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

information collection and recordkeeping requirements must be mailed and/or faxed to the designees referenced below by April 25, 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.

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

Dated: March 18, 2011.

Martique Jones,

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

[FR Doc. 2011–7106 Filed 3–24–11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier CMS–370, CMS–377, CMS–378; CMS–10145, CMS–10362, CMS–10384, CMS–10342 and CMS–10338]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers 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 & Medicaid Services (CMS) 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.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Titles of Information Collection:* (CMS–370) Health Insurance Benefits Agreement, (CMS–377) ASC Request for Certification or Update of Certification Information in the Medicare Program, and (CMS–378) Ambulatory Surgical Center (ASC) Survey Report Form; *Use:* CMS–370 has not been revised and will continue to be used to establish eligibility for payment under Title XVIII of the Social Security Act (the "Act"). As revised, CMS–377 will be used to collect facility-specific characteristics that facilitate CMS' oversight of ASCs. The data also enables CMS to respond to inquiries from the Congress, GAO, and the OIG concerning the characteristics of Medicare-participating ASCs. The data base that supports survey and certification activities will be revised to reflect changes in the data fields on this revised form, such as the data on the types of surgical procedures performed in the ASC. CMS–378 will be discontinued since it duplicates information collected by other means; *Form Numbers:* CMS–370, –377 and –378 (OCN: 0938–0266); *Frequency:* Occasionally (initially an then every three years); *Affected Public:* Private Sector: Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 7,213; *Total Annual Responses:* 1,795; *Total Annual Hours:* 648. (For policy questions regarding this collection contact Gail Vong at 410–786–0787. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Medicare Part B Drug and Biological Competitive Acquisition Program (CAP) and Supporting Regulations in 42 CFR Sections 414.906, 414.908, 414.910, 414.914, 414.916, and 414.917; *Use:* Section 303(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides an alternative payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. In particular, Section 303(d) of the MMA amends Title XVIII of the Social Security Act by adding a new section 1847B, which establishes a competitive acquisition program for the acquisition of and payment for Part B covered drugs and biologicals furnished on or after January 1, 2006. Since its inception, additional legislation has augmented the CAP. Section 108 of the Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief Health Care Act of 2006 (MIEA–TRHCA) amended Section 1847b(a)(3) of the Social Security Act and requires that CAP implement a post payment review process. This procedure is done to assure that payment is made for a drug or biological under this section only if the drug or biological has been administered to a beneficiary. *Form Number:* CMS–10145 (OCN: 0938–0945); *Frequency:* Weekly, quarterly and occasionally; *Affected Public:* Private sector—Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 3000; *Total Annual Responses:* 156,020; *Total Annual Hours:* 31,208.

3. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Autism Spectrum Disorders (ASD): State of the States Services and Supports for People with ASD; *Use:* The information that is collected in the interviews will be used to communicate additional information about services available to people with ASD and the public policy issues that affect people with ASD to key stakeholder audiences. The format of the report will include data tables from various state programs and narrative about the data being presented based on the interviews with state agency staff. We propose interviewing multiple staff in each state because several state agencies have an impact on services and supports for people with ASD; *Form Number:* CMS–10362 (OCN: 0938–New); *Frequency:* Once; *Affected Public:* State, local, or Tribal Governments; *Number of Respondents:* 459; *Total Annual Responses:* 459; *Total Annual Hours:* 803. (For policy questions regarding this collection contact Ellen Blackwell at 410–786–4498. For all other issues call 410–786–1326.)

4. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Health Insurance Assistance Database; *Use:* In October 2010, the Office of Consumer Support began to take and respond to direct consumer inquiries related to the Affordable Care Act. As of February 15th 2011, CCIIO has received 906 consumer inquiries. Consumer inquiries continue to come in to CCIIO at a rate of 30 to 35 inquiries per week. Starting in January 2011, the HHS Hotline will begin to refer ACA calls to CCIIO. To date, the HHS Hotline receives, on average, 400 calls per month pertaining to ACA.

Accordingly, a system to collect, track and store consumer information is urgently needed in order to accomplish