information regarding present and future FDA issues. This portion of the meeting will be closed to permit discussion of this information (5 U.S.C. 522b(c)(4)).

Each public advisory committee meeting listed above may have as many as four separable portions: (1) An open public hearing, (2) an open committee discussion, (3) a closed presentation of data, and (4) a closed committee deliberation. Every advisory committee meeting shall have an open public hearing portion. Whether or not it also includes any of the other three portions will depend upon the specific meeting involved. The dates and times reserved for the separate portions of each committee meeting are listed above.

The open public hearing portion of the meeting(s) shall be at least 1 hour long unless public participation does not last that long. It is emphasized, however, that the 1 hour time limit for an open public hearing represents a minimum rather than a maximum time 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 (a)(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: October 29, 1996.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 96–28208 Filed 11–1–96; 8:45 am]

BILLING CODE 4160–01–F

Health Care Financing Administration

[HCFA–R–137]

Agency Information Collection Activities: Proposed Collection; 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, is publishing the following summary of proposed collections for public comment. 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.

Type of Information Collection Request: Reinstatement, with change, of a previously approved collection for which approval has expired; *Title of*

Information Collection: Internal Revenue Service/Social Security Administration/Health Care Financing Administration Data Match 42 CFR 411; *Form No.*: HCFA–R–137; *Use:* Employers who are identified through a match of IRS, SSA, and Medicare records will be contacted concerning group health plan coverage of identified individuals to ensure compliance with Medicare Secondary Payer provisions found at 42 U.S.C. 1395y(b). *Frequency:* Semi-annually; *Affected Public:* Individuals or Households, Business or other for profit, Not for profit institutions, Farms, Federal Government and State, Local or Tribal Government; *Number of Respondents:* 596,241; *Total Annual Responses:* 596,241; *Total Annual Hours Requested:* 2,325,449.

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 60 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: HCFA, Office of Financial and Human Resources, Management Analysis and Planning Staff, Attention: Louis Blank, Room C2–26–17, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: October 25, 1996.

Edwin J. Glatzel,

Director, Management Analysis and Planning Staff, Office of Financial and Human Resources.

[FR Doc. 96–28147 Filed 11–01–96; 8:45 am]

BILLING CODE 4120–03–P

[OACT–054–N]

RIN 0938–AHO8

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 1997

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

ACTION: Notice.

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year 1997 under Medicare's hospital insurance program (Medicare Part A). The Medicare statute specifies the formulae to be used to determine these amounts.

The inpatient hospital deductible will be $760. The daily coinsurance amounts will be: (a) $190 for the 61st through 90th days of hospitalization in a benefit period; (b) $380 for lifetime reserve days; and (c) $95 for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period.

EFFECTIVE DATE: This notice is effective on January 1, 1997.

FOR FURTHER INFORMATION CONTACT: John Wandishin, (410) 786–6389. For case-mix analysis only: Gregory J. Savord, (410) 786–6384.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires us to determine and publish between September 1 and September 15 of each year the amount of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts applicable for services furnished in the following calendar year.

II. Computing the Inpatient Hospital Deductible for 1997

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by our best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act). This estimate is used for updating the payment rates to hospitals for discharges in the fiscal year that begins on October 1 of the same preceding calendar year and adjusted to reflect real case mix. The adjustment to reflect real case mix is determined on the basis of the most recent case mix data available. The amount determined under this formula is rounded to the nearest multiple of $4 (or, if midway between two multiples of $4, to the next higher multiple of $4).

For fiscal year 1997, section 1886(b)(3)(B)(i)(XI) of the Act provides that the applicable percentage increase for hospitals in all areas is the market basket percentage increase minus 0.5 percent. Section 1886(b)(3)(B)(ii)(V) of the Act provides that, for fiscal year 1997, the otherwise applicable rate-of-increase percentages (the market basket percentage increase) for hospitals that are excluded from the prospective payment system are reduced by the lesser of 1 percentage point or the percentage point difference between 10 percent and the percentage by which the hospital's allowable operating costs of inpatient hospital services for cost reporting periods beginning in fiscal year 1990 exceeds the hospital's target amount. Hospitals or distinct part hospital units with fiscal year 1990 operating costs exceeding target amounts by 10 percent or more receive the market basket index percentage. The market basket percentage increases for fiscal year 1997 are 2.5 percent for prospective payment system hospitals and 2.5 percent for hospitals excluded from the prospective payment system, as announced in the Federal Register on August 30, 1996 (VOL. 61, No. 170 FR 46166). Therefore, the percentage increases for Medicare prospective payment rates are 2.0 percent for all hospitals. The average payment percentage increase for hospitals excluded from the prospective payment system is 1.96 percent. Thus, weighting these percentages in accordance with payment volume, our best estimate of the payment-weighted average of the increases in the payment rates for fiscal year 1997 is 2.0 percent.

To develop the adjustment for real case mix, an average case mix was first calculated for each hospital that reflects the relative costliness of that hospital's mix of cases compared to that of other hospitals. We then computed the increase in average case mix for hospitals paid under the Medicare prospective payment system in fiscal year 1996 compared to fiscal year 1995. (Hospitals excluded from the prospective payment system were excluded from this calculation since their payments are based on reasonable costs and are affected only by real increases in case mix.) We used bills from prospective payment hospitals received in HCFA as of July 1996. These bills represent a total of about 8.2 million discharges for fiscal year 1996 and provide the most recent case mix data available at this time. Based on these bills, the increase in average case mix in fiscal year 1996 is 1.1 percent. Based on past experience, we expect overall case mix to increase to 1.4