## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[Document Identifiers: CMS–10596, CMS–906, CMS–1771, CMS–1450, CMS–1500 (02–12)]**

### 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 April 5, 2016.

**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) 395–5806 *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:* New collection (Request for a new OMB control number); *Title of Information Collection:* Reapplication Submission Requirement for Qualified Entities under ACA Section 10332; *Use:* Section 10332 of the Patient Protection and Affordable Care Act (ACA) requires the Secretary to make standardized extracts of Medicare claims data under Parts A, B, and D available to ''qualified entities'' for the evaluation of the performance of providers of services and suppliers. The statute provides the Secretary with discretion to establish criteria to determine whether an entity is qualified to use claims data to evaluate the performance of providers of services and suppliers. After consideration of comments from a wide variety of stakeholders during the public comment period, CMS established ''Medicare Program; Availability of Medicare Data for Performance Measurement'' (hereinafter called the Final Rule and referred to as the Medicare Data Sharing Program). It was published in the **Federal Register** on December 7, 2011 (42 CFR, Part 401, Subpart G). To implement the requirements outlined in the legislation, the Centers for Medicare and Medicaid Services (CMS) established the Qualified Entity Certification Program (QECP). The Qualified Entity Certification Program (QECP) was established to implement the Final Rule. One of the requirements in the Final Rule is that QEs must reapply for certification six months prior to the end of their 3-year certification period to remain in good standing. This form is the official reapplication that QEs must complete to reapply to the QECP. *Form Number:* CMS–10596 (OMB Control Number: 0938—New); *Frequency:* Occasionally; *Affected Public:* Private sector (Business or other for-profit and Not-for-profit institutions); *Number of Respondents:* 10; *Total Annual Responses:* 10; *Total Annual Hours:* 1,200. (For policy questions regarding this collection contact Kari Gaare at 410–786–8612.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* The Fiscal Soundness Reporting Requirements; *Use:* The CMS is assigned responsibility for overseeing all Medicare Advantage Organizations (MAOs), Prescription Drug Plan (PDP) sponsors and PACE organizations on-going financial performance. Specifically, CMS needs the requested collection of information to establish that contracting entities within those programs maintain fiscally sound organizations and thereby remain a going concern. All contracting organizations must submit annual independently audited financial statements one time per year. The MAOs with a negative net worth and/or a net loss and the amount of that loss is greater than one-half of the organization's total net worth must file three quarterly financial statements. Currently, there are approximately 71 MAOs filing quarterly financial statements. Part D organizations must also 3 quarterly financial statements. The PACE organizations are required to file 4 quarterly financial statements for the first three years in the program as well as PACE organizations with a negative net worth and/or a net loss and the amount of that loss is greater than one-half of the organization's total net worth. *Form Number:* CMS–906 (OMB control number: 0938–0469); *Frequency:* Annually; *Affected Public:* Business or other for-profits; *Number of Respondents:* 815; *Total Annual Responses:* 1,518; *Total Annual Hours:* 506. (For policy questions regarding this collection contact Geralyn Glenn at 410–786–0973.)

3. *Type of Information Collection Request:* Reinstatement without change of a previously approved collection; *Title of Information Collection:*

Emergency and Foreign Hospital Services; *Use:* Section 1866 of the Social Security Act states that any provider of services shall be qualified to participate in the Medicare program and shall be eligible for payments under Medicare if it files an agreement with the Secretary to meet the conditions outlined in this section of the Act. Section 1814 (d)(1) of the Social Security Act and 42 CFR 424.100, allows payment of Medicare benefits for a Medicare beneficiary to a nonparticipating hospital that does not have an agreement in effect with the Centers for Medicare and Medicaid Services. These payments can be made if such services were emergency services and if CMS would be required to make the payment if the hospital had an agreement in effect and met the conditions of payment. This form is used in connection with claims for emergency hospital services provided by hospitals that do not have an agreement in effect under Section 1866 of the Social Security Act. As specified in 42 CFR 424.103(b), before a non-participating hospital may be paid for emergency services rendered to a Medicare beneficiary, a statement must be submitted that is sufficiently comprehensive to support that an emergency existed. Form CMS–1771 contains a series of questions relating to the medical necessity of the emergency. The attending physician must attest that the hospitalization was required under the regulatory emergency definition and give clinical documentation to support the claim. A photocopy of the beneficiary's hospital records may be used in lieu of the CMS–1771 if the records contain all the information required by the form. *Form Number:* CMS–1771 (OMB control number: 0938–0023); *Frequency:* Annually; *Affected Public:* Private sector (Business or other for-profits and Not-for-profit institutions); *Number of Respondents:* 100; *Total Annual Responses:* 200; *Total Annual Hours:* 50. (For policy questions regarding this collection contact Shauntari Cheely at 410–786–1818.)

4. *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; *Use:* Section 42 CFR 424.5(a)(5) requires providers of services to submit a claim for payment prior to any Medicare reimbursement. Charges billed 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 CMS 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. *Form Numbers:* CMS–1450 (UB–04) (OMB control number: 0938–0997); *Frequency:* On occasion; *Affected Public:* Private sector (Business or other for-profit and Not-for-profit institutions); *Number of Respondents:* 53,111; *Total Annual Responses:* 181,909,654; *Total Annual Hours:* 1,567,455. (For policy questions regarding this collection contact Matt Klischer at 410–786–7488.)

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Health Insurance Common Claims Form and Supporting Regulations at 42 CFR part 424, subpart C; *Use:* The Form CMS–1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program for claims from physicians and suppliers. The Medicaid State Agencies, CHAMPUS/TriCare, Blue Cross/Blue Shield Plans, the Federal Employees Health Benefit Plan, and several private health plans also use it; it is the de facto standard ''professional'' claim form. Medicare carriers use the data collected on the CMS–1500 and the CMS–1490S to determine the proper amount of reimbursement for Part B medical and other health services (as listed in section 1861(s) of the Social Security Act) provided by physicians and suppliers to beneficiaries. The CMS–1500 is submitted by physicians/suppliers for all Part B Medicare. Serving as a common claim form, the CMS–1500 can be used by other third-party payers (commercial and nonprofit health insurers) and other Federal programs (*e.g.,* CHAMPUS/TriCare, Railroad Retirement Board (RRB), and Medicaid). However, as the CMS–1500 displays data items required for other third-party payers in addition to Medicare, the form is considered too complex for use by beneficiaries when they file their own claims. Therefore, the CMS–1490S (Patient's Request for Medicare Payment) was explicitly developed for easy use by beneficiaries who file their own claims. The form can be obtained from any Social Security office or Medicare carrier. *Form Number:* CMS–1500(02–12), CMS–1490S (OMB control number: 0938–1197) *Frequency:* On occasion; *Affected Public:* State, Local, or Tribal Governments, Private sector (Business or other-for-profit and Not-for-profit institutions); *Number of Respondents:* 1,448,346; *Total Annual Responses:* 988,005,045; *Total Annual Hours:* 21,418,336. (For policy questions regarding this collection contact Shannon Seales at 410–786–4089.)

Dated: February 2, 2016.

**William N. Parham, III,**

*Director, Paperwork Reduction Staff, Office of Strategic Operations and Regulatory Affairs.*

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**BILLING CODE 4120–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Health Resources and Services Administration

### National Vaccine Injury Compensation Program; List of Petitions Received

**AGENCY:** Health Resources and Services Administration, HHS.

**ACTION:** Notice.

**SUMMARY:** The Health Resources and Services Administration (HRSA) is publishing this notice of petitions received under the National Vaccine Injury Compensation Program (the Program), as required by Section 2112(b)(2) of the Public Health Service (PHS) Act, as amended. While the Secretary of Health and Human Services is named as the respondent in all proceedings brought by the filing of petitions for compensation under the Program, the United States Court of Federal Claims is charged by statute with responsibility for considering and acting upon the petitions.

**FOR FURTHER INFORMATION CONTACT:** For information about requirements for filing petitions, and the Program in general, contact the Clerk, United States Court of Federal Claims, 717 Madison Place NW., Washington, DC 20005, (202) 357–6400. For information on HRSA's role in the Program, contact the Director, National Vaccine Injury Compensation Program, 5600 Fishers Lane, Room 11C–26, Rockville, MD 20857; (301) 443–6593, or visit our Web site at: *http://www.hrsa.gov/vaccinecompensation/index.html.*

**SUPPLEMENTARY INFORMATION:** The Program provides a system of no-fault compensation for certain individuals who have been injured by specified childhood vaccines. Subtitle 2 of Title XXI of the PHS Act, 42 U.S.C. 300aa–10 *et seq.,* provides that those seeking compensation are to file a petition with the U.S. Court of Federal Claims and to