minimize the information collection burden.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Integrity Program Organizational Conflict of Interest Disclosure Certificate and Supporting Regulations at 42 CFR 421.300—421.316; *Form Number:* CMS–R–232 (OMB#: 0938–0723); *Use:* Section 1893(d)(1) of the Social Security Act requires CMS to establish a process for identifying, evaluating, and resolving conflicts of interest. CMS proposed a process under § 421.310 to mandate submission of pertinent information regarding conflicts of interest. The entities providing the information will be organizations that have been awarded, or seek award of, a Medicare Integrity Program contract. CMS needs this information to assess whether contractors who perform, or who seek to perform, Medicare Integrity Program functions, such as medical review, fraud review or cost audits, have organizational conflicts of interest and whether any conflicts have been resolved. *Frequency:* Reporting—On occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 11; *Total Annual Responses:* 11; *Total Annual Hours:* 2,200.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Request for Accelerated Payments and Supporting Regulations in 42 CFR, sections 412.116, 412.632, 413.64, 413.350, and 484.245; *Form Number:* CMS–9042 (OMB#: 0938–0269); *Use:* Section 1815(a) of the Social Security Act describes payment to providers of services. 42 CFR 412.116, 42 CFR 412.632, 42 CFR 413.64, 42 CFR 413.350, and 42 CFR 484.245 define the conditions under which accelerated payments may be requested. Sections 2412.2 and 2412.3 of the Provider Reimbursement Manual identify the information that providers must supply to their intermediary to request an accelerated payment. A request for an accelerated payment can be made by a hospital, skilled nursing facility, home health agency, inpatient rehabilitation facility, critical access hospital, or hospice that is not receiving periodic interim payments. Accelerated payment request forms are used by fiscal intermediaries to assess a provider's eligibility for accelerated payments. *Frequency:* Reporting—On occasion; *Affected Public:* Business or other for-profit, Not-for-profit institutions; *Number of Respondents:* 822; *Total Annual Responses:* 822; *Total Annual Hours:* 411.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare and Medicaid: Programs of All-Inclusive Care for the Elderly (PACE) contained in 42 CFR 460.12—460.210 / Medicare and Medicaid: Programs of All-Inclusive Care for the Elderly (PACE; Program Revisions) contained in 42 CFR 460.10—460.210; *Form Number:* CMS–R–244 (OMB#: 0938–0790); *Use:* PACE is a pre-paid, capitated plan that provides comprehensive health care services to frail, older adults in the community, who are eligible for nursing home care according to State standards. The Balanced Budget Act (BBA) of 1997 authorized coverage of PACE under the Medicare program and as a State option under Medicaid. The Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) amended section 1894 and 1943 of Social Security Act to provide authority for CMS to modify or waive PACE regulatory provisions. Organizations that seek participation under PACE must apply for approval and are evaluated in terms of specific criteria. The information collection requirement is necessary to ensure that only appropriate organizations are selected to become PACE organizations. CMS and the State Administering Agencies will use the information to select PACE organizations and monitor their performance. *Frequency:* Recordkeeping, Reporting—Quarterly and Annually; *Affected Public:* Not-for-profit institutions, Federal Government and State, Local, or Tribal Government; *Number of Respondents:* 54; *Total Annual Responses:* 54; *Total Annual Hours:* 44,378.

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* 1–800–MEDICARE Customer Experience Questionnaire; *Form Number:* CMS–10163 (OMB#: 0938–0963); *Use:* Section 923(d) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 established 1–800 MEDICARE as the primary source of general Medicare information and assistance. As part of the Medicare Modernization Act (MMA), CMS must provide Part D eligibles and their representatives with the information they need to make informed decisions among the available choices for Part D coverage. Part D sponsors can start marketing their programs on October 1, 2005. The initial enrollment period for the general population will occur from November 15, 2005 to May 15, 2006. The information collected from this survey will allow CMS to monitor callers' satisfaction with various aspects of both the Interactive Voice Recognition (IVR) component and live Customer Service Representative (CSR) component of the 1–800 MEDICARE line. Timely feedback from customers on key satisfaction indicators will be used for continuous quality enhancement. *Frequency:* Reporting—Weekly, Quarterly and Monthly; *Affected Public:* Individuals and Households; *Number of Respondents:* 31,200; *Total Annual Responses:* 31,200; *Total Annual Hours:* 4940.

To obtain copies of the supporting statement and any related forms for these paperwork collections referenced above, access CMS Web site address at *http://www.cms.hhs.gov/regulations/pra/,* 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 January 9, 2006. OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, CMS Desk Officer, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: December 1, 2005.

Michelle Shortt,

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

[FR Doc. 05–23789 Filed 12–8–05; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10177 and CMS–10044]

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:* New collection; *Title of Information Collection:* Survey of Contract Labor in Selected Health Industries; *Form Number:* CMS–10177 (OMB#: 0938–NEW); *Use:* CMS Medicare reimbursement to hospitals and skilled nursing facilities is based, in part, on the portion of costs which are related to, are influenced by, or vary with the local labor markets. This portion is known as the labor-related share. Currently, contract labor costs for accounting and auditing services, engineering services, legal services, and management consulting services are included in the labor-related share. These costs are calculated based on data published in the Medicare cost reports and the Input-Output tables published by the Bureau of Economic Analysis (BEA). At this time, the labor-related share is not used to reimburse end-stage renal disease centers (ESRDs) for providing Medicare services. However, there is a possibility that this circumstance may change; therefore CMS will include ESRDs in the survey. It is assumed that these professional services contract labor costs are purchased in the local labor market and thus should be included in the labor-related share. A search of the literature reveals no existing work on this subject. Therefore, CMS will survey hospitals, skilled nursing facilities, and kidney dialysis centers to determine if their professional service contract labor is hired from local or national labor markets.; *Frequency:* Reporting—One-time; *Affected Public:* Not-for-profit institutions, Business or other for-profit, Federal Government, State, Local, or Tribal Government; *Number of Respondents:* 4,000; *Total Annual Responses:* 4,000; Total Annual Hours: 4,000.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Lifestyle Modification Program Demonstration; *Form Number:* CMS–10044 (OMB#: 0938–0871); *Use:* The Medicare Lifestyle Modification Program Demonstration will focus on two Medicare-sponsored, lifestyle modification programs designed to reverse, reduce, or ameliorate the progression of coronary artery disease (CAD) at risk for significant morbidity and mortality. Lifestyle modification programs are an increasingly important approach to the secondary prevention of coronary morbidity. Research has provided evidence that lifestyle changes decrease cardiovascular risk factors, resulting in lower morbidity and mortality associated with coronary artery disease (CAD). Such programs may reduce the incidence of hospitalizations and invasive procedures among patients with substantial coronary occlusion. Consequently, lifestyle modification may also reduce the need for revascularization procedures (coronary artery bypass graft (CABG) and percutaneous coronary angioplasty (PTCA)) as well as the use of ambulatory and inpatient services for this disease. This demonstration will test the cost effectiveness and feasibility of providing payment for cardiovascular lifestyle modification program services to Medicare beneficiaries.; *Frequency:* Reporting—Monthly; *Affected Public:* Individuals or Households; *Number of Respondents:* 2,240; *Total Annual Responses:* 1,680; *Total Annual Hours:* 1106.

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/regulations/pra/,* 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 February 7, 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: December 2, 2005.

Michelle Shortt,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–10175]

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. We cannot reasonably comply with the normal clearance procedures because public harm will ensue from the continued denial of access from providers obtaining National Provider Identifiers (NPI) *en masse.*

Currently, providers can obtain a NPI via a paper application or over the Internet through the National Plan and Provider Enumeration System (NPPES). These applications must be submitted individually, on a per-provider basis. We are seeking OMB approval for the electronic file interchange (EFI) process.