Status:

Open 8 a.m.–8:30 a.m., June 13, 2006.
Closed 8:30 a.m.–5 p.m., June 13, 2006.
Closed 8:30 a.m.–5 p.m., June 14, 2006.

Purpose: The Safety and Occupational Health Study Section will review, discuss, and evaluate grant application(s) received in response to the Institute's standard grants review and funding cycles pertaining to research issues in occupational safety and health and allied areas.

It is the intent of the Institute to support broad-based research endeavors in keeping their program goals. This will lead to improved understanding and appreciation for the magnitude of the aggregate health burden associated with occupational injuries and illnesses, as well as to support more focused research projects, which will lead to improvements in the delivery of occupational safety and health services, and the prevention of work-related injury and illness. It is anticipated that research funding will promote these program goals.

Matters to be Discussed: The meeting will convene in open session from 8 a.m.–8:30 a.m. on June 13, 2006, to address matters related to the conduct of Study Section business. The remainder of the meeting will proceed in closed session. The purpose of the closed session is for the study section to consider safety and occupational health-related grant applications. These portions of the meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, Centers for Disease Control and Prevention, pursuant to section 10(d) Public Law 92–463.

Agenda items are subject to change as priorities dictate.

For Further Information Contact: Price Connor, Ph.D., NIOSH Health Scientist, 1600 Clifton Road, NE., Mailstop E–20, Atlanta, Georgia 30333, telephone 404.498.2511, fax 404.498.2569.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: May 22, 2006.

Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E6–8126 Filed 5–25–06; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–668B, CMS–R–284, CMS–R–205, CMS–10187, and CMS–10116]

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:* Post Clinical Laboratory Survey Questionnaire and Supporting Regulations in 42 CFR 493.1771, 493.1773, and 493.1777; *Use:* To provide an opportunity and a mechanism for Clinical Laboratory Improvement Amendments of 1988 (CLIA) laboratories surveyed by CMS or CMS' agents to express their satisfaction and concerns about the CLIA survey process.; *Form Number:* CMS–668B (OMB#: 0938–0653); *Frequency:* Recordkeeping, Reporting—Biennially; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 21,000; *Total Annual Responses:* 10,500; *Total Annual Hours:* 2,625.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicaid Statistical Information System; *Use:* State data are reported by the Federally mandated electronic process, known as Medicaid Statistical Information System (MSIS). These data are the basis of actuarial forecasts for Medicaid service utilization and costs; of analysis and cost savings estimates required for legislative initiatives relating to Medicaid; and for responding to requests for information from CMS components, the Department, Congress and other customers.; *Form Number:* CMS–R–284 (OMB#: 0938–0345); *Frequency:* Quarterly; *Affected Public:* State, Local or Tribal Government; *Number of Respondents:* 53; *Total Annual Responses:* 212; *Total Annual Hours:* 2,120.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Information Collection Requirements Referenced in HIPAA, Title 1 for the Individual Market, supporting regulations at 45 CFR 148.120, 148.122, 148.124, 148.126, and 148.128, and Forms/instructions; *Use:* The provisions of Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) amend the Public Health Service Act (PHS Act) and are designed to make it easier for people to get access to health care coverage, reduce the limitations that can be put on the coverage, and limit the issuers' ability to terminate coverage. This information collection requirement will ensure that issuers in the individual market comply with Title 1 of HIPAA, provide individuals with certificates of creditable coverage necessary to demonstrate prior creditable coverage, file the necessary documentation with CMS for review in States that have Federal direct enforcement, and ensure States' flexibility to implement State alternative mechanisms. Individuals and their dependents need certificates of creditable coverage to take advantage of the rights they have under HIPAA. States and CMS need the information supplied by issuers to properly perform their regulatory functions under HIPAA and or existing State law.; *Form Number:* CMS–R–205 (OMB#: 0938–0703); *Frequency:* Recordkeeping, Third party disclosure, and Reporting—On Occasion; *Affected Public:* Individuals or Households, Business or other for-profit, Not-for-profit institutions and Federal, State, Local or Tribal Government; *Number of Respondents:* 1,042; *Total Annual Responses:* 2,987,501; *Total Annual Hours:* 868,147.

4. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Evaluation of the Demonstration of Coverage of Chiropractic Services Under Medicare; *Use:* Section 651 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, authorizes a

two-year demonstration ''to evaluate the feasibility and advisability of covering chiropractic services under Medicare''. The Demonstration aims to evaluate both the costs and the benefits of expanded coverage for chiropractic services. The evaluation will examine the achievements as well as the difficulties inherent in demonstration implementation. The study includes a descriptive evaluation of the program, a survey of a total of 2,000 beneficiaries using expanded services, analyses of medical claims to determine service utilization and expenditures, as well as the cost impact on the Medicare program. These data will allow the researchers to examine use, effectiveness, and satisfaction of Medicare beneficiaries with the chiropractic services they receive in relation to their demographic and clinical characteristics. The results will help CMS to understand the user's experience with chiropractic services and with this Medicare demonstration.; *Form Number:* CMS–10187 (OMB#: 0938-New); *Frequency:* Reporting—Monthly; *Affected Public:* Individuals or Households; *Number of Respondents:* 2000; *Total Annual Responses:* 2000; *Total Annual Hours:* 667.

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Conditions of Payment of Power Mobility Devices, including Power Wheelchairs and Power-Operated Vehicles (CMS–3017–IFC); *Use:* CMS–3017–IFC (Conditions for Payment of Power Mobility Devices, including Power Wheelchairs and Power-Operated Vehicles) provides further guidance with respect to the prescribing of and payment for Power Mobility Devices (PMDs). This rule defines the term power mobility devices (PMDs) as power wheelchairs and power operated vehicles (POVs or scooters). This rule conforms our regulations to section 302(a)(2)(E)(iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The MMA mandated: (1) A face-to-face examination of the individual be conducted by a physician (as defined in section 1861(r)(1) of the Social Security Act (the Act)), a physician assistant, a nurse practitioner or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5) of the Act; and (2) that payment may not be made for a power wheelchair unless the physician or treating practitioner has written a prescription for the item. With this information collection request, CMS is seeking approval for the collection requirements associated with CMS–3017–IFC (70 FR 50940).; *Form Number:* CMS–10116 (OMB#: 0938–0971); *Frequency:* Recordkeeping and Reporting—On occasion; *Affected Public:* Business or other for-profit, Not-for-profit institutions, Federal government, State, Local, or Tribal governments; *Number of Respondents:* 17,000; *Total Annual Responses:* 37,400; *Total Annual Hours:* 37,400.

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: May 15, 2006.

Michelle Shortt,

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

[FR Doc. E6–7944 Filed 5–25–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4117–FN]

Medicare Program; Approval of URAC for Deeming Authority for Medicare Advantage Health Maintenance Organizations and Local Preferred Provider Organizations

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

ACTION: Final notice.

SUMMARY: This final notice announces the approval of URAC for deeming authority as a national accreditation organization for health maintenance organizations and local preferred provider organizations participating in the Medicare Advantage program, for a term of 6 years upon publication of this notice in the **Federal Register.** This notice describes the processes and criteria used in evaluating the application. We did not receive any public comments during the public comment period, which ended on April 28, 2006.

FOR FURTHER INFORMATION CONTACT: Shaheen Halim, Ph.D., (410) 786–0641.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a managed care organization (MCO) that has a Medicare Advantage (MA) (formerly, Medicare+Choice) contract with the Centers for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met in order for an MCO to enter into an MA contract with CMS are located at 42 CFR part 422. These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MCO must provide and the requirements that the organization must meet to be an MA contractor. Other relevant sections of the Act are Parts A and B of Title XVIII and Part A of Title XI pertaining to the provision of services by Medicare-certified providers and suppliers.

Generally, for an organization to enter into an MA contract, the organization must be licensed by the State as a risk-bearing organization as set forth in part 422 of our regulations. Additionally, the organization must file an application demonstrating that it meets other Medicare requirements in part 422 of our regulations. Following approval of the contract, we engage in routine monitoring and oversight audits of the MA organization to ensure continuing compliance. The monitoring and oversight audit process is comprehensive and uses a written protocol that itemizes the Medicare requirements the MA organization must meet.

As an alternative for meeting some Medicare requirements, an MA organization may be exempt from our monitoring of certain requirements in subsets listed in section 1852(e)(4)(B) of the Act as a result of an MA organization's accreditation by a CMS-approved accrediting organization (AO). In essence, the Secretary ''deems'' that the Medicare requirements are met based on a determination that the AO's standards are at least as stringent as Medicare requirements.

An organization that applies for MA deeming authority is generally recognized by the industry as an entity that accredits MCOs that are licensed as a health maintenance organization (HMO) or a preferred provider organization (PPO). As we specify at