Contents

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS–10633 QIC Demonstration Evaluation Contractor (QDEC): Analyze Medicare Appeals To Conduct Formal Discussions and Reopenings With Suppliers

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 Collection

1. *Type of Information Collection Request:* New Collection (Request for a new OMB control number); *Title of Information Collection:* QIC Demonstration Evaluation Contractor (QDEC): Analyze Medicare Appeals to Conduct Formal Discussions and Reopenings with Suppliers; *Use:* The Formal Telephone Discussions Demonstration is designed to improve the efficiency of Medicare's five-level appeals system for fee-for-service (FFS) claims, which currently is experiencing a backlog. In the Demonstration, the Qualified Independent Contractor (QIC) provides education through a formal telephone discussion process to improve suppliers' understanding of the reasons for claim denials, and ultimately improve the quality of future claims submissions. CMS is interested in determining whether engagement between suppliers and the QIC will improve the understanding of the cause of Level 2 appeal denials, and over time, whether this results in increased submission of accurate and complete claims at the Medicare Administrative Contractor (MAC) level. The evaluation of the Demonstration will use both quantitative and qualitative techniques to analyze the outcomes and impact of the Demonstration. Claims analysis, a web-based supplier survey, and supplier key informant interviews will inform the evaluation, and: (1) Focus specifically on outcomes including supplier satisfaction with the discussions, the rate of claims denials, and the number of claims that go through appeals Levels 2 and 3; (2) seek to determine whether further engagement between suppliers and the QIC improves understanding of the reasons for claim denials; and (3) support CMS in assessing the QIC's effectiveness in meeting a number of criteria established by CMS, including how satisfied participating suppliers were with the formal telephone discussion process. *Form Number:* CMS–10633 (OMB control number: 0938–NEW); *Frequency:* Monthly; *Affected Public:* Private Sector Business or other for-profits, Not-for-Profit Institutions; *Number of Respondents:* 10,560; *Total Annual Responses:* 2,640; *Total Annual Hours:* 473.3. (For policy questions regarding this collection contact Lynnsie Doty at 410–786–2175.)

Dated: December 21, 2016.

William N. Parham, III,

Director, Paperwork Reduction Staff, 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–10180, CMS–R–138, CMS–10088, and CMS–10466]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

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 January 27, 2017.

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:* Extension of a currently approved collection; *Title of Information Collection:* Children's Health Insurance Program (CHIP) Report on Payables and Receivables; *Use:* Collection of CHIP data and the calculation of the CHIP Incurred But Not Reported (IBNR) estimate are pertinent to CMS' financial audit. Section 2105 of the Social Security Act (Title XXI) requires the Secretary to estimate the amount each State should be paid at the beginning of each quarter. This amount is based on a report filed by the State. Section 2105 of the Social Security Act authorizes the Secretary to pay the amount estimated, reduced or increased to the extent of any overpayment or underpayment for any prior quarter. Section 3515 of the CFO Act requires government agencies to produce auditable financial statements in accordance with Office of Management and Budget guidelines on Form and Content. The Government Management and Reform Act of 1994 requires that all offices, bureaus and associated activities of the 24 CFO Act agencies must be covered in an agency-wide, audited financial statement. Collection of CHIP data and the calculation of the CHIP Incurred But Not Reported (IBNR) estimate are pertinent to CMS' financial audit. The CHIP Report on Payables and Receivables will provide the information needed to calculate the CHIP IBNR. Failure to collect this information could result in non-compliance with the law. Program expenditures for the CHIP have increased since its inception; as such, CHIP receivables and payables may materially impact the financial statements. The CHIP Report on Payables and Receivables will provide the information needed to calculate the CHIP IBNR. *Form Number:* CMS–10180 (OMB control number: 0938–0988); *Frequency:* Reporting—Annually; *Affected Public:* State, Local or Tribal governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 392. (For policy questions regarding this collection contact Beverly Boher at 410–786–7806.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Geographic Classification Review Board Procedures and Criteria; *Use:* During the first few years of IPPS, hospitals were paid strictly based on their physical geographic location concerning the wage index (Metropolitan Statistical Areas (MSAs)) and the standardized amount (rural, other urban, or large urban). However, a growing number of hospitals became concerned that their payment rates were not providing accurate compensation. The hospitals argued that they were not competing with the hospitals in their own geographic area, but instead that they were competing with hospitals in neighboring geographic areas. At that point, Congress enacted Section 1886(d)(10) of the Act which enabled hospitals to apply to be considered part of neighboring geographic areas for payment purposes based on certain criteria. The application and decision process is administered by the MGCRB which is not a part of CMS so that CMS could not be accused of any untoward action. However, CMS needs to remain apprised of any potential payment changes. Hospitals are required to provide CMS with copy of any applications that they made to the MGCRB. CMS also developed the guidelines for the MGCRB that were the interim final issue of the **Federal Register**, and must ensure that the MGCRB properly applied the guidelines. This check and balance process also contributes to limiting the number of hospitals that ultimately need to appeal their MGCRB decisions to the CMS Administrator. *Form Number:* CMS–R–138 (OMB control number: 0938–0573); *Frequency:* Occasionally; *Affected Public:* Businesses or other for-profits and Not-for-profit institutions; *Number of Respondents:* 300; *Total Annual Responses:* 300; *Total Annual Hours:* 300. (For policy questions regarding this collection contact Noel Manlove at 410–786–5161.)

3. *Type of Information Collection Request:* Reinstatement of a previously approved collection; *Title of Information Collection:* Notification of FIs and CMS of co-located Medicare providers; *Use:* Many long-term care hospitals (LTCHs) are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs, psychiatric facilities), which leads to potential gaming of the Medicare system based on patient shifting. In regulations at 42 CFR 412.22(e)(3) and (h)(6) and 412.532(i), CMS is requiring LTCHs to notify Medicare Administrative Contractors (MACs) and CMS of co-located providers in order to establish policies to limit payment abuse that will be based on FIs tracking patient movement among these co-located providers. *Form Number:* CMS–10088 (OMB control number: 0938–0897); *Frequency:* Annually; *Affected Public:* Businesses or other for-profits and Not-for-profit institutions; *Number of Respondents:* 25; *Total Annual Responses:* 25; *Total Annual Hours:* 6. (For policy questions regarding this collection contact Emily Lipkin at 410–786–3633.)

4. *Type of Information Collection Request:* Revision of a previously approved collection; *Title of Information Collection:* Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; *Use:* The data collection and reporting requirements in ''Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions'' (CMS–9958–F, 78 FR 39518), address federal requirements that states must meet with regard to the Exchange minimum function of performing eligibility determinations and issuing certificates of exemption from the shared responsibility payment. In the final regulation, CMS addresses standards related to eligibility, including the verification and eligibility determination process, eligibility redeterminations, options for states to rely on HHS to make eligibility determinations for certificates of exemption, and reporting. The data collection and reporting requirements included in this information collection request are critical to the basic ability of Exchanges to determine eligibility for and issue certificates of exemption, and will also assist Exchanges, HHS, and IRS in ensuring program integrity and quality improvement. *Form Number:* CMS–10466 (OMB control number: 0938–1190); *Frequency:* Monthly, Yearly; *Affected Public:* Business or other for-profit, Not-for-profit institutions; *Number of Respondents:* 2,000,000; *Total Annual Responses:* 2,000,000; *Total Annual Hours:* 540,000. (For policy questions regarding this collection contact Kate Ficke at 301–492–4256).

Dated: December 21, 2016.

William N. Parham, III,

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

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