proposed changes in regulations and manual instructions related to physician 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 & 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 osteopathy. The remaining 4 members may include dentists, podiatrists, optometrists, and chiropractors. Members serve for overlapping 4-year terms.

Section 1868(a)(2) of the Act requires that the Council meet quarterly to discuss certain proposed changes in regulations and manual issuances that relate to physicians' services, identified by the Secretary. Section 1868(a)(3) of the Act provides for payment of expenses and per diem for Council members in the same manner as members of other advisory committees appointed by the Secretary. In addition to making these payments, the Department of Health and Human Services and CMS provide management and support services to the Council. The Secretary will appoint new members to the Council from among those candidates determined to have the expertise required to meet specific agency needs in a manner to ensure appropriate balance of the Council's membership.

The Council held its first meeting on May 11, 1992. The current members are: Chiledum A. Ahaghotu, M.D.; John E. Arradondo, M.D., MPH; Vincent J. Bufalino, M.D., Chairperson; Joseph A. Giaimo, D.O.; Pamela A. Howard, M.D.; Roger L. Jordan, O.D.; Janice A. Kirsch, M.D.; Tye J. Ouzounian, M.D.; Jeffrey A. Ross, DPM, M.D.; Jonathan E. Siff, M.D., MBA; Fredrica E. Smith, M.D.; Richard E. Smith, M.D.; Arthur D. Snow, Jr., M.D.; Christopher J. Standaert, M.D.; and Karen S. Williams, M.D.

II. Meeting Format and Agenda

The meeting will commence with the Council's Executive Director providing a status report, and the CMS responses to the recommendations made by the Council at the December 7, 2009 meeting, as well as prior meeting recommendations. Additionally, an update will be provided on the Physician Regulatory Issues Team. In accordance with the Council charter, we are requesting assistance with the following agenda topics:

- Provider Enrollment and Chain Ownership System (PECOS) Update.
- Fraud and Abuse Update.
- Electronic Health Records (EHR) Update.

For additional information and clarification on these topics, contact the DFO as provided in the **FOR FURTHER INFORMATION CONTACT** section of this notice. Individual physicians or medical organizations that represent physicians wishing to present a 5-minute oral testimony on agenda issues must register with the DFO by the date listed in the **DATES** section of this notice. Testimony is limited to agenda topics only. The number of oral testimonies may be limited by the time available. A written copy of the presenter's oral remarks must be submitted to the DFO for distribution to Council members for review before the meeting by the date listed in the **DATES** section of this notice. Physicians and medical organizations not scheduled to speak may also submit written comments to the DFO for distribution by the date listed in the **DATES** section of this notice.

III. Meeting Registration and Security Information

The meeting is open to the public, but attendance is limited to the space available. Persons wishing to attend this meeting must register by contacting the DFO at the address listed in the **ADDRESSES** section of this notice or by telephone at the number listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice by the date specified in the **DATES** section of this notice.

Since this meeting will be held in a Federal Government Building, the Hubert H. Humphrey Building, Federal security measures are applicable. In planning your arrival time, we recommend allowing additional time to clear security. To gain access to the building, participants will be required to show a government-issued photo identification (for example, driver's license, or passport), and must 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.

All persons entering the building must pass through a metal detector. In addition, all items brought to the Hubert H. Humphrey Building, whether personal or for the purpose of presentation, 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 the purpose of presentation.

Individuals requiring sign language interpretation or other special accommodations must contact the DFO via the contact information specified in the **FOR FURTHER INFORMATION CONTACT** section of this notice by the date listed in the **DATES** section of this notice.

Authority: (Section 1868 of the Social Security Act (42 U.S.C. 1395ee) and section 10(a) of Pub. L. 92–463 (5 U.S.C. App. 2, section 10(a)).)

Dated: January 14, 2010.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2010–1333 Filed 1–21–10; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

National Advisory Committee on Rural Health and Human Services; Notice of Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), notice is hereby given that the following committee will convene its sixty-fourth meeting.

Name: National Advisory Committee on Rural Health and Human Services.

Dates and Times: February 17, 2010, 1 p.m.–5 p.m.

February 18, 2010, 9 a.m.–5 p.m.

February 19, 2010, 9 a.m.–10:30 a.m.

Place: The Sofitel Lafayette Square, 806 15th Street, NW., Washington, DC, 20005, Phone: 202–730–8800.

Status: The meeting will be open to the public.

Purpose: The National Advisory Committee on Rural Health and Human Services provides advice and recommendations to the Secretary with respect to the delivery, research, development and administration of health and human services in rural areas.

Agenda: Wednesday afternoon, February 17, at 1 p.m., the meeting will be called to order by the Chairperson of the Committee, the Honorable David Beasley and the Vice Chairperson, the Honorable Larry Otis. The Chair will open with a review of the Committee's 2010 Report to the Secretary and a vote on the approval of that report. The meeting will then focus on the Committee's

work for the 2011 report, which will focus on the implications of health system change in rural communities. The meeting will include an address by HRSA Administrator

Dr. Mary Wakefield as well as presentations by experts in the fields of hospital and health care delivery as well as workforce. Committee discussion on the issues and an overview of rest of the meeting will follow. The Wednesday meeting will close at 5 p.m.

Thursday morning, February 18, at 9 a.m., the Committee will open with presentations by experts in the area of human service delivery and will be followed by another presentation by a speaker from the Rural Policy Research Institute. This will be followed by Committee discussion and overview from staff to the Committee. Following these presentations, Subcommittees will be selected and meet for small group discussions. There will be a review of the Subcommittee meetings and action items will be developed for the Committee members and staff. The formal meeting for Thursday will close at 5 p.m.

The final session will be convened Friday morning, February 19, at 9 a.m. The Committee will hear additional presentations on emerging rural policy issues from both internal and external experts. This will be followed by Committee discussion on the Report format and an overview of the Work Plan. The Committee will draft the letter to the Secretary and discuss the June meeting. The meeting will be adjourned at 10:30 a.m.

For Further Information Contact: Anyone requiring information regarding the Committee should contact Thomas F. Morris, MPA, Acting Executive Secretary, National Advisory Committee on Rural Health and Human Services, Health Resources and Services Administration, Parklawn Building, Room 9A–42, 5600 Fishers Lane, Rockville, MD 20857, Telephone (301) 443–0835, Fax (301) 443–2803.

Persons interested in attending any portion of the meeting should contact Michele Pray Gibson, Office of Rural Health Policy (ORHP), Telephone (301) 443–0835. The Committee meeting agenda will be posted on ORHP's Web site *http://www.ruralhealth.hrsa.gov.*

Dated: January 14, 2010.

Sahira Rafiullah,

Deputy Director, Division of Policy Review and Coordination.

[FR Doc. 2010–1178 Filed 1–21–10; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights; Notice

Notice is hereby given by the National Institutes of Health (NIH) of the "NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights" to be held March 8–10, 2010, in the NIH Natcher Conference Center, 45 Center Drive, Bethesda, Maryland 20892. The conference will begin at 8:30 a.m. on March 8 and 9 and at 9 a.m. on March 10, and it will be open to the public.

Vaginal birth after cesarean (VBAC) is the delivery of a baby through the vagina after a previous cesarean delivery. For most of the 20th century, once a woman had undergone a cesarean (the delivery of a baby through an incision made in the abdominal wall and uterus), many clinicians believed that all of her future pregnancies required delivery by cesarean as well. However, in 1980, an NIH Consensus Development Conference panel questioned the necessity of routine repeat cesarean deliveries and outlined situations in which VBAC could be considered. The option for a woman with a previous cesarean delivery to try to labor and deliver vaginally rather than plan a cesarean delivery was thus offered and exercised more often from the 1980s through the early 1990s. Since 1996, however, VBAC rates in the United States have consistently declined, while cesarean delivery rates have been steadily rising.

The exact causes of these shifts are not entirely understood. A frequently cited concern about VBAC is the possibility of uterine rupture during labor because a cesarean delivery leaves a scar in the wall of the uterus at the incision site, which is weaker than other uterine tissue. Attempted VBAC may also be associated with endometritis (infection of the lining of the uterus), the need for a hysterectomy (removal of the uterus) or blood transfusion, as well as neurologic injury to the baby. However, repeat cesarean delivery may also carry a risk of bleeding or hysterectomy, uterine infections, and respiratory problems for the newborn. Having multiple cesarean deliveries may also be associated with placental problems in future pregnancies. Other important considerations that may influence decisionmaking include the number of previous cesarean deliveries a woman has experienced, the surgical incision used during previous cesarean delivery, the reason for the previous surgical delivery, her age, how far along the pregnancy is relative to her due date, and the size and position of her baby. Given the complexity of this issue, a thorough examination of the relative balance of benefits and harms to mother and baby will be of immediate utility to practitioners and pregnant mothers in deciding upon a planned mode of delivery.

A number of nonclinical factors are involved in this decision as well and may be influencing the decline in VBAC rates. Some individual practitioners and hospitals in the U.S. have decreased or eliminated their use of VBAC. Professional society guidelines may influence utilization rates because some medical centers do not offer the recommended supporting services for a trial of labor after cesarean (*e.g.,* immediate availability of a surgeon who can perform a cesarean delivery and on-site anesthesiologists). Information related to complications of an unsuccessful attempt at VBAC, medico-legal concerns, personal preferences of patients and clinicians, and insurance policies and economic considerations may all play a role in changing practice patterns. Improved understanding of the clinical risks and benefits and how they interact with legal, ethical, and economic forces to shape provider and patient choices about VBAC may have important implications for health services planning.

To advance understanding of these important issues, the Eunice Kennedy Shriver National Institute of Child Health and Human Development and the Office of Medical Applications of Research of the NIH will convene a Consensus Development Conference from March 8 to 10, 2010. The conference will address the following key questions:

- What are the rates and patterns of utilization of trial of labor after prior cesarean, vaginal birth after cesarean, and repeat cesarean delivery in the United States?
- Among women who attempt a trial of labor after prior cesarean, what are the vaginal delivery rate and the factors that influence it?
- What are the short- and long-term benefits and harms to the mother of attempting trial of labor after prior cesarean versus elective repeat cesarean delivery, and what factors influence benefits and harms?
- What are the short- and long-term benefits and harms to the baby of maternal attempt at trial of labor after prior cesarean versus elective repeat cesarean delivery, and what factors influence benefits and harms?
- What are the nonmedical factors that influence the patterns and utilization of trial of labor after prior cesarean?
- What are the critical gaps in the evidence for decision-making, and what are the priority investigations needed to address these gaps?

An impartial, independent panel will be charged with reviewing the available published literature in advance of the