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 un-reimbursed 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.

[FR Doc. E8–25204 Filed 10–23–08; 8:45 am]

BILLING CODE 4120–01–P

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

inpatient rehabilitation facility prospective payment system for cost reporting periods beginning on or after January 1, 2002. *Form Number:* CMS–10036 (OMB# 0938–0842); *Frequency:* Annually; *Affected Public:* Business or other for-profit, Not-for-profit institutions, State, Local or Tribal Governments and Federal Government; *Number of Respondents:* 1202; *Total Annual Responses:* 396,660; *Total Annual Hours:* 337,161.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* New Freedom Initiative—Web-based Reporting System for Grantees; *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 support systems. CMS currently requires grantees to report on a quarterly, semi-annual, and or annual basis depending upon 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. *Form Number:* CMS–10161 (OMB# 0938–0979); *Frequency:* annually, semi-annually, and quarterly; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 171; *Total Annual Responses:* 428; *Total Annual Hours:* 3,764.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Request for Certification as a Supplier of Portable X-ray Services and Portable X-ray Survey Report Form under the Medicare/Medicaid Program and Supporting Regulations in 42 CFR 486.100–486.110; *Use:* The Medicare program requires portable X-ray suppliers to be surveyed for health and safety standards. The CMS–1882 is the survey form that records survey results. The CMS–1880 is used by the surveyor to determine if a portable X-ray applicant meets the eligibility requirements. *Form Numbers:* CMS–1880/1882 (OMB# 0938–0027); *Frequency:* Occasionally; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 544; *Total Annual Responses:* 68; *Total Annual Hours:* 4,760.

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 23, 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: October 16, 2008.

Michelle Shortt,

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

[FR Doc. E8–25206 Filed 10–23–08; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2896–FN]

Medicare and Medicaid Programs; Conditional Approval of the Joint Commission's Continued Deeming Authority for Critical Access Hospitals

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

ACTION: Conditional Notice of Approval.

SUMMARY: This notice announces our decision to conditionally approve, with a probationary period, the Joint Commission's request for continued recognition as a national accreditation program for critical access hospitals (CAHs) seeking to participate in the Medicare or Medicaid programs.

DATES: *Effective Date:* This conditional notice of approval is effective November 21, 2008 through November 21, 2011, with a 180-day probationary period through May 20, 2009.

FOR FURTHER INFORMATION CONTACT: Cindy Melanson, (410) 786–0310, Patricia Chmielewski (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a CAH provided certain requirements are met. Sections 1820(c)(2)(B) and 1861(mm) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as a CAH. Under this authority, the minimum requirements that a CAH must meet to participate in Medicare are set forth in regulations at 42 CFR part 485, subpart F (Conditions of Participation: Critical Access Hospitals (CAHs)) which determine the basis and scope of CAH covered services. Conditions for Medicare payment for CAHs can be found at 42 CFR 413.70. Applicable regulations concerning provider agreements are at 42 CFR part 489 (Provider Agreements and Supplier Approval) and those pertaining to facility survey and certification are at part 488, subparts A and B.

A. Verifying Medicare Conditions of Participation

In general, we approve a CAH for participation in the Medicare program if it is participating as a hospital at the time it applies for CAH designation, and it is in compliance with parts 482 (Conditions of Participation for Hospitals) and 485, subpart F (Conditions of Participation: Critical Access Hospital (CAHs)).

For a CAH to enter into a provider agreement, a State survey agency must certify that the CAH is in compliance with the conditions or standards set forth in section 1820 of the Social Security Act and part 485 of our regulations. Thereafter, the CAH is subject to ongoing review by a State survey agency to determine whether it continues to meet the Medicare requirements. There is, however, an alternative to State compliance surveys. Accreditation by a nationally-recognized accreditation program can substitute for ongoing State review.

Section 1865(b)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accreditation organization that all applicable Medicare conditions are met or exceeded, we may ''deem'' those provider entities as having met the requirements. Accreditation by an