Dated: October 12, 2004.

Alvin Hall,

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

[FR Doc. 04–23220 Filed 10–15–04; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel: Occupational Health and Safety Research, Program Announcement (PA) 04038

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 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): Occupational Health and Safety Research, Program Announcement (PA) 04038.

Times and Dates: 7 p.m.–7:30 p.m., November 4, 2004 (Open); 7:30 p.m.–9 p.m., November 4, 2004 (Closed); 8 a.m.–5 p.m., November 5, 2004 (Closed).

Place: Courtyard by Marriott Louisville Downtown, 100 South Second Street, Louisville, KY 40202, phone (502) 562–0200.

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 a site visit and the review, discussion, and evaluation of an application received in response to Program Announcement Number 04038.

Contact Person for More Information: Chuck Rafferty, Ph.D., Research Grants Program Officer, Office of Extramural Programs, National Institute for Occupational Safety and Health, CDC, 1600 Clifton Road, NE., MS–E74, Atlanta, GA 30333, Telephone (404) 498–2530.

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: October 12, 2004.

Alvin Hall,

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

[FR Doc. 04–23221 Filed 10–15–04; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of California's Medicaid State Plan Amendment 03–028B

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing on California's Medicaid State Plan Amendment (SPA) 03–28B to be held on December 2, 2004, 10 a.m., 75 Hawthorne Street; 4th Floor Conference Room, San Francisco, California 94105–3901 to reconsider our decision to disapprove SPA 03–028B.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by November 2, 2004.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS, LB–23–20, Lord Baltimore Drive, Baltimore, Maryland 21244, Telephone: (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider our decision to disapprove California's Medicaid State Plan Amendment (SPA) 03–28B.

California submitted SPA 03–28B on September 18, 2003. In this SPA, California proposed to provide targeted case management (TCM) services in several counties for two populations: persons on probation, and individuals with a public guardian. By letter dated July 6, 2004, the Centers for Medicare & Medicaid Services (CMS) disapproved the SPA.

At issue in this reconsideration is whether SPA 03–28B is consistent with the requirements contained in sections 1902(a)(10) and 1902(a)(23), of the Social Security Act (the Act), as described in more detail below. In general, CMS found that the SPA had three fundamental problems: (1) The proposed TCM services duplicate services that are integral components of the State's adult probation program and the State's public guardian program; (2) the amendment would result in charges to Medicaid for services available without charge to individuals on probation; and (3) the provider qualifications limit providers of services for these groups to the probation officers employed by the county probation departments and to court-appointed guardians under county public guardian agencies.

More specifically, at issue is whether the SPA complies with the requirement in section 1902(a)(10) of the Act which authorizes State Medicaid plans to provide for ''medical assistance.'' In the definition of that term, at section 1905(a)(19) of the Act, case management services are authorized ''as defined in section 1915 (g)(2).'' That section defines case management as services that assist beneficiaries in gaining access to needed services. The Congressional Conference committee report accompanying Pub. L. 99–272, which added section 1915(g) to the Act, emphasized that payment for case management services must not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. CMS uses the term ''duplication of required coverage to refer to this situation. In this instance, Medicaid payment for services provided by the adult probation program and the public guardian program would duplicate payments under other programs that are the responsibility of the State government. Because the congressional definition of Medicaid TCM excluded duplicate coverage, CMS determined that the proposed case management services are not within the scope of the definition of ''medical assistance'' that is authorized to be included in a State Medicaid plan by section 1902(a)(10).

The CMS' reading of the term ''medical assistance'' to exclude ''duplication of required coverage'' is also consistent with the language of section 8435 of Pub. L. 100–647, which states that the Medicaid case management benefit is not to be construed as to require the Secretary of Health and Human Services to make payment for case management services that are provided without charge to the users of such services. Approval of SPA 03–028B would be contrary to this provision, because the proposed adult population services are available without charge.

In addition, at issue is whether the proposed SPA is consistent with the requirements at section 1902(a)(23) of the Act that a state plan must provide that beneficiaries may obtain services from any qualified entity or person who undertakes to provide such services. The proposed SPA restricts providers of

services to the two target groups in question, to probation officers employed by the county probation department and to court-appointed guardians. While states are free to set qualifications for providers, states must comply with Medicaid laws and regulations concerning freedom-of-choice at section 1902(a)(23) of the Act and the implementing regulation at 42 CFR 431.51. The State did not establish why it is consistent with those requirements to restrict providers to probation officers or public guardians. The State did not show why those providers are uniquely qualified to assist the target population nor did the State explain how beneficiaries would have access to qualified providers who do not work as a probation officer or public guardian. As a result, CMS found that the State did not demonstrate compliance with the requirements of section 1902(a)(23) and its implementing regulation.

Section 1116 of the Act and 42 CFR part 430 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a state plan or plan amendment. CMS is required to publish a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing and the issues to be considered. If we subsequently notify the agency of additional issues that will be considered at the hearing, we will also publish that notice.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as amicus curiae must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants. Therefore, based on the reasoning set forth above, and after consultation with the Secretary as required under 42 CFR 430.15(c)(2), CMS disapproved California SPA 03–28B.

The notice to California announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Mr. Stan Rosenstein,
Deputy Director, Department of Health Services,
MS 40900, P.O. Box 942732, Sacramento, CA 94231–7320.

Dear Mr. Rosenstein:

I am responding to your request for reconsideration of the decision to disapprove California State Plan Amendment (SPA) 03–28B, which the State submitted on September 18, 2003. In this SPA, California proposed to provide targeted case management (TCM) services in several counties for two populations, persons on probation and individuals with a public guardian. The Centers for Medicare & Medicaid Services (CMS) reviewed this proposal, and for the reasons set forth below, was unable to approve SPA 03–28B as submitted.

At issue in this reconsideration is whether SPA 03–28B is consistent with the requirements contained in sections 1902(a)(10) and 1902(a)(23) of the Social Security Act (the Act), as described in more detail below. In general CMS found that the SPA has three fundamental problems: (1) The proposed TCM services duplicate services that are integral components of the State's adult probation program and the State's public guardian program; (2) the amendment would result in charges to Medicaid for services available without charge to individuals on probation; and (3) the provider qualifications limit providers of services for these groups to the probation officers employed by the county probation departments and to court-appointed guardians under county public guardian agencies.

Section 1902(a)(10) of the Act authorizes state Medicaid plans to provide for ''medical assistance.'' In the definition of that term, at section 1905(a)(19) of the Act, case management services are authorized ''as defined in section 1915(g)(2).'' That section defines case management as services that assist beneficiaries in gaining access to needed services. The Congressional Conference committee report accompanying Pub. L. 99–272, which added section 1915(g) to the Act, emphasized that payment for case management services must not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

The CMS uses the term ''duplication of required coverage'' to refer to this situation, in order to distinguish it from circumstances in which two payments are actually made for the same claim. In this instance, Medicaid payment for services provided by the adult probation program and the public guardian program would duplicate payments under other programs that are the responsibility of the State government. Therefore, CMS determined that Medicaid funding is not available for case management for individuals in the adult probation or public guardian system because claiming such activities as Medicaid TCM would result in duplication of necessary coverage. Because the congressional definition of Medicaid TCM excluded duplicate coverage, CMS determined that the proposed case management services are not within the scope of the definition of ''medical assistance'' that is authorized to be included in a state Medicaid plan by section 1902(a)(10).

Congress further states in section 8435 of Pub. L. 100–647 that the Medicaid case management benefit was not to be construed as to require the Secretary of Health and Human Services to make payment for case management services that are provided without charge to the users of such services. Approval of SPA 03–028B would be contrary to this provision. The activities in question are key service and/or administrative activities of the State's adult probation program. Thus, CMS determined that the SPA cannot be approved because the adult population services are available without charge.

The proposed SPA restricts providers of services to the two target groups in question, to probation officers employed by the county probation department and to court-appointed guardians. While states are free to set qualifications for providers, states must comply with Medicaid laws and regulations concerning freedom-of-choice at section 1902(a)(23) of the Act and the implementing regulation at 42 CFR 431.51. The State did not establish why it is consistent with those requirements to restrict providers to probation officers or public guardians. The State did not show why those providers are uniquely qualified to assist the target population in gaining access to medical, educational, social, and other services. Nor did the State explain how beneficiaries would have access to qualified providers who do not work as a probation officer or public guardian. As a result, the State did not demonstrate compliance with the requirements of section 1902(a)(23) and its implementing regulation.

Therefore, based on the reasoning set forth above, and after consultation with the Secretary as required under 42 CFR 430.15(c)(2), CMS disapproved California SPA 03–28B. This disapproval only applies to SPA 03–028B. The currently approved sections of the State Plan for these target groups will remain in effect. However, CMS would like to emphasize that providing Medicaid TCM to individuals in the adult probation or public guardian State systems is not consistent with CMS' interpretation of applicable laws, as noted above. To the extent that current plan provisions do so, CMS expects the State to revise its plan in order to come into compliance on this issue. Moreover, CMS may review State claims to determine if Federal Medicaid funding is appropriate when another program or entity is liable for payment.

I am scheduling a hearing on your request for reconsideration to be held December 2, 2004, at 10 a.m., 4th Floor Conference Room, 75 Hawthorne Street, San Francisco, California 94105–3901. If this date is not acceptable, we would be glad to set another date that is mutually agreeable to the parties. The hearing will be governed by the procedures prescribed at 42 CFR, part 430.

I am designating Ms. Kathleen Scully-Hayes as the presiding officer. If these arrangements present any problems, please contact the presiding officer. In order to facilitate any communication which may be necessary between the parties to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide names of the individuals who will represent the State at the hearing. The presiding officer may be reached at (410) 786–2055.

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.

[FR Doc. 04–23252 Filed 10–15–04; 8:45 am]

BILLING CODE 4120–03–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)(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,