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 of a currently approved collection; *Title of Information Collection:* ICF/IID Survey Report Form and Supporting Regulations; *Use:* The information collected with forms 3070G–I is used to determine the level of compliance with Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) CoPs necessary to participate in the Medicare/Medicaid program. Information needed to monitor the State's performance as well as the ICF/IID program in general, is available to CMS only through the use of information abstracted from the survey report form. The form serves as a coding worksheet designed to facilitate data entry and retrieval into the Automated Survey Processing Environment Suite (ASPEN) in the State and at the CMS regional offices. *Form Number:* CMS–3070G–I (OMB Control Number: 0938–0062); *Frequency:* Reporting—Yearly; *Affected Public:* Private Sector: Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 6,310; *Total Annual Responses:* 6,310; *Total Annual Hours:* 18,930. (For policy questions regarding this collection contact Melissa Rice at 410–786–3270.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Conditions for Certification for Rural Health Clinics; *Use:* The Rural Health Clinic (RHC) conditions of certification are based on criteria prescribed in law and are designed to ensure that each facility has a properly trained staff to provide appropriate care and to assure a safe physical environment for patients. We use these conditions of participation to certify RHCs wishing to participate in the Medicare program. These requirements are similar in intent to standards developed by industry organizations such as the Joint Commission on Accreditation of Hospitals, and the National League of Nursing and the American Public Association and merely reflect accepted standards of management and care to which rural health clinics must adhere. *Form Number:* CMS–R–38 (OMB control number: 0938–0334); *Frequency:* Recordkeeping and Reporting—Annually; *Affected Public:* Business or other for-profits; *Number of Respondents:* 4,247; *Total Annual Responses:* 4,247; *Total Annual Hours:* 18,284. (For policy questions regarding this collection contact Jacqueline Leach at 410–786–4282.)

3. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Three-Year Network Adequacy Review for Medicare Advantage Organizations; *Use:* The CMS regulations at 42 CFR 422.112(a)(1)(i) and § 422.114(a)(3)(ii) require that all Medicare Advantage organizations (MAOs) offering coordinated care plans (*e.g.,* HMO, PPO) or other network-based plans (*e.g.,* network-based PFFS, network-based MSA, section 1876 cost plan) maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served. To enforce this requirement, CMS has developed network adequacy criteria, which sets forth the minimum number of providers and maximum travel time and distance from enrollees to providers, for each provider specialty type in each county in the United States and its territories. MAOs must be in compliance with the current CMS network adequacy criteria. This proposed collection of information is essential to appropriate and timely compliance monitoring by CMS, in order to ensure that all active MAO contracts offering network-based plans maintain an adequate network. Currently, CMS verifies that MAOs are compliant with the current CMS network adequacy criteria by performing a contract-level network review, which occurs when CMS requests that an MAO upload provider and facility Health Service Delivery (HSD) tables for a given contract to the Health Plan Management System (HPMS). If an MAO does not have its contract-level network formally reviewed by CMS after the initial contract application process, then there is no CMS requirement for a network adequacy review unless one of the above listed triggering events occurs. Therefore, CMS is proposing this collection of information in order to improve monitoring of MAOs' network adequacy. This collection of information requires the uploading of HSD tables to the Network Management Module (NMM) in HPMS for any contract that has not had an entire network review performed by CMS in the previous three years of contract operation. The collection process will occur at the contract level for each MAO that qualifies, and CMS will assess each contract against the current CMS network adequacy criteria. Each time an MAO's contract undergoes an entire network review during any of the triggering events listed on page one, the three-year anniversary date for that contract will be reset, and CMS will maintain an HPMS report to keep track of this date for every active network-based contract. *Form Number:* CMS–10636 (OMB control number 0938-New); *Frequency:* Yearly; *Affected Public:* Private sector (Business or other for-profits); *Number of Respondents:* 484; *Total Annual Responses:* 1,652; *Total Annual Hours:* 15,692. (For policy questions regarding this collection contact Theresa Wachter at 410–786–1157.)

Dated: November 1, 2016.

William N. Parham, III,

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

[FR Doc. 2016–26745 Filed 11–3–16; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10191 and CMS–10305]

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 December 5, 2016.

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*.

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: Under the Paperwork Reduction Act of 1995 (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 (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-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 that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Parts C and D Program Audit Protocols and Data Requests; *Use:* Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and implementing regulations at 42 CFR parts 422 and 423, Medicare Part D plan sponsors and Medicare Advantage organizations are required to comply with all Medicare Parts C and D program requirements. In 2010, the explosive growth of these sponsoring organizations forced CMS to develop an audit strategy to ensure we continue to obtain meaningful audit results. As a result, CMS' audit strategy reflected a move to a more targeted, data-driven and risk-based audit approach. We focused on high-risk areas that have the greatest potential for beneficiary harm.

To maximize resources, CMS will focus on assisting the industry to improve their operations to ensure beneficiaries receive access to care. One way to accomplish this is CMS will develop an annual audit strategy which describes how sponsors will be selected for audit and the areas that will be audited. CMS has developed several audit protocols and these are posted to the CMS Web site each year for use by sponsors to prepare for their audit. Currently CMS utilizes the following 7 protocols to audit sponsor performance: Formulary Administration (FA), Coverage Determinations, Appeals & Grievances (CDAG), Organization Determination, Appeals and Grievances (ODAG), Special Needs Model of Care (SNPMOC) (only administered on organizations who operate SNPs), Compliance Program Effectiveness (CPE), Medication Therapy Management (MTM) and Provider Network Accuracy (PNA). The data collected is detailed in each of these protocols and the exact fields are located in the record layouts, at the end of each protocol. In addition, questionnaires are distributed as part of our CDAG, ODAG and CPE audits. These questionnaires are also included in this package.

As part of a robust audit process, CMS also requires sponsors who have been audited and found to have deficiencies to undergo a validation audit to ensure correction. The validation audit utilizes the same audit protocols, but only tests the elements where deficiencies were found, as opposed to re-administering the entire audit. Finally, to assist in improving the audit process, CMS sends sponsors a link to a survey (Appendix D) at the end of each audit to complete in order to obtain the sponsors' feedback. The sponsor is not required to complete the survey. *Form Number:* CMS–10191 (OMB control number: 0938–1000); *Frequency:* Yearly; *Affected Public:* Private Sector (business or other for-profit and not-for-profit institutions); *Number of Respondents:* 40; *Total Annual Responses:* 40; *Total Annual Hours:* 13,640. (For policy questions regarding this collection contact Dawn Johnson at 410–786–3159.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Part C and Part D Data Validation (42 CFR 422.516(g) and 423.514(g)); *Use:* Organizations contracted to offer Medicare Part C and Part D benefits are required to report data to us on a variety of measures. For the data to be useful for monitoring and performance measurement, the data must be reliable, valid, complete, and comparable among sponsoring organizations. To meet this goal, we have developed reporting standards and data validation specifications with respect to the Part C and Part D reporting requirements. These standards provide a review process for Medicare Advantage Organizations, Cost Plans, and Part D sponsors to use to conduct data validation checks on their reported Part C and Part D data.

The FDCF is revised for the 2017 and 2018 DV collection periods by changing the scoring of six standards from a binary scale to a five-point Likert-type scale. This change is expected to improve the precision of the data validation scores by increasing overall variation in total scores among the MAOs and PDPs. The revision is not expected to alter resource requirements, since the assessment by DV contractors in scoring standards will continue to be based on the percentage of records that meet the standards. *Form Number:* CMS–10305 (OMB control number: 0938–1115); *Frequency:* Yearly; *Affected Public:* Private sector—Business or other for-profits; *Number of Respondents:* 639; *Total Annual Responses:* 639; *Total Annual Hours:* 209,271. (For policy questions regarding this collection contact Terry Lied at 410–786–8973.)

Dated: November 1, 2016.

William N. Parham, III,

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

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