These files contain information received from employers containing verified instances of employment and GHP coverage for Medicare beneficiaries and Medicare-eligible spouses identified from the IMF, EIF, and MEF extracts.

CMS will match GHP information against the Fiscal Intermediary Shared System (FISS) (formerly known as Intermediary Medicare Claims Records), CMS System No. 09–70–0503, published at 71 FR 64961 (November 6, 2006), maintained at the CMS Data Center, located in Baltimore, Maryland. This file contains information or records needed to properly process and pay Medicare benefits to, or on behalf of, eligible individuals. CMS accesses this file upon receiving a claim for payment.

CMS will match GHP information against the Common Working File (CWF), CMS System No. 09–70–0526, published at 71 FR 64955 (November 6, 2006), which is the repository data base for all current hospital and medical coverage MSP information, maintained at the CMS Data Center, located in Baltimore, Maryland. These files contain information or records needed to properly process and pay medical insurance benefits to, or on behalf of, entitled beneficiaries who have submitted claims for Supplementary Medical Insurance Benefits (Medicare Part B). CMS accesses this file upon receiving a claim for payment.

CMS will match GHP information against the National Claims History (NCH), which is contained in the National Claims History File, CMS System No. 09–70–0558, published at 71 FR 67137 (November 20, 2006), maintained at the CMS Data Center, located in Baltimore, Maryland. NCH contains records needed to facilitate obtaining Medicare utilization review data that will be useful for studies of the operation and effectiveness of the Medicare program.

INCLUSIVE DATES OF THE MATCH:

The Matching Program shall become effective 40 days after the report of the Matching Program is sent to OMB and Congress, or 30 days after publication in the **Federal Register**, which ever is later. The matching program will continue for 18 months from the effective date and may be extended for an additional 12 months thereafter, if certain conditions are met.

[FR Doc. 2010–13000 Filed 6–1–10; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Advisory Commission on Childhood Vaccines; Request for Nominations for Voting Members

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice.

SUMMARY: The Health Resources and Services Administration (HRSA) is requesting nominations to fill three vacancies on the Advisory Commission on Childhood Vaccines (ACCV). The ACCV was established by Title XXI of the Public Health Service Act (the Act), as enacted by Public Law (Pub. L.) 99–660 and as subsequently amended, advises the Secretary of Health and Human Services (the Secretary) on issues related to implementation of the National Vaccine Injury Compensation Program (VICP).

DATES: The agency must receive nominations on or before July 2, 2010.

ADDRESSES: All nominations are to be submitted to the Director, Division of Vaccine Injury Compensation, Healthcare Systems Bureau (HSB), HRSA, Parklawn Building, Room 11C–26, 5600 Fishers Lane, Rockville, Maryland 20857.

FOR FURTHER INFORMATION CONTACT: Ms. Andrea Herzog, Principal Staff Liaison, Policy Analysis Branch, Division of Vaccine Injury Compensation, HSB, HRSA at (301) 443–6634 or e-mail: *aherzog@hrsa.gov.*

SUPPLEMENTARY INFORMATION: Under the authorities that established the ACCV, the Federal Advisory Committee Act of October 6, 1972 (Pub. L. 92–463) and section 2119 of the Act, 42 U.S.C. 300aa–19, as added by Pub. L. 99–660 and amended, HRSA is requesting nominations for three voting members of the ACCV.

The ACCV advises the Secretary on the implementation of the VICP. The activities of the ACCV include: Recommending changes in the Vaccine Injury Table at its own initiative or as the result of the filing of a petition; advising the Secretary in implementing section 2127 regarding the need for childhood vaccination products that result in fewer or no significant adverse reactions; surveying Federal, State, and local programs and activities related to gathering information on injuries associated with the administration of childhood vaccines, including the adverse reaction reporting requirements of section 2125(b); advising the Secretary on the methods of obtaining, compiling, publishing, and using credible data related to the frequency and severity of adverse reactions associated with childhood vaccines; consulting on the development or revision of the Vaccine Information Statements and recommending to the Director of the National Vaccine Program that vaccine safety research be conducted on various vaccine injuries.

The ACCV consists of nine voting members appointed by the Secretary as follows: (1) Three health professionals, who are not employees of the United States Government and have expertise in the health care of children, and the epidemiology, etiology, and prevention of childhood diseases, and the adverse reactions associated with vaccines, at least two shall be pediatricians; (2) three members from the general public, at least two shall be legal representatives (parents or guardians) of children who have suffered a vaccine-related injury or death; and (3) three attorneys, at least one shall be an attorney whose specialty includes representation of persons who have suffered a vaccine-related injury or death, and one shall be an attorney whose specialty includes representation of vaccine manufacturers. In addition, the Director of the National Institutes of Health, the Assistant Secretary for Health, the Director of the Centers for Disease Control and Prevention, and the Commissioner of the Food and Drug Administration (or the designees of such officials) serve as nonvoting ex officio members.

Specifically, HRSA is requesting nominations for three voting members of the ACCV representing: (1) A health professional, who has expertise in the health care of children; and the epidemiology, etiology, and prevention of childhood diseases; (2) an attorney whose specialty includes representation of persons who have suffered a vaccine-related injury or death; and (3) a member of the general public who is the legal representative (parents or guardians) of a child who has suffered a vaccine related injury or death. Nominees will be invited to serve a 3-year term beginning January 1, 2011, and ending December 31, 2014.

Interested persons may nominate one or more qualified persons for membership on the ACCV. Nominations shall state that the nominee is willing to serve as a member of the ACCV and appears to have no conflict of interest that would preclude ACCV membership. Potential candidates will be asked to provide detailed information concerning consultancies, research grants, or contracts to permit evaluation

of possible sources of conflicts of interest. A curriculum vitae or resume should be submitted with the nomination.

The Department of Health and Human Services has special interest in assuring that women, minority groups, and the physically disabled are adequately represented on advisory committees; and therefore, extends particular encouragement to nominations for appropriately qualified female, minority, or disabled candidates.

Dated: May 25, 2010.

Sahira Rafiullah,

Director, Division of Policy and Information Coordination.

[FR Doc. 2010–13150 Filed 6–1–10; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Statutorily Mandated Single Source Award Program Name: National Indian Health Board

AGENCY: Indian Health Service, HHS.

ACTION: Notice of Intent to provide supplemental funding to the existing cooperative agreement with the National Indian Health Board (NIHB), Inc.

Project Period: Dates: June 15–December 31, 2010.

Amount of Award: Funding amounts for each project, per Agency are delineated below. All project funding is subject to available funds; hence all supplemental projects outlined in this notice may not be awarded if the Agency does not identify funding for each activity.

Indian Health Service (IHS) Funding

(1) Budget Formulation not to exceed $65,000.

(2) Methamphetamine Abuse and Suicide Prevention Initiative (MSPI) not to exceed $50,000.

(3) IHS Medicaid, Medicare Policy Committee (MMPC) not to exceed $100,000.

Centers for Medicare and Medicaid Services (CMS) Funding

(1) Study and improve the administration and effectiveness of the Medicare, Medicaid and Children's Health Insurance Program (CHIP) in Indian County not to exceed $450,000.

(2) Data Analysis, Consultation and Training not to exceed $250,000.

(3) American Recovery and Reinvestment Act (ARRA) Health Information Technology (HIT) not to exceed $100,000.

Authority: This program is authorized under Public Health Service Act, Section 301(a). This program is described in the Catalog of Federal Domestic Assistance 93.933.

Application Deadline: June 4, 2010.

Anticipated Award Date: June 15, 2010.

Summary: The IHS announces the award of supplemental projects under the existing single source cooperative agreement award to the NIHB, Inc. The Office of Direct Service and Contracting Tribes (ODSCT) has designated supplemental funds for the single source award to the NIHB to further health program objectives in the American Indian/Alaska Natives (AI/AN) community with outreach and education efforts in the interest of improving Indian health care. The NIHB is the only national Indian organization with expertise on the variety of issues related to the provision of health care to the Indian population.

Single Source Justification: The NIHB is governed by twelve elected Tribal Government Officials who represent each of the twelve IHS Areas and the HHS regions where federally recognized Tribes exist. The NIHB represents all 564 federally recognized Tribes: including Tribal Governments operating their own health care delivery systems through self-determination agreements with the IHS and Tribes that continue to receive health care directly from the IHS. The NIHB is the only national Indian organization with an expertise in health policy and health programs, and the only national organization with the designated authority to represent all AI/AN Tribes and villages. The NIHB has a national constituency and clearly supports critical services and activities within the IHS mission of quality health care for AI/AN people. The NIHB can provide advice, consultation and health care advocacy to IHS and HHS based on Tribal input through a broad based consumer network.

The NIHB offers a national network of professional services to provide policy analysis and development, program assessment and development and regional and national meeting coordination. NIHB also provides planning and technical assistance to Tribes, Area Health Boards, other Tribal organizations, the IHS and HHS, other agencies within the Federal Government, private grant-making foundations, and other organizations.

Past performance of NIHB under a cooperative agreement has been exceptional. The NIHB has consistently provided education and outreach to Tribal leadership regarding the potential impact of Health Care Reform legislation. Educational materials were developed for dissemination to the White House, HHS, Tribal Governments and other organizations regarding the priorities and concerns of Tribes as related to health care/insurance reform efforts, IHCIA passage and other health delivery priorities. Their Web site has become a primary source of information to Tribal leaders on healthcare policy issues and is often quoted by national healthcare policy experts. Their outreach and education efforts focused to assist with increased enrollment of AI/AN beneficiaries in Medicaid and Medicare programs and their annual Consumer Conference is a showplace for innovative Tribal practices in healthcare administration. Their ability to bring together Tribes and Federal agencies in an effort to explore new avenues of cooperation and problem solving is an invaluable resource to everyone involved. They were instrumental in supporting program initiatives associated with diabetes, suicide prevention, children's health insurance and H1N1 prevention activities and will remain a solid supporter of improved healthcare in Indian Country. Hence, this all demonstrates the capability and substantiates the need for a non-competitive single source award to be approved and continuity sustained. Supplemental funds have been added to the cooperative agreement and are non-recurring for purposes that are related to the goals of the NIHB and support the scope of work of the cooperative agreement. The nature of the program and this agreement should allow other HHS operating divisions to supplement the NIHB agreement when those funds support the original intent of the original agreement.

This non-competitive single source cooperative agreement will assist the agency in furthering our health program objectives in the AI/AN community; failure to approve the agreement will: Impede consultation with AI/AN Tribal Governments; impede further education of health policy and legislation; would substantially increase the cost of securing these services should the IHS be required to secure these services through a multitude of Area and regional Health Boards; and impede targeting of future resources to AI/AN communities by IHS and HHS.

Use of Cooperative Agreement: A cooperative agreement has been awarded because of anticipated substantial programmatic involvement by IHS staff in the project. Substantial programmatic involvement is as follows:

The NIHB is responsible for the following: