DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS-R-194, CMS-10497 and CMS-10250]

Agency Information Collection Activities: Proposed Collection; 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 (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 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 must be received by **[Insert date 60 days after date of publication in the Federal Register]**:

ADDRESSES: When commenting, please reference the document identifier or OMB control number (OCN). 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' Web Site address at http://www.cms.hhs.gov/PaperworkReductionActof1995.
2. E-mail 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:

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-R-194 Medicare Disproportionate Share Adjustment Procedures and Criteria and Supporting Regulations

CMS-10497 Evaluation of the Medicare Health Care Quality (MHCQ) Demonstration Evaluation: Focus Group and Interview Protocols

CMS-10250 Hospital Outpatient Quality Reporting (OQR) Program

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 Collections

1. Type of Information Collection Request: Reinstatement without change of a previously approved collection; Title of Information Collection: Medicare Disproportionate Share Adjustment (DSH) Procedures and Criteria and Supporting Regulations; Use: Section 1886(d)(5)(F) of the Social Security Act established the Medicare disproportionate share

adjustment (DSH) for hospitals, which provides additional payment to hospitals that serve a disproportionate share of the indigent patient population. This payment is an add-on to the set amount per case that we pay to hospitals under the Medicare Inpatient Prospective Payment System (IPPS).

Under current regulations at 42 CFR 412.106, in order to meet the qualifying criteria for this additional DSH payment, a hospital must prove that a disproportionate percentage of its patients are low income using Supplemental Security Income (SSI) and Medicaid as proxies for this determination. This percentage includes two computations: (1) the "Medicare fraction" or the "SSI ratio" which is the percent of patient days for beneficiaries who are eligible for Medicare Part A and SSI and (2) the "Medicaid fraction" which is the percent of patient days for patients who are eligible for Medicaid but not Medicare. Once a hospital qualifies for this DSH payment, we also determine a hospital's payment adjustment. Form Number: CMS-R-194 (OCN: 0938-0691); Frequency: Occasionally; Affected Public: Private sector - Business or other for-profits and Not-for-profit institutions; Number of Respondents: 800; Total Annual Responses: 800; Total Annual Hours: 400. (For policy questions regarding this collection contact JoAnne Cerne at 410-786-4530.)

2. Type of Information Collection Request: New collection (Request for a new OMB control number); Title of Information Collection: Evaluation of the Medicare Health Care Quality (MHCQ) Demonstration Evaluation: Focus Group and Interview Protocols; Use: The Medicare Health Care Quality (MHCQ) Demonstration was developed to address concerns about the U.S. health care system, which typically fragments care while also encouraging both omissions in and duplication of care. To rectify this situation, Congress has directed us to test

major changes to the delivery and payment systems to improve the quality of care while also increasing efficiency across the health care system. This would be achieved through several types of interventions: adoption and use of information technology and decision support tools by physicians and their patients, such as evidence-based medicine guidelines, best practice guidelines, and shared decision-making programs; reform of payment methodologies; improved coordination of care among payers and providers serving defined communities; measurement of outcomes; and enhanced cultural competence in the delivery of care.

The MHCQ Demonstration programs are designed to examine the extent to which major, multifaceted changes to traditional Medicare's health delivery and financing systems lead to improvements in the quality of care provided to Medicare beneficiaries without increasing total program expenditures. Each demonstration site uses a different approach for changing health delivery and financing systems, but all share the goal of improving the quality and efficiency of medical care provided to Medicare beneficiaries. Focus groups and individual interviews will be conducted at 2 demonstration sites that are active in the demonstration: Gundersen Health System (GHS) and Meridian Health System (MHS).

This MHCQ Demonstration evaluation will include analysis of both quantitative and qualitative sources of information. This multifaceted approach will enable this evaluation to consider a broad variety of evidence for evaluating the nature and impact of each site's interventions. We are seeking approval to conduct in-person focus groups and individual interviews with beneficiaries and their caregivers to inform our evaluation of the MHCQ Demonstration at the GHS and MHS demonstration sites. Form Number: CMS-10497 (OCN: 0938-New); Frequency: Occasionally; Affected Public: Individuals or households; Number of

Respondents: 36; Total Annual Responses: 36; Total Annual Hours: 108. (For policy questions regarding this collection contact Normandy Brangan at 410-786-6640.)

3. Type of Information Collection Request: Revision of a currently approved collection; Title of Information Collection: Hospital Outpatient Quality Reporting (OQR) Program; Use: Section 109(a) of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109-432) amended section 1833(t) of the Social Security Act by adding a new subsection (17) that affects the payment rate update applicable to Outpatient Prospective Payment System (OPPS) payments for services furnished by hospitals in outpatient settings on or after January 1, 2009. Section 1833(t)(17)(A) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to report data required for quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act will incur a reduction in their annual payment update (APU) factor to the hospital outpatient department fee schedule by 2.0 percentage points. Sections 1833(t)(17)(C)(i) and (ii) of the Act require the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings. Such measures must reflect consensus among affected parties and, to the extent feasible and practicable, must be set forth by one or more national consensus building entities. The Secretary also has the authority to replace measures or indicators as appropriate and requires the Secretary to establish procedures for making the data submitted available to the public. Such procedures must provide the hospitals the opportunity to review such data prior to public release. Our program established under these amendments is referred to as the Hospital Outpatient Quality Reporting (OQR) Program.

Hospital OQR Program payment determinations are made based on OQR quality measure

data reported and supporting forms submitted by hospitals as specified through rulemaking. To reduce burden, a variety of different data collection mechanisms are employed, with every consideration taken to employ existing data and data collection systems. The complete list of measures and data collection forms are organized by type of data collected and data collection mechanism.

The Medicare program has a responsibility to ensure that Medicare beneficiaries receive the health care services of appropriately high quality that are comparable to that received by those under other payers. The Hospital OQR Program seeks to encourage care that is both efficient and of high quality in the hospital outpatient setting through collaboration with the hospital community to develop and implement quality measures that are fully and specifically reflective of the quality of hospital outpatient services. Form Number: CMS-10250 (OCN: 0938-1109); Frequency: Occasionally; Affected Public: Private sector – For-profit and not for institutions; Number of Respondents: 3,200; Total Annual Responses: 3,200; Total Annual Hours: 949,590. (For policy questions regarding this collection contact Anita Bhatia at 410-786-7236.)

Dated: August 16, 2013 _____

Martique Jones

Deputy Director, Regulations Development Group

Office of Strategic Operations and Regulatory Affairs

Billing Code: 4120-01-U-P

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