have an associated CMN for the beneficiary. Suppliers (those who bill for the items) complete the administrative information (*e.g.*, patient's name and address, items ordered, etc.) on each CMN. The 1994 Amendments to the Social Security Act require that the supplier also provide a narrative description of the items ordered and all related accessories, their charge for each of these items, and the Medicare fee schedule allowance (where applicable). The supplier then sends the CMN to the treating physician or other clinicians (*e.g.*, physician assistant, LPN, etc.) who completes questions pertaining to the beneficiary's medical condition and signs the CMN. The physician or other clinician returns the CMN to the supplier who has the option to maintain a copy and then submits the CMN (paper or electronic) to CMS, along with a claim for reimbursement. *Form Number:* CMS–846–849, 854, 10125, 10126, 10269 (OMB# 0938–0679); *Frequency:* Occasionally; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 59,200; *Total Annual Responses:* 6,480,000; *Total Annual Hours:* 1,296,000.

3. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Withholding Medicare Payments to Recover Medicaid Overpayments and Supporting Regulations in 42 CFR 44.31; *Use:* Overpayments may occur in either the Medicare and Medicaid program, at times resulting in a situation where an institution or person that provides services owes a repayment to one program while still receiving reimbursement from the other. Certain Medicaid providers which are subject to offsets for the collection of Medicaid overpayments may terminate or substantially reduce their participation in Medicaid, leaving the State Medicaid Agency unable to recover the amounts due. These information collection requirements give CMS the authority to recover Medicaid overpayments by offsetting payments due to a provider under the program. *Form Number:* CMS–R–21 (OMB# 0938–0287); *Frequency:* On occasion; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 54; *Total Annual Responses:* 27; *Total Annual Hours:* 81.

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 October 27, 2008: OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: September 18, 2008.

Michelle Shortt,

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

[FR Doc. E8–22582 Filed 9–25–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–372 and CMS–R–54]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

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:* Annual Report on Home and Community Based Services Waivers and Supporting Regulations in 42 CFR 440.180 and 441.300–310.; *Use:* States within an approved waiver under section 1915(c) of the act are required to submit a report annually in order for CMS to: (1) Verify that State assurances regarding waiver cost-neutrality are met; and (2) Determine the waiver's impact on the type, amount, and cost of services provided under the State Plan and health welfare of recipients. *Form Number:* CMS–372 (OMB# 0938–0272); *Frequency:* Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 49; *Total Annual Responses:* 305; *Total Annual Hours:* 13,115.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* National Medicare & You Education Program (NMEP) Survey of Medicare Beneficiaries *Use:* The Centers for Medicare and Medicaid Services is requesting a revision of this information collection request to continue to collect information from Medicare beneficiaries, caregivers, health care providers, and health information providers. It is critical for this agency to obtain feedback from the aforementioned groups so that the agency can accurately assess the needs of the Medicare audience. Using random digit dial and/or an administrative sample, members of the Medicare audience will be called and asked to complete the survey via telephone. The results of this survey will be compiled and studied so that communication may be amended to benefit Medicare's audience. The survey has the following objectives: To assess satisfaction with and knowledge of the Medicare program; to gather information on health behaviors and quality of health care; to determine the most used source for Medicare information; and to gather information from health care provider and health information providers. *Form Number:* CMS–R–54 (OMB# 0938–0738); *Frequency:* Once; *Affected Public:* Individuals and Households, Private Sector—Business or other for-profits; *Number of Respondents:* 7,000; *Total Annual Responses:* 7,000; *Total Annual Hours:* 1,750.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site 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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways November 25, 2008:

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number _____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: September 18, 2008.

Michelle Shortt,

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

[FR Doc. E8–22584 Filed 9–25–08; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4136–N]

Medicare Program; Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2009

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

ACTION: Notice.

SUMMARY: This notice announces the annual adjustment in the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review under the Medicare appeals process. The adjustment to the AIC threshold amounts will be effective for requests for ALJ hearings and judicial review filed on or after January 1, 2009. The 2009 AIC threshold amounts are $120 for ALJ hearings and $1,220 for judicial review.

DATES: *Effective Date:* This notice is effective on January 1, 2009.

FOR FURTHER INFORMATION CONTACT: Liz Hosna, (410) 786–4993.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1869(b)(1)(E) of the Social Security Act (the Act), as amended by section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), established the AIC threshold amounts for ALJ hearing requests and judicial review at $100 and $1000, respectively, for Medicare Part A and Part B appeals. Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), amended section 1869(b)(1)(E) of the Act to require the AIC threshold amounts for ALJ hearings and judicial review to be adjusted annually. The AIC threshold amounts are to be adjusted, as of January 2005, by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to July of the year preceding the year involved and rounded to the nearest multiple of $10. Section 940(b)(2) of the MMA provided conforming amendments to apply the AIC adjustment requirement to Medicare Part C (Medicare Advantage ''MA'') appeals and certain health maintenance organization and competitive health plan appeals. Health care prepayment plans are also subject to MA appeals rules, including the AIC adjustment requirement. Section 101 of the MMA provides for the application of the AIC adjustment requirement to Medicare Part D appeals.

A. Medicare Part A and Part B Appeals

The statutory formula for the annual adjustment to the AIC threshold amounts for ALJ hearings and judicial review of Medicare Part A and Part B appeals, set forth at section 1869(b)(1)(E) of the Act, is included in the applicable implementing regulations, 42 CFR Part 405, Subpart I, at § 405.1006(b). The regulations require the Secretary of the Department of Health and Human Services (the Secretary) to publish changes to the AIC threshold amounts in the **Federal Register** (§ 405.1006(b)(2)). In order to be entitled to a hearing before an ALJ, a party to a proceeding must meet the AIC requirements at § 405.1006(b). Similarly, a party must meet the AIC requirement at § 405.1006(c) at the time judicial review is requested for the court to have jurisdiction over the appeal (§ 405.1136(a)).

B. Medicare Part C (Medicare Advantage) Appeals

Section 940(b)(2) of the MMA applies the AIC adjustment requirement to Part C (MA) appeals by amending section 1852(g)(5) of the Act. The implementing regulations for Medicare Part C appeals are found at 42 CFR Part 422, Subpart M. Specifically, § 422.600 and § 422.612 discuss the AIC threshold amounts for ALJ hearings and judicial review.

Section 422.600 grants any party to the reconsideration, except the MA organization, a right to an ALJ hearing as long as the amount remaining in controversy after reconsideration meets the threshold requirement established annually by the Secretary. Section 422.612 states that any party, including the MA organization, may request judicial review if the amount in controversy meets the threshold requirement established annually by the Secretary.

C. Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans

Section 1876(c)(5)(B) of the Act states that the annual adjustment to the AIC dollar amounts set forth in section 1869(b)(1)(E) of the Act applies to certain beneficiary appeals within the context of health maintenance organizations and competitive medical plans. The applicable implementing regulations for Medicare Part C appeals are set forth in 42 CFR Part 422, Subpart M, and as discussed above, apply to these appeals. The Medicare Part C appeals rules also apply to health care prepayment plan appeals.

D. Medicare Part D (Prescription Drug Plan) Appeals

The annually adjusted AIC threshold amounts for ALJ hearings and judicial review that apply to Medicare Parts A, B, and C appeals also apply to Medicare Part D appeals. Section 101 of the MMA added section 1860D–4(h)(1) of the Act regarding Part D appeals. This statutory provision requires a prescription drug plan sponsor to meet the requirements set forth in sections 1852(g)(4) and (g)(5) of the Act, in a similar manner as MA organizations. As noted above, the annually adjusted AIC threshold requirement was added to section 1852(g)(5) of the Act by section 940(b)(2)(A) of the MMA. The implementing regulations for Medicare Part D appeals can be found at 42 CFR Part 423, Subpart M. The regulations impart at § 423.562(c) that unless the Part D appeals rules provide otherwise, the Part C appeals rules (including the annually adjusted AIC threshold amount) apply to Part D appeals to the extent they are appropriate. More specifically, § 423.610 and § 423.630 of the Part D appeals rules discuss the AIC threshold amounts for ALJ hearings and judicial review. Section 423.610(a)