aligned to an ACO) targets—both for Medicare and across all significant healthcare payers. Additionally, CMS and Vermont aim for this Model to deliver meaningful improvements in the health of a state's entire population by transforming the relationships between and amongst care delivery and public health systems across Vermont.

II. Provisions of the Notice

The purpose of this notice is to announce a single source cooperative agreement funding opportunity in the amount of $9,500,000 available solely to Vermont's Agency of Human Services (AHS) to support care coordination and bolster collaboration for practices and community-based health care providers as part of the Vermont All-Payer ACO Model. A single-source award to the AHS will enable CMS to provide assistance to Vermont for the following purposes: To connect Medicare fee-for-service beneficiaries with community-based resources, coordinate transitions across care settings with appropriate involvement of the Medicare fee-for-service beneficiaries' primary care providers, coordinate care across health care providers, support health promotion and self-management by Medicare fee-for-service beneficiaries, and support practice improvement and transformation. These activities are necessary for Vermont to achieve the health outcomes and financial goals required under the Vermont All-Payer ACO Model.

CMS and Vermont believe the Vermont All-Payer ACO Model can support health care providers, including physicians in small practices, to succeed as health care moves from fee-for-service to value-based payment systems. Participation by health care providers and payers in the model will be voluntary, and CMS and Vermont expect to work closely together to achieve sufficient uptake. In particular, this Model is being implemented using the Secretary's authority in section 1115A of the Social Security Act (the Act) and Vermont's Global Commitment to Health demonstration project authorized under section 1115 of the Act. Together these authorities make it possible for physicians and other clinicians in Vermont to participate the aligned and state-specific Vermont Medicare ACO Initiative and Medicaid ACO initiative. Under the Quality Payment Program, the two-sided risk portion of the Vermont Medicare ACO Initiative meets the criteria to be an Advanced Alternative Payment Model. Health care providers participating in the two-sided risk portion of the Vermont Medicare ACO Initiative may potentially qualify for the APM Incentive Payments starting in performance year 2018.

This single-source funding opportunity to the AHS is designed to meet the goals of the cooperative agreement based on the AHS' existing knowledge and role in supporting the Model, its existing partnerships and collaborations with Vermont health care providers, and its resources and ability to deploy the funding immediately.

III. 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.*).

Dated: December 6, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2016–30269 Filed 12–15–16; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–4040, CMS–10156, CMS–10170, CMS–10198, CMS–10227, CMS–10344, CMS–10501, CMS–R–266, and CMS–10282]

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 any of the following subjects: 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 February 14, 2017.

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' Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995.*

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: Reports Clearance Office at (410) 786–1326.

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–4040 Request for Enrollment in Supplementary Medical Insurance
CMS–10156 Retiree Drug Subsidy (RDS) Application and Instructions
CMS–10170 Retiree Drug Subsidy (RDS) Payment Request and Instructions

CMS–10198 Creditable Coverage Disclosure to CMS On-Line Form and Instructions
CMS–10227 PACE State Plan Amendment Preprint
CMS–10344 Elimination of Cost-Sharing for Full Benefit Dual-Eligible Individuals Receiving Home and Community-Based Services
CMS–10501 Healthcare Fraud Prevention Partnership HFPP Data Sharing and Information Exchange
CMS–R–266 Medicaid Disproportionate Share Hospital Annual Reporting
CMS–10282 Conditions of Participation for Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Supporting Regulations

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 of a currently approved collection; *Title of Information Collection:* Request for Enrollment in Supplementary Medical Insurance; *Use:* Form CMS–4040 is used to establish entitlement to and enrollment in Medicare Part B for beneficiaries who file for Part B only. The collected information is used to determine entitlement for individuals who meet the requirements in section 1836(2) of the Social Security Act as well as the entitlement of the applicant (or their spouses) to an annuity paid by OPM for premium deduction purposes. *Form Number:* CMS–4040 (OMB control number: 0938–0245); *Frequency:* Once; *Affected Public:* Individuals or households; *Number of Respondents:* 10,000; *Total Annual Responses:* 10,000; *Total Annual Hours:* 2,500. (For policy questions regarding this collection contact Carla Patterson at 410–786–8911.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Retiree Drug Subsidy (RDS) Application and Instructions; *Use:* Plan sponsors (*e.g.,* employers, unions) who offer prescription drug coverage to their qualified covered retirees are eligible to receive a 28 percent tax-free subsidy for allowable drug costs. To qualify, plan sponsors must submit a complete application with a list of retirees for whom it intends to collect the subsidy. Once we review and analyze the information on the application and the retiree list, notification will be sent to the plan sponsor about its eligibility to participate in the RDS program. *Form Number:* CMS–10156 (OMB control number: 0938–0957); *Frequency:* Yearly and monthly; *Affected Public:* Private sector (Business or other for-profits and Not-for-profit institutions); *Number of Respondents:* 2,482; *Total Annual Responses:* 2,482; *Total Annual Hours:* 158,848. (For policy questions regarding this collection contact Ivan Iveljic at 410–786–3312.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Retiree Drug Subsidy (RDS) Payment Request and Instructions; *Use:* Plan sponsors (*e.g.,* employers, unions) who offer prescription drug coverage meeting specified criteria to their qualified covered retirees are eligible to receive a 28 percent tax-free subsidy for allowable drug costs. Plan sponsors must submit required prescription drug cost data and other information in order to receive the subsidy. Plan sponsors may elect to submit RDS payment requests on a monthly, quarterly, interim annual, or annual basis; once selected, the payment frequency may not be changed during the plan year. *Form Number:* CMS–10170 (OMB control number: 0938–0977); *Frequency:* Occasionally; *Affected Public:* Private sector (Business or other for-profits and Not-for-profit institutions); *Number of Respondents:* 2,482; *Total Annual Responses:* 2,482; *Total Annual Hours:* 374,782. (For policy questions regarding this collection contact Ivan Iveljic at 410–786–3312.)

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Creditable Coverage Disclosure to CMS On-Line Form and Instructions; *Use:* Most entities that currently provide prescription drug benefits to any Medicare Part D eligible individual must disclose whether their prescription drug benefit is creditable (expected to pay at least as much, on average, as the standard prescription drug plan under Medicare). The disclosure must be provided annually and upon any change that affects whether the coverage is creditable prescription drug coverage. *Form Number:* CMS–10198 (OMB control number: 0938–1013); *Frequency:* Yearly and semi-annually; *Affected Public:* Private sector (Business or other for-profits and Not-for-profit institutions), and State, Local, or Tribal Governments; *Number of Respondents:* 85,635; *Total Annual Responses:* 87,265; *Total Annual Hours:* 7,272. (For policy questions regarding this collection contact Tammie Wall at 410–786–3317.)

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* PACE State Plan Amendment Preprint; *Use:* If a state elects to offer PACE as an optional Medicaid benefit, it must complete a state plan amendment preprint packet described as ''Enclosures 3, 4, 5, 6, and 7.'' CMS will review the information provided in order to determine if the state has properly elected to cover PACE services as a state plan option. In the event that the state changes something in the state plan, only the affected page must be updated. *Form Number:* CMS–10227 (OMB control number: 0938–1027); *Frequency:* Once and occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 7; *Total Annual Responses:* 2; *Total Annual Hours:* 140. (For policy questions regarding this collection contact Angela Cimino at 410–786–2638.)

6. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Elimination of Cost-Sharing for Full Benefit Dual-Eligible Individuals Receiving Home and Community-Based Services; *Use:* This collection eliminates Part D cost-sharing for full benefit dual-eligible beneficiaries who are receiving home and community based services. In this regard, states are required to identify the affected beneficiaries in their monthly Medicare Modernization Act Phase Down reports. *Form Number:* CMS–10344 (OMB control number: 0938–1127); *Frequency:* Monthly; *Affected Public:* Private sector (Business or other for-profits and Not-for-profit institutions); *Number of Respondents:* 51; *Total Annual Responses:* 612; *Total Annual Hours:* 612. (For policy questions regarding this collection

contact Roland Herrera at 410–786–0668.)

7. *Type of Information Collection Request:* Revision of a previously approved collection; *Title of Information Collection:* Healthcare Fraud Prevention Partnership (HFPP): Data Sharing and Information Exchange; *Use:* The advance directives requirement was enacted because Congress wanted individuals to know that they have a right to make health care decisions and to refuse treatment even when they are unable to communicate. Steps have been taken at both the Federal and State level, to afford greater opportunity for the individual to participate in decisions made concerning the medical treatment to be received by an adult patient in the event that the patient is unable to communicate to others, a preference about medical treatment. The individual may make his preference known through the use of an advance directive, which is a written instruction prepared in advance, such as a living will or durable power of attorney. This information is documented in a prominent part of the individual's medical record. Advance directives as described in the Patient Self-Determination Act have increased the individual's control over decisions concerning medical treatment. Sections 4206 of the Omnibus Budget Reconciliation Act of 1990 defined an advance directive as a written instruction recognized under State law relating to the provision of health care when an individual is incapacitated (those persons unable to communicate their wishes regarding medical treatment).

All states have enacted legislation defining a patient's right to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Participating hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care, hospices, religious nonmedical health care institutions, and prepaid or eligible organizations (including Health Care Prepayment Plans (HCPPs) and Medicare Advantage Organizations (MAOs) such as Coordinated Care Plans, Demonstration Projects, Chronic Care Demonstration Projects, Program of All Inclusive Care for the Elderly, Private Fee for Service, and Medical Savings Accounts must provide written information, at explicit time frames, to all adult individuals about: (a) The right to accept or refuse medical or surgical treatments; (b) the right to formulate an advance directive; (c) a description of applicable State law (provided by the State); and (d) the provider's or organization's policies and procedures for implementing an advance directive. *Form Number:* CMS–10507 (OMB control number: 0938–1251); Frequency: Occasionally; *Affected Public:* Private sector (Business or other for-profits); *Number of Respondents:* 20; *Total Annual Responses:* 20; *Total Annual Hours:* 160. (For policy questions regarding this collection contact Marnie Dorsey at 410–786–5942.)

8. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicaid Disproportionate Share Hospital (DSH) Annual Reporting Requirements; *Use:* States are required to submit an annual report that identifies each disproportionate share hospital (DSH) that received a DSH payment under the state's Medicaid program in the preceding fiscal year and the amount of DSH payments paid to that hospital in the same year along with other information that the Secretary determines necessary to ensure the appropriateness of DSH payments; *Form Number:* CMS–R–266 (OMB control number: 0938–0746); *Frequency:* Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 51; *Total Annual Responses:* 51; *Total Annual Hours:* 2,142. (For policy questions regarding this collection contact Robert Lane at 410–786–2015.)

9. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Conditions of Participation for Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Supporting Regulations; *Use:* The Conditions of Participation (CoPs) and accompanying requirements specified in the regulations are used by our surveyors as a basis for determining whether a comprehensive outpatient rehabilitation facility (CORF) qualifies to be awarded a Medicare provider agreement. We believe the health care industry practice demonstrates that the patient clinical records and general content of records are necessary to ensure the well-being and safety of patients and that professional treatment and accountability are a normal part of industry practice. *Form Number:* CMS–10282 (OMB control number: 0938–1091); *Frequency:* Yearly; *Affected Public:* Private sector—Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 549; *Total Annual Responses:* 549; *Total Annual Hours:* 6,945. (For policy questions regarding this collection contact Jacqueline Leach at 410–786–4282.)

Dated: December 13, 2016.

William N. Parham, III,

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

[FR Doc. 2016–30340 Filed 12–15–16; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–2744]

Agency Information Collection Activities: Submission for OMB Review; 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 (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 any of the following subjects: 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 January 17, 2017.

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* Email: *OIRA_ submission@omb.eop.gov.*