(CFIDS) Association of America, will build the case that chronic fatigue syndrome should be diagnosed quickly to ensure the best possible health outcomes.

To do so, a public education and awareness campaign will be launched to bring about changes in beliefs and social norms among target audiences (women aged 40–60, healthcare practitioners, and the general public) that CFS is a diagnosable and treatable physical illness.

Although considerable research will be done to ensure that campaign themes, messages, and materials are effective, there is no way to test the impact of the campaign on the target audience other than to conduct baseline and follow-up surveys. These surveys will measure not only the level of awareness created by the campaign, but will measure change in key knowledge, attitudes and beliefs about CFS among the target audiences.

There are no costs to respondents other than their time. The total estimated annualized burden hours are 88.

ESTIMATED ANNUALIZED BURDEN TABLE

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden/ response (in hours)
Consumers (Women, 40–60 years of age)	Pre-program survey	133	1	10/60
Consumers (Women, 40–60 years of age)	Post-program survey	133	1	10/60
Physician Assistants	Pre-program survey	67	1	10/60
Physician Assistants	Post-program survey	67	1	10/60
Nurse Practitioners	Pre-program survey	67	1	10/60
Nurse Practitioners	Post-program survey	67	1	10/60

Dated: February 10, 2006.

Betsey Dunaway,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E6–2320 Filed 2–16–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–276]

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:* Extension of a currently approved collection; *Title of Information Collection:* Prepaid Health Plan Cost Report.; *Use:* Health Maintenance Organizations and Competitive Medical Plans (HMO/CMPs) contracting with the Secretary under Section 1876 of the Social Security Act are required to submit a budget and enrollment forecast, four quarterly reports and a final certified cost report. Health Care Prepayment Plans (HCPPs) contracting with the Secretary under Section 1833 of the Social Security Act are required to submit a budget and enrollment forecast, mid-year report, and final cost report. An HMO/CMP is a health care delivery system that furnishes directly or arranges for the delivery of the full spectrum of health services to an enrolled population. An HCPP is a health care delivery system that furnishes directly or arranges for the delivery of certain physician and diagnostics services up to the full spectrum of non-provider Part B health services to an enrolled population. These reports will be used to establish the reasonable cost of delivering covered services furnished to Medicare enrollees by an HMO/CMP or HCPP.; *Form Numbers:* CMS–276 (OMB#: 0938–0165); *Frequency:* Recordkeeping, Reporting—Quarterly and Annually; *Affected Public:* Business or other for-profit; *Number of Respondents:* 45; *Total Annual Responses:* 225; *Total Annual Hours:* 7,860.

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 18, 2006.

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—C, Attention: Bonnie L Harkless, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: February 8, 2006.

Michelle Shortt,

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

[FR Doc. E6–2301 Filed 2–16–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10062, CMS–10177, and CMS–10044]

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:* Revision of a currently approved collection; *Title of Information Collection:* Collection of Diagnostic Data from Medicare Advantage Organizations for Risk Adjusted Payments Supporting Regulations 42 CFR part 422 subparts F and G and 42 CFR part 423 subparts F and G; *Form Number:* CMS–10062 (OMB#: 0938–0878); *Use:* Under the Medicare Prescription Drug Benefit, Improvement and Modernization Act of 2003 (MMA), the Congress restructured the M+C program into the Medicare Advantage (MA) program, Part C, and added an outpatient prescription drug benefit, Part D. In accordance with mandates in these laws, the Secretary of the Department of Health and Human Services must implement health status risk adjustment, a payment methodology for Parts C and D that takes into account the health status of plan enrollees. CMS collects inpatient and outpatient data. Part C data is collected using the CMS–HCC (hierarchical condition category) model. Part D data will be collected using the CMS Rx-HCC model. The Rx-HCC model is different from the CMS–HCC model primarily in that it predicts plan liability for drug costs instead of medical/surgical costs for service under Parts A and B. CMS will use the data to make risk adjusted payment under Parts C and D. MA plans, Medicare Advantage Prescription Drug (MA–PD) plans, and stand-alone Prescription Drug Plans (PDP's) will use the data to develop their Parts C and D bids.; *Frequency:* Reporting—Quarterly; *Affected Public:* Business or other-for-profit and not-for-profit institutions; *Number of Respondents:* 505; *Total Annual Responses:* 14,091,370; *Total Annual Hours: 8,351.*

2. *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.

3. *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 these 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 March 20, 2006.

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

Dated: February 9, 2006.

Michelle Shortt,

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

[FR Doc. E6–2302 Filed 2–16–06; 8:45 am]

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