recommend allowing additional time to clear security.

In order to gain access to the building and grounds, individuals must present photographic identification to the Federal Protective Service or Guard Service personnel before being allowed entrance.

Security measures also include inspection of vehicles, inside and out, at the entrance to the grounds. In addition, all individuals entering the building must pass through a metal detector. All items brought to CMS, whether personal or for the purpose of demonstration or to support a demonstration, are subject to inspection. We cannot assume responsibility for coordinating the receipt, transfer, transport, storage, set-up, safety, or timely arrival of any personal belongings or items used for demonstration or to support a demonstration.

Parking permits and instructions will be issued upon arrival.

**Note:** Individuals who are not registered in advance will not be permitted to enter the building and will be unable to attend the meeting.

The public may not enter the building earlier than 30 to 45 minutes prior to the convening of the meeting.

All visitors must be escorted in areas other than the lower and first floor levels in the Central Building.

**Authority:** 5 U.S.C. App. 2, section 10(a).

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: December 12, 2005.

**Barry M. Straube,**

*Acting Chief Medical Officer and Acting Director, Office of Clinical Standards and Quality, Centers for Medicare and Medicaid Services.*

[FR Doc. E6–704 Filed 1–26–06; 8:45 am]

**BILLING CODE 4120–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare and Medicaid Services

**[CMS–1328–N]**

### Medicare Program; February 15, 2006 Town Hall Meeting on the Practice Expense Methodology Including the Proposal From the Physician Fee Schedule Proposed Rule for Calendar Year 2006

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

**ACTION:** Notice of meeting.

**SUMMARY:** This notice announces a Town Hall meeting on our methodology for establishing practice expense (PE) values for services paid under the physician fee schedule (PFS). The purpose of this meeting is to: (1) Clarify our proposed revisions to the PE methodology contained in the PFS calendar year (CY) 2006 proposed rule; and (2) receive comments and opinions from individuals of the medical community regarding ideas for the CY 2007 PFS proposed rule. This meeting is open to the public, but attendance is limited to space available.

**DATES:** The Town Hall meeting is scheduled for Tuesday, February 15, 2006 from 1:30 p.m. to 4:30 p.m. e.s.t.

**ADDRESSES:** The Town Hall meeting will be held at the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1850 in the auditorium in the central building.

*Meeting Registration:* Persons wishing to attend this meeting must register by contacting Debbie Cooley at Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail stop C4–03–06, Baltimore, MD 21244–1850, or, by FAX at 410–786–4490 to the attention of Debbie Cooley. Please include the name of the attendee and the organization he or she represents, if applicable. This information must be received by 5 p.m., e.s.t, on Friday, February 10, 2006.

This meeting will be held in a Federal Government building, the Centers for Medicare and Medicaid Services; therefore, persons attending this meeting will be required to show a government-issued photo identification and a copy of their confirmation of registration for the meeting. Access may be denied to persons without proper identification. In planning your arrival time, we recommend allowing additional time to clear security.

*Security measures include:* Inspection of vehicles, inside and out, at the entrance to the grounds; passing through a metal detector; and, the inspection of all items brought into the building. Laptops and other computer equipment must be registered with the security desk upon entry. Please note that CMS headquarters is a smoke-free complex.

**FOR FURTHER INFORMATION CONTACT:** Debbie Cooley, (410)786–0007 or Dorothy Shannon, (410)786–3396.

**SUPPLEMENTARY INFORMATION:**

## I. Background

Since January 1, 1992, Medicare has paid for services of physicians and other practitioners under a physician fee schedule. This schedule sets payment rates for 7,000 services based on the resources used to provide those services and is updated annually. To construct the fee schedule, we assign values called relative value units (RVUs) to each service. The total RVUs for a service are the sum of the work RVUs (which include the physician's time and effort); the practice expense RVUs (which cover expenses such as overhead, staff, and supplies); and the malpractice expense RVUs (which cover malpractice premiums).

In the CY 2006 PFS proposed rule (70 FR 45764), we outlined our plans to revise the practice expense (PE) methodology. There were three major parts to our proposal:

1. Changing from a ''top-down'' methodology for calculating direct PE to a ''bottom-up'' approach. Currently, on a specialty-specific basis, we derive a PE per physician hour from aggregate survey data, create a cost pool using Medicare utilization data, and then allocate the pool to all the services performed by the specialty. This methodology is complex, often not intuitive, and produces some PE values that can change significantly from year-to-year. The proposed bottom-up approach would use the sum of the typical resource costs for clinical staff, supplies, and equipment required for each service. These typical costs for each service would be determined based primarily on recommendations we reviewed and accepted from the American Medical Association's Relative Value Update Committee (RUC). We would then convert these costs into direct cost PE RVUs. We believe this methodology is easier to understand and more intuitive than the current top-down approach, and should also improve the stability of the PE RVUs over time. In addition, because most of the inputs that would be used in the bottom-up calculation have been approved by the multi-specialty RUC, the medical community has already agreed to their accuracy.

2. Accepting the supplementary PE surveys from seven specialties—allergy, dermatology, urology, gastrointestinal, cardiology, radiology, and radiation oncology—and using these in the calculation of indirect PE.

3. Calculating, on a code-specific basis, the higher of the current portion of the PE RVU for indirect costs (the indirect PE RVU) or the indirect PE RVU resulting from acceptance of the supplementary surveys.

This proposal was to have the effect of mitigating the redistributive effects of accepting the seven supplementary surveys by ensuring that, before application of PE budget neutrality, the indirect PE RVUs for each service were

no lower than the current indirect PE RVUs.

In comments on the CY 2006 PFS proposed rule, commenters indicated that they did not understand the mechanics of our proposals and that there was not enough information for specialties to analyze them. Many commenters requested a 1-year delay in implementation of our proposals to allow time for CMS to provide further information and to give other specialties an additional opportunity to submit their own supplementary survey.

After reviewing the CY 2006 PFS proposed rule comments, we determined that the proposal for revising the indirect PE was confusing to the public because the published PE values and impacts were incorrect. Therefore, in the CY 2006 PFS final rule (70 FR 70116), we withdrew the proposed PE revision for 2006 and used the 2005 PE RVUs for most services. The only exceptions were to price the codes that were new in 2006 and, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L 108–173), to use the new urology PE data in the calculation of the drug administration codes used by their specialty.

As we indicated when we issued the CY 2006 PFS final rule (70 FR 70116), we intend to work with the medical community to ensure that any future proposals to change the PE methodology are understandable and informed by input from the medical community. As the initial step in this process, we are holding this Town Hall meeting to provide this opportunity.

**II. Meeting Format**

This meeting will begin with an overview of the objectives of the meeting along with an introduction of the topics to be discussed during the meeting which include:

- Clarifying our efforts to revise the PE methodology in the CY 2006 PFS proposed rule which include:

+ The change from a ''top-down'' methodology for calculating direct PE to a ''bottom-up'' approach utilizing the direct cost inputs;

+ The use of the accepted supplementary PE surveys from the seven specialties in the calculation of indirect PE;

+ The intended method of obtaining the indirect PE values; and

+ The elimination of the nonphysician workpool and the related impacts.

- A question and answer session that offers the meeting attendees an opportunity to clarify further the topics discussed.

- Soliciting input from individual attendees on each facet of our methodology: direct PE, indirect PE, supplementary surveys, and nonphysician workpool. The comments provided during this meeting will assist us in the preparation of the physician fee schedule proposed rule for CY 2007.

To provide a basis of understanding before the meeting we will be posting information concerning the PE methodology on our Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/*. This information will include current PE values, examples for deriving PE values using the bottom-up methodology, and projected impacts of these revisions. We encourage individuals to familiarize themselves with this material before the meeting. Copies of this information will be available on the day of the meeting.

**Authority**

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program).

Dated: January 19, 2006.

**Mark B. McClellan,**

*Administrator, Centers for Medicare & Medicaid Services.*

[FR Doc. 06–747 Filed 1–26–06; 8:45 am]

**BILLING CODE 4120–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare and Medicaid Services

**[CMS–1318–N]**

### Medicare Program; Meeting of the Practicing Physicians Advisory Council, March 6, 2006

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

**ACTION:** Notice.

**SUMMARY:** This notice announces a quarterly meeting of the Practicing Physicians Advisory Council (the Council). The Council will meet to discuss certain proposed changes in regulations and carrier manual instructions related to physicians' services, as identified by the Secretary of Health and Human Services (the Secretary). This meeting is open to the public.

**DATES:** The Council meeting is scheduled for Monday, March 6, 2006, from 8 a.m. until 5 p.m. e.s.t.

**ADDRESS:** The meeting will be held in Room 705A 7th floor, in the Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

**MEETING REGISTRATION:** Persons wishing to attend this meeting must register by contacting Kelly Buchanan, the Designated Federal Official (DFO) by e-mail at *PPAC@cms.hhs.gov* or by telephone at (410) 786–6132, at least 72 hours in advance of the meeting. This meeting will be held in a Federal Government Building, Hubert H. Humphrey Building, and persons attending the meeting will be required to show a photographic identification, preferably a valid driver's license, and will be listed on an approved security list before persons are permitted entrance. Persons not registered in advance will not be permitted into the Hubert H. Humphrey Building and will not be permitted to attend the Council meeting.

**FOR FURTHER INFORMATION CONTACT:** Kelly Buchanan, (410) 786–6132, or e-mail *PPAC@cms.hhs.gov*. News media representatives must contact the CMS Press Office, (202) 690–6145. Please refer to the CMS Advisory Committees' Information Line (1–877–449–5659 toll free), (410) 786–9379 local) or the Internet at *http://www.cms.hhs.gov/faca/ppac/default.asp* for additional information and updates on committee activities.

**SUPPLEMENTARY INFORMATION:** In accordance with section 10(a) of the Federal Advisory Committee Act, this notice announces the quarterly meeting of the Practicing Physicians Advisory Council (the Council). The Secretary is mandated by section 1868(a)(1) of the Social Security Act (the Act) to appoint a Practicing Physicians Advisory Council based on nominations submitted by medical organizations representing physicians. The Council meets quarterly to discuss certain proposed changes in regulations and carrier manual instructions related to physicians' services, as identified by the Secretary. To the extent feasible and consistent with statutory deadlines, the Council's consultation must occur before **Federal Register** publication of the proposed changes. The Council submits an annual report on its recommendations to the Secretary and the Administrator of the Centers for Medicare and Medicaid Services (CMS) not later than December 31 of each year.

The Council consists of 15 physicians, including the Chair. Members of the Council include both participating and nonparticipating physicians, and physicians practicing in rural and underserved urban areas. At least 11 members of the Council must be physicians as described in section 1861(r)(1) of the Act; that is, State-licensed doctors of medicine or