Status: Open to the public, but without a public comment period. To access by conference call dial the following information 1(866)659–0537, Participant Pass Code 9933701.

Background: The Advisory Board was established under the Energy Employees Occupational Illness Compensation Program Act of 2000 to advise the President on a variety of policy and technical functions required to implement and effectively manage the new compensation program. Key functions of the Advisory Board include providing advice on the development ofprobability of causation guidelines that have been promulgated by the Department of Health and Human Services (HHS) as a final rule; advice on methods of dose reconstruction which have also been promulgated by HHS as a final rule; advice on the scientific validity and quality of dose estimation and reconstruction efforts being performed for purposes of the compensation program; and advice on petitions to add classes of workers to the Special Exposure Cohort (SEC).

In December 2000, the President delegated responsibility for funding, staffing, and operating the Advisory Board to HHS, which subsequently delegated this authority to CDC. NIOSH implements this responsibility for CDC. The charter was issued on August 3, 2001, renewed at appropriate intervals, and will expire on August 3, 2009.

Purpose: The Advisory Board is charged with (a) Providing advice to the Secretary, HHS, on the development of guidelines under Executive Order 13179; (b) providing advice to the Secretary, HHS, on the scientific validity and quality of dose reconstruction efforts performed for this program; and (c) upon request by the Secretary, HHS, advise the Secretary on whether there is a class of employees at any Department of Energy facility who were exposed to radiation but for whom it is not feasible to estimate their radiation dose, and on whether there is reasonable likelihood 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 a discussion of cases under review from the 6th, 7th, and 8th sets of individual dose reconstructions; and selection of cases for future review.

The agenda is subject to change as priorities dictate.

ABRWH determines that agency business requires its consideration of this matter on less than 15 days notice to the public and that no earlier notice of this meeting was possible.

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 personbelow well in advance of the meeting.

Contact Person for More Information: Christine Branche, Ph.D., Executive Secretary, NIOSH, CDC, 395 E. Street, SW., Suite 9200, Washington, DC 20201, 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 CDC and the Agency for Toxic Substances and Disease Registry.

Dated: August 11, 2008.

Lorenzo J. Falgiano,

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

[FR Doc. E8–18904 Filed 8–14–08; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10260 and CMS–10256]

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:* New collection; *Title of Information Collection:* Medicare Advantage (MA) Disclosure Requirements; *Use:* The information collection requirements are mandated by 42 CFR 422.111 and 422.80. MA organizations will be required to notify plan members of the coming year's changes using a combined standardized document. MA organizations and potential MA organizations (applicants) will use the information to comply with the eligibility requirements and the MA contract requirements. CMS will use this information to ensure that correct information is disclosed to Medicare beneficiaries, both potential enrollees and enrollees. *Form Number:* CMS–10260 (OMB# 0938–New); *Frequency:* Yearly; *Affected Public:* Business or other for-profit; *Number of Respondents:* 670; *Total Annual Responses:* 670; *Total Annual Hours:* 8040.

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Medicare Care Management performance (MCMP) Demonstration; *Use:* Section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Secretary of the U.S. Department of Health and Human Services to establish a pay-for-performance (P4P) demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology (HIT) and evidence-based outcome measures. The Medicare Care Management Performance Demonstration was established in response to the MMA. Mathematica Policy Research, Inc. is conducting an evaluation of the MCMP on behalf of CMS. The goals of the three-year demonstration are to improve quality of care to eligible fee-for-service Medicare beneficiaries and encourage the implementation and use of HIT. The specific objectives are to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes. The MMA authorizes a total of four sites in both urban and rural areas. The demonstration sites are in Arkansas, California, Massachusetts, and Utah. The MCMP demonstration will target practices serving at least 50 traditional fee-for-service Medicare beneficiaries with congestive heart failure, coronary heart disease, and diabetes for whom they provide primary care.

An impact analysis using a comparison group design will be conducted as part of the evaluation. Physician practices in selected non-demonstration States that match most closely those in demonstration States on key factors will make up the comparison group. The impact analysis will use data from four data sources: (1) A beneficiary survey, (2) a physician survey, (3) Medicare claims and eligibility data, and (4) practice-specific data. This request relates to the two surveys. *Form Number:* CMS–10256 (OMB# 0938–New); *Frequency:* Once; *Affected Public:*

Business or other for-profits, and Individual and households; *Number of Respondents:* 6,400; *Total Annual Responses:* 6,400; *Total Annual Hours:* 1,472.

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/PaperworkReductionActof1995,* 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.

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 *September 15, 2008.* OMB Human Resources and Housing Branch, *Attention:* OMB Desk Officer, New Executive Office Building, Room 10235, Washington, DC 20503, *Fax Number:* (202) 395–6974.

Dated: August 7, 2008.

Michelle Shortt,

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

[FR Doc. E8–18957 Filed 8–14–08; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–4040 and 4040SP, CMS–R–10, CMS–10130A and 10130B, and CMS–R–257]

Agency Information Collection Activities: Proposed Collection; 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) 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:* Extension of a currently approved collection; *Title of Information Collection:* Request for Enrollment in Supplementary Medical Insurance; *Use:* Section 1836 of the Social Security Act and 42 CFR 407.10 provide the eligibility requirements for enrollment in Supplementary Medical Insurance (Part B) for individuals age 65 and older who are not entitled to premium-free Hospital Insurance (Part A). The form CMS–4040 is used to establish entitlement to Part B by individuals ineligible for Part A under Title XVIII of the Social Security Act. *Form* Number: CMS–4040 and 4040SP (OMB# 0938–0245); *Frequency:* Once; *Affected Public:* Individuals and households; *Number of Respondents:* 10,000; *Total Annual Responses:* 10,000; *Total Annual Hours:* 2,500.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* BPD–718: Advance Directives (Medicare and Medicaid); *Use:* Steps have been taken at both the Federal and State level to afford greater opportunity for the individual to participate in decisions made concerning the medical treatment to be received by an adult patient in the event that the patient is unable to communicate to others a preference about medical treatment. The individual may make his preference known through the use of an advance directive, which is a written instruction prepared in advance, such as a living will or durable power of attorney. This information is documented in a prominent part of the individual's medical record. Advance directives as described in the Patient Self-Determination Act have increased the individual's control over decisions concerning medical treatment. The advance directives requirement was enacted because Congress wanted individuals to know that they have a right to make health care decisions and to refuse treatment even when they are unable to communicate. Sections 4206 of OBRA '90 defined an advance directive as a written instruction recognized under State law relating to the provision of health care when an individual is incapacitated (those persons unable to communicate their wishes regarding medical treatment).

All states have enacted legislation defining a patient's right to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Participating hospitals, skilled nursing facilities/nursing facilities, home health agencies, providers of home health care, hospices, religious nonmedical health care institutions, and prepaid or eligible organizations (including Health Care Prepayment Plans (HCPPs) and Medicare Advantage Organizations (MAOs) such as Coordinated Care Plans, Demonstration Projects, Chronic Care Demonstration Projects, Program of All Inclusive Care for the Elderly, Private Fee for Service, and Medical Savings Accounts must provide written information, at explicit time frames, to all adult individuals about: (a) The right to accept or refuse medical or surgical treatments; (b) the right to formulate an advance directive; (c) a description of applicable State law (provided by the State); and (d) the provider's or organization's policies and procedures for implementing an advance directive. *Form Number:* CMS–R–10 (OMB# 0938–0610); *Frequency:* Yearly; *Affected Public:* Business or other for-profits; *Number of Respondents:* 35,484; *Total Annual Responses:* 19,870,000; *Total Annual Hours:* 927,550.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA): ''Section 1011 Provider Payment Determination'' and ''Request for Section 1011 Hospital On-Call Payments to Physicians'' Forms; *Use*: Section 1011 of the MMA requires that the Secretary establish a process under which eligible providers (certain hospitals, physicians and ambulance providers) may request payment for (claim) their otherwise un-reimbursed costs of providing eligible services. The Secretary must make quarterly payments directly to such providers. The Secretary must also implement measures to ensure that inappropriate, excessive, or fraudulent payments are not made under Section 1011, including certification by providers of the accuracy of their requests for payment. The Section 1011 Provider Payment Determination and the Request for Section 1011 Hospital On-Call Payments to Physicians forms have been established to address the statutory requirements. *Form Number:* CMS–10130A and 10130B (OMB# 0938–0952); *Frequency:* Daily, Weekly,