Information Collection: Medicaid State Program Integrity Assessment (SPIA); *Use:* Under the provisions of the Deficit Reduction Act (DRA) of 2005, Congress directed CMS to establish the Medicaid Integrity Program (MIP), CMS' first national strategy to combat Medicaid fraud, waste, and abuse. CMS has two broad responsibilities under the MIP:

(1) Reviewing the actions of individuals or entities providing services or furnishing items under Medicaid; conducting audits of claims submitted for payment; identifying overpayments; and educating providers and others on payment integrity and quality of care; and

(2) Providing effective support and assistance to States to combat Medicaid fraud, waste, and abuse.

In order to fulfill the second of these requirements, CMS plans to develop a Medicaid State Program Integrity Assessment (SPIA) system. CMS is seeking approval from the Office of Management and Budget (OMB) to collect information from the States on an annual basis for input into a national SPIA system. Through the SPIA system, CMS will identify current Medicaid program integrity (PI) information, develop profiles for each State based on these data, determine areas to provide States with technical support and assistance, and use the data to develop performance measures to assess States' performance in an ongoing manner. Based on comments received during the 60-day comment period, we revised the supporting statement timeline and the instrument (Appendix B). In addition, we added a draft MIP glossary (Appendix C); *Form Number:* CMS–10244 (OMB#: 0938–NEW); *Frequency:* Reporting: Yearly; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 1,400.

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.

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 November 26, 2007:

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

Dated: October 19, 2007.

Michelle Shortt,

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

[FR Doc. E7–21116 Filed 10–25–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–262 and CMS–10142]

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:* Revision of a currently approved collection; *Title of Information Collection:* CY 2009 Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP); *Use:* Under the Medicare Modernization Act (MMA), Medicare Advantage (MA) and Prescription Drug Plan (PDP) organizations are required to submit plan benefit packages for all Medicare beneficiaries residing in their service area. The plan benefit package submission consists of the formulary file, Plan Benefit Package (PBP) software, and supporting documentation as necessary. MA and PDP organizations will generate a formulary to illustrate their list of drugs, including information on prior authorization, step therapy, tiering, and quantity limits. Additionally, the PBP software will be used to describe their organization's plan benefit packages, including information on premiums, cost sharing, authorization rules, and supplemental benefits. CMS uses the formulary and PBP data to review and approve the plan benefit packages proposed by each MA and PDP organization.

CMS requires that MA and PDP organizations submit a completed formulary and PBP as part of the annual bidding process. During this process, organizations prepare their proposed plan benefit packages for the upcoming contract year and submit them to CMS for review and approval. Based on operational changes and policy clarifications to the Medicare program and continued input and feedback by the industry, CMS has made the necessary changes to the plan benefit package submission. *Form Number:* CMS–R–262 (OMB#: 0938–0763); *Frequency:* Yearly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 475 *Total Annual Responses:* 4987.5; Total Annual Hours: 11,400.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDPs); *Use:* Under the Medicare Prescription Drug, Improvement, and Modernization (MMA), Medicare Advantage organizations (MAO) and Prescription Drug Plans (PDP) are required to submit an actuarial pricing ''bid'' for each plan offered to Medicare beneficiaries. CMS requires that MAOs and PDPs complete the BPT as part of the annual bidding process. During this process, organizations prepare their proposed actuarial bid pricing for the upcoming contract year and submit them to CMS for review and approval. The purpose of the BPT is to collect the actuarial pricing information for each plan. The BPT calculates the plan's bid, enrollee premiums, and payment rates. Refer to ''Attachment C'' for a summary of changes. *Form Number:* CMS–10142 (OMB#: 0938–0944); *Frequency:* Yearly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 550 *Total Annual Responses:* 6,050; *Total Annual Hours:* 42,350.

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 December 26, 2007:

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: October 19, 2007.

Michelle Shortt,

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

[FR Doc. E7–21123 Filed 10–25–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–2276–PN]

Medicare and Medicaid Programs; Application by the Community Health Accreditation Program for Continued Deeming Authority for Home Health Agencies

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of a deeming application from the Community Health Accreditation Program for continued recognition as a national accrediting organization for home health agencies that wish to participate in the Medicare or Medicaid programs. Section 1865(b)(3)(A) of the Social Security Act requires that within 60 days of receipt of an organization's complete application, we publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 26, 2007.

ADDRESSES: In commenting, please refer to file code CMS–2276–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking*. Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2276–PN, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2276–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Cindy Melanson, (410) 786–0310. Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed notice to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–2276–PN and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking*. Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a home health agency (HHA) provided certain requirements are met. Sections 1861(m) and (o), and 1891 of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as an HHA. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at 42 CFR part 484 specify the conditions that an HHA must meet in order to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for Home Health Care.

Generally, in order to enter into a provider agreement with the Medicare program, an HHA must first be certified by a State survey agency as complying