A. OMB Control Number, Title, and Any Associated Form(s)

9000–0064, Organization and Direction of the Work

B. Need and Uses

This clearance covers the information that contractors must submit to comply with the following Federal Acquisition Regulation (FAR) requirement:

• 52.236–19, Organization and Direction of the Work. This clause requires contractors, under cost-reimbursement construction contracts, to submit to the contracting officer a chart showing the general executive and administrative organization, the personnel to be employed in connection with the work under the contract, and their respective duties. The contractor must keep the data furnished current by supplementing it as additional information becomes available.

The contracting officer uses the information to ensure the work is performed by qualified personnel at a reasonable cost to the Government.

C. Annual Burden

Respondents: 34.
Total Annual Responses: 34.
Total Burden Hours: 26.
Obtaining Copies: Requesters may obtain a copy of the information collection documents from the GSA Regulatory Secretariat Division by calling 202–501–4755 or emailing *GSARegSec@gsa.gov.* Please cite OMB Control No. 9000–0064, Organization and Direction of the Work.

William F. Clark,

Director, Federal Acquisition Policy Division, Office of Governmentwide Acquisition Policy, Office of Acquisition Policy, Office of Governmentwide Policy.

[FR Doc. 2020–25801 Filed 11–20–20; 8:45 am]

BILLING CODE 6820–EP–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6090–N]

Medicare, Medicaid, and Children's Health Insurance Programs; Provider Enrollment Application Fee Amount for Calendar Year 2021

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

ACTION: Notice.

SUMMARY: This notice announces a $599.00 calendar year (CY) 2021 application fee for institutional providers that are initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP); revalidating their Medicare, Medicaid, or CHIP enrollment; or adding a new Medicare practice location. This fee is required with any enrollment application submitted on or after January 1, 2021 and on or before December 31, 2021.

DATES: The application fee announced in this notice is effective on January 1, 2021.

FOR FURTHER INFORMATION CONTACT: Melissa Singer, (410) 786–0365.

SUPPLEMENTARY INFORMATION:

I. Background

In the February 2, 2011 **Federal Register** (76 FR 5862), we published a final rule with comment period titled ''Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers.'' This rule finalized, among other things, provisions related to the submission of application fees as part of the Medicare, Medicaid, and CHIP provider enrollment processes. As provided in section 1866(j)(2)(C)(i) of the Social Security Act (the Act) and in 42 CFR 424.514, ''institutional providers'' that are initially enrolling in the Medicare or Medicaid programs or CHIP, revalidating their enrollment, or adding a new Medicare practice location are required to submit a fee with their enrollment application. An ''institutional provider'' for purposes of Medicare is defined at § 424.502 as ''any provider or supplier that submits a paper Medicare enrollment application using the CMS–855A, CMS–855B (not including physician and non-physician practitioner organizations), CMS–855S, CMS–20134, or associated internet-based PECOS enrollment application.'' As we explained in the February 2, 2011 final rule (76 FR 5914), in addition to the providers and suppliers subject to the application fee under Medicare, Medicaid-only and CHIP-only institutional providers would include nursing facilities, intermediate care facilities for persons with intellectual disabilities (ICF/IID), psychiatric residential treatment facilities, and may include other institutional provider types designated by a state in accordance with their approved state plan.

As indicated in § 424.514 and § 455.460, the application fee is not required for either of the following:

• A Medicare physician or non-physician practitioner submitting a CMS–855I.

• A prospective or revalidating Medicaid or CHIP provider—

++ Who is an individual physician or non-physician practitioner; or

++ That is enrolled in Title XVIII of the Act or another state's Title XIX or XXI plan and has paid the application fee to a Medicare contractor or another state.

II. Provisions of the Notice

Section 1866(j)(2)(C)(i)(I) of the Act established a $500 application fee for institutional providers in calendar year (CY) 2010. Consistent with section 1866(j)(2)(C)(i)(II) of the Act, § 424.514(d)(2) states that for CY 2011 and subsequent years, the preceding year's fee will be adjusted by the percentage change in the consumer price index (CPI) for all urban consumers (all items; United States city average, CPI U) for the 12 month period ending on June 30 of the previous year. Each year since 2011, accordingly, we have published in the **Federal Register** an announcement of the application fee amount for the forthcoming CY based on the formula noted previously. Most recently, in the November 12, 2019 **Federal Register** (84 FR 61058), we published a notice announcing a fee amount for the period of January 1, 2020 through December 31, 2020 of $595.00. The $595.00 fee amount for CY 2020 was used to calculate the fee amount for 2021 as specified in § 424.514(d)(2).

According to Bureau of Labor Statistics (BLS) data, the CPU–U increase for the period of July 1, 2019 through June 30, 2020 was 0.6 percent. As required by § 424.514(d)(2), the preceding year's fee of $595 will be adjusted by the CPI–U of 0.6 percent. This results in a CY 2021 application fee amount of $598.57 ($595 × 1.006). As we must round this to the nearest whole dollar amount, the resultant application fee amount for CY 2021 is $599.

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. However, it does reference previously approved information collections. The Forms CMS–855A, CMS–855B, and CMS–855I are approved under OMB control number 0938–0685; the Form

CMS–855S is approved under OMB control number 0938–1056.

IV. Regulatory Impact Statement

A. Background

We have examined the impact of this notice as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits, including potential economic, environmental, public health and safety effects, distributive impacts, and equity. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). As explained in this section of the notice, we estimate that the total cost of the increase in the application fee will not exceed $100 million. Therefore, this notice does not reach the $100 million economic threshold and is not considered a major notice.

B. Costs

The costs associated with this notice involve the increase in the application fee amount that certain providers and suppliers must pay in CY 2021. The CY 2021 cost estimates are as follows:

1. Medicare

Based on CMS data, we estimate that in CY 2021 approximately—

- 10,214 newly enrolling institutional providers will be subject to and pay an application fee; and
- 42,117 revalidating institutional providers will be subject to and pay an application fee.

Using a figure of 52,331 (10,214 newly enrolling + 42,117 revalidating) institutional providers, we estimate an increase in the cost of the Medicare application fee requirement in CY 2021 of $209,324 (or 52,331 × $4 (or $599 minus $595)) from our CY 2020 projections.

2. Medicaid and CHIP

Based on CMS and state statistics, we estimate that approximately 30,000 (9,000 newly enrolling + 21,000 revalidating) Medicaid and CHIP institutional providers will be subject to an application fee in CY 2021. Using this figure, we project an increase in the cost of the Medicaid and CHIP application fee requirement in CY 2021 of $120,000 (or 30,000 × $4 (or $599 minus $595)) from our CY 2020 projections.

3. Total

Based on the foregoing, we estimate the total increase in the cost of the application fee requirement for Medicare, Medicaid, and CHIP providers and suppliers in CY 2021 to be $329,324 ($209,324 + $120,000) from our CY 2020 projections.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than $7.5 million to $38.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. As we stated in the RIA for the February 2, 2011 final rule with comment period (76 FR 5952), we do not believe that the application fee will have a significant impact on small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this notice would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2020, that threshold was approximately $156 million. The Agency has determined that there will be minimal impact from the costs of this notice, as the threshold is not met under the UMRA.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. Since this notice does not impose substantial direct costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

Executive Order 13771, titled ''Reducing Regulation and Controlling Regulatory Costs,'' was issued on January 30, 2017 (82 FR 9339, February 3, 2017). It has been determined that this notice is a transfer notice that does not impose more than de minimis costs and thus is not a regulatory action for the purposes of E.O. 13771.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

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: November 17, 2020.

Lynette Wilson,

Federal Register Liaison, Department of Health and Human Services.

[FR Doc. 2020–25715 Filed 11–20–20; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–6063–N6]

Medicare Program; National Expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports

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

ACTION: Notice.

SUMMARY: This notice announces the national expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports to all states, but we are delaying the implementation of the expansion to all additional states due to