duration of the survey is estimated to be 20 minutes.

Participation is voluntary. There is no cost to the respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of data collection	Number of respondents	Average number of responses per respondent	Average burden per response (hours)	Total burden (hours)
Clinic Patient Survey	450	1	20/60	150

Dated: June 9, 2008.

Maryam I. Daneshvar,

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

[FR Doc. E8–13317 Filed 6–12–08; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Board of Scientific Counselors, National Center for Environmental Health/Agency for Toxic Substances and Disease Registry: Notice of Charter Renewal

This gives notice under the Federal Advisory Committee Act (Pub. L. 92–463) of October 6, 1972, that the Board of Scientific Counselors, National Center for Environmental Health/Agency for Toxic Substances and Disease Registry, Department of Health and Human Services, has been renewed for a 2-year period through May 21, 2010.

For information, contact Mark Bashor, Ph.D., Executive Secretary, Board of Scientific Counselors, National Center for Environmental Health/Agency for Toxic Substances and Disease Registry, Department of Health and Human Services, 4770 Buford Highway, Mailstop F61, Chamblee, Georgia 30341, telephone 770/488–0574 or fax 770/488–3377.

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: June 6, 2008.

Elaine L. Baker,

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

[FR Doc. E8–13318 Filed 6–12–08; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–906, CMS–1696, and CMS–10167]

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:* Revision of a currently approved collection; *Title of Information Collection:* The Fiscal Soundness Reporting Requirements; *Use:* CMS is assigned responsibility for overseeing all Medicare Advantage Organizations (MAO) on-going financial performance. CMS needs the requested collection of information to establish that each MAO maintains a fiscally sound organization. *Form Number:* CMS–906 (OMB# 0938–0469); *Frequency:* Yearly; *Affected Public:* Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 700; *Total Annual Responses:* 700; *Total Annual Hours:* 233.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Appointment of Representative; *Use:* This form will be completed by beneficiaries, providers and suppliers who wish to appoint representatives to assist them with obtaining initial determinations and filing appeals. The appointment of representative form must be signed by the party making the appointment and the individual agreeing to accept the appointment. *Form Number:* CMS–1696 (OMB# 0938–0950); *Frequency:* Occasionally; *Affected Public:* Individuals or households and business or other for-profits; *Number of Respondents:* 268,268; *Total Annual Responses:* 268,268; *Total Annual Hours:* 67,067.

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Competitive Acquisition Program for Medicare Part B Drugs: CAP Physician Election Agreement; *Use:* The Competitive Acquisition Program (CAP) is required by Section 303(d) of the Medicare Modernization Act (MMA), which amended Title XVIII of the Social Security Act (the Act) by adding a new section 1847(B), which establishes a competitive acquisition program for the payment for Part B covered drugs and biologicals furnished on or after January 1, 2006. Physicians are given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. Section 108 of the Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief Health Care Act of 2006 amended Section 1847(b)(a)(3) of the Act and requires that CAP implement a post payment review process.

The CAP Physician Election Agreement is used annually by physicians to elect to participate in the CAP or to make changes to the previous

year's selections. The information collected by these documents is used by CMS, its Medicare contractor, and the approved CAP vendor to meet programmatic requirements pertaining to physician election as established by the MMA. *Form Number:* CMS–10167 (OMB# 0938–0955); *Frequency:* Yearly; *Affected Public:* Business or other for-profits; *Number of Respondents:* 3800; *Total Annual Responses:* 3800; *Total Annual Hours:* 7600.

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 *July 14, 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: June 5, 2008.

Michelle Shortt,

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

[FR Doc. E8–13095 Filed 6–12–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1402–N]

Medicare Program; Public Meeting in Calendar Year 2008 for New Clinical Laboratory Tests Payment Determinations

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

ACTION: Notice.

SUMMARY: This notice announces a public meeting to discuss payment determinations for specific new Physicians' Current Procedural Terminology (CPT) codes for clinical laboratory tests. The meeting provides a forum for interested parties to make oral presentations and submit written comments on the new codes that will be included in Medicare's Clinical Laboratory Fee Schedule for calendar year 2009, which will be effective on January 1, 2009. The meeting will address technical issues relating to payment determinations for a specified list of new clinical laboratory codes. The development of the codes for clinical laboratory tests is largely performed by the CPT Editorial Panel and will not be further discussed at the CMS meeting.

DATES: The public meeting is scheduled for Monday, July 14, 2008 from 9 a.m. to 2 p.m., Eastern Standard Time (EST).

ADDRESSES: The public meeting will be held in the main auditorium of the central building of the Centers for Medicare & Medicaid Services (CMS) located at 7500 Security Boulevard, Baltimore, Maryland 21244.

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), Public Law 106–554, mandated procedures that permit public consultation for payment determinations for new clinical laboratory tests under Part B of title XVIII of the Social Security Act (the Act) 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 clinical laboratory 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. Also, section 942(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, added section 1833(h)(8)(B)(iii) of the Act to require that we convene a public meeting not less than 30 days after publication of this notice in the **Federal Register** to receive comments and recommendations (and data on which recommendations are based) for establishing payment amounts for new clinical laboratory tests.

A newly created Current Procedural Terminology (CPT) code can either represent a refinement or modification of existing test methods, or a substantially new test method. The preliminary list of newly created CPT codes for the calendar year (CY) 2009 will be published on our Web site at *http://www.cms.hhs.gov/ClinicalLabFeeSched* approximately mid-June 2008.

Two methods are used to establish payment amounts for tests paid on the clinical laboratory fee schedule. The first method, called cross-walking, is used when a new test is determined to be similar to an existing test, multiple existing test codes, or a portion of an existing test code. The new test code is then assigned the related existing local fee schedule amounts and the related existing national limitation amount. Payment for the new test code is made at the lesser of the local fee schedule amount or the national limitation amount. The second method, called gap-filling, is used when no comparable, existing test is available. When using this method, instructions are provided to each Medicare carrier or A/B MAC to determine a payment amount for its geographic area(s) for use in the first year. These determinations are based on the following sources of information (if available): Charges for the test and routine discounts to charges; resources required to perform the test; payment amounts determined by other payers; and charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant. The carrier-specific amounts are used to establish a national limitation amount for following years. For each new clinical laboratory test code, a determination must be made to either cross-walk or to gap-fill, and, if cross-walking is appropriate, to know what tests to cross-walk.

II. Format

This meeting is open to the public. The on-site check-in for visitors will be held from 8:30 a.m. to 9 a.m., followed by opening remarks. Registered persons from the public may discuss and recommend payment determinations for specific new CPT codes for the CY 2009 Clinical Laboratory Fee Schedule.

Oral presentations must be brief and must be accompanied by three written copies. Presenters may also make copies available for approximately 50 meeting participants. Presenters should address the—(1) new test code(s) and descriptor; (2) the test purpose and method; (3) costs; (4) charges; and (5) make a recommendation with rationale for one of two methods (cross-walking or gap-fill) for determining payment for new clinical laboratory codes. Additionally, the presenters should provide the data on which their recommendations are based. Presentations that do not address the five items may be considered incomplete and may not be considered by CMS when making a payment determination. CMS may request