DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS-10219, CMS-R-142 and CMS-10695]

Agency Information Collection Activities: Submission for OMB Review; 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 (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 **July 30, 2020**.

ADDRESSES: Written comments and recommendations for the proposed information

collection should be sent within 30 days of publication of this notice to www.reginfo.gov/public/do/PRAMain. Find this particular information collection by selecting "Currently under 30-day Review - Open for Public Comments" or by using the search function.

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
1. E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov.
2. 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 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 with 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:* Extension of a currently approved collection; *Title of Information Collection:* Examination and Treatment for Emergency Medical Conditions and Women in Labor (EMTALA); *Use*: Pursuant to section 1866(a)(1)(I) of the Act, Congress has mandated that the Secretary enforce section 1867 of the Act. Under section 1867, effective August 1, 1986, hospitals may continue to participate in the Medicare program only if they are not out of compliance with its provisions. Continued Paper Work Reduction Act (PRA) approval of the regulation sections cited below will promote uniform and thorough application of the section 1866 and 1867 requirements. They will also provide information when requested by Congress and other interested parties regarding the implementation of the statute. During 2004 through 2018, approximately 8,146 complaints were received, approximately 7,770 of those complaints were investigated, and approximately 3,567 EMTALA deficiencies were found. During Federal fiscal years 2001 through 2005 the Inspector General's Office imposed civil monetary penalties on hospitals in 105 cases, for a total of $2,645,750 in penalties. An audit completed by the Office of Inspector General (OIG) (entitled, Office of Inspector General: Implementation and Enforcement of the Examination and Treatment for Emergency Medical Conditions and Women in Labor by the Health Care Financing Administration, April 1995, A-06-93-00087) determined that CMS's implementation of the Act was generally effective, but Regional Offices (RO) were not consistent with conducting timely investigations, sending acknowledgments to complaints, ensuring that investigations were thorough, or ensuring that violations were referred to the OIG in accordance with CMS policy for possible civil monetary penalty action. OIG further concluded that without proper compliance, there is an increased risk

that individuals with emergency medical conditions will not receive the treatment needed to stabilize their condition, which may place them in greater risk of death. *Form Number:* CMS-R-142 (OMB control number: 0938-0667); *Frequency:* Occasionally; *Affected Public:* Private Sector; Business or other for-profits, Not-for-profit institutions; *Number of Respondents:* 5,291; *Total Annual Responses*: 5,291; *Total Annual Hours:* 5,291. (For policy questions regarding this collection contact Renate Dombrowski at (410) 786-4645.)

3. *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.)

Dated: June 25, 2020.

William N. Parham, III,

Director, Paperwork Reduction Staff,

Office of Strategic Operations and Regulatory Affairs.

BILLING CODE 4120-01-P

[FR Doc. 2020-14087 Filed: 6/30/2020 8:45 am; Publication Date: 7/1/2020]