Hours: 66,370. (For policy questions regarding this collection contact Katherine Hosna at 410–786–4993. 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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments must be received by *December 6, 2011,* and submitted in one of the following ways:

1. *Electronically.* You may submit 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) 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.

Dated: October 4, 2011.

Martique Jones,

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

[FR Doc. 2011–26034 Filed 10–6–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10340, CMS–10237, CMS–10137, and CMS–265–11 and CMS–265–94]

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

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this 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 function; (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.

1. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Collection of Encounter Data from Medicare Advantage Organizations; *Use:* The Centers for Medicare and Medicaid Services (CMS) intends to collect encounter data, or data on each item or service delivered to an enrollee, from Medicare Advantage Organizations. Medicare Advantage organizations will obtain this data from providers. CMS would collect the data electronically from Medicare Advantage Organizations via the Health Insurance Portability and Accountability Act (HIPAA) compliant standard Health Care Claims transactions for professional data and institutional data. The information is used to submit health care claims or equivalent health encounter information, carry out health plan enrollments and disenrollments, determine health plan eligibility, send and receive health care payment and remittance advices, transmit health plan premium payments, determine health care claim status, provide referral certifications and authorizations, and coordinate the benefits for individuals who have more than one health plan. *Form Number:* CMS–10340 (OMB#: 0938–New); *Frequency:* Weekly; *Affected Public:* Private Sector; Businesses or other for-profits; *Number of Respondents:* 827; Total *Annual Responses:* 517,793,438; *Total Annual Hours:* 34,520. (For policy questions regarding this collection contact Sean Creighton at 410–786–9302 or Deondra Moseley at 410–786–4577. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Revision of a currently approved collection;

Title of Information Collection: Part C Medicare Advantage and 1876 Cost Plan Expansion Application; *Use:* Collection of this information is mandated in Part C of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) in Subpart K of 42 CFR part 422 entitled *Contracts with Medicare Advantage Organizations.* In addition, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended titles XVII and XIX of the Social Security Act to improve the Medicare program.

In general, coverage for the prescription drug benefit is provided through prescription drug plans (PDPs) that offer drug-only coverage or through Medicare Advantage (MA) organizations that offer integrated prescription drug and health care products (MA–PD plans). PDPs must offer a basic drug benefit. Medicare Advantage Coordinated Care Plans (MA–CCPs) either must offer 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 enrollees a Part D benefit. Employer Group Plans may also provide Part D benefits. If any of the contracting organizations meet basic requirements, they may also offer supplemental benefits through enhanced alternative coverage for an additional premium.

Organizations wishing to provide healthcare services under MA and/or MA–PD plans must complete an application, file a bid, and receive final approval from CMS. Existing MA plans may request to expand their contracted service area by completing the Service Area Expansion (SAE) application. Applicants may offer a local MA plan in a county, a portion of a county (*i.e.,* a partial county) or multiple counties. Applicants may offer a MA regional plan in one or more of the 26 MA regions.

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. The information will be collected under the solicitation of Part C application from MA, EGWP Plan, and Cost Plan applicants. The collection information will be used by CMS to: (1) Ensure that applicants meet CMS requirements, (2) support the determination of contract awards. Participation in all Programs is voluntary in nature. Only organizations that are interested in participating in the program will respond to the solicitation. MA–PDs that voluntarily participate in the Part C program must submit a Part D application and successful bid. *Form Number:* CMS–10237 (OMB # 0938–0935); *Frequency:* Yearly; *Affected Public:* Private Sector; *Number of Respondents:* 378; *Total Annual Responses:* 378; *Total Annual Hours:*

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 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]

BILLING CODE 4120–01–P

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