



Centers for Medicare & Medicaid Services

[Document Identifier: CMS-10450, CMS-10652 and CMS-10540]

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 **[INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

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, please access the CMS PRA web site by copying and pasting the following web address into your web browser: <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing>

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 of a currently approved Information Collection; *Title of Information Collection:* Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for Merit-based Incentive Payment Systems (MIPS); *Use:* The CAHPS for MIPS survey is used in the Quality Payment Program (QPP) to collect data on fee-for-service Medicare beneficiaries’ experiences of care with eligible clinicians participating in MIPS and is designed to gather only the necessary data that CMS needs for assessing physician quality performance, and related public reporting on physician performance, and should complement other data collection efforts. The survey consists of the core Agency for Healthcare Research and Quality (AHRQ) CAHPS Clinician & Group Survey, version 3.0, plus additional survey questions to meet CMS’s information and program needs. The survey

information is used for quality reporting, the compare tool on the Medicare.gov website, and annual statistical experience reports describing MIPS data for all MIPS eligible clinicians.

This 2024 information collection request addresses the requirements related to the statutorily required quality measurement. The CAHPS for MIPS survey results in burden to three different types of entities: groups, virtual groups, and subgroups; vendors; and beneficiaries associated with administering the survey. Virtual groups are subject to the same requirements as groups and subgroups; therefore, we will refer only to “groups” as an inclusive term for all entities unless otherwise noted. *Form Number:* CMS-10450 (OMB control number: 0938–1222); *Frequency:* Yearly; *Affected Public:* Business or other for-profits and Not-for-profit institutions and Individuals and Households; *Number of Respondents:* 25,536; *Total Annual Responses:* 25,536; *Total Annual Hours:* 5,867 (For policy questions regarding this collection contact Renee Oneill at 410–786–8821.)

2. *Type of Information Collection Request:* Extension of currently approved Information Collection; *Title of Information Collection:* Virtual Groups for Merit-Based Incentive Payment System (MIPS); *Use:* Section 1848(q)(5)(I)(ii) of the 2018 Quality Payment Program final rule establishes that a process must be in place to allow an individual MIPS eligible clinician or group consisting of not more than 10 MIPS eligible clinicians to elect, with respect to a performance period for a year, to be in a virtual group with at least one other such individual MIPS eligible clinician or group. Section 1848(q)(5)(I)(iii) of the Act establishes the following requirements that pertain to an election process: (1) individual eligible clinicians and groups forming virtual groups are required to make the election prior to the start of the applicable performance period under MIPS and cannot change their election during the performance period; (2) an individual eligible clinician or group may elect to be in no more than one virtual group for a performance period and in the case of the group electing to be in a virtual group for the performance period, the election applies to all eligible clinicians in the group; (3) a virtual group is a combination of TINs; (4) formal written agreements are required among the eligible

clinicians (includes individual eligible clinicians and eligible clinicians within the groups) electing to be a virtual group; and (5) the Secretary has the authority to include other requirements determined appropriate.

Section 1848(q)(5)(I)(i) of the Act also provides that MIPS eligible clinicians electing to be a virtual group must: (1) have their performance assessed for the quality and cost performance categories in a manner that applies the combined performance of all the MIPS eligible clinicians in the virtual group to each MIPS eligible clinician in the virtual group for the applicable performance period; and (2) be scored for the quality and cost performance categories based on such assessment. *Form Number:* CMS-10652 (OMB control number: 0938–1343); *Frequency:* Yearly; *Affected Public:* Individuals and Households, Private Sector, Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 16; *Total Annual Responses:* 16; *Total Annual Hours:* 160 (For policy questions regarding this collection contact Renee O’Neill at 410-786-8821.)

3. *Type of Information Collection Request:* Revision of a currently approved collection. *Title of Information Collection:* Quality Improvement Strategy Implementation Plan, Progress Report, and Modification Summary Supplement Forms. *Use:* Section 1311(c)(1)(E) of the Affordable Care Act requires qualified health plans (QHPs) offered through an Exchange must implement a quality improvement strategy (QIS) as described in section 1311(g)(1). Section 1311(g)(3) of the Affordable Care Act specifies the guidelines under Section 1311(g)(2) shall require the periodic reporting to the applicable Exchange the activities that a qualified health plan has conducted to implement a strategy as described in section 1311(g)(1). CMS intends to have QHP issuers complete the appropriate QIS forms annually for implementation and progress reporting of their quality improvement strategies. The QIS forms will include topics to assess an issuer’s compliance in creating a payment structure that provides increased reimbursement or other incentives to improve the health outcomes of plan enrollees, prevent hospital readmissions, improve patient safety and reduce medical errors, promote wellness and

health, and reduce health and health care disparities, as described in Section 1311(g)(1) of the Affordable Care Act.

The QIS forms will allow: (1) the Department of Health & Human Services (HHS) to evaluate the compliance and adequacy of QHP issuers' quality improvement efforts, as required by Section 1311(c) of the Affordable Care Act, and (2) HHS will use the issuers' validated information to evaluate the issuers' quality improvement strategies for compliance with the requirements of Section 1311(g) of the Affordable Care Act. *Form Number:* CMS-10540 (OMB control number: 0938-1286); *Frequency:* Annually; *Affected Public:* Public sector (Individuals and Households), Private sector (Business or other for-profits and not-for-profit institutions); *Number of Respondents:* 250; *Total Annual Responses:* 250; *Annual Hours:* 4,933. (For policy questions regarding this collection, contact Preeti Hans at 301-492-1444).

Dated: January 10, 2024.

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4120-01-U-P

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