from individual Medicare physicians, providers, and suppliers. Topics to be discussed during the meeting include, but are not limited to, FFS Medicare implementation of the National Provider Identifier (NPI), Medicare contractor provider satisfaction survey (MCPSS): ''Relevancy of questions in the business functions of appeals and medical review'', Medicare contracting reform, and value based purchasing.

There will be a question and answer session that offers meeting attendees an opportunity to provide feedback on how CMS serves physicians, providers, and suppliers, as well as make suggestions on how this process can be improved. The time for participants to ask questions and provide feedback will be limited according to the number of registered participants; however, written submissions will be accepted. Individuals who wish to provide written feedback should e-mail Colette Shatto at MFG@cms.hhs.gov. We will give consideration to feedback received on the topics discussed at the Town Hall meeting, but written responses will not be provided.

III. Registration Instructions

The Division of Provider Relations and Evaluations, Provider Communications Group, Center for Medicare Management, is coordinating the meeting registration. While there is no registration fee, individuals, providers, and suppliers must register to participate. Individuals interested in attending the meeting in person or by teleconference must complete the on-line registration located at *http://registration.intercall.com/go/cms2*.

The on-line registration system will capture contact information and practice characteristics, such as names, e-mail addresses, and provider and supplier types. Registration will be open on September 28, 2007 and close on October 12, 2007. Registration after 5 p.m. e.s.t. on October 12, 2007 will not be accepted.

The on-line registration system will generate a confirmation page to indicate the completion of your registration. Please print this page as your registration receipt. Teleconference instructions will be issued once participants have registered by using the on-line registration tool. If seating capacity has been reached, you will be notified that the meeting has reached capacity.

Special Accommodations: Individuals requiring sign language interpretation or other special accommodations must contact Colette Shatto by e-mail at *MFG@cms.hhs.gov*.

IV. Security, Building, and Parking Guidelines

Because this meeting will be located on Federal property, for security reasons, any persons wishing to attend this meeting must register by 5 p.m. e.s.t. on October 12, 2007. Individuals who have not registered in advance will not be allowed to enter the building to attend the meeting. Seating capacity is limited to the first 250 registrants.

The on-site check-in for visitors will be held from 12:30 p.m. to 1:30 p.m. e.s.t. Please allow sufficient time to go through the security checkpoints. It is suggested that you arrive at 7500 Security Boulevard no later than 1:30 p.m. e.s.t. so that you will be able to arrive promptly at the meeting by 2 p.m. e.s.t. All items brought to the building, whether personal or for the purpose of demonstration or to support a presentation, are subject to inspection.

Security measures will include inspection of vehicles, inside and out, at the entrance to the grounds. In addition, all persons entering the building must pass through a metal detector. All items brought to CMS, including personal items such as desktops, cell phones, and palm pilots, are subject to physical inspection.

Authority: Section 1811 and 1831 of the Social Security Act (42 U.S.C. 1395c and 1395j).

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

Dated: September 6, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E7–18113 Filed 9–27–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of a New System of Records

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

ACTION: Notice of a new System of Records (SOR).

SUMMARY: In accordance with the Privacy Act of 1974, we are proposing to establish a new SOR, ''Post-Acute Care Payment Reform / Continuity of Assessment Record and Evaluation Demonstration and Evaluation (PAC–CARE),'' System No. 09–70–0569. Information maintained in this system will continue to enable CMS to better understand the relationships among patient needs, post-acute care placement, patient outcomes, and post-acute care related costs in the Medicare program. Additionally, as required by Section 5008 of the Deficit Reduction Act of 2005, CMS is developing a comprehensive assessment for use at the time of hospital discharge which identifies the needs and clinical characteristics of the patient. Additionally, this standardized patient assessment instrument shall be used across post-acute care sites, including skilled nursing facilities, home health agencies, long term care hospitals and inpatient rehabilitation facilities, to measure functional status and other factors during treatment and at discharge from each provider.

CMS proposes to broaden the scope of the disclosure requirement by adding a new routine use number 6, authorizing disclosure of personal health information to providers to facilitate the proper transfer of health information for beneficiaries being discharged from their site of care to an admitting provider's care. Individuals from the admitting providers will only be granted access to personal health information, if they have the approved, authenticated, role based authority to do so, and the need to know and review the admitted patient's personal health information. Individuals will only be granted access to this information if they meet the following requirements: they must (1) provide an attestation or other qualifying information that they are providing assistance to qualified acute care or post-acute care beneficiaries admitted to their care site, (2) have physically admitted the beneficiary to their site and have initiated an assessment of the beneficiary, (3) safeguard the confidentiality of the data and prevent unauthorized access, and (4) accept an on-line statement attesting to the information recipient's understanding of and willingness to abide by these provisions. The routine uses will then be prioritized and reordered according to their usage.

The primary purpose of this proposed system is to collect and maintain, and release when appropriate, demographic, health records, and health resource use related data on the target population of Medicare and potentially, Medicaid beneficiaries who require treatment by a designated acute care or post-acute care provider. We will also collect certain identifying information on Medicare providers who provide services to such beneficiaries. Information retrieved from this system may be disclosed to: (1) Support regulatory, reimbursement, and

policy functions performed within the agency or by a contractor, grantee, consultant or other legal agent; (2) assist another Federal or state agency with information to contribute to the accuracy of CMS's proper payment of Medicare benefits, enable such agency to administer a Federal health benefits program, or to enable such agency to fulfill a requirement of Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds; (3) support an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects; (4) support the functions of Quality Improvement Organizations; (5) support the functions of national accreditation organizations; (6) permit the release of personal health information to complete a transfer-out (discharge) event and/or a transfer-in (admission) event; (7) support litigation involving the agency; and (8) combat fraud, waste, and abuse in certain Federally-funded health benefits 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 new 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 September 21, 2007. To ensure that all parties have adequate time in which to comment, the new 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: Shannon Flood, Division of Research on Traditional Medicare, Research and Evaluation Group, Office of Research Development & Information, Mail Stop C3–19–26, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1849. She can be reached by telephone at 410–786–2583, or via e-mail at *Shannon.Flood@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION: As required by Section 5008 of the Deficit Reduction Act of 2005, CMS is developing a comprehensive assessment for use at the time of hospital discharge which identifies the needs and clinical characteristics of the patient. Additionally this standardized patient assessment instrument shall be used across post-acute care sites, including skilled nursing facilities, home health agencies, long term care hospitals and inpatient rehabilitation facilities, to measure functional status and other factors during treatment and at discharge from each provider. This standardized patient assessment instrument is being developed under a contract between the CMS Office of Clinical Standards & Quality and the Research Triangle International (RTI) is referred to as ''Continuity Assessment Record and Evaluation (CARE).'' CARE consists of a set of assessment items under 5 major domains: medical, functional, social/environmental, cognitive and continuity of care. This assessment data, as well as demographic, medication, procedure, and treatment information will be collected for Medicare and potentially Medicaid beneficiaries. The CARE instrument will provide a foundation for a continuity of care record for patients across settings, over time. The new proposed routine use (6) refers only to data contained within the CARE tool and not the other data used in the project. The CARE tool is one of the data collection aspects of the demonstration. In addition, the demonstration will make use of such information as claims, staff time measurement logs, and unstructured staff interviews in its analyses.

I. Description of the Proposed System of Records

A. Statutory and Regulatory Basis for SOR

The statutory authority for this system is given under Sections 5008 of the Deficit Reduction Act of 2005.

B. Collection and Maintenance of Data in the System

This system will collect and maintain individually identifiable and other data collected on Medicare and potentially Medicaid beneficiaries who require treatment in a designated acute care or post-acute care provider. We will also collect certain identifying information on Medicare providers who provide services to such beneficiaries. The collected information will include, but is not limited to: Medicare claims and eligibility data, name, health insurance claims number (HICN), social security number (SSN) (the submission of a beneficiary's SSN is optional), race/ethnicity, gender, date of birth, provider name, unique CMS Certification Number (CCN), medical record number, as well as clinical, demographic, medication, procedure, treatment information, health/well-being, and background information relating to Medicare issues. Data will be collected from Medicare administrative and claims records, PAC–CARE site administrative data systems, patient medical charts, physician records, and via information submitted by beneficiaries and providers.

II. Agency Policies, Procedures, and Restrictions on Routine Uses

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 PAC–CARE 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 PAC–CARE. 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, and release when appropriate, demographic, health, and health resource use related data on the

target population of Medicare and potentially Medicaid beneficiaries who require treatment by a designated acute care or post-acute care provider. We will also collect certain identifying information on Medicare providers who provide services to such beneficiaries.

2. Determines that:

a. The purpose for which the disclosure is to be made can only be accomplished if the record is provided in individually identifiable form;

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, consultants or grantees, who have been engaged by the agency to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.

We contemplate disclosing 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 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 or state agency 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 PAC–CARE information in order to support evaluations and monitoring of Medicare claims information of beneficiaries, including proper reimbursement for services provided.

3. To an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects.

The PAC–CARE data will provide for research or support of evaluation projects and a broader, longitudinal, national perspective of the status of Medicare beneficiaries. CMS anticipates that researchers may have legitimate requests to use these data in projects that could ultimately improve the care provided to Medicare beneficiaries and the policies that govern their care.

4. To support Quality Improvement Organizations (QIO) in connection with review of claims, or in connection with studies or other review activities conducted pursuant to Part B of Title XI of the Act, and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans.

The QIO may use this data to support quality improvement activities and other QIO responsibilities as detailed in Title XI §§ 1151–1164. 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 assist national accreditation organization(s) whose accredited facilities are deemed to meet certain Medicare conditions of participation for inpatient hospital rehabilitation services (e.g., the Joint Commission and the American Osteopathic Association) with their survey process information will be released by CMS for only those providers that they deem and that participate in the Medicare program if they meet the following requirements:

a. Provide identifying information for post acute care facilities that have deemed status with the requesting accreditation organization;

b. Submission of a finder file identifying beneficiaries/patients receiving post-acute care services;

c. Safeguard the confidentiality of the data and prevent unauthorized access; and

d. Upon completion of a signed data exchange agreement or a CMS data use agreement.

At this time, CMS anticipates providing accreditation organizations with PAC–CARE information to enable them to target potential identified problems during the organization's accreditation review process of the facility.

6. To assist with a transfer-out event from a discharging acute or post-acute care provider and/or a transfer-in event to an admitting acute or post-acute care provider to:

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

b. Enable such providers to ensure the proper transfer of health records, and/or as necessary to enable such a provider to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal fund.

Individuals from the admitting providers will only be granted access to personal health information, if they have the approved, authenticated, role-based authority, and the defined need for access to that information. Individuals will only be granted access to information if they meet the following requirements:

a. Provide an attestation or other qualifying information that they are providing assistance to a qualified acute or post-acute care beneficiary receiving care/services through their provider site;

b. Have physically admitted the beneficiary to their care site, and are initiating an assessment of the

beneficiary, and can validate the beneficiary's name, HICN (or payer number or SSN), date of birth, and gender;

c. Safeguard the confidentiality of the data and prevent unauthorized access; and

d. Accept a written, on-line statement attesting to the information recipient's understanding of and willingness to abide by these provisions.

The PAC–CARE data will give the provider patient-specific personal health information which may facilitate the provider's required utilization reviews and medication management program activities; and assist in quality of care issues as they relate to the beneficiary.

7. 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.

8. To a CMS contractor (including, but not necessarily limited to, Medicare Administrative Contractors (MAC), 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, waste, and abuse in such program.

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

9. To 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, waste, 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, waste, or abuse in such programs.

Other agencies may require PAC–CARE information for the purpose of combating fraud, waste, 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, Subparts A and E) 65 FR 82462 (12–28–00). 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.'' (See 45 CFR 164.512(a)(1)).

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 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 include 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 NIST publications; the DHHS Information Systems Program Handbook and the CMS Information Security Handbook.

V. Effects of the Modified 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: September 18, 2007.

Charlene Frizzera,

Chief Operating Officer, Centers for Medicare & Medicaid Services.

SYSTEM NO. 09–70–0569

SYSTEM NAME:

''Post-Acute Care Payment Reform / Continuity of Assessment Record and Evaluation Demonstration and Evaluation (PAC–CARE),'' HHS/CMS/ORDI.

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 contractor sites and at CMS Regional Offices.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

This system will collect and maintain individually identifiable and other data collected on Medicare and potentially, Medicaid beneficiaries who require treatment in a designated acute care or post-acute care provider. We will also collect certain identifying information on Medicare providers who provide services to such beneficiaries.

CATEGORIES OF RECORDS IN THE SYSTEM:

The collected information will include, but is not limited to: Medicare claims and eligibility data, name, health insurance claims number (HICN), social security number (SSN) (the submission of a beneficiary's SSN is optional), race/ethnicity, gender, date of birth, provider name, unique CMS Certification Number (CCN), medical record number, as well as clinical, demographic, medication, procedure, treatment information, health/well-being, and background information relating to Medicare issues. Data will be collected from Medicare administrative and claims records, PAC–CARE site administrative data systems, patient medical charts, physician records, and via information submitted by beneficiaries and providers.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

The statutory authority for this system is given under Sections 5008 of the Deficit Reduction Act of 2005.

PURPOSE(S) OF THE SYSTEM:

The primary purpose of this proposed system is to collect and maintain, and release when appropriate, demographic, health records, and health resource use related data on the target population of Medicare and potentially, Medicaid beneficiaries who require treatment by a designated acute care or post-acute care provider. We will also collect certain identifying information on Medicare providers who provide services to such beneficiaries. Information retrieved from this system may be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, grantee, consultant or other legal agent; (2) assist another Federal or state agency with information to contribute to the accuracy of CMS's proper payment of Medicare benefits, enable such agency to administer a Federal health benefits program, or to enable such agency to fulfill a requirement of Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds; (3) support an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects; (4) support the functions of Quality Improvement Organizations; (5) support the functions of national accreditation organizations; (6) permit the release of personal health information to complete a transfer-out (discharge) event and/or a transfer-in (admission) event; (7) support litigation involving the agency; and (8) combat fraud, waste, and abuse in certain Federally-funded health benefits 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, consultants or grantees, who have been engaged by the agency to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.

2. To another Federal or state agency 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.

3. To an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects.

4. To support Quality Improvement Organizations (QIO) in connection with review of claims, or in connection with studies or other review activities conducted pursuant to Part B of Title XI of the Act, and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans.

5. To assist national accreditation organization(s) whose accredited facilities are deemed to meet certain Medicare conditions of participation for inpatient hospital rehabilitation services (*e.g.*, the Joint Commission and the American Osteopathic Association) with their survey process, information will be released by CMS for only those providers that they deem and that participate in the Medicare program and if they meet the following requirements:

a. Provide identifying information for post acute care facilities that have deemed status with the requesting accreditation organization;

b. Submission of a finder file identifying beneficiaries/patients receiving post acute care services;

c. Safeguard the confidentiality of the data and prevent unauthorized access; and

d. Upon completion of a signed data exchange agreement or a CMS data use agreement.

6. To assist with a transfer-out event from a discharging acute or post-acute care provider and/or a transfer-in event to an admitting acute or post-acute care provider to:

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

b. Enable such providers to ensure the proper transfer of health records, and/or as necessary to enable such a provider to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal fund.

Individuals from the admitting providers will only be granted access to personal health information, if they have the approved, authenticated, role-based authority, and the defined need for access to that information. Individuals will only be granted access

to information if they meet the following requirements:

a. Provide an attestation or other qualifying information that they are providing assistance to a qualified acute or post-acute care beneficiary receiving care/services through their provider site;

b. Have physically admitted the beneficiary to their care site, and are initiating an assessment of the beneficiary, and can validate the beneficiary's name, HICN (or payer number or SSN), date of birth, and gender;

c. Safeguard the confidentiality of the data and prevent unauthorized access; and

d. Accept a written, on-line statement attesting to the information recipient's understanding of and willingness to abide by these provisions.

7. 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.

8. To a CMS contractor (including, but not necessarily limited to, Medicare Administrative Contractors (MAC), 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, waste, and abuse in such program.

9. To 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, waste, 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, waste, 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, Subparts A and E) 65 FR 82462 (12–28–00). 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.'' (See 45 CFR 164.512(a)(1)).

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 magnetic media.

RETRIEVABILITY:

The Medicare records are retrieved by the HICN and SSN.

SAFEGUARDS:

CMS has safeguards in place for authorized users and monitors such users to ensure against 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 DHHS Information Systems Program Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

Records will be retained until an approved disposition authority is obtained from the National Archives and Records Administration. All claims-related records are encompassed by the document preservation order and will be retained until notification is received from DOJ.

SYSTEM MANAGER(S) AND ADDRESS:

Director, Research and Evaluation Group, Office of Research Development & Information, Mail Stop C3–19–26, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1849.

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:

Data will be collected from Medicare administrative and claims records

(Outcome and Assessment Information Set, Inpatient Rehabilitation Facilities Patient Assessment Instrument, Long Term Care Minimum Data Set), post-acute care site administrative data systems, patient medical charts, physician records, and via information submitted by beneficiaries and providers.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

[FR Doc. E7–19110 Filed 9–27–07; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Office of Planning, Research and Evaluation

AGENCY: Office of Planning, Research and Evaluation (OPRE), Administration for Children and Families (ACF), Department of Health and Human Services (HHS).

ACTION: Notice.

CFDA#: 93.600.

Statutory Authority: Section 649 of the Head Start Act, as amended by the COATES Human Services Reauthorization Act of 1998 (Pub. L. 105–285) and 42 U.S.C. 9844.

SUMMARY: Notice is hereby given that the Administration for Children and Families (ACF), Office of Planning, Research and Evaluation (OPRE) will award a non-competitive successor grant to OMNI Institute, Inc., a non-profit research organization located in Denver, CO. OMNI Institute, Inc. will assume a grant awarded under the Head Start University Partnership Research Grants: Curriculum Development and Enhancement for Head Start and Early Head Start Programs for the remainder of the project period July 15, 2007 to September 29, 2008. This action is taken as the original grantee, the University of Colorado Health Sciences Center, has relinquished the grant.

FOR FURTHER INFORMATION CONTACT: Wendy DeCourcey, PhD., Social Science Research Analyst, Administration for Children and Families, Office of Planning, Research and Evaluation, 370 L'Enfant Promenade, SW., Washington, DC 20447, or by phone at (202) 260–2039, or by e-mail at *wdecourcey@acf.hhs.gov.*

Dated: September 24, 2007.

Naomi Goldstein,

Director, Office of Planning, Research and Evaluation.

[FR Doc. E7–19276 Filed 9–27–07; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Submission for OMB Review; Comment Request; Revision of OMB No. 0925–0001/exp. 09/30/07, Research and Research Training Grant Applications and Related Forms

SUMMARY: Under the provisions of section 3507(a)(1)(D) of the Paperwork Reduction Act of 1995, the National Institutes of Health (NIH) has submitted to the Office of Management and Budget (OMB) a request for review and approval of the information collection listed below. This proposed information collection was previously published in the **Federal Register** on July 24, 2007, page 40313 and allowed 60-days for public comment. No public comments were received. The purpose of this notice is to allow an additional 30 days for public comment. The National Institutes of Health may not conduct or sponsor, and the respondent is not required to respond to, an information collection that has been extended, revised, or implemented on or after September 30, 2007, unless it displays a currently valid OMB control number.

Proposed Collection: Title: Research and Research Training Grant Applications and Related Forms. *Type of Information Collection Request:* Revision, OMB 0925–0001, Expiration Date 9/30/2007, Form Numbers: PHS 398, 2590, 2271, 3734 and HHS 568. *Need and Use of Information Collection:* The application is used by applicants to request Federal assistance for research and research-related training. The other related forms are used for trainee appointment, final invention reporting, and to relinquish rights to a research grant. *Frequency of Response:* Applicants may submit applications for published receipt dates. If awarded, annual progress is reported and trainees may be appointed or reappointed. *Affected Public:* Individuals or Households; Business or other for-profit; Not-for-profit institutions; Federal Government; and State, Local or Tribal Government. *Type of Respondents:* Adult scientific professionals. The annual reporting burden is as follows: *Estimated Number of Respondents:* 164,820; *Estimated Number of Responses per Respondent:* 1; *Average Burden Hours per Response:* 15.2; and *Estimated Total Annual Burden Hours Requested:* 2,517,458. The estimated annualized cost to respondents is $88,110,030.

Request for Comments: Written comments and/or suggestions from the public and affected agencies are invited on one or more of the following points: (1) Whether the proposed collection of information is necessary for the proper performance of the function of the agency, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Direct Comments to OMB: Written comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the: Office of Management and Budget, Office of Regulatory Affairs, New Executive Office Building, Room 10235, Washington, DC 20503, Attention: Desk Officer for NIH. To request more information on the proposed project or to obtain a copy of the data collection plans and instruments, contact: Contact Ms. Mikia Currie, Division of Grants Policy, Office of Policy for Extramural Research Administration, NIH, Rockledge 1 Building, Room 3505, 6705 Rockledge Drive, Bethesda, MD 20892–7974, or call non-toll-free number 301–435–0941, or e-mail your request, including your address to: *curriem@od.nih.gov.*

Comments Due Date: Comments regarding this information collection are best assured of having their full effect if received within 30 days of the date of this publication.

Dated: September 25, 2007.

Mikia Currie,

Program Analyst, National Institutes of Health.

[FR Doc. E7–19265 Filed 9–27–07; 8:45 am]

BILLING CODE 4140–01–P