Exchange. An Exchange is an organized marketplace to help consumers and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits, and quality. By pooling people together, reducing transaction costs, and increasing price and quality transparency, Exchanges create more efficient and competitive health insurance markets for individuals and small employers. The Exchange will carry out a number of functions as required by the Affordable Care Act, including certifying qualified health plans, administering premium tax credits and cost-sharing reductions, responding to consumer requests for assistance, and providing an easy-to-use website and written materials that individuals can use to assess eligibility and enroll in health insurance coverage, and coordinating eligibility for and enrollment in other state health subsidy programs, including Medicaid and CHIP. Section 1311 of the Affordable Care Act provides for grants to States for the planning and establishment of American Health Benefit Exchanges. The Secretary is planning to disburse funds in at least three phases: first, for planning; second, for early information technology development; and third, for implementation. $51 million was made available for States for State Exchange planning. Forty-nine States and the District of Columbia applied and have been awarded grant funds. $5 million was made available for Territories Exchange early implementation. Five Territories were eligible to receive a Notice of Grant Award; four applied and have been awarded funds. States and Territories are eligible for up to $1 million each from this grant announcement, which will extend for up to twelve months. *Form Number:* CMS–10337 (OCN: 0938–1101); *Frequency:* Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 54; *Number of Responses:* 594; *Total Annual Hours:* 277,533. (For policy questions regarding this collection, contact Katherine Harkins at (301) 492–4445. For all other issues call (410) 786–1326.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Consumer Assistance Program Grants; *Use:* Section 1002 of the Affordable Care Act provides for the establishment of consumer assistance (or ombudsman) programs, starting in FY 2010. Federal grants will support these programs. For FY 2010, $30 million is appropriated. These programs will assist consumers with filing complaints and appeals, assist consumers with enrollment into health coverage, collect data on consumer inquiries and complaints to identify problems in the marketplace, educate consumers on their rights and responsibilities, and starting in 2014, resolve problems with premium credits for Exchange coverage. Importantly, these programs must provide detailed reporting on the types of problems and questions consumers may experience with health coverage, and how these are resolved. In order to strengthen oversight, the law requires programs to report data to the Secretary of the Department of Health and Human Services (HHS) "As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers" (Sec. 2793 (d)). *Form Number:* CMS–10333 (OMB–0938–1097); *Frequency:* Quarterly; *Affected Public:* Private Sector: State, Local, or Tribal Governments; *Number of Respondents:* 40; *Number of Responses:* 200; *Total Annual Hours:* 4,800 . (For policy questions regarding this collection, contact Eliza Bangit at (301) 492–4219. 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 *June 14, 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.

Martique Jones,

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

[FR Doc. 2011–9208 Filed 4–14–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5055–N2]

Medicare Program; Solicitation for Proposals for the Medicare Community-Based Care Transitions Program

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

ACTION: Notice.

SUMMARY: This notice informs interested parties of an opportunity to apply to participate in the Medicare Community-based Care Transitions Program, which was authorized by section 3026 of the Affordable Care Act.

DATES: Proposals will be accepted on a rolling basis. Acceptable applicants will be awarded on an ongoing basis as funds permit.

FOR FURTHER INFORMATION CONTACT: Juliana Tiongson, (410) 786–0342 or by e-mail at *CareTransitions@cms.hhs.gov.*

ADDRESSES: Proposals should be mailed to the following address:

Centers for Medicare & Medicaid Services, Attention: Juliana Tiongson, 7500 Security Boulevard, Mail Stop: C4–14–15, Baltimore, Maryland 21244–1850.

SUPPLEMENTARY INFORMATION:

I. Background

Section 3026 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010) (Affordable Care Act) authorized the Medicare Community-based Care Transitions Program (CCTP). The goals of the CCTP are to improve the quality of care transitions, reduce readmissions for high risk Medicare beneficiaries, and document measurable savings to the Medicare program by reducing unnecessary readmissions. The CCTP is part of Partnership for Patients, a national patient safety initiative through which the Administration is supporting broad-based efforts to reduce harm caused to patients in hospitals and improve care transitions.

II. Criteria for Applicants

We are seeking eligible organizations which are a subsection (d) hospital, as defined in section 1886(d)(1)(B) of the Social Security Act (the Act), with high readmission rates that partner with community-based organizations (CBOs) or CBOs that provide care transition services. CBOs are defined as community-based organizations that provide care transition services across the continuum of care through arrangements with subsection (d) hospitals and whose governing bodies include sufficient representation of multiple health care stakeholders, including consumers.

This program creates a source of funding for care transition services that effectively manage transitions from acute to community-based settings and report specified process and outcome measures on their results. CBOs will be paid on a per eligible discharge basis for eligible Medicare beneficiaries at high risk for readmission, including those with multiple chronic conditions, depression, or cognitive impairments.

In selecting CBOs to participate in the program, preference will be given to eligible entities that are Administration on Aging (AoA) grantees that provide concurrent care transition interventions with multiple hospitals and practitioners or entities that provide services to medically-underserved populations, small communities, and rural areas. The program will run for 5 years beginning April 11, 2011; however, participants will be awarded 2-year agreements that may be extended on an annual basis for the remaining 3 years based on performance.

Applicants must identify root causes of readmissions and define their target population and strategies for identifying high risk patients. Applicants must also specify care transition interventions including strategies for improving provider communications in care transitions and improving patient activation. Lastly, applicants will be required to provide a budget including a per eligible discharge rate for care transition services, provide an implementation plan with milestones, and demonstrate prior experience with effectively managing care transition services and reducing readmissions.

A competitive process will be used to select eligible organizations. We will accept proposals on a rolling basis. The program will continue through 2015.

For specific details regarding the CCTP and the application process, please refer to the solicitation on the CMS Web site at *http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313.*

III. Application Information

Please refer to file code [CMS–5055–N2] on the application. Proposals (an unbound original and 3 copies plus an electronic copy on CD–ROM) must be typed for clarity and should not exceed 30 double-spaced pages, exclusive of cover letter, the executive summary, resumes, forms, and supporting documentation. Because of staffing and resource limitations, we cannot accept proposals by facsimile (FAX) transmission. Applicants may, but are not required to, submit a total of 10 copies to assure that each reviewer receive a proposal in the manner intended by the applicant (for example, collated, tabulated color copies). Hard copies and electronic copies must be identical.

IV. Eligible Organizations

As discussed above, subsection (d) hospitals with high readmission rates that partner with CBOs or CBOs that provide care transition services are eligible to participate in the CCTP. We anticipate that a wide variety of interested parties may be eligible to form a CBO in order to apply in collaboration with other organizations to perform the responsibilities specified. CBOs may be characterized as physician practices, particularly primary care practices, a corporate entity that has a separate quality improvement organization (QIO) contract with CMS under Part B of title XI of the Act, in situations that will not result in or create the appearance of a conflict of interest between the QIO's review tasks under title XI and the corporate entity's role as a CBO, an Aging and Disability Resource Center, Area Agency on Aging, or other appropriate organization that meets the statutory definition at section 3026(b)(1)(B) of the Act.

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

Dated: December 27, 2010.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2011–9126 Filed 4–12–11; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of a New System of Records

AGENCY: Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice of a new Privacy Act system of records.

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, the Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO) is establishing a new system of records (SOR) titled the "Health Insurance Assistance Database (HIAD)," System No. 09–70–0586. This SOR is established under the authority of Sections 2719, 2723, and 2761 of the Public Health Service Act (PHS Act) (Public Law (Pub. L.) 97–35) and § 1321(c) of the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. 111–148). Section 1321(c) of the Affordable Care Act authorizes HHS (1) to ensure that States with Exchanges are substantially enforcing the Federal standards to be set for the Exchanges and (2) to set up Exchanges in States that elect not to do so or are not substantially enforcing related provisions. Sections 2723 and 2761 of the PHS Act authorize HHS to enforce provisions that apply to non-Federal governmental plans and to enforce PHS Act provisions that apply to other health insurance coverage in States that HHS has determined are not substantially enforcing those provisions. The HIAD database will be maintained by the Office of Consumer Support Health Insurance Assistance Team (the Team) to assist the Office of Oversight with its compliance activities. HIAD is the primary tool through which the Team will track information for the purposes of oversight.

The primary purpose of this system is to collect and maintain information on consumer inquiries and complaints regarding insurance issuers that will permit CCIIO to exercise its direct enforcement authority over non-Federal governmental health plans, investigate any inquiries or complaints from enrollees of those plans, to determine which States may not be substantially enforcing the Affordable Care Act and PHS Act provisions and to determine whether complaints that indicate