Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. The Centers for Medicare & Medicaid Services (CMS) completed the rulemaking process for the competitive acquisition of DMEPOS items and services in 42 CFR parts 411 and 414 published in the **Federal Register** Volume 72 on April 10, 2007. CMS conducted the Round 1 competition in 10 areas and for 10 DMEPOS product categories, and implemented the program on July 1, 2008. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, made limited changes to the Competitive Bidding Program, including termination of existing contracts that were in effect and a requirement to re-bid Round 1.

As required by MIPPA, CMS conducted the competition for the Round 1 Rebid in 2009. The Round 1 Rebid contracts and prices became effective on January 1, 2011. The Affordable Care Act (ACA), enacted on March 23, 2010, expanded the Round 2 competition by adding an additional 21 metropolitan statistical areas (MSAs), bringing the total MSAs for Round 2 to 91. The competition for Round 2 began in December 2011. CMS also began a competition for National Mail Order (NMO) of diabetes testing supplies at the same time as Round 2. The Round 2 and NMO contracts and prices were implemented on July 1, 2013.

The MMA requires the Secretary to recompete contracts not less often than once every three years. The Round 1 Rebid contract period for all product categories except mail-order diabetes testing supplies expired on December 31, 2013. (Round 1 Rebid contracts for mail-order diabetes testing supplies ended on December 31, 2012.) The competition for the Round 1 Recompete began in August of 2012 and contracts and prices became effective on January 1, 2014. The Round 1 Recompete contract period expires on December 31, 2016. Round 1 2017 contracts will become effective on January 1, 2017 through December 31, 2018. Round 2 and NMO contracts and prices expired on June 30, 2016. Round 2 Recompete and the NMO Recompete contracts became effective on July 1, 2016, and expired on December 31, 2018. CMS will be implementing a consolidated round of competition to include all Round 1 2017 and Round 2 Recompete competitive bidding areas, referred to as Round 2021. Round 2021 will not include NMO, which will be competed again in future rounds of the program.

The forms included in this ICR were previously included in the ICR currently approved under 0938–1016. Due to the temporary gap in the DMEPOS Competitive Bidding Program, which started on January 1, 2019, we do not currently have any active PRA package for this specific collection of information (Form C, Subcontracting, Change of Ownerships, and Grandfathering). We are now seeking approval of a PRA package based on estimates from previous rounds of the program (specifically Round 2 Recompete and Round 1 2017) and without reference to changes in burden *Form Number:* CMS–10744 (OMB control number: 0938-New); *Frequency:* Occasionally (varies by form); *Affected Public:* Private Sector, Business or other for-profits; *Number of Respondents:* 2,984; *Total Annual Responses:* 271,597; *Total Annual Hours:* 31,121. (For policy questions regarding this collection contact Julia Howard at 410–786–8645.)

Dated: June 25, 2020.

William N. Parham, III,

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

[FR Doc. 2020–14088 Filed 6–30–20; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10219, CMS–R–142 and CMS–10695]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, Health and Human 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 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 July 30, 2020.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

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.*

1. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov.*

2. Call the Reports Clearance Office at (410) 786–1326.

FOR FURTHER INFORMATION CONTACT: William Parham at (410) 786–4669.

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 with change of a currently approved collection; *Title of Information Collection:* HEDIS® Data Collection for Medicare Advantage; *Use:* The HEDIS® data collection supports the CMS strategic goal of improving the quality of care and health status for Medicare beneficiaries. The HEDIS® measures are part of the Medicare Part C Star Ratings as described at §§ 422.160, 422.162, 422.164, and 422.166. CMS publishes the Medicare Part C Star Ratings each year to: (1) Incentivize quality improvement in Medicare Advantage (MA); and (2) assist beneficiaries in finding the best plan for them. The ratings feed into MA Quality Bonus Payments. The Medicare Star Ratings support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other providers.

HEDIS® data support the agency's goal to hold MA contracts accountable for delivering care in accordance with widely accepted clinical guidelines and standards of care. CMS uses HEDIS® data to obtain the information necessary for the proper oversight of the Medicare Advantage program. NCQA trains and licenses organizations to conduct audits on-site at the MAOs secure record-keeping facilities where they compile their administrative and medical records for the HEDIS data file submissions *Form Number:* CMS–10219 (OMB control number: 0938–1028); *Frequency:* Yearly; *Affected Public:* Federal Government; *Number of Respondents:* 677; *Total Annual Responses:* 677; *Total Annual Hours:* 216,640. (For policy questions regarding this collection contact Lori Teichman at 410–786–6684.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Examination and Treatment for Emergency Medical Conditions and Women in Labor (EMTALA); *Use:* Pursuant to section 1866(a)(1)(I) of the Act, Congress has mandated that the Secretary enforce section 1867 of the Act. Under section 1867, effective August 1, 1986, hospitals may continue to participate in the Medicare program only if they are not out of compliance with its provisions. Continued Paper Work Reduction Act (PRA) approval of the regulation sections cited below will promote uniform and thorough application of the section 1866 and 1867 requirements. They will also provide information when requested by Congress and other interested parties regarding the implementation of the statute. During 2004 through 2018, approximately 8,146 complaints were received, approximately 7,770 of those complaints were investigated, and approximately 3,567 EMTALA deficiencies were found. During Federal fiscal years 2001 through 2005 the Inspector General's Office imposed civil monetary penalties on hospitals in 105 cases, for a total of $2,645,750 in penalties. An audit completed by the Office of Inspector General (OIG) (entitled, Office of Inspector General: Implementation and Enforcement of the Examination and Treatment for Emergency Medical Conditions and Women in Labor by the Health Care Financing Administration, April 1995, A–06–93–00087) determined that CMS's implementation of the Act was generally effective, but Regional Offices (RO) were not consistent with conducting timely investigations, sending acknowledgments to complaints, ensuring that investigations were thorough, or ensuring that violations were referred to the OIG in accordance with CMS policy for possible civil monetary penalty action. OIG further concluded that without proper compliance, there is an increased risk that individuals with emergency medical conditions will not receive the treatment needed to stabilize their condition, which may place them in greater risk of death. *Form Number:* CMS–R–142 (OMB control number: 0938–0667); *Frequency:* Occasionally; *Affected Public:* Private Sector; Business or other for-profits, Not-for-profit institutions; *Number of Respondents:* 5,291; *Total Annual Responses:* 5,291; *Total Annual Hours:* 5,291. (For policy questions regarding this collection contact Renate Dombrowski at (410) 786–4645.)

3. *Type of Information Collection Request:* New collection of information request; *Title of Information Collection:* Quality Payment Program/Merit-Based Incentive Payment System (MIPS) Surveys and Feedback Collections; *Use:* The purpose of this submission is to request approval for generic clearance of a program of survey and feedback collections supporting the Quality Payment Program which includes the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs). MIPS is a program for certain eligible clinicians that makes Medicare payment adjustments based on performance on quality, cost and other measures and activities, and that consolidates components of three precursor programs—the Physician Quality Reporting system (PQRS), the Value Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals. AAPMs are a track of the Quality Payment Program that offer incentives for achieving threshold levels of payments or patients in Advanced APMs or Other Payer Advanced APMs. Under the AAPM path, eligible clinicians may become Qualifying APM Participants (QPs) and are excluded from MIPS. Partial Qualifying APM Participants (Partial QPs) may opt to report and be scored under MIPS.

This generic clearance will cover a program of surveys and feedback collections designed to strategically obtain data and feedback from MIPS eligible clinicians, third-party intermediaries, Medicare beneficiaries, and any other audiences that would support the Agency in improving MIPS or the Quality Payment Program. The specific collections we intend to conduct are: Human Centered Design (HCD) User Testing Volunteer Sign-Up Survey; HCD User Satisfaction, Product Usage, and Benchmarking Surveys; and Physician Compare (and/or successor website) User Testing. *Form Number:* CMS–10695 (OMB control number: 0938–NEW); *Frequency:* Occasionally; *Affected Public:* Private Sector: Business or other for-profits and Not-for-profit institutions and Individuals; *Number of Respondents:* 630,300; *Total Annual Responses:* 630,300; *Total Annual Hours:* 57,950. (For policy questions regarding this collection, contact Michelle Peterman at 410–786–2591.)

Dated: June 25, 2020.

William N. Parham, III,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

[OMHA–1903–N]

Medicare Program; Administrative Law Judge Hearing Program for Medicare Claim and Entitlement Appeals; Quarterly Listing of Program Issuances—October 2019 Through March 2020

AGENCY: Office of Medicare Hearings and Appeals (OMHA), Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice lists the OMHA Case Processing Manual (OCPM) instructions that were published from October 2019 through March 2020. This