committee of experts. A petition is to be in the form of a petition for reconsideration under § 10.33(b) (21 CFR 10.33(b)). A petitioner shall identify the form of review requested (hearing or independent advisory committee) and shall submit with the petition supporting data and information showing that there is a genuine and substantial issue of material fact for resolution through administrative review. After reviewing the petition, FDA will decide whether to grant or deny the petition and will publish a notice of its decision in the Federal Register. If FDA grants the petition, the notice will state the issue to be reviewed, the form of review to be used, the persons who may participate in the review, the time and place where the review will occur, and other details.

Petitioners may, at any time on or before October 23, 1996, file with the Dockets Management Branch (address above) two copies of each petition and supporting data and information, identified with the name of the device and the docket number found in brackets in the heading of this document. Received petitions may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

This notice is issued under the Federal Food, Drug, and Cosmetic Act (secs. 515(d), 520(h) (21 U.S.C. 360e(d), 360j(h))) and under authority delegated to the Commissioner of Food and Drugs (21 CFR 5.10) and redelegated to the Director, Center for Devices and Radiological Health (21 CFR 5.53).

Dated: September 11, 1996.

Joseph A. Levitt,

Deputy Director for Regulations Policy, Center for Devices and Radiological Health.

[FR Doc. 96–24364 Filed 9–18–96; 4:05 pm]

BILLING CODE 4160–01–F

Health Care Financing Administration

[HCFA–9042, R–197]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services, has submitted to the Office of Management and Budget (OMB) the following proposal for the collection of information. Interested persons are invited to send comments regarding the 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:* Reinstatement, without change, of a previously approved collection for which approval has expired; *Title of Information Collection:* Request for Accelerated Payments; *Form No.:* HCFA–9042; *Use:* These forms are used by fiscal intermediaries to access a provider's eligibility for accelerated payments. Such payment is granted if there is an unusual delay in processing bills. *Frequency:* On occasion; *Affected Public:* Business or other for-profit, and Not for-profit institutions; *Number of Respondents:* 854; *Total Annual Responses:* 854; *Total Annual Hours Requested:* 427.

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Maximizing the Effective Use of Telemedicine: A Study of the Effect, Cost Effectiveness, and Utilization Patterns of Consultations via Telemedicine; *Form No.:* HCFA–R–197; *Use:* The major objective of this study is to evaluate the medical and cost effectiveness of three different categories of telemedicine services. *Frequency:* Other (periodically); *Affected Public:* Individuals and households, Business or other for profit, and Not for profit institutions; *Number of Respondents:* 1,819; *Total Annual Responses:* 11,095; *Total Annual Hours Requested:* 1,564.

To obtain copies of the supporting statement for the proposed paperwork collections referenced above, access HCFA's WEB SITE ADDRESS at http://www.hcfa.gov , or to obtain the supporting statement and any related forms, E-mail your request, including your address and phone number, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: OMB Human Resources and Housing Branch, Attention: Allison Eydt, New Executive Office Building, Room 10235, Washington, D.C. 20503.

Dated: September 10, 1996.

Edwin J. Glatzel,

Director, Management Analysis and Planning Staff, Office of Financial and Human Resources, Health Care Financing Administration.

[FR Doc. 96–24214 Filed 9–20–96; 8:45 am]

BILLING CODE 4120–03–P

[MB–100–N]
RIN 0938–AH44

Medicaid Program; Final Limitations on Aggregate Payments to Disproportionate Share Hospitals: Federal Fiscal Year 1996

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: This notice announces the final Federal fiscal year (FFY) 1996 national target and individual State allotments for Medicaid payment adjustments made to hospitals that serve a disproportionate number of Medicaid recipients and low-income patients with special needs. We are publishing this notice in accordance with the provisions of section 1923(f)(1)(C) of the Social Security Act and implementing regulations at 42 CFR 447.297 through 447.299. The final FFY 1996 State DSH allotments published in this notice supersede the preliminary FFY 1996 DSH allotments that were published in the Federal Register on May 9, 1996.

EFFECTIVE DATE: The final DSH payment adjustment expenditure limits included in this notice apply to Medicaid DSH payment adjustments for FFY 1996.

FOR FURTHER INFORMATION CONTACT: Richard Strauss, (410) 786–2019.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1902(a)(13)(A) of the Social Security Act (the Act) requires States to ensure that their Medicaid payment rates include payment adjustments for Medicaid-participating hospitals that serve a large number of Medicaid recipients and other low-income individuals with special needs (referred to as disproportionate share hospitals (DSH)). The DSH payment adjustments are calculated on the basis of formulas specified in section 1923 of the Act.

Section 1923(f) of the Act and implementing Medicaid regulations at 42 CFR 447.297 through 447.299 require us to estimate and publish in the Federal Register the national target and each State's allotment for DSH payments for each Federal fiscal year (FFY). The implementing regulations provide that the national aggregate DSH

limit for a FFY specified in the Act is a target rather than an absolute cap when determining the amount that can be allocated for DSH payments. The national DSH target is 12 percent of the total amount of medical assistance expenditures (excluding total administrative costs) that are projected to be made under approved Medicaid State plans during the FFY. (Note: Whenever the phrases ''total medical assistance expenditures'' or ''total administrative costs'' are used in this notice, they mean both the State and Federal share of expenditures or costs.)

In addition to the national DSH target, there is a specific State DSH limit for each State for each FFY. The State DSH limit is a specified amount of DSH payment adjustments applicable to a FFY above which FFP will not be available. This is called the ''State DSH allotment.''

Each State's DSH allotment for FFY 1996 is calculated by first determining whether the State is a ''high-DSH State'' or a ''low-DSH State.'' This is determined by using the State's ''base allotment.'' A State's base allotment is the greater of the following amounts: (1) The total amount of the State's actual and projected DSH payment adjustments made under the State's approved State plan applicable to FFY 1992, as adjusted by HCFA; or (2) $1,000,000.

A State whose base allotment exceeds 12 percent of the State's total medical assistance expenditures (excluding administrative costs) projected to be made in FFY 1996 is referred to as a ''high-DSH State'' for FFY 1996. The FFY 1996 State DSH allotment for a high-DSH State is limited to the State's base allotment.

A State whose base allotment is equal to or less than 12 percent of the State's total medical assistance expenditures (excluding administrative costs) projected to be made in FFY 1996 is referred to as a ''low-DSH State.'' The FFY 1996 State DSH allotment for a low-DSH State is equal to the State's DSH allotment for FFY 1995 increased by growth amounts and supplemental amounts, if any. However, the FFY 1996 DSH allotment for a low-DSH State cannot exceed 12 percent of the State's total medical assistance expenditures for FFY 1996 (excluding administrative costs).

The growth amount for FFY 1996 is equal to the projected percentage increase (the growth factor) in a low-DSH State's total Medicaid program expenditures between FFY 1995 and FFY 1996 multiplied by the State's final DSH allotment for FFY 1995. Because the national DSH limit is considered a target, low-DSH States whose programs grow from one year to the next can receive a growth amount that would not be permitted if the national limit was viewed as an absolute cap.

There is no growth factor and no growth amount for any low-DSH State whose Medicaid program does not grow (that is, stayed the same or declined) between FFY 1995 and FFY 1996. Furthermore, because a low-DSH State's FFY 1996 DSH allotment cannot exceed 12 percent of the State's total medical assistance expenditures, it is possible for its FFY 1996 DSH allotment to be lower than its FFY 1995 DSH allotment. This occurs when the State experiences a decrease in its program expenditures between years and its prior FFY DSH allotment is greater than 12 percent of the total projected medical assistance expenditures for the current FFY. For FFY 1996, no States' final State DSH allotments are lower than their final FFY 1995 State DSH allotments.

There is no supplemental amount available for redistribution for FFY 1996. The supplemental amount, if any, is equal to a low-DSH State's proportional share of a pool of funds (the redistribution pool). The redistribution pool is equal to the national 12-percent DSH target reduced by the total of the base allotments for high-DSH States, the total of the State DSH allotments for the previous FFY for low-DSH States, and the total of the low-DSH State growth amounts. Since the sum of these amounts is above the projected FFY 1996 national 12-percent DSH target, there is no redistribution pool and, therefore, no supplemental amounts for FFY 1996.

As prescribed in the law and regulations, no State's DSH allotment will be below a minimum of $1,000,000.

As an exception to the above requirements, under section 1923(f)(1)(A)(i)(II) of the Act and regulations at 42 CFR 447.296(b)(5) and 447.298(f), a State may make DSH payments for a FFY in accordance with the minimum payment adjustments required by Medicare methodology described in section 1923(c)(1) of the Act. The final FFY 1996 State DSH allotment for the District of Columbia, Iowa, and Nebraska has been determined in accordance with this exception. We have also redetermined the State DSH allotments for FFYs 1993, 1994, and 1995 for the District of Columbia and the State DSH allotment for FFY 1995 for Iowa in accordance with the provisions of section 1923(c)(1) of the Act.

We are publishing in this notice the final FFY 1996 national DSH target and State DSH allotments based on the best available data we received to date from the States, as adjusted by HCFA. These data are taken from each State's actual Medicaid expenditures for FFY 1995 as reported on the State's quarterly expenditure report Form HCFA–64 submissions and the FFY 1996 projected Medicaid expenditures as reported on the February 1996 Form HCFA–37 submission. All data are adjusted as necessary.

II. Calculations of the Final FFY 1996 DSH Limits

The total of the final State DSH allotments for FFY 1996 is equal to the sum of the base allotments for all high-DSH States, the FFY 1995 State DSH allotments for all low-DSH States, and the growth amounts for all low-DSH States. A State-by-State breakdown is presented in section III of this notice.

We classified States as high-DSH or low-DSH States. If a State's base allotment exceeded 12 percent of its total unadjusted medical assistance expenditures (excluding administrative costs) projected to be made under the State's approved plan in FFY 1996, we classified that State as a ''high-DSH'' State. If a State's base allotment was 12 percent or less of its total unadjusted medical assistance expenditures projected to be made under the State's approved State plan under title XIX of the Act in FFY 1996, we classified that State as a ''low-DSH'' State. Based on this classification, there are 35 low-DSH States and 15 high-DSH States for FFY 1996.

Using the most recent data from the States' February 1996 budget projections (Form HCFA–37), we estimate the States' FFY 1996 national total medical assistance expenditures to be $159,875,082,000. Thus, the overall final national FFY 1996 DSH expenditure target is $19,185,010,000 (12 percent of $159,875,082,000).

In the final FFY 1996 State DSH allotments, we provide a total of $368,619,000 ($213,827,000 Federal share) in growth amounts for the 35 low-DSH States. The growth factor percentage for each of the low-DSH States was determined by calculating the Medicaid program growth percentage for each low-DSH State between FFY 1995 and FFY 1996. To compute this percentage, we first ascertained each low-DSH State's total FFY 1995 actual medical assistance and administrative expenditures as reported on the State's four quarterly Medicaid expenditure reports (Form HCFA–64) for FFY 1995. Next, we compared those expenditures to each low-DSH State's total estimated unadjusted FFY 1996 medical assistance and administrative

expenditures as reported to HCFA on the State's February 15, 1996 submission of the Medicaid Budget Report (Form HCFA–37).

The growth factor percentage was multiplied by the low-DSH State's final FFY 1995 DSH allotment amount to establish the State's final growth amount for FFY 1996.

Since the sum of the total of the base allotments for high-DSH States, the total of the State DSH allotments for the previous FFY for low-DSH States, and the growth for low-DSH States ($19,467,072,000) is greater than the final FFY 1996 national target ($19,185,010,000), there is no final FFY 1996 redistribution pool.

The low-DSH State's growth amount was then added to the low-DSH State's final FFY 1995 DSH allotment amount to establish the final total low-DSH State DSH allotment for FFY 1996. If a State's growth amount, when added to its final FFY 1995 DSH allotment amount, exceeds 12 percent of its FFY 1996 estimated medical assistance expenditures, the State only receives a partial growth amount that, when added to its final FFY 1995 allotment, limits its total State DSH allotment for FFY 1996 to 12 percent of its estimated FFY 1996 medical assistance expenditures. For this reason, five of the low-DSH States received partial growth amounts, and two low-DSH States received no growth amount.

Also, in accordance with the minimum payment adjustments required by Medicare methodology, the final FFY 1996 State DSH allotments for the District of Columbia, Iowa, and Nebraska are $61,854,000, $15,735,000, and $12,031,000, respectively. In addition in accordance with this provision, we have redetermined the State DSH allotments for FFYs 1993, 1994, and 1995 for the District of Columbia to be $47,849,689, $50,669,700, and $52,219,263, respectively, and the State DSH allotment for FFY 1995 for Iowa to be $14,620,261.

In summary, the total of all final State DSH allotments for FFY 1996 is $19,467,072,000 ($11,049,723,000 Federal share). This total is composed of the prior FFY's final State DSH allotments ($19,098,453,000) plus growth amounts for all low-DSH States ($368,619,000), plus supplemental amounts for low-DSH States ($0). The total of all final FFY 1996 State DSH allotments is 12.2 percent of the total medical assistance expenditures (excluding administrative costs) projected to be made by these States in FFY 1996. The total of all final DSH allotments for FFY 1996 is $282,062,000 over the FFY 1996 national target amount of $19,185,010,000.

Each State should monitor and make any necessary adjustments to its DSH spending during FFY 1996 to ensure that its actual FFY 1996 DSH payment adjustment expenditures do not exceed its final State DSH allotment for FFY 1996 published in this notice. As the ongoing reconciliation between actual FFY 1996 DSH payment adjustment expenditures and the FFY 1996 DSH allotments takes place, each State should amend its plan as may be necessary to make any adjustments to its FFY 1996 DSH payment adjustment expenditure patterns so that the State will not exceed its FFY 1996 DSH allotment.

The FFY 1996 reconciliation of DSH allotments to actual expenditures will take place on an ongoing basis as States file expenditure reports with HCFA for DSH payment adjustment expenditures applicable to FFY 1996. Additional DSH payment adjustment expenditures made in succeeding FFYs that are applicable to FFY 1996 will continue to be reconciled with each State's FFY 1996 DSH allotment as additional expenditure reports are submitted to ensure that the FFY 1996 DSH allotment is not exceeded. As a result, any DSH payment adjustment expenditures for FFY 1996 in excess of the FFY 1996 DSH allotment will be disallowed, and therefore, subject to the normal Medicaid disallowance procedures.

III. Final FFY 1996 DSH Allotments Under Public Law 102–234

Key to Chart:

Column and Description

Column A=Name of State

Column B=Final FFY 1995 DSH Allotments for All States. For a high-DSH State, this is the State's base allotment, which is the greater of the State's FFY 1992 allowable DSH payment adjustment expenditures applicable to FFY 1992, or $1,000,000. For a low-DSH State, this is equal to the final DSH allotment for FFY 1995, which was published in the Federal Register on September 8, 1995.

Column C=Growth Amounts for Low-DSH States. This is an increase in a low-DSH State's final FFY 1995 DSH allotment to the extent that the State's Medicaid program grew between FFY 1995 and FFY 1996.

Column D=Final FFY 1996 State DSH Allotments. For high-DSH States, this is equal to the base allotment from column B. For low-DSH States, this is equal to the final State DSH allotments for FFY 1995 from column B plus the growth amounts from column C and the supplemental amounts, if any, from column D.

Column E=High or Low DSH State Designation for FFY 1996. ''High'' indicates the State is a high-DSH State and ''Low'' indicates the State is a low-DSH State.

BILLING CODE 4120–01–P

FINAL FEDERAL FISCAL YEAR
1996 DISPROPORTIONATE SHARE HOSPITAL
ALLOTMENTS UNDER PUBLIC LAW 102-234
AMOUNTS ARE STATE AND FEDERAL SHARES
DOLLARS ARE IN THOUSANDS (000)

A STATE	B FINAL FFY 95 DSH ALLOTMENTS FOR ALL STATES	C GROWTH AMOUNTS FOR LOW DSH STATES (1)	D FINAL FFY 96 STATE DSH ALLOTMENTS	E HIGH OR LOW DSH STATE DESIGNATION
AL	$417,458	NOT APPLICABLE	$417,458	HIGH
AK	$20,600	$1,100	$21,700	LOW
AR	$3,338	$266	$3,605	LOW
CA	$2,191,451	NOT APPLICABLE	$2,191,451	HIGH
CO	$302,014	NOT APPLICABLE	$302,014	HIGH
CT	$408,933	NOT APPLICABLE	$408,933	HIGH
DE	$7,069	$1,544	$8,613	LOW
DC (2)	$52,219	$9,635	$61,854	LOW
FL	$334,183	$5,835	$340,018	LOW
GA	$409,142	$17,574	$426,717	LOW
HI	$82,686	NOT APPLICABLE	$82,686	LOW
ID	$2,085	$297	$2,382	LOW
IL	$452,172	$90,053	$542,225	LOW
IN	$286,634	$55,505	$342,139	LOW
IA (2)	$14,620	$1,115	$15,735	LOW
KS	$188,935	NOT APPLICABLE	$188,935	HIGH
KY	$264,289	$20,574	$284,863	LOW
LA	$1,217,636	NOT APPLICABLE	$1,217,636	HIGH
ME	$165,317	NOT APPLICABLE	$165,317	HIGH
MD	$143,100	$7,852	$150,952	LOW
MA	$575,289	NOT APPLICABLE	$575,289	LOW
MI	$674,005	$12,473	$686,478	LOW
MN	$61,398	$2,492	$63,890	LOW
MS	$183,200	$17,712	$200,912	LOW
MO	$731,894	NOT APPLICABLE	$731,894	HIGH
MT	$1,342	$75	$1,417	LOW
NE (2)	$11,000	$1,031	$12,031	LOW
NV	$73,560	NOT APPLICABLE	$73,560	HIGH
NH	$392,006	NOT APPLICABLE	$392,006	HIGH
NJ	$1,094,113	NOT APPLICABLE	$1,094,113	HIGH
NM	$17,303	$2,968	$20,272	LOW
NY	$3,023,871	$23,657	$3,047,528	LOW
NC	$430,106	$28,869	$458,975	LOW
ND	$1,203	$59	$1,262	LOW
OH	$629,925	$21,672	$651,596	LOW
OK	$24,225	$796	$25,021	LOW
OR	$31,413	$1,705	$33,118	LOW
PA	$967,407	NOT APPLICABLE	$967,407	HIGH
RI	$110,901	$579	$111,480	LOW
SC	$439,759	NOT APPLICABLE	$439,759	HIGH
SD	$1,443	$113	$1,555	LOW
TN	$430,611	NOT APPLICABLE	$430,611	HIGH
TX	$1,513,029	NOT APPLICABLE	$1,513,029	HIGH
UT	$5,943	$364	$6,307	LOW
VT	$29,081	$2,659	$31,740	LOW
VA	$204,798	$17,207	$222,005	LOW
WA	$336,527	$16,272	$352,800	LOW
WV	$126,094	$6,322	$132,415	LOW
WI	$11,605	$141	$11,746	LOW
WY	$1,520	$103	$1,623	LOW
TOTAL	$19,098,453	$368,619	$19,467,072	

NOTES:
(1) THERE WERE 2 LOW DSH STATES WITH NO GROWTH, AND 5 LOW DSH STATES WITH PARTIAL GROWTH UP TO 12% OF FFY 96 MAP
(2) ALLOTMENT BASED UPON MINIMUM PAYMENT ADJUSTMENT AMOUNT

BILLING CODE 4120-01-C

IV. Regulatory Impact

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

This is not a major rule as defined at 5 U.S.C. 804(2).

(Catalog of Federal Assistance Program No. 93.778, Medical Assistance Program)

Dated: June 26, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: August 16, 1996.

Donna E. Shalala,

Secretary.

[FR Doc. 96–24229 Filed 9–20–96; 8:45 am]

BILLING CODE 4120–01–P

Centers for Disease Control and Prevention

Statement of Organization, Functions, and Delegations of Authority

Part C (Centers for Disease Control and Prevention) of the Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (45 FR 67772–67776, dated October 14, 1980, and corrected at 45 FR 69296, October 20, 1980, as amended most recently at 61 FR 35219–35228, dated July 5, 1996) is amended to reflect the following changes within the National Center for Health Statistics (NCHS): (1) Abolish the Office of Planning and Extramural Programs; (2) establish the Office of Data Standards, Program Development, and Extramural Programs and the Office of Planning, Budget, and Legislation; and (3) revise the functional statement for the Office of International Statistics.

Section C–B, *Organization and Functions,* is hereby amended as follows:

After the functional statement for the *Office of Research and Methodology (CS13),* delete in their entirely the title and functional statement for the *Office of Planning and Extramural Programs (CS14).*

Revise the functional statement for the *Office of International Statistics (CS15)* by deleting item (5) and renumbering the remaining items accordingly.

After the functional statement for the *Office of International Statistics (CS15),* insert the following:

Office of Data Standards, Program Development, and Extramural Programs (CS16). (1) Participates in the development of policy, long-range plans, and programs of the Center; (2) develops proposed policies for the coordination of NCHS programs with external agencies, both public and private; (3) provides leadership, and serves as a focal point, for NCHS outreach efforts to organizations in the public and private sectors; serves a focal point for developing collaborative statistical activities of NCHS with other organizations and agencies, and the development of public/private partnerships in health statistics; facilitates communication with outside agencies regarding program and policy issues; (4) provides a focus for program development and review of policy implications as related to emerging priority data needs of the country; coordinates the assessment of needs and the perspectives of other agencies; participates actively in program planning and policy development by reviewing the relevance of current and proposed programs to defined priorities of need and the requirements of other agencies and principal user groups; (5) evaluates or arranges for the evaluation of the adequacy, completeness, and responsiveness of Center programs both nationally and internationally to the NCHS mission and national priorities. Based on the results of evaluations, makes proposals for changes in NCHS programs or policies and collaborative enterprises; (6) assures leadership in the definition, development, and coordination of cooperative and collaborative programs in health statistics, working with state and local governments, and other organizations including the private and academic sectors in the development and strengthening of shared subnational statistical systems or services to meet the needs of the country; (7) conducts research, analyses, and demonstrations related to subnational systems; (8) develops, pilots, and implements new programs through direct activities and through grants and contracts; organizes Center-wide teams or special work groups for selected high priority initiatives; (9) provides scientific and technical support and Executive Secretariat services to the National Committee on Vital and Health Statistics (NCVHS), the legislatively-mandated advisory committee to the Secretary, DHHS; (10) provides for programmatic review and leadership for the NCHS Reimbursable Work Program; (11) provides guidance and staff support for major Center conferences and committee meetings; (12) provides advice and assistance to outside agencies and organizations in the conduct of statistical training activities; conducts training in key areas, as appropriate; and promotes appropriate training and educational materials for implementation and use of data sets and classification systems and for other purposes; (13) coordinates required clearances for Human Subjects Review; (14) provides leadership and serves as advisor to the Director on policy issues related to data standards and classification systems; (15) provides scientific and technical advice to the DHHS Data Council on data standards and classification issues, and takes a leadership role in HHS-wide workgroups addressing such issues; (16) serves as NCHS's focal point to other organizations regarding efforts to develop minimum data sets, core data sets, data definitions, common approaches to medical and statistical terminology, and other standards-related efforts;

(17) participates with appropriate agencies and organizations to promote the dissemination, adoption, and use of standards advocated by NCHS, DHHS, and the NCVHS; serves as a nucleus for data policy, data standards, and medical classification by fostering the collaborative development of tools and guidelines to enhance the integrity, comparability, quality, and usefulness of the data products from a wide variety of public and private agencies at the national and subnational levels; (18) assures and provides interface of data confidentiality, linkage, and security issues with other data policies and standards; (19) serves as the focal point and coordinator of U.S. Government activities related to the International Classification of Diseases (ICD) and maintains liaison with the World Health Organization through the direction of the WHO Collaborating Center for Classification of Diseases for North America working with appropriate programs throughout NCHS; (20) provides a focus for enhancing collaborative activities in advancing the science and practice of health statistics, stimulating working arrangements with universities, schools of public health, schools of medicine and professional organizations of same; provides a focus for the development of a reliance upon NCHS data for research in these settings and provides leadership for graduate student training and interaction with NCHS.

Data Policy and Standards Staff (CS163). (1) Provides a focus within NCHS for the development and continuing responsive modification of a conceptual framework for a broad-based definition of the basic health information systems of the country; (2) serves as a nucleus for data policy, data standards, and medical classification by