

health and nutrition status of the general population. Through the use of questionnaires, physical examinations, and laboratory tests, NHANES studies the relationship between diet, nutrition and health in a representative sample of the United States. NHANES monitors the prevalence of chronic conditions and risk factors related to health such as arthritis, asthma, osteoporosis, infectious diseases, diabetes, high blood pressure, high cholesterol, obesity, smoking, drug and alcohol use, physical activity, environmental exposures, and diet. NHANES data are used to produce national reference data on height,

weight, and nutrient levels in the blood. Results from more recent NHANES can be compared to findings reported from previous surveys to monitor changes in the health of the U.S. population over time. NHANES continues to collect genetic material on a national probability sample for future genetic research aimed at understanding disease susceptibility in the U.S. population. NHANES data users include the U.S. Congress; the World Health Organization; numerous Federal agencies such as the National Institutes of Health, the Environmental Protection Agency, and the United States

Department of Agriculture; private groups such as the American Heart Association; schools of public health; private businesses; individual practitioners; and administrators. NHANES data are used to establish, monitor, and/or evaluate recommended dietary allowances, food fortification policies, environmental exposures, immunization guidelines and health education and disease prevention programs.

There is no cost to respondents other than their time. The total estimated annualized burden hours are 49,626.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
NHANES Respondents	18,813	1	2
Special study/pretest participants	4,000	1	3

Dated: October 17, 2008.
Maryam I. Daneshvar,
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-10, CMS-4040 and 4040SP, CMS-10130A and 10130B, and CMS-R-257]

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:* BPD-718: Advance Directives (Medicare and Medicaid); *Use:* Steps have been taken, at both the Federal and State level, to afford greater opportunity for the individual to participate in decisions made concerning the medical treatment to be received by an adult patient in the event that the patient is unable to communicate to others a preference about medical treatment. The individual may make his preference known through the use of an advance directive, which is a written instruction prepared in advance, such as a living will or durable power of attorney. This information is documented in a prominent part of the individual's medical record. Advance directives as described in the Patient Self-Determination Act have increased the individual's control over decisions concerning medical treatment. The advance directives requirement was enacted because Congress wanted individuals to know that they have a right to make health care decisions and to refuse treatment even when they are unable to communicate. Sections 4206 of OBRA '90 defined an advance directive as a written instruction recognized under State law relating to the provision of health care when an

individual is incapacitated (those persons unable to communicate their wishes regarding medical treatment). All States have enacted legislation defining a patient's right to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Participating hospitals, skilled nursing facilities/nursing facilities, home health agencies, providers of home health care, hospices, religious nonmedical health care institutions, and prepaid or eligible organizations (including Health Care Prepayment Plans (HCPPs) and Medicare Advantage Organizations (MAOs) such as Coordinated Care Plans, Demonstration Projects, Chronic Care Demonstration Projects, Program of All Inclusive Care for the Elderly, Private Fee for Service, and Medical Savings Accounts) must provide written information, at explicit time frames, to all adult individuals about: (a) The right to accept or refuse medical or surgical treatments; (b) the right to formulate an advance directive; (c) a description of applicable State law (provided by the State); and (d) the provider's or organization's policies and procedures for implementing an advance directive. *Form Number:* CMS-R-10 (OMB# 0938-0610); *Frequency:* Yearly; *Affected Public:* Business or other for-profits; *Number of Respondents:* 35,484; *Total Annual Responses:* 19,870,000; *Total Annual Hours:* 927,550.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of*

Information Collection: Request for Enrollment in Supplementary Medical Insurance; *Use:* Section 1836 of the Social Security Act and 42 CFR 407.10 provide the eligibility requirements for enrollment in Supplementary Medical Insurance (Part B) for individuals age 65 and older who are not entitled to premium-free Hospital Insurance (Part A). The form CMS-4040 is used to establish entitlement to Part B by individuals ineligible for Part A under Title XVIII of the Social Security Act. *Form Number:* CMS-4040 and 4040SP (OMB# 0938-0245); *Frequency:* Once; *Affected Public:* Individuals and households; *Number of Respondents:* 10,000; *Total Annual Responses:* 10,000; *Total Annual Hours:* 2,500.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA): "Section 1011 Provider Payment Determination" and "Request for section 1011 Hospital On-Call Payments to Physicians" Forms; *Use:* Section 1011 of the MMA requires that the Secretary establish a process under which eligible providers (certain hospitals, physicians and ambulance providers) may request payment for (claim) their otherwise unreimbursed costs of providing eligible services. The Secretary must make quarterly payments directly to such providers. The Secretary must also implement measures to ensure that inappropriate, excessive, or fraudulent payments are not made under section 1011, including certification by providers of the accuracy of their requests for payment. The Section 1011 Provider Payment Determination and the Request for section 1011 Hospital On-Call Payments to Physicians forms have been established to address the statutory requirements. *Form Number:* CMS-10130A and 10130B (OMB# 0938-0952); *Frequency:* Daily, Weekly, Monthly, Quarterly and Yearly; *Affected Public:* Business or Other For-Profits and Not-for-Profit Institutions; *Number of Respondents:* 12,037; *Total Annual Responses:* 300,148; *Total Annual Hours:* 75,007.

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Advantage & Part D Disenrollment Requests Collected Through 1-800-MEDICARE; *Use:* Section 4001 of the Balanced Budget Act of 1997 amended the Social Security Act to add section

1851(c)(1), through which Medicare Advantage elections are made and changed. Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act amended the Social Security Act to include section 1860D-1(b)(1), through which Medicare Prescription Drug Plan enrollments are made and changed. The disenrollment process offered at 1-800-MEDICARE provides beneficiaries with the option of submitting a disenrollment request to a neutral third party, who then processes the disenrollment action as a change of enrollment.

The collection updates: 1. Continue to allow Medicare beneficiaries to disenroll from Medicare Advantage plans by calling CMS' toll-free call center; 2. Continue to allow Medicare beneficiaries enrolled in Medicare Prescription Drug (Part D) Plans to request disenrollment from Medicare Prescription Drug Plans, and 3. Retire the CMS-R-257 Medicare Advantage Disenrollment Form given limited (zero) requests for the paper form since 2005. The information collected in the disenrollment process will be used to update the Medicare beneficiary's Health Insurance Master Record System in order to disenroll the beneficiary from a Medicare Advantage managed care plan or a Medicare prescription drug plan on a timely basis. *Form Number:* CMS-R-257 (OMB# 0938-0741); *Frequency:* Occasionally; *Affected Public:* Individuals or households; *Number of Respondents:* 117,000; *Total Annual Responses:* 117,000; *Total Annual Hours:* 19,539.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access the 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 24, 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: October 16, 2008.

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

[Document Identifier: CMS-10036, CMS-10161 and CMS-1880/1882]

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:* Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) data and Supporting Regulations in 42 CFR 412 Subpart P; *Use:* This instrument with its supporting manual is needed to permit the Secretary of Health and Human Services, and CMS, to implement section 1886(j) of the Social Security Act. The statute requires the Secretary to develop a prospective payment system for inpatient rehabilitation facility services for the Medicare program. This payment system is to cover both operating and capital costs for inpatient rehabilitation facility services. It applies to inpatient rehabilitation hospitals as well as rehabilitation units of acute care hospitals. CMS implemented the