assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The applications will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than January 17, 2017.

A. Federal Reserve Bank of St. Louis (David L. Hubbard, Senior Manager) P.O. Box 442, St. Louis, Missouri 63166–2034. Comments can also be sent electronically to *Comments.applications@stls.frb.org:*

1. *Farmers Bancorp, Inc.,* Blytheville, Arkansas; to acquire 100 percent of Tennessee Bank & Trust, Nashville, Tennessee, a de nova bank.

Board of Governors of the Federal Reserve System, December 13, 2016.

Yao-Chin Chao,

Assistant Secretary of the Board.

[FR Doc. 2016–30301 Filed 12–15–16; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5521–N]

Medicare Program; Start-Up Funding in Support of the Vermont All-Payer Accountable Care Organization (ACO) Model—Cooperative Agreement

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: The purpose of this notice is to announce issuance of the November 23, 2016 single-source cooperative agreement funding opportunity available solely to Vermont's Agency of Human Services in order to provide care coordination and bolster collaboration for practices and community-based health care providers as part of the Vermont All-Payer Accountable Care Organization (ACO) Model.

DATES: The performance period of the Vermont All-Payer ACO Model will begin on January 1, 2017, and conclude on December 31, 2022.

FOR FURTHER INFORMATION CONTACT: Stephen Cha, (410) 786–1876.

SUPPLEMENTARY INFORMATION:

I. Background

The Vermont All-Payer Accountable Care Organization Model (Model) is the Centers for Medicare & Medicaid Services' (CMS) new test within the Center for Medicare and Medicaid Innovation of an alternative payment model in which the major health care payers—Medicare, Medicaid, and commercial health care payers—incentivize health care value and quality under the same payment structure for health care providers throughout the state's care delivery system to transform health care for the entire state and its population. An Accountable Care Organization (ACO) is an entity formed by certain health care providers that accepts financial accountability for the overall quality and cost of medical care furnished to, and health of, beneficiaries attributed to the entity.

CMS believes that states can be critical partners of the federal government and other health care payers to facilitate the design, implementation, and evaluation of community-centered health systems that can deliver significantly improved cost, quality, and population health performance results for all state residents, including Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. States have policy and regulatory authorities, as well as ongoing relationships with commercial healthcare payers, health plans, and health care providers that can accelerate delivery system reform. CMS has previously partnered with states to accelerate delivery system reform through initiatives such as the State Innovations Model (SIM). SIM provides state-based healthcare transformation efforts with funding to test the ability of states to utilize policy and regulatory levers to accelerate multi-payer health care transformation.

Vermont, a SIM state awardee, approached CMS with a desire to include Medicare in the state's multipayer payment and care delivery model, and Vermont publicly released its proposal on January 25, 2016. CMS reviewed Vermont's proposal and determined that it met the necessary requirements to explore a potential Vermont-specific model in which Medicare aligns with Vermont's healthcare transformation efforts. In October 2016, CMS and the State of Vermont entered into the Vermont All-Payer Accountable Care Organization Model Agreement (''State Agreement'') to implement the Vermont All-Payer ACO Model. The Vermont All-Payer ACO Model will be a 6-year model beginning in 2017 and ending in 2022.

As part of the Model, Vermont health care providers will participate in a Vermont-specific Medicare ACO initiative (the Vermont Medicare ACO Initiative), which is largely based on CMS' Next Generation ACO Model. CMS will provide one-time start-up funding in the amount of $9,500,000 to the State to assist Vermont health care providers with care coordination and bolster their collaboration with community-based resources. CMS will provide the start-up funding as a cooperative agreement funding opportunity available solely to Vermont's Agency of Human Services, as announced in this notice. More information about the Vermont All-Payer ACO Model can be found at *https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/.*

Through the Model, CMS will test whether the quality of health care for Vermont residents improves and healthcare expenditures for beneficiaries across payers (including Medicare fee-for-service, Vermont Medicaid, Vermont commercial plans, and Vermont self-insured plans) decrease if—

- The aforementioned payers offer Vermont ACOs risk-based arrangements tied to health outcomes and healthcare expenditures;
- The majority of Vermont health care providers enter into such risk-based arrangements; and
- The majority of Vermont residents across payers are aligned to an ACO bound by these arrangements.

CMS and Vermont aim for broad ACO participation throughout the state, across all the significant payers and the majority of the care delivery system, to make redesigning the entire care delivery system a rational business strategy for Vermont health care providers and payers. As set forth in the State Agreement, Vermont commits to achieving statewide health outcomes, financial targets, and ACO scale (percentage of Vermont residents

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