Information Collection

1. *Type of Information Collection Request:* Reinstatement without change of a currently approved collection; *Title of Information Collection:* QECP Annual Report Workbook Submission Requirement for Qualified Entities under ACA Section 10332; *Use:* This collection focuses on the expansion of qualified entities. This collection covers the requirement that a qualified entity must submit an annual report to CMS. In addition, this collection covers the requirement that a qualified entity must have a qualified entity data use agreement (QE DUA) or non-public analyses agreement in place with an authorized user prior to providing or selling data or analyses to that authorized user.

Section 10332 of the Patient Protection and Affordable Care Act (ACA) requires the Secretary to make standardized extracts of Medicare claims data under Parts A, B, and D available to ''qualified entities'' for the evaluation of the performance of providers of services and suppliers. The statute provides the Secretary with discretion to establish criteria to determine whether an entity is qualified to use claims data to evaluate the performance of providers of services and suppliers.

Section 105 of the Medicare Access and Reauthorization Act of 2015 (MACRA) expands how qualified entities will be allowed to use and disclose data under the qualified entity program consistent with other applicable laws, including information, privacy, security, and disclosure laws.

The information from the collection will be used by CMS to determine whether a qualified entity continues to meet the qualified entity certification requirements under section 10332 of the Affordable Care Act and Section 105 of MACRA. In addition, it will ensure that certain privacy and security requirements are met when qualified entities provide or sell data or sell non-public analyses that contains individually identifiable beneficiary information to authorized users. *Form Number:* CMS–10589 (OMB control number: 0938–1309); *Frequency:* Yearly; *Affected Public:* Private Sector, Business or other for profits, and Not for profits institutions; *Number of Respondents:* 15; *Total Annual Responses:* 15; *Total Annual Hours:* 3,450. (For policy questions regarding this collection contact Kari Gaare at 410–786–8612.)

Dated: February 26, 2020.

William N. Parham, III,

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

[FR Doc. 2020–04241 Filed 2–28–20; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3388–PN]

Medicare and Medicaid Programs; Application From DNV–GL Healthcare USA Inc. for Initial CMS Approval of Its Psychiatric Hospital Accreditation Program

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

ACTION: Notice with request for comment.

SUMMARY: This proposed notice acknowledges the receipt of an application from the DNV–GL Healthcare USA Inc. (DNV–GL) for initial recognition as a national accrediting organization (AO) for psychiatric hospitals that wish to participate in the Medicare or Medicaid programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on April 1, 2020.

ADDRESSES: In commenting, refer to file code CMS–3388–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3388–PN, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3388–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Joann Fitzell, (410) 786–4280. Lillian Williams, (410) 786–8636.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a psychiatric hospital, provided certain requirements are met. Section 1861(f) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a psychiatric hospital. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at part 42 CFR part 482 subpart E specify the minimum conditions that a psychiatric hospital must meet to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for psychiatric hospitals.

Generally, to enter into an agreement, a psychiatric hospital must first be certified by a state survey agency as complying with the conditions or requirements set forth in part 482 subpart E of our regulations. Thereafter, the psychiatric hospital is subject to regular surveys by a state survey agency to determine whether it continues to meet these requirements.

However, there is an alternative to surveys by state agencies. Section 1865(a)(1) of the Act states, if a provider entity demonstrates through accreditation by an approved national accrediting organization (AO) that all applicable Medicare conditions are met or exceeded, we may treat the provider entity as having met those conditions, that is, we may deem those provider entities as having met the requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by the Center for Medicare & Medicaid Services (CMS) as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program may be deemed to meet the Medicare conditions. An AO applying for approval of its accreditation program under part 488, subpart A, must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of AOs are set forth at § 488.5.

II. Approval of Accreditation Organizations

Section 1865(a)(2) of the Act and our regulations at § 488.5 require that findings concerning review and approval of an AO's requirements consider, among other factors, the applying AO's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide CMS with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of the DNV–GL Healthcare USA Inc. (DNV–GL) request for initial approval of its psychiatric hospital accreditation program. This notice also solicits public comment on whether the DNV–GL's requirements meet or exceed the Medicare conditions of participation (CoPs) for psychiatric hospitals.

III. Evaluation of Deeming Authority Request

DNV–GL submitted all the necessary materials to enable us to make a determination concerning its request for initial approval of its psychiatric hospital accreditation program. This application was determined to be complete on January 2, 2020. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of the DNV–GL will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of the DNV–GL standards for psychiatric hospitals as compared with CMS' psychiatric hospital CoPs.
- The DNV–GL survey process to determine the following:

++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

++ The comparability of the DNV–GL's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ The DNV–GL's processes and procedures for monitoring a psychiatric hospital found out of compliance with the DNV–GL's program requirements. These monitoring procedures are used only when the DNV–GL identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the state survey agency monitors corrections as specified at § 488.9(c).

++ The DNV–GL's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

++ The DNV–GL's capacity to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ The adequacy of the DNV–GL's staff and other resources, and its financial viability.

++ The DNV–GL's capacity to adequately fund required surveys.

++ The DNV–GL's policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.

++ The DNV–GL's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

++ The DNV–GL's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as CMS may require (including corrective action plans).

Upon completion of our evaluation, including evaluation of public comments received as a result of this notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation.

IV. 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 (44 U.S.C. 3501 *et seq.*).

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Dated: February 13, 2020.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2020–04137 Filed 2–28–20; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Public Comment Request; Questionnaire and Data Collection Testing, Evaluation, and Research for the Health Resources and Services Administration, OMB No. 0915–0379— Extension

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services.

ACTION: Notice.

SUMMARY: In compliance with the requirement for opportunity for public comment on proposed data collection projects of the Paperwork Reduction Act of 1995, HRSA announces plans to submit an Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting the ICR to OMB, HRSA seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

DATES: Comments on this ICR must be received no later than May 1, 2020.

ADDRESSES: Submit your comments to *paperwork@hrsa.gov* or mail the HRSA Information Collection Clearance