

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Hospital Chief Medical Officer	Hospital Induction (NHAMCS-101)	470	1	55/60
Ancillary Service Executive	Ambulatory Unit Induction (NHAMCS-101/U)	845	2	1
Physician/Registered Nurse/Medical Record Clerk.	ED Patient Record form NHAMCS-100 (ED)]	220	100	7/60
Medical Record Clerk	Pulling and re-filing Patient Records	393	132	1/60
Physician/Registered Nurse/Medical Record Clerk.	OPD Patient Record form [NHAMCS-100 (OPD)].	125	200	6/60
Physician/Phys. Asst./Nurse Practitioner/Nurse Midwife.	Cervical Cancer Screening Supplement (CCSS) (NHAMCS-906).	250	1	15/60
Physician/Registered Nurse/Medical Record Clerk.	ASC Patient Record form NHAMCS-100 (ASC).	107	100	6/60

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-08-0212]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 639-5960 or send an e-mail to omb@cdc.gov. Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395-6974. Written comments should be received within 30 days of this notice.

Proposed Project

National Hospital Discharge Survey—Revision—The National Hospital Discharge Survey (NHDS) (OMB# 0920-0212), National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Section 306 of the Public Health Service (PHS) Act (42 U.S.C. 242k), as amended, authorizes that the Secretary of Health and Human Services (DHHS), acting through NCHS, shall collect statistics on the extent and nature of illness and disability of the population of the United States. This three-year

clearance request includes the data collection in 2008 and 2009 using the current NHDS design; a pretest of a new design; and data collection for 2010 and 2011 of the survey using the new design.

Current NHDS

The National Hospital Discharge Survey (NHDS) has been conducted continuously by the National Center for Health Statistics, CDC, since 1965. It is the principal source of data on inpatient utilization of short-stay, non-Federal hospitals and is the principal annual source of nationally representative estimates on the characteristics of discharges, the lengths of stay, diagnoses, surgical and non-surgical procedures, and the patterns of use of care in hospitals in various regions of the country. It is the benchmark against which special programmatic data sources are measured. The data items collected are the basic core of the variables contained in the Uniform Hospital Discharge Data Set (UHDDS) in addition to several variables (admission source and type, admitting diagnosis and present on admission indicators) which are identical to those needed for billing of inpatient services for Medicare patients. In the current survey, data are obtained in one of three ways: Abstracted by hospital staff; abstracted by Bureau of the Census Staff under an interagency agreement; and provided in electronic format. Due to budgetary constraints, the number of hospitals and the number of discharges for the 2008 and 2009 NHDS data collections will decrease by approximately 50% from previous years.

Redesigned NHDS

Although the current NHDS is still fulfilling its intended functions, it is based on concepts from the health care delivery system, as well as the hospital and patient universes, of previous

decades. It has become clear that a redesign of the NHDS that provides greater depth of information is necessary.

In 2008, a sample of 30 hospitals will be selected for a pretest. These hospitals will not be a probability sample, but instead will be intentionally selected to include hospitals of differing size, location and other characteristics related to their service and patient clientele.

In 2010, a redesigned NHDS will be implemented and will consist of a completely new sample of approximately 240 hospitals. The redesigned NHDS will use a modified two stage design. The first stage sampling will be hospitals. The second stage of sampling will be discharges. A stratified, random sample of 120 discharges is targeted within each hospital. In the redesigned survey all data will be abstracted by trained health care staff under contract. All data will be obtained from hospital records and charts and computer systems.

The current data items will be collected with significant additional details. Patient level data items to be collected include personal identifiers such as social security number (last 4 digits), name and medical record number; clinical laboratory results such as hematocrit and white blood cell count; and financial billing and record data. The survey includes detailed questions for three modules: Acute myocardial infarction; infectious disease; and end of life issues. Facility level data items include demographic information, clinical capabilities, and financial information.

Users of NHDS data include, but are not limited to the CDC; the Congressional Research Office; the Office of the Assistant Secretary for Planning and Evaluation (ASPE); American Health Care Association, Centers for Medicare and Medicaid

Services (CMS), and Bureau of the Census. Data collected through the NHDS are essential for evaluating health status of the population, for the planning of programs and policy to elevate the health status of the Nation, for studying morbidity trends, and for research activities in the health field.

NHDS data have been used extensively in the development and monitoring of goals for the Year 2000 and 2010 Healthy People Objectives. In addition, NHDS data provide annual updates for numerous tables in the Congressionally-mandated NCHS report, *Health, United States*. Other users of these data include

universities, research organizations, foundations, and a variety of users in the print media. There is no cost to respondents other than their time to participate. The total estimated annualized burden hours are 5,591.

TABLE 1—ESTIMATED ANNUALIZED BURDEN HOURS

Type of data collection	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Current NHDS Primary Procedure Hospitals Sample Listing Sheet	13	12	25/60
Current NHDS Primary Procedure Hospitals Medical Abstract Form	13	250	5/60
Current NHDS Primary Procedure Hospitals Transmittal Notice	13	12	1/60
Current NHDS Alternate Procedure Hospitals locating medical records	41	250	1/60
Current NHDS In-House Tape or Printout Hospital—computer programming and submission	29	12	13/60
Current NHDS Hospital Interview Questionnaire	10	1	2
Redesigned pretest Survey presentation to hospital	10	1	1
Redesigned pretest Facility questionnaire	10	1	4
Redesigned pretest Sample discharges within hospital, obtain UB-04 & payment data	10	10	14/60
Redesigned pretest Verify sampling & reabstract medical records	2	10	14/60
Redesign pretest Debrief hospital staff	10	1	1
Redesigned 2010–2011 Survey presentation to hospital	80	1	1
Redesigned 2010–2011 Facility questionnaire	80	1	4
Redesigned 2010–2011 Sample discharges within hospital, obtain UB-04 & payment data	160	120	14/60
Redesigned 2010–2011 Verify sampling & re-abstract medical records	3	25	14/60

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10265]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

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:* New collection; *Title of Information Collection:* Mandatory Insurer Reporting Requirements of Section 111 of the Medicare, Medicaid and SCHIP Act of 2007 (MMSEA) (Pub. L. 110–173); *Use:* Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (Pub. L. 110–173) amends the Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)) to provide for mandatory reporting by group health plan arrangements and by liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws and plans. The law provides that, notwithstanding any other provision of law, the Secretary of Health and Human Services may implement this provision by program instruction or otherwise. The Secretary has elected not to implement the provision through rulemaking and will implement by publishing instructions on a publicly available Web site and submitting an information collection request to OMB for review and approval of the associated information collection requirements.

Effective January 1, 2009, as required by the MMSEA, an entity serving as an insurer or third party administrator for a group health plan and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary must: (1) Secure from the plan sponsor and plan participants such information as the Secretary may specify to identify situations where the group health plan is a primary plan to Medicare; and (2) report such information to the Secretary in the form and manner (including frequency) specified by the Secretary.

Effective July 1, 2009, as required by the MMSEA, “applicable plans,” must: (1) Determine whether a claimant is entitled to Medicare benefits; and, if so, (2) report the identity of such claimant and provide such other information as the Secretary may require to properly coordinate Medicare benefits with respect to such insurance arrangements in the form and manner (including frequency) as the Secretary may specify after the claim is resolved through a settlement, judgment, award or other payment (regardless of whether or not there is a determination or admission of liability). Applicable plan refers to the following laws, plans or other arrangements, including the fiduciary or administrator for such law, plan or arrangement: (1) Liability insurance (including self-insurance); (2) No-fault