

Each individual will be asked to complete the form which will include providing the individual's name, PCIP account number (if known), date of birth, what personal health information they agree to share, the length of time the individual agrees their personal health information can be shared, the names and addresses of the third party the individual wants PCIP to share their personal health information with, and an attestation that the individual is giving PCIP permission to share their personal health information with the third party listed in the form. This completed form will be submitted to the PCIP benefits administrator, GEHA, which contracts with CMS.

We estimate that it will take approximately 15 minutes per applicant to complete and submit a HIPAA Authorization Form to the PCIP program.

The federally-run PCIP program operates in 23 states plus the District of Columbia and receives an average of 35,000 enrollment applications per year. To estimate the number of PCIP applicants and enrollees who may complete an authorization, we looked at the percentage of individuals who request an authorization in Medicare as a baseline. Medicare estimates 3% of its population will submit an authorization per year. However, since the PCIP program caters to an exclusive population comprised of individuals who have one or more pre-existing conditions, we believe it is likely we could receive double the percentage estimated by Medicare. Accordingly, PCIP estimates 6% (or 2,100) of its applicants and enrollees may submit an authorization per year.

Based on the above, it is estimated that up to 2,100 applicants and enrollees may submit an authorization annually. There is no cost to PCIP beneficiaries to request, complete, submit, or have the authorization form processed by PCIP. It should take approximately 15 minutes for a beneficiary to complete the authorization form. 15 minutes multiplied by 2,100 beneficiaries equals 525 hours. *Form Number:* CMS-10428 (OCN#: 0938-1161); *Frequency:* Once; *Affected Public:* Individuals or households; *Number of Respondents:* 2,100; *Total Annual Responses:* 2,100; *Total Annual Hours:* 525. (For policy questions regarding this collection contact Geoffrey Cabin at 410-786-1744. For all other issues call 410-786-1326.)

1. *Type of Information Collection Request:* New collection (request for a new OMB control number). *Title of Information Collection:* Consumer

Research Supporting Outreach for Health Insurance Marketplace. *Use:* The Centers for Medicare and Medicaid Services is requesting clearance for two surveys to aid in understanding levels of awareness and customer service needs associated with the Health Insurance Marketplace established by the Affordable Care Act. Because the Marketplace will provide coverage to the almost 50 million uninsured in the United States through individual and small employer programs, we have developed one survey to be administered to individual consumers most likely to use the Marketplace and another to be administered to small employers most likely to use the Small Business Health Options portion of the Marketplace. These brief surveys, designed to be conducted quarterly, will give CMS the ability to obtain a rough indication of the types of outreach and marketing that will be needed to enhance awareness of and knowledge about the Marketplace for individual and business customers. CMS' biggest customer service need is likely to be providing sufficient education so consumers: (a) Can take advantage of the Marketplace and (b) know how to access CMS' customer service channels. The surveys will provide information on media use, concept awareness, and conceptual or content areas where education for customer service delivery can be improved. Awareness and knowledge gaps are likely to change over time based not only on effectiveness of CMS' marketing efforts, but also of those of state, local, private sector, and nongovernmental organizations. *Form Number:* CMS-10458 (OCN: 0938-New). *Frequency:* Quarterly. *Affected Public:* Individuals or households, private sector (business or other for-profits). *Number of Responses:* 40,200. *Total Annual Responses:* 40,200. *Total Annual Hours:* 2,480. (For policy questions regarding this collection contact Julie Franklin at 410-786-8126. 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](mailto:Paperwork@cms.hhs.gov), or call the Reports Clearance Office on (410) 786-1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at

the address below, no later than 5 p.m. on May 6, 2013.

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395-6974, Email: [OIRA\\_submission@omb.eop.gov](mailto:OIRA_submission@omb.eop.gov).

Dated: March 29, 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 Identifier: CMS-10467, CMS-10330, and CMS-10325]

#### 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 of Information Collection:* Evaluation of the Graduate Nurse Education Demonstration Program; *Use:* The Graduate Nurse Education (GNE) Demonstration is mandated under Section 5509 of the Affordable Care Act (ACA) under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). According to Section 5509 of the ACA, the five selected demonstration sites receive "payment for the hospital's reasonable costs for the provision of qualified clinical training to advance practice registered nurses." Section 5509 of the ACA also states that an

evaluation of the graduate nurse education demonstration must be completed no later than October 17, 2017. This evaluation includes analysis of the following: (1) Growth in the number of advanced practice registered nurses (APRNs) with respect to a specific base year as a result of the demonstration; (2) growth for each of the following specialties: clinical nurse specialist, nurse practitioner, certified nurse anesthetist, certified nurse-midwife; and (3) costs to the Medicare program as result of the demonstration.

Quantitative and qualitative data from primary and secondary sources will be gathered and analyzed for this evaluation. The primary data will be collected through site visits, key stakeholder interviews, small discussion groups and focus groups, telephone interviews, electronic templates for quantitative data submission, and quarterly demonstration-site reports. The secondary data will come from mandatory hospital cost reports provided to the Centers for Medicare and Medicaid Services, and several other existing secondary data sources, such as the American Association of Colleges of Nursing (AACN). *Form Number:* CMS-10467 (OCN: 0938-NEW); *Frequency:* Annually; *Affected Public:* State, Local, or Tribal Governments, Business and other for-profit and not-for-profit institutions; *Number of Respondents:* 330; *Total Annual Responses:* 330; *Total Annual Hours:* 3,370. (For policy questions regarding this collection, contact Pauline Karikari-Martin at 410-786-1040. For all other issues call 410-786-1326.)

**2. Type of Information Collection Request:** Reinstatement with change of a previously approved information collection; *Title of Information Collection:* Enrollment Opportunity Notice Relating to Lifetime Limits; Required Notice of Rescission of Coverage; and Disclosure Requirements for Patient Protection under the Affordable Care Act; *Use:* Under section 2711 of the Public Health Service Act (PHS Act) amended by the Affordable Care Act, the enrollment opportunity notice was to be used by health plans to notify certain individuals of their right to re-enroll in their plan. The affected individuals were those whose coverage ended due to reaching a lifetime limit on the dollar value of all benefits for any individual. This notice was a one-time requirement and is being discontinued. Under section 2712 of the PHS Act as amended by the Affordable Care Act, the rescission notice will be used by health plans to provide advance notice to certain individuals that their coverage

may be rescinded. The affected individuals are those who are at risk of rescission on their health insurance coverage. Under section 2719A of the PHS Act as amended by the Affordable Care Act, the patient protection notification will be used by health plans to inform certain individuals of their right to choose a primary care provider or pediatrician and to use obstetrical/gynecological services without prior authorization. *Form Number:* CMS-10330 (OCN: 0938-1094); *Frequency:* On Occasion; *Affected Public:* Private Sector; State, Local, or Tribal Governments; *Number of Respondents:* 8,382; *Number of Responses:* 1,583,371; *Total Annual Hours:* 2,267. (For policy questions regarding this collection, contact Usree Bandyopadhyay at 410-786-6650. For all other issues call (410) 786-1326.)

**3. Type of Information Collection Request:** Reinstatement with change of a previously approved collection of information; *Title of Information Collection:* Disclosure and recordkeeping requirements for Grandfathered Health Plans under the Affordable care Act *Use:* Section 1251 of the Patient Protection and Affordable Care Act, Public Law 111-148, (the Affordable Care Act) provides that certain plans and health insurance coverage in existence as of March 23, 2010, known as grandfathered health plans, are not required to comply with certain statutory provisions in the Act. To maintain its status as a grandfathered health plan, the interim final regulations titled "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act" (75 FR 34538, June 17, 2010) require the plan to maintain records documenting the terms of the plan in effect on March 23, 2010, and any other documents that are necessary to verify, explain or clarify status as a grandfathered health plan. The plan must make such records available for examination upon request by participants, beneficiaries, individual policy subscribers, or a State or Federal agency official. The recordkeeping requirement will allow a participant, beneficiary, or federal or state official to inspect plan documents to verify that a plan or health insurance coverage is a grandfathered health plan. A grandfathered health plan must include a statement in any plan materials provided to participants or beneficiaries (in the individual market, primary subscriber) describing the benefits provided under the plan or health

insurance coverage, and that the plan or coverage is intended to be grandfathered health plan. The disclosure requirement will provide participants and beneficiaries with important information about their grandfathered health plans, such as that grandfathered plans are not required to comply with certain consumer protection provisions contained in the Act. It also will provide important contact information for participants to find out which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered to non-grandfathered health plan status. An amendment to the interim final regulations (75 FR 70114, November 17, 2010) requires a grandfathered group health plan that is changing health insurance issuers to provide the succeeding health insurance issuer (and the succeeding health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health insurance coverage sufficient to make a determination whether the standards set forth in paragraph (g)(1) of the interim final regulations are exceeded. *Form Number:* CMS-10325 (OCN: 0938-1093); *Frequency:* Annually; *Affected Public:* State, Local, or Tribal governments and health insurance coverage issuers; *Number of Respondents:* 64,552; *Number of Responses:* 10,113,926; *Total Annual Hours:* 85. (For policy questions regarding this collection, contact Usree Bandyopadhyay at (410) 786-6650. 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](mailto: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 June 3, 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: March 29, 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-10309, CMS-10475, CMS-R-5, CMS-R-234, and CMS-R-297]

#### 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:* Reinstatement with change of a previously approved collection. *Title of Information Collection:* Grandfathering Provisions of the Medicare DMEPOS Competitive Bidding Program. *Use:* Section 1847(a)(4) of the Social Security Act (the Act) requires that (in the case of covered durable medical equipment (DME) items for which payment is made on a rental basis under section 1834(a) of the Act and in the case of oxygen for which payment is made under section

1834(a)(5) of the Act) the Secretary shall establish a grandfathering process by which covered items and supplies that were rented by suppliers before the implementation of a competitive bidding program may be continued.

We established the grandfathering process in the April 10, 2007 final rule for competitive bidding (72 FR 17992) for rented DME and oxygen and oxygen equipment when these items are included under the Medicare DMEPOS Competitive Bidding Program. This process only applies to suppliers that rented DME and oxygen and oxygen equipment to beneficiaries who maintain a permanent residence in a competitive bidding area (CBA) before the implementation of the competitive bidding program.

The competitive bidding program will require some beneficiaries to change their suppliers. In order to avoid a beneficiary being without medically necessary equipment we felt it necessary to establish this notification process.

The notification to the beneficiaries is a beneficiary protection that will keep them informed of whether or not they can continue to rent an item from their current supplier or go to a contract supplier. The notification will also provide information to the beneficiary as to how to find a contract supplier in their CBA. In the event that the beneficiary must go to a contract supplier, the notification will identify the procedure for the pick-up of their current equipment and delivery of new equipment.

*Form Number:* CMS-10309 (OCN 0938-1079). *Frequency:* Once. *Affected Public:* Private sector (business or other for-profits). *Number of Respondents:* 2,697 (or 8,091/3). *Total Annual Responses:* 536,667 (or 1,610,000/3). *Total Annual Hours:* 65 (or 196/3). (For policy questions regarding this collection contact Michael Keane at 410-786-4495. For all other issues call 410-786-1326.)

2. *Type of Information Collection Request:* New collection (request for a new OMB control number). *Title of Information Collection:* Hospice Experience of Care Survey. *Use:* This survey supports the National Quality Strategy that was called for under the Affordable Care Act 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 a three-part aim focusing on better care, better health, and lower costs through improvement. Because the hospice survey focuses on experiences of care, implementation of the survey supports

the following national priorities for improving care: engaging patients and families in care and promoting effective communication and coordination. In addition, upon national implementation and public reporting of hospice survey results, the survey will provide data on experiences with hospice care that enable consumers to make meaningful comparisons between hospices across the nation. *Form Number:* CMS-10475 (OCN 0938-New). *Frequency:* Once. *Affected Public:* Individuals and households. *Number of Respondents:* 730. *Total Annual Responses:* 730. *Total Annual Hours:* 185. (For policy questions regarding this collection contact Lori Teichman at 410-786-6684. For all other issues call 410-786-1326.)

3. *Type of Information Collection Request:* Reinstatement without change of a previously approved collection. *Title of Information Collection:* Physician Certification/Recertification in Skilled Nursing Facilities (SNFs) Manual Instructions and Supporting Regulation in 42 CFR 424.20. *Use:* The Medicare program requires, as a condition for Medicare Part A payment for posthospital SNF services that a physician must certify and periodically recertify that a beneficiary requires an SNF level of care. The physician certification and recertification is intended to ensure that the beneficiary's need for services has been established and then reviewed and updated at appropriate intervals. The documentation is a condition for Medicare Part A payment for post-hospital SNF care. *Form Number:* CMS-R-5 (OCN 0938-0454). *Frequency:* Occasionally. *Affected Public:* Private sector (business or other for-profit and not-for-profit institutions). *Number of Respondents:* 1,796,502. *Total Annual Responses:* 1,796,502. *Total Annual Hours:* 559,713. (For policy questions regarding this collection contact Kia Sidbury at 410-786-7816. For all other issues call 410-786-1326.)

4. *Type of Information Collection Request:* Extension without change of a currently approved collection. *Title of Information Collection:* Subpart D—Private Contracts and Supporting Regulations contained in 42 CFR 405.410, 405.430, 405.435, 405.440, 405.445, and 405.455. *Use:* Section 4507 of Balancing Budget Act (BBA) 1997 amended section 1802 of the Social Security Act to permit certain physicians and practitioners to opt-out of Medicare and to provide (through private contracts) services that would otherwise be covered by Medicare. Under such contracts the mandatory claims submission and limiting charge