DC 20006. Officers: Stephen P. Druhot, Exec. Vice President, (Qualifying Individual), Mariano Echevarria, President.

Dated: November 30, 2001.

Bryant L. VanBrakle,

Secretary.

[FR Doc. 01–30181 Filed 12–5–01; 8:45 am]

BILLING CODE 6730–01–P

FEDERAL RESERVE SYSTEM

Sunshine Act Meeting

AGENCY HOLDING THE MEETING: Board of Governors of the Federal Reserve System.

TIME AND DATE: 3:30 p.m. on Tuesday, December 4, 2001.

The business of the Board requires that this meeting be held with less than one week's advance notice to the public, and no earlier announcement of the meeting was practicable.

PLACE: Marriner S. Eccles Federal Reserve Board Building, 20th and C Streets, NW., Washington, DC 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Future capital framework. (This item was originally announced for a closed meeting on December 3, 2001.)

2. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.

3. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Michelle A. Smith, Assistant to the Board; 202–452–3204.

SUPPLEMENTARY INFORMATION: You may call 202–452–3206 beginning at approximately 5 p.m. two business days before the meeting for a recorded announcement of bank and bank holding company applications scheduled for the meeting; or you may contact the Board's Web site at *http://www.federalreserve.gov* for an electronic announcement that not only lists applications, but also indicates procedural and other information about the meeting.

Dated: December 3, 2001.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 01–30321 Filed 12–3–01; 5:15 pm]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; System of Records

AGENCY: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), formerly Health Care Financing Administration (HCFA).

ACTION: Notice of a new system of records.

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, we are proposing to establish a new system of records. The proposed system is titled ''Medicare Beneficiary Database (MBD),'' HHS/CMS/CBS, System No. 09–70–0536. The Medicare program is rapidly changing to accommodate expansion of new service delivery models and payment options, allowing for more medical choices for its beneficiaries. To successfully support ongoing and expanded program administration, service delivery modalities and payment coverage options, CMS proposes to establish an enterprise database. More specifically, the proposed system will contain a complete ''beneficiary insurance profile'' that reflects individual Medicare and Medicaid health insurance coverage and Medicare health plan and demonstration enrollment. Once fully developed, the MBD would provide a database of pertinent and comprehensive personal data on people with Medicare and persons dually eligible for both Medicare and Medicaid under either the Fee for Service or Managed Care Programs. It would support data processing, at the discrete beneficiary level, necessary for continued and evolving program operations including but not limited to Medicare claims payment, entitlement, Medicare + Choice elections and payments, coordination of benefits for the purpose of conducting Medicare business, payment demonstrations and Medicaid coverage. The data in this database is held at the person level and is identified through use of an individual health insurance claim number. As such, the MBD would serve as CMS's singular, reliable and authoritative data source, from which all systems can retrieve current, standard, valid and timely data necessary for Medicare Program administration. MBD will provide CMS with a centralized database that is able to communicate with other systems while being able to view, manage, and update beneficiary information. It will also provide new sets of data not found in existing CMS systems. Other groups of information maintained in this data management structure will be initially extracted from data elements currently maintained in other CMS systems of records: ''Enrollment Database (EDB)'' (formerly known as the Health Insurance Master Record), System No. 09–70–0502, ''Group Health Plan (GHP), System No. 09–70–5001,'' and the ''Medicaid Statistical Information System (MSIS), System No. 09–70–4001.'' These systems will remain active for the purposes stated in their current notices. The data elements include, but are not limited to, standard data for identification such as health insurance claim number (HICN), social security number (SSN), sex, race/ethnicity, date of birth, geographical location, Medicare entitlement information, M+C plan elections and enrollment, End Stage Renal Disease (ESRD) coverage, primary insurance coverage, e.g., the ''working aged'' population, historic and current listing of residences, and Medicaid eligibility and Managed Care institutional status.

The MBD is in its first stage of a multi-year implementation. In its full implementation the MBD will be the national source of comprehensive beneficiary information and provide consistent information throughout Medicare operations. The first application of the MBD focuses on the Medicare Managed Care Program. The system is being developed in several different stages and this notice addresses the initial stage of development that will contain data of interest to the Medicare Managed Care program rather than the Fee For Service Program. The initial stage will include two major functions: (1) Allows system users to view and update beneficiary data based upon role based security access and (2) allows accurate and timely processing of beneficiary residence information particularly for mailings and to processing managed care payments. The MBD update function will ensure the accuracy and timeliness of data using business rules developed to assess and validate the correctness of new and changed data. However, historic data will be retained to provide insurance profiles for specified ''points in time''. Further, for accurate beneficiary residence address processing, the MBD identifies the conditions where the acceptance of new or corrected address information will trigger the establishment of a new or corrected period of Beneficiary

Residence History Information or Beneficiary Temporary Residency History Information. It also would identify the conditions where new Social Security Administration (SSA) State and County Codes must be derived when an address is changed. Future modifications of the MBD that substantially change the system of records will follow a corresponding modification or alteration of this system notice.

The primary purpose of this system of records is to provide the Centers for Medicare & Medicaid Services (CMS) with a singular, authoritative, database of comprehensive data on people enrolled in Medicare. The development and operation of the MBD would establish within CMS, a singular, national source of comprehensive beneficiary information. This information would be consistent throughout the Medicare Program, providing key benefits to CMS's program, administrative and customer service goals. The MBD will combine and house beneficiary centric data that resides currently within CMS databases such as the EDB, MSIS and GHP. It will be the authoritative database for approved agency contractors who need specific types of data to support and implement business processes. Although the MBD does not replace any of these systems at this time, the MBD will provide the most current and reliable information for contractors to make timely decisions about payment and service delivery. The Information retrieved from this system of records will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor or consultant, (2) another federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent, (3) providers and suppliers of services for administration of Title XVIII, (4) third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs, (5) Peer Review Organizations, (6) other insurers for processing individual insurance claims, (7) facilitate research on the quality and effectiveness of care provided, as well as payment related projects, (8) support constituent requests made to a congressional representative, (9) support litigation involving the agency, and (10) combat fraud and abuse in certain health benefits programs. We have provided background information about the modified system in the **SUPPLEMENTARY INFORMATION** section below. Although the Privacy Act requires only that CMS provide an opportunity for interested persons to comment on the proposed routine uses, CMS invites comments on all portions of this notice. See **EFFECTIVE DATES** section for comment period.

EFFECTIVE DATES: CMS has filed a new system of records 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 November 28, 2001. We will not disclose any information under a routine use until 40 days after notification to OMB and Congress, whichever is latest. We may defer implementation of this system of records or one or more of the routine use statements listed below if we receive comments that persuade us to defer implementation.

ADDRESSES: The public should address comments to: Director, Division of Data Liaison and Distribution (DDLD), CMS, Room N2–04–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Comments received will be available for review at this location, by appointment, during regular business hours, Monday through Friday from 9 a.m.–3 p.m., eastern time zone.

FOR FURTHER INFORMATION CONTACT: William Seabrease, Health Insurance Specialist, Center for Beneficiary Choices, CMS, Mail-stop C5–16–15, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. The telephone number is (410) 786–6187.

SUPPLEMENTARY INFORMATION:

I. Description of the New System of Records

A. Background

The MBD was established to provide CMS with a singular, authoritative database of comprehensive data on people with Medicare. The MBD is necessary to successfully support ongoing program administration including Medicare claims payment, entitlement; Medicaid coverage, Medicare+Choice elections and payments; coordination of benefits for the purpose of conducting Medicare business; payment demonstrations; and demographic research. As CMS's authoritative enterprise beneficiary database, it will provide new sets of data that is not currently available in the EDB, GHP or MSIS. The ''Medicare Beneficiary Database (MBD),'' System No. 09–70–0536 will also maintain beneficiary data elements extracted from existing CMS systems of records: EDB, GHP, and MSIS. The renamed ''Enrollment Database,'' was established in 1965 to maintain accurate and complete data on Medicare enrollment and entitlement. Notice of the modification to this system, ''Health Insurance Master Record (HIMR),'' HHS/CMS/BDMS, System No. 09–70–0502 was published in the **Federal Register** at 55 FR 37549 (September 12, 1990), 61 FR 6645 (Feb. 21, 1996) (added unnumbered social security use), 63 FR 38414 (July 16, 1998) (added three fraud and abuse uses), and 65 FR 50552 (Aug. 18, 2000) (deleted one and modified two fraud and abuse uses). The ''Group Health Plan (GHP),'' System No. 09–70–4001, published in the **Federal Register** at 57 FR 60819 (December 22,1992), was established to maintain a master file of group health plan members for accounting control, to expedite the exchange of data with the plans, and to control the posting of pro-rata amounts to the part B deductible of enrolled members. The ''Medicaid Statistical Information System (MSIS),'' System No. 09–70–6001, published in the **Federal Register** at 59 FR 41327 (August 11, 1994), was established to maintain an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claims of Medicaid beneficiaries to be used for the administration of the Medicaid program at the Federal level, produce statistical reports, support Medicaid research, and assist in the detection of fraud and abuse.

CMS has long realized that the Medicare program is in the middle of rapidly changing health insurance industry characterized by an expansion of service delivery models and payment options. The Medicare+Choice provisions of the Balance Budget Act (BBA) of 1997 (Pub. L. 105–217) has made the challenge of managing beneficiary health choices one of the most critical challenges facing CMS and the health industry at large. To be of maximum use, the data must be organized and categorized into a comprehensive system. CMS sought to identify key sources, including both organizations and systems that could provide valid and reliable information. Medicare will no longer exist within an environment characterized by limited health insurance options and standard delivery models. The MBD provides CMS with a timely model for data inventory of beneficiary information retained in a database environment that provides flexibility to react quickly to changing Medicare program needs.

Data relating to Medicare Managed Care beneficiaries will be the initial focus of the system implementation.

The MBD provides a solution as a singular, reliable and authoritative source, in which all systems can retrieve current, standard, valid and timely data for processing beneficiary selections of capitated delivery options. It will provide a comprehensive ''national view'' of beneficiary information that is consistent throughout the Medicare program, which will primarily benefit CMS's operational and customer service business goals. In addition to providing a flexible system to accommodate changes, the MBD will support significant improvements in the accuracy of the beneficiary residence address used for capitation, determining payments and will serve as the first identifying record of dual Medicare/Medicaid eligible population which is essential to the capitation process.

An independent technical evaluation of CMS's managed care systems found that without major enhancements, Medicare+Choice provisions could not be supported by existing Medicare systems. Also the comprehensive review of existing systems was necessary in order to proceed with a development effort that would ensure that future customer service and program management objectives were met. The MBD alters an old architecture that could only support two beneficiary Medicare choice options: Fee-for service or traditional Health Maintenance Organizations (HMO). As these models merge and additional choices become available, (i.e., Medicare+Choice Organizations, Medicare Savings Accounts (MSA) and Private Fee for Service options), CMS determined the need for a beneficiary management structure, the MBD, designed to support these expanded program and coverage options.

The MBD design will accommodate the future growth in delivery service options; scalable to support the entire Medicare beneficiary population of approximately 42 million. This would include both the targeted sets of business requirements and processes for beneficiary choice between capitated delivery service options, now, and later to support all beneficiaries remaining in the traditional Medicare Fee For Service Program.

The MBD includes standard data for identification such as the Medicare HICN, SSN, sex, race/ethnicity, date of birth, and geographical location for Medicare beneficiaries. Further, the MBD will maintain data on the following types of beneficiary information: demographic information, Medicare entitlement information, Medicare Secondary Payer data, hospice election, Plan elections and enrollments, End Stage Renal Disease (ESRD) entitlement, historic and current listing of residences, and Medicaid eligibility and Managed Care institutional status. The MBD will have a common interface layer that enables existing legacy systems and new applications to access MBD in a uniform fashion. The system shall support both online and batch transaction volumes up to 200,000-batch update transaction per-day; up to 2 million interactive inquiries per-day. An operational day is assumed to be 16 hours. It is envisioned to be capable of supporting access and interoperability across mainframe, mid-tier, and desktop systems. The MBD is currently scoped to encompass up to 15 logical database tables, containing about 250 logically grouped data elements. The logical database tables include: The Beneficiary Demographics and Communication Profiles, Medicare Entitlement Information, Hospice Election and Usage Information, Beneficiary Service and Delivery Elections, Other Beneficiary Explicit Elections, Fee-For-Service Periods, Managed Care Institutional Status Information, ESRD Medicare entitlement information, Medicaid Eligibility information, and Other Required Beneficiary Specific information. It also will accommodate new and modified beneficiary data that was determined to be necessary to support effective implementation of the BBA.

B. Statutory and Regulatory Basis for System of Records

Authority for maintenance of the system is given under §§ 226, 226A, 1811, 1818, 1818A, 1831, 1833(a)(1)(A), 1836, 1837, 1838, 1843, 1866, 1876, 1881, and 1902(a)(6) of the Social Security Act and Title 42 United States Code (U.S.C.) 426, 1395(a)(1)(A), 1395c, 1395cc, 1395i–2, 1395i–2a, 1395j, 1395l, 1395mm, 1395o, 1395p, 1395q, 1395rr, 1395v, and 1396(a).

II. Collection and Maintenance of Data in the System

A. Scope of the Data Collected

Individuals age 65 or over who have been, or currently are, entitled to health insurance (Medicare) benefits under Title XVIII of the Social Security Act or under provisions of the Railroad Retirement Act; individuals under age 65 who have been, or currently are, entitled to such benefits on the basis of having been entitled for not less than 24 months to disability benefits under title II of the Act or under the Railroad Retirement Act; individuals who have been, or currently are, entitled to such benefits because they have end-stage renal disease; individuals age 64 and 8 months or over who are likely to become entitled to health insurance (Medicare) benefits upon attaining age 65, individuals under age 65 who have at least 21 months of disability benefits who are likely to become entitled to Medicare upon the 25th month of entitlement to such benefits, and the populations dually eligible for both Medicare and Medicaid (Title XIX of the Social Security Act).

The data elements include, but are not limited to, standard data for identification such as HICN, SSN, sex, race/ethnicity, date of birth, geographic location, Medicare enrollment and entitlement information, Medicare Secondary Payer (MSP) data containing insurance information on payers primary to Medicare necessary for appropriate Medicare claim payment, hospice election, plan elections and enrollment, End Stage Renal Disease (ESRD) entitlement, historic and current listing of residences, and Medicaid eligibility and institutional status.

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 MBD 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 disclose the minimum personal data necessary to achieve the purpose of the MBD. CMS has the following policies and procedures concerning disclosures of information that will be maintained in the system. Disclosure of information from the system of records will be approved only to the extent necessary to accomplish the purpose of the disclosure and only after CMS:

1. Determines that the use or disclosure is consistent with the reason that the data is being collected, e.g., ensuring proper enrollment, establishing the validity of individual's entitlement to benefits, verifying the accuracy of information presented by the individual, insuring proper reimbursement for services provided, and claims 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 Disclosure 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 MBD without the consent of the individual to whom such information pertains. Each proposed disclosure of information under these routine uses will be evaluated to ensure that the disclosure is legally permissible, including but not limited to ensuring that the purpose of the disclosure is compatible with the purpose for which the information was collected. In addition, our policy will be to prohibit release even of non-identifiable data, except pursuant to one of the routine uses, if there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that individuals who are familiar with the enrollees could, because of the small size, use this information to deduce the identity of the beneficiary). We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To 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.

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 of records.

CMS occasionally contracts out certain of its functions when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor or consultant whatever information is necessary for the contractor or consultant to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor or consultant from using or disclosing the information for any purpose other than that described in the contract and requires the contractor or consultant to return or destroy all information at the completion of the contract.

2. To another federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent to:

a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,

b. Enable such agency to administer a federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a federal statute or regulation that implements a health benefits program funded in whole or in part with federal funds, and/or

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

Other federal or state agencies in their administration of a federal health program may require MBD information in order to support evaluations and monitoring of Medicare claims information of beneficiaries, including proper reimbursement for services provided;

The Internal Revenue Service may require MBD 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);

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

The Railroad Retirement Board requires MBD information to administer provisions of the Railroad Retirement and Social Security Acts relating to railroad employment and/or the administration of the Medicare program;

The Social Security Administration requires MBD data to enable them to assist in the implementation and maintenance of the Medicare program;

Disclosure under this routine use shall be used by state Medicaid agencies pursuant to agreements with the Department of Health and Human Services 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, 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;

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

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

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

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

Third parties contacts require MBD 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 Peer Review Organizations (PRO) 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 Social Security Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans.

The PRO will work to implement quality improvement programs, provide consultation to CMS, its contractors, and to state agencies. The PRO will assist state agencies in related monitoring and enforcement efforts, assist CMS and intermediaries in program integrity assessment, and prepare summary information for release to CMS.

6. 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 (HMO) or a Medicare-approved health care prepayment plan (HCPP), directly or through a contractor. Information to be disclosed shall be limited to Medicare enrollment 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;

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

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

Other insurers, HMO, and HCPP may require MBD information in order to support evaluations and monitoring of Medicare claims information of beneficiaries, including proper reimbursement for services provided.

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

The MBD data will provide for research or in support of evaluation 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.

8. To a Member of Congress or to 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 sometimes 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.

9. 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.

10. To 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 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.

11. 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 MBD information for the purpose of combating fraud and abuse in such federally funded programs.

B. Additional Provisions Affecting Routine Use Disclosures

In addition, our policy will be to prohibit release even of non-identifiable data, except pursuant to one of the routine uses, if there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that individuals who are familiar with the enrollees could, because of the small size, use this information to deduce the identity of the beneficiary).

This System of Records contains Protected Health Information as defined by the Department of Health and Human Services' regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR parts 160 and 164, 65 FR 82462 as amended by 66 FR 12434). 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.''

IV. Safeguards

The MBD system will conform to applicable law and policy governing the privacy and security of federal automated information systems. These include but are not limited to: the

Privacy Act of 1974, Computer Security Act of 1987, the Paperwork Reduction Act (PRA) of 1995, the Clinger-Cohen Act of 1996, and OMB Circular A–130, Appendix III, ''Security of Federal Automated Information Resources.'' CMS has prepared a comprehensive system security plan as required by the Office and Management and Budget (OMB) Circular A–130, Appendix III. This plan conforms fully to guidance issued by the National Institute for Standards and Technology (NIST) in NIST Special Publication 800–18, ''Guide for Developing Security Plans for Information Technology Systems.'' Paragraphs A–C of this section highlight some of the specific methods that CMS is using to ensure the security of this system and the information within it.

A. Authorized Users

Personnel having access to the system have been trained in Privacy Act and systems security requirements. Employees and contractors who maintain records in the system are instructed not to release any data until the intended recipient agrees to implement appropriate administrative, technical, procedural, and physical safeguards sufficient to protect the confidentiality of the data and to prevent unauthorized access to the data. In addition, CMS is monitoring the authorized users to ensure against excessive or unauthorized use. Records are used in a designated work area or workstation and the system location is attended at all times during working hours.

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

➢ Database Administrator class owns the database objects; e.g., tables, triggers, indexes, stored procedures, packages, and has database administration privileges to these objects;

➢ Quality Control Administrator class has read and write access to key fields in the database;

➢ Quality Indicator (QI) Report Generator class has read-only access to all fields and tables;

➢ Policy Research class has query access to tables, but are not allowed to access confidential patient identification information; and

➢ Submitter class has read and write access to database objects, but no database administration privileges.

B. Physical Safeguards

All server sites have implemented the following minimum requirements to assist in reducing the exposure of computer equipment and thus achieve an optimum level of protection and security for the MBD system: Access to all servers is controlled, with access limited to only those support personnel with a demonstrated need for access. Servers are to be kept in a locked room accessible only by specified management and system support personnel. Each server requires a specific log-on process. All entrance doors are identified and marked. A log is kept of all personnel who were issued a security card, key and/or combination, which grants access to the room housing the server, and all visitors are escorted while in this room. All servers are housed in an area where appropriate environmental security controls are implemented, which include measures implemented to mitigate damage to Automated Information System (AIS) resources caused by fire, electricity, water and inadequate climate controls.

Protection applied to the workstations, servers and databases include:

➢ User Log-ons—Authentication is performed by the Primary Domain Controller/Backup Domain Controller of the log-on domain.

➢ Workstation Names—Workstation naming conventions may be defined and implemented at the agency level.

➢ Hours of Operation—May be restricted by Windows NT. When activated all applicable processes will automatically shut down at a specific time and not be permitted to resume until the predetermined time. The appropriate hours of operation are determined and implemented at the agency level.

➢ Inactivity Log-out—Access to the NT workstation is automatically logged out after a specified period of inactivity.

➢ Warnings—Legal notices and security warnings display on all servers and workstations.

➢ Remote Access Services (RAS)—Windows NT RAS security handles resource access control. Access to NT resources is controlled for remote users in the same manner as local users, by utilizing Windows NT file and sharing permissions. Dial-in access can be granted or restricted on a user-by-user basis through the Windows NT RAS administration tool.

C. Procedural Safeguards

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

V. Effect of the New 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. We will only disclose the minimum personal data necessary to achieve the purpose of MBD. Disclosure of information from the system of records will be approved only to the extent necessary to accomplish the purpose of the disclosure. CMS has assigned a higher level of security clearance for the information maintained in this system in an effort to provide added security and protection of data in this system.

CMS will take precautionary measures to minimize the risks of unauthorized access to the records and the potential harm to individual privacy or other personal or property rights. CMS will collect only that information necessary to perform the system's functions. In addition, CMS will make disclosure from the proposed system only with consent of the subject individual, or his/her legal representative, or in accordance with an applicable exception provision of the Privacy Act.

CMS, therefore, does not anticipate an unfavorable effect on individual privacy as a result of the disclosure of information relating to individuals.

Dated: November 28, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

09–70–0536

SYSTEM NAME:

Medicare Beneficiary Database, HHS/CMS/CBS.

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive Data.

SYSTEM LOCATION:

CMS Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, Maryland 21244–1850, and at various other remote locations (See Appendix A).

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Individuals age 65 or over who have been, or currently are, entitled to health insurance (Medicare) benefits under Title XVIII of the Social Security Act or under provisions of the Railroad Retirement Act; individuals under age 65 who have been, or currently are, entitled to such benefits on the basis of having been entitled for not less than 24 months to disability benefits under title II of the Act or under the Railroad Retirement Act; individuals who have been, or currently are, entitled to such benefits because they have end-stage renal disease; individuals age 64 and 8 months or over who are likely to become entitled to health insurance (Medicare) benefits upon attaining age 65, and individuals under age 65 who have at least 21 months of disability benefits who are likely to become entitled to Medicare upon the 25th month of entitlement to such benefits and those populations that are dually eligible for both Medicare and Medicaid (Title XIX of the Social Security Act).

CATEGORIES OF RECORDS IN THE SYSTEM:

The data elements include, but are not limited to, standard data for identification such as health insurance claim number (HICN), social security number (SSN), sex, race/ethnicity, date of birth, geographic location, Medicare enrollment and entitlement information, Medicare Secondary Payer data necessary for appropriate Medicare claim payment, hospice election, plan elections and enrollment, End Stage Renal Disease (ESRD) entitlement, historic and current listing of residences, and Medicaid eligibility and Managed Care institutional status.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Authority for maintenance of the system is given under sections 226, 226A, 1811, 1818, 1818A, 1831, 1833(a)(1)(A), 1836, 1837, 1838, 1843, 1866, 1876, 1881, and 1902(a)(6) of the Social Security Act and Title 42 United States Code (U.S.C.) 426, 1395(a)(1)(A), 1395c, 1395cc, 1395i–2, 1395i–2a, 1395j, 1395l, 1395mm, 1395o, 1395p, 1395q, 1395rr, 1395v, and 1396(a).

PURPOSE(S):

The primary purpose of this system of records is to provide the Centers for Medicare & Medicaid Services (CMS) with a singular, authoritative, database of comprehensive data on people with Medicare. The development and operation of the MBD would establish within CMS, a singular, national source of comprehensive beneficiary information. This information would be consistent throughout the Medicare Program, providing key benefits to CMS's operation, administrative and customer service goals. The MBD will combine and house beneficiary centric data that resides currently within CMS databases such as the EDB, MSIS and GHP. It becomes the authoritative database for approved agency contractors who need specific types of data to support and implement business processes, based upon a beneficiary's health insurance needs. Although the MBD does not replace any of these systems at this time, the MBD does provide the most current and reliable information for contractors to make timely decisions about payment and service delivery elections. Information retrieved from this system of records will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor or consultant, (2) another federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent, (3) providers and suppliers of services for administration of Title XVIII, (4) third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs, (5) Peer Review Organizations, (6) other insurers for processing individual insurance claims, (7) facilitate research on the quality and effectiveness of care provided, as well as payment related projects, (8) support constituent requests made to a congressional representative, (9) support litigation involving the agency, and (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:

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 MBD without the consent of the individual to whom such information pertains. Each proposed disclosure of information under these routine uses will be evaluated to ensure that the disclosure is legally permissible, including but not limited to ensuring that the purpose of the disclosure is compatible with the purpose for which the information was collected. In addition, our policy will be to prohibit release even of non-identifiable data, except pursuant to one of the routine uses, if there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that individuals who are familiar with the enrollees could, because of the small size, use this information to deduce the identity of the beneficiary). We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To 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.

2. To another federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent to:

a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,

b. Enable such agency to administer a federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a federal statute or regulation that implements a health benefits program funded in whole or in part with federal funds, and/or

c. To assist federal/state Medicaid programs within the state.

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

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

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

b. The data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns one or

more of the following: the individual's entitlement to benefits under the Medicare program, the amount of reimbursement, and in cases in which the evidence is being reviewed as a result of suspected fraud and abuse, program integrity, quality appraisal, or evaluation and measurement of activities.

5. To Peer Review Organizations (PRO) 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 Social Security 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.

6. 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 (HMO), Cost Plans, or a Medicare-approved health care prepayment plan (HCPP), Programs for All Inclusive Care for the Elderly, Medicare + Choice Organizations (i.e. Coordinated Care Plans (CCPs), Religious Based Fraternal Plans Private Fee For Service (PFFS), Medical Savings Accounts (MSAs), Demonstrations) directly or through a contractor. Information to be disclosed shall be limited to Medicare enrollment 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;

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

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

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

8. To a Member of Congress or to 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.

9. 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.

10. To 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 programs.

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

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

STORAGE:

All records are stored on magnetic media.

RETRIEVABILITY:

All Medicare records are accessible by Health Insurance Claim Number, and SSN search. This system supports both on-line and batch access.

SAFEGUARDS:

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

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

RETENTION AND DISPOSAL:

Records are maintained in the active files for a period of 15 years. The records are then retired to archival files maintained at the Health Care Data Center.

SYSTEM MANAGER(S) AND ADDRESS:

Acting Director, Center for Medicare Choices & Deputy Director for Beneficiary Education in the Center for Beneficiary Choices, CMS, 7500 Security Boulevard, C5–18–27, Baltimore, Maryland 21244–1850.

NOTIFICATION PROCEDURE:

For purpose of access, the subject individual should write to the system manager who will require the system name, health insurance claim number, address, date of birth, and sex, and for verification purposes, the subject individual's name (woman's maiden name, if applicable), and social security number (SSN). Furnishing the SSN is voluntary, but it may make searching for a record easier and prevent delay.

RECORD ACCESS PROCEDURE:

For purpose of access, use the same procedures outlined in Notification Procedures above. Requestors should also reasonably specify the record contents being sought. (These procedures are in accordance with department regulation 45 CFR 5b.5(a)(2)).

CONTESTING RECORD PROCEDURES:

The subject individual should contact the 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:

The data contained in this system of records are extracted from other CMS systems of records: Enrollment Database, Group Health Plan, and the Medicaid Statistical Information System.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

Appendix A. Health Insurance Records

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 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 Managed Care Organizations, 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 information on MCOs).

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 Street, 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. *Managed Care Organizations:* Monthly report of Managed Care Organizations is available at *www.cms.gov.*

[FR Doc. 01–30005 Filed 12–5–01; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Statement of Organization, Functions, and Delegations of Authority

This notice amends Part R of the Statement of Organization, Functions and Delegations of Authority of the Department of Health and Human Services (DHHS), Health Resources and Services Administration (60 FR 56605 as amended November 6, 1995, as last amended at 66 FR 56333–34, dated November 7, 2001).

This notice establishes the Office for the Advancement of Telehealth and revises the functional statement for the Office of Policy and Program Development (RV3) in the HIV/AIDS Bureau (RV).

1. Establish the Office for the Advancement of Telehealth as follows:

Office for the Advancement of Telehealth (RV9)

Telehealth is the use of electronic communications and information technologies to provide and support health care services and training when distance separates the participants. The Office for the Advancement of Telehealth (OAT) serves as the focal point for coordinating and advancing the use of electronic communications and information (telehealth) technologies across all of HRSA's programs. Telehealth information can be used in a broad array of applications, including, but not limited to, the provision of: health care at a distance (telemedicine); distance-based learning to improve the knowledge of the agency grantees, and others; and improved information dissemination to both consumers and providers about the latest developments in health care, and other activities designed to improve the health status of the nation. The Office for the Advancement of Telehealth carries out the following functions, specifically; (1) provides leadership in developing and coordinating telehealth programs and policies; (2) provides professional assistance and support in developing telehealth initiatives; (3) administers grant programs to promulgate and evaluate the use of appropriate telehealth technologies among grantees and others; (4) in conjunction with HRSA's OIT assesses new and existing telehealth technologies and advises on strategies to maximize the potential of these technologies for meeting educational and technical assistance objectives; (5) in conjunction with OIT disseminates the latest information and research findings related to the use of telehealth technologies in the agency programs and underserved areas, including findings on ''best practices''; (6) works with other components of the Department, with other Federal and state agencies, and with the private sector to promote and overcome barriers to cost-effective telehealth programs; and (7) provides advise on telehealth policy.

2. Abolish the functional statement for the Office of Policy and Program Development (RV3) in its entirety and replace with the following:

Office of Policy and Program Development (RV3)

Serves as the Bureau's focal point for program planning and related coordination activities including the development and dissemination of program objectives, alternatives, policy statements and the formulation and interpretation of program related policies. Specifically: (1) Advises the Associate Administrator and Division Directors in the development of plans and proposals to support Administration goals, and serves as the primary staff unit on special projects for the Associate Administrator; (2) coordinates with the Office of Planning and Evaluation, HRSA, and other appropriate offices in the preparation of