DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10232, CMS–10251, CMS–R–185, and CMS–R–211]

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 currently approved collection; *Title of Information Collection:* State Plan Template to Implement Section 6062 of the Deficit Reduction Act; *Form No.:* CMS–10232 (OMB#: 0938–1045); *Use:* The Deficit Reduction Act (DRA) provides States with numerous flexibilities in operating their State Medicaid Programs. Section 6062 of the DRA (Opportunity for families of Disabled Children to Purchase Medicaid Coverage for Such Children) provides States the opportunity to provide Medicaid benefits to disabled children who would otherwise be ineligible because of family income that is above the State's highest Medicaid eligibility standards for children. States must establish a State Plan for medical assistance to implement this provision. To do this, State Medicaid Agencies will complete the template. CMS will review the information to determine if the State has met all the requirements of the DRA provision; *Frequency:* Once; *Affected Public:* State, Federal, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 10; *Total Annual Hours:* 60. (For policy questions regarding this collection contact Barbara Washington at 410–786–9964. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Integrated Medicare and Medicaid State Plan Preprint; *Form No.:* CMS–10251 (OMB#: 0938–1047); *Use:* The Integrated Care Preprint is an optional tool for use by States to highlight the arrangements provided between the State and Medicare Advantage Special Needs Plans that are also providing Medicaid services. The preprint also provides the opportunity for States to confirm that their integrated care model complies with Federal statutory and regulatory requirements. State Medicaid Agencies may complete the preprint and CMS will review the information provided to determine if the State has properly completed and explained their integrated care arrangements and that the appropriate assurances have been met; *Frequency:* Once; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 10; *Total Annual Hours:* 200. (For policy questions regarding this collection contact Mary Pat Farkas at 410–786–5731. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* Extension of currently approved collection; *Title of Information Collection:* Granting and Withdrawal of Deeming Authority to Private Nonprofit Accreditation Organizations and of State Exemption Under State Laboratory Programs and Supporting Regulations; *Form No.:* CMS–R–185 (OMB#: 0938–0686); *Use:* The information required is necessary to determine whether a private accreditation organization/State licensure program standards and accreditation/licensure process is at least equal to or more stringent than those of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). If an accreditation organization is approved, the laboratories that it accredits are "deemed" to meet the CLIA requirements based on this accreditation. Similarly, if a State licensure program is determined to have requirements that are equal to or more stringent than those of CLIA, its laboratories are considered to be exempt from CLIA certification and requirements. The information collected will be used by HHS to: Determine comparability/equivalency of the accreditation organization standards and policies or State licensure program standards and policies to those of the CLIA program; to ensure the continued comparability/equivalency of the standards; and to fulfill certain statutory reporting requirements; *Frequency:* Occasionally; *Affected Public:* Private Sector: Business or other for-profits, Not-for-profit institutions; *Number of Respondents:* 8; *Total Annual Responses:* 96; *Total Annual Hours:* 384. (For policy questions regarding this collection contact Minnie Christian at 410–786–3339. For all other issues call 410–786–1326.)

4. *Type of Information Collection Request:* Revision of currently approved collection; *Title of Information Collection:* Model Application Template and Instructions for State Child Health Plan Under Title XXI of the Social Security Act, State Children's Health Insurance Program; *Form No.:* CMS–R–211 (OMB#: 0938–0707); *Use:* The information will be used to assess State plan performance and health outcomes and to evaluate the amount of substitute private coverage and the effect of subsidies on access to coverage; *Frequency:* Yearly, occasionally; *Affected Public:* State, Federal, or Tribal Governments; *Number of Respondents:* 40; *Total Annual Responses:* 40; *Total Annual Hours:* 3,200. (For policy questions regarding this collection contact Nancy Goetschius at 410–786–0707. For all other issues call 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 June 20, 2011.

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, *Fax Number:* (202) 395–6974, *E-mail: OIRA_submission@omb.eop.gov.*

Dated: May 16, 2011.

Martique Jones,

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

[FR Doc. 2011–12394 Filed 5–19–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5501–N]

Medicare Program; Pioneer Accountable Care Organization Model: Request for Applications

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

ACTION: Notice.

SUMMARY: This notice announces a request for applications for organizations to participate in the Pioneer Accountable Care Organization Model for a period beginning in 2011 and ending December 2016.

DATES: *Letter of Intent Submission Deadline:* Interested organizations must submit a nonbinding letter of intent by June 10, 2011 as described on the Innovation Center Web site *http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco.*

Application Submission Deadline: Applications must be received on or before July 19, 2011.

ADDRESSES: Applications should be submitted by mail to the following address by the date specified in the **DATES** section of this notice: Pioneer ACO Model, *Attention:* Maria Alexander, Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services, Mail Stop S3–13–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

FOR FURTHER INFORMATION CONTACT: *PioneerACO@cms.hhs.gov* for questions regarding the aspects of the Pioneer Accountable Care Organization Model or the application process.

SUPPLEMENTARY INFORMATION:

I. Background

We are committed to achieving the three-part aim of better health, better health care, and lower per-capita costs for Medicare, Medicaid, and Childrens' Health Insurance Program beneficiaries. One potential mechanism for achieving this goal is for CMS to partner with groups of health care providers of services and suppliers with a mechanism for shared governance that have formed an Accountable Care Organization (ACO) through which they work together to manage and coordinate care for a specified group of patients. We will pursue such partnerships through two complementary efforts—the Medicare Shared Savings Program and initiatives undertaken by the Center for Medicare and Medicaid Innovation (Innovation Center). The Pioneer ACO Model is an Innovation Center initiative targeted at organizations that can demonstrate the improvements in financial and clinical performance with respect to the care of Medicare beneficiaries that are possible in a mature ACO. To be eligible to participate in the Pioneer ACO Model, organizations would ideally already be coordinating care for a significant portion of patients under financial risk sharing contracts and be positioned to transform both their care and financial models from fee-for-service to a three-part aim, value based model. This notice provides a general overview of the Pioneer ACO Model. For more details see the request for application which is available on the Innovation Center Web site at *http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco.*

II. Provisions of the Notice

Consistent with its authority under section 1115A of the Social Security Act (of the Act), as added by section 3021 of the Affordable Care Act, to test innovative payment and service delivery models that reduce spending under Medicare, Medicaid, or CHIP, while preserving or enhancing the quality of care, the Innovation Center aims to achieve the following goals through implementation of the Pioneer ACO Model:

- Test a more rapid transition for providers from volume based FFS payments to payment for coordination and outcomes.
- Promote a diversity of successful ACOs, including physician-led ACOs and those serving indigent or rural populations.

This Model will test the effectiveness of a combination of the following:

- Payment arrangements that place a group of providers at joint risk for quality performance and financial performance for the majority of their patients and revenues (including non-Medicare patients and revenues). Such payment arrangements will require participants to transition from fee-for-service to population-based payment by the third performance year. We believe the payment arrangements being tested will provide more opportunities for rapid escalation of shared savings and risk compared to the Medicare Shared Savings Program.
- Technical support in the form of rapid data feedback and shared learning activities.
- Size and scope of testing: We expect to partner with approximately 30 organizations in the Model, with a minimum of 15,000 Medicare beneficiaries each (5,000 for rural ACOs). The application process and selection criteria are described in Section IV of the Request for Applications but in general, applications will be prioritized based on the strength of their care improvement plans, leadership, and commitment to outcomes-based contracts with non-Medicare purchasers. Final selection will be based on the strength of the application and interviews of finalists, together with other factors to promote representation of diverse geographic areas, types of organizations, and types of Medicare populations served.
- Population: ACOs will be accountable for all fee-for-service Medicare beneficiaries that CMS determines are aligned with them, and who have continuous enrollment in Parts A and B during baseline and performance periods, with emphasis on encouraging care of underserved populations and dual eligibles.
- Duration: Between 5 and 6 years (start third or fourth quarter of 2011 and end December 2016, which includes two 1-year optional periods).

III. Collection of Information Requirements

Section 1115A(d) of the Act waives the requirements of the Paperwork Reduction Act of 1995 for the Innovation Center for purposes of testing new payment and service delivery models.

Authority: Section 1115A of the Social Security Act.

Dated: March 10, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2011–12383 Filed 5–17–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

President's Committee for People With Intellectual Disabilities; Notice of Meeting

AGENCY: President's Committee for People with Intellectual Disabilities (PCPID), HHS.

ACTION: Notice of Quarterly Meeting.

DATES: Thursday, June 16, 2011, from 9:30 a.m. to 4 p.m. EST; and Friday, June 17, 2011, from 9 a.m. to 5 p.m. EST. The meeting will be open to the public.

ADDRESSES: The meeting will be held in Room 800 on the Penthouse Level of the Hubert H. Humphrey Building, U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Washington, DC 20201. Individuals who would like to participate via conference call may do so by dialing 888–323–9869, pass code: PCPID. Individuals who will need accommodations for a disability in order to attend the meeting (*e.g.,* sign language interpreting services, assistive listening devices, materials in alternative format