DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Office for State, Tribal, Local, and Territorial Support

In accordance with Presidential Executive Order No. 13175, November 6, 2000, and the Presidential Memorandum of November 5, 2009 and September 23, 2004, Consultation and Coordination with Indian Tribal Governments, CDC, OSTLTS announces the following meeting and Tribal Consultation Session:

Name: Tribal Advisory Committee (TAC) Meeting and 7th Biannual Tribal Consultation Session.

Times and Dates:

8:30 a.m.–5 p.m., August 22–23, 2011 (TAC Meeting).

8:30 a.m.–4 p.m., August 24, 2011 (7th Biannual Tribal Consultation Session).

Place: Suquamish Clearwater Casino Resort, 15347 Suquamish Way, NE., Suquamish, Washington 98392.

Status: All meetings are being hosted by the Northwest Portland Area Indian Health Board and are open to the public. August 23, 2011, has been reserved as a day to tour and interact with local Tribes. A special invitation has been extended to the Washington and Oregon American Indian Tribal Leaders, Washington and Oregon State Health Department Officials, and all American Indian/Alaska Native (AI/AN) Tribal leaders from across the nation.

Purpose: CDC released its Tribal Consultation Policy in October of 2005 with the primary purpose of providing guidance across the agency to work effectively with AI/AN tribes, communities, and organizations to enhance AI/AN access to CDC resources and programs. In November of 2006, an Agency Advisory Committee (the CDC/Agency for Toxic Substances and Disease Registry Tribal Advisory Committee—TAC) was established to provide a complementary venue wherein tribal representatives and CDC staff could exchange information about public health issues in Indian Country, identifying urgent public health needs in AI/AN communities, and discuss collaborative approaches to these issues and needs. Within the CDC Consultation Policy, it is stated that CDC will conduct government-to-government consultation with elected tribal officials or their designated representatives and confer with tribal and American Native organizations and AI/AN urban and rural communities before taking actions and or making decisions that affect them.

Consultation is an enhanced form of communication that emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties that leads to mutual understanding and comprehension. CDC believes that consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. Although formal responsibility for the agency's overall government-to-government consultation activities rests within the CDC Office of the Director (OD), other CDC Centers, Institutes, and Offices, leadership shall actively participate in TAC meetings and HHS-sponsored regional and national tribal consultation sessions as frequently as possible.

Matters to be Discussed: The TAC will convene their advisory committee meeting with discussions and presentations from various CDC senior leaderships on activities and areas identified by TAC members and other tribal leaders as priority public health issues. The Biannual Tribal Consultation Session will engage CDC Senior leadership from the CDC OD and various CDC Centers, Institutes and Offices, including the Financial Management Office, the Office of the Associate Director of Communications, OSTLTS, the National Center for Environmental Health and the Agency for Toxic Substances and Disease Registry, the National Center for Chronic Disease Prevention and Health Promotion, as well as others. Opportunities will be provided during the consultation session for tribal testimony. Tribal Leaders are encouraged to submit written testimony by close of business on August 5, 2011, to the contact person listed below.

It may be necessary to limit the time of each presenter due to the availability of time.

The agenda is subject to change as priorities dictate.

Information about TAC and CDC's Tribal Consultation Policy and previous meetings may be referenced on the following Web link: *http://www.cdc.gov/ostlts/tribal_public_health/announcements.html.*

Contact Person for more Information: Kimberly Cantrell, Public Health Advisor, Tribal Support, OSTLTS, CDC, 1600 Clifton Road, NE., MS K–70, Atlanta, Georgia 30333, telephone (404) 498–0411, e-mail: *KLW6@cdc.gov.*

The Director, Management Analysis and Services Office has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention, and the Agency for Toxic Substances and Disease Registry.

Dated: June 24, 2011.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2011–16558 Filed 6–30–11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10398, CMS–10399, CMS–10137, and CMS–10237]

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:* New collection; *Title of Information Collection:* Generic Clearance for Medicaid and CHIP State Plan, Waiver, and Program Submissions; *Use:* CMS is requesting a generic PRA clearance for a body of forms necessary to conduct ongoing business with State partners in the implementation of Medicaid and the Children's Health Insurance Program (CHIP). The specific forms have not yet been developed but will be developed over the 3-year approval period. The types of forms to be produced in this collection include State plan amendment templates, waiver and demonstration templates, and reporting templates. The development of streamlined submission forms is critical for States to implement timely health reform initiatives in Medicaid and CHIP state plans, demonstrations, and waivers, including legislative requirements enacted by the Affordable Care Act. The development of streamlined submissions forms enhances the collaboration and partnership between States and CMS by documenting CMS policy for States to use as they are developing program changes. Streamlined forms improve efficiency of administration by creating

a common and user-friendly understanding of the information needed by CMS to quickly process requests for State plan amendments, waivers, and demonstration, as well as ongoing reporting; *Form Number:* CMS–10398 (OMB # 0938–NEW); *Frequency:* Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 1120; *Total Annual Hours:* 28,747. (For policy questions regarding this collection contact Candice Payne at 410–786–4453. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Analysis of Transportation Barriers to Utilization of Medicare Services by American Indian and Alaska Native Medicare Beneficiaries; *Use:* The purpose of the proposed study is to identify and analyze transportation barriers associated with the utilization of Medicare services by American Indian and Alaska Native (AI/AN) beneficiaries, to identify and analyze the health outcomes resulting from those barriers, and ultimately to identify potential solutions that could help mitigate the problem and produce meaningful improvements in health care use and health outcomes for this population. Specifically, the information that will be collected through the use of instruments and the study developed under the Analysis of Transportation Barriers to Utilization of Medicare Services by American Indian and Alaska Native Medicare Beneficiaries Project has not been collected or evaluated previously by any agency or individual, so data on the extent of transportation barriers for rural AI/AN beneficiaries to Medicare services by AI/AN Medicare beneficiaries are not available except from the proposed data collection activity.

The information gathered as part of the project—through the use of survey, interview, and focus group instruments—will be used by CMS to identify transportation barriers to Medicare services for AI/AN Medicare beneficiaries. It will provide the first ever complete evaluation of transportation barriers to health care for this population.; *Form Number:* CMS–10399 (OMB # 0938–NEW); *Frequency:* Occasionally; *Affected Public:* Individuals and Households, Private Sector; *Number of Respondents:* 3,418; *Total Annual Responses:* 3,418; *Total Annual Hours:* 2,544. (For policy questions regarding this collection contact Roger Goodacre at 410–786–3209. 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:* Yearly; *Affected Public:* Privates Sector; *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:* 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 CRF 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.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at *http://www.cms.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage* 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 at 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 *August 30, 2011:*

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: June 28, 2011.

Michelle Shortt,

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

[FR Doc. 2011–16600 Filed 6–30–11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–2540–10 and CMS–10385]

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:* Revision of a currently approved collection; *Title of Information Collection:* Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Cost Report. *Use:* Form CMS 2540–10 is used by Skilled Nursing Facilities (SNFs) and Skilled Nursing Facility Complexes participating in the Medicare program to report the health care costs to determine the amount of reimbursable costs for services rendered to Medicare beneficiaries. It is required under sections 1815(a), 1833(e) and 1861(v)(1)(A) 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 revision is due to new reporting requirements as mandated by the Patient Protection and Affordability Act section 6104. Section 6104(1) of Public Law 111–148 amended § 1888(f) of the Social Security Act (''Reporting of Direct Care Expenditures''), by requiring that SNFs separately report expenditures for wages and benefits for direct care staff (registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff). In implementing these changes Worksheet S–3, part V, was added. With the addition of this worksheet the average recordkeeping time for each provider will be increased by 5 hours and the average reporting time by 1 hour. *Form Number:* CMS–2540–10 (OMB#: 0938–0463); *Frequency:* Yearly; *Affected Public:* Private Sector; Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 15,071; *Total Annual Responses:* 15,071; *Total Annual Hours:* 3,171,602 (For policy questions regarding this collection contact Amelia Citerone. at 410–786–3901. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Expedited Checklist: Medicaid Eligibility & Enrollment Systems—Advance Planning Document (E&E–APD); *Use:* Under sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act, CMS has issued new standards and conditions that must be met by States for Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for enhanced match funding. The Checklist will be submitted by States to the E&E APD