

The Centers for Medicare and Medicaid Services (CMS) is requesting that a paperwork Reduction Act (PRA) package for a new CMS Real-Time Eligibility Agreement and Access Request form be processed under the emergency clearance process. The approval of this data collection process is essential in order to support the necessary national database and infrastructure to process Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant health care eligibility inquiries (270) and responses (271) in a real-time basis.

CMS is requiring that trading partners who wish to conduct the eligibility transaction on a real-time basis to access Medicare beneficiary information provide certain assurances as a condition of receiving access to the Medicare database for the purpose of conducting eligibility verification. Health care providers, clearinghouses, and health plans that wish to access the Medicare database are required to complete the access request form. The information will be used to assure that those entities that access the Medicare database are aware of applicable provisions and penalties.

CMS is requesting OMB review and approval of this collection by July 1, 2005, with a 180-day approval period. Written comments and recommendation will be accepted from the public if received by the individuals designated below by June 28, 2005.

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/regulations/prare> or e-mail 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.

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 June 28, 2005:

Centers for Medicare and Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Room C5-13-27, 7500 Security Boulevard, Baltimore, MD 21244-1850. *Fax Number:* (410) 786-0262, *Attn:* William N. Parham, III, CMS-10157; and
OMB Human Resources and Housing Branch, Attention: Christopher

Martin, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: June 3, 2005.

Jim L. Wickliffe,

CMS Reports Clearance Officer, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS-250-254]

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

AGENCY: Center 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), 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) of 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 an initiative of the Administration. We cannot reasonably comply with the normal clearance procedures the use of normal clearance

procedures is reasonably likely to cause a statutory deadline to be missed.

The Centers for Medicare & Medicaid Services (CMS) is seeking approval to collect information from beneficiaries, providers, physicians, or suppliers on health insurance coverage that is primary to Medicare. Collecting this information allows CMS to identify those Medicare beneficiaries who have other group health insurance that would pay before Medicare, safeguarding the Medicare Trust Fund. The annual savings from the Medicare Secondary Payer (MSP) program for Parts A and B are more than \$4.5 billion per year. With the impending implementation of Medicare Part D under the Medicare Prescription Drug, Modernization and Improvement Act of 2003 (MMA), a new approval is needed in order to include prescription drug-related questions on the already-approved MSP collections and increase the savings to the Medicare Trust Fund.

CMS is requesting OMB review and approval of this collection by July 15, 2005, with a 180-day approval period. Written comments and recommendation will be accepted from the public if received by the individuals designated below by June 11, 2005.

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/regulations/prare> or e-mail 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.

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 July 11, 2005:

Centers for Medicare and Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Room C5-13-27, 7500 Security Boulevard, Baltimore, MD 21244-1850. *Fax Number:* (410) 786-0262. *Attn:* William N. Parham, III, CMS-250-254; and

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

Dated: June 3, 2005.

Jim L. Wickliffe,

CMS Paperwork Reduction Act Reports Clearance Officer, 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-10143, CMS-10140, CMS-460, CMS-R-65]

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:* New collection; *Title of Information Collection:* Monthly State File of Medicaid/Medicare Dual Eligible Enrollees and Supporting Regulations in 42 CFR 423.900 through 423.910; *Use:* The monthly file of dual eligible enrollees will be used to determine those duals with drug benefits for the phased-down State contribution process required by the Medicare Modernization Act of 2003 (MMA). Section 103(a)(2) of the MMA addresses the phased-down state contribution (PDSC) process for the Medicare program. The reporting of the Medicare/Medicaid dual eligibles on a monthly basis is necessary to implement those provisions, and to Support Part D subsidy determinations and auto-assignment of individuals to Part D plans. The PDSC is a partial recoupment

from the States of ongoing Medicaid drug costs for dual eligibles assumed by Medicare under MMA, which absent the MMA would have been paid for by the States; *Form Number:* CMS-10143 (OMB# 0938-NEW); *Frequency:* Recordkeeping and Monthly reporting; *Affected Public:* State, local or tribal government; *Number of Respondents:* 51; *Total Annual Responses:* 612; *Total Annual hours:* 10,710.

2. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Claims Error Rate Testing (CERT)/Electronic Medical Records Exploratory Survey; *Form No.:* CMS-10140 (OMB# 0938-NEW); *Use:* The Centers for Medicare and Medicaid Services (CMS) is using a private vendor to conduct market research to assess the value of electronic patient medical records relative to the Claims Error Rate Testing (CERT) program and determine what actions CMS can take to encourage the use of electronic records for the purpose of lowering the CERT error rate. The proposed effort will test the hypothesis that increased functionality of electronic records (meaning, greater connectivity and features), is associated with lower CERT error rates related to coding, non-response and incomplete documentation. The project is expected to assist CMS in identifying a strategy to improve the CERT claims error rate by developing an approach that would both facilitate and encourage the use of electronic patient medical records in the health care setting. This research focuses on physician practices, outpatient hospitals, durable medical equipment (DME) providers and skilled nursing facilities (SNFs) that have been randomly sampled as part of the CERT process.; *Frequency:* On occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 1600; *Total Annual Responses:* 1600; *Total Annual Hours:* 454.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Participating Physician or Supplier Agreement; *Form No.:* CMS-460 (OMB# 0938-0373); *Use:* Form number CMS-460 is completed by nonparticipating physicians and suppliers if they choose to participate in Medicare Part B. By signing the agreement, the physician or supplier agrees to take assignment on all Medicare claims. To take assignment means to accept the Medicare allowed amount as payment in full for the services they furnish and to charge the beneficiary no more than the deductible and coinsurance for the covered service. In exchange for signing the agreement, the physician or supplier receives a

significant number of program benefits not available to nonparticipating suppliers. The information associated with this collection is needed to identify the recipients of the program benefits; *Frequency:* Other—when starting a new business; *Affected Public:* Business or other for-profit; *Number of Respondents:* 6000; *Total Annual Responses:* 6000; *Total Annual Hours:* 1500.

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Information Collection Requirements in Final Peer Review Organization Regulations, 42 CFR sections 1004.40, 1004.50, 1004.60, 1004.70; *Form No.:* CMS-R-65 (OMB# 0938-0444); *Use:* This final rule updates the procedures governing the imposition and adjudication of program sanctions predicated on the recommendations of Peer Review Organizations (PROs). These changes are being made as a result of statutory revisions designed to address health care fraud and abuse issues in the OIG sanction process. The Peer Review Improvement Act of 1982 amended Title XI of the Social Security Act, creating the Utilization and Quality Control Peer Review Organization program. Section 1156 of the Social Security Act imposes obligations on health care practitioners and other persons who furnish or order services or items under Medicare. This section also provides for sanction actions, if the Secretary determines that the obligations as stated by this section are not met. Quality Improvement Organizations (QIOs) are responsible for identifying violations. QIOs may allow practitioners or other persons, opportunities to submit relevant information before determining that a violation has occurred. These requirements are used by the QIOs to collect the information necessary to make their determinations; *Frequency:* On occasion; *Affected Public:* Not-for-profit institutions; *Number of Respondents:* 53; *Total Annual Responses:* 1060; *Total Annual Hours:* 22,684.

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/regulations/pr/>, or e-mail 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.

Written comments and recommendations for the proposed information collections must be mailed