

**FOR FURTHER INFORMATION CONTACT:**

William Parham at (410) 786-4669.

**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:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Advantage, Medicare Part D, and Medicare Fee-For-Service Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey; *Use:* The Centers for Medicare & Medicaid Services (CMS) has authority to collect various types of quality data under section 1852(e) of the Act and use this information to develop and publicly post a 5-star rating system for Medicare Advantage (MA) plans based on its authority to disseminate comparative information, including about quality, to beneficiaries under sections 1851(d) and 1860D-1(c) of the Act. As codified at § 422.152(b)(3), Medicare health plans are required to report on quality performance data which CMS can use to help beneficiaries compare plans. Cost plans under section 1876 of the Act are also included in the MA Star Rating system, as codified at § 417.472(k), and are required by regulation (§ 417.472(j)) to make CAHPS survey data available to CMS.

The MMA under Sec. 1860D-4 (Information to Facilitate Enrollment) requires CMS to conduct consumer satisfaction surveys of enrollees in MA and Part D contracts and report the results to Medicare beneficiaries prior to the annual enrollment period. This request for approval is for CMS to continue conducting the Medicare CAHPS surveys annually to meet the requirement to conduct consumer

satisfaction surveys regarding the experiences of beneficiaries with their health and prescription drug plans.

The primary purpose of the Medicare CAHPS surveys is to provide information to Medicare beneficiaries to help them make more informed choices among health and prescription drug plans available to them. Survey results are reported by CMS in the Medicare & You handbook published each fall and on the Medicare Plan Finder website. Beneficiaries can compare CAHPS scores for each health and drug plan as well as compare MA and FFS scores when making enrollment decisions. The Medicare CAHPS also provides data to help CMS and others monitor the quality and performance of Medicare health and prescription drug plans and identify areas to improve the quality of care and services provided to enrollees of these plans. CAHPS data are included in the Medicare Part C & D Star Ratings and used to calculate MA Quality Bonus Payments. *Form Number:* CMS-R-246 (OMB control number: 0938-1088); *Frequency:* Annually; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 537; *Total Annual Responses:* 745,350; *Total Annual Hours:* 179,108. (For policy questions regarding this collection contact Sarah Gaillot at 410-786-4637.)

Dated: February 2, 2021.

**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-10203, CMS-2088-17, CMS-1763, and CMS-1696]

#### Agency Information Collection Activities: Proposed Collection; Comment Request

**AGENCY:** Centers for Medicare & Medicaid Services, Health and Human Services (HHS).

**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 (the 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 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

**DATES:** Comments must be received by April 6, 2021.

**ADDRESSES:** When commenting, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send 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) that are 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.

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' website address at website address at <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html>.

**FOR FURTHER INFORMATION CONTACT:** William N. Parham at (410) 786-4669.

**SUPPLEMENTARY INFORMATION:**

#### 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-10203 Medicare Health Outcomes Survey

CMS–2088–17 Community Mental Health Center Cost Report  
 CMS–1763 Request For Termination of Premium-Hospital and or Supplementary Medical Insurance  
 CMS–1696 Appointment of Representative

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:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Health Outcomes Survey (HOS); *Use:* The HOS is a longitudinal patient-reported outcome measure (PROM) that assesses self-reported beneficiary quality of life and daily functioning. As a PROM, the HOS measures the impact of services provided by MAOs, whereas process and patient experience measures only provide a snapshot of activities or experiences at a specific point in time. PROM data collected by the HOS allows CMS to continue to assess the health of the Medicare Advantage population. This older population is at increased risk of adverse health outcomes, including chronic diseases and mobility impairments that may significantly hamper quality of life. The HOS supports CMS’s commitment to improve health outcomes for beneficiaries while reducing burden on providers. CMS accomplishes this by focusing on high-priority areas for quality measurement and improvement established in the agency’s Meaningful Measures Framework. The HOS uses quality measures that ask beneficiaries about health outcomes related to specific mental and Physical Conditions. *Form Number:* CMS–10203 (OMB control number: 0938–0701); *Frequency:* Annually; *Affected Public:* Individuals and Households; *Number of*

*Respondents:* 1,485; *Total Annual Responses:* 629,280; *Total Annual Hours:* 201,370. (For policy questions regarding this collection contact Debra Start at 410–786–6646.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Community Mental Health Center Cost Report *Use:* CMS requires the Form CMS–2088–17 to determine a provider’s reasonable cost incurred in furnishing medical services to Medicare beneficiaries and reimbursement due to or from a provider. In addition, CMHCs may receive reimbursement through the cost report for Medicare reimbursable bad debts. CMS uses the Form CMS–2088–17 for rate setting; payment refinement activities, including market basket analysis; Medicare Trust Fund projections; and to support program operations. The primary function of the cost report is to determine provider reimbursement for services rendered to Medicare beneficiaries. Each CMHC submits the cost report to its contractor for reimbursement determination.

Section 1874A of the Act describes the functions of the contractor. CMHCs must follow the principles of cost reimbursement, which require they maintain sufficient financial records and statistical data for proper determination of costs. The S series of worksheets collects the provider’s location, CBSA, date of certification, operations, and unduplicated census days. The A series of worksheets collects the provider’s trial balance of expenses for overhead costs, direct patient care services, and non-revenue generating cost centers. The B series of worksheets allocates the overhead costs to the direct patient care and non-revenue generating cost centers using functional statistical bases. The Worksheet C computes the apportionment of costs between Medicare beneficiaries and other patients. The D series of worksheets are Medicare specific and calculate the reimbursement settlement for services rendered to Medicare beneficiaries. The Worksheet F collects the provider’s revenues and expenses data from the provider’s income statement. *Form Number:* CMS–2088–17 (OMB control number: 0938–0378); *Frequency:* Annually; *Affected Public:* Private Sector, Business or other for-profits, Not-for-profits institutions; *Number of Respondents:* 184; *Total Annual Responses:* 184; *Total Annual Hours:* 16,560. (For policy questions regarding this collection contact Jill Keplinger at 410–786–4550.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Request For Termination of Premium-Hospital and or Supplementary Medical Insurance; *Use:* Form CMS–1763 provides the necessary information to process the enrollee’s request for termination of Part B and/or premium Part A coverage. Sections 1818(c)(5), 1818A(c)(2)(B) and 1838(b)(1) of the Act and corresponding regulations at 42 CFR 406.28(a) and 407.27(c) require that a Medicare enrollee wishing to voluntarily terminate Part B and/or premium Part A coverage file a written request with CMS or SSA. The statute and regulations also specify when coverage ends based upon the date the request for termination is filed.

Form CMS–1763 collects the information necessary to process Medicare enrollment terminations. The Request for Termination of Premium Hospital and/or Supplementary Medical Insurance (Form CMS–1763) provides a standardized means to satisfy the requirements of law, as well as allow both agencies to protect the individual from an inappropriate decision. *Form Number:* CMS–1763 (OMB control number: 0938–0025); *Frequency:* Annually; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 114,215; *Total Annual Responses:* 114,215; *Total Annual Hours:* 19,074. (For policy questions regarding this collection contact Carla Patterson at 410–786–1000.)

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Appointment of Representative; *Use:* This form would be completed by beneficiaries, providers and suppliers (typically their billing clerk, or billing company), and any party who wish to appoint a representative to assist them with their initial Medicare claims determinations, and filing appeals on Medicare claims. The authority for collecting this information is under 42 CFR 405.910(a) of the Medicare claims appeal procedures.

The information supplied on the form is reviewed by Medicare claims and appeals adjudicators. The adjudicators make determinations whether the form was completed accurately, and if the form is correct and accepted, the form is appended to the claim or appeal that it pertains to. *Form Number:* CMS–1696 (OMB control number: 0938–0950); *Frequency:* Annually; *Affected Public:* Private Sector, Business or other for-profits; *Number of Respondents:* 270,544; *Total Annual Responses:*

270,544; Total Annual Hours: 67,637. (For policy questions regarding this collection contact Katherine E. Hosna at 410-786-4993.)

Dated: February 2, 2021.

**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**

**Health Resources and Services Administration**

**Agency Information Collection Activities: Proposed Collection: Public Comment Request Information Collection Request Title: Federal Tort Claims Act Program Deeming Applications for Health Centers, OMB No. 0906-0035 Extension**

**AGENCY:** Health Resources and Services Administration (HRSA), Department of Health and Human Services.

**ACTION:** Notice.

**SUMMARY:** In compliance with the requirement for opportunity for public comment on proposed data collection projects of the Paperwork Reduction Act of 1995, HRSA announces plans to submit an Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting the ICR to OMB, HRSA seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

**DATES:** Comments on this Information Collection Request must be received no later than April 6, 2021.

**ADDRESSES:** Submit your comments to *paperwork@hrsa.gov* or mail the HRSA Information Collection Clearance Officer, Room 14N136B, 5600 Fishers Lane, Rockville, MD 20857.

**FOR FURTHER INFORMATION CONTACT:** To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, email *paperwork@hrsa.gov* or call Lisa Wright-Solomon, the HRSA Information Collection Clearance Officer at (301) 443-1984.

**SUPPLEMENTARY INFORMATION:** When submitting comments or requesting information, please include the information request collection title for reference.

*Information Collection Request Title:* Federal Tort Claims Act Program Deeming Applications for Health Centers, OMB No. 0906-0035—Extension.

*Abstract:* Section 224(g)-(n) of the Public Health Service (PHS) Act (42 U.S.C. 233(g)-(n)), as amended, authorizes the “deeming” of entities receiving funds under section 330 of the PHS Act as PHS employees for the purpose of receiving Federal Tort Claims Act (FTCA) coverage for the performance of medical, surgical, dental, and related functions for their officers, board members, employees, and certain contractors. The Health Center Program is administered by HRSA’s Bureau of Primary Health Care. Health centers submit deeming applications annually to HRSA in the prescribed form and manner in order to obtain deemed PHS employee status, with the associated FTCA coverage.

Deemed PHS employment provides the covered individual with immunity from lawsuits and related civil actions resulting from the performance of medical, surgical, dental, and related functions within the scope of deemed employment.

The FTCA Program utilizes a web based application system, the Electronic Handbooks. The application includes the following: Contact information; Section 1: Review of Risk Management Systems; Section 2: Quality Improvement/Quality Assurance Attestations; Section 3: Credentialing and Privileging; Section 4: Claims

Management; and Section 5: Additional Information, Certification, and Signatures.

HRSA is proposing no changes to the Application for Health Center Program Deemed Public Health Service Employment Status information collection request to be used for health center deeming applications for Calendar Year 2022 and thereafter.

*Need and Proposed Use of the Information:* Deeming applications must address certain specified criteria required by law in order for deeming determinations to be issued, and FTCA application forms are critical to HRSA’s deeming determination process. The application submissions provide HRSA with the information essential for application evaluation and a deeming determination for the purposes of FTCA coverage. The application information is also used to determine whether a site visit is appropriate to assess issues relating to the health center’s quality of care and to determine technical assistance needs.

*Likely Respondents:* Respondents include Health Center Program funds recipients seeking deemed PHS employee status for purposes of FTCA coverage.

*Burden Statement:* Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install, and utilize technology and systems for the purpose of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

**TOTAL ESTIMATED ANNUALIZED BURDEN HOURS**

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Application for Health Center Program Deemed Public Health Service Employment Status (Initial)	35	1	35	2.5	87.5
Application for Health Center Program Deemed Public Health Service Employment Status (Re-deeming)	1,125	1	1,125	2.5	2,812.5
Total	1,160	.....	1,160	.....	2,900