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]

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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

substantial impact on prevention program development and monitoring at the local, State, and national levels.

CDC estimates that NHBS will involve, per year in each of the 25 MSAs, eligibility screening of 50 to 200 persons and eligibility screening plus the behavioral assessment with 500 eligible respondents, resulting in a total of 37,500 eligible survey respondents and 7,500 ineligible screened persons during a 3-year period. Data collection will rotate such that interviews will be conducted among one group per year: MSM in year 1, IDU in year 2, and HET in year 3. The type of data collected for each group will vary slightly due to different sampling methods and risk characteristics of the group.

Participation of respondents is voluntary and there is no cost to the respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondent	Form	Number of respondents	Number of responses per respondent	Average burden per response (hours)	Total burden (in hours)
Year 1:					
Men Approached at Eligible Venue.	Screener	17,500	1	5/60	1,458
Eligible Men	Behavioral Assessment	12,500	1	60/60	12,500
Year 2:					
Injecting Drug Users Referred by Peer Recruiters.	Screener	13,750	1	5/60	1,146
Eligible Injecting Drug Users	Behavioral Assessment	12,500	1	85/60	17,708
Year 3:					
Heterosexual Men and Women Referred by Peer Recruiters.	Screener	13,750	1	5/60	1,146
Eligible Heterosexual Men and Women.	Behavioral Assessment	12,500	1	70/60	14,583
Total		45,000	1		48,541

Dated: December 2, 2010.

Carol E. Walker,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3234–N]

Medicare Program; Renewal of the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC)

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

ACTION: Notice.

SUMMARY: This notice announces the renewal of the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC).

ADDRESSES: *Copies of the Charter:* To obtain a copy of the Secretary's Charter for the MEDCAC submit a request to: *See* **FOR FURTHER INFORMATION CONTACT.**

FOR FURTHER INFORMATION CONTACT: Maria Ellis, Executive Secretary for MEDCAC, Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality, Coverage and Analysis Group, C1–09–06, 7500 Security Boulevard, Baltimore, MD 21244 or contact Ms. Ellis by phone (410–786–0309) or via e-mail at *Maria.Ellis@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

On December 14, 1998, we published a notice in the **Federal Register** (63 FR 68780) announcing the establishment of the Medicare Coverage Advisory Committee (MCAC). The Secretary signed the initial charter for the MCAC on November 24, 1998. The MCAC was originally established to provide independent guidance and expert advice to CMS on specific clinical topics. In 2007 the Charter was renewed and the name MCAC was modified to Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) to more accurately reflect the Committee's role. The MEDCAC is advisory, with the final decision on all issues resting with CMS. Under the current charter, the MEDCAC advises the Secretary of the Department of Health and Human Services (DHHS) and the Administrator of the CMS, on the quality of evidence on clinical topics under review by CMS.

The MEDCAC consists of a pool of 100 appointed members. Members are selected from authorities in clinical medicine of all specialties, administrative medicine, public health, biologic and physical sciences, health care data and information management and analysis, patient advocacy, the economics of health care, medical ethics and other related professions such as epidemiology and biostatistics, and methodology of trial design. There are 94 at-large standing voting members. Six of the members are patient advocates and six are nonvoting members representing the industry interest.

II. Provisions of this Notice

This notice announces the signing of the MEDCAC charter renewal by the Secretary on November 23, 2010. The new charter makes the following changes:

- There are 4–8 meetings per year.
- A period of service for the Chair and Vice-Chair of no more than 4 years.

The MEDCAC functions on a committee basis. The MEDCAC—(1) Hears public testimony; (2) reviews medical literature, technology assessments and other relevant evidence and advises CMS on the strength and weaknesses of that evidence; (3) advises CMS of any evidence gaps that may exist and recommends the types of evidence that should be developed to fill those evidentiary gaps. The Committee may be asked to develop recommendations about specific clinical issues under review and to review and comment upon proposed or existing Medicare coverage policies. The Committee may also be asked to comment on pertinent aspects of