A Subcommittee was established at the SACHRP's fourth meeting on October 5, 2004, to provide assistance in addressing issues related to the specified topics.

On February 1, 2005, SACHRP will hear presentations from experts on the following topics: Adverse Events reporting and Compliance Oversight Issues.

Public attendance at the meeting is limited to space available. Individuals who plan to attend the meeting and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the designated contact persons. Members of the public will have the opportunity to provide comments on both days of the meeting. Public comment will be limited to five minutes per speaker. Any members of the public who wish to have printed materials distributed to SACHRP members for this scheduled meeting should submit materials to the Executive Director, SACHRP, prior to the close of business on January 14, 2005.

Information about SACHRP and the draft meeting agenda will be posted on the SACHRP Web site at *http://www.dhhs.gov/ohrp/sachrp/index.html.*

Dated: December 10, 2004.

Bernard A. Schwetz,

Director, Office for Human Research Protections, Executive Secretary, Secretary's Advisory Committee on Human Research Protections.

[FR Doc. 04–27490 Filed 12–15–04; 8:45 am]

BILLING CODE 4150–36–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Reproductive Health Research, Request for Applications Number (RFA) DP–05–010

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Public Law 92–463), the Centers for Disease Control and Prevention (CDC) announces the following meeting:

Name: Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Reproductive Health Research, RFA DP–05–010.

Times and Dates: 8:30 a.m.–9 a.m., January 10, 2005 Panel A (Open). 9 a.m.–5 p.m., January 10, 2005 Panel A (Closed). 9 a.m.–2 p.m., January 11, 2005 Panel A (Closed). 8:30 a.m.–9 a.m., January 11, 2005 Panel B (Open). 9 a.m.–5 p.m., January 11, 2005 Panel B (Closed). 9 a.m.–2 p.m., January 12, 2005 Panel B (Closed). 8:30 a.m.–9 a.m., January 12, 2005 Panel C (Open). 9 a.m.–5 p.m., January 12, 2005 Panel C (Closed). 9 a.m.–5 p.m., January 13, 2005 Panel C (Closed).

Place: Sheraton Colony Square Hotel, 188 14th Street, NE., Atlanta, GA 30361, Telephone Number 404.892.6000.

Status: Portions of the meeting will be closed to the public in accordance with provisions set forth in Section 552b(c) (4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters to be Discussed: The meeting will include the review, discussion, and evaluation of applications received in response to: Reproductive Health Research, RFA DP–05–010.

Contact Person for More Information: Antonia J. Spadaro, EdD, Centers for Disease Control and Prevention, National Center for Chronic Disease and Health Promotion, 4770 Buford Hwy, Mailstop K–92, Atlanta, GA 30341, Telephone 770.488.5809.

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

Dated: December 8, 2004.

Alvin Hall,

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

[FR Doc. 04–27516 Filed 12–15–04; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Procedures and Costs for Use of the Research Data Center; Amendment

In the notice document announcing the ''Procedures and Costs for Use of the Research Data Center,'' appearing on page 67584 in the **Federal Register** issue of Thursday, November 18, 2004, the notice is amended to extend the comment period as follows:

On page 67584 under the **DATES** heading, change ''December 9, 2004'', to ''March 1, 2005.''

All other information in the document remains unchanged.

Dated: December 8, 2004.

James D. Seligman,

Associate Director for Program Services, Centers for Disease Control and Prevention (CDC).

[FR Doc. 04–27514 Filed 12–15–04; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of Modified or Altered System

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

ACTION: Notice of proposed modification or alteration to a 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, ''Unique Physician/Practitioner Identification Number (UPIN) (formerly known as the Medicare Physician Identification and Eligibility System),'' System No. 09–70–0525. We propose to delete published routine use number 1 authorizing disclosure to contractors for refining or processing records, and in connection with Automated Data Processing software or a telecommunication system containing or supporting records in the system, number 3 authorizing disclosure to the Railroad Retirement Board (RRB), number 6 authorizing disclosure to the Department of Justice (DOJ) for investigating and prosecuting violations of the Social Security Act (the Act), number 7 authorizing disclosure to state licensing boards for review of unethical practices or non-professional conduct, and an unnumbered routine use authorizing disclosure to the Social Security Administration (SSA). Disclosures that were previously permitted under published routine use number 1 will now be authorized under proposed routine use number 2. Proposed routine use number 2 will release information to ''agency contractors or consultants'' who have been engaged by the agency to assist in accomplishment of a CMS function related to this system of records (SOR).

Disclosures previously permitted under published routine uses number 3, 7, and to the SSA will be authorized by proposed routine use number 3, which will release information to ''another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent.'' Disclosures authorizing release to DOJ for investigating and prosecuting violations of the Act will be carried out under proposed routine use number 9, which authorizes release of data to ''combat fraud and abuse.'' We propose to add 3 new routine uses to provide disclosure of records when all

requirements have been met: number 1, to provide beneficiaries and other individuals with the identification of each physician or non-physician practitioner assigned a UPIN and who are participating in the Medicare program; number 2, to provide records to contractors who need to have access to records in order to assist CMS; number 3, to provide records to fiscal intermediaries and state and Federal agencies to contribute to the accuracy of Medicare payments, enable CMS to administer benefits programs and/or comply with Federal statutes or regulations, and to assist Medicaid programs within the state. The language in previous routine uses numbered 2, 4, 5, and 8 has been modified. Routine uses previously numbered 2, 5, 8, 9, and 10 have been renumbered as 6, 7, 5, 8 and 9 respectively.

The security classification previously reported as ''None'' will be modified to reflect that the data in this system is considered to be ''Level Three Privacy Act Sensitive.'' We are modifying the language in the remaining routine uses to provide clarity to CMS's intention to disclose individual-specific information contained in this system. The routine uses will then be prioritized and reordered according to their usage. We will also take the opportunity to update any sections of the system that were affected by a 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 maintain unique identification of each physician, non-physician practitioner, or medical group practice requesting or receiving Medicare payment. Information retrieved from this SOR will be used to: (1) Provide beneficiaries and other individuals with the identification of each physician or non-physician practitioner assigned an unique identification number and who are participating in the Medicare program; (2) support regulatory, reimbursement, and policy functions performed within the agency or by a contractor or consultant; (3) assist another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (4) assist Quality Improvement Organizations; (5) provide the American Medical Association with information needed for them to assist us in identifying physicians; (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 modifications to the routine uses, CMS invites comments on all portions of this notice. See **EFFECTIVE DATES** section for comment period.

DATES: *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 October 14, 2004. To ensure that all parties have adequate time in which to comment, the modified system of records, 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, 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: Kimberly Brandt, Acting, Director, Program Integrity Group, Office of Financial Management, CMS, 7500 Security Boulevard, C3–02–17, Baltimore, Maryland 21244–1850. The telephone number is (410) 786–1909.

SUPPLEMENTARY INFORMATION:

I. Description of the Modified System of Records

A. Statutory and Regulatory Basis For System of Records

In 1988, CMS modified an SOR under the authority of sections 1842 (r)–(42 U.S.C. 1395u) of Public Law 101–508; 1861(s)(1)–(42 U.S.C. 1395x); sections 1833 (q)(1)–(42 U.S.C. 1395l); 1842(b)(18)–(42 U.S.C. 1395u); (1842 (h)(4) & (5)–(42 U.S.C. 1395u); and 4164 of Omnibus Budget Reconciliation Act of 1990 (OBRA). Section 1871 (a)(1)–(42 U.S.C. 1395hh) provides that the Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance program under Title XVIII. Section 1833 (d)–(42 U.S.C. 1395l), prohibits making payment under Part B for services which are payable under Part A. Notice for this system, ''Unique Physician/Practitioner Identification Number (UPIN),'' System No. 09–70–0525, was most recently published in full at 54 FR 28119 (July 5, 1989), an expanded function and purpose of system and name change are at 61 FR 20528, (May 7, 1996), an unnumbered routine use was added for the Social Security Administration (SSA) at 61 FR 6645 (Feb. 21, 1996), three new fraud and abuse routine uses were added at 63 FR 38414 (July 16, 1998), and then at 65 FR 50552 (Aug. 18, 2000), two of the fraud and abuse routine uses were revised and a third deleted. UPIN contains records of all physicians, non-physician practitioners and medical group practice as defined by section 1861(r)–(42 U.S.C. 1395x), 1877(h) (4)–(42 U.S.C. 1395) of Title XVIII of the Act, who provide services for which payment is made under Medicare. By uniquely identifying all Part B health professional and practitioners and groups, CMS believes we will eliminate the possibility of double payment.

Medicare carriers currently identify physicians, non-physician practitioners and groups using their own individual systems of assigned numbers. These individualized systems allow for Physician Identification Numbers (PIN) ranging from 4 to 16 alphabetic and/or numeric characters. Some carriers assign separate PINs to the same physician providing medical services in more than one locality, office or practice and lack the capability to cross reference the PIN and related physician data (e.g., group affiliation).

Other carriers maintain a single PIN or cross-referenced PIN for each physician practicing within the carrier's geographic area of responsibility. The assignment of a unique, nationwide identification number will help eliminate the possibility of double billing where physicians, non-physician practitioners, and groups can furnish medical services in, as well as bill for these services from several locations or states which are in different carrier jurisdictions. In addition, independent physicians who have been found to be ineligible for Medicare payments in one area, location or state are prevented from receiving inappropriate or illegal payment in one or more other areas, locations or states.

In order to rectify the problems inherent in these individualized identification systems, CMS proposed to expand the Registry under Congressional mandate (Section 9202 of the Consolidated Omnibus Reconciliation Act of 1985, Public Law 99272), that created a uniform record

system under UPIN. The proposed changes to this national system or Registry of Unique Physician/Practitioner Identification Number will enable CMS to more readily identify all physicians, non-physician practitioners, and group practices deemed ineligible for Medicare payments and maintain more comprehensive data on physician credentials.

II. Collection and Maintenance of Data in the System

A. Scope of the Data Collected

The records contain a UPIN for each physician, non-physician practitioner, and medical group practices defined by sections 1124(A)–(42 U.S.C. 1320A–3), 1861(r), 1842(b)(18)(ii)(iii)(iv)(v)(r), and 1877(h)(4) of the Act who request or receive Medicare reimbursement for medical services. The system contains a UPIN, tax identification, and social security number for each physician, non-physician practitioner and medical group. Also, the system contains information concerning a provider's birth date, place of residence, medical education, and eligibility information necessary for Medicare reimbursement.

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 UPIN information that can be associated with each physician, non-physician practitioner and medical group practices 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. Identifiable data includes individual records with UPIN information and identifiers. Non-identifiable data includes individual records with UPIN information and masked identifiers or UPIN information with identifiers stripped out of the file.

We will only disclose the minimum personal data necessary to achieve the purpose of UPIN. CMS has the following policies and procedures concerning disclosures of information that will be maintained in the system. In general, disclosure of information from the system of records will be approved only for the minimum information necessary to accomplish the purpose of the disclosure after CMS:

1. Determines that the use or disclosure is consistent with the reason that the data is being collected; e.g., assure accurate identification of each physician, non-physician practitioner, or medical group practice requesting or receiving Medicare payment.

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 UPIN 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 propose to establish or modify the following routine use disclosures of information maintained in the system:

1. To provide beneficiaries and other individuals, the identification of each physician or non-physician practitioner who have been assigned a Unique Physician/Practitioner Identification Number (UPIN) and who are participating in the Medicare program.

Beneficiaries and providers often request the help of Medicare contractors (carriers and intermediaries) in the proper identification of physicians and non-physician providers participating in the Medicare program. The Secretary of HHS is required under provision of section 1863 of the Act to provide to the public certain information maintained in this system that serves this purpose.

2. To support Agency contractors or consultants who have been engaged 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.

Carriers and intermediaries occasionally work with contractors to identify and recover erroneous Medicare payments for which workers' compensation programs are liable.

3. To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent pursuant to agreements with CMS 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 UPIN information for the purposes of determining, evaluating, and/or assessing cost, effectiveness, and/or the quality of health care services provided in the state, to support evaluations and monitoring of Medicare claims information of beneficiaries, including

proper reimbursement for services provided.

RRB requires UPIN information to enable them to assist in the implementation and maintenance of the Medicare program.

SSA requires UPIN data to enable them to assist in the implementation and maintenance of the Medicare program.

The Internal Revenue Service may require UPIN data for the application of tax penalties against employers and employee organizations that contribute to Employer Group Health Plan or Large Group Health Plans that are not in compliance with 42 U.S.C. 1395y (b).

State and other governmental worker's compensation agencies working with CMS to assure that workers' compensation payments are made where Medicare has erroneously paid and workers' compensation programs are liable.

Disclosure under this routine use shall be used by state Medicaid agencies pursuant to agreements with HHS for administration of state supplementation payments for determinations of eligibility for Medicaid, for enrollment of welfare recipients for medical insurance under section 1843 of the Act, for quality control studies, for determining eligibility of recipients of assistance under Titles IV, and XVIII of the Act, and for the complete administration of the Medicaid program.

Occasionally state licensing boards require access to the UPIN data for review of unethical practices or nonprofessional conduct.

We also contemplate disclosing information under this routine use in situations in which state auditing agencies require UPIN information for auditing of Medicaid eligibility considerations. Disclosure of physicians' customary charge data are made to state audit agencies in order to ascertain the correctness of Title XVIII charges and payments. CMS may enter into an agreement with state auditing agencies to assist in accomplishing functions relating to the purposes for this SOR.

4. To assist 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.

QIOs will work to implement quality improvement programs, provide consultation to CMS, its contractors, and to state agencies. QIOs will assist the 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 provide the American Medical Association (AMA), for the purpose of assisting CMS to identify medical doctors when CMS is unable to establish an identity, provided the AMA agrees to:

a. Use the information provided by CMS solely to identify a medical doctor;

b. Make no copies of the information it receives from the CMS, except for one back-up copy;

c. Return such information to CMS upon completion of its matching operation, and erase the back-up copy;

d. Establish appropriate administrative, technical, and physical safeguards to prevent unauthorized use or disclosure of the records; and,

e. Sign a written statement attesting to its understanding of, and willingness to abide by these provisions.

CMS exchanges information with the AMA for the purpose of attempting to identify medical doctors when the UPIN Registry is unable to establish identity after matching carrier-submitted data to the data extract provided by the AMA. The AMA would attempt to establish medical doctor identity by matching the UPIN data to data maintained in the AMA Physician Master File.

6. To support a Member of Congress or 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 and other individuals often request the help of a Member of Congress in resolving an issue relating to a matter before CMS. The Member of Congress then writes CMS, and CMS must be able to give sufficient information to be responsive to the inquiry.

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

We contemplate disclosing information under this routine use only in situations in which CMS may enter into a 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 assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such programs.

Other agencies may require UPIN 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).

IV. Safeguards

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

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws and regulations 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 HHS Automated Information Systems Security Handbook and the CMS Information Security Handbook.

V. Effect of the Modified System of Records 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. 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 monitor the collection and reporting of UPIN data. UPIN information on individuals is completed by contractor personnel and submitted to CMS through standard systems located at different locations. CMS will utilize a variety of onsite and offsite edits and audits to increase the accuracy of UPIN data.

CMS will take precautionary measures (see item IV. above) 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 of identifiable data from the modified 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: October 14, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

System No. 09–70–0525

SYSTEM NAME:

Unique Physician/Practitioner Identification Number (UPIN), HHS/CMS/OFM.

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive.

SYSTEM LOCATION:

CMS Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, Maryland 21244–1850. The system is also located at CMS contractors and agents at various locations (see Appendix A).

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

All physicians, non-practitioners and medical groups practices, defined by sections 1124(A), 1861(r), 1842(b)(I)(ii)(iii)(iv)(v)(r), and 1877(h)(4) of the Act who request or receive Medicare reimbursement for medical services.

CATEGORIES OF RECORDS IN THE SYSTEM:

The system contains a UPIN, tax identification, and social security number (SSN) for each physician, non-physician practitioner and medical group. Also, the system contains information concerning a provider's birth date, place of residence, medical education, and eligibility information for Medicare reimbursement.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Section 1842(r) of Pub. L. 101–508; sections 1833(q)(1), 1842(b)(18), (1842 (h)(4), and (5), 1861(s)(I), and 4146 of Title XVIII of the Act.

PURPOSE(S) OF THE SYSTEM:

The primary purpose of the SOR is to maintain unique identification of each physician, non-physician practitioner, or medical group practice requesting or receiving Medicare payment. Information retrieved from this SOR will be used to: (1) Provide beneficiaries and other individuals with the identification of each physician or non-physician practitioner assigned an unique identification number and who are participating in the Medicare program; (2) support regulatory, reimbursement, and policy functions performed within the agency or by a contractor or consultant; (3) assist another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (4) assist Quality Improvement Organizations; (5) provide the American Medical Association with information needed for them to assist us in identifying physicians; (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 UPIN 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.

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 FR 82462 (Dec. 28, 00), as amended by 66 FR 12434 (Feb. 26, 01)). 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 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). We propose to establish or modify the following routine use disclosures of information maintained in the system:

1. To provide beneficiaries and other individuals of the identification of each physician or non-physician practitioner who have been assigned a Unique Physician/Practitioner Identification Number (UPIN) and who are participating in the Medicare program.

2. To support agency contractors or consultants who have been engaged by the agency to assist in accomplishment of a CMS function relating to the purposes for this system of records and who need to have access to the records in order to assist CMS.

3. To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent pursuant to agreements with CMS 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.

4. To assist Quality Improvement Organizations 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 provide the American Medical Association (AMA), for the purpose of assisting CMS to identify medical doctors when CMS is unable to establish an identity, provided the AMA agrees to:

a. Use the information provided by CMS solely to identify a medical doctor;

b. Make no copies of the information it receives from the CMS, except for one back-up copy;

c. Return such information to CMS upon completion of its matching operation, and erase the back-up copy;

d. Establish appropriate administrative, technical, and physical safeguards to prevent unauthorized use or disclosure of the records; and

e. Sign a written statement attesting to its understanding of, and willingness to abide by these provisions.

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

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

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 records are retrieved alphabetically by the provider name, social security number or by their assigned UPIN.

SAFEGUARDS:

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

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws and regulations 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 HHS Automated Information Systems Security Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

CMS and the repository of the National Archive and Records Administration (NARA) will retain identifiable UPIN assessment data for a total period not to exceed fifteen (15) years.

SYSTEM MANAGER AND ADDRESS:

Director, Program Integrity Group, Office of Financial Management, CMS, 7500 Security Boulevard, 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, and for verification purposes, the subject individual's name (woman's maiden name, if applicable), social security number (SSN) (furnishing the SSN is voluntary, but it may make searching for a record easier and prevent delay), address, date of birth, and sex.

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 system 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:

CMS obtains the identifying information in this system from carriers. Information in these records concerning the eligibility of physicians, practitioners, and medical groups for Medicare reimbursement is obtained either directly from such entities through Medicare Regional Offices, contractors, PRO, Department of Justice, state or local judicial systems, medical licensing and certification agencies or organizations, medical societies and medical associations.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

Appendix A. Health Insurance Claims

Medicare records are maintained at the CMS Central Office (see section 1 below for the address). Health Insurance Records of the Medicare program can also be accessed through a representative of the CMS Regional Office (see section 2 below for addresses). Medicare claims records are also maintained by private insurance organizations that share in administering provisions of the health insurance programs. These private insurance organizations, referred to as carriers and intermediaries, are under contract to the Centers for Medicare & Medicaid Services and the Social Security Administration to perform specific task in the Medicare program (see section three below for addresses for intermediaries, section four addresses the carriers, and section five addresses the Payment Safeguard Contractors.

1. Central Office Address

CMS Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, Maryland 21244–1850.

2. CMS Regional Offices

BOSTON REGION—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont. John F. Kennedy Federal Building, Room 1211, Boston, Massachusetts 02203. Office Hours: 8:30 a.m.–5 p.m.

NEW YORK REGION—New Jersey, New York, Puerto Rico, Virgin Islands. 26 Federal Plaza, Room 715, New York, New York 10007, Office Hours: 8:30 a.m.–5 p.m.

PHILADELPHIA REGION—Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia. Post Office Box 8460, Philadelphia, Pennsylvania 19101. Office Hours: 8:30 a.m.–5 p.m.

ATLANTA REGION—Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, Tennessee. 101 Marietta Street, Suite 702, Atlanta, Georgia 30223, Office Hours: 8:30 a.m.–4:30 p.m.

CHICAGO REGION—Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin. Suite A—824, Chicago, Illinois 60604. Office Hours: 8 a.m.–4:45 p.m.

DALLAS REGION—Arkansas, Louisiana, New Mexico, Oklahoma, Texas, 1200 Main Tower Building, Dallas, Texas. Office Hours: 8 a.m.–4:30 p.m.

KANSAS CITY REGION—Iowa, Kansas, Missouri, Nebraska. New Federal Office Building, 601 East 12th Street—Room 436, Kansas City, Missouri 64106. Office Hours: 8 a.m.–4:45 p.m.

DENVER REGION—Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming. Federal Office Building, 1961 Stout St—Room 1185, Denver, Colorado 80294. Office Hours: 8 a.m.–4:30 p.m.

SAN FRANCISCO REGION—American Samoa, Arizona, California, Guam, Hawaii, Nevada. Federal Office Building, 10 Van Ness Avenue, 20th Floor, San Francisco, California 94102. Office Hours: 8 a.m.–4:30 p.m.

SEATTLE REGION—Alaska, Idaho, Oregon, Washington. 1321 Second Avenue, Room 615, Mail Stop 211, Seattle, Washington 98101. Office Hours 8 a.m.–4:30 p.m.

3. Intermediary Addresses (Hospital Insurance)

Medicare Coordinator, Assoc. Hospital Serv. Maine (ME BC), 2 Gannett Drive South Portland, ME 04106–6911.

Medicare Coordinator, Anthem New Hampshire, 300 Goffs Falls Road, Manchester, NH 03111–0001.

Medicare Coordinator, BC/BS Rhode Island (RI BC), 444 Westminster Street, Providence, RI 02903–3279.

Medicare Coordinator, Empire Medicare Services, 400 S. Salina Street, Syracuse, NY 13202.

Medicare Coordinator, Cooperativa, P.O. Box 363428, San Juan, PR 00936–3428.

Medicare Coordinator, Maryland B/C, P.O. Box 4368, 1946 Greenspring Ave., Timonium, MD 21093.

Medicare Coordinator, Highmark, P5103, 120 Fifth Avenue Place, Pittsburgh, PA 15222–3099.

Medicare Coordinator, United Government Services, 1515 N. Rivercenter Dr., Milwaukee, WI 53212.

Medicare Coordinator, Alabama B/C, 450 Riverchase Parkway East, Birmingham, AL 35298.

Medicare Coordinator, Florida B/C, 532 Riverside Ave., Jacksonville, FL 32202–4918.

Medicare Coordinator, Georgia B/C, P.O. Box 9048, 2357 Warm Springs Road, Columbus, GA 31908.

Medicare Coordinator, Mississippi B/C MS, P.O. Box 23035, 3545 Lakeland Drive, Jackson, MI 39225–3035.

Medicare Coordinator, North Carolina B/C, P.O. Box 2291, Durham, NC 27702–2291.

Medicare Coordinator, Palmetto GBA A/RHHI, 17 Technology Circle, Columbia, SC 29203–0001.

Medicare Coordinator, Tennessee B/C, 801 Pine Street, Chattanooga, TN 37402–2555.

Medicare Coordinator, Anthem Insurance Co. (Anthm IN), P.O. Box 50451, 8115 Knue Road, Indianapolis, IN 46250–1936.

Medicare Coordinator, Arkansas B/C, 601 Gaines Street, Little Rock, AR 72203.

Medicare Coordinator, Group Health of Oklahoma, 1215 South Boulder, Tulsa, OK 74119–2827.

Medicare Coordinator, Trailblazer, P.O. Box 660156, Dallas, TX 75266–0156.

Medicare Coordinator, Cahaba GBA, Station 7, 636 Grand Avenue, Des Moines, IA 50309–2551.

Medicare Coordinator, Kansas B/C, P.O. Box 239, 1133 Topeka Ave., Topeka, KS 66629–0001.

Medicare Coordinator, Nebraska B/C, P.O. Box 3248, Main PO Station, Omaha, NE 68180–0001.

Medicare Coordinator, Mutual of Omaha, P.O. Box 1602, Omaha, NE 68101.

Medicare Coordinator, Montana B/C, P.O. Box 5017, Great Falls Div., Great Falls, MT 59403–5017.

Medicare Coordinator, Noridian, 4510 13th Avenue SW., Fargo, ND 58121–0001.

Medicare Coordinator, Utah B/C, P.O. Box 30270, 2455 Parleys Way, Salt Lake City, UT 84130–0270.

Medicare Coordinator, Wyoming B/C, 4000 House Avenue, Cheyenne, WY 82003.

Medicare Coordinator, Arizona B/C, P.O. Box 37700, Phoenix, AZ 85069.

Medicare Coordinator, UGS, P.O. Box 70000, Van Nuys, CA 91470–0000.

Medicare Coordinator, Regents BC, P.O. Box 8110 M/S D–4A, Portland, OR 97207–8110.

Medicare Coordinator, Premera BC, P.O. Box 2847, Seattle, WA 98111–2847.

4. Medicare Carriers

Medicare Coordinator, NHIC, 75 Sargent William Terry Drive, Hingham, MA 02044.

Medicare Coordinator, B/S Rhode Island (RI BS), 444 Westminster Street, Providence, RI 02903–2790.
Medicare Coordinator, Trailblazer Health Enterprises, Meriden Park, 538 Preston Ave., Meriden, CT 06450.
Medicare Coordinator, Upstate Medicare Division, 11 Lewis Road, Binghamton, NY 13902.
Medicare Coordinator, Empire Medicare Services, 2651 Strang Blvd., Yorktown Heights, NY, 10598.
Medicare Coordinator, Empire Medicare Services, NJ, 300 East Park Drive, Harrisburg, PA 17106.
Medicare Coordinator, Triple S, #1441 F.D., Roosevelt Ave., Guaynabo, PR 00968.
Medicare Coordinator, Group Health Inc., 4th Floor, 88 West End Avenue, New York, NY 10023.
Medicare Coordinator, Highmark, P.O. Box 89065, 1800 Center Street, Camp Hill, PA 17089–9065.
Medicare Coordinator, Trailblazers Part B, 11150 McCormick Drive, Executive Plaza 3 Suite 200, Hunt Valley, MD 21031.
Medicare Coordinator, Trailblazer Health Enterprises, Virginia, P.O. Box 26463, Richmond, VA 23261–6463. United Medicare Coordinator, Tricenturion, 1 Tower Square, Hartford, CT 06183.
Medicare Coordinator, Alabama B/S, 450 Riverchase Parkway East, Birmingham, AL 35298.
Medicare Coordinator, Cahaba GBA, 12052 Middleground Road, Suite A, Savannah, GA 31419.
Medicare Coordinator, Florida B/S, 532 Riverside Ave, Jacksonville, FL 32202–4918.
Medicare Coordinator, Administar Federal, 9901 Linnstation Road, Louisville, KY 40223.
Medicare Coordinator, Palmetto GBA, 17 Technology Circle, Columbia, SC 29203–0001.
Medicare Coordinator, CIGNA, 2 Vantage Way, Nashville, TN 37228.
Medicare Coordinator, Railroad Retirement Board, 2743 Perimeter Parkway, Building 250, Augusta, GA 30999.
Medicare Coordinator, Cahaba GBA, Jackson, Miss, P.O. Box 22545, Jackson, MI 39225–2545.
Medicare Coordinator, Adminastar Federal (IN), 8115 Knue Road, Indianapolis, IN 46250–1936.
Medicare Coordinator, Wisconsin Physicians Service, P.O. Box 8190, Madison, WI 53708–8190.
Medicare Coordinator, Nationwide Mutual Insurance Co., P.O. Box 16788, 1 Nationwide Plaza, Columbus, OH 43216–6788.
Medicare Coordinator, Arkansas B/S, 601 Gaines Street, Little Rock, AR 72203.
Medicare Coordinator, Arkansas-New Mexico, 601 Gaines Street, Little Rock, AR 72203.
Medicare Coordinator, Palmetto GBA—DMERC, 17 Technology Circle, Columbia, SC 29203–0001.
Medicare Coordinator, Trailblazer Health Enterprises, 901 South Central Expressway, Richardson, TX 75080.
Medicare Coordinator, Nordian, 636 Grand Avenue, Des Moines, IA 50309–2551.
Medicare Coordinator, Kansas B/S, P.O. Box 239, 1133 Topeka Ave., Topeka, KS 66629–0001.
Medicare Coordinator, Kansas B/S—NE, P.O. Box 239, 1133 Topeka Ave., Topeka, KS 66629–0239.
Medicare Coordinator, Montana B/S, P.O. Box 4309, Helena, MT 59601.
Medicare Coordinator, Nordian, 4305 13th Avenue South, Fargo, ND 58103–3373.
Medicare Coordinator, Noridian Bcbsnd (C0), 730 N. Simms #100, Golden, CO 80401–4730.
Medicare Coordinator, Noridian Bcbsnd (WY), 4305 13th Avenue South, Fargo, ND 58103–3373.
Medicare Coordinator, Utah B/S, P.O. Box 30270, 2455 Parleys Way, Salt Lake City, UT 84130–0270.
Medicare Coordinator, Transamerica Occidental, P.O. Box 54905, Los Angeles, CA 90054–4905.
Medicare Coordinator, NHIC—California, 450 W. East Avenue, Chico, CA 95926.
Medicare Coordinator, Cigna, Suite 254, 3150 Lakeharbor, Boise, ID 83703.
Medicare Coordinator, Cigna, Suite 506, 2 Vantage Way, Nashville, TN 37228.

Payment Safeguard Contractors

Medicare Coordinator, Aspen Systems Corporation, 2277 Research Blvd., Rockville, MD 20850.
Medicare Coordinator, DynCorp Electronic Data Systems (EDS, 11710 Plaza America Drive 5400 Legacy Drive, Reston, VA 20190–6017.
Medicare Coordinator, Lifecare Management Partners Mutual of Omaha Insurance Co. 6601 Little River Turnpike, Suite 300 Mutual of Omaha Plaza, Omaha, NE 68175.
Medicare Coordinator, Reliance Safeguard Solutions, Inc., P.O. Box 30207 400 South Salina Street, 2890 East Cottonwood Pkwy. Syracuse, NY 13202.
Medicare Coordinator, Science Applications International, Inc., 6565 Arlington Blvd. P.O. Box 100282, Falls Church, VA.
Medicare Coordinator, California Medical Review, Inc. Integriguard Division Federal Sector Civil Group One Sansome Street, San Francisco, CA 94104–4448.
Medicare Coordinator, Computer Sciences Corporation Suite 600 3120 Timanus Lane, Baltimore, MD 21244.
Medicare Coordinator, Electronic Data Systems (EDS), 11710 Plaza America Drive 5400 Legacy Drive, Plano, TX 75204.
Medicare Coordinator, TriCenturion, L.L.C., P.O. Box 100282, Columbia, SC 29202.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of Modified or Altered System

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

ACTION: Notice of 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, ''Medicare Hearings and Appeals System (MHAS), System No. 09–70–5001.'' We propose to broaden the scope of this system to support additional levels of claim determination appeals administered by CMS pursuant to Title XVIII of the Social Security Act (the Act). We propose to change the name of the system from MHAS to the ''Medicare Appeals System'' (MAS) to more closely reflect the new and broadened scope of activities that will become a part of this system. We propose to further broaden the scope of this system with the inclusions of support for appeals processes for both the Medicare Fee-for-Service (FFS) appeals at the Qualified Independent Contractors (QIC) and Medicare Advantage appeals at the Independent Review Entity (IRE) Second Level Appeal. As an orderly timetable will permit, CMS will explore the possibility of extending the scope of MAS to include all five appeal levels:

Affiliated Contractors (Carriers and Fiscal Intermediaries) and Medicare Advantage Organizations (MAO)—the First Level Appeal; QIC and IRE—the Second Level Appeal; ALJ Hearing—the Third Level Appeal; Medicare Departmental Appeals Board (DAB) Hearing—the Fourth Level Appeal; and Federal District Court Judicial Review—the Fifth Level Appeal.

In the interim, before deployment of the MAS, CMS has developed a mid-tier, client server-based system known as the Medicare Case Tracking System (MCATS). MCATS will be utilized if the MAS is not available to collect and track appeals data, including status, timelines, and decision data. It has the capability to provide summary reports for data analysis, and will comply with applicable security and privacy rules, regulations, and policies.

We propose to broaden the scope of activities covered by this system with the inclusion of related activities presented in the 2 published CMS systems identified below: (1) ''Reconsideration and Hearing Case Files (Part A)—Hospital Insurance Program,'' System No. 09–70–0508 (published 47 FR 45725 (Oct. 13, 1982)), and (2) ''Review and Fair Hearing Case Files (Part B)—Supplementary Medical Insurance Program,'' System No. 09–70–0512 (47 FR 45727 (Oct. 13, 1982)). These 2 systems will be discontinued with the completion of this proposed