DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–250 through 254, CMS–10008, and CMS–287]

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

AGENCY: Centers for Medicare and 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 and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA), 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 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 Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Secondary Payer Information Collection and Supporting Regulations in 42 CFR 411.25, 489.2, and 489.20; *Form Number:* CMS–250 through CMS–254 (OMB# 0938–0214); *Use:* Medicare Secondary Payer (MSP) is essentially the same concept known in the private insurance industry as coordination of benefits and refers to those situations where Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. CMS contracts with health insuring organizations, herein referred to as intermediaries and carriers, to process Medicare claims. CMS charges its Medicare intermediaries and carriers with various tasks to detect MSP cases; develops and disseminates tools to enable them to better perform their tasks; and monitors their performance in achievement of their assigned MSP functions. Because intermediaries and carriers are also marketing health insurance products that may have liability when Medicare is secondary, the MSP provisions create the potential for conflict of interest. Recognizing this inherent conflict, CMS has taken steps to ensure that its intermediaries and carriers process claims in accordance with the MSP provisions, regardless of what other insurer is primary. These information collection requirements describe the MSP requirements and consist of the following:

1. Initial enrollment questionnaire
2. MSP claims investigation, which consists of first claim development, trauma code development, self-reporting MSP liability development, notice to responsible third party development (411.25 notice), secondary claims development, and ''08'' development (involving claims where information cannot be obtained from the beneficiary)
3. Provider MSP development, which requires the provider to request information from the beneficiary or representative during admission and other encounters; *Frequency:* On occasion; *Affected Public:* Individuals or households, business or other for-profit, and not-for-profit institutions; *Number of Respondents:* 867,863,540; *Total Annual Responses:* 867,863,540; *Total Annual Hours Requested:* 2,779,942.

(2.) *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Recognition of Pass-Through Payment for Drugs and Biologicals Under the Outpatient Prospective Payment System and Supporting Regulations in 42 CFR 419.43 formerly known as ''Recognition of New Technology/Pass-Through Items Under the Prospective Payment System for Hospital Outpatient Services''; *Form No.:* CMS–10008 (OMB# 0938–0802); *Use:* This information is necessary to determine items eligible for payment as new technology within the ambulatory payment classification (APC) system as well as items eligible for the transitional pass-through payment provision as required by section 201 of the BBRA. This collection will enable CMS to implement those special payment provisions; *Frequency:* On Occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 55; *Total Annual Responses:* 55; *Total Annual Hours:* 193.

(3.) *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Home Office Cost Statement and Supporting Regulations in 42 CFR 413.17 and 413.20; *Form No.:* CMS–287 (OMB# 0938–0202); *Use:* Medicare law permits components of chain organizations to be reimbursed for certain costs incurred by the chain home offices. The Home Office Cost Statement is required by the fiscal intermediary to verify Home Office Costs claimed by the components. *Frequency:* Annually; *Affected Public:* Not-for-profit institutions and business or other for-profit; *Number of Respondents:* 1,231; *Total Annual Responses:* 1,231; *Total Annual Hours Requested:* 573,646.

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.hcfa.gov/regs/prdact95.htm,* or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.gov,* or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB desk officer:

OMB Human Resources and Housing Branch, Attention: Allison Eydt, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: March 12, 2002.

John P. Burke, III,

CMS Reports Clearance Officer, CMS Office of Information Services, Security and Standards Group, Division of CMS Enterprise Standards.

[FR Doc. 02–7210 Filed 3–25–02; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–339]

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

AGENCY: Centers for Medicare and 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 and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA)), 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 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.

We are, however, requesting an emergency review of the information collection referenced below. In compliance with the requirement of section 3506(c)(2)(A) if the Paperwork Reduction Act of 1995, we have submitted to the Office of Management and Budget (OMB) the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR part 1320. This is necessary to ensure compliance with 5 U.S.C. 1395g and 42 CFR 413.20 and 413.24. We cannot reasonably comply with the normal clearance procedures because the approval for this collection was inadvertently allowed to lapse. The CMS–339's purpose is to assist the provider in preparing an acceptable cost report and to minimize subsequent contact between the provider and its intermediary. If the information is not collected, then the fiscal intermediary will have to go onsite to each provider to get this information. Consequently, it is far less burdensome and extremely cost effective to capture this information through the CMS–339. It is essential to have this information to maintain the provider profile and to scope (i.e., special, limited or full) the audit.

We are currently working on elimination of form CMS–339 and including the applicable questions on the individual cost report forms. In an effort to eliminate the requirement for information no longer needed, we reviewed the comments received from the Federation of American Hospitals, American Hospital Association, and others. This resulted in our issuance of Program Memorandum A–01–137, entitled Modification to Form CMS–339 Requirements, Provider Cost Reimbursement Questionnaire. This has deleted Exhibit 6, Providers Owners/Management Personnel Compensation Exhibit. It has eliminated several questions from other exhibits for all providers. Exhibits 2, 3, and 4, Provider-Based Physicians, were eliminated for many providers.

We intend to revise the CMS–339 if the revisions planned for the cost reports are not operational before we have completely implemented the revised forms CMS–885 (Provider enrollment) (there are redundancies between the forms CMS–339 and 855). Those forms will not have been collected from all providers until three years after OMB approval. If the cost reports are revised to include the pertinent questions from the form CMS–339 (and the latter form eliminated) before the end of that three year period, we will then remove those questions from the cost reports.

CMS is requesting OMB review and approval of this collection by March 29, 2002, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individuals designated below by March 28, 2002. We published a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements on February 8, 2002. We will submit the requirements for OMB review and an extension of this emergency approval during the 180-day approval period.

Type of Information Collection Request: Reinstatement of a previously approved collection.

Title of Information Collection: Medicare Provider Cost Report Reimbursement Questionnaire and Supporting Regulations in 42 CFR 413.20, 413.24, 415.50, 415.55, 415.60, 415.70, 415.150, 415.152, 415.160, and 415.162.

Form No.: CMS–339 (OMB# 0938–0301).

Use: The Medicare Provider Cost Report Reimbursement Questionnaire must be completed by all providers to assist in preparing an acceptable cost report, to ensure proper Medicare reimbursement, and to minimize subsequent contact between the provider and it fiscal intermediary. It is designed to answer pertinent questions about key reimbursement concepts found in the cost report and to gather information necessary to support certain financial and statistical entries on the cost report. In addition, it provides an audit trail for the fiscal intermediary.

Frequency: Annually.

Affected Public: Business or other for-profit, not-for-profit institutions, and State, local and tribal government.

Number of Respondents: 33,144.

Total Annual Responses: 33,144.

Total Annual Hours: 1,342,332.

We have submitted a copy of this notice to OMB for its review of these information collections. A notice will be published in the **Federal Register** when approval is obtained.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS's Web Site address at *http://www.hcfa.gov/regs/prdact95.htm,* or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of information requirements. However, as noted above, comments on these information collection and recordkeeping requirements must be mailed and/or faxed to the designees referenced below, by March 28, 2002.

Centers for Medicare and Medicaid Services, Office of Information Services, Security and Standards Group, Division of CMS Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850. Fax Number: (410) 786–0262. Attn: Julie Brown, CMS–339, and,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Fax Number: (202) 395–6974 or (202) 395–5167 Attn: Allison Eydt, CMS Desk Officer.

Dated: March 20, 2002.

Julie Brown,

Acting CMS Reports Clearance Officer, CMS, Office of Information Services, Security and Standards Group, Division of CMS Enterprise Standards.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

[Program Announcement No. 93631–02–01]

Developmental Disabilities: Notice of Availability of Financial Assistance and Request for Applications To Fund Family Support Model Demonstration Projects Under the Projects of National Significance Program

AGENCY: Administration on Developmental Disabilities (ADD), ACF, DHHS.

ACTION: Notice.

SUMMARY: The Administration on Developmental Disabilities (ADD), Administration for Children and Families (ACF), is accepting