

13,296. (For policy questions regarding this collection contact Letticia Ramsey at 410-786-5262. For all other issues call 410-786-1326.)

3. Type of Information Collection

Request: Revision of a currently approved collection; *Title of Information Collection:* Application for Prescription Drug Plans (PDP); Application for Medicare Advantage Prescription Drug (MA-PD); Application for Cost Plans to Offer Qualified Prescription Drug Coverage; Application for Employer Group Waiver Plans to Offer Prescription Drug Coverage; Service Area Expansion Application for Prescription Drug Coverage; *Use:* The Medicare Prescription Drug Benefit program was established by section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and is codified in section 1860D of the Social Security Act (the Act). Section 101 of the MMA amended Title XVIII of the Social Security Act by redesignating Part D as Part E and inserting a new Part D, which establishes the voluntary Prescription Drug Benefit Program ("Part D"). The MMA was amended on July 15, 2008 by the enactment of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), on March 23, 2010 by the enactment of the Patient Protection and Affordable Care Act and on March 30, 2010 by the enactment of the Health Care and Education Reconciliation Act of 2010 (collectively the Affordable Care Act).

Coverage for the prescription drug benefit is provided through contracted prescription drug plans (PDPs) or through Medicare Advantage (MA) plans that offer integrated prescription drug and health care coverage (MA-PD plans). Cost Plans that are regulated under Section 1876 of the Social Security Act, and Employer Group Waiver Plans (EGWP) may also provide a Part D benefit. Organizations wishing to provide services under the Prescription Drug Benefit Program must complete an application, negotiate rates, and receive final approval from CMS. Existing Part D Sponsors may also expand their contracted service area by completing the Service Area Expansion (SAE) application.

Effective January 1, 2006, the Part D program established an optional prescription drug benefit for individuals who are entitled to Medicare Part A or enrolled in Part B. In general, coverage for the prescription drug benefit is provided through PDPs that offer drug-only coverage, or through MA organizations that offer integrated prescription drug and health care

coverage (MA-PD plans). PDPs must offer a basic drug benefit. Medicare Advantage Coordinated Care Plans (MA-CCPs) must offer either a basic benefit or may offer broader coverage for no additional cost. Medicare Advantage Private Fee for Service Plans (MA-PFFS) may choose to offer a Part D benefit. Cost Plans that are regulated under Section 1876 of the Social Security Act, and Employer Group Plans may also provide a Part D benefit. If any of the contracting organizations meet basic requirements, they may also offer supplemental benefits through enhanced alternative coverage for an additional premium.

Applicants may offer either a PDP or MA-PD plan with a service area covering the nation (*i.e.*, offering a plan in every region) or covering a limited number of regions. MA-PD and Cost Plan applicants may offer local plans. There are 34 PDP regions and 26 MA regions in which PDPs or regional MA-PDs may be offered respectively. The MMA requires that each region have at least two Medicare prescription drug plans from which to choose, and at least one of those must be a PDP. Requirements for contracting with Part D Sponsors are defined in part 423 of 42 CFR.

This clearance request is for the information collected to ensure applicant compliance with CMS requirements and to gather data used to support determination of contract awards.; *Form Number:* CMS-10137 (OMB # 0938-0936); *Frequency:* Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 178; *Total Annual Responses:* 178; *Total Annual Hours:* 2,322. (For policy questions regarding this collection contact Linda Anders at 410-786-0459. For all other issues call 410-786-1326.)

4. Type of Information Collection

Request: Revision of a currently approved collection; *Title of Information Collection:* Independent Renal Dialysis Facility Cost Report; *Use:* Form CMS-265-94 has not been revised and will be used for cost reporting periods ending on or before December 31, 2010. Form CMS-265-11 is a new form that incorporates portions of CMS-265-94 and CMS-339. It is effective for cost reporting that begins or overlaps January 1, 2011. Providers of services participating in the Medicare program are required under sections 1815(a), 1833(e), 1861(v)(1)(A) and 1881(b)(2)(B) of the Social Security Act (42 U.S.C. 1395g) to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. The Form CMS-265-11

cost report is needed to determine the amount of reasonable cost due to the providers for furnishing medical services to Medicare beneficiaries; *Form Numbers:* CMS-265-11 and CMS-265-94 (OMB#: 0938-0236); *Frequency:* Yearly; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 5,654 *Total Annual Responses:* 5,654; *Total Annual Hours:* 367,510 (For policy questions regarding this collection contact Gail Duncan at 410-786-7278. For all other issues call 410-786-1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web site address at <http://www.cms.hhs.gov/PaperworkReductionActof1995>, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on November 7, 2011.

OMB, Office of Information and Regulatory Affairs,
Attention: CMS Desk Officer.
Fax Number: (202) 395-6974.
E-mail:
OIRA_submission@omb.eop.gov.

Dated: October 4, 2011.

Martique Jones,
*Director, Regulations Development Group,
Division B, Office of Strategic Operations and
Regulatory Affairs.*

[FR Doc. 2011-26026 Filed 10-6-11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8049-N]

Medicare Program; Establishment of the Medicare Economic Index Technical Advisory Panel and Request for Nominations for Members

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

ACTION: Notice.

SUMMARY: This notice announces the establishment of the Medicare Economic Index Technical Advisory Panel and discusses the group's purpose and

charter. It also requests nominations for individuals to serve on the panel.

DATES: Nominations will be considered if we receive them at the appropriate address, provided in the **ADDRESSES** section of this notice, no later than 5 p.m., eastern day light time on November 7, 2011.

ADDRESSES: Send nominations to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore Maryland 21244-1850, Office of the Actuary, Mail stop N3-02-02, Attention: John Poisal.

FOR FURTHER INFORMATION CONTACT: John Poisal, (410) 786-6397. Press inquiries are handled through the CMS Press Office at (202) 690-6145.

SUPPLEMENTARY INFORMATION:

I. Background

In the calendar year (CY) 2011 Physician Fee Schedule (PFS) proposed and final rules (75 FR 40095 and 75 FR 73274), we solicited and responded to comments regarding the convening of a technical advisory panel to review all aspects of the Medicare Economic Index (MEI), including the inputs, input weights, price-measurement proxies, and productivity adjustment. We noted that we would ask the panel to assess the relevance and accuracy of these inputs to current physician practices. The panel's analysis and recommendations will be considered for future rulemaking to ensure that the MEI accurately and appropriately meets its intended statutory purpose. We also solicited comments from the physician community and other interested members of the public on any other specific issues that should be considered by the technical panel.

The Secretary of the Department of Health and Human Services (the Secretary) is establishing a Medicare Economic Index Technical Advisory Panel under Public Law 92-463, Federal Advisory Committee Act, to conduct a technical review of the MEI.

II. Charter, General Responsibilities, and Composition of the Medicare Economic Index Technical Advisory Panel

A. Charter Information and General Responsibilities

On September 28, 2011, the Secretary signed the charter establishing the Medicare Economic Index Technical Advisory Panel (the Panel). The Panel will conduct a technical review of the MEI, including the inputs, input weights, price-measurement proxies, and productivity adjustment. The Panel will be asked to assess the relevance and accuracy of these inputs to current

physician practices. Following the technical review meeting(s), the Panel shall issue a report that summarizes its recommendations for the MEI.

Meetings will be open to the public except when closure is specifically required by statute, and after all statutory and regulatory requirements for doing so have been met. The Secretary or other official to whom the authority has been delegated will make such determinations. Notice of all meetings will be given to the public via a **Federal Register** notice.

The Secretary will request that the Centers for Medicare & Medicaid Services (CMS) consider the Panel's recommendations for future rulemaking to ensure that the MEI accurately and appropriately meets its intended statutory purpose. The Panel will not consider issues such as replacing the price index with a cost index, or other issues that lie outside the limits of CMS' statutory authority, such as replacing the sustainable growth rate (SGR) formula with the MEI.

The Panel, as chartered under the legal authority of section 222 of the Public Health Service Act (42 U.S.C. 217a), is also governed by the provisions of the Public Law 92-463, as amended (5 U.S.C. appendix 2), which sets forth standards for the formation and use of advisory committees, and the provisions of the Government in the Sunshine Act, 5 U.S.C. 552b(b).

The Panel will terminate 30 days after the date of submission of the final report to the Secretary, but no later than September 28, 2012.

You may view and obtain a copy of the Secretary's charter for the Panel at <https://www.cms.gov/FACA/>.

B. Composition of the Panel

The Panel will consist of not more than seven members, including the chair(s). The Panel may be composed of, but is not necessarily limited to, representatives of other government agencies (such as the Bureau of Labor Statistics and the Bureau of Economic Analysis), members of the Medicare Payment Advisory Commission, researchers, and other independent experts.

III. Submission of Nominations

We are requesting nominations for individuals to serve as members on the Panel. We will consider qualified individuals who are self-nominated or are nominated by agency officials, members of Congress, the general public, professional societies, trade associations, or other organizations. Non-federal employee members of the Panel will be appointed as Special

Government Employees and will be required to go through an ethics review. The Secretary or the Secretary's designee will appoint members to serve on the Panel from amongst the candidates that we determine have the technical expertise to meet specific agency needs in a manner to ensure an appropriate balance of membership.

Any interested person may nominate one or more qualified individuals. Each nomination must include the name and contact information for both the nominator and nominee (if not the same).

To ensure that a nomination is considered, we must receive the nomination information by the date specified in the **DATES** section of this notice. Nominations should be mailed to the address specified in the **ADDRESSES** section of this notice.

Authority: 42 U.S.C 217a, section 222 of the Public Health Service Act.

Dated: September 29, 2011.

Donald M. Berwick,
Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2011-26040 Filed 10-6-11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: State Court Improvement Program.
OMB No.: 0970-0307.

Description

The Court Improvement Program (CIP) is composed of three grants, the basic, data, and training grants, governed by two separate Program Instructions (PIs). The training and data grants are governed by the "new grant" PI and the basic grant is governed by the "basic grant" PI. Current PIs require separate applications and program assessment reports for each grant. Every State applies for at least two of the grants annually and most States apply for all three. As many of the application requirements are the same for all three grants, this results in duplicative work and high degrees of repetition for State courts applying for more than one CIP grant.

The purpose of this Program Instruction is to streamline and simplify the application and reporting processes by consolidating the PIs into one single PI and requiring one single,