program these Star Ratings were used only to provide additional information for beneficiaries to consider in making their Part C and D plan elections. Additionally, section 1854(b)(1)(C)(v) of the Act, as added by the Affordable Care Act, also requires CMS to change the share of savings that MA organizations must provide to enrollees as the beneficiary rebate specified at § 422.266(a) based on the level of a sponsor's Star Rating for quality performance.

The information collected on the Request for Reconsideration form from MA organizations is considered by the reconsideration official and potentially the hearing officer to review CMS's determination of the organization's eligibility for a QBP. The form asks MA organizations to select the Star Ratings measure(s) they believe was miscalculated or used incorrect data and describe what they believe is the issue. Under § 422.260(c)(3)(ii) these are the only bases for appeals. In conducting the reconsideration, the reconsideration official will review the QBP determination, the evidence and findings upon which it was based, and any other written evidence submitted by the organization with their Request for Reconsideration or by CMS before the reconsideration determination is made.

The administrative review process is a two-step process that includes a request for reconsideration and a request for an informal hearing on the record after CMS has sent the MA organization the reconsideration decision. Both steps are conducted at the contract level. The first step allows the MA organization to request a reconsideration of how its Star Rating for the given measure in question was calculated and/or what data were included in the measure. If the MA organization is dissatisfied with CMS's reconsideration decision, the contract may request an informal hearing to be conducted by a hearing officer designated by CMS. MA organizations will have 10 business days from the time we issue the notice of QBP status to submit a request for reconsideration. MA organizations will have 10 business days after the issuance of the reconsideration determination to request an informal hearing on the record. *Form Number:* CMS–10346 (OMB control number: 0938–1129); *Frequency:* Yearly; *Affected Public:* Private Sector, Business or other for-profits, Not-for-profit institutions; *Number of Respondents:* 20; *Total Annual Responses:* 20; *Total Annual Hours:* 160. (For policy questions regarding this collection contact Joy Binion at 410–786–6567.)

2. *Type of Information Collection Request:* Revision with change of a currently approved collection; *Title of Information Collection:* Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP); *Use:* This collection dates back to 2005. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and implementing regulations at 42 CFR, Medicare Advantage organizations (MAO) and Prescription Drug Plans (PDP) are required to submit an actuarial pricing ''bid'' for each plan offered to Medicare beneficiaries for approval by the Centers for Medicare & Medicaid Services (CMS). MAOs and PDPs use the Bid Pricing Tool (BPT) software to develop their actuarial pricing bid. The competitive bidding process defined by the ''The Medicare Prescription Drug, Improvement, and Modernization Act'' (MMA) applies to both the MA and Part D programs. It is an annual process that encompasses the release of the MA rate book in April, the bid's that plans submit to CMS in June, and the release of the Part D and RPPO benchmarks, which typically occurs in August. *Form Number:* CMS–10142 (OMB control number: 0938–0944); *Frequency:* Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 555; *Total Annual Responses:* 4,995; *Total Annual Hours:* 149,850. (For policy questions regarding this collection contact Rachel Shevland at 410–786–3026.)

3. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Fast Track Appeals Notices: NOMNC/DENC; *Use:* The purpose of the NOMNC is to help a beneficiary/enrollee decide whether to pursue a fast appeal by a Quality Improvement Organization (QIO) and how to file that request. Consistent with §§ 405.1200 and 422.624, SNFs, HHAs, CORFs, and hospices must provide notice to all beneficiaries/enrollees whose Medicare-covered services are ending, no later than two days in advance of the proposed termination of service. This information is conveyed to the beneficiary/enrollee via the NOMNC.

If a beneficiary/enrollee appeals the termination decision, the beneficiary/enrollee and the QIO, consistent with §§ 405.1200(b) and 405.1202(f) for Original Medicare, and §§ 422.624(b) and 422.626(e)(1)–(5) for Medicare health plans, will receive a detailed explanation of the reasons services should end. This detailed explanation is provided to the beneficiary/enrollee using the DENC, the second notice included in this renewal package. *Form Number:* CMS–10123/10124 (OMB control number: 0938–0953); *Frequency:* Yearly; *Affected Public:* Private Sector, Business or other for-profits, Not-for-profit institutions; *Number of Respondents:* 24,915; *Total Annual Responses:* 5,314,194; *Total Annual Hours:* 1,142,749. (For policy questions regarding this collection contact Janet Miller at *Janet.Miller@cms.hhs.gov.*)

Dated: October 1, 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

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10261 & CMS–10636]

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 November 5, 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.*

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 previously approved collection; *Title of Information Collection:* Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR 422.516(a); *Use:* Section 1852(m) of the Social Security Act (the Act) and CMS regulations at 42 CFR 422.135 allow Medicare Advantage (MA) plans the ability to provide ''additional telehealth benefits'' to enrollees starting in plan year 2020 and treat them as basic benefits. MA additional telehealth benefits are limited to services for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act. In addition, MA additional telehealth benefits are services that been identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic information and telecommunications technology (or ''electronic exchange'') when the physician (as defined in section 1861(r) of the Act) or practitioner (as defined in section 1842(b)(18)(C) of the Act) providing the service is not in the same location as the enrollee. Per § 422.135(d), MA plans may only furnish MA additional telehealth benefits using contracted providers. The data collected in this measure will provide CMS with a better understanding of the number of organizations utilizing Telehealth per contract and to also capture those specialties used for both in-person and Telehealth. This data will allow CMS to improve its policy and process surrounding Telehealth. In addition, the specialist and facility data we are collecting aligns with some of the provider and facility specialty types that organizations are required to include in their networks and to submit on their HSD tables in the Network Management Module in Health Plan Management System. *Form Number:* CMS–10261 (OMB control number 0938–1054); *Frequency:* Occasionally; *Affected Public:* State, Local, and Tribal Governments; *Number of Respondents:* 759; *Total Annual Responses:* 5,313; *Total Annual Hours:* 224,664 (For policy questions regarding this collection contact Maria Sotirelis at 410–786–0552.)

2. *Type of Information Collection Request:* Revision with change of a previously approved collection; *Title of Information Collection:* Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans; *Use:* CMS regulations at 42 CFR 417.414, 417.416, 422.112(a)(1)(i), and 422.114(a)(3)(ii) require that all Medicare Advantage organizations (MAOs) offering coordinated care plans, network-based private fee-for-service (PFFS) plans, and as well as section 1876 cost organizations, 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 developed network adequacy criteria which set forth the minimum number of providers and maximum travel time and distance from enrollees to providers, for required provider specialty types in each county in the United States and its territories. Organizations must be in compliance with the current CMS network adequacy criteria guidance, which is updated and published annually on CMS's website. Additional network policy guidance is also located in chapter 4 of the Medicare Managed Care Manual. This collection of information is essential to appropriate and timely compliance monitoring by CMS, in order to ensure that all active contracts offering network-based plans maintain an adequate network.

CMS verifies that organizations are compliant with the CMS network adequacy criteria by performing a contract-level network review, which occurs when CMS requests an organization upload provider and facility Health Service Delivery (HSD) tables for a given contract to the Health Plan Management System (HPMS). CMS reviews networks on a three-year cycle, unless there is an event that triggers an intermediate full network review, thus resetting the organization's triennial review. The triennial review cycle will help ensure a consistent process for network oversight and monitoring.

Once CMS staff reviews the ACC reports and any Exception Requests and/or Partial County Justifications, CMS then makes its final determination on whether the organization is operating in compliance with current CMS network adequacy criteria. If the organization passes its network review for a given contract, then CMS will take no further action. If the organization fails its network review for a given contract, then CMS will take appropriate compliance actions. CMS has developed a compliance methodology for network adequacy reviews that will ensure a consistent approach across all organizations. *Form Number:* CMS–10636 (OMB control number 0938–1346); *Frequency:* Occasionally; *Affected Public:* State, Local, and Tribal Governments; *Number of Respondents:* 140; *Total Annual Responses:* 1,416; *Total Annual Hours:* 13,372. (For policy questions regarding this collection contact Amber Casserly at 410–786–5530.)

Dated: October 1, 2020.

William N. Parham, III,

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

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