and should be submitted to the contact person below in advance of the meeting.

Contact Person for More Information:
Theodore M. Katz, M.P.A., Executive Secretary, NIOSH, CDC, 1600 Clifton Road
NE., Mailstop: E–20, Atlanta, GA 30333;
Telephone (404) 332–4000, Toll Free 1–800–
CDCINFO, E-mail oce@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.

Lorenzo J. Falgiano,
Acting Director, Management Analysis and
Services Office Centers for Disease Control
and Prevention.

[FR Doc. 2010–32421 Filed 12–23–10; 8:45 am]
BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND
HUMAN SERVICES

Centers for Medicare & Medicaid
Services

[CMS–6041–NC]

Medicare Program: Solicitation of
Comments Regarding Development of
a Recovery Audit Contractor Program
for the Medicare Part C and D
Programs

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

ACTION: Request for information.

SUMMARY: This notice presents an
approach and requests comments on the
provision of the Patient Protection and
Affordable Care Act (Pub. L. 111–148),
as amended by the Health Care and
Education Reconciliation Act of 2010
(Pub. L. 111–152), (collectively known as
The Affordable Care Act (ACA)) that
requires the expansion of the Recovery
Audit Contractor (RAC) Program to the
Medicare Part C and D programs.

DATES: Comment Date: To be assured
consideration, comments must be
received at one of the addresses
provided below, no later than 5 p.m. on
February 25, 2011.

ADDRESSES: In commenting, please refer
to file code CMS–6041–NC. Because of
staff and resource limitations, we cannot
accept comments by facsimile (FAX)
transmission.

You may submit comments in one of
four ways (please choose only one of
the ways listed):
1. Electronically. You may submit
electronic comments on this regulation to
http://www.regulations.gov. Follow the “Submit a comment” instructions.

2. By regular mail. You may mail
written comments to the following
address ONLY: Centers for Medicare &
Medicaid Services, Department of
Health and Human Services, Attention:
CMS–6041–NC, P.O. Box 8013,
Baltimore, MD 21244–8013.

Please allow sufficient time for mailed
comments to be received before the
close of the comment period.

3. By express or overnight mail. You
may send written comments to the
following address ONLY: Centers for
Medicare & Medicaid Services
Department of Health and Human
Services, Attention: CMS–6041–NC,
Mail Stop C4–26–05, 7500 Security
Boulevard, Baltimore, MD 21244–1850.

4. By hand or courier. Alternatively, you
can deliver your comments in person
by hand or courier to the Department of
Health and Human Services, Room 445–G,
Hubert H. Humphrey Building, 200
Independence Avenue, SW., Washington, DC
20201. (Because access to the interior of
the Hubert H. Humphrey Building is not
readily available to persons without
Federal government identification,
commenters are encouraged to leave
their comments in the CMS drop slots
located in the main lobby of the
building. A stamp-in clock is available
for persons wishing to retain a proof of
filing by stamping in and retaining an
extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—
Centers for Medicare & Medicaid
Services Department of Health and
Human Services, 7500 Security
Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your
comments to the Baltimore address, call
(410) 786–9994 in advance to schedule
your arrival with one of our staff
members.

Comments erroneously mailed to the
addresses indicated as appropriate for
hand or courier delivery may be delayed
and received after the comment period.

Submission of comments on
paperwork requirements. You may
submit comments on this document’s
paperwork requirements by following
the instructions at the end of the
“Collection of Information
Requirements” section in this document.

For information on viewing public
comments, see the beginning of the
SUPPLEMENTARY INFORMATION
section.

For further information contact:
Cynthia Moreno (410) 786–1164.

SUPPLEMENTARY INFORMATION:
Inspection of Public Comments: All
comments received before the close of
the comment period are available for
viewing by the public, including any
personally identifiable or confidential
business information that is included in
a comment. We post all comments
received before the close of the
comment period on the following Web
site as soon as possible after they have
been received: http://
www.regulations.gov. Follow the search
instructions on that Web site to view
public comments.

Comments received timely will also
be available for public inspection as
they are received, generally beginning
approximately three weeks after
publication of a document, at the
headquarters of CMS, 7500 Security
Boulevard, Baltimore, Maryland 21244,
Monday through Friday of each week
from 8:30 a.m. to 4 p.m. To schedule an
appointment to view public comments,
phone 1–800–743–3951.

I. Background

The Balanced Budget Act of 1997
(BBA) (Pub. L. 105–33) established the
Medicare+Choice (M+C) program.
Under section 1851(a)(1) of the Social
Security Act (the Act), every individual
with Medicare Parts A and B, except for
individuals with end stage renal
disease, could elect to receive benefits
either through the original Medicare
program or an M+C plan, if one was
offered where the beneficiary lived. The
primary goal of the M+C program was
to provide Medicare beneficiaries with a
wider range of health plan choices.

The Medicare, Medicaid, and SCHIP
Balanced Budget Refinement Act of
1999, (Pub. L. 106–113), amended the
M+C provisions of the BBA. Further
amendments were made to the M+C
program by the Medicare, Medicaid,
and SCHIP Benefits Improvement and
Protection Act of 2000 (Pub. L. 106–

On December 8, 2003, the Congress
enacted the Medicare Prescription Drug,
Improvement, and Modernization Act of
2003 (MMA) (Pub. L. 108–173), Title I
of the MMA added new sections 1860D–
1 through 1860D–42 to the Act creating
the Medicare Prescription Drug Benefit
(Part D) program, a landmark change to
the Medicare program.

Sections 201 through 241 of Title II of
the MMA made significant changes to
the M+C program. As directed by Title
II of the MMA, we renamed the M+C
program the Medicare Advantage (MA)
program. We also revised our
regulations to include new payment and
billing provisions based largely on risk,
to recognize the addition of regional
Preferred Provider Organization plans,
to address the provision of prescription
The Tax Relief and Health Care Act of 2006 (Pub. L. 109–432) gave the Secretary until January 1, 2010 to implement the national RAC program nationwide. As of October 29, 2009 the RAC FFS Medicare program was fully implemented. Currently, the RACs are reviewing all claim and provider types upon approval from us. The ACA makes a number of changes to Medicare programs, including Medicare Part C and Part D, to enhance the agency’s current efforts to further reduce fraud, waste, and abuse in Medicare programs. Section 6411(b) of ACA expands the use of RACs to all of Medicare (Title XVIII) amending the existing FFS RAC statute at section 1893(h) of the Act. The amendments to 1893(h) of the Act provide us with general authority to enter into contracts with RACs to identify overpayments and underpayments and recoup overpayments in Medicare Part C and Part D. In addition to the identification of underpayments and overpayments and the recoupment of overpayments, Section 6411(b) of ACA also establishes special rules for Part C and Part D that require RACs to—

- Ensure that each MA plan and Part D plan has anti-fraud plans in place and to review the effectiveness of the anti-fraud plans;
- Examine claims for reinsurance payments to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under the statute; and
- Review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.

II. Proposed Approach and Solicitation of Comments for Section 6411 of the Affordable Care Act

We want to utilize RAC overpayment and underpayment findings to reduce future improper payments in the Medicare Parts C and D programs. With that objective, we are interested in knowing how the RAC findings could be used to more accurately inform Medicare’s reimbursement to Part C and Part D plans. Our current experience for utilizing RACs has been limited to the Medicare FFS model. Given the fundamental differences between Medicare FFS and the Medicare Parts C and D programs and since this is the first time we have attempted to expand RACs to other parts of the Medicare program, we are soliciting the views of industry stakeholders on how to best implement the RAC program requirements established in section 6411(b) of the ACA for the Medicare Part C and Part D programs. We recognize that the payment structure in the Medicare Part C and Part D programs is different than in Medicare FFS, so we want to ensure that the RACs are utilized in the most efficient and appropriate manner to return any identified overpayments to the Medicare Trust Fund.

Based on the comments received from this solicitation, we may do further rulemaking on the development and implementation of requirements for RACs in the Part C and Part D programs. We are most interested in receiving comments on the following:

- Methods for RACs to identify underpayments and overpayments in the Medicare Part C and Part D programs.
- Utilizing a phased-in approach for RACs in the Medicare Part C and Part D programs, similar to the development of RACs in the Medicare FFS program.
- The criteria or qualifications necessary to enable a RAC to knowledgeable and appropriately review the payments in Medicare Part C and Part D plans. (We note that in order to meet the qualifications, the Medicare FFS RACs must obtain the services of certified coders, nurses, or therapists, and a Contractor Medical Director.)
- Specific conflict of interest rules that should apply to RACs for the Medicare Parts C and D programs.
- Establishing an oversight entity for Medicare Part C and Part D RAC Issue Approval. We are considering establishing a review board for the Part C and Part D RACs. (We note that FFS RACs have the authority to pursue clear-cut vulnerabilities that can lead to improper payments. However, for more complex vulnerabilities, a review board is utilized. This board decides whether FFS RACs can proceed with the proposed review.)
- Methods for resolving underpayments and how payments related to underpayments identified by the RAC would be implemented in the Part C and Part D programs.
- Potential for allowing Part C and Part D plans to use RACs within their own plans to identify overpayments in its operations. Working through us, the RAC contractor would come to an agreement with interested MA organizations (MAO) to conduct claims review. The claims review would be conducted on claims submitted to the MAO for payment by serving the MAO enrollees. The RAC would be paid by the MA organization on a...
Under-reporting of DIR by plans would overstate plans’ drug costs, including in the catastrophic phase of the benefit, and would result in an overpayment to the plan. We are interested in receiving comments on how RACs could be used to review the accuracy and completeness of DIR information provided to us by plans.

++ The statute also requires that we use RACs to review estimates submitted by Part D plans with respect to enrollment of high cost beneficiaries. A Part D sponsor’s estimates for the enrollment of high cost beneficiaries may impact the reinsurance estimates in their Part D bids and thus, the prospective reinsurance subsidy payments they receive from us. However, given the structure of the Part D program that requires us to reconcile reinsurance subsidy payments against a Part D sponsor’s actual costs, requiring RACs to undertake this activity is less likely to result in recovery of any reinsurance overpayments. However, as noted previously, we are interested in receiving comments on how RACs might be used to identify overpayments and underpayments associated with DIR reporting.

++ We are interested in learning about successful overpayment recoupment models in managed care that may already exist in the commercial sector and to what extent these models are applicable to Part C. Successfully integrating RACs into Part C presents a particular challenge because of how Part C payments are made. Under the statutory payment formula, plans are paid on a capitated basis. Therefore, the plan, not the government, is at direct risk for any overpayments and underpayments made to its providers. We are interested in learning whether and how other purchasers have identified overpayments and underpayments made by capitated plans and to what extent savings were shared between the plan and the purchaser.

• Any additional information concerning the development of a RAC program in Medicare Part C and Part D and how we can establish the required program elements to protect the Medicare Parts C and D programs from fraud, waste, and abuse.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: December 8, 2010,
Donald M. Berwick,
Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2010–32498 Filed 12–23–10; 8:45 am]
BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Office of Head Start; Statement of Organization, Functions, and Delegations of Authority

AGENCY: Administration for Children and Families, HHS.

ACTION: Notice.

SUMMARY: Statement of Organizations, Functions, and Delegations of Authority. The Administration for Children and Families (ACF) has reorganized the Office of Head Start (OHS). This reorganization creates the Grants and Contracts Division and the State Initiatives Division. It replaces the Educational Development and Partnership Division, titling it the Education and Comprehensive Services Division. It also renews the Immediate Office of Head Start, the Office of the Director. Additionally, it replaces the Policy and Budget Division, the Policy and Planning Division.


This notice amends Part K of the Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (HHS), Administration for Children and Families (ACF) as follows: Chapter KU, Office of Head Start (OHS), as last amended 71 FR 59117–59123, October 6, 2006.

I. Under Chapter, KU, Office of Head Start, delete KU in its entirety and replace with the following:

KU.00 MISSION. The Office of Head Start (OHS) advises the Assistant Secretary for Children and Families on issues regarding the Head Start program (including Early Head Start). OHS develops legislative and budgetary proposals; identifies areas for research, demonstration and developmental activities; presents operational planning objectives and initiatives relating to Head Start and Early Head Start to the Assistant Secretary; and oversees the progress of approved activities. It provides leadership and coordination for the activities of the Head Start program in the ACF Central Office including the Head Start Regional Program Units. OHS represents Head Start in inter-agency activities with other Federal and non-Federal organizations.

KU.10 ORGANIZATION. OHS is headed by a director who reports