Director of the Agency for Healthcare Research and Quality (AHRQ) on matters related to activities of the Agency to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.

Seven current members' terms will expire in November 2015. To fill these positions, we are seeking individuals who are distinguished in: (1) The conduct of research, demonstration projects, and evaluations with respect to health care; (2) the fields of health care quality research or health care improvement; (3) the practice of medicine; (4) other health professions; (5) representing the private health care sector (including health plans, providers, and purchasers) or administrators of health care delivery systems; (6) the fields of health care economics, information systems, law, ethics, business, or public policy; and, (7) representing the interests of patients and consumers of health care. 42 U.S.C. 299c(c)(2). Individuals are particularly sought with experience and success in activities specified in the summary above.

**DATES:** Nominations should be received on or before 60 days after date of publication.

**ADDRESSES:** Nominations should be sent to Ms. Karen Brooks, AHRQ, 540 Gaither Road, Room 3006, Rockville, Maryland 20850. Nominations may also be emailed to *Karen.Brooks@ahrq.hhs.gov*.

**FOR FURTHER INFORMATION CONTACT:** Jaime Zimmerman, AHRQ, at (301) 427–1456.

**SUPPLEMENTARY INFORMATION:** 42 U.S.C. 299c provides that the Secretary shall appoint to the National Advisory Council for Healthcare Research and Quality twenty one appropriately qualified individuals. At least seventeen members shall be representatives of the public and at least one member shall be a specialist in the rural aspects of one or more of the professions or fields listed in the above summary. In addition, the Secretary designates, as ex officio members, representatives from other Federal agencies, principally agencies that conduct or support health care research, as well as Federal officials the Secretary may consider appropriate. 42 U.S.C. 299c(c)(3). The Council meets in the Washington, DC, metropolitan area, generally in Rockville, Maryland, approximately three times a year to provide broad guidance to the Secretary and AHRQ's Director on the direction of and programs undertaken by AHRQ.

Seven individuals will be selected by the Secretary to serve on the Council beginning with the meeting in the spring of 2016. Members generally serve 3-year terms. Appointments are staggered to permit an orderly rotation of membership.

Interested persons may nominate one or more qualified persons for membership on the Council. Self-nominations are accepted. Nominations shall include: (1) A copy of the nominee's resume or curriculum vitae; and (2) a statement that the nominee is willing to serve as a member of the Council. Selected candidates will be asked to provide detailed information concerning their financial interests, consultant positions and research grants and contracts, to permit evaluation of possible sources of conflict of interest. Please note that once a candidate is nominated, AHRQ may consider that nomination for future positions on the Council. Federally registered lobbyists are not permitted to serve on this advisory board pursuant to the Presidential Memorandum entitled ''Lobbyists on Agency Boards and Commissions'' dated June 10, 2010, and the Office of Management and Budget's ''Final Guidance on Appointment of Lobbyists to Federal Boards and Commissions,'' 76 FR 61756 (October 5, 2011).

The Department seeks a broad geographic representation. In addition, AHRQ conducts and supports research concerning priority populations, which include: low-income groups; minority groups; women; children; the elderly; and individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care. See 42 U.S.C. 299(c). Nominations of persons with expertise in health care for these priority populations are encouraged.

**Sharon B. Arnold,**

*Deputy Director.*

[FR Doc. 2015–10983 Filed 5–6–15; 8:45 am]

**BILLING CODE 4160–90–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Agency for Healthcare Research and Quality

### Agency Information Collection Activities: Proposed Collection; Comment Request

**AGENCY:** Agency for Healthcare Research and Quality, HHS.

**ACTION:** Notice.

**SUMMARY:** This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed changes to the currently approved information collection project: *''Medical Expenditure Panel Survey—Insurance Component.''* In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the **Federal Register** on February 18th, 2015 and allowed 60 days for public comment. No comments were received. The purpose of this notice is to allow an additional 30 days for public comment.

**DATES:** Comments on this notice must be received by June 8, 2015.

**ADDRESSES:** Written comments should be submitted to: AHRQ's OMB Desk Officer by fax at (202) 395–6974 (attention: AHRQ's desk officer) or by email at *OIRA_submission@omb.eop.gov* (attention: AHRQ's desk officer).

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

**FOR FURTHER INFORMATION CONTACT:** Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427–1477, or by email at *doris.lefkowitz@AHRQ.hhs.gov.*

**SUPPLEMENTARY INFORMATION:**

**Proposed Project**

*Medical Expenditure Panel Survey—Insurance Component*

Employer-sponsored health insurance is the source of coverage for 78 million current and former workers, plus many of their family members, and is a cornerstone of the U.S. health care system. The Medical Expenditure Panel Survey—Insurance Component (MEPS–IC) measures on an annual basis the extent, cost, and coverage of employer-sponsored health insurance. These statistics are produced at the National, State, and sub-State (metropolitan area) level for private industry. Statistics are also produced for State and local governments. The MEPS–IC was last approved by OMB on November 21, 2013 and will expire on November 30, 2016. The OMB control number for the MEPS–IC is 0935–0110. All of the supporting documents for the current MEPS–IC can be downloaded from OMB's Web site at *http://www.reginfo.gov/public/do/*

*PRAViewDocument?ref_nbr=201310-0935-001.*

In order to ensure that the MEPS–IC is able to capture important changes in the employer-sponsored health insurance market due to the implementation of the Patient Protection and Affordable Care Act (ACA), AHRQ will field a longitudinal survey in 2015 to include a sample of 5,000 small private sector employers that responded to the 2014 MEPS–IC. The OMB clearance that was approved on November 21, 2013 included the 2014 longitudinal survey, a survey of 3,000 respondents to the 2013 MEPS–IC, but did not include the 2015 longitudinal survey. This submission is for the 2015 longitudinal survey only; there are no other changes.

This research has the following goals:

(1) Provide data for Federal policymakers evaluating the effects of National and State health care reforms.

(2) Provide descriptive data on the current employer-sponsored health insurance system and data for modeling the differential impacts of proposed health policy initiatives.

(3) Supply critical State and National estimates of health insurance spending for the National Health Accounts and Gross Domestic Product.

(4) Support evaluation of the impact on health insurance offered by small employers due to the implementation of Small Business Health Options Program (SHOP) exchanges under the ACA, through the addition of a longitudinal component to the sample.

The MEPS–IC is conducted pursuant to AHRQ's statutory authority to conduct surveys to collect data on the cost, use and quality of health care, including the types and costs of private insurance. 42 U.S.C. 299b–2(a).

**Method of Collection**

To achieve the goals of this project for both private sector and state and local government employers, the following data collections will be implemented:

(1) Prescreener Questionnaire—The purpose of the Prescreener Questionnaire, which is collected via telephone, varies depending on the insurance status of the establishment contacted. (Establishment is defined as a single, physical location in the private sector and a governmental unit in state and local governments.) For establishments that do not offer health insurance to their employees, the prescreener is used to collect basic information such as number of employees via a phone call. For establishments that do offer health insurance, the prescreener is used to collect contact names and address information is that are used to mail a written establishment and plan questionnaires. Obtaining this contact information helps ensure that the questionnaires are directed to the person best equipped to complete them.

(2) Establishment Questionnaire—The purpose of the mailed Establishment Questionnaire is to obtain general information from employers who provide health insurance to their employees. The Questionnaire collects such information as total active enrollment in health insurance, other employee benefits offered, demographic characteristics of employees, and retiree health insurance.

(3) Plan Questionnaire—The purpose of the mailed Plan Questionnaire is to collect plan-specific information on each plan (up to four) offered by establishments that provide health insurance to their employees. This questionnaire asks about total premiums, employer and employee contributions to the premium, and plan enrollment for each type of coverage offered—single, employee-plus-one, and family—within a plan. It also asks for information on deductibles, copays, and other plan characteristics.

(4) Longitudinal Sample (LS)—For 2015, an additional sample of small employers (those with 100 or fewer employees) will be included in the collection. The LS will consist of 5,000 small, private-sector employers who responded to the 2014 MEPS–IC regular survey. These employers will be surveyed again in 2015—using the same collection methods as the regular survey—in order to track changes in their health insurance offerings, characteristics, and costs.

The primary objective of the MEPS–IC is to collect information on employer-sponsored health insurance. Such information is needed in order to provide the tools for Federal, State, and academic researchers to evaluate current and proposed health policies and to support the production of important statistical measures for other Federal agencies.

**Estimated Annual Respondent Burden**

Exhibit 1 shows the estimated annualized burden hours for the respondent's time to provide the requested data for the 2015 longitudinal survey. The Prescreener questionnaire will be completed by 4,300 respondents and takes about 5½ minutes to complete. The Establishment questionnaire will be completed by 2,054 respondents and takes about 23 minutes to complete. The Plan questionnaire will be completed by 2,054 respondents and will require an average of 1.4 responses per respondent. Each Plan questionnaire takes about 11 minutes to complete. The total burden hours are estimated to be 1,686 hours.

Exhibit 2 shows the estimated annualized cost burden associated with the respondents' time to participate in this data collection. The annualized cost burden is estimated to be $52,709.

EXHIBIT 1—ESTIMATED BURDEN HOURS FOR THE 2015 LONGITUDINAL SURVEY

| Form name | Number of respondents | Number of responses per respondent | Hours per response | Total burden hours |
|---|---|---|---|---|
| Prescreener Questionnaire | 4,326 | 1 | 0.09 | 389 |
| Establishment Questionnaire | 2,078 | 1 | 0.38* | 790 |
| Plan Questionnaire | 2,078 | 1.4 | 0.18 | 524 |
| Total | 8,482 | na | na | 1,703 |

*The burden estimate printed on the establishment questionnaire is 45 minutes which includes the burden estimate for completing the establishment questionnaire, an average of 1.4 plan questionnaires, plus the prescreener. The establishment and plan questionnaires are sent to the respondent as a package and are completed by the respondent at the same time.

EXHIBIT 2—ESTIMATED COST BURDEN FOR THE 2015 LONGITUDINAL SURVEY

| Form name | Number of respondents | Total burden hours | Average hourly wage rate* | Total cost burden |
|---|---|---|---|---|
| Prescreener Questionnaire | 4,326 | 389 | $30.95 | $12,040 |
| Establishment Questionnaire | 2,078 | 790 | 30.95 | 24,451 |
| Plan Questionnaire | 2,078 | 524 | 30.95 | 16,218 |
| Total | 8,482 | 1,703 | na | $52,709 |

*Based upon the mean hourly wage for Compensation, Benefits, and Job Analysis Specialists occupation code 13–1141, at *http://www.bls.gov/oes/current/oes131141.htm* (U.S. Department of Labor, Bureau of Labor Statistics.)

**Request for Comments**

In accordance with the Paperwork Reduction Act, comments on AHRQ's information collection are requested with regard to any of the following: (a) whether the proposed collection of information is necessary for the proper performance of AHRQ health care research and information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: April 27, 2015.

**Sharon B. Arnold,**

*Deputy Director, AHRQ.*

[FR Doc. 2015–10981 Filed 5–6–15; 8:45 am]

**BILLING CODE 4160–90–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[CMS–1623–N]**

### Medicare Program; Public Meeting on July 16, 2015 Regarding New and Reconsidered Clinical Diagnostic Laboratory Test Codes for the Clinical Laboratory Fee Schedule for Calendar Year 2016

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

**ACTION:** Notice.

**SUMMARY:** This notice announces a public meeting to receive comments and recommendations (including accompanying data on which recommendations are based) from the public on the appropriate basis for establishing payment amounts for new or substantially revised Healthcare Common Procedure Coding System (HCPCS) codes being considered for Medicare payment under the clinical laboratory fee schedule (CLFS) for calendar year (CY) 2016. This meeting also provides a forum for those who submitted certain reconsideration requests regarding final determinations made last year on new test codes and for the public to provide comment on the requests.

**DATES:** *Meeting Date:* The public meeting is scheduled for Thursday, July 16, 2015 from 9:00 a.m. to 3:00 p.m., Eastern Daylight Savings Time.

*Deadline for Registration of Presenters and Submission of Presentations:* All presenters for the public meeting must register and submit their presentations electronically to Glenn McGuirk at *Glenn.McGuirk@cms.hhs.gov* by July 2, 2015.

*Deadline for Submitting Requests for Special Accommodations:* Requests for special accommodations must be received no later than 5:00 p.m. on July 2, 2015.

*Deadline for Submission of Written Comments:* We intend to publish our proposed determinations for new test codes and our preliminary determinations for reconsidered codes (as described below) for CY 2016 by early September 2015. Interested parties may submit written comments on these determinations by early October, 2015 to the address specified in the **ADDRESSES** section of this notice or electronically to Glenn McGuirk at *Glenn.McGuirk@cms.hhs.gov* (the specific date for the publication of these determinations on the CMS Web site, as well as the deadline for submitting comments regarding these determinations will be published on the CMS Web site).

**ADDRESSES:** The public meeting will be held in the main auditorium of the Centers for Medicare & Medicaid Services (CMS), Central Building, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

**FOR FURTHER INFORMATION CONTACT:** Glenn McGuirk, (410) 786–5723.

**SUPPLEMENTARY INFORMATION:**

**I. Background**

Section 531(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) requires the Secretary of the Department of Health and Human Services (the Secretary) to establish procedures for coding and payment determinations for new clinical diagnostic laboratory tests under Part B of title XVIII of the Social Security Act (the Act) that permit public consultation in a manner consistent with the procedures established for implementing coding modifications for International Classification of Diseases (ICD–9–CM). The procedures and public meeting announced in this notice for new tests are in accordance with the procedures published on November 23, 2001 in the **Federal Register** (66 FR 58743) to implement section 531(b) of BIPA.

Section 942(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) added section 1833(h)(8) of the Act. Section 1833(h)(8)(A) of the Act requires the Secretary to establish by regulation procedures for determining the basis for, and amount of, payment for any clinical diagnostic laboratory test with respect to which a new or substantially revised Healthcare Common Procedure Coding System (HCPCS) code is assigned on or after January 1, 2005 (hereinafter referred to as ''new tests''). A code is considered to be substantially revised if there is a substantive change to the definition of the test or procedure to which the code applies (such as, a new analyte or a new methodology for measuring an existing analyte-specific test). (See section 1833(h)(8)(E)(ii) of the Act).