eligibility for benefits or premium or contribution amounts; and (iii) no genetic information collected or acquired will be used for underwriting purposes. The Secretary of Labor or the Secretary of Health and Human Services is required to be notified if a group health plan or health insurance issuer intends to claim the research exception permitted under Title I of GINA. Nonfederal governmental group health plans and issuers solely in the individual health insurance market or Medigap market will be required to file with the Centers for Medicare & Medicaid Services (CMS). The Notice of Research Exception under the Genetic Information Nondiscrimination Act is a model notice that can be completed by group health plans and health insurance issuers and filed with either the Department of Labor or CMS to comply with the notification requirement. *Form Number:* CMS–10286 (OMB Control Number 0938–1077); *Frequency:* Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 2; *Total Annual Responses:* 2; *Total Annual Hours:* 0.5. (For policy questions regarding this collection contact Russell Tipps at 301–492–4371).

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Consumer Experience Survey Data Collection; *Use:* Section 1311(c)(4) of the Affordable Care Act requires the Department of Health and Human Services (HHS) to develop an enrollee satisfaction survey system that assesses consumer experience with qualified health plans (QHPs) offered through an Exchange. It also requires public display of enrollee satisfaction information by the Exchange to allow individuals to easily compare enrollee satisfaction levels between comparable plans. HHS established the QHP Enrollee Experience Survey (QHP Enrollee Survey) to assess consumer experience with the QHPs offered through the Marketplaces. The survey include topics to assess consumer experience with the health care system such as communication skills of providers and ease of access to health care services. CMS developed the survey using the Consumer Assessment of Health Providers and Systems (CAHPS®) principles (*http://www.cahps.ahrq.gov/about.htm*) and established an application and approval process for survey vendors who want to participate in collecting QHP enrollee experience data.

The QHP Enrollee Survey, which is based on the CAHPS® Health Plan Survey, will (1) help consumers choose among competing health plans, (2) provide actionable information that the QHPs can use to improve performance, (3) provide information that regulatory and accreditation organizations can use to regulate and accredit plans, and (4) provide a longitudinal database for consumer research. CMS completed two rounds of developmental testing including 2014 psychometric testing and 2015 beta testing of the QHP Enrollee Survey. The psychometric testing helped determine psychometric properties and provided an initial measure of performance for Marketplaces and QHPs to use for quality improvement. Based on psychometric test results, CMS further refined the questionnaire and sampling design to conduct the 2015 beta test of the QHP Enrollee Survey. CMS obtained clearance for the national implementation of the QHP Enrollee Survey which is currently being conducted in 2016.

At this time, CMS is requesting approval of adding six disability status items required by section 4302 of the Affordable Care Act and that were tested during the 2014 psychometric testing of the QHP Enrollee Survey. With the addition of these six questions, the revised total estimated annual burden hours of national implementation of the QHP Enrollee Survey is 37,823 hours with 120,000 responses. The revised total annualized burden over three years for this requested information collection is 113,469 hours and the total average annualized number of responses is 315,045 responses. *Form Number:* CMS–10488 (OMB Control Number: 0938–1221); *Frequency:* Annually; *Affected Public:* Public sector (Individuals and Households), Private sector (Business or other for-profits and Not-for-profit institutions); *Number of Respondents:* 120,000; *Total Annual Responses:* 120,000; *Total Annual Hours:* 37,823. (For policy questions regarding this collection contact Nidhi Singh Shah at 301–492–5110.)

Dated: April 26, 2016.

William N. Parham, III,

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

[FR Doc. 2016–10083 Filed 4–28–16; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10406, CMS–10572 and CMS–P–0015A]

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

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 any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) 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 May 31, 2016.

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' Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995.*

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: Reports Clearance Office at (410) 786–1326.

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 of a currently approved information collection; *Title:* Probable Fraud Measurement Pilot; *Use:* The Centers for Medicare & Medicaid Services (CMS) is seeking Office of Management and Budget (OMB) approval of the collections required for a probable fraud measurement pilot. The probable fraud measurement pilot would establish a baseline estimate of probable fraud in payments for home health care services in the fee-for-service Medicare program. CMS and its agents will collect information from home health agencies, the referring physicians and Medicare beneficiaries selected in a national random sample of home health claims. The pilot will rely on the information collected along with a summary of the service history of the HHA, the referring provider, and the beneficiary to estimate the percentage of total payments that are associated with probable fraud and the percentage of all claims that are associated with probable fraud for Medicare fee-for-service home health. *Form Number:* CMS–10406 (OMB control number: 0938–1192); *Frequency:* Yearly; *Affected Public:* Individual and Private Sector—Business or other for-profits; *Number of Respondents:* 6,000; *Total Annual Responses:* 6,000; *Total Annual Hours:* 7,500. (For policy questions regarding this collection contact Cecilia Franco at (786) 313–0737.)

2. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title Information Collection:* Information Collection for Transparency in Coverage Reporting by Qualified Health Plan Issuers; *Use:* Section 1311(e)(3) of the Affordable Care Act requires issuers of Qualified Health Plans (QHPs), to make available and submit transparency in coverage data. This data collection would collect certain information from QHP issuers in Federally-facilitated Exchanges and State-based Exchanges that rely on the federal IT platform (*i.e.,* HealthCare.gov). HHS anticipates that consumers may use this information to inform plan selection.

Although this proposed data collection is limited to certain QHP issuers, HHS intends to phase in implementation for other entities over time. As stated in the final rule Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (77 FR 18310; March 27, 2012), broader implementation (including under Public Health Service Act (PHS Act) 2715A), will continue to be addressed in separate rulemaking issued by HHS, the Department of Labor, and the Department of the Treasury (the Departments). For State-based Exchanges not addressed in the current proposal, standards will be proposed later.

Consistent with PHS Act section 2715A, which largely extends the transparency reporting provisions set forth in section 1311(e)(3) to non-grandfathered group health plans (including large group and self-insured health plans) and health insurance issuers offering group and individual health insurance coverage (non-QHP issuers), the Departments intend to propose other transparency reporting requirements, through a separate rulemaking, for non-QHP issuers and non-grandfathered group health plans. Those proposed reporting requirements may differ from those prescribed in the HHS proposal under section 1311(e)(3), and will take into account differences in markets and other relevant factors. Importantly, the Departments intend to streamline reporting under multiple reporting provisions and reduce unnecessary duplication. The Departments intend to implement any transparency reporting requirements applicable to non-QHP issuers and non-grandfathered group health plans only after notice and comment, and after giving those issuers and plans sufficient time, following the publication of final rules, to come into compliance with those requirements.

CMS received a total of 13 comments during the 60-day comment period (August 12, 2015, 80 FR 48320). *Form Number:* CMS–10572 (OMB control number: 0938–NEW); *Frequency:* Annually; *Affected Public:* Private Sector; *Number of Respondents:* 475; *Number of Responses:* 475; *Total Annual Hours:* 16,150. (For questions regarding this collection, contact Valisha Price at (301) 492–4343.)

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Current Beneficiary Survey; *Use:* CMS is the largest single payer of health care in the United States. With full implementation of the Affordable Care Act of 2010 (ACA), the agency will play a direct or indirect role in administering health insurance coverage for more than 120 million people across the Medicare, Medicaid, CHIP, and Exchange populations. One of our critical aims is to be an effective steward, major force, and trustworthy partner in leading the transformation of the health care system. We also aim to provide Americans with high quality care and better health at lower costs through improvement. At the forefront of these initiatives is the newly formed Center for Medicare and Medicaid Innovation (CMMI).

The CMMI is authorized by Section 1115A of the Social Security Act, as established by section 3021 of the ACA and was established to ''test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished'' to Medicare, Medicaid and CHIP beneficiaries. Implicit across all of CMMI activities is an emphasis on diffusion—finding and validating innovative models that have the potential to scale, facilitating rapid adoption, and letting them take root in organizations, health systems, and communities across America.

The Medicare Current Beneficiary Survey (MCBS) is the most comprehensive and complete survey available on the Medicare population and is essential in capturing data not otherwise collected through our operations. The MCBS is an in-person, nationally-representative, longitudinal survey of Medicare beneficiaries that we sponsor and is directed by the Office of Enterprise Data and Analytics (OEDA) in partnership with the CMMI. The survey captures beneficiary information whether aged or disabled, living in the community or facility, or serviced by

managed care or fee-for-service. Data produced as part of the MCBS are enhanced with our administrative data (*e.g.* fee-for-service claims, prescription drug event data, enrollment, etc.) to provide users with more accurate and complete estimates of total health care costs and utilization. The MCBS has been continuously fielded for more than 20 years (encompassing over 1 million interviews), and consists of three annual interviews per survey participant.

The MCBS continues to provide unique insight into the Medicare program and helps CMS and our external stakeholders better understand and evaluate the impact of existing programs and significant new policy initiatives. In the past, MCBS data have been used to assess potential changes to the Medicare program. For example, the MCBS was instrumental in supporting the development and implementation of the Medicare prescription drug benefit by providing a means to evaluate prescription drug costs and out-of-pocket burden for these drugs to Medicare beneficiaries. The revision will streamline some questionnaire sections, add a few new measures, and update the wording of questions and response categories. Most of the revised questions reflect an effort to bring the MCBS questionnaire in line with other national surveys that have more current wording of questions and response categories with well-established measures. As a whole, these revisions do not change the respondent burden; there is a small increase in overall burden reflecting a program change to oversample small population groups. *Form Number:* CMS–P–0015A (OMB control number: 0938–0568); *Frequency:* Occasionally; *Affected Public:* Individuals or Households; *Number of Respondents:* 16,071; *Total Annual Responses:* 43,199; *Total Annual Hours:* 60,103. (For policy questions regarding this collection contact William Long at 410–786–7927.)

Dated: April 26, 2016.

William N. Parham, III,

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

[FR Doc. 2016–10084 Filed 4–28–16; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3329–FN]

Medicare and Medicaid Programs; Approval of the Institute for Medical Quality's Ambulatory Surgical Center Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve the Institute for Medical Quality (IMQ) for recognition as a national accrediting organization for ambulatory surgical centers (ASCs) that wish to participate in the Medicare or Medicaid programs. An ASC that participates in Medicaid must also meet the Medicare conditions for coverage (CfCs) as required under our regulations.

DATES: This final notice is effective April 29, 2016 through April 29 2020.

FOR FURTHER INFORMATION CONTACT: Lillian Williams, (410) 786–8636. Monda Shaver, (410) 786–3410. Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in an Ambulatory Surgical Center (ASC) provided certain requirements are met. Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as an ASC. 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 42 CFR part 416 specify the conditions that an ASC must meet in order to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for ASCs.

Generally, to enter into a Medicare provider agreement, an ASC must first be certified as complying with the conditions set forth in part 416 and be recommended to the Centers for Medicare & Medicaid Services (CMS) for participation by a state survey agency. Thereafter, the ASC is subject to periodic surveys by a state survey agency to determine whether it continues to meet these conditions. However, there is an alternative to certification surveys by state agencies. Accreditation by a nationally recognized Medicare accreditation program approved by CMS may substitute for both initial and ongoing state review.

Section 1865(a)(1) of the Act provides that if the Secretary of the Department of Health and Human Services finds that accreditation of a provider entity by an approved national accrediting organization meets or exceeds all applicable Medicare conditions, we may treat the provider entity as having met those conditions, that is, we may ''deem'' the provider entity to be in compliance. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

Part 488 subpart A, implements the provisions of section 1865 of the Act and requires that a national accrediting organization applying for approval of its Medicare accreditation program must provide CMS with reasonable assurance that the accrediting organization requires its accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.5.

II. Application Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for CMS-approval of an accreditation program is conducted in a timely manner. The Act provides us 210 days after the date of receipt of a complete application, with any documentation necessary to make the determination, to complete our survey activities and application process. Within 60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accrediting body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** approving or denying the application.

III. Provisions of the Proposed Notice

In the December 04, 2015 **Federal Register** (80 FR 75866), we published a proposed notice announcing the Institute for Medical Quality's (IMQ's) request for initial approval of its Medicare ASC accreditation program. In the December 04, 2015 proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.5, we conducted a review of IMQ's Medicare ASC accreditation application in accordance with the criteria specified by our regulations, which include, but are not limited to the following: