audit and payment modules will be operational by November 2006. GSA will start a phased-in implementation plan for the pre-payment audit and payment modules in November 2006. TSPs that provide transportation services for GSA, Global Supply, will be required to submit all invoices in TMSS either manually or via electronic data interchange (EDI).

GSA will assess the 4% fee effective January 1, 2007, to ensure that the TMSS implementation phase is complete. TSPs will be required to remit the 4% fee for transportation invoices paid after December 31, 2006, directly to GSA quarterly instead of deducting the 4% fee from each invoice via TMSS prior to payment. TSP's will be able to access TMSS to generate a quarterly report that lists each transaction, total transportation charges, and transaction fee. The first remittance will be due for the quarter ending March 31, 2007.

Dated: August 22, 2006.

Susan T. May,

Acting Director, Travel and Transportation Management Division (FBL), GSA.

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BILLING CODE 6820–89–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–2744, CMS–2746, CMS–685, and CMS–10168]

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:* Extension of a currently approved collection; *Title of Information Collection:* End Stage Renal Disease Medical Information ESRD Facility Survey; *Use:* The ESRD Facility Survey is completed by all Medicare-approved ESRD facilities once a year. The survey was designed to collect information concerning treatment trends, utilization of services and patterns of practice in treating ESRD patients. The aggregate patient information is collected from each Medicare-approved provider of dialysis and kidney transplant services. The information is used to assess and evaluate the local, regional and national levels of medical and social impact of ESRD care and are used extensively by researchers and suppliers of services for trend analysis. The information is available on the CMS Dialysis Facility Compare Web site and will enable patients to make informed decisions about their care by comparing dialysis facilities in their area. The ESRD Facility Survey Public Use File is also posted at: *http://www.cms.hhs.gov/ESRDGeneralInformation/02_Data.asp#TopOfPage*; *Form Number:* CMS–2744 (OMB#: 0938–0447); *Frequency:* Reporting—Annually; *Affected Public:* Business or other for-profit, not-for-profit institutions; *Number of Respondents:* 4,800; *Total Annual Responses:* 4,800; *Total Annual Hours:* 38,400.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* End Stage Renal Disease Death Notification P.L. 95–292; 42 CFR 405.2133, 45 CFR 5–5b; 20 CFR Parts 401 and 422E *Use:* The ESRD Death Notification (CMS–2746) is completed by all Medicare-approved ESRD facilities upon the death of an ESRD patient. Its primary purpose is to collect fact of death and cause of death of ESRD patients. Certain other identifying information (e.g., name, Medicare claim number, and date of birth) is required for matching purposes. Federal regulations require that the ESRD Networks examine the mortality rates of every Medicare-approved facility within its area of responsibility. The Death Form provides the necessary data to assist the ESRD Networks in making decisions that result in improved patient care and in cost-effective distribution of ESRD resources. The data is used by the ESRD Networks to verify facility deaths and to monitor facility performance.; *Form Number:* CMS–2746 (OMB#: 0938–0448); *Frequency:* On occasion, weekly; *Affected Public:* Business or other for-profit, not-for-profit institutions; *Number of Respondents:* 4,719; *Total Annual Responses:* 75,504; *Total Annual Hours:* 37,752.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* End Stage Renal Disease (ESRD) Network Semi-Annual Cost Report Forms and Supporting Regulations in 42 CFR section 405.2110 and 42 CFR 405.2112; *Use:* Section 1881(c) of the Social Security Act establishes End Stage Renal Disease (ESRD) Network contracts. The regulations found at 42 CFR 405.2110 and 405.2112 designated 18 ESRD Networks which are funded by renewable contracts. These contracts are on 3-year cycles. To better administer the program, CMS is requiring contractors to submit semi-annual cost reports. The purpose of the cost reports is to enable the ESRD Networks to report costs in a standardized manner. This will allow CMS to review, compare and project ESRD Network costs during the life of the contract. *Form Number:* CMS–685 (OMB#: 0938–0657); *Frequency:* Reporting—semi-annually; *Affected Public:* Not-for-profit institutions; *Number of Respondents:* 18; *Total Annual Responses:* 36; *Total Annual Hours:* 108.

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Program: Complex Medical Review; *Use:* Complex medical review involves the application of clinical judgment by a licensed medical professional in order to evaluate medical records to determine whether an item or service is covered, and is reasonable and necessary. The information required under this collection is requested by Medicare contractors, and is requested of providers or suppliers submitting claims for payment from the Medicare program when data analysis indicates aberrant billing patterns which may present a vulnerability to the Medicare program. *Form Number:* CMS–10168 (OMB#: 0938–0969); *Frequency:* Recordkeeping and Reporting—As requested; *Affected Public:* Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 1,169,683; *Total Annual Responses:* 2,900,000; *Total Annual Hours:* 966,666.

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.

Written comments and recommendations for the proposed information collections must be mailed or faxed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, *Attention:* Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: August 17, 2006.

Michelle Shortt,

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

[FR Doc. E6–14043 Filed 8–24–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5030–N]

Frontier Extended Stay Clinic Demonstration

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

ACTION: Notice.

SUMMARY: This notice informs interested parties of an opportunity to apply for the Frontier Extended Stay Clinic (FESC) demonstration, which is mandated by section 434 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. A FESC is designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care hospitals, or patients who do not need a hospital level of care but need monitoring and observation for limited periods of time.

DATES: Applications will be considered timely if we receive them no later than 5 p.m., Eastern Standard Time (e.s.t), on November 24, 2006.

ADDRESSES: Mail or deliver applications to the following address: Centers for Medicare & Medicaid Services, Attention: Sid Mazumdar, Mail Stop: C4–15–27, 7500 Security Boulevard, Baltimore, MD 21244, *Siddhartha.Mazumdar@cms.hhs.gov*. Fax: 410–786–1048. Because of staff and resource limitations, we cannot accept applications by facsimile (fax) transmission or by e-mail.

FOR FURTHER INFORMATION CONTACT: Sid Mazumdar at (410) 786–6673. Interested parties can obtain the complete application on the CMS Web site at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS061689*. Paper copies can be obtained by writing to Sid Mazumdar at the address listed in the **ADDRESSES** section of this notice.

SUPPLEMENTARY INFORMATION:

I. Background

We have previously developed alternative provider types designed to make available basic acute care and emergency services in remote geographic areas. In response to Congressional mandates, in 1991 we piloted the Montana Medical Assistance Facility (MAF) Demonstration and in 1993 implemented the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) Program. These programs tested the concept of a limited service hospital, including lower required levels of physician and nurse staffing than full service hospitals. In the Balanced Budget Act of 1997, Congress mandated a nationwide program called ''Rural Hospital Flexibility Program'', the purpose of which is the provision of needed acute care services by a new type of provider type known as a ''critical access hospital'' (CAH). CAHs are entities in rural areas that generally provide limited services.

Now under section 434 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) the Congress established ''The Frontier Extended Stay Clinic Demonstration Project,'' to test the feasibility of providing extended stay services to remote frontier areas under Medicare payment and regulations. In remote frontier areas, weather and distance can prevent patients who experience severe injury or illness from obtaining immediate transport to an acute care hospital. In some instances, when patients are unable to be transported, local clinics staffed by physicians or other health professionals may offer observation services until the patient can be transferred or is no longer in need of transport. This type of extended stay service is not currently reimbursed by Medicare, Medicaid, or most third-party payers. For several years, officials in the State of Alaska and several state offices of Rural Health, Primary Care Offices, and Primary Care Associations have explored the development of a new provider type that would enable reimbursement of these services.

In designing the demonstration, the goal is to allow flexibility for these remote clinics to serve the needs of a range of patients for whom transportation to a full-service acute care hospital is problematic. In addition, this demonstration also attempts to ensure safety in clinics that have neither the institutional experience nor the level of technological sophistication of hospitals. As authorized by statute, we are defining requirements for providers to participate in the Frontier Extended Stay Clinic (FESC) demonstration.

Specifically, section 434(a) of the MMA allows waiver of provisions of the Medicare program as are necessary to conduct the demonstration project, under which a FESC is treated as a provider of items and services under the Medicare program. The FESC must be located in a community which is–(1) at least 75 miles away from the nearest acute care hospital, critical access hospital, or (2) is inaccessible by public road. The distance requirement is in relation to the nearest acute care or critical access hospital, regardless of whether patients are generally transferred to that hospital. In addition, we are determining mileage as measured in terms of the shortest distance by road.

We believe the FESC should be designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care hospitals, or patients who do not meet CMS inpatient hospital admission criteria and who need monitoring and observation for a limited period of time. We believe that the FESC should provide extended stay services under circumstances when weather and transportation conditions prevent transfer, but apart from such circumstances when a patient's condition warrants hospitalization, he or she should be transported to an acute care hospital.

According to section 434(e) of the MMA, the FESC demonstration will last for three years. Unless reauthorized, at the end of this period, the FESCs will lose their certification as Medicare providers. Moreover, pursuant to section 434(d)(2) of the MMA, the demonstration is to be budget neutral.

II. Provisions of the Notice

A. Eligible Organizations

Potentially qualifying applicants are currently operational primary care clinics, including clinics operated by the Indian Health Service or tribal authorities. Other clinics may be eligible