ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Type of respondent	Form	Number of respondents	Number of responses per respondent	Average burden per respondent (in hours)	Total burden hours
Community Leaders	On-line survey	600	1	1	600
Total Burden Hours					1,800

Kimberly S. Lane,

Deputy Director, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2012–17984 Filed 7–23–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10389, CMS–855S and CMS–855(A,B,I,R)]

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:* New collection (request for a new OMB control number). *Title of Information Collection:* The Home and Community-Based Service (HCBS) Experience Survey. *Use:* This study is a one-time pilot field test involving individuals who receive HCBS from Medicaid programs. The field test will be conducted for the following purposes: (a) To assess survey methodology—to determine how well a face-to-face survey and telephone survey performs with individuals who receive HCBS services; (b) Psychometric Analysis—to provide information for the revision and shortening of the survey based on the assessment of the reliability and construct validity of survey items and composites; and (c) Case mix adjustment analysis—to assess the variables that may be considered as case mix adjusters. These preliminary research activities are not required by regulation, and will not be used by CMS to regulate or sanction its customers. They will be entirely voluntary and the confidentiality of respondents and their responses will be preserved.

The information collected will be used to revise and test the survey instrument described in the Background section of the PRA package's Supporting Statement. Within the PRA package, Attachment B includes two versions of the survey (one modified for accessibility) and Attachment C has the introductory information. The end result will be an improvement in information collection instruments and in the quality of data collected, a reduction or minimization of respondent burden, increased agency efficiency, and improved responsiveness to the public. Following the field test, CMS will seek approval from the CAHPS consortium for the HCBS Experience Survey to be a new addition to the CAHPS® family of surveys. *Form Number:* CMS–10389 (OCN 0938–New). *Frequency:* Once. *Affected Public:* Individuals and Households. *Number of Respondents:* 18,000. *Total Annual Responses:* 18,000. *Total Annual Hours:* 9,000. (For policy questions regarding this collection contact Anita Yuskauskas at 410–786–0268. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Enrollment Application—Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers *Use:* The primary function of the CMS 855S Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier enrollment application is to gather information from a supplier that tells us who it is, whether it meets certain qualifications to be a health care supplier, where it renders its services or supplies, the identity of the owners of the enrolling entity, and information necessary to establish the correct claims payment. The goal of evaluating and revising the CMS 855S DMEPOS supplier enrollment application is to simplify and clarify the information collection without jeopardizing our need to collect specific information. The majority of the revisions contained in this submission are non-substantive in nature such as spelling and formatting corrections; however, we also removed duplicate fields and obsolete questions and provided clarification and simplified the instructions for the completing the application. *Form Number:* CMS–855(S) (OCN: 0938–1056); *Frequency:* Yearly; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 43,350; *Total Annual Responses:* 43,350; *Total Annual Hours:* 113,550 (For policy questions regarding this contact Kim McPhillips at 410–786–5374. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Enrollment Application *Use:* The primary function of the CMS–855 Medicare enrollment application is to gather information from a provider or supplier that tells us who it is, whether it meets certain qualifications to be a health care provider or supplier, where it practices or renders its services, the identity of the owners of the enrolling entity, and other information necessary to establish correct claims payments. *Form Number:* CMS–855(A, B, I, R) (OCN: 0938–0685); *Frequency:* Yearly; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 440,450; *Total Annual Responses:* 440,450; *Total Annual Hours:* 856,395 (For policy questions regarding this

contact Kim McPhillips at 410–786–5374. For all other issues call 410–786–1326.)

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 Email 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 *August 23, 2012.*

OMB, Office of Information and Regulatory Affairs,
Attention: CMS Desk Officer,
Fax Number: (202) 395–6974,
Email: OIRA_submission@omb.eop.gov.

Dated: July 18, 2012.

Martique Jones,

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

[FR Doc. 2012–17924 Filed 7–23–12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10305]

Agency Information Collection Activities: Proposed Collection; 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) 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:* Medicare Part C and Part D Data Validation (42 CFR 422.516g and 423.514g); *Use:* The Centers for Medicare and Medicaid Services (CMS) established reporting requirements for Medicare Part C and Part D sponsoring organizations (Medicare Advantage Organizations [MAOs], Cost Plans, and Medicare Part D sponsors) under the authority described in 42 CFR 422.516(a) and 423.514(a), respectively. Under these reporting requirements, each sponsoring organization must submit Medicare Part C, Medicare Part D, or Medicare Part C and Part D data (depending on the type of contracts they have in place with CMS). In order for the reported data to be useful for monitoring and performance measurement, it must be reliable, valid, complete, and comparable among sponsoring organizations. In 2009, CMS developed the data validation program as a mechanism to verify the data reported are accurate, valid, and reliable. To maintain the independence of the validation process, sponsoring organizations do not use their own staff to conduct the data validation. Instead, sponsoring organizations are responsible for hiring external, independent data validation contractors (DVCs) who meet a minimum set of qualifications and credentials.

CMS developed standards and data validation criteria for specific Medicare Part C and Part D reporting requirements that the DVCs use in validating the sponsoring organizations' data.[1] These standards and criteria are described in Appendix 1 ''Data Validation Standards.'' The data validation standards for each measure include standard instructions relating to the types of information that should be reviewed, and measure-specific criteria (MSC) that are aligned with the ''Medicare Part C and Part D Reporting Requirement Technical Specifications.,, Furthermore, the standards and criteria describe how the DVCs should validate the sponsoring organizations' compilations of reported data, taking into account appropriate data exclusions, and verifying calculations, source code, and algorithms. The data validation reviews are conducted at the contract level given that the Medicare Part C and Part D data are generally available at the contract level and the contract is the basis of any legal and accountability issues concerning the rendering of services.

The review is conducted over a three-month period following the final submission of data by the sponsoring organizations. In addition to the ''Data Validation Standards'' described in Appendix 1, the DVCs employ a set of information collection tools when performing their reviews, which are included in the appendices described below:

Appendix 2: Organizational Assessment Instrument
Appendix 3: Data Extraction and Sampling Instructions
Appendix 4: Instructions for the Findings Data Collection Form
Appendix 5: Findings Data Collection Form (FDCF)

Data collected via ''Medicare Part C and Part D Reporting Requirements'' is an integral resource for oversight, monitoring, compliance and auditing activities necessary to ensure quality provision of the Medicare benefits to beneficiaries. CMS uses the data collected through the Medicare data validation program to substantiate the data collected via Medicare Part C and Part D Reporting Requirements. If CMS detects data anomalies, the CMS division with primary responsibility for the applicable reporting requirement assists with determining a resolution. The hour burden on industry is estimated at 179,301 total hours, or 879 hours for one contract within one organization reporting both Part C and Part D measures. The validation would require 378 hours from the sponsoring organization and 501 from the data validation contractors. The estimates are based on the total number of Part C and/or Part D measures, the average number of sponsors, and the average number of contracts by type (Part C, Part D, Part C/D) being validated as well as a level of effort associated with the individual activities associated with the data validation process. *Form Number:* CMS–10305 (OCN: 0938–1115); *Frequency:* Reporting—Annually; *Affected Public:* Private sector—Business or other for-profits; *Number of Respondents:* 135; *Total Annual Responses:* 657; *Total Annual Hours:* 179,301. (For policy questions regarding this collection contact Terry Lied at 410–786–8973. For all other issues call 410–786–1326.)

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/*

[1] CMS determines annually which Medicare Part C and Part D measures are included in the data validation program.