many of the questions raised by outdoor users and public health officials, and improve and strengthen evidence-based NPS guidelines for backcountry health and sanitation practices. To gather this information, consent to contact after the conclusion of the backcountry trip will be obtained from an estimated 7,000 backcountry users 18 years of age or older when they present to the Yellowstone National Park's permit offices prior to entering the backcountry. A questionnaire (in either Internet-based or paper-based format) will then be offered to an estimated 5,600 backcountry users who consent to be contacted. Participants will be asked about their health (before, during and after backcountry travel), water consumption, water preparation habits, food consumption, food preparation habits, sanitation practices, recreational water use, animal exposure, and demographics.

This study is the beginning of what will be an ongoing effort to improve the scientific basis of NPS recommendations and policies related to protecting human health in the backcountry. This effort seeks to begin to identify disease transmission pathways and assess disease and injury risks associated with specific activities, choices, and behaviors of backcountry visitors, such as water purification, sanitation practices, and hygiene. Thoroughly understanding transmission pathways and the interactions of agent, environment, and host will enable the NPS to effectively and efficiently improve visitor protection efforts.

There will be no cost to or remuneration of respondents other than their time. Their participation is voluntary and there will be no penalty for non-participation.

Estimate of Annualized Burden Table

Respondents	Form name	Number of respondents	Number responses per respondent	Hrs/response (in hours)	Total response burden hours
Backcountry Users of Yellowstone Park ...	Consent to Further Contact	7000	1	2/60	233
	Web-Based Questionnaire	5600	1	15/60	1400
	Total	....	....	....	1633

Dated: October 21, 2005.

Betsey Dunaway,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–0021, CMS–838, CMS–10134, CMS–R–137, CMS–R–257, CMS–29/CMS–30, CMS–10150, CMS–381, CMS–10161, CMS–10162, and 10136]

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:* Withholding Medicare Payments to Recover Medicaid Overpayments and Supporting Regulations in 42 CFR 447.31; *Use:* Overpayments may occur in either the Medicare and Medicaid program, at times resulting in a situation where an institution or person that provides services owes a repayment to one program while still receiving reimbursement from the other. Certain Medicaid providers which are subject to offsets for the collection of Medicaid overpayments may terminate or substantially reduce their participation in Medicaid, leaving the State Medicaid Agency unable to recover the amounts due. These information collection requirements give CMS the authority to recover Medicaid overpayments by offsetting payments due to a provider under the program. *Form Number:* CMS–R–0021 (OMB #0938–0287); *Frequency:* Reporting—On occasion; *Affected Public:* State, Local or Tribal Government; *Number of Respondents:* 54; *Total Annual Responses:* 27; *Total Annual Hours:* 81.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Credit Balance Reporting Requirements and Supporting Regulations in 42 CFR 405.371, 405.378, and 413.20; *Form Number:* CMS–838 (OMB #0938–0600); *Use:* Section 1815(a) of the Social Security Act authorizes the Secretary to request information from providers which is necessary to properly administer the Medicare program. Quarterly credit balance reporting is needed to monitor and control the identification and timely collection of improper payments. The reporting requirements provide CMS with the authority to impose sanctions such as the suspension of program payments in accordance with 42 CFR 413.20(e) and 405.371 if providers do not report credit balances on a timely basis. Furthermore, once a credit balance has been identified on a CMS–838 form and demand for payment is made, CMS has the authority to charge interest if the amount is not repaid within 30 days in accordance with 42 CFR 405.378. The collection of credit balance information is needed to ensure that millions of dollars in improper program payments are collected. Approximately 48,300 health care providers will be required to submit a quarterly credit balance report that identifies the amount of improper payments they received that are due to Medicare. The intermediaries will monitor the reports to ensure these funds are collected; *Frequency:* Quarterly; *Affected Public:* Not-for-profit institutions, Business or other for-profit; *Number of Respondents:* 48,300; *Total Annual Responses:* 193,200; *Total Annual Hours:* 579,600.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Physician Group Practice (PGP) Standardized Ambulatory Care Quality Measure Collection Initiative; *Use:* The Benefits Improvement & Protection Act of 2000 mandated the PGP Demonstration and gave the Secretary discretion to use quality measures to assess physician performance in order to reward physicians for improvements in the quality and efficiency of health care. This demonstration is intended to strengthen the Medicare program by offering innovative models to people on Medicare that improve quality and access and lower costs. As a result, Medicare beneficiaries will directly benefit from these innovative models. The demonstration represents the first pay for performance project for physician group practices and will enable comparisons across groups and geography; *Form Number:* CMS–10134 (OMB #0938–0942); *Frequency:* Annually; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 10; *Total Annual Responses:* 10; *Total Annual Hours:* 790.

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Internal Revenue Service/Social Security Administration/Centers for Medicare and Medicaid Services Data Match and Supporting Regulations in 42 CFR 411.20–491.206; *Form Number:* CMS–R–137 (OMB #0938–0565); *Use:* The Data Match project and information collection activity provides a ''check and balance'' against the Medicare program relying solely on a single information collection system. It gives CMS the opportunity to pursue collection of identified mistaken payments (within legal constraints) and to update incorrect status indicators to prevent further incorrect suspensions or mistaken payment or denial. Employers identified through a match of IRS, SSA, and Medicare records will be contacted concerning group health plan coverage of identified individuals to ensure compliance with Medicare Secondary Payer provisions, in accordance with the Medicare statute found at 42 U.S.C. 1395y(b); *Frequency:* Reporting—Annually; *Affected Public:* Business or other for-profit, Not-for-profit institutions, Farms, Federal Government, State, Local or Tribal Government; *Number of Respondents:* 341,065; *Total Annual Responses:* 341,065; *Total Annual Hours:* 1,986,810.

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Advantage Disenrollment Form to original Medicare; *Form Number:* CMS–R–257 (OMB #0938–0741); *Use:* Section 4001 of the Balanced Budget Act of 1997 amended the Social Security Act to add Section 1851, including 1851(c)(1) which required the establishment of a procedure and form to make and change Medicare Advantage elections, which include disenrollment. The disenrollment form provides beneficiaries an option to submit a disenrollment to a neutral third party, process the disenrollment action as a change of election and to elicit the reasons for disenrollment in order to discern and report disenrollment rates; *Frequency:* On occasion and Other (one-time only); *Affected Public:* Individuals or Households, Business or other for-profit, Not-for-profit institutions, and Federal Government; *Number of Respondents:* 50,000; *Total Annual Responses:* 50,000; *Total Annual Hours:* 3,300.

6. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Request for Certification as Rural Health Clinic and Rural Health Clinic Survey Report Form and Supporting Regulations in 42 CFR 491.1–491.11; *Form Number:* CMS–29 and CMS–30 (OMB #0938–0074); *Use:* The form CMS–29 is utilized as an application to be completed by suppliers of Rural Health Clinic (RHC) services requesting participation in the Medicare/Medicaid programs. This form initiates the process of obtaining a decision as to whether the conditions for certification are met as a supplier of RHC services. It also promotes data reduction or introduction to and retrieval from the Online Survey and Certification and Reporting System (OSCAR) by CMS Regional Offices (RO). The Form CMS–30 is an instrument used by the State survey agency to record data collected in order to determine RHC compliance with individual conditions of participation and to report it to the Federal government. The form is primarily a coding worksheet designed to facilitate data reduction (keypunching) and retrieval into OSCAR at the CMS ROs. The form includes basic information on compliance (i.e., met, not met and explanatory statements) and does not require any descriptive information regarding the survey activity itself; *Frequency:* Reporting—Annually; *Affected Public:* State, Local or Tribal Government; *Number of Respondents:* 698; *Total Annual Responses:* 698; *Total Annual Hours:* 1,222.

7. *Type of Information Collection Request:* Extension 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; *Form Number:* CMS–10150 (OMB #0938–0951); *Use:* Both stand alone prescription drug plans (PDPs) and Medicare Advantage Prescription Drug (MA–PDs) plans will be required to submit drug pricing and pharmacy network data to CMS. These data will be made publicly available to Medicare beneficiaries through the new Medicare prescription drug plan finder tool that will be launched in the fall of 2005 on *http://www.medicare.gov*. The purpose of the data is to enable beneficiaries to compare, learn, select and enroll in a plan that best meets their needs; *Frequency:* Reporting—Weekly; *Affected Public:* Business or other for-profit; *Number of Respondents:* 350; *Total Annual Responses:* 18,200; *Total Annual Hours:* 36,400.

8. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Identification of Extension Units of Outpatient Physical Therapy/Outpatient Speech Pathology (OPT/OSP) Providers and Supporting Regulations in 42 CFR Sections 485.701–485.729; *Form Number:* CMS–381 (OMB #0938–0273); *Use:* Medicare provides OPT/OSP providers to be surveyed to determine compliance with Federal regulations. All locations where OPT/OSP providers furnish services must meet these requirements. The CMS–381 is the form used to identify all the OPT/OSP locations. *Frequency:* Reporting—Annually; *Affected Public:* Business or other for-profit; *Number of Respondents:* 2960; *Total Annual Responses:* 2960; *Total Annual Hours:* 740.

9. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* New Freedom Initiative—Web-based Reporting System for Grantees; *Form Number:* CMS–10161 (OMB #0938–NEW); *Use:* CMS currently awards competitive grants to States and other eligible entities for the purpose of designing and implementing effective and enduring improvements in community-based long-term services and supporting systems. We currently require grantees to report quarterly, semi-annual, and or annually, depending on the grant type. CMS requires the information obtained

through web-based grantee reporting for two reasons: (1) In order to effectively monitor the grants, and; (2) to report to Congress and other interested stakeholders the progress and obstacles experienced by the grantees. The grantees are the respondents to the web-based reporting system; *Frequency:* Reporting—Quarterly, Semi-annually, and Annually; *Affected Public:* State, Local or Tribal Government and Not-for-profit institutions; *Number of Respondents:* 298; *Total Annual Responses:* 836; *Total Annual Hours:* 6,440.

10. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Medicare Care Improvement Survey; *Use:* The purpose of this beneficiary survey is to obtain information about beneficiary behavioral change, physical functioning and satisfaction with the Chronic Care Improvement (CCI) programs. Legislation requires that all of the aforementioned data elements be collected, as they provide information that is critical to the decision-making process as it pertains to the expansion of the pilot programs. The chronic care improvement programs are to be designed to incorporate relevant features from private sector programs but also be sufficiently flexible to adapt to the unique needs of their Medicare populations. This survey is required to support the legislative mandate to evaluate the Chronic Care Improvement Programs. Beneficiary participation in the CCI–I program will be voluntary and will not change the scope, duration or amount of Medicare fee-for-service (FFS) benefits currently received by FFS Medicare beneficiaries; *Form Number:* CMS–10162 (OMB #0938–NEW); *Frequency:* Reporting—On occasion; *Affected Public:* Individuals or Households; *Number of Respondents:* 9,449; *Total Annual Responses:* 9,449; *Total Annual Hours:* 2,636.

11. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Care Management Performance (MCMP) Demonstration—Standardized Ambulatory Care Quality Collection Initiative; *Use:* The MCMP Demonstration was authorized by Section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This project requires the Secretary to establish a pay-for-performance 3-year pilot with physicians to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients. This demonstration represents the first pay for performance project fostering the adoption of health information technology in small physician group practices and will enable a test of the concept to improve the quality and efficiency of care in Fee-for-Service Medicare; *Form Number:* CMS–10136 (OMB #0938–0941); *Frequency:* Annually; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 800; *Total Annual Responses:* 800; *Total Annual Hours:* 19,200.

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 and (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 28, 2005. OMB Human Resources and Housing Branch, Attention: CMS Desk Officer, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: October 21, 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 & Medicaid Services

[CMS–1316–N]

Medicare Program; Meeting of the Practicing Physicians Advisory Council, December 5, 2005

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

ACTION: Notice.

SUMMARY: This notice announces a quarterly meeting of the Practicing Physicians Advisory Council (the Council). The Council will meet to discuss certain proposed changes in regulations and carrier manual instructions related to physicians' services, as identified by the Secretary of Health and Human Services (the Secretary). This meeting is open to the public.

DATES: The Council meeting is scheduled for Monday, December 5, 2005, from 8:30 a.m. until 3:30 p.m. e.s.t.

ADDRESSES: The meeting will be held in Room 705A 7th floor, in the Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

MEETING REGISTRATION: Persons wishing to attend this meeting must register by contacting Kelly Buchanan, the Designated Federal Official (DFO) by e-mail at *PPAC@cms.hhs.gov* or by telephone at (410) 786–6132, at least 72 hours in advance of the meeting. This meeting will be held in a Federal Government Building, Hubert H. Humphrey Building, and persons attending the meeting will be required to show a photographic identification, preferably a valid driver's license, and will be listed on an approved security list before persons are permitted entrance. Persons not registered in advance will not be permitted into the Hubert H. Humphrey Building and will not be permitted to attend the Council meeting.

FOR FURTHER INFORMATION CONTACT: Kelly Buchanan, (410)786–6132, or e-mail *PPAC@cms.hhs.gov.* News media representatives must contact the CMS Press Office, (202) 690–6145. Please refer to the CMS Advisory Committees' Information Line (1–877–449–5659 toll free), (410)786–9379 local) or the Internet at *http://www.cms.hhs.gov/faca/ppac/default.asp* for additional information and updates on committee activities.

SUPPLEMENTARY INFORMATION: In accordance with section 10(a) of the Federal Advisory Committee Act, this notice announces the quarterly meeting of the Practicing Physicians Advisory Council (the Council). The Secretary is mandated by section 1868(a)(1) of the Social Security Act (the Act) to appoint a Practicing Physicians Advisory Council based on nominations submitted by medical organizations representing physicians. The Council meets quarterly to discuss certain proposed changes in regulations and carrier manual instructions related to physicians' services, as identified by the Secretary. To the extent feasible and consistent with statutory deadlines, the Council's consultation must occur before **Federal Register** publication of the proposed changes. The Council submits an annual report on its recommendations to the Secretary and the Administrator of the Centers for Medicare & Medicaid Services (CMS) not later than December 31 of each year.