and use of these standards, implementation specifications, certification criteria and certification processes?

3. Given currently implemented information technology (IT) architectures and enterprises, what challenges will the industry face with respect to transitioning to the approach discussed in the PCAST report?

a. Given currently implemented provider workflows, what are some challenges to populating the metadata that may be necessary to implement the approach discussed in the PCAST report?

b. Alternatively, what are proposed solutions, or best practices from other industries, that could be leveraged to expedite these transitions?

4. What technological developments and policy actions would be required to assure the privacy and security of health data in a national infrastructure for HIT that embodies the PCAST vision and recommendations?

5. How might a system of Data Element Access Services (DEAS), as described in the report, be established, and what role should the Federal government assume in the oversight and/or governance of such a system?

6. How might ONC best integrate the changes envisioned by the PCAST report into its work in preparation for Stage 2 of Meaningful Use?

7. What are the implications of the PCAST report on HIT programs and activities, specifically, health information exchange and Federal agency activities, and how could ONC address those implications?

8. Are there lessons learned regarding metadata tagging in other industries that ONC should be aware of?

9. Are there lessons learned from initiatives to establish information-sharing languages ("universal languages") in other sectors?

Dated: December 7, 2010.

David Blumenthal,

National Coordinator, Office of the National Coordinator for HIT.

[FR Doc. 2010–31159 Filed 12–8–10; 11:15 am]

BILLING CODE 4150–45–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Epidemiologic and Ecologic Determinants of Monkeypox in a Disease-Endemic Setting, Funding Opportunity Announcement (FOA) CK11–003, Initial Review

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting:

Time and Date: 12 p.m.–2 p.m., February 1, 2011 (Closed).

Place: Teleconference.

Status: The meeting will be closed to the public in accordance with provisions set forth in Section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters to Be Discussed: The meeting will include the initial review, discussion, and evaluation of applications received in response to "Epidemiologic and Ecologic Determinants of Monkeypox in a Disease-endemic Setting, Funding Opportunity Announcement FOA CK11–003."

Contact Person for More Information: Amy Yang, PhD, Scientific Review Officer, CDC, 1600 Clifton Road, NE., Mailstop E60, Atlanta, Georgia 30333, *Telephone:* (404) 498–2733.

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: December 2, 2010.

Elaine L. Baker,

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

[FR Doc. 2010–31046 Filed 12–9–10; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–1500(08–05)]

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:* Reinstatement of a previously approved collection; *Title of Information Collection:* Health Insurance Common Claims Form and Supporting Regulations at 42 CFR part 424, Subpart C; *Form Number:* CMS–1500(08–05), CMS–1490–S (OMB#: 0938–0999); *Use:* The Form CMS–1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program for claims from physicians and suppliers. The Medicaid State Agencies, CHAMPUS/TriCare, Blue Cross/Blue Shield Plans, the Federal Employees Health Benefit Plan, and several private health plans also use it; it is the de facto standard "professional" claim form.

Medicare carriers use the data collected on the CMS–1500 and the CMS–1490S to determine the proper amount of reimbursement for Part B medical and other health services (as listed in section 1861(s) of the Social Security Act) provided by physicians and suppliers to beneficiaries. The CMS–1500 is submitted by physicians/suppliers for all Part B Medicare. Serving as a common claim form, the CMS–1500 can be used by other third-party payers (commercial and nonprofit health insurers) and other Federal programs (*e.g.,* CHAMPUS/TriCare, Railroad Retirement Board (RRB), and Medicaid).

However, as the CMS–1500 displays data items required for other third-party payers in addition to Medicare, the form is considered too complex for use by beneficiaries when they file their own claims. Therefore, the CMS–1490S (Patient's Request for Medicare Payment) was explicitly developed for