

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10450 and CMS–10079]

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: New collection; **Title:** Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for Physician Quality Reporting; **Use:** The Physician Quality Reporting System (PQRS) was established in 2006 as a voluntary “pay-for-reporting” program that allows physicians and other eligible healthcare professionals to report information to Medicare about the quality of care provided to beneficiaries who have certain medical conditions. PQRS provides incentive payments to physicians who report quality data. Since program inception, these results have not been publicly available for use by consumers.

The Physician Compare Web site was launched December 30, 2010, to meet requirements set forth by Section 10331 of the Affordable Care Act (ACA). The ACA requires CMS to establish a Physician Compare Web site by January 1, 2011, containing information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative. By no later than January 1, 2013 (and for reporting periods beginning no earlier than January 1, 2012), CMS is required to

implement a plan to make information on physician performance publicly available through Physician Compare. A key component of the reporting requirements under the ACA is public reporting on physician performance that includes patient experience measures. The collection and reporting of a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Physician Quality Reporting will fulfill this requirement.

The U.S. Department of Health and Human Services (HHS) has developed the National Quality Strategy that was called for under the ACA to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care. This strategy has established six priorities that support the three-part aim. The three-part aim focuses on better care, better health, and lower costs through improvement. The six priorities include: Making care safer by reducing harm caused by the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models. Because the CAHPS Survey for Physician Quality Reporting focuses on patient experience implementation of the survey supports the six national priorities for improving care, particularly engaging patients and families in care and promoting effective communication and coordination.

This survey supports the administration of the Quality Improvement Organizations Program (QIO). The Social Security Act, as set forth in Part B of Title XI—Section 1862(g), established the Utilization and Quality Control Peer Review Organization Program, now known as the QIO Program. The statutory mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. This survey will provide patient experience of care data that is an essential component of assessing the quality of services delivered to Medicare beneficiaries. It also would permit beneficiaries to have this information to help them choose health care providers that provide services that meet their needs and preferences, thus encouraging

providers to improve quality of care that Medicare beneficiaries receive. **Form Number:** CMS–10450 (OCN: 0938–New); **Frequency:** Annual; **Affected Public:** Individuals and Households; **Number of Respondents:** 234,600 **Total Annual Responses:** 117,300; **Total Annual Hours:** 39,530. (For policy questions regarding this collection contact Regina Chell at 410–786–6551. For all other issues call 410–786–1326.)

2. Type of Information Collection Request: Revision of a currently approved collection;

Title of Information Collection: Hospital Wage Index Occupational Mix Survey and Supporting Regulations in 42 CFR, Section 412.64; **Use:** Section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Social Security Act to require CMS to collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, for application beginning October 1, 2004 (the FY 2005 wage index). The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. Refer to the summary of changes document for a list of current changes. **Form Number:** CMS–10079 (OMB#: 0938–0907); **Frequency:** Reporting—Yearly, Biennially and Occasionally; **Affected Public:** Private Sector—Business or other for-profits and Not-for-profit institutions; **Number of Respondents:** 3,500; **Total Annual Responses:** 3,500; **Total Annual Hours:** 1,680,000. (For policy questions regarding this collection contact Gerry Mondowney at 410–786–1172. For all other issues call 410–786–1326.)

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 Email 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 February 5, 2013:

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: December 4, 2012.

Martique Jones,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10333 and CMS–10381]

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:* Revision of a currently approved collection; *Title:* Consumer Assistance Program Grants *Use:* Section 1002 of the Affordable Care Act provides for the establishment of consumer assistance (or ombudsman) programs, starting in FY 2010. Federal grants will support these programs.

These programs will assist consumers with filing complaints and appeals, assist consumers with enrollment into health coverage, collect data on consumer inquiries and complaints to identify problems in the marketplace, educate consumers on their rights and responsibilities, and with the establishment of the new Exchange marketplaces, resolve problems with premium credits for Exchange coverage. Importantly, these programs must provide detailed reporting on the types of problems and questions consumers may experience with health coverage, and how these problems and questions are resolved. In order to strengthen oversight, the law requires programs to report data to the Secretary of the Department of Health and Human Services (HHS). “As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers” (Sec. 2793 (d)). Analysis of this data reporting will help identify patterns of practice in the insurance marketplaces and uncover suspected patterns of noncompliance. HHS must share program data reports with the Departments of Labor and Treasury, and state regulators. Program data also can offer CCIIO one indication of the effectiveness of state enforcement, affording opportunities to provide technical assistance and support to state insurance regulators and, in extreme cases, inform the need to trigger federal enforcement.

The 60-day **Federal Register** notice published on July 27, 2012, and the comment period ended September 25, 2012. We received a total of 21 comments. All comments were summarized, consolidated (where overlap existed), and addressed. The majority of comments involved feedback on providing CAPs with more flexibility in collecting and reporting data. The implementation of a new progress report will allow CAPs to provide more information about their progress and activities. In addition, CMS received comments suggesting that collection of all of the CMS-required data elements is difficult and that adjustments to pre-existing databases is too expensive and laborious. CMS recognizes these concerns and acknowledges that CAPs are in the best situation to determine the level of information that is able to be collected for any given consumer. CMS also received comments suggesting that CMS provide guidance to CAPs on how to accurately measure savings to

consumers. CMS has provided CAPs with suggestions on ways to calculate recovered benefits and will explore whether more comprehensive guidance is necessary. The comments received in response to the 60-day notice have not resulted in a change in burden estimates. *Form Number:* CMS–10333 (OCN: 0938–1097); *Frequency:* Quarterly and Annual; *Affected Public:* Private Sector: State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 504; *Total Annual Hours:* 261 hours. (For policy questions regarding this collection contact Eliza Bangit at 301–492–4219. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title:* ICD–10 Industry Readiness Assessment; *Use:* The Congress addressed the need for a consistent framework for electronic transactions and other administrative simplification issues in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, enacted on August 21, 1996. Through subtitle F of title II of HIPAA, the Congress added to title XI of the Social Security Act (the Act) a new Part C, entitled “Administrative Simplification.” Part C of title XI of the Act now consists of sections 1171 through 1180, which define various terms and impose several requirements on HHS, health plans, health care clearinghouses, and certain health care providers concerning the transmission of health information. Specifically, HIPAA requires the Secretary of HHS to adopt standards that covered entities are required to use in conducting certain health care administrative transactions, such as claims, remittance, eligibility, and claims status requests and responses. Findings from the ICD–10 industry readiness assessment will be used by CMS to understand each sector’s progress toward compliance and to determine what communication and educational efforts can best help affected entities obtain the tools and resources they need to achieve timely compliance with ICD–10. Insights gleaned from the proposed research will be valid for education and outreach purposes only, and will not be used for policy purposes. *Form Number:* CMS–10381 (OMB#: 0938–1149); *Frequency:* Annual; *Affected Public:* Private Sector—Business or other for-profits, Not-for-profits; *Number of Respondents:* 1,200; *Total Annual Responses:* 1,200; *Total Annual Hours:* 204. (For policy questions regarding this collection contact Rosali Topper at 410–786–7260. For all other issues call 410–786–1326.)