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 (OIC: 0036–1101); 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.)

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.

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

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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 populations 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/