more accurately measure health spending. Although panelists are not limited in the topics they may discuss, the Panel is not expected to discuss or recommend changes in current or future Medicare provider payment rates or coverage policy.

*Meeting Dates:* December 13, 2010, 9:30 a.m. to 5 p.m. and December 14, 2010, 8:30 a.m.–1 p.m. *e.t.*

**ADDRESSES:** The meeting will be held at HHS Centers for Medicare and Medicaid Services headquarters located at 7500 Security Blvd., Baltimore, Maryland 21244, Conference Room B.

*Comments:* The meeting will allocate time on the agenda to hear public comments. In lieu of oral comments, formal written comments may be submitted for the record to Donald T. Oellerich, OASPE, 200 Independence Ave., SW., 20201, Room 405F. Those submitting written comments should identify themselves and any relevant organizational affiliations.

**FOR FURTHER INFORMATION CONTACT:** Donald T. Oellerich (202) 690–8410, *Don.oellerich@hhs.gov.* **Note:** Although the meeting is open to the public, procedures governing security procedures and the entrance to Federal buildings may change without notice. Those wishing to attend the meeting must call or e-mail Dr. Oellerich by Thursday, December 9, 2010, so that their name may be put on a list of expected attendees and forwarded to the security officers at HHS Headquarters.

**SUPPLEMENTARY INFORMATION:** *Topics of the Meeting:* The Panel is specifically charged with discussing and possibly making recommendations to the Medicare Trustees on how the Trustees might more accurately estimate the long term rate of health spending in the United States. The discussion is expected to focus on highly technical aspects of estimation involving economics and actuarial science. Panelists are not restricted, however, in the topics that they choose to discuss.

Procedure and Agenda: This meeting is open to the public. The Panel will likely hear presentations from Medicare public trustees on issues they wish the panel to address. This may be followed by HHS staff presentations regarding long range growth. After any presentations, the Panel will deliberate openly on the topic. Interested persons may observe the deliberations, but the Panel will not hear public comments during this time. The Panel will also allow an open public session for any attendee to address issues specific to the topic.

**Authority:** 42 U.S.C. 217a; Section 222 of the Public Health Services Act, as amended. The panel is governed by provisions of Public Law 92–463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees.

Dated: December 2, 2010.

**Sherry Glied,**

*Assistant Secretary for Planning and Evaluation.*

[FR Doc. 2010–30838 Filed 12–7–10; 8:45 am]

**BILLING CODE P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

**[60Day–11–0679]**

### Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–5960 or send comments to Carol E. Walker, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS D–74, Atlanta, GA 30333 or send an e-mail to *omb@cdc.gov.*

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection 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 through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

**Proposed Project**

Division of Heart Disease and Stroke Prevention Management Information System—Revision—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

*Background and Brief Description*

CDC's Division of Heart Disease and Stroke Prevention (DHDSP) is currently approved to collect progress and activity information from awardees funded through two programs: The National Heart Disease and Stroke Prevention Program (NHDSPP), and the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program. Information is collected semi-annually through an electronic Management Information System (MIS). The current approval is scheduled to expire 5/31/2011 (OMB No. 0920–0679).

CDC plans to request OMB approval to continue information collection, with changes, for three years. A net reduction in the number of respondents will result in a net reduction in burden hours. Although there will be an increase in the number of state-based heart disease and stroke prevention (HDSP) programs funded through the NHDSPP, reporting requirements involving the MIS will be discontinued for awardees funded through the WISEWOMAN program. No changes are proposed to the information collection instrument, the burden per response, or the frequency of information collection.

In 1998, Congress provided CDC with initial funding to establish the NHDSPP, authorized under sections 301(a) and 317b(k)(2) of the Public Health Service (PHS) Act [42 U.S.C. 241(a) and 247b(k)(2)], as amended. The program currently supports population-based heart disease and stroke prevention efforts in selected States and the District of Columbia. As funding allows, CDC's strategic plan calls for expanding the program to health departments in all U.S. States and territories. CDC works with HDSP program awardees to implement and evaluate evidence-based public health prevention and control strategies that address risk factors and reduce disparities, disease, disability, and death from heart disease and stroke. Awardees are encouraged to work at the highest levels within priority environments to change policies and systems that will improve cardiovascular outcomes.

All HDSP program awardees are required to submit continuation applications and semi-annual progress reports to CDC. The DHDSP MIS provides a standardized, electronic interface for the collection of this progress information, which includes work plans, objectives, partners, data sources, and policy and environmental assessments. The MIS also produces both state-specific and aggregate reports that are used for performance

monitoring, program evaluation, and technical assistance. The monitoring and evaluation plan for the HDSP program is part of an overall initiative within CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) to promote more efficient ways of using resources and achieving greater health impact. CDC plans to increase the number of HDSP awardees reporting through the MIS from 33 to 42.

CDC will discontinue approval to use the DHDSP MIS for collecting information from WISEWOMAN program awardees. The WISEWOMAN program is a demonstration program that extends cardiovascular disease-related services to a subset of women who also receive services through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Although approval was obtained to use the DHDSP MIS for collecting progress and activity information from WISEWOMAN awardees, the information collection was not implemented due to a change in plans for monitoring these awardees. The current WISEWOMAN data collection is described in OMB No. 0920–0612 (WISEWOMAN Reporting System, exp. 3/31/2013).

CDC will continue to use the information collected through the DHDSP MIS to identify state-specific heart disease and stroke prevention priorities and objectives, and to describe the impact and reach of program interventions. Respondents will be 42 health departments in 41 States and the District of Columbia (DC). Respondents will continue to submit their progress and activity information to CDC semi-annually. The estimated burden per response is six hours. There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

| Respondents | Number of respondents | Number of responses per respondent | Average burden per response (in hours) | Total burden (in hours) |
|---|---|---|---|---|
| State-Based HDSP Programs | 42 | 2 | 6 | 504 |

Dated: December 2, 2010.

**Carol Walker,**

*Acting Reports Clearance Officer, Centers for Disease Control and Prevention.*

[FR Doc. 2010–30764 Filed 12–7–10; 8:45 am]

**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

**[60 Day–11–0770]**

### Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–5960 or send comments to Carol Walker, Acting CDC Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail to *omb@cdc.gov.*

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection 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 through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

**Proposed Project**

National HIV Behavioral Surveillance System (NHBS) (OMB no. 0920–0770, exp. 03/31/2011)—Extension—National Center for HIV, Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

*Background and Brief Description*

The purpose of this data collection is to monitor behaviors related to Human Immunodeficiency Virus (HIV) infection among persons at high risk for infection in the United States. The primary objectives of the NHBS system are to obtain data from samples of persons at risk to: (a) Describe the prevalence and trends in risk behaviors; (b) describe the prevalence of and trends in HIV testing and HIV infection; (c) describe the prevalence of and trends in use of HIV prevention services; (d) identify met and unmet needs for HIV prevention services in order to inform health departments, community based organizations, community planning groups and other stakeholders.

This project addresses the goals of the National HIV/AIDS Strategy for the United States, which calls for State and local health departments to monitor progress towards the national goal of reducing new HIV infections by 25% by 2015. NHBS contributes to this national goal by describing and monitoring the HIV risk behaviors, HIV seroprevalence and incidence, and HIV prevention experiences of persons at highest risk for HIV infection.

The Centers for Disease Control and Prevention request approval for a 3-year extension for the previously approved National HIV Behavioral Surveillance System (NHBS), OMB number 0920–0770, which expires 03/31/2011. Data are collected through anonymous, in-person interviews conducted with persons systematically selected from 25 Metropolitan Statistical Areas (MSAs) throughout the United States; these 25 MSAs were chosen based on having high AIDS prevalence. Persons at risk for HIV infection to be interviewed for NHBS include men who have sex with men (MSM), injecting drug users (IDU), and heterosexuals at increased risk of HIV (HET). A brief screening interview will be used to determine eligibility for participation in the behavioral assessment.

The data from the behavioral assessment will provide frequency estimates of behavior related to the risk of HIV and other sexually transmitted diseases, prior testing for HIV, and use of HIV prevention services. All persons interviewed will also be offered an HIV test, and will participate in a pre-test counseling session. No other Federal agency systematically collects this type of information from persons at risk for HIV infection. These data will have a