DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS-10265 and CMS-10638]

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 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 on the collection(s) of information must be received by the OMB desk officer by **[Insert date 30 days after the date of publication in the Federal Register]**.

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

E-mail: *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 Web Site address at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html
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: 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, revision 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: Reinstatement of a currently approved collection; Title of Information Collection: Mandatory Insurer Reporting Requirements of Section 111 of the Medicare, Medicaid and SCHIP Act of 2007; Use: The CMS is responsible for oversight and implementation of the MSP provisions as part of its overall authority for the Medicare program. The CMS accomplishes this through a combination of direct CMS action and work by CMS' contractors. The CMS efforts include policy and operational guidelines, including regulations (as necessary), as well as oversight over contractor MSP responsibilities. As a result of litigation in the mid-1990's, certain GHP insurers were mandated to report coverage information for a number of years. Subsequent to this litigation related mandatory reporting, CMS instituted a Voluntary Data Sharing Agreement (VDSA) effort which expanded the scope of the GHP participants and added some NGHP participants. This VDSA process complemented the IRS/SSA/CMS Data Match reporting by employers, but clearly did not include the universe of primary payers and had few NGHP participants. Both GHP and NGHP entities have had and continue to have the responsibility for determining when they are primary to Medicare and to pay appropriately, even without the mandatory Section 111 process. In order to make this

determination, they should already and always be collecting most of the information CMS will require in connection with Section 111 of the MMSEA. Section 111 establishes separate mandatory reporting requirements for GHP arrangements as well as for liability insurance (including self-insurance), no-fault insurance, and workers' compensation, these may collectively be referred to as "Non-GHP or NGHP." Form Number: CMS-10265 (OMB control number: 0938-1074); Frequency: Yearly, Quarterly; Affected Public: Private Sector (Business or other for-profits); Number of Respondents: 19,248; Total Annual Responses: 5,019,248; Total Annual Hours: 557,826. (For policy questions regarding this collection contact John Albert at 410-786-7457.)

2. Type of Information Collection Request: New collection (Request for a new OMB control number); Title of Information Collection: Add-On Payments for New Medical Services and Technologies Paid Under the Inpatient Prospective Payment System; Use: Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as ''new technologies'') under the IPPS. Section1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered new if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that a new medical service or technology may be considered for new technology add-on payment if, ''based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.'' The regulations at 42 CFR 412.87 implement

these provisions and specify three criteria for a new medical service or technology to receive the additional payment: (1) The medical service or technology must be new; (2) the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies. We use the application in order to determine if a technology meets the new technology criteria. Form Number: CMS-10638 (OMB Control Number: 0938-New); Frequency: Yearly; Affected Public: Individuals and households, Private sector (Business or other for-profits and Not-for-profits institutions; Number of Respondents: 15; Total Annual Responses: 15; Total Annual Hours: 600. (For policy questions regarding this collection contact Noel Manlove at 410-786-5161.)

Dated: June 15, 2017

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William N. Parham, III

Director, Paperwork Reduction Staff

Office of Strategic Operations and Regulatory Affairs

Billing Code: 4120-01-U-P

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