

speech-language pathology services. It is used by the State agencies to enter new provider into the Automated Survey Process Environment (ASPEN). CMS-1893 is used by the State survey agency to record data collected during an on-site survey of a provider of outpatient physical therapy and/or speech-language pathology services, to determine compliance with the applicable conditions of participation, and to report this information to the Federal government. The form is primarily a coding worksheet designed to facilitate data reduction and retrieval into the ASPEN system. The information needed to make certification decisions is available to CMS only through the use of information abstracted from the form; *Form Numbers:* CMS-1856 and CMS-1893 (OMB#: 0938-0065); *Frequency:* Annually, occasionally; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 2,968; *Total Annual Responses:* 495; *Total Annual Hours:* 866. (For policy questions regarding this collection contact Georgia Johnson at 410-786-6859. For all other issues call 410-786-1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web Site address at <http://www.cms.hhs.gov/PaperworkReductionActof1995>, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on *July 18, 2011*: OMB, Office of Information and Regulatory Affairs, *Attention:* CMS Desk Officer, *Fax Number:* (202) 395-6974, *E-mail:* OIRA_submission@omb.eop.gov.

Dated: June 14, 2011.

Michelle Shortt,

*Director, Regulations Development Group,
Office of Strategic Operations and Regulatory Affairs.*

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS-10334 and CMS-10373]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS) is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this 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.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Application for Coverage in the Pre-Existing Condition Insurance Plan; *Use:* The Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight is requesting clearance by the Office of Management and Budget for modifications to this previously approved collection package. These changes are being requested to (1) provide a mechanism for a PCIP enrollee who has moved from a state-administered PCIP to quickly and efficiently enroll into the federally-administered PCIP (2) provide a mechanism for a PCIP applicant to identify a third party entity will pay their premium to ensure appropriate premium billing (3) provide a mechanism whereby a licensed insurance agent or broker may identify their referral of an applicant (4) request employer information to expand ways to identify and prevent instances of insurer dumping and (5) make clarifications to existing application language. *Form Number:* CMS-10334 (OCN: 0938-1095)

Frequency: Once; *Affected Public:* Individuals or households; *Number of Respondents:* 83,333; *Number of Responses:* 83,333; *Total Annual Hours:* 179,499. (For policy questions regarding this collection, contact Laura Dash at 410-786-8623. For all other issues call (410) 786-1326.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medical Loss Ratio Quarterly Reporting; *Use:* Under Section 2718 of the Affordable Care Act and implementing regulations at 45 CFR Part 158 (75 FR 74865, December 1, 2010) as modified by technical corrections on December 30, 2010 (75 FR 82277), a health insurance issuer (issuer) offering group or individual health insurance coverage must submit a report to the Secretary concerning the amount the issuer spends each year on claims, quality improvement expenses, non-claims costs, Federal and State taxes and licensing or regulatory fees, and the amount of earned premium. An issuer must provide an annual rebate to enrollees if the amount it spends on certain costs compared to its premium revenue (excluding Federal and States taxes and licensing or regulatory fees) does not meet a certain ratio, referred to as the medical loss ratio (MLR). An interim final rule (IFR) implementing the MLR was published on December 1, 2010 (75 FR 74865) and modified by technical corrections on December 30, 2010 (75 FR 82277), which added Part 158 to Title 45 of the Code of Federal Regulations. The IFR is effective January 1, 2011. Issuers are required to submit annual MLR reporting data for each large group market, small group market, and individual market within each State in which the issuer conducts business. For policies that have a total annual limit of \$250,000 or less (sometimes referred to as "mini-med plans") and for group policies that primarily cover employees working outside the United States (referred to as "expatriate plans"), the IFR applies a special circumstance adjustment to the MLR data for the 2011 MLR reporting year. In order to evaluate the appropriateness of this special circumstance adjustment for years 2012 and beyond, issuers that provide such policies are required to submit quarterly MLR data to the Secretary for the 2011 MLR reporting year. We received several comments in response to the emergency 30-day comment period that was associated with CMS-10373. We have taken into consideration all of the revisions that were proposed and have amended the quarterly reporting form to include issuer contact information and

technical amendments to better align the proposed quarterly reporting form to the reporting forms that issuers submit to the National Association of Insurance Commissioners (NAIC). We have also amended the form to create two separate, but practically identical, forms with corresponding instructions, so as to allow issuers to nationally aggregate the experience of expatriate plans and to allow issuers to separately report the experience of mini-med plans and expatriate plans. We have also supplied the instructions in a separate document rather than at the bottom of each reporting form. *Form Number:* CMS-10373 (OCN: 0938-1132); *Frequency:* Quarterly; *Affected Public:* Private Sector; Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 75; *Number of Responses:* 825; *Total Annual Hours:* 51,480. (For policy questions regarding this collection, contact Carol Jimenez at (301) 492-4109. For all other issues, call (410) 786-1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at <http://www.cms.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage> or email your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office at 410-786-1326.

In commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by August 16, 2011:

1. Electronically. You may submit 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) 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.

Dated: June 14, 2011.

Martique Jones,

Director, Regulations Development Group, Division B, Office of Strategic Operations and Regulatory Affairs.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS-1856 and CMS-1893, CMS-10381 and CMS-10342]

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

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this 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 function; (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.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* (CMS-1856) Request for Certification in the Medicare and/or Medicaid Program to Provide Outpatient Physical Therapy and/or Speech Pathology Services, and (CMS-1893) Outpatient Physical Therapy—Speech Pathology Survey Report; *Use:* CMS-1856 is used as an application to be completed by providers of outpatient physical therapy and/or speech-language pathology services requesting participation in the Medicare and Medicaid programs. This form initiates the process for obtaining a decision as to whether the conditions of participation are met as a provider of outpatient physical therapy and/or speech-language pathology services. It is used by the State agencies to enter new

provider into the Automated Survey Process Environment (ASPEN). CMS-1893 is used by the State survey agency to record data collected during an on-site survey of a provider of outpatient physical therapy and/or speech-language pathology services, to determine compliance with the applicable conditions of participation, and to report this information to the Federal government. The form is primarily a coding worksheet designed to facilitate data reduction and retrieval into the ASPEN system. The information needed to make certification decisions is available to CMS only through the use of information abstracted from the form; *Form Numbers:* CMS-1856 and CMS-1893 (OMB#: 0938-0065); *Frequency:* Annually, occasionally; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 2,968; *Total Annual Responses:* 495; *Total Annual Hours:* 866. (For policy questions regarding this collection contact Georgia Johnson at 410-786-6859. For all other issues call 410-786-1326.)

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Version 5010/ICD-10 Industry Readiness Assessment, *Use:* The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Secretary of HHS to adopt transaction standards that covered entities are required to use when electronically conducting certain health care administrative transactions, such as claims, remittance, eligibility and claims status requests and responses. Accordingly, on January 16, 2009, HHS published final rules adopting by regulation two sets of standards for HIPAA transactions: Version 5010 standards for eight types of electronic health care transactions (claims, eligibility inquiries, remittance advices, etc.) and ICD-10 code set standards. The final rules set compliance dates of January 1, 2012 for Version 5010 standards and October 1, 2013 for ICD-10 standards. HIPAA transactions not meeting the standards by those dates will be rejected. The final rules also outlined interim milestones that organizations should meet in order to achieve compliance by the required dates. For Version 5010, these interim milestones include completing internal testing and being able to send and receive compliant transactions by December 2010, commencing external testing with trading partners by January 2011, and completing that testing and moving into production by the compliance date of January 1, 2012.