

resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide CMS with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of the Joint Commission's request for continued approval of its hospice accreditation program. This notice also solicits public comment on whether the Joint Commission's requirements meet or exceed the Medicare conditions of participation (CoPs) for hospices.

### III. Evaluation of Deeming Authority Request

The Joint Commission submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its hospices accreditation program. This application was determined to be complete on August 26, 2020. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of the Joint Commission will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of the Joint Commission's standards for hospices as compared with CMS' hospice CoPs.

- The Joint Commission's survey process to determine the following:

- ++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

- ++ The comparability of the Joint Commission's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

- ++ The Joint Commission's processes and procedures for monitoring hospices, which are found out of compliance with the Joint Commission's program requirements. These monitoring procedures are used only when the Joint Commission identifies noncompliance. If noncompliance is identified through

validation reviews or complaint surveys, the SA monitors corrections as specified at § 488.9.

- ++ The Joint Commission's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

- ++ The Joint Commission's capacity to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

- ++ The adequacy of the Joint Commission's staff and other resources, and its financial viability.

- ++ The Joint Commission's capacity to adequately fund required surveys.

- ++ The Joint Commission's policies with respect to whether surveys are announced or unannounced, to ensure that surveys are unannounced.

- ++ The Joint Commission's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

- ++ The Joint Commission's agreement to provide CMS with a copy of the most current accreditation survey, together with any other information related to the survey as we may require (including corrective action plans).

### IV. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

### V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Seema Verma, having reviewed and approved this document, authorizes Lynette Wilson, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: October 29, 2020.

**Lynette Wilson,**

*Federal Register Liaison, Department of Health and Human Services.*

[FR Doc. 2020-24859 Filed 11-6-20; 8:45 am]

**BILLING CODE 4120-01-P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

[Document Identifier: CMS-10756, CMS-R-246]

### Agency Information Collection Activities: Proposed Collection; 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 (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 January 8, 2021.

**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. 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-10576 Results of Your Drug Coverage Request

CMS-R-246 Medicare Advantage, Medicare Part D, and Medicare Fee-For-Service Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

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:* New Collection (Request for a new OMB control number); *Title of Information Collection:* Results of Your

Drug Coverage Request; *Use:* The purpose of this notice is to provide information to enrollees whenever a Medicare Advantage Prescription Drug plan (MA-PD) covers a prescription drug under a different Medicare benefit than was requested by the enrollee. The enrollee may request coverage under their Part B or Part D benefit. When the MA-PD approves coverage in the benefit that was not requested by the beneficiary, the determination involves both an approval and a denial of benefits. The plan must send written notification that is readable, understandable, and explains the specific reasons for the denial of the alternate benefit. The notice must also remind enrollees about their rights and protections related to requests for prescription drug coverage and include an explanation of both the standard and expedited redetermination processes and the rest of the appeal process.

This collection replaces the current forms for communicating coverage provided to Medicare Advantage Prescription Drug (MA-PD) enrollees with regard to Part B vs. Part D drug requests. The new notice, Results of Your Drug Coverage Request, provides both approval messaging and the required denial messaging to beneficiaries in a more readable and understandable format than the existing Part D denial notice (CMS-10146, OMB-0938-0976) and Integrated Denial Notice (CMS-10003, OMB-0938-0829). Currently, coverage for drugs that are subject to a Part B vs. Part D adjudication is communicated by two separate forms: CMS-10146 (OMB-0938-0976) (communicating denial under Part D) and CMS-10003 (OMB-0938-0829) (communicating denial under Part B).

This proposed collection corrects this confusion by satisfying the denial and approval requirement in one form that brings focus to the approval rather than the denial. This proposed collection consolidates and streamlines the communication with enrollees by requiring one notice for communication when a drug request is subject to coordination of Part B and Part D benefits under 42 CFR 422.112. This collection is structured so that the enrollee receives a single notice that communicates both approval and denial under the respective benefits. *Form Number:* CMS-CMS-10756 (OMB control number: 0938-New); *Frequency:* Occasionally; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 755; *Total Annual Responses:* 68,413; *Total Annual Hours:* 17,103. (For policy questions regarding

this collection contact Trevor Rose at 410-786-7768.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Advantage, Medicare Part D, and Medicare Fee-For-Service Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey; *Use:* The Centers for Medicare & Medicaid Services (CMS) has authority to collect various types of quality data under section 1852(e) of the Act and use this information to develop and publicly post a 5-star rating system for Medicare Advantage (MA) plans based on its authority to disseminate comparative information, including about quality, to beneficiaries under sections 1851(d) and 1860D-1(c) of the Act. As codified at § 422.152(b)(3), Medicare health plans are required to report on quality performance data which CMS can use to help beneficiaries compare plans. Cost plans under section 1876 of the Act are also included in the MA Star Rating system, as codified at § 417.472(k), and are required by regulation (§ 417.472(j)) to make CAHPS survey data available to CMS.

The MMA under Sec. 1860D-4 (Information to Facilitate Enrollment) requires CMS to conduct consumer satisfaction surveys of enrollees in MA and Part D contracts and report the results to Medicare beneficiaries prior to the annual enrollment period. This request for approval is for CMS to continue conducting the Medicare CAHPS surveys annually to meet the requirement to conduct consumer satisfaction surveys regarding the experiences of beneficiaries with their health and prescription drug plans.

The primary purpose of the Medicare CAHPS surveys is to provide information to Medicare beneficiaries to help them make more informed choices among health and prescription drug plans available to them. Survey results are reported by CMS in the Medicare & You handbook published each fall and on the Medicare Plan Finder website. Beneficiaries can compare CAHPS scores for each health and drug plan as well as compare MA and FFS scores when making enrollment decisions. The Medicare CAHPS also provides data to help CMS and others monitor the quality and performance of Medicare health and prescription drug plans and identify areas to improve the quality of care and services provided to enrollees of these plans. CAHPS data are included in the Medicare Part C & D Star Ratings and used to calculate MA Quality Bonus Payments. *Form Number:* CMS-R-246 (OMB control number: 0938-0732);

*Frequency:* Yearly; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 537; *Total Annual Responses:* 745,350; *Total Annual Hours:* 179,108. (For policy questions regarding this collection contact Sarah Gaillot at 410-786-4637.)

Dated: November 4, 2020.

**William N. Parham, III,**

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

[FR Doc. 2020-24852 Filed 11-6-20; 8:45 am]

**BILLING CODE 4120-01-P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

[CMS-4195-PN]

#### Medicare Program; Request for Renewal of Deeming Authority of the National Committee for Quality Assurance (NCQA) for Medicare Advantage Health Maintenance Organizations and Preferred Provider Organizations

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS).

**ACTION:** Notice with request for comment.

**SUMMARY:** This proposed notice announces that CMS is considering granting approval of the National Committee for Quality Assurance's (NCQA) renewal application for Medicare Advantage "deeming authority" of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). If approved, this new 6-year term of approval would be announced in a subsequent final notice. This proposed notice also announces a 30-day period for the public to submit comments on NCQA's application.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. December 9, 2020.

**ADDRESSES:** In commenting, refer to file code CMS-4195-PN.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following

address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-4195-PN, P.O. Box 8016 Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-4195-PN, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

**FOR FURTHER INFORMATION CONTACT:** Greg McDonald, (410) 786-8941; or Nick Proy, (410) 786-8407.

#### SUPPLEMENTARY INFORMATION:

*Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments.

#### I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a Medicare Advantage (MA) organization that contracts with CMS. The regulations specifying the Medicare requirements that must be met for a Medicare Advantage organization (MAO) to enter into a contract with CMS are located at 42 CFR part 422. These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MAO must provide and the requirements that the organization must meet to be an MA contractor. Other relevant sections of the Act are Parts A and B of Title XVIII and Part A of Title XI pertaining to the provision of services by Medicare-certified providers and suppliers. Generally, for an entity to be an MA organization, the organization must be licensed by the state as a risk bearing organization, as set forth in 42 CFR part 422.

As a method of assuring compliance with certain Medicare requirements, an MA organization may choose to become accredited by a CMS-approved accreditation organization (AO). By virtue of its accreditation by a CMS-approved AO, the MA organization may be "deemed" compliant in one or more

requirements set forth in section 1852(e)(4)(B) of the Act. For CMS to recognize an AO's accreditation program as establishing an MA plan's compliance with our requirements, the AO must prove to CMS that their standards are at least as stringent as Medicare requirements for MA organizations. MA organizations that are licensed as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) and are accredited by an approved accreditation organization may receive, at their request, "deemed" status for CMS requirements for the deemable areas. At this time, recognition of accreditation does not include the Part D areas of review set out at 42 CFR 423.165(b). AOs that apply for MA deeming authority are generally recognized by the health care industry as entities that accredit HMOs and PPOs. As we specify at § 422.157(b)(2)(ii), the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO must apply to CMS to renew their "deeming authority" for a subsequent approval period.

The National Committee for Quality Assurance (NCQA) was previously approved by CMS as an accreditation organization for MA deeming of HMOs and PPOs for a term to begin on October 19, 2014. That term lapsed on October 18, 2020, prior to our decision on its renewal application. On May 22, 2020, NCQA submitted its initial application to renew its deeming authority. On that same date, NCQA submitted materials requested by CMS that included information intended to address the requirements set out in our regulations at § 422.158(a) and (b) that are prerequisites for receiving approval of its accreditation program from CMS. CMS subsequently requested that additional materials be submitted by NCQA to satisfy these requirements.

#### II. Provisions of the Proposed Notice

The purpose of this proposed notice is to notify the public of NCQA's request to renew its Medicare Advantage deeming authority for HMOs and PPOs. NCQA submitted all the necessary materials (including its standards and monitoring protocol) to enable us to make a determination concerning its request for approval as an accreditation organization for CMS. This renewal application was determined to be complete on August 28, 2020. Under section 1852(e)(4) of the Act and § 422.158 (federal review of accreditation organizations), our review and evaluation of NCQA will be conducted as discussed below.