DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10305, CMS–10488, CMS–R–71, CMS–R–10, CMS–10220 and CMS–855C]

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 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 a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the 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.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by December 2, 2013:

ADDRESSES: When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be received by the OMB desk officer via one of the following transmissions: OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974 *OR* Email: *OIRA_submission@omb.eop.gov.*

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: 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 (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-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 that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title:* Medicare Part C and Part D Data Validation (42 CFR 422.516(g) and 423.514(g)); *Use:* Data collected via the Medicare Part C and Part D Reporting Requirements Technical Specifications is an integral resource for oversight, monitoring, compliance and auditing activities necessary to ensure quality provision of the Medicare benefits to beneficiaries. We use the data collected through the Medicare Data Validation Program to substantiate the data collected via Medicare Part C and Part D Reporting Requirements Technical Specifications. If we detect data anomalies, the CMS division with primary responsibility for the applicable reporting requirement assists with determining a resolution. *Form Number:* CMS–10305 (OCN: 0938–1115); *Frequency:* Yearly; *Affected Public:* Private sector—Business or other for-profit or Not-for-profit organizations; *Number of Respondents:* 208; *Total Annual Responses:* 657; *Total Annual Hours:* 179,301. (For policy questions regarding this collection contact Terry Lied at 410–786–8973.)

2. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Health Insurance Marketplace Consumer Experience Surveys: Enrollee Satisfaction Survey and Marketplace Survey Data Collection; *Use:* Section 1311(c)(4) of the Affordable Care Act (ACA) requires the Department of Health and Human Services (HHS) to develop an enrollee satisfaction survey system that assesses consumer experience with qualified health plans (QHPs) offered through an Exchange. It also requires public display of enrollee satisfaction information by the Exchange to allow individuals to easily compare enrollee satisfaction levels between comparable plans. The HHS intends to establish two surveys that assess consumer experience with the Marketplaces and the QHPs offered through the Marketplaces. The surveys will include topics to assess consumer experience with the Marketplace such as enrollment and customer service, as well as experience with the health care system such as communication skills of providers and ease of access to health care services. We are considering using the Consumer Assessment of Health Providers and Systems (CAHPS®) principles (*http://www.cahps.ahrq.gov/about.htm*) for developing the surveys. We have proposed an application and approval process for enrollee satisfaction survey vendors who want to participate in collecting ESS data. The application form for survey vendors includes information regarding organization name and contact(s) as well as minimum business requirements such as relevant survey experience, organizational survey capacity, and quality control procedures.

The Marketplace Survey will provide (1) Actionable information that the Marketplaces can use to improve performance, (2) information that CMS and state regulatory organizations can use for general oversight, and (3) a longitudinal database for future Marketplace research. The CAHPS® family of instruments does not have a survey that assesses entities similar to Marketplaces, so the Marketplace survey items were generated by the project team. The QHP Enrollee Experience survey will (1) help consumers choose among competing health plans, (2) provide actionable information that the QHPs can use to improve performance, (3) provide information that regulatory and accreditation organizations can use to regulate and accredit plans, and (4) provide a longitudinal database for consumer research. We plan to base the QHP survey on the CAHPS® Health Plan Survey.

We are planning for two rounds of developmental testing for the Marketplace and QHP surveys. The 2014 survey field tests will help

determine psychometric properties and provide an initial measure of performance for Marketplaces and QHPs to use for quality improvement. Based on field test results, there will be further refinement of the questionnaires and sampling designs to conduct the 2015 beta test of each survey. We plan to request clearance for two additional rounds of national implementation with reporting of scores for each survey in the future. A summary of findings from the testing rounds will be included when requesting clearance for the additional two rounds of national implementation in 2016 and 2017. In 2014, the total annual burden hours for the Marketplace and QHP Survey field tests are 34,668 hours with 93,802 responses. In 2015, the total annual burden hours for the Marketplace and QHP Survey beta tests are 267,460 hours with 661,241 responses. The total average annualized burden over three years for this requested information collection is 100,709 hours and the total average annualized number of responses is 251,681 responses. *Form Number:* CMS–10488 (OCN: 0938–NEW); *Frequency:* Annually; *Affected Public:* Public sector—Individuals and Households and Private sector—Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 251,681; *Total Annual Responses:* 251,681; *Total Annual Hours:* 100,709. (For policy questions regarding this collection contact Kathleen Jack at 410–786–7214.)

3. *Type of Information Collection Request:* Reinstatement with change of a previously approved collection; *Title of Information Collection:* Quality Improvement Organization (QIO) Assumption of Responsibilities and Supporting Regulations; *Use:* The Peer Review Improvement Act of 1982 amended Title XI of the Social Security Act to create the Utilization and Quality Control Peer Review Organization (PRO) program which replaces the Professional Standards Review Organization (PSRO) program and streamlines peer review activities. The term PRO has been renamed Quality Improvement Organization (QIO). This information collection describes the review functions to be performed by the QIO. It outlines relationships among QIOs, providers, practitioners, beneficiaries, intermediaries, and carriers. *Form Number:* CMS–R–71 (OCN: 0938–0445); *Frequency:* Yearly; *Affected Public:* Private sector—Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 6,939; *Total Annual Responses:* 50,377; *Total Annual Hours:* 158,993. (For policy questions regarding this collection contact Coles Mercier at 410–786–2112.)

4. *Type of Information Collection Request:* Reinstatement with change of a previously approved collection; *Title of Information Collection:* Advance Directives (Medicare and Medicaid) and Supporting Regulations; *Use:* 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. 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. Sections 4206 of the Omnibus Budget Reconciliation Act of 1990 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 (OCN: 0938–0610); *Frequency:* Yearly; *Affected Public:* Private sector—Business or other for-profits; *Number of Respondents:* 39,575; *Total Annual Responses:* 39,575; *Total Annual Hours:* 2,836,441. (For policy questions regarding this collection contact Sonia Swancy at 410–786–8445.)

5. *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—Business or other for-profits and Not-for-profit institutions; *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.)

6. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Medicare Enrollment Application for Registration of Eligible Entities That Provide Health Insurance Coverage Complementary to Medicare Part B; *Use:* The primary function of a Medicare enrollment application is to gather information from a provider, supplier or other entity that tells us who it is, whether it meets certain qualifications to be a health care provider, supplier or entity, where it practices or renders its services, the identity of the owners of the enrolling entity, and information necessary to establish correct claims payments. We are adding a new CMS–855 Medicare Registration Application, the CMS–855C: Medicare Enrollment Application for Registration of Eligible Entities That Provide Health Insurance Coverage Complementary to Medicare Part B. This Medicare registration application is to be completed by all entities that provide a complimentary health benefit plan and intend to bill Medicare as an indirect payment procedure (IPP) biller and the entity or health plan meets all Medicare requirements to submit claims for indirect payments. The entity must furnish the name of at least one authorized official, preferably the administrator of the health plan, who must sign this registration application attesting that the registering entity meets the requirements to register as an indirect payment procedure biller and will also abide by the requirements stated in the Certification & Attestation Statement in Section 10 of the application.

The CMS–855C will be submitted at the time the applicant first requests a Medicare identification number for the sole purpose of submitting claims under the ''Indirect Payment Procedure (IPP)'' for reimbursement, and when necessary to report any changes to information previously submitted. The application will be used by Medicare contractors to collect data to ensure the applicant has the necessary credentials to submit Medicare claims for reimbursement, including information that allows Medicare contractors to ensure that the entity and its owners and administrators are not sanctioned from the Medicare program, or debarred, suspended or excluded from any other Federal agency or program. *Form Number:* CMS–855C (OCN: 0938—New); *Frequency:* Occasionally; *Affected Public:* Private sector—Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 440; *Total Annual Responses:* 440; *Total Annual Hours:* 500. (For policy questions regarding this collection contact Kim McPhillips at 410–786–5374.)

Dated: October 29, 2013.

Martique Jones,

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

[FR Doc. 2013–26107 Filed 10–31–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1462–N]

Medicare Program; Solicitation of Five Nominations to the Advisory Panel on Hospital Outpatient Payment (HOP, the Panel)

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

ACTION: Notice.

SUMMARY: This notice solicits nominations for five new members to the Advisory Panel on Hospital Outpatient Payment (HOP, the Panel). There are five vacancies on the Panel effective September 30, 2013.

The purpose of the Panel is to advise the Secretary of the Department of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services on the clinical integrity of the Ambulatory Payment Classification (APC) groups and their associated weights, and supervision of hospital outpatient services.

The Secretary rechartered the Panel in 2012 for a 2-year period effective through November 19, 2014.

DATES: *Submission of Nominations:* We will consider nominations if they are received no later than 5 p.m. (e.s.t.) December 31, 2013.

ADDRESSES: Please mail or hand deliver nominations to the following address: Centers for Medicare & Medicaid Services; Attn: Chuck Braver, Advisory Panel on HOP; Center for Medicare, Hospital & Ambulatory Policy Group, Division of Outpatient Care; 7500 Security Boulevard; Mail Stop C4–05–17 Baltimore, MD 21244–1850.

Web site: For additional information on the Panel and updates to the Panel's activities, we refer readers to our Web site at the following address: *http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.*

FOR FURTHER INFORMATION CONTACT: Persons wishing to nominate individuals to serve on the Panel or to obtain further information may contact Chuck Braver at the following email address: *APCPanel@cms.hhs.gov* or call (410) 786–3985.

News Media: Representatives should contact the CMS Press Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION: