that such radiation doses may have endangered the health of members of this class. The Subcommittee for Dose Reconstruction Reviews was established to aid the Advisory Board in carrying out its duty to advise the Secretary, HHS, on dose reconstruction.

Matters to be Discussed: The agenda for the Subcommittee meeting includes: Selection of individual radiation dose reconstruction cases to be considered for review by the Procedures Subcommittee to evaluate the implementation of the Program Evaluation Report: OCAS–PER–012—Evaluation of Highly Insoluble Plutonium Compounds; discussion of dose reconstruction cases under review (sets 7–9); OCAS dose reconstruction quality management and assurance activities.

The agenda is subject to change as priorities dictate.

In the event an individual cannot attend, written comments may be submitted. Any written comments received will be provided at the meeting and should be submitted to the contact person below well in advance of the meeting.

Contact Person for More Information: Theodore Katz, Executive Secretary, NIOSH, CDC, 1600 Clifton Road, Mailstop E–20, Atlanta GA 30333, Telephone (513) 533–6800, Toll Free 1 (800) CDC–INFO, E-mail *ocas@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: March 21, 2011.

Elaine L. Baker,

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

[FR Doc. 2011–7075 Filed 3–24–11; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–1583–N]

Medicare Program; Solicitation of Two Nominations to the Advisory Panel on Ambulatory Payment Classification Groups

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

ACTION: Notice.

SUMMARY: This notice solicits nominations of two new members to the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel). There will be two vacancies on the Panel as of September 30, 2011.

The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary of the Department of Health and Human Services (DHHS), and the Administrator of the Centers for Medicare & Medicaid Services (CMS), concerning the clinical integrity of the APC groups and their associated weights.

The Secretary rechartered the Panel in 2010 for a 2-year period effective through November 21, 2012.

DATES: *Submission of Nominations:* We will consider nominations if they are received no later than 5 p.m. (e.s.t.) May 24, 2011.

ADDRESSES: Please mail or hand deliver nominations to the following address: Centers for Medicare & Medicaid Services; *Attn:* Paula Smith, Advisory Panel on APC Groups; Center for Medicare, Hospital & Ambulatory Policy Group, Division of Outpatient Care; 7500 Security Boulevard, Mail Stop C4–05–17; Baltimore, MD 21244–1850.

Web site: For additional information on the APC Panel and updates to the Panel's activities, we refer readers to view our Web site at the following: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.* (Use control + click the mouse in order to access the previous URL.) (**Note:** There is an UNDERSCORE after FACA/05_; there is no space.)

FOR FURTHER INFORMATION CONTACT:

Contact: Persons wishing to nominate individuals to serve on the Panel or to obtain further information may also contact Paula Smith at the following e-mail address: *APCPanel@cms.hhs.gov* or call 410–786–3985.

Advisory Committees' Information Lines: You may also refer to the CMS Federal Advisory Committee Hotlines at 1–877–449–5659 (toll-free) or 410–786–9379 (local) for additional information.

News Media: Representatives should contact the CMS Press Office at 202–690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary is required by section 1833(t)(9)(A) of the Social Security Act (the Act) to consult with an expert outside advisory panel regarding the clinical integrity of the APC groups and relative payment weights that are components of the Medicare Hospital Outpatient Prospective Payment System (OPPS).

The Charter requires that the Panel meet up to three times annually. CMS considers the technical advice provided by the Panel as we prepare the proposed and final rules to update the OPPS for the next calendar year.

The Panel may consist of a chair and up to 15 members who are full-time employees of hospitals, hospital systems, or other Medicare providers that are subject to the OPPS. (For purposes of the Panel, consultants or independent contractors are not considered to be full-time employees in these organizations.)

The current Panel members are as follows: (**Note:** The asterisk [*] indicates the Panel members whose terms end on September 30, 2011.)

- E. L. Hambrick, M.D., J.D., Chair, a CMS Medical Officer
- Ruth L. Bush, M.D., M.P.H.
- Kari S. Cornicelli, C.P.A., FHFMA
- Dawn L. Francis, M.D., M.H.S.
- Kathleen Graham, R.N., M.S.H.A.
- Patrick A. Grusenmeyer, Sc.D., FACHE *
- David A. Halsey, M.D.
- Brain D. Kavanagh, M.D., M.P.H.
- Judith T. Kelly, B.S.H.A., RHIT, RHIA, CCS
- Scott Manaker, M.D., PhD
- John Marshall, CRA, RCC, RT
- Agatha L. Nolan, D.Ph., M.S., FASHP *
- Randall A. Oyer, M.D.
- Daniel J. Pothen, M.S., RHIA, CHPS, CPHIMS, CCS, CCS–P, CHC
- Gregory J. Przbylski, M.D.
- Neville B. Sarkari, M.D., FACP

Panel members serve without compensation, according to an advance written agreement; however, for the meetings, CMS reimburses travel, meals, lodging, and related expenses in accordance with standard Government travel regulations. CMS has a special interest in attempting to ensure, while taking into account the nominee pool, that the Panel is diverse in all respects of the following: Geography; rural or urban practice; race, ethnicity, sex, and disability; medical or technical specialty; and type of hospital, hospital health system, or other Medicare provider subject to the OPPS.

Based upon either self-nominations or nominations submitted by providers or interested organizations, the Secretary, or his or her designee, appoints new members to the Panel from among those candidates determined to have the required expertise. New appointments are made in a manner that ensures a balanced membership under the guidelines of the Federal Advisory Committee Act.

II. Criteria for Nominees

The Panel must be fairly balanced in its membership in terms of the points of view represented and the functions to be performed. Each Panel member must

be employed full-time by a hospital, hospital system, or other Medicare provider subject to payment under the OPPS. All members must have technical expertise to enable them to participate fully in the Panel's work. Such expertise encompasses hospital payment systems; hospital medical care delivery systems; provider billing systems; APC groups; Current Procedural Terminology codes; and alpha-numeric Health Care Common Procedure Coding System codes; and the use of, and payment for, drugs, medical devices, and other services in the outpatient setting, as well as other forms of relevant expertise.

It is not necessary for a nominee to possess expertise in all of the areas listed, but each must have a minimum of 5 years experience and currently have full-time employment in his or her area of expertise. Generally, members of the Panel serve overlapping terms up to 4 years, based on the needs of the Panel and contingent upon the rechartering of the Panel.

Any interested person or organization may nominate one or more qualified individuals. Self-nominations will also be accepted. Each nomination must include the following:

- Letter of Nomination.
- Curriculum Vita of the nominee.
- Written statement from the nominee that the nominee is willing to serve on the Panel under the conditions described in this notice and further specified in the Charter.

III. Copies of the Charter

To obtain a copy of the Panel's Charter, submit a written request to Paula Smith at the address provided in the **ADDRESSES** section or by e-mail at APCPanel@cms.hhs.gov, or by telephone at 410–786–3985.

IV. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

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

Dated: March 10, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2011–6811 Filed 3–24–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier CMS–10373]

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

AGENCY: Center for Medicare and 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 and 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 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.

We are, however, requesting an emergency review of the information collection referenced below. In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have submitted to the Office of Management and Budget (OMB) the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR 1320(a)(2)(ii). This is necessary to ensure compliance with an initiative of the Administration.

1. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Medical Loss Ratio Quarterly Reporting; *Use:* Under Section 2718 of the Affordable Care Act and implementing regulations at 45 CFR part 158 (75 FR 74865, December 1, 2010), a health insurance issuer (issuer) offering group or individual health insurance coverage must submit a report to the Secretary concerning the amount the issuer spends each year on claims, quality improvement expenses, non-claims costs, Federal and State taxes and licensing or regulatory fees, and the amount of earned premium. An issuer must provide an annual rebate to enrollees if the amount it spends on certain costs compared to its premium revenue (excluding Federal and States taxes and licensing or regulatory fees) does not meet a certain ratio, referred to as the medical loss ratio (MLR). An interim final rule (IFR) implementing the MLR was published on December 1, 2010 (75 FR 74865), which added part 158 to Title 45 of the Code of Federal Regulations. The IFR is effective January 1, 2011. Issuers are required to submit annual MLR reporting data for each large group market, small group market, and individual market within each State in which the issuer conducts business. For policies that have a total annual limit of $250,000 or less (sometimes referred to as "mini-med plans") and for policies that primarily cover employees working outside the United States (referred to as "expatriate plans"), the IFR applies a special circumstance adjustment to the MLR data for the 2011 MLR reporting year. In order to evaluate the appropriateness of this special circumstance adjustment for years 2012 and beyond, issuers that provide such policies are required to submit quarterly MLR data to the Secretary for the 2011 MLR reporting year. *Form Number:* CMS–10373; *Frequency:* Quarterly submissions for each respondent; *Affected Public:* Private Sector: Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 75; *Number of Responses:* 1,125; *Total Annual Hours:* 70,200. (For policy questions regarding this collection, contact Carol Jimenez at (301) 492–4109. For all other issues call (410) 786–1326.)

CMS is requesting OMB review and approval of this collection by *May 1, 2011,* with a 180-day approval period. Written comments and recommendations will be considered from the public if received by the individuals designated below by *April 25, 2011.*

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site address at *http://www.cms.hhs.gov/regulations/pra* 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 on (410) 786–1326.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of information requirements. However, as noted above, comments on these