notices to the affected parties when disclosing information about them. These requirements serve to protect the rights of the affected parties. The information provided in these notices is used by the patients, practitioners and providers to: Obtain access to the data maintained and collected on them by the QIOs; add additional data or make changes to existing QIO data; and reflect in the QIO's record the reasons for the QIO's disagreeing with an individual's or provider's request for amendment.; *Form Number:* CMS–R–70 (OMB#: 0938–0426); *Frequency:* Reporting—On occasion; *Affected Public:* Business or other for-profit, individuals or households, not-for-profit institutions, Federal government, and State, Local or Tribal governments; *Number of Respondents:* 362; *Total Annual Responses*: 3729; *Total Annual Hours:* 60,919.

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Collection of Medicaid and State Children's Health Insurance (SCHIP) Managed Care Claims and Related Information; *Use:* The Improper Payments Information Act (IPIA) of 2002 (Pub. L. 107–300) requires CMS to produce national error rates in the Medicaid program and the State Children's Health Insurance Program (SCHIP). To comply with the IPIA, CMS will engage a Federal contractor to produce error rates in Medicaid managed care and SCHIP managed care. Beginning in 2007, CMS will use a rotational approach to review up to 18 States for each program, for a total 36 States each year. CMS has completed the State selection process for the Medicaid improper payments measurement. States have not yet been selected for the measurement of improper payments in SCHIP. CMS expects to select the SCHIP States in the fall of 2006.; *Form Number:* CMS–10178 (OMB#: 0938–NEW); *Frequency:* Reporting—On occasion, quarterly; *Affected Public:* State, Local, or Tribal governments; *Number of Respondents:* 36; *Total Annual Responses:* 23,400; *Total Annual Hours:* 23,400.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare and Medicaid Programs: Reporting OASIS Data as Part of the Conditions of Participation for Home Health Agencies and Supporting Regulations in 42 CFR 484.11 and 484.20; *Use:* This request is for OMB approval to continue to require home health agencies (HHAs) to electronically report the Outcome and Assessment Information Set (OASIS) data to CMS. OASIS is a requirement of one of the Conditions of Participation (CoP) that HHAs must meet in order to participate in the Medicare program. Specifically, the aforementioned regulation sections provide guidelines for HHAs for the electronic transmission of the OASIS data as well as responsibilities of the State agency or OASIS contractor in collecting and transmitting this information to CMS. These requirements are necessary to achieve broad-based, measurable improvement, in the quality of care furnished through Federal programs, and to establish a prospective payment system for HHAs.; *Form Number:* CMS–R–209 (OMB#: 0938–0761); *Frequency:* Reporting—Monthly; *Affected Public:* Business or other for-profit, not-for-profit institutions, Federal government, State, local, or tribal governments; *Number of Respondents:* 8,277; *Total Annual Responses:* 102,203; *Total Annual Hours:* 1,374,051.

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare and Medicaid Programs OASIS Collection Requirements as Part of the Conditions of Participation for Home Health Agencies and Supporting Regulations in 42 CFR Sections 484.55, 484.205, 484.245, 484.250; *Use:* The Medicare and Medicaid Programs OASIS Collection Requirements as Part of the Conditions of Participation for Home Health Agencies (HHAs) information collection requires HHAs to use a standard core assessment data set, the Outcome and Assessment Information Set (OASIS), to collect information and to evaluate adult non-maternity patients. In addition, data from the OASIS will be used for purposes of case mix adjusting patients under the home health prospective payment system and will facilitate the production of necessary case mix information at relevant time points in the patient's home health stay.; *Form Number:* CMS–R–245 (OMB#: 0938–0760); *Frequency:* Recordkeeping and reporting—Other, upon patient assessment; *Affected Public:* Business or other for-profit, not-for-profit institutions, Federal government, State, local, or tribal governments; *Number of Respondents:* 8,277; *Total Annual Responses:* 11,087,565; *Total Annual Hours:* 9,339,184.

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 April 4, 2006. CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—B, Attention: William N. Parham, III, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: January 25, 2006.

Michelle Shortt,

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

[FR Doc. 06–974 Filed 2–2–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

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

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

AGENCY: Center for Medicare and Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare and 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 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.

We are, however, requesting an emergency review of the information collection referenced below. In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have

submitted to the Office of Management and Budget (OMB) the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR part 1320. This is necessary to ensure compliance with an initiative of the Administration. CMS does not have sufficient time to complete the normal PRA clearance process while making corrections and enhancements to the software and ensuring that organizations have ample time to complete and submit their tools by the statutory deadline in June 2006. The normal PRA clearance process would result in violating this statutory deadline which would prevent Medicare Advantage (MA) and Prescription Drug Plan (PDP) organizations from providing benefits to millions of Medicare beneficiaries.

CMS is requesting to continue its use of the Plan Benefit Package software, formulary and Bid Pricing Tool for the collection of benefits, pricing and related information for CY 2007 through CY 2009 as part of the annual bidding process. CMS estimates that MA and PDP organizations will be required to submit this information, per year, throughout this time period. 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 Bid Pricing Tool and plan benefit package submission.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDPs); *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. 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; *Form Number:* CMS–R–262 (OMB#: 0938–0763); *Frequency:* On occasion, Annually, and Other: As required by new legislation; *Affected Public:* Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 553; *Total Annual Responses:* 5,807; *Total Annual Hours:* 13,272.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Bid Pricing Tool (BPT) for Medicare Advantage Organizations (MAOs) 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. *Form Number:* CMS–10142 (OMB#: 0938–0944); *Frequency:* On occasion, Annually, and Other: As required by new legislation; *Affected Public:* Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 570; *Total Annual Responses:* 4,830; Total Annual Hours: 36,190.

CMS is requesting OMB review and approval of these collections by *March 16, 2006,* with a 180-day approval period. Written comments and recommendation will be considered from the public if received by the individuals designated below by *March 5, 2006.*

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.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of information requirements. However, as noted above, comments on these information collection and recordkeeping requirements must be mailed and/or faxed to the designees referenced below by March 5, 2006:

Centers for Medicare and Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850, Fax Number: (410) 786–5267, Attn: Bonnie L Harkless and,

OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503.

Date: January 31, 2006.

Michelle Shortt,

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

[FR Doc. 06–1054 Filed 2–2–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: Follow-Up Study of Issues Affecting the Duration of Child Care Subsidy Use.

OMB No.: New Collection.

Description: Child care subsidies provide an important benefit to low-income working families, offering them increased access to forms of child care that would otherwise be beyond their means. However, recent research suggests that, for many families, this benefit may be short-lived or unstable. There are many possible explanations for these patterns, and the explanations may be different for different types of families.

Recognizing that information about the reasons for short subsidy duration would be helpful to States, the Child Care Bureau has funded Abt Associates Inc. to conduct a two-State investigative study on the duration and use of child care subsidies. This study will, in the short term, provide States with information to shape or modify their child care subsidy procedures. In addition, the study will generate hypotheses that could be systematically tested in later research.

The study will examine the use of child care subsidies by 840 families in Illinois and 840 in Oregon. In each State, the sample will be a representative sample of current Temporary Assistance for Needy Families (TANF) families and non-TANF families—all of whom apply and are approved for subsidies and who use them for at least one month. Families will be contacted by telephone approximately nine months after they began using subsidies and will be asked to participate in the study. If they agree, a 45-minute telephone interview will