Integrated Plan Coverage Decision Letter; *Use:* The Bipartisan Budget Act (BBA) of 2018 directed the establishment of procedures to unify Medicare and Medicaid grievance and appeals procedures to the extent feasible for dual eligible special needs plans (D–SNPs) beginning in 2021. On April 16, 2019, CMS finalized rules (hereafter referred to as the April 2019 final rule) to implement these new statutory provisions.[1] As a result of these regulations, starting in 2021, a subset of full integrated dual special needs plans (FIDE SNPs) and highly integrated dual special needs plans (HIDE SNPs) will need to unify and update appeals and grievance procedures, including how enrollees are notified of their appeal rights.

Applicable integrated plans as defined at § 422.561 are required to issue form CMS–10716 when a request for either a medical service or payment covered under the Medicare or Medicaid benefit is denied in whole or in part. The notice explains why the plan denied the service or payment and informs the plan enrollees of their appeal rights.

The ''Applicable Integrated Plan Coverage Decision Letter'' or the ''coverage decision letter'', which will be issued as a result of an integrated organization determination under 42 CFR 422.631 when an applicable integrated plan reduces, stops, suspends, or denies, in whole or in part, a request for a service/item (including a Part B drug) or a request for payment of a service/item (including a Part B drug) the member has already received. ''Applicable integrated plans,'' hereinafter referred to as ''plans'', are defined at 42 CFR 422.561 as FIDE SNPs or HIDE SNPs with exclusively aligned enrollment, where state policy limits the D–SNP's membership to a Medicaid managed care plan offered by the same organization. Applicable integrated plans will issue the coverage decision letter starting in CY 2021 in place of the Notice of Denial of Medical Coverage (or Payment) (NDMCP) form (CMS–10003) as part of requirements to unify appeals and grievance processes. All other Medicare Advantage (MA) plans will continue to use the NDMCP form (CMS–10003). *Form Number:* CMS–10716 (OMB control number: 0938-New); *Frequency:* Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 693; *Total Annual Responses:* 693; *Total Annual Hours:* 116. (For policy questions regarding this collection contact Marna Metcalf Akbar at 410–786–8251.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* CMS Plan Benefit Package (PBP) and Formulary CY 2021; *Use:* This information is mandated by the Social Security Act in order to collect plan bids that will establish the Medicare Advantage (Part C) and Prescription Drug (Part D) plan benefit package options to be offered to Medicare beneficiaries during the next annual open enrollment period. The Part C bid deadline (the first Monday in June) is stated at Section 1854(a)(6)(A) of the Social Security Act. The same deadline is applied to Part D bids by reference to the Part C requirement at Section 1860D–11(b)(1) of the Act and is cited in the 42 CFR references listed above. Copies of these references are provided in Appendix D. Section 6062 of the SUPPORT Act amended section 1860D–4(e)(2) of the Act to require the adoption of transaction standards for the Part D e-prescribing program to ensure secure ePA request and response transactions between prescribers and Part D plan sponsors no later than January 1, 2021. *Form Number:* CMS–R–262 (OMB control number: 0938–0763); *Frequency:* Yearly; *Affected Public:* Private sector (Business or other for-profits and Not-for-profits institutions); *Number of Respondents:* 774; *Total Annual Responses:* 9,201; *Total Annual Hours:* 77,343. (For policy questions regarding this collection contact Joella Roland at 410–786–7638.)

Dated: April 9, 2020.

William N. Parham, III,

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

[FR Doc. 2020–07884 Filed 4–14–20; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10219, CMS–10695 and CMS–10526]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid 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 June 15, 2020.

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.*

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: 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–10219 HEDIS® Data Collection for Medicare Advantage

CMS–10695 Quality Payment Program/Merit-Based Incentive Payment System (MIPS) Surveys and Feedback Collections

CMS–10526 Cost-sharing Reduction Reconciliation Data Template

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:* Extension without change of a currently approved collection; *Title of Information Collection:* HEDIS® Data Collection for Medicare Advantage; *Use:* The HEDIS® data collection supports the CMS strategic goal of improving the quality of care and health status for Medicare beneficiaries. The HEDIS® measures are part of the Medicare Part C Star Ratings as described at §§ 422.160, 422.162, 422.164, and 422.166. CMS publishes the Medicare Part C Star Ratings each year to: (1) Incentivize quality improvement in Medicare Advantage (MA); and (2) assist beneficiaries in finding the best plan for them. The ratings feed into MA Quality Bonus Payments. The Medicare Star Ratings support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other providers.

HEDIS® data support the agency's goal to hold MA contracts accountable for delivering care in accordance with widely accepted clinical guidelines and standards of care. CMS uses HEDIS® data to obtain the information necessary for the proper oversight of the Medicare Advantage program. NCQA trains and licenses organizations to conduct audits on-site at the MAOs secure record-keeping facilities where they compile their administrative and medical records for the HEDIS data file submissions *Form Number:* CMS–10219 (OMB control number: 0938–1028); *Frequency:* Yearly; *Affected Public:* Federal Government; *Number of Respondents:* 677; *Total Annual Responses:* 677; *Total Annual Hours:* 216,640. (For policy questions regarding this collection contact Lori Teichman at 410–786–6684.)

2. *Type of Information Collection Request:* New collection of information request; *Title of Information Collection:* Quality Payment Program/Merit-Based Incentive Payment System (MIPS) Surveys and Feedback Collections; *Use:* The purpose of this submission is to request approval for generic clearance of a program of survey and feedback collections supporting the Quality Payment Program which includes the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs). MIPS is a program for certain eligible clinicians that makes Medicare payment adjustments based on performance on quality, cost and other measures and activities, and that consolidates components of three precursor programs—the Physician Quality Reporting system (PQRS), the Value Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals. AAPMs are a track of the Quality Payment Program that offer incentives for achieving threshold levels of payments or patients in Advanced APMs or Other Payer Advanced APMs. Under the AAPM path, eligible clinicians may become Qualifying APM Participants (QPs) and are excluded from MIPS. Partial Qualifying APM Participants (Partial QPs) may opt to report and be scored under MIPS.

This generic clearance will cover a program of surveys and feedback collections designed to strategically obtain data and feedback from MIPS eligible clinicians, third-party intermediaries, Medicare beneficiaries, and any other audiences that would support the Agency in improving MIPS or the Quality Payment Program. The specific collections we intend to conduct are: Human Centered Design (HCD) User Testing Volunteer Sign-Up Survey; HCD User Satisfaction, Product Usage, and Benchmarking Surveys; and Physician Compare (and/or successor website) User Testing. *Form Number:* CMS–10695 (OMB control number: 0938–NEW); *Frequency:* Occasionally; *Affected Public:* Private Sector: Business or other for-profits and Not-for-profit institutions and Individuals; *Number of Respondents:* 630,300; *Total Annual Responses:* 630,300; *Total Annual Hours:* 57,950. (For policy questions regarding this collection, contact Michelle Peterman at 410–786–2591.)

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Cost-sharing Reduction Reconciliation Data Template; *Use:* Under established Department of Health and Human Services (HHS) regulations, although payments are not being advanced to qualified health plan (QHP) issuers at the present time, issuers are still permitted to submit data that compares the CSR-eligible enrollment for each issuer with their actual cost sharing reductions made by the issuer for medical services for each eligible enrollee in a benefit year. HHS will compare this CSR-eligible enrollment with the actual cost sharing reductions provided by the issuers that participate in the optional data submission window to verify the issuer's reporting of cost-sharing reductions provided. This revised collection does not add any data elements, and continues to make optional summary plan level reporting. *Form Number:* CMS–10526 (OMB control number: 0938–1266); *Frequency:* Annually; *Affected Public:* Private Sector: Not-for-profits; *Number of Respondents:* 150; *Total Annual Responses:* 150; *Total Annual Hours:* 2,250. (For policy questions regarding this collection contact Alper Ozinal 301–492–4178.)

Dated: April 9, 2020.

William N. Parham, III,

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

[FR Doc. 2020–07876 Filed 4–14–20; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10525]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice; partial withdrawal.

SUMMARY: On Tuesday, March 24, 2020, the Centers for Medicare & Medicaid Services (CMS) published a notice