

Email 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 and recommendations must be submitted in one of the following ways by *February 14, 2012*:

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: December 9, 2011.

Martique Jones,

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

[FR Doc. 2011-32296 Filed 12-15-11; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS-10412]

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:* Section 1115 Demonstration: Long Term Services and Supports (LTSS) and Other Service Models for Individuals with Disabilities and Chronic Conditions; *Use:* Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow States to test substantially new ideas of policy merit. States seeking interventions for individuals needing LTSS to lower costs, improve care and improve health can utilize the 1115 demonstration to test and deliver innovative services and approaches to better and more efficiently meet the needs of this population. Section 1115 demonstrations provide a vehicle for innovations in both care delivery and payment methodologies. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the Federal government more than it would cost without the waiver. State Medicaid agencies are responsible for developing section 1115 demonstration applications and submitting them to CMS; *Form Number:* CMS-10412 (OCN: 0938-New); *Frequency:* Once; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 2,240. (For policy questions regarding this collection contact Adrienne Delozer at (410) 786-0278. 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 Email 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 January 17, 2012.

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395-6974, Email:

OIRA_submission@omb.eop.gov.

Dated: December 9, 2011.

Martique Jones,

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

[FR Doc. 2011-32294 Filed 12-15-11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS-10180, CMS-R-199, CMS-10379 and CMS-10418]

Agency Information Collection Activities: Proposed Collection; 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) 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 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.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Children's Health Insurance Program (CHIP) Report on Payables and Receivables; *Use:* Collection of CHIP data and the calculation of the CHIP Incurred But Not Reported (IBNR) estimate are pertinent to CMS' financial audit. The CFO auditors have reported the lack of an estimate for CHIP IBNR payables and receivables as a reportable condition in the FY 2005 audit of CMS's financial statements. It is essential that CMS

collect the necessary data from State agencies in FY 2006, so that CMS continues to receive an unqualified audit opinion on its financial statements. Program expenditures for the CHIP have increased since its inception; as such, CHIP receivables and payables may materially impact the financial statements. The CHIP Report on Payables and Receivables will provide the information needed to calculate the CHIP IBNR. *Form Number:* CMS-10180 (OMB#: 0938-0988); *Frequency:* Reporting—Annually; *Affected Public:* State, Local or Tribal governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 392. (For policy questions regarding this collection contact Michele Myers at (410) 786-7911. For all other issues call (410) 786-1326.)

2. Type of Information Collection

Request: Extension of a currently approved collection; *Title of Information Collection:* Medicaid Report on Payables and Receivables; *Use:* The Chief Financial Officers (CFO) Act of 1990, as amended by the Government Management Reform Act (GMRA) of 1994, requires government agencies to produce auditable financial statements. Because the Centers for Medicare & Medicaid Services (CMS) fulfills its mission through its contractors and the States; these entities are the primary source of information for the financial statements. There are three basic categories of data: expenses, payables, and receivables. The CMS-64 is used to collect data on Medicaid expenses. The CMS-R-199 collects Medicaid payable and receivable accounting data from the States. *Form Number:* CMS-R-199 (OMB#: 0938-0697); *Frequency:* Reporting—Annually; *Affected Public:* State, Local or Tribal governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 336. (For policy questions regarding this collection contact Michele Myers at (410) 786-7911. For all other issues call (410) 786-1326.)

3. Type of Information Collection

Request: Extension of a currently approved collection; *Title of Information Collection:* Rate Increase Disclosure and Review Reporting Requirements (45 CFR Part 154). *Use:* Under the Section 1003 of the Affordable Care Act (Section 2794 of the Public Health Service Act), The Secretary, in conjunction with the States, is required to establish a process for the annual review, beginning with the 2010 plan year, of unreasonable increases in premiums for health insurance coverage. Section 2794 directs the Secretary to ensure the public

disclosure of information of unreasonable rate increases and justification for those increases.

On December 23, 2010, CMS published a proposed rate review regulation in the **Federal Register** for public comment (Rate Increase Disclosure and Review Rule, 75 FR 81004). CMS revised the proposed rule based on the public comments and published the final rate review regulation in the **Federal Register** on May 19, 2011. The final rule defines the unreasonable rate review process and issuer reporting and disclosure requirements (Rate Increase Disclosure and Review Rule, 76 FR 29964). The regulation establishes the following reporting requirements:

- **The Preliminary Justification:** This data collection is required of all health insurance issuers for all rate increases that exceed the “subject to review” reporting threshold as defined in the rule. This information will be posted on an HHS Web site.

- **Rate Review Final Determination:** This data collection requires States with effective rate review programs and CMS to report their review findings and unreasonable rate increase determinations on all rate increases that are subject to review. This information will be posted on an HHS Web site.

- **The Final Justification for an Unreasonable Rate Increase:** This data collection is required of health insurance issuers that elect to implement a rate increase that is determined to be unreasonable based on State or CMS review. This information will be posted on the Health Insurance Issuer's Web site and on a CMS Web site.

1. Preliminary Justification

The Preliminary Justification consists of three parts, Part I: Rate Increase Summary, Part II: Written Explanation of the Rate Increase, and Part III: Rate Filing Documentation. Issuers must complete Parts I and II for all rate increases that exceed the reporting threshold as defined in the rule. As described in the preamble of the rule, this information would be collected to provide consumers with basic information on all rate increases that are subject to review under the rate review program.

Under the rule, “subject to review” rate increases would be reviewed by either States or CMS, depending on whether a State has an effective rate review program. Issuers would only be required to submit Part III of the Preliminary Justification when CMS is conducting the review of a rate increase that is “subject to review.” Accordingly,

Part III requires health insurance issuers to provide detailed rate data that would be used for the purposes of conducting thorough actuarial reviews and for making determinations about whether rate increases are unreasonable.

This Notice contains the following information about the Preliminary Justification:

- **Preliminary Justification Issuer Instructions:** health insurance issuer instructions for completing all three parts of the Preliminary Justification.
- **Part I Worksheet:** a standardized Excel worksheet that must be used to complete Part I of the Preliminary Justification.
- **Sample Internet display of the Rate Review Consumer Disclosure:** Information provided in the Preliminary Justification would be posted on an HHS Web site. This sample display shows how the information contained in the Part I Worksheet would be displayed to consumers.

2. Rate Review Final Determination

Under the rule, States and CMS would have to provide a Rate Review Final Determination at the close of their review of all “subject to review” rate increases. The Rate Review Final Determination must provide the State's or CMS' determination on whether a rate increase is “unreasonable.” Section 154.301(a)(3) of the rule provides a list of actuarial review elements that must be taken into account as part of the rate review process. The Final Determination must provide a brief statement explaining how the review of elements set forth in § 154.301(a)(3) caused the State or CMS to arrive at its determination that the rate is unreasonable.

The Rate Review Final Determination will be entered into a data entry text box in the Rate Review Data Collection System. CMS is estimating that this statement would be approximately a paragraph in length. There is no specific form or set of instructions associated with this reporting requirement, apart from the reporting requirements provided in the rule. The information provided in the Rate Review Final Determination will be posted as part of the rate review consumer disclosure information on an HHS Web site.

3. Final Justification for an Unreasonable Rate Increase

The rule states that if a health insurance issuer implements a rate increase determined by CMS or a State to be unreasonable, the health insurance issuer must provide a Final Justification for an Unreasonable Rate Increase. In the Final Justification, issuers would

have to provide a short statement about why they are electing to implement an unreasonable rate increase. This statement would be entered into a data entry text box in the Rate Review Data Collection System and would not need to be more than a paragraph or two in length. There is no form or instructions associated with this statement apart from the requirements provided in the regulation.

The Final Justification Statement will be posted on an HHS Web site in the same location as the Preliminary Justification and Rate Review Final Determination. Additionally, health insurance issuers implementing rate increases that were determined to be unreasonable, must post all of this information—the Preliminary Justification, the Rate Review Final Determination, and the Final Justification Statement on their Web sites for a period of 3 years.

In addition to the aforementioned requirements, we revised the information collection request as a result of an amendment to the regulation discussed in the final rule that published September 6, 2011 (76 FR 54969). The amendment to the rate review final rule updated the applicability of the rate review requirements to include products that would be considered part of the individual or small group market had they not been sold through associations, including those that are considered to be large group products under State law or have been otherwise excluded from State's existing definitions for individual and small group products. This change resulted in an increase in the total number of rate increases that are subject to the rate review reporting requirements. The amendment did not propose any changes to the information that issuers must submit for each rate increase. Thus, burden associated with each rate increase submission remains unchanged from the final rate review rule. The revised association product reporting requirements took effect on November 1, 2011. CMS received a 6 month Emergency PRA approval for the revised association reporting requirements on October 31, 2011 (OMB-0938-1141). CMS is now requesting a 3-year OMB approval of these collection requirements. *Form Number:* CMS-10379 (OCN: 0938-1141); *Frequency:* Annually; *Affected Public:* Private Sector and States; *Number of Respondents:* 452; *Number of Responses:* 3,571; *Total Annual Hours:* 14,630. (For policy questions regarding this collection, contact Sally McCarty at (301) 492-4489. For all other issues call (410) 786-1326.)

4. Type of Information Collection Request: New information collection; **Title of Information Collection:** Medical Loss Ratio Annual Reporting and Rebate Calculation; **Use:** Under Section 2718 of the Affordable Care Act and implementing regulations at 45 CFR Part 158 (75 FR 74864, December 1, 2010 (Interim Final Rule); 75 FR 82277, December 30, 2010 (Technical Correction); and 76 FR 76574, December 7, 2011 (Final Rule with comment period)), a health insurance issuer (issuer) offering group or individual health insurance coverage must submit a report to the Secretary concerning the amount the issuer spends each year on claims, quality improvement expenses, non-claims costs, Federal and State taxes and licensing and regulatory fees, and the amount of earned premium. An issuer must provide an annual rebate to enrollees if the amount it spends on certain costs compared to its premium revenue (excluding Federal and States taxes and licensing and regulatory fees) does not meet a certain ratio, referred to as the medical loss ratio (MLR). An interim final rule (IFR) implementing the MLR was published on December 1, 2010 (75 FR 74865) and modified by technical corrections on December 30, 2010 (75 FR 82277), which added Part 158 to Title 45 of the Code of Federal Regulations. The IFR is effective January 1, 2011. A final rule regarding selected provisions of the interim final rule was published on December 7, 2011 (76 FR 76574) and an interim final rule regarding an issue not included in issuers' reporting requirements (distribution of rebates by non-federal governmental plans) was also published on December 7, 2011 (76 FR 76596). Each issuer is required to submit MLR data annually, including information about any rebates it must provide, on a form prescribed by CMS for each large group market, small group market, and individual market within each State in which the issuer conducts business. Data is to be submitted electronically through CMS' Health Insurance Oversight System (HIOS). Additionally, each issuer is required to maintain for a period of seven years all documents, records and other evidence that support the data included in each issuer's annual report to the Secretary. *Form Number:* CMS-10418; *Frequency:* Annually; *Affected Public:* Private Sector; Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 527; *Number of Responses:* 5,530; *Total Annual Hours:* 352,563. (For policy questions regarding this collection, contact Carol Jimenez at

(301) 492-4457. For all other issues, call (410) 786-1326.)

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Dated: December 13, 2011.

Martique Jones,

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

[FR Doc. 2011-32290 Filed 12-15-11; 8:45 a.m.]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-9068-N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—July Through September 2011

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

ACTION: Notice.

SUMMARY: This quarterly notice lists CMS manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published from July through September 2011, relating to the Medicare and