1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
3. Enhance the quality, utility, and clarity of the information to be collected; and
4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses.
5. Assess information collection costs.

Proposed Project

Public Health Accreditation Board (PHAB): Assessment of Processes and Outcomes—New—Center for State, Tribal, Local and Territorial Support (CSTLTS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention (CDC) works to protect America from health, safety and security threats, both foreign, and in the U.S. CDC strives to fulfill this mission, in part, by supporting state, tribal, local, and territorial (STLT) health departments. One mechanism for supporting STLT health departments is through CDC's support of a national, voluntary accreditation program.

CDC supports the Public Health Accreditation Board (PHAB), a non-profit organization that serves as the independent accrediting body. PHAB, with considerable input from national, state, tribal, and local public health professionals, developed a consensus set of standards to assess the capacity of state, tribal, local, and territorial health departments. The first health departments were accredited by PHAB in early 2013; as of August 2019, a total of 268 health departments (36 state, three Tribal and 229 local), as well as one statewide integrated local public health department system have been accredited. Accreditation is granted for a five-year period and the first several health departments have successfully completed the reaccreditation process. Formal efforts to assess the outcomes of the accreditation program began in late 2012, and continue to date. Priorities focus on gathering feedback for program improvement and documenting program outcomes to demonstrate impact and inform decision making about future program direction. Starting in 2012 and running through December 2019, the Robert Wood Johnson Foundation (RWJF) and the social science organization NORC at the University of Chicago, led evaluation efforts. CDC will assume support of the evaluation starting in 2020 and as a result, OMB approval for data collection is being sought.

The purpose of this ICR is to support the collection of information from participating health departments through a series of five surveys. The surveys seek to collect longitudinal data on each health department throughout their accreditation process.

The respondent universe will include STLT health department directors or designees. All surveys will be administered electronically; a link to the survey website will be provided in the email invitation. The surveys will be administered on a quarterly basis and sent to all health departments that reach each milestone in the accreditation process (application, recently accredited, accredited for one year, approaching reaccreditation, and reaccreditation). Each health department will be invited to participate in each survey once (for a total of five surveys max per health department). The total annualized estimated burden is 100 hours. There are no costs to respondents except their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
STLT HD Directors or Designee	Survey 1: Applicants	60	1	20/60	20
STLT HD Directors or Designee	Survey 2: Recently Accredited HDs	60	1	20/60	20
STLT HD Directors or Designee	Survey 3: HDs Accredited One Year	60	1	20/60	20
STLT HD Directors or Designee	Survey 4: HDs Approaching Re-accreditation.	60	1	20/60	20
STLT HD Directors or Designee	Survey 5: Reaccredited HDs	60	1	20/60	20
Total					100

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

[FR Doc. 2019–20704 Filed 9–24–19; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10062, CMS–10344 and CMS–588]

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 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 November 25, 2019.

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' website address at website address at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html.*

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: William N. Parham at (410) 786–4669.

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–10062 Collection of Diagnostic Data in the Abbreviated RAPS Format from Medicare Advantage Organizations for Risk Adjusted Payments

CMS–10344 Elimination of Cost-Sharing for full benefit dual-eligible Individuals Receiving Home and Community-Based Services

CMS–588 Electronic Funds Transfer Authorization Agreement

Under the 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 requires federal agencies to publish a 60-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.

Information Collection

1. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Collection of Diagnostic Data in the Abbreviated RAPS Format from Medicare Advantage Organizations for Risk Adjusted Payments; *Use:* The 1997 BBA and later legislation required CMS to adjust per-beneficiary payments with a risk adjustment methodology using diagnoses to measure relative risk due to health status instead of just demographic characteristics such as age, sex, and Medicaid eligibility. The purpose of risk adjustment is to pay plan sponsors accurately based on the health status and diagnoses of their Medicare enrollees. Risk adjustment using diagnoses provides more accurate payments for Medicare Advantage Organizations (MAO), with higher payments for enrollees at risk for being sicker, and lower payments for enrollees predicted to be healthier.

The BBA constituted the first legislative mandate for health status risk adjustment. Section 1853 (a)(3) of the Social Security Act as enacted by Section 4001 of Subtitle A of the BBA required the Secretary to implement a risk adjustment methodology that accounted for variations in per capita costs based on health status and other demographic factors for payment to Medicare+Choice (now MA) organizations. The new methodology was to be effective no later than January 1, 2000. The BBA also required that M+C organizations submit data for use in developing risk adjusted payments.

Risk adjustment allows CMS to pay plans for the health risk of the beneficiaries they enroll, instead of paying an identical an average amount for each enrollee Medicare beneficiaries. By risk adjusting plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs. Risk adjustment is used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee. Risk scores measure individual beneficiaries' relative risk and the risk scores are used to adjust payments for each beneficiary's expected expenditures. By risk adjusting plan bids, CMS is able to also use standardized bids as base payments to plans.

CMS' fundamental goal for the abbreviate format RAPS data is to require collection of the minimum data necessary for accurate risk-adjusted payment. We believe that diagnostic data provide the most reliable approach to measuring health status, as required by statute. In the absence of these data, we would not be able to accurately determine the beneficiary's health (risk) status. *Form Number:* CMS–10062 (OMB control number: 0938–0878); *Frequency:* Quarterly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 761; *Total Annual Responses:* 46,610,448; *Total Annual Hours:* 33,484. (For policy questions regarding this collection contact Michael P. Massimini at 410–786–1566.)

2. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Elimination of Cost-Sharing for full benefit dual-eligible Individuals Receiving Home and Community-Based Services; *Use:* Each month CMS deems individuals automatically eligible for the full subsidy, based on data from State Medicaid Agencies and the Social Security Administration (SSA). The SSA sends a monthly file of Supplementary Security Income-eligible beneficiaries to CMS. Similarly, the State Medicaid agencies submit Medicare Modernization Act files to CMS that identify full subsidy beneficiaries. CMS deems the beneficiaries as having full subsidy and auto-assigns these beneficiaries to bench mark Part D plans. Part D plans receive premium amounts based on the monthly assessments.

State MMA Phase Down (SPD) exchange enables CMS to implement the Medicare Prescription Drug, Improvement, and Modernization Act, also called the Medicare Modernization Act (MMA), which was enacted into law in 2003. This data exchange allows the State Medicaid Agency (SMA) to identify Medicare beneficiaries with coverage under the Medicaid program. The SMAs also identify other low-income Medicare beneficiaries who have applied for the Part D Low-Income Subsidy (LIS). As a result of the identification of these two groups of beneficiaries, CMS auto-assigns and/or facilitates enrollment of the appropriate beneficiaries into Part D plans.

Section 1860 D–14 of the Social Security Act sets forth requirements for premium and cost-sharing subsidies for low-income beneficiaries enrolled in Medicare Part D. Based on this statute, 42 CFR 423.771, provides guidance concerning limitations for payments made by and on behalf of low-income Medicare beneficiaries who enroll in Part D plans. 42 CFR 423.771 (b) establishes requirements for determining a beneficiary's eligibility for full subsidy under the Part D program. Regulations set forth in 423.780 and 423.782 outline premium and cost sharing subsidies to which full subsidy eligible are entitled under the Part D program. *Form Number:* CMS–10344 (OMB control number: 0938–1127); *Frequency:* Monthly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 51; *Total Annual Responses:* 612; *Total Annual Hours:* 612. (For policy questions regarding this collection contact Roland Horrea at 410–786–0668.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Electronic Funds Transfer Authorization Agreement; *Use:* Section 1815(a) of the Social Security Act provides the authority for the Secretary of Health and Human Services to pay providers/suppliers of Medicare services at such time or times as the Secretary determines appropriate (but no less frequently than monthly). Under Medicare, CMS, acting for the Secretary, contracts with Fiscal Intermediaries and Carriers to pay claims submitted by providers/suppliers who furnish services to Medicare beneficiaries. Under CMS' payment policy, Medicare providers/suppliers have the option of receiving payments electronically. *Form Number:* CMS–588 (OMB control number: 0938–0626); *Frequency:* On occasion; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 100,000; *Total Annual Responses:* 100,000; *Total Annual Hours:* 100,000. For questions regarding this collection contact Kim McPhillips at 410–786–5374.

Dated: September 20, 2019.

William N. Parham, III,

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

[FR Doc. 2019–20858 Filed 9–24–19; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10595]

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 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 October 25, 2019.

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' 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: Extension without change of a currently approved collection; *Title of Information Collection:* QHP Issuers Data Collection for Notices for Plan or Display Errors Special Enrollment Periods; *Use:* The Patient Protection and Affordable Care Act (Pub. L. 111–148) and Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), collectively referred to as the PPACA, established new competitive private health insurance markets called Marketplaces, or Exchanges, which gave millions of Americans and small businesses access to qualified health plans (QHPs), including stand-alone dental plans (SADPs)— private health