

Leading Age (formerly the American Association of Homes and Services for the Aging), National Center for Assisted Living, American Seniors Housing Association, and Assisted Living Federation of America; universities; foundations; and other private sector organizations.

Burden is estimated at approximately 2.5 hours per state each time the frame will be developed, including time to verify contact information, to respond to a semi-structured telephone protocol, and to develop the facility listing in an electronic format. Three year clearance is requested to cover two collections of

frame information. The burden for the two collections is shown in Table 1 below. There is no cost to respondents other than their time to participate. The total estimate of annualized burden is 88 hours based on two data collections during the three year clearance period.

TABLE 1—ESTIMATED ANNUALIZED BURDEN TABLE

Type of respondent	Form name	Number of respondents	Number of responses/respondent	Average burden/response (in hours)
State Government Representatives	Contact info verification	34	1	5/60
State Government Representatives	Telephone protocol	34	1	30/60
State Government Representatives	Electronic file development	34	1	2

Ron A. Otten,

Director, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS-8003, CMS-10166, CMS-10184, CMS-10219, CMS-10242, CMS-2744, CMS-3070, CMS-10336, CMS-10220 and CMS-10175]

Agency Information Collection Activities; Proposed Collection; Comment Request

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information (including each proposed extension or reinstatement of an existing collection of information) and to allow 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates 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.

DATES: Comments must be received by August 6, 2013.

ADDRESSES: When commenting, please reference the document identifier or OMB control number (OCN). To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send 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) that are 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.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web site address at <http://www.cms.hhs.gov/PaperworkReductionActof1995>.

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov.

3. Call the Reports Clearance Office at (410) 786-1326.

FOR FURTHER INFORMATION CONTACT:

Reports Clearance Office at (410) 786-1326.

SUPPLEMENTARY INFORMATION: This notice sets out a summary of the use and

burden associated with the following information collections:

CMS-8003—1915(c) Home and Community Based Services (HCBS) Waiver

CMS-10166—Payment Error Rate Measurement in Medicaid & Children's Health Insurance Program (CHIP)

CMS-10184—Eligibility Error Rate Measurement in Medicaid and the Children's Health Insurance Program
CMS-10219—Healthcare Effectiveness Data and Information Set (HEDIS®) Data Collection for Medicare Advantage

CMS-10242—Emergency and Non-Emergency Ambulance Transports and Beneficiary Signature Requirements in 42 CFR 424.36(b)
CMS-2744—End Stage Renal Disease (ESRD) Medical Information Facility Survey

CMS-3070—Intermediate Care Facility (ICF) for the Mentally Retarded (MR) or Persons with Related Conditions Survey Report Form

CMS-10336—Medicare and Medicaid Programs: Electronic Health Record Incentive Program

CMS-10220—Security Consent and Surrogate Authorization Form
CMS-10175—Certification Statement for Electronic File Interchange Organizations

More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501-3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term "collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or

provide information to a third party. Section 3506(c)(2)(A) of the PRA requires federal agencies to publish a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice.

Proposed Information Collections

1. *Type of Information Collection Request:* Reinstatement without change of a previously approved collection; *Title of Information Collection:* 1915(c) Home and Community Based Services (HCBS) Waiver; *Use:* The web-based application will be used by CMS to review and adjudicate individual waiver actions. The web-based application will also be used by states to submit and revise their waiver requests. *Form Number:* CMS-8003 (OCN: 0938-0449). *Frequency:* Yearly. *Affected Public:* State, Local, or Tribal Governments. *Number of Respondents:* 47. *Total Annual Responses:* 71. *Total Annual Hours:* 6,005. (For policy questions regarding this collection contact Kathy Poisal at 410-786-5940. For all other issues call 410-786-1326.)

2. *Type of Information Collection Request:* Reinstatement of a previously approved collection; *Title of Information Collection:* Payment Error Rate Measurement in Medicaid & Children's Health Insurance Program (CHIP); *Use:* The Improper Payments Information Act (IPIA) of 2002 as amended by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012 requires CMS to produce national error rates for Medicaid and Children's Health Insurance Program (CHIP). To comply with the IPIA, we will engage a federal contractor to produce the error rates in Medicaid and CHIP. The error rates for Medicaid and CHIP are calculated based on the reviews on three components of both Medicaid and CHIP program. They are: Fee-for-service claims medical reviews and data processing reviews, managed care claims data-processing reviews, and eligibility reviews. Each of the review components collects different types of information, and the state-specific error rates for each of the review components will be used to calculate an overall state-specific error rate, and the individual state-specific error rates will be used to produce a national error rate for Medicaid and CHIP. The states will be requested to submit, at their option, test data which include full claims details to the

contractor prior to the quarterly submissions to detect potential problems in the dataset to and ensure the quality of the data. These states will be required to submit quarterly claims data to the contractor who will pull a statistically valid random sample, each quarter, by strata, so that medical and data processing reviews can be performed. State-specific error rates will be based on these review results. We need to collect the fee-for-service claims data, medical policies, and other information from states as well as medical records from providers in order for the contractor to sample and review adjudicated claims in those states selected for medical reviews and data processing reviews. Based on the reviews, state-specific error rates will be calculated which will serve as part of the basis for calculating national Medicaid and CHIP error rates. *Form Number:* CMS-10166 (OCN: 0938-0974); *Frequency:* Yearly, Quarterly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 34; *Total Annual Responses:* 1650; *Total Annual Hours:* 56,100. (For policy questions regarding this collection contact Monetha Dockery at 410-786-0155. For all other issues call 410-786-1326.)

3. *Type of Information Collection Request:* Reinstatement with a change of a previously approved collection; *Title of Information Collection:* Eligibility Error Rate Measurement in Medicaid and the Children's Health Insurance Program; *Use:* The Improper Payments Information Act (IPIA) of 2002 requires us to produce national error rates for Medicaid and the Children's Health Insurance Program (CHIP). To comply with the IPIA, we will use a national contracting strategy to produce error rates for Medicaid and CHIP fee-for-service and managed care improper payments. The federal contractor will review states on a rotational basis so that each state will be measured for improper payments, in each program, once and only once every three years.

Subsequent to the first publication, we determined that we will measure Medicaid and CHIP in the same state. Therefore, states will measure Medicaid and CHIP eligibility in the same year measured for fee-for-service and managed care. We believe this approach will advantage states through economies of scale (e.g. administrative ease and shared staffing for both programs reviews). We also determined that interim case completion timeframes and reporting are critical to the integrity of the reviews and to keep the reviews on schedule to produce a timely error rate. Lastly, the sample sizes were increased

slightly in order to produce an equal sample size per strata each month. Each month states submit a monthly sample selection list, eligibility review findings for active and negative cases and claims review findings. At the end of the cycle, states would have submitted 48 forms. We are submitting a new instrument in which we compile all of the information from the 48 forms into a format that will allow states to submit 12 forms for 12 months of eligibility data. This form will also serve either of the data substitution options. Periodically, we will conduct federal re-reviews of states' PERM files to ensure the accuracy of states' review findings and the validity of the review process. We will select a random subsample of Medicaid and CHIP cases from the sample selection lists provided by each state. States will submit all pertinent information related to the review of each sampled case that we select. *Form Number:* CMS-10184 (OCN: 0938-1012); *Frequency:* Yearly, Quarterly *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 34; *Total Annual Responses:* 120; *Total Annual Hours:* 15,755. (For policy questions regarding this collection contact Monetha Dockery at 410-786-0155. For all other issues call 410-786-1326.)

4. *Type of Information Collection Request:* Revision of a currently approved collection. *Title of Information Collection:* Healthcare Effectiveness Data and Information Set (HEDIS®) Data Collection for Medicare Advantage; *Use:* The data is used by CMS to: monitor Medicare Advantage organization performance, inform audit strategies, and inform beneficiary choice through their display in CMS' consumer-oriented public compare tools and Web sites. Medicare Advantage organizations use the data for quality assessment and as part of their quality improvement programs and activities. Quality Improvement Organizations and CMS contractors use HEDIS® data in conjunction with their statutory authority to improve quality of care, and consumers who are making informed health care choices. In addition, we make health plan level HEDIS® data available to researchers and others as public use files at www.cms.hhs.gov. *Form Number:* CMS-10219 (OCN: 0938-1028). *Frequency:* Yearly. *Affected Public:* Private sector (business or other for-profit and not-for-profit institutions); *Number of Respondents:* 576. *Total Annual Responses:* 576. *Total Annual Hours:* 184,320. (For policy questions regarding this collection contact Lori Teichman at 410-786-6684. For all other issues call 410-786-1326.)

5. *Type of Information Collection*

Request: Reinstatement with change of a previously approved collection; **Title of Information Collection:** Emergency and Non-Emergency Ambulance Transports and Beneficiary Signature Requirements in 42 CFR 424.36(b); **Use:** Ambulance providers and suppliers are the primary information users. Specifically, when ambulance providers and suppliers sign claims on behalf of beneficiaries they are required by § 424.36(b)(6) to keep certain documentation in their files for at least four years from the date of service. The purpose of this information collection is to document emergency and nonemergency ambulance transports where the beneficiary was incapable of signing the claim and the ambulance provider or supplier signed the claim on the beneficiary's behalf. The information may also be used by: (1) Our Part A and Part B Medicare Administrative Contractors that process and pay ambulance claims; (2) our staff who review and audit claims for medical necessity; (3) our staff who review claims for overpayments; and (4) by others who investigate ambulance billing practices to ensure compliance under the False Claims Act and anti-kickback statute. Therefore, besides ambulance providers and suppliers, the information collected may be used by CMS, the Office of the General Counsel, the Office of the Inspector General, the Department of Justice, and the Federal Bureau of Investigations. **Form Number:** CMS-10242 (OCN: 0938-1049). **Frequency:** Occasionally. **Affected Public:** Private sector (business or other for-profit and not-for-profit institutions). **Number of Respondents:** 11,564. **Total Annual Responses:** 15,633,781. **Total Annual Hours:** 1,303,857. (For policy questions regarding this collection contact David Walczak at 410-786-4475. For all other issues call 410-786-1326.)

6. *Type of Information Collection*

Request: Revision of a previously approved collection; **Title of Information Collection:** End Stage Renal Disease (ESRD) Medical Information Facility Survey; **Use:** The End Stage Renal Disease (ESRD) Medical Information Facility Survey form (CMS-2744) is completed annually by Medicare-approved providers of dialysis and transplant services. The CMS-2744 is designed to collect information concerning treatment trends, utilization of services and patterns of practice in treating ESRD patients. The information is used to assess and evaluate the local, regional and national levels of medical and social impact of ESRD care and is used extensively by researchers and

suppliers of services for trend analysis. The information is available on the CMS Dialysis Facility Compare Web site and will enable patients to make informed decisions about their care by comparing dialysis facilities in their area. **Form Number:** CMS-2744 (OCN: 0938-0447); **Frequency:** Yearly; **Affected Public:** Business or other for-profit, Not-for-profit institutions; **Number of Respondents:** 5,964; **Total Annual Responses:** 5,964; **Total Annual Hours:** 47,712. (For policy questions regarding this collection contact Michelle Tucker at 410-786-0736. For all other issues call 410-786-1326.)

7. *Type of Information Collection*

Request: Reinstatement with change of a currently approved collection; **Title of Information Collection:** Intermediate Care Facility (ICF) for the Mentally Retarded (MR) or Persons with Related Conditions Survey Report Form; **Use:** This survey form is needed to ensure intermediate care facility (ICF) for the mentally retarded (MR) provider and client characteristics are available and updated annually for the federal government's Online Survey Certification and Reporting (OSCAR) system. It is required for the provider to fill out at the time of the annual recertification or initial certification survey conducted by the state Medicaid agency. The team leader for the state survey team must review and approve the completed form before completion of the survey. The state Medicaid survey agency is responsible for transferring the 3070 information into OSCAR. **Form Number:** CMS-3070 (OCN: 0938-0062); **Frequency:** Reporting—Yearly; **Affected Public:** Private Sector: Business or other for-profits and Not-for-profit institutions; **Number of Respondents:** 6,446; **Total Annual Responses:** 6,446; **Total Annual Hours:** 19,388. (For policy questions regarding this collection contact Adrienne Rogers at 410-786-3411. For all other issues call 410-786-1326.)

8. *Type of Information Collection*

Request: Reinstatement with change of a previously approved collection; **Title of Information Collection:** Medicare and Medicaid Programs: Electronic Health Record Incentive Program; **Use:** The American Recovery and Reinvestment Act of 2009 (Recovery Act) (Pub. L. 111-5) was enacted on February 17, 2009. The Recovery Act includes many measures to modernize our nation's infrastructure, and improve affordable health care. Expanded use of health information technology (HIT) and certified electronic health record (EHR) technology will improve the quality and value of America's health care. Title IV of Division B of the Recovery Act

amends Titles XVIII and XIX of the Social Security Act (the Act) by establishing incentive payments to eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs), and Medicare Advantage (MA) organizations participating in the Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology. These Recovery Act provisions, together with Title XIII of Division A of the Recovery Act, may be cited as the "Health Information Technology for Economic and Clinical Health Act" or the "HITECH Act."

The HITECH Act creates incentive programs for EPs and eligible hospitals, including CAHs, in the Medicare Fee-for-Service (FFS), MA, and Medicaid programs that successfully demonstrate meaningful use of certified EHR technology. In their first payment year, Medicaid EPs and eligible hospitals may adopt, implement or upgrade to certified EHR technology. It also, provides for payment adjustments in the Medicare FFS and MA programs starting in FY 2015 for EPs and eligible hospitals participating in Medicare that are not meaningful users of certified EHR technology. These payment adjustments do not pertain to Medicaid providers.

The first final rule for the Medicare and Medicaid EHR Incentive Program, which was published in the **Federal Register** on July 28, 2010 (CMS-0033-F), specified the initial criteria EPs, eligible hospitals and CAHs, and MA organizations must meet in order to qualify for incentive payments; calculation of incentive payment amounts; payment adjustments under Medicare for covered professional services and inpatient hospital services provided by EPs, eligible hospitals and CAHs failing to demonstrate meaningful use of certified EHR technology beginning in 2015; and other program participation requirements. On the same date, the Office of the National Coordinator of Health Information Technology (ONC) issued a closely related final rule (45 CFR part 170, RIN 0991-AB58) that specified the initial set of standards, implementation specifications, and certification criteria for certified EHR technology. ONC has also issued a separate final rule on the establishment of certification programs for health information technology (HIT) (45 CFR part 170, RIN 0991-AB59). The functionality of certified EHR technology should facilitate the implementation of meaningful use. Subsequently, final rules have been issued by CMS (77 FR 53968) and ONC (77 FR 72985) to create a Stage 2 of meaningful use criteria and other

changes to the CMS EHR Incentive Programs and the 2014 Edition Certification Criteria for EHR technology.

The information collection requirements contained in this information collection request are needed to implement the HITECH Act. In order to avoid duplicate payments, all EPs are enumerated through their National Provider Identifier (NPI), while all eligible hospitals and CAHs are enumerated through their CMS Certification Number (CCN). State Medicaid agencies and CMS use the provider's tax identification number and NPI or CCN combination in order to make payment, validate payment eligibility and detect and prevent duplicate payments for EPs, eligible hospitals and CAHs. *Form Number:* CMS-10336 (OCN: 0938-1158). *Frequency:* Occasionally; *Affected Public:* Private sector. *Number of Respondents:* 214,694; *Total Annual Responses:* 214,694. *Total Annual Hours:* 2,034,740.16. (For policy questions regarding this collection contact Travis Broome at 214-767-4450. For all other issues call 410-786-1326.)

9. Type of Information Collection Request: Reinstatement with change of a previously approved collection; *Title of Information Collection:* Security Consent and Surrogate Authorization Form; *Use:* The primary function of the Medicare enrollment application is to obtain information about the Provider or supplier and whether they meet the Federal and/or State qualifications to participate in the Medicare program. In addition, the Medicare enrollment application gathers information regarding the provider or supplier's practice location, the identity of the owners of the enrolling organization, and information necessary to establish the correct claims payment.

Enrollees have the option of submitting either a CMS 855 form, or submitting information via a web based process. In establishing a web based application process, we allow providers and suppliers the ability to enroll in the Medicare program, revalidate their enrollment and make changes to their enrollment information via Internet-based Provider Enrollment, Chain and Ownership System (PECOS). Individual providers/suppliers (hereinafter referred to as "Individual Providers") log into Internet-based PECOS using their User IDs and passwords established when they applied on-line to the National Plan and Provider Enumeration System (NPPES) for their National Provider Identifiers (NPIs). Authorized Officials (AOs) of the provider or supplier organizations (hereinafter referred to as

"Organizational Providers") must register for a user account and authenticate their identity and connection to the organization they represent before being able to log into Internet-based PECOS. Once authenticated, AOs for Organizational Providers, receive complete access to their enrollment information via Internet-based PECOS. Individuals and AOs of Organizational Providers are not required to submit a Security Consent and Surrogate Authorization Form to enroll, revalidate or make changes to their Medicare enrollment information.

Individual and Organizational Providers may complete their Medicare enrollment responsibilities on their own or elect to delegate this task to a Surrogate. A Surrogate is an individual or organization identified by an Individual or Organizational Provider as someone authorized to access CMS computer systems, such as Internet-based PECOS, National Provider Plan and Enumeration System (NPPES) and the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program Registration and Attestation System (HITECH), on their behalf and to modify or view any information contained therein that the Individual or Organizational Provider may have permission or right to access in accordance with Medicare statutes, regulations, policies, and usage guidelines for any CMS system. Surrogates may consist of administrative staff, independent contractors, 3rd party consulting companies or credentialing departments. In order for an Individual or Organizational Provider to delegate the Medicare credentialing process to a Surrogate to access and update their enrollment information in the above mentioned CMS systems on their behalf, it is required that a Security Consent and Surrogate Authorization Form be completed, or Individual and Organizational Providers use an equivalent online process via the PECOS Identity and Access Management (I&A) system. The Security Consent and Surrogate Authorization form replicates business service agreements between Medicare providers, suppliers or both and Surrogates providing enrollment services.

We are proposing one version of the Security Consent and Surrogate Authorization Form. The form, once signed, mailed and approved, grants a Surrogate access to all current and future enrollment data for the Individual or Organization Provider. *Form Number:* CMS-10220 (OCN: 0938-1035). *Frequency:* Occasionally. *Affected Public:* Individuals and Private

Sector; *Number of Respondents:* 88,650; *Total Annual Responses:* 88,650; *Total Annual Hours:* 22,162. (For policy questions regarding this collection contact Alisha Banks at 410-786-0671. For all other issues call 410-786-1326.)

10. Type of Information Collection Request: Reinstatement with change of a previously approved collection; *Title of Information Collection:* Certification Statement for Electronic File Interchange Organizations; *Use:* Health care providers can currently obtain a National Provider Identifier (NPI) via a paper application or over the Internet through the National Plan and Provider Enumeration System (NPPES). These applications must be submitted individually, on a per-provider basis. The Electronic File Interchange (EFI) process allows provider-designated organizations (EFIOs) to capture multiple providers' NPI application information on a single electronic file for submission to NPPES. This process is also referred to as bulk enumeration. To ensure that the EFIO has the authority to act on behalf of each provider and complies with other federal requirements, an authorized official of the EFIO must sign a certification statement and mail it to us. *Form Number:* CMS-10175 (OCN: 0938-0984). *Frequency:* Occasionally. *Affected Public:* Private Sector; *Number of Respondents:* 25; *Total Annual Responses:* 25; *Total Annual Hours:* 75. (For policy questions regarding this collection contact Leslie Jones at 410-786-6599. For all other issues call 410-786-1326.)

Dated: June 4, 2013.

Martique Jones,

Deputy 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-10309, CMS-10475, CMS-R-5 and CMS-R-234]

Agency Information Collection Activities; Submission for OMB Review; Comment Request

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the