CMS–10497 Evaluation of the Medicare Health Care Quality (MHCQ) Demonstration Evaluation: Focus Group and Interview Protocols

Under the 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.

Information Collections

1. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Evaluation of the Medicare Health Care Quality (MHCQ) Demonstration Evaluation: Focus Group and Interview Protocols; *Use:* The Medicare Health Care Quality (MHCQ) Demonstration was developed to address concerns about the U.S. health care system, which typically fragments care while also encouraging both omissions in and duplication of care. To rectify this situation, Congress has directed the Centers for Medicare & Medicaid Services (CMS) to test major changes to the delivery and payment systems to improve the quality of care while also increasing efficiency across the health care system. This would be achieved through several types of interventions: adoption and use of information technology and decision support tools by physicians and their patients, such as evidence-based medicine guidelines, best practice guidelines, and shared decision-making programs; reform of payment methodologies; improved coordination of care among payers and providers serving defined communities; measurement of outcomes; and enhanced cultural competence in the delivery of care.

Section 1866C of the Social Security Act, as amended by Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173), section 1866C(b)), requires the Secretary of the Department of Health and Human Services to establish a 5-year demonstration program under which the Secretary may approve demonstration projects that examine health delivery factors that encourage improved quality in patient care. This section also authorizes the Secretary to waive compliance with such requirements of Titles XI and XVIII of the Social Security Act (42 U.S.C. 1395 *et seq.*) as may be necessary for the purposes of carrying out the demonstration project.

The MHCQ Demonstration programs are designed to examine the extent to which major, multifaceted changes to traditional Medicare's health delivery and financing systems lead to improvements in the quality of care provided to Medicare beneficiaries without increasing total program expenditures. Each demonstration site uses a different approach for changing health delivery and financing systems, but all share the goal of improving the quality and efficiency of medical care provided to Medicare beneficiaries. Focus groups and individual interviews will be conducted at 2 demonstration sites that are active in the demonstration: Gundersen Health System (GHS) and Meridian Health System (MHS).

This MHCQ Demonstration evaluation will include analysis of both quantitative and qualitative sources of information. This multifaceted approach will enable this evaluation to consider a broad variety of evidence for evaluating the nature and impact of each site's interventions. *Form Number:* CMS–10497 (OCN: 0938–NEW); *Frequency:* Occasionally; *Affected Public:* Individuals or households and Private sector (Not-for-profit organizations); *Number of Respondents:* 36; *Total Annual Responses:* 36; *Total Annual Hours:* 108. (For policy questions regarding this collection contact Normandy Brangan at 410–786–6640.).

Dated: August 27, 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 Identifiers: CMS–4040, CMS–10174, CMS–R–285, CMS–10166, CMS–10184, CMS–1572, CMS–10175, CMS–379 and CMS–10336)]

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 September 30, 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:* Reinstatement without change of a previously approved collection; *Title of Information Collection:* Request for Enrollment in Supplementary Medical Insurance; *Use:* Form CMS–4040 (and CMS–4040SP) is used to establish entitlement to and enrollment in Medicare Part B for beneficiaries who file for Part B only. The collected information is used to determine entitlement for individuals who meet the requirements in section 1836(2) of the Social Security Act as well as the entitlement of the applicant or their spouses to an annuity paid by OPM for premium deduction purposes. *Form Number:* CMS–4040 (OCN: 0938–0245); *Frequency:* Once; *Affected Public:* Individuals or households; *Number of Respondents:* 10,000; *Total Annual Responses:* 10,000; *Total Annual Hours:* 2,500. (For policy questions regarding this collection contact Lindsay Smith at 410–786–6843.)

2. *Type of Information Collection Request:* Reinstatement without change of a previously approved collection; *Title of Information Collection:* Collection of Prescription Drug Event Data from Contracted Part D Providers for Payment; *Use:* The information users would include Pharmacy Benefit Managers, third party administrators and pharmacies and prescription drug plans, Medicare Advantage plans that offer integrated prescription drug and health care coverage, Fallbacks and other plans that offer coverage of outpatient prescription drugs under the Medicare Part D benefit to Medicare beneficiaries. The data is used primarily for payment, but is also used for claim validation as well as for other legislated functions such as quality monitoring, program integrity, and oversight. *Form Number:* CMS–10174 (OCN: 0938–0982); *Frequency:* Monthly; *Affected Public:* Private sector (business or other for-profits and not-for-profit institutions); *Number of Respondents:* 747; *Total Annual Responses:* 947,881,770; *Total Annual Hours:* 1,896. (For policy questions regarding this collection contact Ivan Iveljic at 410–786–3312.)

3. *Type of Information Collection Request:* Reinstatement without change of a previously approved collection; *Title of Information Collection:* Request for Retirement Benefit Information; *Use:* Section 1818(d)(5) of the Social Security Act provides that former state and local government employees (who are age 65 or older, have been entitled to Premium Part A for at least 7 years, and did not have the premium paid for by a state, a political subdivision of a state, or an agency or instrumentality of one or more states or political subdivisions) may have the Part A premium reduced to zero. These individuals must also have 10 years of employment with the state or local government employer or a combination of 10 years of employment with a state or local government employer and a non-government employer. Form CMS–R–285 is an essential part of the process of determining whether an individual qualifies for the premium reduction. The Social Security Administration will use this information to help determine whether a beneficiary meets the requirements for reduction of the Part A premium. *Form Number:* CMS–R–285 (OCN: 0938–0769); *Frequency:* Once; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 500; *Total Annual Responses:* 500; *Total Annual Hours:* 125. (For policy questions regarding this collection contact Lindsay Smith at 410–786–6843.)

4. *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.)

5. *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 CMS 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 is we select. *Form Number:* CMS–10184 (OCN: 0938–1012); *Frequency:* Yearly and 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.)

6. *Type of Information Collection Request:* Reinstatement with change of a previously approved collection; *Title of Information Collection:* Home Health Agency Survey and Deficiencies Report; *Use:* In order to participate in the Medicare Program as a Home Health Agency (HHA) provider, the HHA must meet federal standards. This form is used to record information and patients' health and provider compliance with requirements and to report the information to the federal government. *Form Number:* CMS–1572 (OCN: 0938–0355); *Frequency:* Yearly; *Affected Public:* State, Local or Tribal Government; *Number of Respondents:* 3,830; *Total Annual Responses:* 3,830; *Total Annual Hours:* 958. (For policy questions regarding this collection contact Patricia Sevast at 410–786–8135.)

7. *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.).

8. *Type of Information Collection Request:* Reinstatement without change of a previously approved collection; *Title of Information Collection:* Financial Statement of Debtor and Supporting Regulations; *Use:* The Form CMS–379 is used to collect financial information which is needed to evaluate requests from physicians and suppliers to pay indebtedness under an extended repayment schedule, or to compromise a debt less than the full amount. Normally, when a Medicare Administrative Contractor (MAC) overpays a physician or supplier, the overpayment is associated with a single claim, and the amount of the overpayment is moderate. In these cases, the physician/supplier usually refunds the overpaid amount in a lump sum. Alternatively, the MAC may recoup the overpaid amount against future payments. A recoupment is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. The recoupment can be made only if the physician or supplier accepts assignment since the MAC makes payment to the physician or supplier only on assigned claims.

Sometimes, however, an overpayment to a physician or supplier is exceptionally large, and it cannot be recovered in the normal fashion. The large overpayment usually results from aberrant billing practices, such as billing for more expensive services than were rendered. This could be discovered during routine review of a statistically valid sample of claims. The physician or supplier may be unable to refund a large overpaid amount in a single payment. The MAC cannot recover the overpayment by recoupment if the physician/supplier does not accept assignment of future claims, or is not expected to file future claims because of going out of business, illness or death. In these unusual circumstances, the MAC has authority to approve or deny extended repayment schedules up to 12 months, or may recommend to that we approve up to 60 months. Before the MAC takes these actions, the MAC will require full documentation of the physician's or supplier's financial situation. Thus, the physician or supplier must complete Form CMS–379. *Form Number:* CMS–379 (OCN: 0938–0270); *Frequency:* Occasionally; *Affected Public:* Private sector (business or other for-profits); *Number of Respondents:* 500; *Total Annual Responses:* 500; *Total Annual Hours:* 1,000. (For policy questions regarding this collection contact Ronke Fabayo at 410–786–4460.)

9. *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. (For policy questions regarding this collection contact Travis Broome at 214–767–4450.)

Dated: August 27, 2013.

Martique Jones,

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

[FR Doc. 2013–21257 Filed 8–29–13; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–7030–N]

Medicare, Medicaid, and Children's Health Insurance Programs; Meeting of the Advisory Panel on Outreach and Education

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a meeting of the Advisory Panel on Outreach and Education (APOE) (the Panel) in accordance with the Federal Advisory Committee Act. The Panel advises and makes recommendations to the Secretary of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services on opportunities to enhance the effectiveness of consumer education strategies concerning Medicare, Medicaid and the Children's Health Insurance Program (CHIP). This meeting is open to the public.

DATES: *Meeting Date:* Monday, September 16, 2013, 8:30 a.m. to 4:00 p.m. Eastern Standard Time (EST).

Deadline for Meeting Registration, Presentations and Comments: Monday, September 9, 2013, 5:00 p.m., EST.

Deadline for Requesting Special Accommodations: Monday, September 9, 2013, 5:00 p.m., EST.

ADDRESSES: *Meeting Location:* Sheraton Silver Spring, 8777 Georgia Avenue, Silver Spring, Maryland 20910.

Presentations and Written Comments: Kirsten Knutson, Acting Designated Federal Official (DFO), Division of Forum and Conference Development, Office of Communications, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mailstop S1–13–05, Baltimore, MD 21244–1850 or contact Ms. Knutson via email at *mailto:Kirsten.Knutson@cms.hhs.gov.*

Registration: The meeting is open to the public, but attendance is limited to the space available. Persons wishing to attend this meeting must register at the Web site *http://events.SignUp4.com/APOESEPT2013MTG* or by contacting the DFO at the address listed in the **ADDRESSES** section of this notice or by telephone at number listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice, by the date listed in the **DATES** section of this notice. Individuals requiring sign language interpretation or other special accommodations should contact the DFO at the address listed in the **ADDRESSES** section of this notice by the date listed in the **DATES''** section of this notice.

FOR FURTHER INFORMATION CONTACT: Kirsten Knutson, (410) 786–5886. Additional information about the APOE is available on the Internet at: *http://www.cms.gov/Regulations-and Guidance/Guidance/FACA/APOE.html.*

Press inquiries are handled through the CMS Press Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION: In accordance with section 10(a) of the Federal Advisory Committee Act (FACA), this notice announces a meeting of the Advisory Panel on Outreach and Education (APOE) (the Panel). Section 9(a)(2) of the Federal Advisory Committee Act authorizes the Secretary of Health and Human Services (the Secretary) to establish an advisory panel if the Secretary determines that the panel is ''in the public interest in connection with the performance of duties imposed . . . by law.'' Such duties are imposed by section 1804 of the Social Security Act (the Act), requiring the Secretary to provide informational materials to Medicare beneficiaries about the Medicare program, and section 1851(d) of the Act, requiring the Secretary to provide for ''activities . . . to broadly disseminate information to [M]edicare beneficiaries . . . on the