identify opportunities for improvement, and to effectively target quality improvement initiatives in order to meet the statutory requirements for QIOs. The information will be made available to hospitals for their use in internal quality improvement initiatives. The information is used by CMS to direct its contractors to focus on particular areas of improvement, and to develop quality improvement initiatives. Most importantly, this information is available to beneficiaries, as well as to the public in general, to provide hospital information to assist them in making decisions about their health care. CMS conducts focus groups or market testing prior to public reporting hospital quality data on the Hospital Compare Web site.

For FY 2008, we propose to add the HCAHPS Survey to the measure set. For FY 2009, the set of measures for the RHQDAPU program will consist of measures previously approved through the PRA process, as well as additional measures identified through this rulemaking. We propose to add the following additional measures for FY 2009: Pneumonia 30-day Mortality (Medicare patients); SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose; SCIP Infection 6: Surgery Patients with Appropriate Hair Removal.

These three measures were recently endorsed by the National Quality Forum (NQF) and will be added to the set. All of these measures have been approved by the Hospital Quality Alliance (HQA) for inclusion in the national voluntary hospital reporting set, and are fully specified and included in The Joint Commission *Specifications Manual for National Hospital Quality Measures.* The measures offer important additions to our understanding of patient outcomes (mortality) and patient safety efforts, and could help encourage additional systems change in hospitals in the areas of pneumonia care and surgical services. *Frequency:* Recordkeeping, reporting, third-party disclosure—quarterly; *Affected Public:* Business or other for-profit, not-for-profit; *Number of Respondents:* 3,700; *Total Annual Responses:* 3,700; *Total Annual Hours:* 806,250.

CMS is requesting OMB review and approval of this collection by February 29, 2008, with a 180-day approval period. Written comments and recommendations will be considered from the public if received by the individuals designated below by February 25, 2008.

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/regulations/pra* 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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by February 27, 2008.

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address:

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number _____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

and,

OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: January 18, 2008.

Michelle Shortt,

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

[FR Doc. E8–1361 Filed 1–25–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10255, CMS–10112, CMS–R–148 and CMS–287–05]

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:* New collection; *Title of Information Collection:* Evaluation of Care and Disease Management Under Medicare Advantage. *Use:* CMS is conducting an evaluation of care and disease management programs under Medicare Advantage (MA), which includes a survey of all MA plans. The survey will help describe the structure and operation of these programs. The survey will gather information about MA health plans' care and disease management programs that is not available from other sources, such as relations with health providers, the use of electronic data systems, characteristics of care and disease management programs, population served, physician intervention, differences with regular MA plans and special needs plans, and evidence of effectiveness and assessment of costs. Information is collected through a one-time, self-administered mail questionnaire. *Form Number:* CMS–10255 (OMB# 0938–New); *Frequency:* Once; *Affected Public:* Private sector–Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 475; *Total Annual Responses:* 475; *Total Annual Hours:* 435.

2. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Phone Surveys of Products and Services for Medicare Payment Validation and Supporting Regulations in 42 CFR 405.502. *Use:* The phone surveys of products and services for Medicare payment validation and supporting regulations in 42 CFR 405.502 will be used to identify specific products/services provided to Medicare beneficiaries and the costs associated with the provision of those products/services. The information collected will be used to validate the Medicare payment amounts for those products/services and institute revisions of payment amounts where necessary.

The respondents will be the companies that have provided the product/service under review to Medicare beneficiaries. *Form Number:* CMS–10112 (OMB# 0938–0939); *Frequency:* Occasionally; *Affected Public:* Private sector–Business or other for-profit; *Number of Respondents:* 4,000; *Total Annual Responses:* 4,000; *Total Annual Hours:* 16,000.

3. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Limitations on Provider Related Donations and Health Care Related Taxes; Limitation on Payments for Disproportionate Share Hospitals and Supporting Regulations in 42 CFR 433.68, 433.74 and 447.272; *Use:* This information collection is necessary to ensure compliance with Sections 1903 and 1923 of the Social Security Act for the purpose of preventing payments of Federal financial participation on amounts prohibited by statute. *Form Number:* CMS–R–148 (OMB# 0938–0618); *Frequency:* Quarterly and occasionally; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 50; *Total Annual Responses:* 40; *Total Annual Hours:* 3,200.

4. *Type of Information Collection Request:* Extension without change of a currently approved collection; *Title of Information Collection:* Chain Home Office Cost Statement and supporting Regulations in 42 CFR 413.17 and 413.20; *Use:* The Form CMS–287–05 is filed annually by Chain Home Offices to report the information necessary for the determination of Medicare reimbursement to components of chain organizations. However, where providers are components of chain organizations, information included in the chain home office cost statement is in addition to that included in the provider cost report and is needed to determine whether payments are appropriate. *Form Number:* CMS–287–05 (OMB# 0938–0202); *Frequency:* Yearly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 1,345; *Total Annual Responses:* 1,345; *Total Annual Hours:* 626,770.

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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by March 28, 2008.

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number _____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: January 18, 2008.

Michelle Shortt,

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

[FR Doc. E8–1363 Filed 1–25–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–3195–N]

Medicare Program; Request for Nominations for Members of the Medicare Evidence Development and Coverage Advisory Committee (MedCAC)

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

ACTION: Notice.

SUMMARY: This notice announces the request for nominations for consideration for membership on the Medicare Evidence Development and Coverage Advisory Committee (MedCAC).

We are requesting nominations for both voting and nonvoting members to serve on the MedCAC. Nominees are selected based upon their individual qualifications and not as representatives of professional associations or societies. We have a special interest in ensuring that women, minority groups, and physically challenged individuals are adequately represented on the MedCAC. Therefore, we encourage nominations of qualified candidates from these groups.

The MedCAC reviews and evaluates medical literature, reviews technology assessments, and examines data and information on the effectiveness and appropriateness of medical items and services that are covered or eligible for coverage under Medicare. The MedCAC advises the Secretary of the Department of Health and Human Services (the Secretary) and the Administrator of the Centers for Medicare and Medicaid Services (CMS), as requested by the Secretary, whether medical items and services are reasonable and necessary under Title XVIII of the Social Security Act.

DATES: Nominations will be considered if postmarked by 5 p.m., d.s.t. on March 10, 2008 and sent to the designated address provided in the **ADDRESSES** section of this notice.

ADDRESSES: You may mail nominations for membership to: Centers for Medicare and Medicaid Services, Office of Clinical Standards and Quality, Attention: Maria A. Ellis, 7500 Security Blvd., Mail Stop: 1–09–06, Baltimore, MD 21244.

FOR FURTHER INFORMATION CONTACT: Maria Ellis, Executive Secretary for MedCAC, Centers for Medicare and Medicaid Services OCSQ–Coverage and Analysis Group, C1–09–06, 7500 Security Blvd., Baltimore, MD 21244. 410–786–0309; *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 Medicare Coverage Advisory Committee on November 24, 1998. In January 2007, CMS redesignated the MCAC to the Medicare Evidence Development and Coverage Advisory Committee (MedCAC). The charter was renewed by the Secretary and will terminate on November 23, 2008, unless renewed again by the Secretary.

The MedCAC is governed by provisions of the Federal Advisory Committee Act, (Pub. L. 92–463), as amended (5 U.S.C. App. 2), which sets forth standards for the formulation and use of advisory committees, and is authorized by section 222 of the Public Health Service Act as amended (42 U.S.C. 217a).

The MedCAC consists of a maximum of 100 appointed members. Of these, a maximum of 88 members are at-large standing voting members. Six of the 88 at-large voting member positions are reserved for patient advocates. The remaining 12 are nonvoting members (6