Report	Number of respondents	Responses per respondent	Average burden per response (in hours)	Total burden (hours)
Screening MDE Report	15	2	16	480
Intervention MDE Report	15	2	8	240
Cost Report	15	2	16	480
Quarterly Report	15	4	16	960
Total				2,160

Dated: September 21, 2006.

Joan F. Karr,

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

[FR Doc. E6–16048 Filed 9–28–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10109]

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:* Revision of a currently approved collection; *Title of Information Collection:* Hospital Reporting Initiative—Hospital Quality Measures; *Use:* The recently enacted section 5001(a) of the Deficit Reduction Act (DRA) sets out new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The RHQDAPU program was established to implement section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The DRA builds on our ongoing voluntary Hospital Quality Initiative, which is intended to empower consumers with quality of care information to make more informed decisions about their health care, while also encouraging hospitals and clinicians to improve the quality of care provided to Medicare beneficiaries. The DRA revises the current hospital reporting initiative by stipulating new data collection requirements. The law provides a 2.0 percent reduction in points to the update percentage increase for any hospital that does not submit the quality data in the form, and manner, and at a time, specified by the Secretary. The Act also requires that we expand the ''starter set'' of 10 quality measures that we have used since 2003. To comply with these new requirements we must make changes to the Hospital Reporting Initiative. *Form Number:* CMS–10109 (OMB#: 0938–0918); *Frequency:* Recordkeeping, Third party disclosure, and Reporting—Quarterly; *Affected Public:* State, local or tribal Government; Number of Respondents: 3,700; *Total Annual Responses:* 14,800; *Total Annual Hours:* 583,760.

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 25, 2006.

Michelle Shortt,

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

[FR Doc. E6–15982 Filed 9–28–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1333–GNC]

RIN: 0938–ZA94

Medicare Program; Criteria and Standards for Evaluating Intermediary and Carrier Performance During Fiscal Year 2007

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

ACTION: General notice with comment period.

SUMMARY: This general notice with comment period describes the criteria and standards to be used for evaluating the performance of fiscal intermediaries (FIs) and carriers in the administration of the Medicare program.

The results of these evaluations are considered whenever we enter into, renew, or terminate an intermediary agreement, carrier contract, or take other contract actions, for example, assigning or reassigning providers or services to an intermediary or designating regional or national intermediaries. We are requesting public comment on these criteria and standards.

DATES: *Effective Date:* The criteria and standards are effective on October 1, 2006.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 28, 2006.

ADDRESSES: In commenting, please refer to file code CMS–1333–GNC. Because of staff and resource limitations, we cannot accept comments by facsimile (fax) transmission.