reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirement on respondents can be properly assessed.

Currently, the Corporation is soliciting comments concerning the proposed renewal of its Learn and Serve America Progress Report. These reports must be completed by all Learn and Serve America grantees in order to ensure appropriate Federal oversight, determine progress toward meeting program objectives and to make decisions related to continuation funding.

Copies of the information collection requests can be obtained by contacting the office listed in the addresses section of this notice.

DATES: Written comments must be submitted to the individual and office listed in the **ADDRESSES** section by December 11, 2006.

ADDRESSES: You may submit comments, identified by the title of the information collection activity, by any of the following methods:

(1) *By mail sent to:* Corporation for National and Community Service, Learn and Serve America; Attention: Cara Patrick; 1201 New York Avenue, NW., Washington, DC 20525.

(2) By hand delivery or by courier to the Corporation's mailroom at Room 6010 at the mail address given in paragraph (1) above, between 9 a.m. and 4 p.m. Monday through Friday, except Federal holidays.

(3) *By fax to:* (202) 606–3477, Attention: Cara Patrick, Learn and Serve America.

(4) *Electronically through the Corporation's e-mail address system: cpatrick@cns.gov.*

FOR FUTHER INFORMATION CONTACT: Cara Patrick, (202) 606–6905, or by e-mail at *cpatrick@cns.gov.*

SUPPLEMENTARY INFORMATION: The Corporation is particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Corporation, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are expected to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology (*e.g.*, permitting electronic submissions of responses).

Background

Learn and Serve America provides grants to state education agencies, higher education institutions, tribes and U.S. Territories, national nonprofits and state commissions on national and community service to implement service-learning programs. To ensure appropriate oversight of Federal funds, Learn and Serve America requires all grant recipients to submit Progress Reports describing grant activities and progress toward approved program objectives. Information received from the reports informs continuation funding decisions and how to target training and technical assistance.

Progress Report instructions will be available from the agency Web site and should be completed through our grants management system, eGrants.

Type of Review: Renewal.

Agency: Corporation for National and Community Service.

Title: Learn and Serve America Progress Report.

OMB Number: 3045–0089.

Agency Number: None.

Affected Public: State and Local Government, Not-for-profit institutions.

Total Respondents: 103.

Frequency: Twice annually.

Average Time per Response: 2 hours.

Estimated Total Burden Hours: 412 hours.

Total Burden Cost (capital/startup): None.

Total Burden Cost (operating/maintenance): None.

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget approval of the information collection request; they will also become a matter of public record.

Dated: October 3, 2006.

Amy Cohen,

Director, Learn and Serve America.

[FR Doc. E6–16839 Filed 10–11–06; 8:45 am]

BILLING CODE 6050–$$–P

DEPARTMENT OF DEFENSE

Office of the Secretary

TRICARE; Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Fiscal Year 2007 Diagnosis Related Group (DRF) Updates

AGENCY: Office of the Secretary, DoD.

ACTION: Notice of DRG revised rates.

SUMMARY: This notice describes the changes made to the TRICARE DRG-based payment system in order to conform to changes made to the Medicare Prospective Payment System (PPS).

It also provides the updated fixed loss cost outliner threshold, cost-to-charge ratios and the Internet address for accessing the updated adjusted standardized amount and DRG relative weights to be used for FY 2007 under the TRICARE DRG-based payment system.

DATES: *Effective Dates:* The rates, weights and Medicare PPS changes which affect the TRICARE DRG-based payment system contained in this notice are effective for admissions occurring on or after October 1, 2006.

ADDRESSES: TRICARE Management Activity (TMA), Medical Benefits and Reimbursement Systems, 16401 East Centretech Parkway, Aurora, CO 80011–9066.

FOR FURTHER INFORMATION CONTACT: Ann N. Fazzini, Medical Benefits and Reimbursement Systems, TMA, telephone (303) 676–3803.

Questions regarding payment of specific claims under the TRICARE DRG-based payment system should be addressed to the appropriate contractor.

SUPPLEMENTARY INFORMATION: The final rule published on September 1, 1987 (52 FR 32993) set forth the basic procedures used under the CHAMPUS DRG-based payment system. This was subsequently amended by final rules published August 31, 1988 (53 FR 33461), October 21, 1988 (53 FR 41331), December 16, 1988 (53 FR 50515), May 30, 1990 (55 FR 21863), October 22, 1990 (55 FR 42560), and September 10, 1998 (63 FR 48439).

An explicit tenet of these final rules, and one based on the statute authorizing the use of DRGs by TRICARE, is that the TRICARE DRG-based payment system is modeled on the Medicare PPS, and that, whenever practicable, the TRICARE system will follow the same rules that apply to the Medicare PPS. The Centers for Medicare and Medicaid Services (CMS) publishes these changes annually in the **Federal Register** and discusses in detail the impact of the changes.

In addition, this notice updates the rates and weights in accordance with our previous final rules. The actual changes we are making, along with a description of their relationship to the Medicare PPS, are detailed below.

I. Medicare PPS Changes Which Affect the TRICARE DRG-Based Payment System

Following is a discussion of the changes CMS had made to the Medicare PPS that affect the TRICARE DRG-based payment system.

A. DRG Classifications

Under both the Medicare PPS and the TRICARE DRG-based payment system cases are classified into the appropriate DRG by a Grouper program. The Grouper classifies each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). The Grouper used for the TRICARE DRG-based payment system is the same as the current Medicare Grouper with two modifications. The TRICARE system has replaced Medicare DRG 435 with two age-based DRGs (900 and 901), and has implemented thirty-four (34) neonatal DRGs is place of Medicare DRGs 385 through 390. For admissions occurring on or after October 1, 2001, DRG 435 has been replaced by DRG 523. The TRICARE system has replaced DRG 523 with the two age-based DRGs (900 and 901). For admissions occurring on or after October 1, 1995, the CHAMPUS grouper hierarchy logic was changed so the age split (age <29 days) and assignments to MDC 15 occur before assignment of the PreMDC DRGs. This resulted in all neonate tracheostomies and organ transplants to be grouped to MDC 15 and not to DRGs 480–483 or 495. For admissions occurring on or after October 1, 1998, the CHAMPUS grouper hierarchy logic was changed to move DRG 103 to the PreMDC DRGs and to assign patients to PreMDC DRGs 480, 103 and 495 before assignment to MDC 15 DRGs and the neonatal DRGs. For admissions occurring on or after October 1, 2001, DRGs 512 and 513 were added to the PreMDC DRGs, between DRGs 480 and 103 in the TRICARE grouper hierarchy logic. For admissions occurring on or after October 1, 2004, DRG 483 was deleted and replaced with DRGs 541 and 542, splitting the assignment of cases on the basis of the performance of a major operating room procedure. The description for DRG 480 was changed to ''Liver Transplant and/or Intestinal Transplant'' and the description for DRG 103 was changed to ''Heart/Heart Lung Transplant or Implant of Heart Assist System''. For FY 2007, CMS will implement classification changes, including surgical hierarchy changes. The TRICARE Grouper will incorporate all changes made to the Medicare Grouper, with the exception of the pre-surgical hierarchy changes, which will remain the same as FY 2006.

B . Wage Index and Medicare Geographic Classification Review Board Guidelines

TRICARE will continue to use the same wage index amounts used for the Medicare PPS. TRICARE will also duplicate all changes with regard to the wage index for specific hospitals that are redesignated by the Medicare Geographic Classification Review Board. In addition, TRICARE will continue to utilize the out commuting wage index adjustment.

C. Revision of the Labor-Related Share of the Wage Index

TRICARE is adopting CMS' percentage of labor related share of the standardized amount. For wage index values greater than 1.0, the labor related portion of the ASA shall equal 69.7 percent. For wage index values less than or equal to 1.0 the labor related portion of the ASA shall continue to equal 62 percent.

D. Hospital Market Basket

TRICARE will update the adjusted standardized amounts according to the final updated hospital market basket used for the Medicare PPS for all hospitals subject to the TRICARE DRG-based payment system according to CMS' August 18, 2006, final rule.

E. Outlier Payments

Since TRICARE does not include capital payments in our DRG-based payments (TRICARE reimburses hospitals for their capital costs as reported annually to the contractor on a pass through basis), we will use the fixed loss cost outlier threshold calculated by CMS for paying cost outliers in the absence of capital prospective payments. For FY 2007, the fixed loss cost outlier threshold is based on the sum of the applicable DRG-based payment rate plus any amounts payable for IDME plus a fixed dollar amount. Thus, for FY 2007, in order for a case to qualify for cost outlier payments, the costs must exceed the TRICARE DRG base payment rate (wage adjusted) for the DRG plus the IDME payment plus $22,639 (wage adjusted). The marginal cost factor for cost outliers continues to be 80 percent.

F. National Operating Standard Cost as a Share of Total Costs

The FY 2007 TRICARE National Operating Standard Cost as a Share of Total Costs (NOSCASTC) used in calculating the cost outlier threshold is 0.925. TRICARE uses the same methodology as CMS for calculating the NOSCASTC, however, the variables are different because TRICARE uses national cost to charge ratios while CMS uses hospital specific cost to charge ratios.

G. Indirect Medical Education (IDME) Adjustment

Passage of the MMA of 2003 modified the formula multipliers to be used in the calculation of the indirect medical education IDME adjustment factor. Since the IDME formula used by TRICARE does not include disproportionate share hospitals (DSHs), the variables in the formula are different than Medicare's, however; the percentage reductions that will be applied to Medicare's formula will also be applied to the TRICARE IDME formula. The new multiplier for the IDME adjustment factor for TRICARE for FY 2007 is 1.00.

H. Expansion of the Post Acute Care Transfer Policy

For FY 2007 TRICARE is adopting CMS' expanded post acute care transfer policy according to CMS' final rule published August 18, 2006.

I. Blood Clotting Factor

For FY 2007, TRICARE is adopting CMS' payment methodology for blood clotting factor according to CMS' final rule published August 18, 2006.

II. Cost to Charge Ratio

While CMS uses hospital-specific cost to charge ratios, TRICARE uses a national cost to charge ratio. For FY 2007, the cost-to-charge ratio used for the TRICARE DRG-based payment system for acute care hospitals and neonates will be 0.3897 which is increased to 0.3967 to account for bad debts. This shall be used to calculate the adjusted standardized amounts and to calculate cost outlier payments, except for children's hospitals. For children's hospital cost outliers, the cost-to-charge ratio used is 0.4282.

III. Updated Rates and Weights

The updated rates and weights are accessible through the Internet at *http://www.tricare.osd.mil* under the sequential headings TRICARE Provider Information, Rates and Reimbursements, and DRG Information. Table 1 provides the ASA rates and Table 2 provides the DRG weights to be used under the TRICARE DRG-based payment system during FY 2007 and which is a result of the changes described above. The implementing regulations for the

TRICARE/CHAMPUS DRG-based payment system are in 32 CFR part 199.

Dated: October 5, 2006.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 06–8624 Filed 10–11–06; 8:45 am]

BILLING CODE 5001–06–M

DEPARTMENT OF DEFENSE

Office of the Secretary

TRICARE Formerly Known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Fiscal Year 2007 Mental Health Rate Updates

AGENCY: Office of the Secretary, DoD.

ACTION: Notice of updated mental health per diem rates.

SUMMARY: This notice provides for the updating of hospital-specific per diem rates for high volume providers and regional per diem rates for low volume providers; the updated cap per diem for high volume providers; the beneficiary per diem cost-share amount for low volume providers for FY 2007 under the TRICARE Mental Health Per Diem Payment System; and the updated per diem rates for both full-day and half-day TRICARE Partial Hospitalization Programs for fiscal year 2007.

DATES: *Effective Date:* The fiscal year 2007 rates contained in this notice are effective for services occurring on or after October 1, 2006.

FOR FURTHER INFORMATION CONTACT: Christine Covie, Office of Medical Benefits and Reimbursement Systems, TRICARE Management Activity, telephone (303) 676–3841.

SUPPLEMENTARY INFORMATION: The final rule published in the **Federal Register** on September 6, 1988, (53 FR 34285) set forth reimbursement changes that were effective for all inpatient hospital admissions in psychiatric hospitals and exempt psychiatric units occurring on or after January 1, 1989. The final rule published in the **Federal Register** on July 1, 1993, (58 FR 35–400) set forth maximum per diem rates for all partial hospitalization admissions on or after September 29, 1993. Included in these final rules were provisions for updating reimbursement rates for each federal fiscal year. As stated in the final rules, each per diem shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare Prospective Payment System. For fiscal year 2007, Medicare has recommended a rate of increase of 3.4 percent for hospitals and units excluded from the prospective payment system. TRICARE will adopt this update factor for FY 2007 as the final update factor. Hospitals and units with hospital-specific rates (hospitals and units with high TRICARE volume) and regional specific rates for psychiatric hospitals and units with low TRICARE volume will have their TRICARE rates for FY 2006 updated by 3.4 percent for FY 2007. Partial hospitalization rates for full day and half day programs will also be updated by 3.4 percent for FY 2007. The cap amount for high volume hospitals and units will also be updated by the 3.4 percent for FY 2007. The beneficiary cost-share for low volume hospitals and units will also be updated by the 3.4 percent for FY 2007. Consistent with Medicare, the wage portion of the regional rate subject to the area wage adjustment is 75.665 percent for FY 2007.