contact Beverly Boher at (410) 786–7806.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Children's Health Insurance Program (CHIP) Report on Payables and Receivables; *Use:* Section 2105 of the Social Security Act (Title XXI) requires the Secretary to estimate the amount each State should be paid at the beginning of each quarter. This amount is based on a report filed by the State. Section 2105 of the Social Security Act authorizes the Secretary to pay the amount estimated, reduced or increased to the extent of any overpayment or underpayment for any prior quarter. Section 3515 of the CFO Act requires government agencies to produce auditable financial statements in accordance with Office of Management and Budget guidelines on Form and Content. The Government Management and Reform Act of 1994 requires that all offices, bureaus and associated activities of the 24 CFO Act agencies must be covered in an agency-wide, audited financial statement. Collection of CHIP data and the calculation of the CHIP Incurred But Not Reported (IBNR) estimate are pertinent to CMS' financial audit. The CHIP Report on Payables and Receivables will provide the information needed to calculate the CHIP IBNR. Failure to collect this information could result in non-compliance with the law. *Form Number:* CMS–10180 (OMB control number: 0938–0988); *Frequency:* Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 504. (*For policy questions regarding this collection contact* Beverly Boher at (410) 786–7806.)

3. *Type of Information Collection Request:* Reinstatement without change of a currently approved collection*; Title of Information Collection:* Emergency and Foreign Hospital Services and Supporting Regulation in 42 CFR Section 424.103*; Use:* Section 1866 of the Social Security Act states that any provider of services shall be qualified to participate in the Medicare program and shall be eligible for payments under Medicare if it files an agreement with the Secretary to meet the conditions outlined in this section of the Act. Section 1814 (d)(1) of the Social Security Act and 42 CFR 424.100, allows payment of Medicare benefits for a Medicare beneficiary to a nonparticipating hospital that does not have an agreement in effect with the Centers for Medicare and Medicaid Services. These payments can be made if such services were emergency services and if CMS would be required to make the payment if the hospital had an agreement in effect and met the conditions of payment. This form is used in connection with claims for emergency hospital services provided by hospitals that do not have an agreement in effect under Section 1866 of the Social Security Act. 42 CFR 424.103 (b) requires that before a non-participating hospital may be paid for emergency services rendered to a Medicare beneficiary, a statement must be submitted that is sufficiently comprehensive to support that an emergency existed. Form CMS- 1771 contains a series of questions relating to the medical necessity of the emergency. The attending physician must attest that the hospitalization was required under the regulatory emergency definition (42 CFR 424.101 attached) and give clinical documentation to support the claim. A photocopy of the beneficiary's hospital records may be used in lieu of the CMS–1771 if the records contain all the information required by the form. *Form Number:* CMS–1771 (OMB control number: 0938–0023); *Frequency:* Yearly; *Affected Public:* Private Sector; Business or other for-profits, Not-for-profit Institutions; *Number of Respondents:* 100; *Total Annual Responses:* 200; *Total Annual Hours:* 50. *(For policy questions regarding this collection contact* Shauntari Cheely *at (410) 786–1818.)*

Dated: February 18, 2020.

William N. Parham, III,

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

[FR Doc. 2020–03537 Filed 2–21–20; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–267 and CMS–10396]

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 April 24, 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–R–267 Medicare Plus Choice Program Requirements Referenced in 42 CFR 422.000—422.700

CMS–10396 Medication Therapy Management Program Improvements—Standardized Format

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:* Revision with change of a currently approved collection; *Title of Information Collection:* Medicare Plus Choice Program Requirements Referenced in 42 CFR 422.000–422.700; *Use:* The information collection requirements are mandated by 42 CFR part 422. Section 4001 of the Balanced Budget Act of 1997 (BBA) added sections 1851 through 1859 to the Social Security Act to establish the Managed Care program. The Medicare, Medicaid, and SCHIP Benefits Improvement Act and Protection Act of 2000, Public Law 106–554 added requirements to the Managed Care program. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) created the Medicare Advantage program.

A major goal of the Medicare Advantage program is to provide ease of access for Original Medicare beneficiaries who wish to enroll in a Medicare Advantage program. Certain populations of beneficiaries such as the dually eligible population (those beneficiaries enrolled in both Medicaid and Medicare) have grown since the program was created and these populations require more flexibilities.

MA organizations (formerly M+C organizations) and potential MA organizations (applicants) use the information collected based on the regulations at 42 CFR part 422 to comply with the application requirements and the MA contract requirements. CMS uses the information collected based on the regulations at 42 CFR part 422 to approve contract applications, monitor compliance with contract requirements, make proper payment to MA organizations, determine compliance with the new prescription drug benefit requirements established by the MMA, and to ensure that correct information is disclosed to Medicare beneficiaries, both potential enrollees and enrollees.

Information supplied by organizations is used to determine eligibility for contracting with CMS, for determining compliance with contract requirements, and for calculating proper payment to the organizations. Information supplied by Medicare beneficiaries is used to determine eligibility to enroll in the M+C organization and to determine proper payment to the organization that enrolled the beneficiary. Separate OMB approval was sought for each form as required.

The information collection request also incorporates the new minimum criteria for dual eligible special needs plans (D–SNPs) to integrate Medicare and Medicaid benefits detailed in Section 50311(b) of the Bipartisan Budget Act of 2018 and set forth in in Final rule (CMS–4185–F, RIN 0938–AT59) for CY2020 and 2021. The integration requirements improve care coordination, quality of care, and beneficiary satisfaction while reducing administrative burden. *Form Number:* CMS–R–267 (OMB control number: 0938–0753); *Frequency:* Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 6,727,508; *Total Annual Responses:* 6,750,814; *Total Annual Hours:* 1,848,180. (For policy questions regarding this collection contact Marna Metcalf Akbar at 410–786–8251.)

2. *Type of Information Collection Request:* Revision with change of a currently approved collection; *Title of Information Collection:* Medication Therapy Management Program Improvements—Standardized Format; *Use:* The Medicare Modernization Act of 2003 (MMA) under title 42 CFR part 423, subpart D, establishes the requirements that Part D sponsors, an organization which has one or more contract(s) with CMS to provide Part D benefits to Medicare beneficiaries, must meet with regard to cost control and quality improvement including requirements for medication therapy management (MTM) programs. MTM is a patient-centric and comprehensive approach to improve medication use, reduce the risk of adverse events, and improve medication adherence. At minimum, a Part D sponsors' MTM program must offer to its enrollees an annual comprehensive medication review with written summaries, quarterly targeted medication reviews, and follow-up interventions for both beneficiaries and prescribers when necessary.

Information collected by Part D MTM programs as required by the Standardized Format for the CMR summary, which is used by beneficiaries or their authorized representatives, caregivers, and their healthcare providers to improve medication use and achieve better healthcare outcomes. The Standardized Format must comply with applicable industry standards for medication therapy management and electronic data interchange, and should enable CMR data elements to be captured for clinical, reporting or measurement purposes.

After a CMR is performed, the sponsor creates and sends a summary of the CMR to the beneficiary that includes a medication action plan and personal medication list using the Standardized Format. The information users are beneficiaries or their authorized representatives, caregivers, and their healthcare providers as stated in this section. *Form Number:* CMS–10396 (OMB control number: 0938–1154); *Frequency:* Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 735; *Total Annual Responses:* 2,173,254; *Total Annual Hours:* 1,448,908. (For policy questions regarding this collection contact Victoria Dang at 410–786–3991.)

Dated: February 18, 2020.

William N. Parham, III,

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

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