then send reports to CDC using de-identified data. It is from these reports that CDC is able to determine funding levels.

In addition to reporting child blood lead levels, many laboratories also report adult blood lead levels. Thus, this OMB request would also like to include the Adult Blood Lead Epidemiology and Surveillance Program (ABLES). The ABLES Program is a state-based surveillance system under which participating States provide information to CDC's National Institute for Occupational Safety and Health (NIOSH) on laboratory reported blood lead levels among adults. For all adults (16 and older) the State will provide data on all laboratory reports when the adult's blood lead level is equal to or greater than 25 mcg/dl. These data are to be consolidated into a single data submission by task time periods.

The ABLES program ultimately aims to collect the complete list of variables for all blood lead tests, including blood lead levels less than 25 mcg/dl, and urges all States to progressively supply this information as it becomes available. All data submissions must be delivered in the supplied format providing a field for 20 variables, even if some variables have no data available at the time.

The use of both Childhood Lead Surveillance System and the ABLES Program will allow us to systematically track pockets of exposure to lead. It will also allow us to fully understand exposure potential and ways in which to prevent future sources of lead poisoning. Both systems are invaluable and will no doubt help us as we continue our stride in the elimination of lead poisoning in our nation.

There is no cost to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN TABLE

Respondents	Number of respondents	Number of response per respondent	Average burden per response (in hrs.)	Total burden hours
State and Local Health Departments for Child Surveillance	42	4	2	336
State and Local Health Departments for Adult Surveillance	40	4	2	320
Total				656

Dated: February 6, 2008.

Maryam I. Daneshvar,

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

[FR Doc. E8–2836 Filed 2–14–08; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10242, CMS–10165, CMS–10251, CMS–R–218 and CMS–10252]

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:* Revisions to Payment Policies Under the Physician Fee Schedule, Other Changes to Payment Under Part B, and Revisions to Payment Policies for Ambulance Services for CY 2008 (42 CFR 424.36—Signature Requirements); *Use:* Section 42 CFR 424.33(a)(3) states that all claims must be signed by the beneficiary or the beneficiary's representative (in accordance with 42 CFR 424.36(b)). Section 42 CFR 424.36(a) states that the beneficiary's signature is required on a claim unless the beneficiary has died or the provisions of 424.36(b), (c), or (d) apply. The statutory authority requiring a beneficiary's signature on a claim submitted by a provider is located in section 1835(a) and in 1814(a) of the Social Security Act (the Act), for Part B and Part A services, respectively. The authority requiring a beneficiary's signature for supplier claims is implicit in sections 1842(b)(3)(B)(ii) and in 1848(g)(4) of the Act. Because it is very difficult to obtain a beneficiary's signature (or the signature of a person authorized to sign on behalf of the beneficiary) on a claim when the beneficiary is being transported by ambulance in emergency situations, CMS is proposing that, for emergency ambulance transport services, an ambulance provider or supplier may submit the claim without a beneficiary's signature, as long as certain documentation requirements are met. The information collected will be used by CMS contractors (both, fiscal intermediaries and carriers) that process and pay emergency ambulance transport claims. *Form Number:* CMS–10242 (OMB#: 0938–New); *Frequency:* Reporting: Hourly, Daily, Weekly, Monthly and Yearly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 9,000; *Total Annual Responses:* 6,500,000; *Total Annual Hours:* 541,667.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Electronic Health Record; *Use:* The purpose of this demonstration project is to reward the delivery of high-quality care supported by the adoption and use of electronic health records in small to medium-sized primary care physician practices. While this is separate and distinct from the Medicare Care Management Performance (MCMP) Demonstration, it expands upon the foundation created by the MCMP Demonstration, which was mandated by Section 649 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The electronic health record demonstration will be operational for a 5-year period and will be operated

under section 402 demonstration waiver authority. The information to be obtained as part of the application form is necessary to document basic information for physician practices that intend to participate in this demonstration initiative. *Form Number:* CMS–10165 (OMB#: 0938–0965); *Frequency: Once; Affected Public:* Private sector—Business or other for-profit; *Number of Respondents:* 2400; *Total Annual Responses:* 2400; *Total Annual Hours:* 520.

3. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* State Plan Pre-print for Integrated Medicare and Medicaid Programs; *Use:* Information submitted via the State Plan Amendment (SPA) pre-print will be used by CMS Central and Regional Offices to analyze a State's proposal to implement integrated Medicare and Medicaid programs. The pre-print is an optional document for use by States to highlight the arrangements between a State and Medicare Advantage Special Needs Plans that are also providing Medicaid services. State Medicaid Agencies will complete the SPA pre-print and submit it to CMS for a comprehensive analysis. The pre-print provides the opportunity for States to confirm that their integrated care model complies with both Federal statutory and regulatory requirements. The pre-print contains assurances, check-off items, and areas for States to describe policies and procedures for subjects such as enrollment, marketing and quality assurance. Based on comments received during the 60-day comment period, both the instructions and pre-print have been revised. *Form Numbers:* CMS–10251 (OMB#: 0938–NEW); *Frequency:* Reporting—Once; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 30; *Total Annual Hours:* 600.

4. *Type of Information Collection Request:* Extension of currently approved collection; *Title of Information Collection:* Information Collection Requirements Contained in 45 CFR Part 162; HIPAA Standards for Electronic Transactions; *Use:* This submission contains information collection requirements in HCFA–0149–F, CMS–0003–P, CMS–0005–P, and CMS–003/005–F. This collection establishes standards for electronic transactions and for code sets to be used in those transactions. The collection standardizes the approximately 400 formats of electronic health care claims used in the United States. The use of these standards significantly reduces the administrative burden associated with paper documents, lowers operating costs, and improves data quality for health care providers and health plans; *Form Number:* CMS–R–218 (OMB# 0938–0866); *Frequency:* On occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 3,400,000; *Total Annual Responses:* 3,400,000; *Total Annual Hours:* 1.

5. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Certificate of Destruction for Data Acquired from the Centers for Medicare and Medicaid Services; *Use:* The Certificate of Destruction will be used by recipients of CMS data to certify that they have destroyed the data they have received through a CMS Data Use Agreement (DUA). The DUA requires the destruction of the data at the completion of the project/expiration of the DUA. The DUA addresses the conditions under which CMS will disclose and the User will maintain CMS data that are protected by the Privacy Act of 1974, § 552a and the Health Insurance Portability Accountability Act of 1996. CMS has developed policies and procedures for such disclosures that are based on the Privacy Act and the Health Insurance Portability Act (HIPAA). The Certificate of Destruction is required to close out the DUA and to ensure the data are destroyed and not used for another purpose. *Form Number:* CMS–10252 (OMB# 0938-New); *Frequency:* On occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 500; *Total Annual Responses:* 500; *Total Annual Hours:* 84.

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 *March 17, 2008.*

OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: February 8, 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–R–267]

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:* Medicare Advantage Program Requirements Referenced in 42 CFR part 422; *Use:* The information collection requirements are mandated by 42 CFR part 422. Section 4001 of the Balanced Budget Act of 1997 (BBA) added sections 1851 through 1859 to the Social Security Act to establish this program. The Medicare, Medicaid, and SCHIP Benefits Improvement Act and Protection Act of 2000, also added new requirements in addition to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Medicare Advantage (MA) organizations (formerly M+C organizations) and potential MA organizations (applicants) use the information discussed to comply with the eligibility requirements and the MA