for public participation, and an open public hearing may last for whatever longer period the committee chairperson determines will facilitate the committee's work.

Public hearings are subject to FDA's guideline (subpart C of 21 CFR part 10) concerning the policy and procedures for electronic media coverage of FDA's public administrative proceedings, including hearings before public advisory committees under 21 CFR part 14. Under 21 CFR 10.205, representatives of the electronic media may be permitted, subject to certain limitations, to videotape, film, or otherwise record FDA's public administrative proceedings, including presentations by participants.

Meetings of advisory committees shall be conducted, insofar as is practical, in accordance with the agenda published in this Federal Register notice. Changes in the agenda will be announced at the beginning of the open portion of a meeting.

Any interested person who wishes to be assured of the right to make an oral presentation at the open public hearing portion of a meeting shall inform the contact person listed above, either orally or in writing, prior to the meeting. Any person attending the hearing who does not in advance of the meeting request an opportunity to speak will be allowed to make an oral presentation at the hearing's conclusion, if time permits, at the chairperson's discretion.

The agenda, the questions to be addressed by the committee, and a current list of committee members will be available at the meeting location on the day of the meeting.

Transcripts of the open portion of the meeting may be requested in writing from the Freedom of Information Office (HFI–35), Food and Drug Administration, 5600 Fishers Lane, rm. 12A–16, Rockville, MD 20857, approximately 15 working days after the meeting, at a cost of 10 cents per page. The transcript may be viewed at the Dockets Management Branch (HFA–305), Food and Drug Administration, 12420 Parklawn Dr., rm. 1–23, Rockville, MD 20857, approximately 15 working days after the meeting, between the hours of 9 a.m. and 4 p.m., Monday through Friday. Summary minutes of the open portion of the meeting may be requested in writing from the Freedom of Information Office (address above) beginning approximately 90 days after the meeting.

The Commissioner has determined for the reasons stated that those portions of the advisory committee meetings so designated in this notice shall be closed. The Federal Advisory Committee Act (FACA) (5 U.S.C. app. 2, 10(d)), permits such closed advisory committee meetings in certain circumstances. Those portions of a meeting designated as closed, however, shall be closed for the shortest possible time, consistent with the intent of the cited statutes.

The FACA, as amended, provides that a portion of a meeting may be closed where the matter for discussion involves a trade secret; commercial or financial information that is privileged or confidential; information of a personal nature, disclosure of which would be a clearly unwarranted invasion of personal privacy; investigatory files compiled for law enforcement purposes; information the premature disclosure of which would be likely to significantly frustrate implementation of a proposed agency action; and information in certain other instances not generally relevant to FDA matters.

Examples of portions of FDA advisory committee meetings that ordinarily may be closed, where necessary and in accordance with FACA criteria, include the review, discussion, and evaluation of drafts of regulations or guidelines or similar preexisting internal agency documents, but only if their premature disclosure is likely to significantly frustrate implementation of proposed agency action; review of trade secrets and confidential commercial or financial information submitted to the agency; consideration of matters involving investigatory files compiled for law enforcement purposes; and review of matters, such as personnel records or individual patient records, where disclosure would constitute a clearly unwarranted invasion of personal privacy.

Examples of portions of FDA advisory committee meetings that ordinarily shall not be closed include the review, discussion, and evaluation of general preclinical and clinical test protocols and procedures for a class of drugs or devices; consideration of labeling requirements for a class of marketed drugs or devices; review of data and information on specific investigational or marketed drugs and devices that have previously been made public; presentation of any other data or information that is not exempt from public disclosure pursuant to the FACA, as amended; and, deliberation to formulate advice and recommendations to the agency on matters that do not independently justify closing.

This notice is issued under section 10(a)(1) and (2) of the Federal Advisory Committee Act (5 U.S.C. app. 2), and FDA's regulations (21 CFR part 14) on advisory committees.

Dated: May 2, 1996.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 96–11435 Filed 5–6–96; 8:45 am]

BILLING CODE 4160–01–F

Health Care Financing Administration

Privacy Act of 1974; System of Records

AGENCY: Department of Health and Human Services (HHS), Health Care Financing Administration (HCFA).

ACTION: Notice of proposal to alter an existing system of records by: Expanding the purpose of the system, changing the name of the system, changing the name of the ''Unique Physician Identification Number (UPIN)'' to the ''Unique Physician/Practitioner Identification Number,'' changing the structure of the UPIN, adding tax identification numbers to the data fields, and adding a new routine use (number 10) to the system of records for the release of data to Federal and state agencies.

SUMMARY: HCFA is proposing to revise the systems notice for the ''Medicare Physician Identification and Eligibility System (MPIES), '' System No. 09–70–0525. The following alterations will be made to this system of records:

1. The purpose statement for the system will be revised to better reflect the system's expanded function. The new purpose of this system of records will read as follows: ''to maintain unique identification of each physician, practitioner, and medical group practice requesting and/or receiving Medicare reimbursement.''

2. The name of the system will be changed from the ''Medicare Physician Identification and Eligibility System (MPIES),'' to the ''Unique Physician/Practitioner Identification Number (UPIN) System.''

3. The name of the ''Unique Physician Identification Number (UPIN)'' will be changed to the ''Unique Physician/Practitioner Identification Number.'' Despite this amendment, the acronym UPIN will not be changed because Federal and state agencies and private and public insurance entities are familiar with the use of this acronym.

4. The structure of the UPIN identifier is being changed from a 6-digit identifier to a 10-digit identifier so as to uniquely identify all physicians, practitioners and medical group practices, and to rectify current problems with existing individualized identification systems.

5. Tax identification numbers will be collected and added to the data fields

maintained on all physicians, practitioners, and medical group practices in this system.

6. HCFA is also proposing to add a new routine use (number 10) to this system notice for the release of data to other Federal and state agencies.

EFFECTIVE DATE: HCFA filed a new system report with the Chairman of the Committee on Government Reform and Oversight of the House of Representatives, the Chairman of the Committee on Governmental Affairs of the Senate, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on May 1, 1996. To ensure that all parties have adequate time in which to comment, the revised system of records, including routine uses, will become effective 40 days from the publication of this notice or from the date it is submitted to OMB and the Congress, whichever is later, unless HCFA receives comments which require alterations to this notice.

ADDRESS: Please address comments to: Richard A. DeMeo, HCFA Privacy Act Officer, Freedom of Information and Privacy Office, Associate Administrator for External Affairs (AAEA), Health Care Financing Administration, Room C2–26–21, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Comments received will be available for examination at this location.

FOR FURTHER INFORMATION CONTACT: Gerald Wright, Provider Enrollment Unit, Office of Program Requirements, Bureau of Program Operations, Health Care Financing Administration, Room S1–04–20, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. His telephone number is (410) 786–5798.

SUPPLEMENTARY INFORMATION: In 1988, HCFA established a new system of records, under the authority of section 1842(r) of the Social Security Act Pub. L. 101–508, 42 U.S.C. 1395u(r)), to maintain a UPIN for each physician who provides services for which payment is made under Medicare. Notice of this system, the ''Medicare Physician Identification and Eligibility System (MPIES),'' HHS/HCFA/BPO, no. 09–70–0525, was most recently published on June 10, 1989 in the Federal Register. This system contains records of all physicians, as defined by § 1861(r) of Title XVIII of the Social Security Act, who provide services for which payment is made under Medicare.

At this time, HCFA is proposing to expand the purpose of this system of records: ''to maintain unique identification of each physician, practitioner, and medical group practice requesting and/or receiving Medicare reimbursement.'' Expanding the purpose to include other health care professionals and practitioners will assist HCFA in identifying billers and in determining the appropriate amount to pay for Medicare services.

A practitioner includes, but is not limited to, a physical therapist, certified registered nurse anesthetist, certified registered nurse midwife, physician assistant, occupational therapist, audiologist, family nurse practitioner, anesthesia assistant, mammography screening center, ambulance service supplier, portable x-ray supplier, independent physiological laboratory, clinical social worker, psychologist, nurse practitioner, certified clinical nurse specialist or any other practitioner as may be specified by the Secretary as defined in Social Security Act sections 1861(r) and 1877(h)(4).

A medical group practice is defined as a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association (A) In which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel; (B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; (C) in which overhead expenses of, and the income from the practice are distributed in accordance with methods previously determined by members of the group; and (D) which meets other standards such as the Secretary may impose by regulation to implement section 1877(h)(4) of the Social Security Act.

Section 1871(a)(1) of the Act provides that the Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance program under this title (XVIII). Section 1833(d) of the Act prohibits making payment under part B for services which are payable under Part A. By uniquely identifying Part B health professionals, practitioners, and groups we believe we will eliminate the possibility of duplicate payments.

Medicare carriers currently identify physicians, practitioners, and groups using their own systems of assigned numbers. These individualized systems allow for Physician Identification Numbers (PINs) ranging from four to 16 alphabetic and/or numeric characters. Some carriers assign separate PINs to the same physician providing medical services in more than one locality, office or practice, and lack the capability to cross-reference the PINs and related physician data (e.g., group affiliation).

Other carriers maintain a single PIN or cross-referenced PINs for each physician practicing within the carrier's geographic area of responsibility. Since physicians, groups, and practitioners can furnish medical services as well as bill for these services from several locations or states which are in different carrier jurisdictions, the independent providers who have been found to be ineligible for Medicare payments in one area, location or state could move to a different location or state in order to receive inappropriate or illegal payment.

In order to rectify the problems inherent in these individualized identification systems, HCFA proposes to expand the national registry of physicians under Congressional mandate, (section 1842(r) of the Social Security Act, (42 U.S.C. 1395u(r))) so as to identify physicians, practitioners and medical group practices deemed eligible for Medicare payments and to maintain more comprehensive data on provider credentials.

This initiative will also support the Medicare Transaction System (MTS) development effort. MTS is a single, national, government owned, standard, integrated claims processing system that will perform automated claims processing functions for Part A and Part B Medicare claims. HCFA must, therefore, build a national Medicare database of provider information, to be known as the MTS Provider File, in order to support all MTS functions.

The MTS Provider File would retain all provider information in a standard format so as to facilitate Medicare functions, both internal and external to MTS.

The Medicare Provider Database would uniquely identify and enumerate all Medicare providers and would provide summary information to support MTS functions. In order to develop that capability, HCFA is proposing to expand the UPIN system to provide identifying numbers for physicians, practitioners and medical group practices.

At this time, HCFA is also proposing to change the name of this system to better reflect the system's expanded purpose. We are proposing to change the name of this system from the ''Medicare Physician Identification and Eligibility System (MPIES),'' System No. 09–70–0525, to the ''Unique Physician/

Practitioner Identification Number (UPIN) System.'' This system will now be referred to as the UPIN system.

HCFA is proposing to change the name and structure of the unique identifier from ''Unique Physician Identification Numbers (UPIN)'' to ''Unique Physician/Practitioner Identification Numbers.'' HCFA will continue to use the acronym UPIN because Federal and state agencies, as well as private and public insurance entities are familiar with its use.

The structure of the UPIN will be changed from a 6-digit alphanumeric identifier to a 10-digit alphanumeric identifier. It will have a 6-digit base (who) identifier along with a 4-digit location (where) identifier.

These changes will enable HCFA to determine the location where the service was rendered and to decide whether a physician, practitioner and group practice whose services are billed to the program, is entitled to Medicare reimbursement. The 4-digit location identifier for physicians and the 10-digit UPINs assigned to practitioners and medical groups will be used by Medicare only for internal use—to link locally assigned providers to a national provider identifier.

Carriers will continue to use their locally assigned provider numbers in claims processing. Practitioners and group practices will not need to use their UPINs for claims reimbursement. Physicians, suppliers, and laboratories will continue to report the physicians' base 6-digit identifier for ordering and referring requirements.

The UPIN expansion will increase system standardization, identify providers across lines, facilitate development of provider data to support MTS, and permit HCFA to respond timely to and Federal initiative to implement standard, universal health care provider identifiers.

Section 4164 (c) of the Omnibus Budget Reconciliation Act (OBRA) of 1990 requires HCFA to ''publish a directory of the unique physician identification numbers (UPIN) of all physicians providing services for which payment may be made under Part B of Title XVIII of the Social Security Act and shall include in such directory the names, provider numbers, and business addresses of all listed physicians.'' The modification and expansion of the UPIN System will enable HFCA to execute regulations found at 42 Code of Federal Regulations (CFR) 421.200 et seq., as well as the provisions of section 6204(b) of OBRA 1989 (section 1833(q) of the Act) which help HCFA identify utilization patterns that deviate from professionally-established norms, both in the performance of services and in the referral of patients for other services or ordering of other services or suppliers. This requires laboratories and durable medical equipment (DME) suppliers, as well as consulting physicians, to show on the Medicare claim form the UPIN of the ordering or referring physician.

HCFA will continue to publish an annual hard copy directory of UPINs for physicians which will assist in the identification of an ordering or referring physician. The directory will include the names, credentials, state licensed in, zip code, provider numbers, specialty, and business addresses of all listed physicians. HCFA will publish only the 6-digit base number in the directory at this time. The UPINs of practitioners and medical groups as well as the 4-digit location identifiers will not be published in the annual hard copy of the UPIN directory because these numbers will not be used for claims processing, are temporary, transitional internal-control numbers to assist HCFA to transfer locally-assigned carrier numbers to the MTS claims processing system, will not fit on existing billing forms, and may cause confusion as to which numbers should be noted on the claim form. The 10-digit UPINs of physician, practitioners and medical groups will be published annually in an electronic version of the UPIN directory.

Enrollment information will be obtained from data currently available in carrier systems. The data will be researched, verified, and complied by carriers before submission to HCFA for assignment of UPINs. Duplicate data for two or more providers will be investigated by the carrier to determine if the identified providers are the same or different individuals. Once assured that no duplication exists, HCFA will notify each carrier of the assigned UPINs. The carriers will issue the UPINs to physicians, practitioners, and group practices.

HCFA is also proposing to add the collection of tax identification numbers to the data maintained on physicians, practitioners, and medical group practices in this system. Carriers will be required to provide tax identification numbers (e.g., social security or employee identification number) for all physicians, practitioners, and groups to the UPIN system. Tax identification numbers are needed to assure accurate identification of carriers' physician, practitioner, and group records.

The tax identification number provided by a carrier should be the one reported to the Internal Revenue Service and used in HCFA's 1099 program. Carriers are currently collecting this information. Records will not be retrieved by tax identification numbers. Records are retrieved alphabetically by an individual's or group's name or UPIN. Any uses of social security numbers in data identification, retrieval, and analysis are in full compliance with section 7 of the Privacy Act. Data identification at the individual level is necessary to link information collected by HCFA to other data records in order to further the operation and effectiveness of the Medicare program.

Also at this time, HCFA is proposing to add a new routine use (number 10) to this systems notice for the release of data to other Federal and state agencies. The Privacy Act (5 U.S.C. 552a) permits us to disclose information about an individual without consent of the individual for ''routine uses,'' that is, disclosure is permitted for purposes that are compatible with the purpose for which we have collected the information.

The new proposed routine use would permit release of data to other Federal and to state agencies. This routine use has two purposes: First, disclosure would be permitted to other Federal and to state agencies to enhance the accuracy of Medicare's payment of health benefits through improved coordination of benefits and second, disclosure would be permitted to enable other Federal and state agencies to fulfill their own Medicare-related processing procedures.

HCFA has recently received a number of requests from other Federal agencies, e.g., the Department of Labor, Veterans Affairs (Office of Civilian Health and Medical Programs of the Uniformed Services), and from state Medicaid agencies, asking for help in coordinating benefits and fulfilling their own Medicare-related processing procedures. To fulfill these requests requires the release of data from the UPIN system. A primary purpose of the Medicare program, for which this system of records was established, is to assure high quality and effective health care to Medicare beneficiaries. We believe that this purpose can be better accomplished through coordination of provider data between and among other Federal and state agencies. The proposed new routine use in the revised system meets the compatibility criteria, inasmuch as the information is collected for administering payments to providers in accordance with Title XVIII of the Social Security Act. We anticipate that disclosure under the routine use will not result in any unwarranted adverse effects on personal privacy.

The routine use will be numbered (10) and will read as follows:

(10) To another Federal or a state agency to: (1) Contribute to the accuracy of HCFA's proper payment of Medicare health benefits, or (2) enable such agency to administer a Federal or state health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal or state statute or regulation, if HCFA:

a. Determines that the use or disclosure does not violate legal limitations under which the data were provided, collected, or obtained;

b. Determines that the purpose for which the disclosure is be made cannot reasonably be accomplished unless the data are provided in individually identifiable form;

c. Requires the recipient to:

(1) Establish reasonable administrative, technical, and physical safeguards to prevent unauthorized use or disclosure of the record;

(2) Make no further use or disclosure of the record except:

(a) In emergency circumstances affecting the health or safety of any individual;

(b) For use on another project under the same conditions and with written authorization from HCFA; and

(c) When required by law;

(d) Secures a written statement attesting to the next recipient's understanding of, and willingness to abide by the following provisions:

(1) Not to use the data for purposes other than those for which the data were disclosed;

(2) Not to publish or otherwise disclose the data in a form raising unacceptable possibilities that individuals could be identified (i.e., the data must not be individual-specific and must be aggregated to a level where no data cells have 10 or fewer individuals); and

(3) Not to publish any aggregation of the data without HCFA's approval.

The proposed new routine use for the MPIES (hereafter UPIN) system is consistent with the Privacy Act, 5 U.S.C. 552a(a)(7), since it is compatible with the purpose for which the data were collected. We are publishing the notice in its entirety below for the convenience of the reader.

Dated: April 30, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 96–11260 Filed 5–6–96; 8:45 am]

BILLING CODE 4120–03–M

Health Resources and Services Administration

Advisory Council; Notice of Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Public Law 92–463), announcement is made of the following National Advisory bodies scheduled to meet during the month of June 1996.

Name: Advisory Commission on Childhood Vaccines (ACCV).

Date and Time: June 6–7, 9:00 am–5:00 p.m.

Place: Parklawn Building, Conference Rooms G & H, 5600 Fishers Lane, Rockville, Maryland 20857.

The meeting is open to the public.

Agenda: The full Commission will meet on Thursday, June 6 from 9:00 a.m. to 5:00 p.m. and Friday, June 7 from 9:00 am. to 12:00 noon. Agenda items will include, but not be limited to: a report on the National Vaccine Program; a report on the Advisory Committee on Immunization Practices' (ACIP) Polio Vaccine Policy; a report on the Acellular Pertussis Vaccines Symposium; a report on Vaccine-Associated Paralytic Poliomeyelitis; an update on the Centers of Disease Control and Prevention and Food and Drug Administration's Vaccine Safety Activities; report of the Vaccine Safety Subcommittee; and routine Program reports.

Public comment will be permitted before noon and/or at the end of the Commission meeting, as time permits. Oral presentations will be limited to 5 minutes per public speaker.

Persons interested in providing an oral presentation should submit a written request, along with a copy of their presentation to Mr. Jerry Anderson, Principal Staff Liaison, Division of Vaccine Injury Compensation, Bureau of Health Professions, Health Resources and Services Administration, Room 8A–35, 5600 Fishers Lane, Rockville, MD 20852; Telephone (301) 443–6593.

Requests should contain the name, address, telephone number, and any business or professional affiliation of the person desiring to make an oral presentation. Groups having similar interests are requested to combine their comments and present them through a single representative. The allocation of time may be adjusted to accommodate the level of expressed interest. The Division of Vaccine Injury Compensation will notify each presenter by mail or telephone of their assigned presentation time. Persons who do not file an advance request for presentation, but desire to make an oral statement, may sign up in Conference Room G and H before 10:00 on June 6–7. These persons will be allocated time as time permits.

Anyone requiring information regarding the Commission should contact Mr. Anderson, Division of Vaccine Injury Compensation, Bureau of Health Professions, Health Resources and Services Administration, Room 8A–35, 5600 Fishers Lane, Rockville, Maryland 20852; Telephone (301) 443–6593.

Name: National Advisory Committee on Rural Health.

Date and Time: June 9–12, 1996; 3:00 p.m.

Place: Tamarron Hilton, 40290 U.S. Highway 550 North, Durango, CO 81301 (970) 259–2000 FAX (970) 259–0745

The meeting is open to the public.

Agenda: The meeting will begin on Sunday, June 9, with a working session for the Health Care Financing and Education and Health Services Work Groups and a legislative update. The plenary session will begin at 8:30 a.m. on Monday, June 10, with topics including a discussion of Employee Retirement Income Security Act, Medicaid, and the Colorado Rural Perspective. On Tuesday, June 11, there will be a site visit to Shiprock, NM, with transportation provided. Individuals interested in participating in the site visit should contact Arlene Granderson at (301) 443–0613.

The meeting will convene at 8:30 a.m. on Wednesday, June 12. Adjournment is anticipated by 12:30 p.m.

Anyone requiring information regarding the subject Committee should contact Dena S. Puskin, Executive Secretary, National Advisory Committee on Rural Health, Health Resources and Services Administration, Room 9–05, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857, Telephone (301) 443–0835, FAX (301) 443–2803.

Persons interested in attending any portion of the meeting should contact Ms. Arlene Granderson or Lisa Shelton, Office of Rural Health Policy, Health Resources and Services Administration, Telephone (301) 443–0835.

Name: Material and Child Health Research Grants Review Committee.

Date and Time: June 12–14, 1996, 9:00 a.m.

Place: Conference Room ''O'', Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857.

Open on June 12, 1996, 9:00 a.m.—10:00 a.m.

Closed for remainder of meeting

Agenda: The open portion of the meeting will cover opening remarks by the Director, Division of Science, Education and Analysis, Maternal and Child Health Bureau, who will report on program issues, congressional activities and other topics of interest to the field of maternal and child health. The meeting will be closed to the public on June 12 at 10:00 a.m. for the remainder of the meeting for the review of grant applications. The closing is in accordance with the provisions set forth in section 552b(c)(6), Title 5 U.S.C., and the Determination by the Associate Administrator for Policy Coordination, Health Resources and Services Administration, pursuant to Public Law 92–463.

Anyone requiring information regarding the subject Council should contact Gontran Lamberty, Dr.P.H., Executive Secretary, Maternal and Child Health Research Grants Review Committee, Room 18A–55, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857, Telephone (301) 443–2190.

Agenda Items are subject to change as priorities dictate.

Dated: May 2, 1996.

Jackie E. Baum,

Advisory Committee Management Officer, HRSA.

[FR Doc. 96–11305 Filed 5–6–96; 8:45 am]

BILLING CODE 4160–15–M