to use the payment error rate measurement (PERM) reviews to satisfy MEQC statutory and regulatory requirements. We are concerned that using the PERM eligibility reviews to satisfy requirements for the MEQC program under 1903(u) of the Act would necessarily require that the data derived from the reviews be used to determine potential disallowances of Federal funds under the MEQC program. Therefore, we are still considering whether or not to make this option available to States. We expect to make a final decision before the start of the eligibility reviews in FY 2007. However, in response to State resource concerns, CMS will provide States the option to contract out the PERM eligibility reviews to entities not actively involved in the state's eligibility determination and enrollment activities. The supporting statement reflects those changes.

As outlined in the October 5, 2005, interim final rule (70 FR 58260), CMS convened an eligibility workgroup comprised of the Department of Health and Human Services, the Office of Management and Budget (OMB) and representatives from two states. The Office of Inspector General (OIG) participated in an advisory capacity. The workgroup was charged to make recommendations for measuring Medicaid and SCHIP improper payments based on eligibility errors within the confines of current statute, with minimal impact on States' resources and considering public comments on the August 27, 2004, proposed rule and the October 5, 2005, interim final rule. Based on the eligibility workgroup's recommendations and public comments, we developed an eligibility review methodology that we expect will provide consistency in the reviews of active (i.e., beneficiaries receiving Medicaid or SCHIP) and negative cases (i.e., beneficiaries whose benefits were denied or terminated) as well as achieve the confidence and precision requirements at the national level required by the IPIA.

Form Number: CMS–10184 (OMB#: 0938–NEW).

Frequency: Reporting—On occasion and Monthly.

Affected Public: Business or other for-profit, Not-for-profit institutions.

Number of Respondents: 34.

Total Annual Responses: 1,326.

Total Annual Hours: 535,670.

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: August 25, 2006.

Michelle Shortt,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1535–N]

RIN 0938–AO26

Medicare Program; Hospice Wage Index for Fiscal Year 2007

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

ACTION: Notice.

SUMMARY: This notice announces the annual update to the hospice wage index as required by statute. This fiscal year 2007 update is effective from October 1, 2006 through September 30, 2007. The wage index is used to reflect local differences in wage levels. The hospice wage index methodology and values are based on recommendations of a negotiated rulemaking advisory committee and were originally published in the August 8, 1997 **Federal Register**.

EFFECTIVE DATE: This notice is effective on October 1, 2006.

FOR FURTHER INFORMATION CONTACT: Terri Deutsch, (410) 786–9462.

SUPPLEMENTARY INFORMATION:

I. Background

A. General

1. Hospice Care

Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, social, psychological, emotional, and spiritual services through use of a broad spectrum of professional and other caregivers, with the goal of making the individual as physically and emotionally comfortable as possible. Counseling services and inpatient respite services are available to the family of the hospice patient. Hospice programs consider both the patient and the family as a unit of care.

Section 1861(dd) of the Social Security Act (the Act) provides for coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. Section 1814(i) of the Act