assertion that their conduct was legitimate ''messengering'' of health plan contract offers. The prohibition on using the same agent as any other physician in connection with health plan contracting would not apply where respondents are obtaining bona fide legal services (that is, activities undertaken by an attorney that constitute the practice of law as defined by New Mexico law).

As in other orders addressing providers' collective bargaining with health care purchasers, certain kinds of agreements are excluded from the general bar on joint negotiations.

First, respondents would not be precluded from engaging in conduct that is reasonably necessary to form or participate in legitimate joint contracting arrangements among competing physicians, whether a ''qualified risk-sharing joint arrangement'' or a ''qualified clinically-integrated joint arrangement.''

As defined in the proposed order, a ''qualified risk-sharing joint arrangement'' possesses two key characteristics. First, all physician participants must share substantial financial risk through the arrangement, such that the arrangement creates incentives for the participants to control costs and improve quality by managing the provision of services. Second, any agreement concerning reimbursement or other terms or conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

A ''qualified clinically-integrated joint arrangement,'' on the other hand, need not involve any sharing of financial risk. Instead, as defined in the proposed order, physician participants must participate in active and ongoing programs to evaluate and modify their clinical practice patterns in order to control costs and ensure the quality of services provided, and the arrangement must create a high degree of interdependence and cooperation among physicians. As with qualified risk-sharing arrangements, any agreement concerning price or other terms of dealing must be reasonably necessary to achieve the efficiency goals of the joint arrangement.

Second, because the order is intended to reach agreements among horizontal competitors, Paragraph II would not bar agreements that only involve physicians who are part of the same medical group practice (defined in Paragraph I.E).

Paragraph III, which applies only to CPA, provides for the dissolution of the organization following the expiration or termination of all payor contracts, and in the interim requires that CPA cease all activities except those necessary to comply with the order and the winding down of its affairs. Further, Paragraph III.B requires CPA to distribute the complaint and order to all physicians who have participated in CPA, to payors that negotiated contracts with CPA or indicated an interest in contracting, and to the Carlsbad Medical Center. Paragraph III.C requires CPA, at any payor's request and without penalty, to terminate its current contracts with respect to providing physician services.

In the event that CPA fails to comply with the requirement to send out the notices set forth in Paragraph III.B, Paragraph IV requires Mr. Moore to do so.

Paragraphs V through IX of the proposed order impose various obligations on respondents to report or provide access to information to the Commission to facilitate monitoring respondents' compliance with the order.

The proposed order will expire in 20 years.

By direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. 03–11721 Filed 5–9–03; 8:45 am]

BILLING CODE 6750–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Delegations of Authority

Notice is hereby given that I have delegated to the Director, Indian Health Service, with authority to redelegate, all the authorities vested in the Secretary of Health and Human Services under Pub. L. 107–63, the Interior and Related Agencies Appropriations Act for Fiscal Year 2002, 115 Stat. 458, to accept land donated by the Tanadgusix Corporation.

This delegation is effective upon date of signature. In addition, I hereby ratify and affirm any actions taken by the Director, Indian Health Service, or his subordinates which involved the exercise of the authorities delegated herein prior to the effective date of this delegation.

Dated: May 2, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–11685 Filed 5–9–03; 8:45 am]

BILLING CODE 4160–16–M

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)(formerly the Health Care Financing Administration).

ACTION: Notice of a modified or altered System of Records (SOR).

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, we are proposing to modify or alter an SOR, ''1–800 Medicare + Choices Helpline (HELPLINE), System No. 09–70–0535.'' We are proposing to amend the purpose of the HELPLINE to include maintaining utilization and bill processing data and change the name to read the ''1–800–Medicare Helpline'' to reflect this amended purpose. Information collected will also be used to update the Enrollment Data Base, System No. 09–70–0502, which is now used to maintain enrollment-related data. The HELPLINE will retrieve utilization data used for bill payment record processing maintained in the ''Common Working File,'' System No. 09–70–0526.

CMS proposes 6 new routine uses to permit release of information to: (1) Another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (2) providers and suppliers of services for administration of Title XVIII of the Social Security Act (the Act); (3) third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs; (4) other insurers, third party administrators (TPA), employers, self-insurers, managed care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, group health plans (*i.e.*, health maintenance organizations (HMOs) or a competitive medical plan (CMP) with a Medicare contract, or a Medicare-approved health care prepayment plan (HCPP)), directly or through a contractor, and other groups providing protection for their enrollees to assist in the processing of individual insurance claims; and (5) combat fraud and abuse in certain health benefits programs.

We are modifying the language in the remaining routine uses to provide an easy to read format 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 proposed usage. We will also take the opportunity to update any sections of the system that were affected by the recent reorganization and to update language in the administrative sections to correspond with language used in other CMS SORs.

The primary purpose of the SOR is to provide general information to beneficiaries and future beneficiaries so that they can make informed Medicare decisions, maintain information on Medicare enrollment for the administration of the Medicare program, including the following functions: Ensuring proper Medicare enrollment, claims payment, Medicare premium billing and collection, coordination of benefits by validating and verifying the enrollment status of beneficiaries, and validating and studying the characteristics of persons enrolled in the Medicare program including their requirements for information. Information retrieved from this SOR will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the Agency or by a contractor or consultant; (2) another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3) providers and suppliers of services for administration of Title XVIII of the Act; (4) third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs; (5) other insurers for processing individual insurance claims; (6) support constituent requests made to a congressional representative; (7) support litigation involving the Agency; and (8) combat fraud and abuse in certain 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 proposed routine uses, CMS invites comments on all portions of this notice. See **EFFECTIVE DATES** section for comment period.

EFFECTIVE DATES: CMS filed a modified system report with the Chair of the House Committee on Government Reform and Oversight, the Chair of the Senate Committee on Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on March 13, 2003. To ensure that all parties have adequate time in which to comment, the new SOR, including routine uses, will become effective 40 days from the publication of the notice, or from the date it was submitted to OMB and the Congress, whichever is later, unless CMS receives comments that require alterations to this notice.

ADDRESSES: The public should address comments to: Director, Division of Privacy Compliance Data Development, OIS, 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 daylight time.

FOR FURTHER INFORMATION CONTACT: Kenneth Taylor, Health Insurance Specialist, Division of Call Center Operations, Customer Teleservice Operations Group, Center for Beneficiary Choices, CMS, 7500 Security Boulevard, C2–26–20, Baltimore, Maryland 21244–1850. The telephone number is 410–786–6736.

SUPPLEMENTARY INFORMATION:

I. Description of the Modified System

A. Background

The ''1–800–Medicare + Choices Helpline, System No. 09–70–0535, was established as a new system to broadly disseminate information to Medicare beneficiaries and prospective Medicare beneficiaries on the coverage options provided under the Medicare + Choice program in order to promote an active, informed selection among such options. The information campaign included, general information, information comparing plan options, information on Medi-gap and Medicare Select. This information is to be provided through toll-free telephone service, Internet site, print, and local education and outreach. Notice of this system was published at 66 **Federal Register** 16679 (Mar 20, 2001).

B. Statutory and Regulatory Basis for System

Authority for maintenance of the system is given under Title 41 Code of Federal Regulation (CFR) Chapter 101–20.302, Conduct on Federal Property, and OMB Circular A–123, Internal Control Systems, and Title 42 United States Code (U.S.C.) section 1395w–21 (d) (Pub. L. 105–3, the Balanced Budget Act of 1997).

II. Collection and Maintenance of Data in the System

A. Scope of the Data Collected

The collected information will contain name, address, telephone number, health insurance claim (HIC) number, geographic location, race/ethnicity, sex, date of birth, as well as, background information relating to Medicare or Medicaid issues. The HELPLINE will also maintain a caller history for purposes of re-contacts by customer service representatives or CMS, contain information related to Medicare enrollment and entitlement, group health plan enrollment data, as well as, background information relating to Medicare or Medicaid issues.

Information is collected on individuals age 65 or over who have been, or currently are, entitled to health insurance (Medicare) benefits under Title XVIII of the Act or under provisions of the Railroad Retirement Act, individuals under age 65 who have been, or currently are, entitled to such benefits on the basis of having been entitled for not less than 24 months to disability benefits under Title II of the Act or under the Railroad Retirement Act, individuals who have been, or currently are, entitled to such benefits because they have ESRD, individuals age 64 and 8 months or over who are likely to become entitled to health insurance (Medicare) benefits upon attaining age 65, and individuals under age 65 who have at least 21 months of disability benefits who are likely to become entitled to Medicare upon the 25th month of their being disabled.

B. 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 HELPLINE 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 HELPLINE. CMS has the following policies and procedures concerning disclosures of information that will be maintained in the system. Disclosure of information from the SOR 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 data is being collected; *e.g.*, maintain a caller history for purposes of re-contacts by customer service representatives or CMS, contain information related to Medicare enrollment and entitlement, group health plan enrollment data, as well as, background information relating to Medicare or Medicaid issues, insuring proper reimbursement for services provided, claims payment, and coordination of benefits provided to patients.

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. Entities Who May Receive Disclosures Under Routine Use

These routine uses specify circumstances, in addition to those provided by statute in the Privacy Act of 1974, under which CMS may release information from the HELPLINE without the consent of the individual to whom such information pertains. Each proposed disclosure of information under these routine uses will be evaluated to ensure that the disclosure is legally permissible, including but not limited to ensuring that the purpose of the disclosure is compatible with the purpose for which the information was collected. We are proposing to establish or modify the following routine use disclosures of information maintained in the system:

1. To Agency contractors, or consultants who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this SOR and who need to have access to the records in order to assist CMS.

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 a CMS function relating to purposes for this SOR.

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 or consultant 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 or consultant from using or disclosing the information for any purpose other than that described in the contract and requires the contractor or consultant to return or destroy all information at the completion of the contract.

2. To 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/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 HELPLINE information in order to support evaluations and monitoring of Medicare claims information of beneficiaries, including proper reimbursement for services provided;

In addition, other state agencies in their administration of a Federal health program may require HELPLINE information for the purposes of determining, evaluating and/or assessing cost, effectiveness, and /or the quality of health care services provided in the state;

Disclosure under this routine use shall be used by state Medicaid agencies pursuant to agreements with the HHS for determining Medicaid and Medicare eligibility, for quality control studies, for determining eligibility of recipients of assistance under Titles IV, XVIII, and XIX of the Act, and for the administration of the Medicaid program. Data will be released to the state only on those individuals who are patients under the services of a Medicaid program within the state or who are residents of that state.

We also contemplate disclosing information under this routine use in situations in which state auditing agencies require HELPLINE information for auditing state Medicaid eligibility considerations. CMS may enter into an agreement with state auditing agencies to assist in accomplishing functions relating to purposes for this SOR.

3. To providers and suppliers of services directly or through fiscal intermediaries (FIs) or carriers for the administration of Title XVIII of the Act.

Providers and suppliers of services require HELPLINE information in order to establish the validity of evidence or to verify the accuracy of information presented by the individual, as it concerns the individual's entitlement to benefits under the Medicare program, including proper reimbursement for services provided.

4. To third party contacts in situations where the party to be contacted has, or is expected to have information relating to the individual's capacity to manage his or her affairs or to his or her eligibility for, or an entitlement to, benefits under the Medicare program and,

a. The individual is unable to provide the information being sought (an individual is considered to be unable to provide certain types of information when any of the following conditions exists: The individual is confined to a mental institution, a court of competent jurisdiction has appointed a guardian to manage the affairs of that individual, a court of competent jurisdiction has declared the individual to be mentally incompetent, or the individual's attending physician has certified that the individual is not sufficiently mentally competent to manage his or her own affairs or to provide the information being sought, the individual cannot read or write, cannot afford the cost of obtaining the information, a language barrier exist, or the custodian of the information will not, as a matter of policy, provide it to the individual), or

b. The data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns one or more of the following: The individual's entitlement to benefits under the Medicare program, the amount of reimbursement, and in cases in which the evidence is being reviewed as a result of suspected fraud and abuse, program integrity, quality appraisal, or

evaluation and measurement of activities.

Third parties contacts require HELPLINE information in order to provide support for the individual's entitlement to benefits under the Medicare program; to establish the validity of evidence or to verify the accuracy of information presented by the individual, and assist in the monitoring of Medicare claims information of beneficiaries, including proper reimbursement of services provided.

5. To insurance companies, third party administrators (TPA), employers, self-insurers, managed care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, group health plans (*i.e.*, health maintenance organizations (HMOs) or a competitive medical plan (CMP) with a Medicare contract, or a Medicare-approved health care prepayment plan (HCPP)), directly or through a contractor, and other groups providing protection for their enrollees. Information to be disclosed shall be limited to Medicare entitlement data. In order to receive the information, they must agree to:

a. Certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a TPA;

b. Utilize the information solely for the purpose of processing the identified individual's insurance claims; and

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

Other insurers, TPAs, HMOs, and HCPPs may require HELPLINE information in order to support evaluations and monitoring of Medicare claims information of beneficiaries, including proper reimbursement for services provided.

6. To a Member of Congress or a congressional staff member in response to an inquiry of the congressional office made at the written request of the constituent about whom the record is maintained.

Beneficiaries often request the help of a Member of Congress in resolving some issue relating to a matter before HCFA. The Member of Congress then writes HCFA, and HCFA must be able to give sufficient information tin response to the inquiry.

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.

Whenever CMS is involved in litigation, or occasionally when another party is involved in litigation and CMS's 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 limited to FIs 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 programs.

We contemplate disclosing information under this routine use only in situations in which CMS may enter into a contract 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 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.

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 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 HELPLINE information for the purpose of combating fraud and abuse in such Federally funded programs.

B. Additional Circumstances Affecting Routine Use Disclosures

This system contains Protected Health Information 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 Protected Health Information 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 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 who are familiar with the enrollees could, because of the small size, use this information to deduce the identity of the beneficiary).

I. Safeguards

A. Administrative Safeguards

The HELPLINE system will conform to applicable law and policy governing the privacy and security of Federal automated information systems. These include but are not limited to: The Privacy Act of 1984, Computer Security Act of 1987, the Paperwork Reduction Act of 1995, the Clinger-Cohen Act of 1996, and the Office and Management and Budget (OMB) Circular A–130, Appendix III, ''Security of Federal Automated Information Resources.'' CMS has prepared a comprehensive system security plan as required by OMB Circular A–130, Appendix III. This plan conforms fully to guidance issued by the National Institute for Standards and Technology (NIST) in NIST Special Publication 800–18, ''Guide for Developing Security Plans for Information Technology Systems. Paragraphs A–C of this section highlight some of the specific methods that CMS is using to ensure the security of this system and the information within it.

Authorized users: Personnel having access to the system have been trained in Privacy Act and systems security requirements. Employees and contractors who maintain records in the system are instructed not to release any data until the intended recipient agrees to implement appropriate administrative, technical, procedural, and physical safeguards sufficient to protect the confidentiality of the data and to prevent unauthorized access to the data. In addition, CMS is monitoring

the authorized users to ensure against excessive or unauthorized use. Records are used in a designated work area or workstation and the system location is attended at all times during working hours.

To insure security of the data, the proper level of class user is assigned for each individual user as determined at the Agency level. This prevents unauthorized users from accessing and modifying critical data. The system database configuration includes five classes of database users:

- Database Administrator class owns the database objects; *e.g.*, tables, triggers, indexes, stored procedures, packages, and has database administration privileges to these objects;
- Quality Controls Administrator classes have read and write access to key fields in the database;
- Quality Indicator Report Generator class has read-only access to all fields and tables;
- Policy Research class has query access to tables, but are not allowed to access confidential patient identification information; and
- Submitter classes have read and write access to database objects, but no database administration privileges.

B. Physical Safeguards

All server sites have implemented the following minimum requirements to assist in reducing the exposure of computer equipment and thus achieve an optimum level of protection and security for the HELPLINE system:

Access to all servers is controlled, with access limited to only those support personnel with a demonstrated need for access. Servers are to be kept in a locked room accessible only by specified management and system support personnel. Each server requires a specific log-on process. All entrance doors are identified and marked. A log is kept of all personnel who were issued a security card; key and/or combination that grant access to the room housing the server, and all visitors are escorted while in this room. All servers are housed in an area where appropriate environmental security controls are implemented, which include measures implemented to mitigate damage to Automated Information System resources caused by fire, electricity, water and inadequate climate controls.

Protection applied to the workstations, servers and databases include:

- User Log on—Authentication is performed by the Primary Domain Controller/Backup Domain Controller of the log-on domain.
- Workstation Names—Workstation naming conventions may be defined and implemented at the Agency level.
- Hours of Operation—May be restricted by Windows NT. When activated all applicable processes will automatically shut down at a specific time and not be permitted to resume until the predetermined time. The appropriate hours of operation are determined and implemented at the Agency level.
- Inactivity Log-out—Access to the NT workstation is automatically logged out after a specified period of inactivity.
- Warnings—Legal notices and security warnings display on all servers and workstations.
- Remote Access Services (RAS)—Windows NT RAS security handles resource access control. Access to NT resources is controlled for remote users in the same manner as local users, by utilizing Windows NT file and sharing permissions. Dial-in access can be granted or restricted on a user-by-user basis through the Windows NT RAS administration tool.

C. Procedural Safeguards

All automated systems must comply with Federal laws, guidance, and policies for information systems security as stated previously in this section. Each automated information system should ensure a level of security commensurate with the level of sensitivity of the data, risk, and magnitude of the harm that may result from the loss, misuse, disclosure, or modification of the information contained in the system.

V. Effect of the Modified System on Individual Rights

CMS proposes to establish this system in accordance with the principles and requirements of the Privacy Act and will collect, use, and disseminate information only as prescribed therein. We will only disclose the minimum personal data necessary to achieve the purpose of HELPLINE. Disclosure of information from the SOR will be approved only to the extent necessary to accomplish the purpose of the disclosure. CMS has assigned a proper level of security clearance for the information in this system to provide added security and protection of data in this system.

CMS will monitor the collection and reporting of HELPLINE data. 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. 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 the disclosure of information relating to individuals.

Dated: March 13, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare and Medicaid Services.

09–70–0535

SYSTEM NAME:

1–800 Medicare Helpline (HELPLINE), HHS/CMS/CBC.

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive.

SYSTEM LOCATION:

CMS Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, Maryland 21244–1850 and at various co-locations of CMS Call Center contractors.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Information is collected on individuals age 65 or over who have been, or currently are, entitled to health insurance (Medicare) benefits under Title XVIII of the Act or under provisions of the Railroad Retirement Act, individuals under age 65 who have been, or currently are, entitled to such benefits on the basis of having been entitled for not less than 24 months to disability benefits under Title II of the Act or under the Railroad Retirement Act, individuals who have been, or currently are, entitled to such benefits because they have ESRD, individuals age 64 and 8 months or over who are likely to become entitled to health insurance (Medicare) benefits upon attaining age 65, and individuals under age 65 who have at least 21 months of disability benefits who are likely to become entitled to Medicare upon the 25th month of their being disabled.

CATEGORIES OF RECORDS IN THE SYSTEM:

The collected information will contain name, address, telephone number, health insurance claim (HIC) number, geographic location, race/ethnicity, sex, and date of birth, as well as, background information relating to Medicare or Medicaid issues. The HELPLINE will also maintain a caller history for purposes of re-contacts by customer service representatives or CMS, contain information related to

Medicare enrollment and entitlement, and group health plan enrollment data, as well as, background information relating to Medicare or Medicaid issues.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Authority for maintenance of this system is given under provisions of 41 Code of Federal Regulations (CFR), Chapter 101–20.302, Conduct on Federal Property, Office of Management and Budget (OMB) Circular A–123, Internal Control, and Title 42 United States Code (U.S.C.) section 1395W–21 (d) (Public Law 105–33, the Balanced Budget Act of 1997).

PURPOSE (S):

The primary purpose of the SOR is to provide general information to beneficiaries and future beneficiaries so that they can make informed Medicare decisions, maintain information on Medicare enrollment for the administration of the Medicare program, including the following functions: ensuring proper Medicare enrollment, claims payment, Medicare premium billing and collection, coordination of benefits by validating and verifying the enrollment status of beneficiaries, and validating and studying the characteristics of persons enrolled in the Medicare program including their requirements for information. Information retrieved from this SOR will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the Agency or by a contractor or consultant; (2) another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3) providers and suppliers of services for administration of Title XVIII of the Social Security Act; (4) third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs; (5) other insurers for processing individual insurance claims; (6) support constituent requests made to a congressional representative; (7) support litigation involving the Agency; and (8) combat fraud and abuse in certain health benefits programs.

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

These routine uses specify circumstances, in addition to those provided by statute in the Privacy Act of 1974, under which CMS may release information from the HELPLINE without the consent of the individual to whom such information pertains. Each proposed disclosure of information under these routine uses will be evaluated to ensure that the disclosure is legally permissible, including but not limited to ensuring that the purpose of the disclosure is compatible with the purpose for which the information was collected. In addition, our policy will be to prohibit release even of non-identifiable data, except pursuant to one of the routine uses, if 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 who are familiar with the enrollees could, because of the small size, use this information to deduce the identity of the beneficiary).

This SOR contains Protected Health Information as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR parts 160 and 164, 65 **Federal Register** (FR) 82462 (12–28–00), subparts A and E. Disclosures of Protected Health Information 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.'' We are proposing to establish or modify the following routine use disclosures of information maintained in the system:

1. To Agency contractors, or consultants who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this SOR and who need to have access to the records in order to assist CMS.

2. To 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/or

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

3. To providers and suppliers of services directly or through fiscal intermediaries or carriers for the administration of Title XVIII of the Social Security Act.

4. To third party contacts in situations where the party to be contacted has, or is expected to have information relating to the individual's capacity to manage his or her affairs or to his or her eligibility for, or an entitlement to, benefits under the Medicare program and,

a. The individual is unable to provide the information being sought (an individual is considered to be unable to provide certain types of information when any of the following conditions exists: The individual is confined to a mental institution, a court of competent jurisdiction has appointed a guardian to manage the affairs of that individual, a court of competent jurisdiction has declared the individual to be mentally incompetent, or the individual's attending physician has certified that the individual is not sufficiently mentally competent to manage his or her own affairs or to provide the information being sought, the individual cannot read or write, cannot afford the cost of obtaining the information, a language barrier exist, or the custodian of the information will not, as a matter of policy, provide it to the individual), or

b. The data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns one or more of the following: The individual's entitlement to benefits under the Medicare program, the amount of reimbursement, and in cases in which the evidence is being reviewed as a result of suspected fraud and abuse, program integrity, quality appraisal, or evaluation and measurement of activities.

5. To insurance companies, third party administrators (TPA), employers, self-insurers, managed care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, group health plans (*i.e.*, health maintenance organizations (HMOs) or a competitive medical plan (CMP) with a Medicare contract, or a Medicare-approved health care prepayment plan (HCPP)), directly or through a contractor, and other groups providing protection for their enrollees. Information to be disclosed shall be limited to Medicare entitlement data. In order to receive the information, they must agree to:

a. Certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a TPA;

b. Utilize the information solely for the purpose of processing the identified individual's insurance claims; and

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

6. To a Member of Congress or a congressional staff member in response to an inquiry of the congressional office made at the written request of the constituent about whom the record is maintained.

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.

8. To a CMS contractor (including, but not limited to FIs 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 programs.

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 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.

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

STORAGE:

Information is maintained on paper, computer diskette and on magnetic storage media.

RETRIEVABILITY:

The records are retrieved by name and identification number.

SAFEGUARDS:

CMS has safeguards 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 systems security requirements. Employees who maintain records in the system are instructed not to release any data until the intended recipient agrees to implement appropriate administrative, technical, procedural, and physical safeguards sufficient to protect the confidentiality of the data and to prevent unauthorized access to the data.

In addition, CMS has physical safeguards in place to reduce the exposure of computer equipment and thus achieve an optimum level of protection and security for the HELPLINE system. For computerized records, safeguards have been established in accordance with the Department of Health and Human Services (HHS) standards and National Institute of Standards and Technology guidelines, *e.g.*, security codes will be used, limiting access to authorized personnel. System securities are established in accordance with HHS, Information Resource Management (IRM) Circular #10, Automated Information Systems Security Program; CMS Automated Information Systems (AIS) Guide, Systems Securities Policies, and OMB Circular No. A–130 (revised), Appendix III.

RETENTION AND DISPOSAL:

Records are maintained for a period of 10 years.

SYSTEM MANAGER(S) AND ADDRESS:

Director, Division of Call Center Operations, Customer Teleservice Operations Group, Center for Beneficiary Choices, CMS, 7500 Security Boulevard, C2–26–20, 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, health insurance claim number, address, date of birth, and sex, and for verification purposes, the subject individual's name (woman's maiden name, if applicable), and social security number (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 reasonably specify the record contents being sought. (These procedures are in accordance with department regulation 45 CFR 5b.5(a)(2)).

CONTESTING RECORD PROCEDURES:

The subject individual should contact the systems manager named above, and reasonably identify the record 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).

RECORD SOURCE CATEGORIES:

The data contained in these records are furnished by the individual, or in the case of some situations, through third party contacts that make calls to the 1–800 Medicare Helpline. Updating information is also obtained from the Enrollment Data Base, Common Working File, and the Master Beneficiary Record maintained by the Social Security Administration.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

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BILLING CODE 4120–03–U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Submission for OMB Review; Comment Request; NCCAM Customer Service Data Collection

SUMMARY: Under the provisions of Section 3507(a)(1)(D) of the Paperwork Reduction Act of 1995, the National Center for Complementary and Alternative Medicine (NCCAM), the National Institutes of Health (NIH), will submit to the Office of Management and Budget (OMB) a request for review and approval of the information collection listed below. A notice of this proposed information collection was previously published in the **Federal Register** on February 24, 2003, page 8610–8611, and allowed 60 days for public comment. No public comments were received. The purpose of this notice is to announce a final 30 days for public comment. NIH 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 October 1, 1995, unless it displays a currently valid OMB control number.

Proposed Collection

Title: NCCAM Customer Service Data Collection. *Type of Information Collection Request:* New. *Need and Use of Information Collection:* NCCAM provides the public, patients, families, health care providers, complementary and alternative medicine (CAM) practitioners, and others with the latest scientifically based information on CAM and information about NCCAM's programs through a variety of channels including its toll-free telephone information service and its quarterly newsletter. NCCAM wishes to measure customer satisfaction with NCCAM telephone interactions and the NCCAM