Sincerely,

Mark B. McClellan, M.D., Ph.D.

Section 1116 of the Social Security Act (42 U.S.C. section 1316); 42 CFR Section 430.18)

(Catalog of Federal Domestic Assistance Program No. 13.714, Medicaid Assistance Program)

Dated: October 6, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

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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)(formerly the Health Care Financing Administration).

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, ''Group Health Plan System,'' System No. 09–70–4001. We propose to broaden the scope of this system with the redesign of the electronic processing procedure used to process data currently from a Common Object Business Oriented Language (commonly referred to as COBOL) format resident on the CMS mainframe to Data Base 2 format (commonly known as DB2). To more accurately reflect the changes proposed for this system, we will modify the name to read: ''Medicare Managed Care System (MMCS).'' We propose to delete published routine use number 5 authorizing disclosures to contractors; published routine use number 6 authorizing disclosures to contractors; and published routine use number 7 authorizing disclosures to a Medicaid State Agency.

Proposed routine use number 1 for contractors and consultants makes material changes to published routine uses numbers 5 and 6. Routine uses 5 and 6 authorized release to contractors. They are being deleted because their meaning is unclear as to what data is being disclosed to what entity. Routine use number 7 is being deleted because disclosure to a State Medicaid Agency will now be made under proposed routine use number 2 that reads, ''to another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent.''

CMS proposes to add new routine uses to permit release of information to: (1) Third parties where the contact has information relating to the individual's capacity to manage his or her own affairs; (2) 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 (3 & 4) combat fraud and abuse in certain health benefits programs.

The security classification previously reported as ''None'' will be modified to reflect that the data in this system are considered to be ''Level Three Privacy Act Sensitive.'' We are modifying the language in the remaining routine uses to provide clarity and uniformity 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 maintain a master file of Medicare Managed Care Organizations (MCO) plan members for accounting and payment control; expedite the exchange of data with MCOs; and control the posting of pro-rata amounts to the Part B deductible of currently enrolled MCO members. MMCS include the following entities: Health Maintenance Organizations (HMO), Competitive Medical Plans (CMP), Health Care Prepayment Plan (HCPP), and Medicare Choice Organizations (MCO). Information in this system will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the Agency or by a contractor or consultant, (2) support another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3) provider and suppliers of service directly or dealing through contractors, fiscal intermediaries (FI) or carriers for administration of Title XVIII; (4) provide information to third party contacts in situations where the contact has information relating to the individual's capacity to manage his or her affairs; (5) other insurers, third party administrators (TPA), and other groups providing protection for their enrollees to assist in the processing of individual insurance claims (6) facilitate research on the quality and effectiveness of care provided, as well as payment-related projects, (7) support constituent requests made to a congressional representative, (8) support litigation involving the Agency, and (9 & 10) combat fraud and abuse in certain health benefits programs.

DATES: CMS filed a modified or altered system report with the Chair of the House Committee on Government Reform and Oversight, the Chair of the Senate Committee on Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on August 19, 2004. To ensure that all parties have adequate time in which to comment, the modified or altered 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 (DPCDD), 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: Laquia Marks, Information Technology Specialist, Division of Managed Care Systems, Informational Services Modernization Group, OIS, CMS, Room N3–16–24, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. The telephone number is 410–786–3312.

SUPPLEMENTARY INFORMATION:

I. Description of the Modified System

A. Statutory and Regulatory Basis for the SOR

In 1987, CMS established an SOR, Group Health Plan System,'' System No. 09–70–4001, under the authority of §§ 1833(a)(1)(A), 1866, and 1876 of Title XVIII of the Social Security Act (the Act) (42 U.S.C. 1395 (a)(1)(A), 1395cc, and 1395mm). Notice of this system,

was published at 52 FR 13525 (Apr. 23, 1987) and a routine use for Medicaid state agencies added at 57 FR 60819 (Dec. 22, 1992). This information includes names and health insurance claims numbers of recipients of Medicare Hospital Insurance (Part A) and Medicare Medical Insurance (Part B) who are enrolled in a MMCS.

II. Collection and Maintenance of Data in the System

A. Scope of the Data Collected

The system includes the following information about a beneficiary's health insurance entitlement and supplementary medical benefits usage, including name, health insurance claims number (HICN), and social security number.

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 MMCS 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 MMCS. 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 master file of MCO plan members for accounting and payment control; expedite the exchange of data with MCOs; and control the posting of pro-rata amounts to the Part B deductible of currently enrolled MCO members.

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

a. 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

b. 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. 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 MMCS 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 system 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 system.

CMS occasionally contracts out certain of its functions when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor 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 support 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 MMCS 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 MMCS 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 Social Security Act (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 MMCS 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 system to providers and suppliers of services directly or through fiscal intermediaries (FIs) or carriers for the administration of Title XVIII of the Act.

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 MMCS 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 provide information to third party contacts in situations where the party to be contacted has 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, 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 MMCS 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 MMCS information in order to support evaluations and monitoring of Medicare claims information of beneficiaries, including proper reimbursement for services provided.

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

MMCS data will provide for research, evaluation, and epidemiological projects, a broader, longitudinal, national perspective of the status of Medicare beneficiaries. CMS anticipates that many researchers will have legitimate requests to use these data in projects that could ultimately improve the care provided to Medicare beneficiaries and the policy that governs the care.

7. 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 issues relating to a matter before CMS. The Member of Congress then writes CMS, and CMS must be able to give sufficient information tin response to the inquiry.

8. 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.

9. 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.

10. 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 MMCS 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 data not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that individuals 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 SOR 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 MMCS data. MMCS 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 MMCS 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: August 19, 2004.

Mark B. McClellan,

Administrator.

SYSTEM No. 09–70–4001

SYSTEM NAME:

''Medicare Managed Care System (MMCS)'' 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.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Recipients of Medicare hospital insurance (Part A) and Medicare medical insurance (Part B) who are enrolled in a Medicare Managed Care Plan.

CATEGORIES OF RECORDS IN THE SYSTEM:

The system contains information about a beneficiary's health insurance entitlement and medical insurance benefits usage.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Authority for maintenance of the system is given under the provisions of §§ 1833(a)(1)(A), 1866, and 1876 of Title XVIII of the Social Security Act (the Act) (42 U.S.C. 1395(A)(1)(a), 1395cc, and 1395mm).

PURPOSE(S) OF THE SYSTEM:

The primary purpose of the SOR is to maintain a master file of Medicare Managed Care Organizations (MCO) plan members for accounting and payment control; expedite the exchange of data with MCOs; and control the posting of pro-rata amounts to the Part B deductible of currently enrolled MCO members. MMCS include the following entities: Health Maintenance Organizations (HMO), Competitive Medical Plans (CMP), Health Care Prepayment Plan (HCPP), and Medicare Choice Organizations (MCO). Information in this system will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the Agency or by a contractor or consultant, (2) support another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3) provider and suppliers of service directly or dealing through contractors, fiscal intermediaries (FI) or carriers for administration of Title XVIII; (4) provide information to third party contacts in situations where the contact has information relating to the individual's capacity to manage his or her affairs; (5) other insurers, third party administrators (TPA), and other groups providing protection for their enrollees to assist in the processing of individual insurance claims (6) facilitate research on the quality and effectiveness of care provided, as well as payment-related projects, (7) support constituent requests made to a congressional representative, (8) support litigation involving the Agency, and (9 & 10) 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:

A. 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 MMCS 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 system and who need to have access to the records in order to assist CMS.

2. To support 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 (FIs) or carriers for the administration of Title XVIII of the Act.

4. To provide information to third party contacts in situations where the party to be contacted has 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, a language barrier exists, 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 an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or payment-related projects.

7. 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.

8. 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.

9. 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.

10. 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.

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

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

STORAGE:

Computer diskette and on magnetic storage media.

RETRIEVABILITY:

Information can be retrieved by name and health insurance claim number of the beneficiary.

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:

Records are maintained in a secure storage area with identifiers. Disposal occurs three years from the last action on the hospital's cost report, and should be coordinated with disposal of the reports.

SYSTEM MANAGER AND ADDRESS:

Director, Division of Managed Care Operations, Information Services Modernization Group, Office of Information Services, CMS, 7500 Security Boulevard, N3–16–24, Baltimore, Maryland 21244–1850.

NOTIFICATION PROCEDURE:

For purpose of access, the subject individual should write to the systems manager who will require the system name, SSN, address, date of birth, sex, and for verification purposes, the subject individual's name (woman's maiden name, if applicable). 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 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:

Data for this system is collected from MCO (which obtained the data from the individuals concerned), Social Security Administration, and the Enrollment Database system of records.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

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BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: Building Strong Families Demonstration and Evaluation—Baseline Information.

OMB No.: New Collection.

Description: The proposed information collection activity is for baseline information during eligibility screening and enrollment in local programs participating in the Building Strong Families (BSF) evaluation. The BSF evaluation is an important opportunity to learn if well-designed interventions can help low-income couples develop the knowledge and relationship skills that research has shown are associated with healthy marriages. BSF programs will provide instruction and support to improve marriage and relationship skills and enhance couples' understanding of marriage. In addition, BSF programs will provide links to a variety of other services that could help couples sustain a healthy relationship (*e.g.,* employment assistance). The evaluation's goal is to include a maximum of six programs that will add a BSF component to existing services and enroll into the evaluation approximately 2,000 couples into each program, *i.e.,* 1,000 couples randomly assigned to participate in BSF services and 1,000 couples in the control group, for a total of 12,000 couples (24,000 individuals). The evaluation will assess the net impact of the BSF interventions on these two groups.

Respondents: The respondents for the baseline data collection will be low-income, unmarried, expectant or recent parents who volunteer to participate in the evaluation. (Some couples may have been recently married since the conception of their child.) There will be four forms used in the baseline data collection: (1) The Mother/Father Eligibility Checklist; (2) the Consent to Participate in the BSF Study Form; (3) the Baseline Information Form; and (4) the Contact Information Form. The Mother/Father Eligibility Checklist will be used by program staff to determine if respondents meet the minimum requirements for participating in the BSF program. We estimate that about 25 percent of couples interviewed will meet the eligibility criteria for the program. The Consent to Participate in the BSF Study Form explains in detail the design of the evaluation, the process for selection, and the results of agreeing to participate in the study (*e.g.,* being contacted for follow-up information). The Baseline Information Form collects basic demographic information about respondents, as well as brief information concerning pregnancies and births, family structure, employment and income, and emotional well-being, all of which is relevant for the study. The Contact Information Form gathers information on friends and relatives who can assist in locating respondents based on respondents' agreements to participate in follow-up surveys that will be conducted many months later. All forms will be administered to both members of the couples by BSF program staff members. The forms will be administered in a number of different settings, but we anticipate the two most common will be in hospitals, following the birth of children, and in the mother's/father's home shortly after births.