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/pra/*, 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

within 30 days of this notice directly to the OMB desk officer:

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

Dated: June 10, 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 & Medicaid Services

[Document Identifier: CMS–R–262, CMS–R–254, CMS–1450, CMS–10146, CMS–10147, CMS–10154, and CMS–10160]

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:* Extension of a currently approved collection; *Title of Information Collection:* Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDPs); *Form No.:* CMS–R–262 (OMB # 0938–0763); *Use:* Under the Medicare Modernization Act (MMA), Medicare Advantage (MA) and Prescription Drug Plan (PDP) organizations are required to submit plan benefit package information to CMS for approval. Organizations will provide this information through the submission of the formulary and the PBP software; *Frequency:* On occasion, annually and other (as required by new legislation); *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 470; *Total Annual Responses:* 2,092; *Total Annual Hours:* 5,546.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* National Medicare Education Program (NMEP); *Form No.:* CMS–R–254 (OMB # 0938–0738); *Use:* The NMEP was developed to inform people with Medicare, their family members, and other interested parties about their Medicare options. The Medicare Modernization Act of 2003 expanded the program to include among other things, a new Prescription Drug Benefit; therefore, this package has been revised to include this information. The NMEP employs numerous communication channels to educate people with Medicare and help them make more informed decisions concerning the Medicare program benefits; health plan choices; supplemental health insurance; rights, responsibilities, and protections; and preventive health services. As part of the NMEP, CMS must provide information to this population about the Medicare program and their Health Plan options, as well as information about the new prescription drug coverage to help them choose the option that is right for them. This survey seeks to assess the awareness, knowledge, understanding and experiences of people with Medicare regarding the Medicare program overall and these new initiatives; *Frequency:* On occasion; *Affected Public:* Individuals or Households; *Number of Respondents:* 5,700; *Total Annual Responses:* 5,700; Total Annual Hours: 1,425.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Uniform Institutional Provider Bill and Supporting Regulations in 42 CFR 424.5; *Form No.:* CMS–1450 (OMB # 0938–0279); *Use:* Section 42 CFR 424.5(a)(5) requires providers of services to submit claims prior to Medicare reimbursement. Charges are coded by revenue codes. The bill specifies diagnoses according to the International Classification of Diseases, Ninth Edition (ICD–9–CM) code. Inpatient procedures are identified by ICD–9–CM codes, and outpatient procedures are described using the Healthcare Common Procedure Coding System (HCPCS). These are standard systems of identification for all major health insurance claims payers. Submission of information on the CMS–1450 permits Medicare intermediaries to receive consistent data for proper payment; *Frequency:* On occasion; *Affected Public:* Not-for-profit institutions, Business or other for profit; *Number of Respondents:* 51,629; *Total Annual Responses:* 174,461,278; *Total Annual Hours:* 1,997,581.

4. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Notice of Denial of Medicare Prescription Drug Coverage; *Form No.:* CMS–10146 (OMB # 0938–NEW); *Use:* Pursuant to 42 CFR 423.568(c), if a Part D plan denies drug coverage, in whole or in part, the Part D plan must give the enrollee written notice of the coverage determination; *Frequency:* Other: Distribution; *Affected Public:* Business or other for profit, Not-for-profit institutions; Individuals or Households and Federal Government; *Number of Respondents:* 450; *Total Annual Responses:* 1,056,000; *Total Annual Hours:* 528,000.

5. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Medicare Prescription Drug Coverage and Your Rights; *Form No.:* CMS–10147 (OMB # 0938–NEW); *Use:* Pursuant to 42 CFR 423.562(a)(3), a Part D plan sponsor must arrange with its network pharmacies to post or distribute notices informing enrollees to contact their plan to request a coverage determination or an exception if the enrollee disagrees with the information provided by the pharmacy; *Frequency:* Other: Distribution; *Affected Public:* Business or other for profit, Not-for-profit institutions; Individuals or Households and Federal Government; *Number of Respondents:* 41,000; *Total Annual Responses:* 35,000,000; *Total Annual Hours:* 583,333.

6. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Physician Assessment of Hospital Quality Reports; *Form No.:* CMS–10154 (OMB # 0938–NEW); *Use:* This assessment will monitor the attitudes and behaviors of physicians as they relate to the concerns of their patients who have been exposed to hospital quality-of-care reports at CMS's Web site; *Affected Public:* Individuals or Households; *Number of Respondents:* 1730; *Total Annual Responses:* 1730; *Total Annual Hours:* 345.75.

7. *Type of Information Collection Request:* New collection; *Title of Information Collection:* The Personal Responsibility Survey; *Form No.:* CMS–10160 (OMB # 0938–NEW); *Use:* New focus on personalizing messages by