Type of respondents	Form name	No. of respondents	No. of responses per respondent	Average burden per response (in hours)
Supervisor/Manager of EMS Personnel	Screening Script to Identify Supervisor for Interview.	2,250	1	2/60
	Local EMS Provider Survey	1,800	1	15/60
Administrator/Director of Sub-state EMS Region	Topic Guide for Semi-Structured Telephone Interview.	10	1	45/60

Dated: January 7, 2008.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E8–425 Filed 1–11–08; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Field Trials to Efficacy of Natural Products for the Control of the Tick Vectors of Lyme Disease Spirochetes, Program Announcement (PA) CK08–001; Evaluation of Reservoir-Targeted Vaccine Formulations To Prevent Enzootic Transmission of Borrelia Burgdorferi (Lyme Borreliosis), PA CK08–002

Correction: This notice was published in the **Federal Register** on December 19, 2007, Volume 72, Number 243, page 71913–71914. The title and place should read as follows:

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Field Trials to Efficacy of Natural Products for the Control of the Tick Vectors of Lyme Disease Spirochetes, Program Announcement (PA) CK08–001; Evaluation of Reservoir-Targeted Vaccine Formulations To Prevent Enzootic Transmission of Borrelia Burgdorferi (Lyme Borreliosis), PA CK08–002.

Place: Teleconference.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: January 8, 2008.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E8–480 Filed 1–11–08; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of a Modified or Altered System of Records

AGENCY: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS).

ACTION: Notice of a Modified or Altered System of Records (SOR).

SUMMARY: In accordance with the Privacy Act of 1974, we are proposing to modify or alter an existing SOR, ''Health Plan Management System (HPMS) ,'' System No. 09–70–4004, established at 63 **Federal Register** 43187 (August 12, 1998). We will broaden the scope of this system by including a new activity related to health plan and Part D plan management referred to as the Complaint Tracking Module (CTM). CTM will collect and maintain identifiable information on individuals who are, but not limited to, complainants, including beneficiaries, relatives and caregivers, Congresspersons and their staff, State Health Insurance Program representatives, and providers of service and their staff. The CTM stores complaint data, including, but not limited to, the following: Date complaint received; date of incident; issue level; complainant and/or beneficiary information; complaint summary; complaint category; complaint resolution summary; and plan resolution summary. Plans use the CTM to track the beneficiary complaints assigned to their organization, enter complaint case resolutions, and close out complaints.

In addition, HPMS will collect information from health plans and Part D plan organizations pertaining to individuals who market and/or sell health insurance and prescription drug plan products on behalf of these plan organizations and who are licensed or authorized by a State Insurance Commissioner or other certifying agencies. We are sharing data pertaining to all agents/brokers to assist CMS and State Insurance Commissioners in improving oversight of the sales marketplace and in avoiding fraudulent sales practices that mislead and harm Medicare beneficiaries. We propose to assign a new CMS identification number to this system to simplify the obsolete and confusing numbering system originally designed to identify the Bureau, Office, or Center that maintained information in the Health Care Financing Administration systems of records. The new assigned identifying number for this system should read: System No. 09–70–0500.

We will delete routine use number 1 authorizing disclosure to support constituent requests made to a congressional representative. If an authorization for the disclosure has been obtained from the data subject, then no routine use is needed. The Privacy Act allows for disclosures with the ''prior written consent'' of the data subject. We propose to delete published routine use number 5 authorizing disclosure to a contractor for the purpose of collating, analyzing, aggregating or otherwise refining or processing records in this system or for developing, modifying and/or manipulating automated information systems software. We also propose to add a routine use for the release of information that permits disclosure to agency contractors, consultants, and CMS grantees that perform a task for the agency. CMS occasionally contracts out certain of its functions when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor, consultant or grantee whatever information is necessary for the contractor, consultant, or grantee to fulfill its duties.

We propose to delete published routine use number 2 authorizing disclosure to the Bureau of Census;

published routine use number 7 authorizing disclosure to state Medicaid agencies; number 8 authorizing disclosure to an agency of a state Government, or established by state law, for purposes of determining the quality of health care services provided in the state; published routine use number 9 authorizing disclosure to another Federal or state agency; published routine use number 10 authorizing disclosure to other Federal agencies or states to support the administration of other Federal or state health care programs; and published routine use number 11 authorizing disclosure to the Social Security Administration. These routine uses duplicate the intended releases and as such will be combined into a single routine use to ''assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent to: (a) Contribute to the accuracy of CMS's proper payment of Medicare benefits, (b) enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with federal funds; and (c) evaluate and monitor the quality of health care in the program and contribute to the accuracy of health plan operations.''

We will modify existing routine use number 6 that permits disclosure to Peer Review Organizations (PRO). Organizations previously referred to as PROs will be renamed to read: Quality Improvement Organizations (QIO). Information will be disclosed to QIOs for health care quality improvement projects. The modified routine use will be renumbered as routine use number 4. We propose to delete published routine use number 14 authorizing disclosures to any entity that makes payment for or oversees administration of health care services to combat fraud and abuse against such entity or the program or services administered by such entity. This disclosure provision falls outside the scope of the stated purpose for the collection of data maintained in this system.

We will broaden the scope of this system by including the section titled ''Additional Circumstances Affecting Routine Use Disclosures,'' that addresses ''Protected Health Information (PHI)'' and ''small cell size.'' The requirement for compliance with HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' apply when ever the system collects or maintain PHI. This system may contain PHI. In addition, our policy to prohibit release if there is a possibility that an individual can be identified through ''small cell size'' will apply to the data disclosed from this system.

The security classification previously reported as ''None'' will be modified to reflect that the data in this system is considered to be ''Level Three Privacy Act Sensitive.'' We are modifying the language in the remaining routine uses to provide a proper explanation as to the need for the routine use and to provide clarity to CMS's intention to disclose individual-specific information contained in this system. The routine uses will then be prioritized and reordered according to their usage. We will also take the opportunity to update any sections of the system that were affected by the impact of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) provisions and to update language in the administrative sections to correspond with language used in other CMS SORs.

The primary purpose of this modified system is to collect and maintain information on Medicare beneficiaries enrolled in Medicare Health Plans in order to develop and disseminate information required by the Balanced Budget Act of 1997 that will inform beneficiaries and the public of indicators of health plan performance to help beneficiaries choose among health plans, support quality improvement activities within the plans, monitor and evaluate quality improvement activities within the plans, monitor and evaluate care provided by health plans; provide guidance to program management and policies, and provide a research data base for CMS and other researchers. The information retrieved from this system of records will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the Agency or by a contractor or consultant; (2) assist another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent, for evaluating and monitoring the quality of home health care and contribute to the accuracy of health insurance operations; (3) support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects; (4) support the functions of Quality Improvement Organizations (QIO); (5) support litigation involving the Agency; (6) combat fraud and abuse in certain health care programs. We have provided background information about the modified system in the **SUPPLEMENTARY INFORMATION** section below. Although the Privacy Act requires only that CMS provide an opportunity for interested persons to comment on the modified or altered routine uses, CMS invites comments on all portions of this notice. See **EFFECTIVE DATES** section for comment period.

EFFECTIVE DATES: CMS filed a modified or altered system report with the Chair of the House Committee on Government Reform and Oversight, the Chair of the Senate Committee on Homeland Security & Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on January 4, 2008. To ensure that all parties have adequate time in which to comment, the modified system, including routine uses, will become effective 30 days from the publication of the notice, or 40 days from the date it was submitted to OMB and Congress, whichever is later, unless CMS receives comments that require alterations to this notice.

ADDRESSES: The public should address comments to: CMS Privacy Officer, Division of Privacy Compliance, Enterprise Architecture and Strategy Group, Office of Information Services, CMS, Room N2–04–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Comments received will be available for review at this location, by appointment, during regular business hours, Monday through Friday from 9 a.m.–3 p.m., eastern time zone.

FOR FURTHER INFORMATION CONTACT: Ms. Lori Robinson, Director, Division of Plan Data, Plan Oversight and Accountability Group, Center for Beneficiary Choices, Center for Medicare & Medicaid Services, 7500 Security Boulevard, C4–14–21, Baltimore, Maryland 21244–1850. Her telephone number is (410) 786–1826 or via e-mail at *lori.robinson@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION: The Health Plan Management System is a database containing rates for selected performance measures for each Medicare health plan. The data are compiled by HIC number, member month contribution, and a flag to indicate if the member was counted in the rate's numerator. The system will collect rate information on categories such as the following:

- ''Use of Services'' measures such as the frequency of selected procedures (e.g., percutaneous transluminal coronary artery angioplasty, prostatectomy, coronary artery bypass with graft, hysterectomy, cholecystectomy, cardiac catheterization, reduction of fracture of

the femur, total hip and knee replacement, partial excision of the large intestine, carotid endarterectomy); percentage of members receiving inpatient, day/night and ambulatory mental health and chemical dependency services; readmission for chemical dependency, and specified mental health disorders.

• ''Effectiveness of Care'' measures such as breast cancer screening, beta blocker treatment after a heart attack, eye exams for people with diabetes, and follow-up after hospitalization for mental illness.

• ''Member Satisfaction'' measures related to quality, access, and general satisfaction.

• ''Functional Status'' measures which are patient centered and track actual outcomes or results of care, addressing both physical and mental well-being over time.

The information from HPMS will be augmented by being linked to other CMS data and other administrative data to provide validation and greater analytic capacity. The HPMS will be used to:

• Develop and disseminate summary information required by the Balanced Budget Act of 1997 that will inform beneficiaries and the public of indicators of health plan performance to help beneficiaries choose among health plans. The information will include plan-to-plan comparisons of benefits and co-payments supplemented with consumer satisfaction information and plan performance data.

• Support quality improvement activities. Summary data will be useful for health plans' internal quality improvement, as well as to CMS and Quality Improvement Organizations in monitoring and evaluating the care provided by health plans.

• Conduct research and demonstrations addressing managed care quality, access, and satisfaction issues.

• Provide guidance for program management and policy development.

HPMS houses the results of the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Survey (CAHPS). The system will contain information on recipients of Medicare Part A and Part B services who are enrolled in health plans and Part D plans. The total number of current enrollees in Medicare Part C health plans is approximately 9 million.

HEDIS reflects a joint effort of public and private purchasers, consumers, labor unions, health plans, and measurement experts to develop a comprehensive set of performance measures for Medicare, Medicaid, and commercial populations enrolled in managed care plans. HEDIS measures eight aspects of health care: Effectiveness of care; access/availability of care, satisfaction with the experience of care, health plan stability, use of services, cost of care, informed health care choices, and health plan descriptive information. In 1997, CMS is requiring reporting of a number of performance measures from HEDIS relevant to the Medicare managed care population. The HEDIS data is subject to audit, to ensure that plans submit accurate and complete data. Another aspect of the audit is to assess the reasonableness of the HEDIS measures. For example, if all or most health plans have problems with a particular measure, the problem could be with the measure, not the plans.

Included in HEDIS is a functional status measure which tracks both physical health and mental health status over a 2-year period through a self-administered instrument in which the beneficiary indicates whether his/her health status has improved, stayed the same, or deteriorated. The measure is risk adjusted for co-morbid conditions, income, race, education, social support, age, and gender. It will be used to compare how well plans care for seniors. It reflects the belief that high quality health care can either improve or at least slow the rate of decline in senior members' ability to lead active and independent lives.

In concert with the Agency for Health Care Policy and Research, CMS sponsored the development of a Medicare specific version of the CAHPS consumer satisfaction survey. The survey will collect information about Medicare enrollees' satisfaction, access, and quality of care within managed care plans. Beginning in 1997, CMS is requiring all Medicare contracting plans to participate in an independent third party administration of an annual member satisfaction survey.

All performance measures are subject to modification as new performance measurement sets are developed with a stronger focus on outcomes and chronic disease issues, including patient satisfaction and quality of life measures relevant to specific diseases.

The Privacy Act permits us to disclose information without the consent of individuals for ''routine uses''—that is, disclosures that are compatible with the purpose for which we collected the information. The proposed routine uses in the new system meet the compatibility criteria since the information is collected to produce estimates of health care use and quality, and determinants thereof, by the aged and disabled enrolled in group health plans. We anticipate the disclosures under the routine uses will not result in any unwarranted adverse effects on personal privacy.

The HPMS Complaints Tracking Module (CTM) stores beneficiary complaints related to the Medicare Advantage (MA) and Part D programs. This module contains beneficiary complaints that have been collected by 1–800–Medicare as well as beneficiary complaints entered directly into the CTM by CMS staff. The CTM stores complaint data, including, but not limited to, the following: Date complaint received; date of incident; issue level; complainant and/or beneficiary information; complaint summary; complaint category; complaint resolution summary; and plan resolution summary. Plans use the CTM to track the beneficiary complaints assigned to their organization, enter complaint case resolutions, and close out complaints. CMS uses the CTM to enter beneficiary complaints received directly by the regional office, perform casework for those complaints not assigned to an organization, and to monitor plan progress on resolving complaints timely.

We are sharing data pertaining to all marketing agents/brokers to assist CMS and State Department of Insurance (DOI) in improving oversight of the sales marketplace and in avoiding fraudulent sales practices that mislead and harm Medicare beneficiaries. Beneficiaries that are enrolled in a health plan or prescription drug plan under false, fraudulent pretense result in plan organizations receiving payments to which they are not entitled. As a result, there is a payment policy component involved. We will require contracted health plans and prescription drug plans, though contract or program memorandum (or both) to notify all agents/brokers that sell their Medicare products that their information is being shared with CMS, its contractors, and State DOIs.

I. Description of the Modified or Altered System of Records

A. Statutory and Regulatory Basis for SOR

Authority for maintenance of the system is given under section 1875 of the Social Security Act (the Act) (42 U.S.C. 1395ll), entitled Studies and Recommendations; section 1121 of the Act (42 U.S.C. 1121), entitled Uniform Reporting System for Health Services Facilities and Organizations; and § 1876 of the Act (42 U.S.C. 1395mm), entitled

Payments to Health Maintenance Organizations and Competitive Medical Plans. Authority for maintenance and dissemination of Health Plan information is also given under the Balanced Budget Act of 1997 (Pub. L. 105–33).

B. Collection and Maintenance of Data in the System.

Information is collected and maintained on recipients of Medicare Part A (Hospital Insurance) and Part B (supplementary medical insurance) services who are enrolled in Medicare health plans and prescription drug plans. CTM will collect and maintain identifiable information on individuals who are, but not limited to, complainants, including beneficiaries, relatives and caregivers, Congresspersons and their staff, State Health Insurance Program representatives, and providers of service and their staff. The system contains demographic and identifying data, as well as survey and deficiency data. Identifying data includes, but is not limited to: Name, title, address, city, state, ZIP code, e-mail address, telephone numbers, fax number, licensure number, SSN, Federal tax identification number, alias names, date of birth, gender, date admitted and/or date discharged. In addition, the CTM stores complaint data, including, but not limited to, the following: Date complaint received; date of incident; issue level; complainant and/or beneficiary information; complaint summary; complaint category; complaint resolution summary; and plan resolution summary.

II. Agency Policies, Procedures, and Restrictions on the Routine Use

A. Agency Policies, Procedures, and Restrictions on the Routine Use

The Privacy Act permits us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a ''routine use.'' The government will only release HPMS information that can be associated with an individual as provided for under ''Section III. Proposed Routine Use Disclosures of Data in the System.'' Both identifiable and non-identifiable data may be disclosed under a routine use.

We will only collect the minimum personal data necessary to achieve the purpose of HPMS. CMS has the following policies and procedures concerning disclosures of information that will be maintained in the system. Disclosure of information from this system will be approved only to the extent necessary to accomplish the purpose of the disclosure and only after CMS:

1. Determines that the use or disclosure is consistent with the reason that the data is being collected, *e.g.*, to collect and maintain information on Medicare beneficiaries enrolled in Medicare Health Plans.

2. Determines that:

a. The purpose for which the disclosure is to collect and maintain information on Medicare beneficiaries enrolled in Medicare Health Plans in order to develop and disseminate information required by the Balanced Budget Act of 1997 that will inform beneficiaries and the public of indicators of health plan performance to help beneficiaries choose among health plans, support quality improvement activities within the plans, monitor and evaluate quality improvement activities within the plans, monitor and evaluate care provided by health plans; provide guidance to program management and policies, and provide a research data base for CMS and other researchers;

b. the purpose for which the disclosure is to be made is of sufficient importance to warrant the effect and/or risk on the privacy of the individual that additional exposure of the record might bring; and

c. there is a strong probability that the proposed use of the data would in fact accomplish the stated purpose(s).

3. Requires the information recipient to:

a. Establish administrative, technical, and physical safeguards to prevent unauthorized use of disclosure of the record;

b. remove or destroy at the earliest time all patient-identifiable information; and

c. agree to not use or disclose the information for any purpose other than the stated purpose under which the information was disclosed.

4. Determines that the data are valid and reliable.

III. Proposed Routine Use Disclosures of Data in the System

A. The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a ''routine use.'' The proposed routine uses in this system meet the compatibility requirement of the Privacy Act. We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To agency contractors, or consultants, or to a grantee of a CMS-administered grant program who have been engaged by the agency to assist in the accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS.

We contemplate disclosing this information under this routine use only in situations in which CMS may enter into a contractual or similar agreement with a third party to assist in accomplishing a CMS function relating to purposes for this system. CMS occasionally contracts out certain of its functions when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor, consultant or grantee whatever information is necessary for the contractor or consultant to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor, consultant or grantee from using or disclosing the information for any purpose other than that described in the contract and requires the contractor, consultant or grantee to return or destroy all information at the completion of the contract.

2. To another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent to:

a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,

b. enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds, and/or

c. assist Federal/state Medicaid programs within the state.

Other Federal or state agencies in their administration of a Federal health program may require HPMS information in order to support evaluations and monitoring of Medicare claims information of beneficiaries, including proper reimbursement for services provided;

To another agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local law enforcement agencies) for a civil or criminal law enforcement activity (e.g. police, FBI, State Attorney General's office);

In addition, other state agencies in their administration of a Federal health program may require HPMS information for the purpose of developing and operating Medicaid reimbursement

systems; or for the purpose of administration of Federal/State program within the State. Data will be released to the State only on those individuals who are either patients within the State, of are legal residents of the State, regardless of the location of the facility in which the patient is receiving services;

To the agency of a State government, or established by State law, for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or the quality of services provided in the State; and

State agencies may use HPMS data to perform Federal certification and State licensure functions, including the investigation of complaints and entity-reported incidents.

3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.

The collected data will provide the research, evaluation and epidemiological projects a broader, longitudinal, national perspective of the data. CMS anticipates that many researchers will have legitimate requests to use these data in projects that could ultimately improve the care provided to Medicare patients and the policy that governs the care. CMS understands the concerns about the privacy and confidentiality of the release of data for a research use. Disclosure of data for research and evaluation purposes may involve aggregate data rather than individual-specific data.

4. To Quality Improvement Organizations (QIO) in order to assist the QIO to perform Title XI and Title XVIII functions relating to assessing and improving quality of care.

The QIO will work to implement quality improvement programs, provide consultation to CMS, its contractors, and to state agencies. The QIO will assist state agencies in related monitoring and enforcement efforts, assist CMS and intermediaries in program integrity assessment, and prepare summary information for release to CMS.

5. To the Department of Justice (DOJ), court or adjudicatory body when:

a. The agency or any component thereof, or

b. any employee of the agency in his or her official capacity, or

c. any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or

d. the United States Government is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

Whenever CMS is involved in litigation, and occasionally when another party is involved in litigation and CMS' policies or operations could be affected by the outcome of the litigation, CMS would be able to disclose information to the DOJ, court or adjudicatory body involved.

6. To assist a CMS contractor (including, but not necessarily limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program.

We contemplate disclosing information under this routine use only in situations in which CMS may enter into a contractual relationship or grant with a third party to assist in accomplishing CMS functions relating to the purpose of combating fraud and abuse.

CMS occasionally contracts out certain of its functions and makes grants when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor or grantee whatever information is necessary for the contractor or grantee to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor or grantee from using or disclosing the information for any purpose other than that described in the contract and requiring the contractor or grantee to return or destroy all information.

7. To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in, a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such programs.

Other agencies may require HPMS information for the purpose of combating fraud and abuse in such Federally-funded programs.

B. Additional Provisions Affecting Routine Use Disclosures

To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR Parts 160 and 164, 65 FR 82462 (12–28–00), Subparts A and E. Disclosures of such PHI that are otherwise authorized by these routine uses may only be made if, and as, permitted or required by the ''Standards for Privacy of Individually Identifiable Health Information.''

In addition, our policy will be to prohibit release even of data not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that individuals could, because of the small size, use this information to deduce the identity of the beneficiary).

IV. Safeguards

CMS has safeguards in place for authorized users and monitors such users to ensure against excessive or unauthorized use. Personnel having access to the system have been trained in the Privacy Act and information security requirements. Employees who maintain records in this system are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws and regulations may apply but are not limited to: the Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002; the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003; and the corresponding implementing regulations. OMB Circular A–130, Management of Federal Resources, Appendix III, Security of Federal Automated Information Resources, also

applies. Federal, HHS, and CMS policies and standards include but are not limited to: all pertinent National Institute of Standards and Technology publications, the HHS Information Systems Program Handbook, and the CMS Information Security Handbook.

V. Effects of the Modified or Altered System of Records on Individual Rights

CMS proposes to modify this system in accordance with the principles and requirements of the Privacy Act and will collect, use, and disseminate information only as prescribed therein. Data in this system will be subject to the authorized releases in accordance with the routine uses identified in this system of records.

CMS will take precautionary measures to minimize the risks of unauthorized access to the records and the potential harm to individual privacy or other personal or property rights of patients whose data are maintained in the system. CMS will collect only that information necessary to perform the system's functions. In addition, CMS will make disclosure from the proposed system only with consent of the subject individual, or his/her legal representative, or in accordance with an applicable exception provision of the Privacy Act. CMS, therefore, does not anticipate an unfavorable effect on individual privacy as a result of information relating to individuals.

Dated: January 3, 2008.

Charlene Frizzera,

Chief Operating Officer, Centers for Medicare & Medicaid Services.

SYSTEM NO. 09–70–0500

SYSTEM NAME:

''Health Plan Management System (HPMS),'' HHS/CMS/CBC.

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive Data.

SYSTEM LOCATION:

The Centers for Medicare & Medicaid Services (CMS) Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, Maryland 21244–1850 and at various co-locations of CMS agents.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Information is collected and maintained on recipients of Medicare Part A (Hospital Insurance) and Part B (supplementary medical insurance) services who are enrolled in Medicare health plans and prescription drug plans. Identifiable information will also be collected on individuals who are, but not limited to, complainants, including beneficiaries, relatives and caregivers, Congresspersons and their staff, State Health Insurance Program representatives, and providers of service and their staff.

CATEGORIES OF RECORDS IN THE SYSTEM:

The system contains demographic and identifying data, as well as survey and deficiency data. Identifying data includes, but is not limited to: name, title, address, city, state, ZIP code, e-mail address, telephone numbers, fax number, licensure number, SSN, Federal tax identification number, alias names, date of birth, gender, date admitted and/or date discharged. In addition, the CTM stores complaint data, including, but not limited to, the following: date complaint received; date of incident; issue level; complainant and/or beneficiary information; complaint summary; complaint category; complaint resolution summary; and plan resolution summary.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Authority for maintenance of the system is given under section 1875 of the Social Security Act (the Act) (42 U.S.C. 1395ll), entitled Studies and Recommendations; section 1121 of the Act (42 U.S.C. 1121), entitled Uniform Reporting System for Health Services Facilities and Organizations; and § 1876 of the Act (42 U.S.C. 1395mm), entitled Payments to Health Maintenance Organizations and Competitive Medical Plans. Authority for maintenance and dissemination of Health Plan information is also given under the Balanced Budget Act of 1997 (Pub. L. 105–33).

PURPOSE(S) OF THE SYSTEM:

The primary purpose of this modified system is to collect and maintain information on Medicare beneficiaries enrolled in Medicare Health Plans in order to develop and disseminate information required by the Balanced Budget Act of 1997 that will inform beneficiaries and the public of indicators of health plan performance to help beneficiaries choose among health plans, support quality improvement activities within the plans, monitor and evaluate quality improvement activities within the plans, monitor and evaluate care provided by health plans; provide guidance to program management and policies, and provide a research data base for CMS and other researchers. The information retrieved from this system of records will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the Agency or by a contractor or consultant; (2) assist another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent, for evaluating and monitoring the quality of home health care and contribute to the accuracy of health insurance operations; (3) support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects; (4) support the functions of Quality Improvement Organizations (QIO); (5) support litigation involving the Agency; (6) combat fraud and abuse in certain health care programs.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OR USERS AND THE PURPOSES OF SUCH USES:

A. The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a ''routine use.'' The proposed routine uses in this system meet the compatibility requirement of the Privacy Act. We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To agency contractors, or consultants, or to a grantee of a CMS-administered grant program who have been engaged by the agency to assist in the accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS.

2. To another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent to:

a. Contribute to the accuracy of CMS' proper payment of Medicare benefits,

b. Enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds, and/or

c. Assist Federal/state Medicaid programs within the state.

3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.

4. To Quality Improvement Organizations (QIO) in order to assist the QIO to perform Title XI and Title XVIII functions relating to assessing and improving quality of care.

5. To the Department of Justice (DOJ), court or adjudicatory body when:

a. The agency or any component thereof, or

b. Any employee of the agency in his or her official capacity, or

c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or

d. The United States Government is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

6. To assist a CMS contractor (including, but not necessarily limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program.

7. To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in, a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such programs.

B. Additional Provisions Affecting Routine Use Disclosures

To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR Parts 160 and 164, 65 Fed. Reg. 82462 (12–28–00), Subparts A and E. Disclosures of such PHI that are otherwise authorized by these routine uses may only be made if, and as, permitted or required by the ''Standards for Privacy of Individually Identifiable Health Information.''

In addition, our policy will be to prohibit release even of data not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that individuals could, because of the small size, use this information to deduce the identity of the beneficiary).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

All records are stored on the magnetic disk sub-system of the Sun Solaris 10 Server. Furthermore, these records are saved to magnetic tape backup on a nightly basis.

RETRIEVABILITY:

The records are retrieved by health insurance claims number or other individually identifying numbers.

SAFEGUARDS:

CMS has safeguards in place for authorized users and monitors such users to ensure against excessive or unauthorized use. Personnel having access to the system have been trained in the Privacy Act and information security requirements. Employees who maintain records in this system are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws and regulations may apply but are not limited to: the Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A–130, Management of Federal Resources, Appendix III, Security of Federal Automated Information Resources also applies. Federal, HHS, and CMS policies and standards include but are not limited to: all pertinent National Institute of Standards and Technology publications; the HHS Information Systems Program Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

CMS will retain identifiable HPMS data for at least 10 years or as long as needed for program research.

SYSTEM MANAGER(S) AND ADDRESS:

Director, Division of Plan Data, Plan Oversight and Accountability Group, Center for Beneficiary Choices, Center for Medicare & Medicaid Services, 7500 Security Boulevard, C4–14–21, Baltimore, Maryland 21244–1850.

NOTIFICATION PROCEDURE:

For purpose of access, the subject individual should write to the system manager who will require the system name, HICN, address, date of birth, and gender, and for verification purposes, the subject individual's name (woman's maiden name, if applicable), and SSN. Furnishing the SSN is voluntary, but it may make searching for a record easier and prevent delay.

RECORD ACCESS PROCEDURE:

For purpose of access, use the same procedures outlined in Notification Procedures above. Requestors should also specify the record contents being sought. (These procedures are in accordance with department regulation 45 CFR 5b.5(a)(2)).

CONTESTING RECORDS PROCEDURES:

The subject individual should contact the system manager named above, and reasonably identify the records and specify the information to be contested. State the corrective action sought and the reasons for the correction with supporting justification. (These Procedures are in accordance with Department regulation 45 CFR 5b.7).

RECORDS SOURCE CATEGORIES:

The identifying information contained in these records is obtained from the health plan and Part D organizations (which obtained the data from the individual concerned) or the individuals themselves. Also, these data will be linked with CMS administrative data, such as claims and enrollment.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Office of Head Start; Request for Nominations for the Secretary's Advisory Committee on Re-Designation of Head Start Grantees

AGENCY: Administration for Children and Families, Department of Health and Human Services (HHS).