executive, physician, and clinical engagement. Hospitals leaders will take the HLQAT instrument via Web-based technology. This function will be carried out in conjunction with CMS and the Quality Improvement Organization (QIO) 9th Scope of Work (SOW), to convey the importance of this effort in relation to Medicare and other public priorities. This administration of the HLQAT seeks responses from approximately a dozen leaders in each hospital, including physicians (*e.g.*, CEO, CMO), board members, director-level, and mid-level clinical managers—these responses can provide a multi-level representation of hospital leadership showing its commitment to institutional change. *Form Number:* CMS–10272 (OMB# 0938–New); *Frequency:* Occasionally; *Affected Public:* Private Sector—Business or Other for-profits; *Number of Respondents:* 18,000; *Total Annual Responses:* 36,000; *Total Annual Hours:* 44,820.

4. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Emergency and Non-Emergency Ambulance Transports and Beneficiary Signature Requirements in 42 CFR 424.36(b); *Use:* In the CY 2008 Physician Fee Schedule (PFS) final rule with comment period, we created an additional exception to the beneficiary signature requirements in § 424.36(b) for emergency ambulance transports (72 FR 66406). The exception allows ambulance providers and suppliers to sign the claim on behalf of the beneficiary, at the time of transport, provided that certain documentation requirements are met. Following publication of the CY 2008 PFS final rule with comment period, ambulance provider and supplier stakeholders requested that we extend the exception in § 424.36(b)(6) to non-emergency ambulance transports, in instances where the beneficiary is physically or mentally incapable of signing the claim form.

The current submission of this information collection request relates to the collection of documentation pertaining to non-emergency ambulance transports. In addition, we are updating the collection of information that relates to the collection of documentation pertaining to emergency ambulance transports. *Form Number:* CMS–10242 (OMB# 0938–1049); *Frequency:* Occasionally; *Affected Public:* Private Sector—Business or Other for-profits and Not-for-profit institutions; *Number of Respondents:* 9,000; *Total Annual Responses:* 13,185,835; *Total Annual Hours:* 1,098,819.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site 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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by *December 2, 2008*.

1. *Electronically*. You may submit your comments electronically to *http://www.regulations.gov*. Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address:

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number _____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: September 26, 2008.

Michelle Shortt,

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

[FR Doc. E8–23414 Filed 10–2–08; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10261, CMS–10182, CMS–10166 and CMS–10150]

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; *Title of Information Collection:* Part C Medicare Advantage (MA) Reporting Requirements and Supporting Regulations in 42 CFR 422.516 (a); *Use:* CMS has authority to establish reporting requirements for Medicare Advantage Organizations (MAOs) as described in 42 CFR 422.516(a). Under that authority, each MAO must have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information with respect to the cost of its operations, patterns of service utilization, availability, accessibility, and acceptability of its services, developments in the health status of its enrollees, and other matters that CMS may require.

CMS will not require cost plans to comply with the following reporting requirements: Benefit utilization; procedure frequency; and serious reportable adverse events. However, CMS has determined that it is essential that all beneficiaries understand rules and requirements of the Medicare plans which they are being invited to join. Prospective enrollees in cost plans should be furnished accurate information by qualified sales people, consistent with CMS' expectation for prospective enrollees in other play types. Thus, CMS is requiring reporting on certain measures CMS' believes is critical in monitoring cost plans. Additionally, CMS believes that section 1876(i)(1)(D) of the Act, and 42 CFR 417.126(a)(6) permits CMS to require cost plans to report to CMS the data identified as follows: Provider network adequacy; grievances; organization determinations/reconsiderations; employer group plan sponsor; agent training and testing; agent commission structure and plan oversight of agents.

Data collected via Medicare Part C Reporting Requirements will be an integral resource for oversight,

monitoring, compliance and auditing activities necessary to ensure quality provision of the benefits provided by MA plans to enrollees. Refer to the ''Summary of Revisions'' document for a list of the recent collection changes. *Form Number:* CMS–10261 (OMB# 0938–New); *Frequency:* Yearly, Quarterly, and Semi-annually; *Affected Public:* Business or other for-profits; *Number of Respondents:* 718; Total Annual Responses: 12,709; *Total Annual Hours:* 286,944.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Model Creditable Coverage Disclosure Notices; *Use:* Section 1860D–1 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and implementing regulations at 42 CFR 423.56 require that entities that offer prescription drug benefits under any of the types of coverage described in 42 CFR 423.56 (b) provide a disclosure of creditable coverage status to all Medicare Part D eligible individuals covered under the entity's plan informing them whether such coverage meets the actuarial requirements specified in guidelines provided by CMS.

These disclosure notices must be provided to Part D eligible individuals, at minimum, at the following times: (1) Prior to an individual's initial enrollment period for Part D, as described under § 423.38 (a); (2) prior to the effective date of enrollment in the entity's coverage, and upon any change in creditable status; (3) prior to the commencement of the Part D Annual Coordinated Election Period (ACEP) which begins on November 15 of each year, as defined in § 423.38 (b); and (4) upon request by the individual. In an effort to reduce the burden associated with providing these notices, our final regulations allow most entities to provide notices of creditable and non-creditable status with other information materials that these entities distribute to beneficiaries.

This collection has been updated by eliminating the separate Model Personalized Disclosure Notice. CMS has incorporated the personalized information into the Model Creditable Disclosure Notice and the Model Non-Creditable Disclosure Notice for use by the public *Form Number:* CMS–10182 (OMB# 0938–0990); *Frequency:* Yearly and Semi-annually; *Affected Public:* Federal Government, Business or Other For-Profits and Not-for-Profit Institutions, and State, Local or Tribal Governments; *Number of Respondents:* 1,225,173; *Total Annual Responses:* 1,225,173; *Total Annual Hours:* 522,204.

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Payment Error Rate Measurement in Medicaid and the State Children Health Insurance Program (SCHIP); *Use:* The Improper Payments Information Act (IPIA) of 2002 requires CMS to produce national error rates for Medicaid and State Children's Health Insurance Program (SCHIP). To comply with the IPIA, CMS will engage a Federal contractor to produce the error rates in Medicaid and SCHIP.

The States will be requested to submit, at their option, test data which include full claims details to the contractor prior to the quarterly submissions to detect potential problems in the dataset and ensure the quality of the data. These States will be required to submit quarterly claims data to the contractor who will pull a statistically valid random sample, each quarter, by strata, so that medical and data processing reviews can be performed. State-specific error rates will be based on these review results.

CMS needs to collect the claims data, medical policies, and other information from States as well as medical records from providers in order for the contractor to sample and review adjudicated claims in those States selected for review. Based on the reviews, state-specific error rates will be calculated which will serve as the basis for calculating national Medicaid and SCHIP error rates.

This revision of the currently approved collection contains minor revisions to the information collection requirements. There is a 10-hour increase in burden per State per program as part of a new process. Based on the past experience in PERM operation, the adjustment is made to ensure the quality of the data will comply with the data requirement during the measurement. *Form Number:* CMS–10166 (OMB# 0938–0974); *Frequency:* Quarterly, Yearly; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 34; *Total Annual Responses:* 4,080; *Total Annual Hours:* 28,560.

4.*Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Collection of Drug Pricing and Network Pharmacy Data from Medicare Prescription Drug Plans (PDPs and MA–PDs) and Supporting Regulations in 42 CFR 423.48; *Use:* Both stand alone prescription drug plans (PDPs) and Medicare Advantage Prescription Drug (MA–PDs) plans are required to submit drug pricing and pharmacy network data to CMS and these data are made publicly available to people with Medicare through the Medicare Prescription Drug Plan Finder Web tool on *http://www.medicare.gov.* Drug prices vary across a plans pharmacy network based on the contracts that each plan negotiates with each pharmacy or pharmacy chain in their networks. The pharmacy networks can change during the course of the year as new pharmacies open, close, change ownership, or plans negotiate new contracts with pharmacies resulting in different dispensing fees for prescriptions. Drug prices also change frequently due to the daily fluctuation of the Average Wholesale Price (AWP), thus plans increase or decrease their drug prices to reflect these changes. The purpose of the data is to enable prospective and current Medicare beneficiaries to compare, learn, select and enroll in a plan that best meets their needs. The database structure provides the necessary drug pricing and pharmacy network information to accurately communicate plan information in a comparative format. *Form Number:* CMS–10150 (OMB# 0938–0951); *Frequency:* Bi-weekly; *Affected Public:* Business or other for-profits; *Number of Respondents:* 680; *Total Annual Responses:* 17,680; *Total Annual Hours:* 70,720.

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 by the OMB desk officer at the address below, no later than 5 p.m. on*November 3, 2008.*

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: September 26, 2008.

Michelle Shortt,

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

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