Act. Federal regulations at 42 CFR 424.32(a)(3) state that all claims must be signed by the beneficiary or on behalf of the Beneficiary (in accordance with 424.36). Section 424.36(a) states that the beneficiary's signature is required on a claim unless the beneficiary has died or the provisions of 424.36(b), (c), or (d) apply. For emergency and nonemergency ambulance transport services, where the beneficiary is physically or mentally incapable of signing the claim (and the beneficiary's authorized representative is unavailable or unwilling to sign the claim), that it is impractical and infeasible to require an ambulance provider or supplier to later locate the beneficiary or the person authorized to sign on behalf of the beneficiary, before submitting the claim to Medicare for payment. Therefore, an exception was created to the beneficiary signature requirement with respect to emergency and nonemergency ambulance transport services, where the beneficiary is physically or mentally incapable of signing the claim, and if certain documentation requirements are met. Thus, we added subsection (6) to paragraph (b) of 42 CFR 424.36. The information required in this ICR is needed to help ensure that services were in fact rendered and were rendered as billed. *Form Number:* CMS–10242(OMB control number: 0938–1049); *Frequency:* Yearly; *Affected Public:* Private Sector; Business or other for-profits, Not-for-profit Institutions; *Number of Respondents:* 10,229; *Total Annual Responses:* 13,318,440; *Total Annual Hours:* 1,110,757. (For policy questions regarding this collection contact Martha Kuespert at (410) 786–4605.)

4. *Type of Information Collection Request:* Revision of a previously approved collection; *Title of Information Collection:* End Stage Renal Disease (ESRD) Network Semi-Annual Cost Report Forms and Supporting Regulations; *Use:* Section 1881(c) of the Social Security Act establishes End Stage Renal Disease (ESRD) Network contracts. The regulations found at 42 CFR 405.2110 and 405.2112 designated 18 ESRD Networks which are funded by renewable contracts. These contracts are on 3-year cycles. To better administer the program, CMS is requiring contractors to submit semi-annual cost reports. The purpose of the cost reports is to enable the ESRD Networks to report costs in a standardized manner. This will allow CMS to review, compare and project ESRD Network costs during the life of the contract. *Form Number:* CMS–685 (OMB Control Number: 0938–0657); *Frequency:* Reporting—Semi-annually; *Affected Public:* Not-for-profit institutions; *Number of Respondents:* 18; *Total Annual Responses:* 36; *Total Annual Hours:* 108. (For policy questions regarding this collection contact Benjamin Bernstein at 410–786–6570).

Dated: February 26, 2020.

William N. Parham, III,

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

[FR Doc. 2020–04242 Filed 2–28–20; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10589]

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 May 1, 2020.

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–10589 QECP Annual Report Workbook Submission Requirement for Qualified Entities Under ACA Section 10332

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:* 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.