and Human Services; Telephone (202) 690–6870, Fax (202) 690–2524.

SUPPLEMENTARY INFORMATION: The Board of Trustees of the Medicare Trust Funds report annually on the financial condition of the HI and SMI trust funds. These reports describe the trust funds' current and projected financial condition over the "short term," or next decade, and the "long term" (75+ years). The Medicare Board of Trustees has requested that the Secretary of Health and Human Services (who is one of the Trustees) establish a panel of technical experts to review the methods used in the HI and SMI annual reports.

The Secretary reestablished the Technical Review Panel on the Medicare Trustees Reports when she signed the charter on July 23, 2010.

Objectives and Scope of Activities

The Technical Review Panel on the Medicare Trustees Reports shall counsel the HHS Secretary regarding the Hospital Insurance and Supplementary Medical Insurance Trust Fund annual reports. The panel's duties shall include, but not be limited to, a review of the following topics: the long-term rate of growth, future changes in utilization of care, and alternate projection methodologies. The panel may also examine other methodological issues identified by panelists. The Panel's final report and its recommendations to the Secretary shall be only advisory in nature.

Membership and Designation

The Secretary is soliciting nominations for appointment to the 7-member Technical Review Panel from among members of the general public who are experts in health economics, actuarial science, statistics, public policy, or other fields that could inform and substantively contribute to panel deliberations. Each member of the panel shall be appointed for a term of 2 years. Nominations should be submitted to Marian Robinson, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 200 Independence Avenue, SW., Room 447D, Washington, DC 20201 no later than August 10, 2010.

When selecting members for this Technical Review Panel, HHS will give close attention to equitable geographic distribution and to minority and female representation so long as the effectiveness of the Panel is not impaired. Appointments shall be made without discrimination on the basis of age, race, ethnicity, gender, sexual orientation, HIV status, disability, and cultural, religious, or socioeconomic status.

The Secretary, or her designee, shall appoint one of the members to serve as the Chair. Members shall be invited to serve for the duration of the panel. If members are selected from the Federal sector, they will be classified as regular government employees. Members who are selected from the public and/or private sector will be classified as special government employees. Any vacancy on the Technical Review Panel shall not affect its powers, but shall be filled in the same manner as the original appointment was made. An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member that is replaced.

Administrative Management and Support

HHS will provide funding and administrative support for the Technical Review Panel to the extent permitted by law within existing appropriations. Staff will be assigned to support the activities of the Panel. Management and oversight for support services provided to the Panel will be the responsibility of the Office of the Assistant Secretary for Planning and Evaluation and the Office of the Actuary, and the Centers for Medicare & Medicaid Services (CMS). All executive departments and agencies and all entities within the Executive Office of the President shall provide information and assistance to the Panel as the Chair may request for purposes of carrying out the Panel's functions, to the extent permitted by law.

A copy of the Panel's charter can be obtained from the designated contacts or by accessing the FACA database that is maintained by the GSA Committee Management Secretariat. The Web site for the FACA database is *http://fido.gov/facadatabase/*.

Dated: July 23, 2010.

Sherry Glied,

Assistant Secretary for Planning and Evaluation.

[FR Doc. 2010–18697 Filed 7–29–10; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS–10171, CMS–460 and CMS–10318]

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

AGENCY: Centers for Medicare & Medicaid Services.

In compliance with the requirement of section 3506I(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:* Revision of a currently approved collection; *Title of Information Collection:* Coordination of Benefits between Part D Plans and Other Prescription Coverage Providers; *Use:* Section 1860D–23 and 1860D–24 of the Social Security Act requires the Secretary to establish requirements for prescription drug plans to ensure the effective coordination between Part D plans, State pharmaceutical Assistance programs and other payers. The requirements must relate to the following elements: (1) Enrollment file sharing; (2) claims processing and payment; (3) claims reconciliation reports; (4) application of the protections against high out-of-pocket expenditures by tracking True out-of-pocket (TrOOP) expenditures; and (5) other processes that the Secretary determines. CMS, via the TrOOP facilitation contractor, automated the transfer of beneficiary coverage information when a beneficiary changes Part D plans. This information is necessary to assist with coordination of prescription drug benefits provided to the Medicare beneficiary. Refer to the crosswalk document for a list of the current changes. *Form Number:* CMS–10171 (OMB#: 0938–0978); *Frequency:* Yearly; *Affected Public:* Business or other for-profits; *Number of Respondents:* 57,227 *Total Annual Responses:* 248,018; *Total Annual Hours:* 754,788 (For policy questions regarding this collection contact Christine Hinds at 410–786–4578. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Participating Physician or Supplier

Agreement; *Form No.:* CMS–460 (OMB# 0938–0373); *Use:* The CMS–460 is the agreement a physician, supplier or their authorized official signs to participate in Medicare Part B. By signing the agreement to participate in Medicare, the physician, supplier or their authorized official agrees to accept the Medicare-determined payment for Medicare covered services as payment in full and to charge the Medicare Part B beneficiary no more than the applicable deductible or coinsurance for the covered services. For purposes of this explanation, the term a supplier means any person or entity that may bill Medicare for Part B services (*e.g.* DME supplier, nurse practitioner, supplier of diagnostic tests) except a Medicare provider of services (*e.g.* hospital), which must participate to be paid by Medicare for covered care.

There are additional benefits associated with payment for services paid under the Medicare fee schedule. Payments made under the Medicare fee schedule for physician services to participating physicians and suppliers are based on 100 percent of the Medicare fee schedule amount, while the Medicare fee schedule payment for physician services by nonparticipating physicians and suppliers is based on 95 percent of the fee schedule amount. Physicians and suppliers who do not participate in Medicare are subject to limits on their actual charges for unassigned claims for physician services. These limits, known as limiting charges, cannot exceed 115 percent of the non-participant fee schedule, which is set at 95 percent of the full fee schedule amount. In addition, if a physician or supplier does not accept assignment on a claim for Medicare payment, the physician or supplier must collect payment from the beneficiary. If the physician or supplier accepts assignment on the claim, Medicare pays its share of the payment directly to the physician or supplier, resulting in faster and more certain payment. *Frequency:* Reporting, Other—when starting a new business; *Affected Public:* Business or other for-profit; *Number of Respondents:* 8,000; *Total Annual Responses:* 8,000; *Total Annual Hours:* 2,000. (For policy questions regarding this collection contact April Billingsley at 410–786–0410. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Survey to Inform the Children's Health Insurance Program (CHIP) National Outreach & Education Campaign; *Form No.:* CMS–10318 (OMB# 0938–New); *Use* The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA or Pub. L. 111–3) reauthorized the Children's Health Insurance Program (CHIP) through FY 2013. It will preserve coverage for the millions of children who rely on CHIP today and provide the resources for States to reach millions of additional uninsured children. This legislation will help ensure the health and well-being of our nation's children. To support this legislation and to help people who would benefit from CHIP make more informed decisions, CMS will be conducting outreach. The outreach will employ numerous communications channels to educate people who would benefit from CHIP concerning the program benefits, eligibility and enrollment requirements, utilization, and retention. As part of the outreach, CMS will seek to increase awareness, enrollment and retention in CHIP for the eligible audiences. The primary target audience for the outreach includes parents and guardians of potentially eligible children as well as pregnant women. Secondary audiences are information intermediaries including State, local, and tribal governments, educators (including non-parental caregivers) health care providers/social workers, national and local partners. The challenge is reaching the population segments that have access barriers to information including language, literacy, location, and culture to understand health insurance. To support the outreach and education, CMS needs to conduct survey research to be able to effectively reach the target audiences. *Frequency:* Reporting—Once; *Affected Public:* Individuals or Households; *Number of Respondents:* 1,850; *Total Annual Responses:* 1,850; *Total Annual Hours:* 2,000. (For policy questions regarding this collection contact Barbara Allen at 410–786–6716. 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 *August 30, 2010.* OMB, Office of Information and Regulatory Affairs, *Attention:* CMS Desk Officer, *Fax Number:* (202) 395–6974, *E-mail: OIRA_submission@omb.eop.gov.*

Dated: July 26, 2010.

Michelle Shortt,

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

[FR Doc. 2010–18610 Filed 7–29–10; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–R–244]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

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:* Medicare and Medicaid Programs: Programs of All-Inclusive Care for the Elderly (PACE); *Use:* PACE organizations must demonstrate their ability to provide quality community-based care for the frail elderly who meet their State's nursing home eligibility standards using capitated payments from Medicare and the state. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management, through which access to and allocation of all health services is controlled. Physician, therapeutic, ancillary, and social support services are provided in the participant's residence or on-site at the adult day health center. PACE programs must