B. Federal Reserve Bank of Chicago (Patrick M. Wilder, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690-1414:

1. 1st Source Corporation, South Bend, Indiana; to acquire 100 percent of the voting shares of FINA Bancorp, Inc., Valparaiso, Indiana, and thereby indirectly acquire First National Bank of Valparaiso, Valparaiso, Indiana.

C. Federal Reserve Bank of San Francisco (Tracy Basinger, Director, Regional and Community Bank Group) 101 Market Street, San Francisco, California 94105-1579:

1. Belvedere SoCal, San Francisco, California; to become a bank holding company by acquiring 100 percent of the voting shares of Professional Business Bank, Pasadena, California. In connection with this application, Belvedere Capital Partners II, LLC, and Belvedere Capital Fund II, LP, San Francisco, California, will indirectly acquire up to 58 percent of the voting shares of Professional Business Bank, Pasadena, California.

Board of Governors of the Federal Reserve System, March 14, 2007.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. E7–4970 Filed 3–16–07; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

Notice of Proposals to Engage in Permissible Nonbanking Activities or to Acquire Companies that are Engaged in Permissible Nonbanking Activities

The companies listed in this notice have given notice under section 4 of the Bank Holding Company Act (12 U.S.C. 1843) (BHC Act) and Regulation Y (12 CFR Part 225) to engage *de novo*, or to acquire or control voting securities or assets of a company, including the companies listed below, that engages either directly or through a subsidiary or other company, in a nonbanking activity that is listed in § 225.28 of Regulation Y (12 CFR 225.28) or that the Board has determined by Order to be closely related to banking and permissible for bank holding companies. Unless otherwise noted, these activities will be conducted throughout the United States.

Each notice is available for inspection at the Federal Reserve Bank indicated. The notice also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether the proposal complies with the standards of section 4 of the BHC Act. Additional information on all bank holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than April 3, 2007.

A. Federal Reserve Bank of Richmond (A. Linwood Gill, III, Vice President) 701 East Byrd Street, Richmond, Virginia 23261-4528:

1. PSB Holding Corp., Preston, Maryland; to engage *de novo* through its subsidiary, Community Bank Mortgage Corporation, Easton, Maryland, in the origination and sale of residential mortgage loans to the secondary market, pursuant to section 225.28(b)(1) of Regulation Y.

Board of Governors of the Federal Reserve System, March 14, 2007.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. E7–4971 Filed 3–16–07; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974: Report of Modified System of Records

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

ACTION: Notice of Modified System of Records (SOR).

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, we are proposing to modify a SOR titled, ''Long Term Care-Minimum Data Set'' (MDS), System No. 09–70–1517, most recently modified at 67 FR 6714 (February 13, 2002). We propose to assign a new CMS identification number to this system to simplify the obsolete and confusing numbering system originally designed to identify the Bureau, Office, or Center that maintained information in the Health Care Financing Administration systems of records. The new identifying number for this system should read: System No. 09–70–0528.

We propose to modify existing routine use number 1 that permits disclosure to agency contractors and consultants to include disclosure to CMS grantees who perform a task for the agency. CMS grantees, charged with completing projects or activities that require CMS data to carry out that activity, are classified separate from CMS contractors and/or consultants. The modified routine use will remain as routine use number 1. We also propose to modify existing routine use number 3 that permits disclosure to Peer Review Organizations (PRO). The name of PROs has been changed to read: ''Quality Improvement Organizations (QIO).'' QIOs will continue work to implement quality improvement programs, provide consultation to CMS, its contractors, and to state agencies. The modified routine use will remain as routine use number 3.

We will delete routine use number 6 authorizing disclosure to support constituent requests made to a congressional representative. If an authorization for the disclosure has been obtained from the data subject, then no routine use is needed. The Privacy Act allows for disclosures with the ''prior written consent'' of the data subject.

We are modifying the language in the remaining routine uses to provide a proper explanation as to the need for the routine use and to provide clarity to CMS's intention to disclose individual-specific information contained in this system. The routine uses will then be prioritized and reordered according to their usage. We will also take the opportunity to update any sections of the system that were affected by the recent reorganization or because of the impact of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) provisions and to update language in the administrative sections to correspond with language used in other CMS SORs.

The primary purpose of the system is to aid in the administration of the survey and certification, and payment of Medicare Long Term Care services, which include skilled nursing facilities (SNFs), nursing facilities (NFs) SNFs/NFs, and hospital swing beds, and to study the effectiveness and quality of care given in those facilities. Information in this system will also be used to: (1) Support regulatory, reimbursement, and policy functions performed within the Agency or by a contractor or consultant; (2) assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3) support Quality Improvement Organizations (QIO); (4) assist other insurers for processing individual insurance claims; (5) facilitate research on the quality and effectiveness of care provided, as well as payment related projects; (6) support litigation involving the Agency; (7) assist national accrediting organizations; and (8)

combat fraud, waste, 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.

DATES: *Effective Dates:* CMS filed a modified system report with the Chair of the House Committee on Government Reform and Oversight, the Chair of the Senate Committee on Homeland Security and Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on February 22, 2007. To ensure that all parties have adequate time in which to comment, the modified 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: CMS Privacy Officer, Division of Privacy Compliance, Enterprise Architecture and Strategy Group, Office of Information Services, 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: Tina Miller, Health Insurance Specialist, Division of Nursing Homes, Survey and Certification Group, Center for Medicaid and State Operations, CMS, Mail stop S2–12–25, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. The telephone number is (410) 786–6735 or e-mail *Tina.Miller@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Description of the Modified System

A. Statutory and Regulatory Basis for System

Authority for maintenance of the system is given under §§ 1102(a), 1819(b) (3)(A), 1819(f), 1919(b)(3)(A), 1919(f), and 1864 of the Social Security Act.

B. Collection and Maintenance of Data in the System

The system contains information on residents in all long-term care facilities that are Medicare and/or Medicaid certified, including private pay individuals including but not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer (MSP) data containing other party liability insurance information necessary for appropriate Medicare claim payment. The system also contains the individual's health insurance numbers, name, geographic location, race/ethnicity, sex, and date of birth, hospice election, premium billing and collection, direct billing information, and group health plan enrollment data.

II. Agency Policies, Procedures, and Restrictions on the Routine Use

A. 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 MDS 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 MDS.

CMS has the following policies and procedures concerning disclosures of information that will be maintained in the system. Disclosure of information from the system 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., to aid in the administration of the survey and certification, and payment of Medicare Long Term Care services, which include skilled nursing facilities (SNFs), nursing facilities (NFs) SNFs/NFs, and hospital swing beds, and to study the effectiveness and quality of care given in those facilities.

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. Modified Routine Use Disclosures of Data in the System

A. Entities Who May Receive Disclosures Under Routine Use

These routine uses specify circumstances, in addition to those provided by statute in the Privacy Act of 1974, under which CMS may release information from the MDS 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 have provided a brief explanation of the routine uses we are proposing to establish or modify for disclosures of information maintained in the system:

1. To support Agency contractors, consultants, or grantees 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 CMS functions relating to purposes for this system.

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

2. To assist 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 MDS 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 MDS 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 Social Security Administration may require MDS 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 HHS for determining Medicaid and Medicare eligibility, for quality control studies, for determining eligibility of recipients of assistance under Titles IV, XVIII, and XIX of the Act, and for the administration of the Medicaid program. Data will be released to the state only on those individuals who are patients under the services of a Medicaid program within the state or who are residents of that state.

We also contemplate disclosing information under this routine use in situations in which state auditing agencies require MDS 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.

3. To assist Quality Improvement Organizations (QIO) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans.

QIOs will work to implement quality improvement programs, provide consultation to CMS, its contractors, and to state agencies. QIOs will assist state agencies and CMS intermediaries in program integrity assessments and preparation of summary information for release to CMS.

4. To assist insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO), health and welfare benefit funds, managed care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, liability insurers, no-fault medical automobile insurers, workers compensation carriers or plans, other groups providing protection against medical expenses without the beneficiary's authorization, and any entity having knowledge of the occurrence of any event affecting (a) an individual's right to any such benefit or payment, or (b) the initial right to any such benefit or payment, for the purpose of coordination of benefits with the Medicare program and implementation of the MSP provision at 42 U.S.C. 1395y (b). Information to be disclosed shall be limited to Medicare utilization data necessary to perform that specific function. 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 individual's insurance claims; and

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

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

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

MDS data will provide research, evaluations 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.

6. To support the Department of Justice (DOJ), court or adjudicatory body when:

a. The Agency or any component thereof, or

b. Any employee of the Agency in his or her official capacity, or

c. Any employee of the Agency in his or her individual capacity where the DOJ has agreed to represent the employee, or

d. The United States Government is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

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.

7. To support a national accrediting organization whose accredited facilities are presumed to meet certain Medicare requirements for inpatient hospital (including swing beds) services; *e.g.*, the Joint Commission for the Accrediting of Healthcare Organizations (JCAHO). Information will be released to accrediting organizations only for those facilities that they accredit and that participate in the Medicare program.

CMS anticipates providing those national accrediting organizations with MDS information to enable them to target potential or identified problems during the organization's accreditation review process of that facility.

8. To assist 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, waste or abuse in such program.

We contemplate disclosing information under this routine use only in situations in which CMS may enter into a contract or grant with a third party to assist in accomplishing CMS functions relating to the purpose of combating fraud, waste, 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 the contractor or grantee duties. In these situations, safeguards are provided in the contract prohibiting the contractor or grantee from using or disclosing the information for any purpose other than that described in the contract and requiring the contractor or grantee to return or destroy all information.

9. To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste, 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, waste, or abuse in such programs.

Other agencies may require MDS information for the purpose of combating fraud, waste, and abuse in such Federally-funded programs.

B. Additional Circumstances Affecting Routine Use Disclosures

To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR parts 160 and 164, subparts A and E) 65 FR 82462 (12–28–00). Disclosures of such PHI that are otherwise 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.'' (See 45 CFR 164–512(a)(1)).

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

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws and regulations include but are not limited to: The Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A–130, Management of Federal Resources, Appendix III, Security of Federal Automated Information Resources also applies. Federal, HHS, and CMS policies and standards include but are not limited to: All pertinent NIST publications; the HHS Automated Information Systems Security Handbook and the CMS Information Security Handbook.

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

CMS will take precautionary measures to minimize the risks of unauthorized access to the records and the potential harm to individual privacy or other personal or property rights. CMS will collect only that information necessary to perform the system's functions. In addition, CMS will make disclosure from the proposed system only with consent of the subject individual, or his/her legal representative, or in accordance with an applicable exception provision of the Privacy Act. CMS, therefore, does not anticipate an unfavorable effect on individual privacy as a result of the disclosure of information relating to individuals.

Dated: February 22, 2007.

Charlene Frizzera,

Acting Chief Operating Officer, Centers for Medicare & Medicaid Services.

System No. 09–70–0528

SYSTEM NAME:

''Long Term Care-Minimum Data Set (MDS),'' Department of Health and Human Services (HHS)/Centers for Medicare & Medicaid Services (CMS)/ Center for Medicaid and State Operations (CMSO).

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive.

SYSTEM LOCATION:

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

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

The system contains information on residents in all long-term care facilities that are Medicare and/or Medicaid certified, including private pay individuals including but not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer (MSP) data containing other party liability insurance information necessary for appropriate Medicare claim payment.

CATEGORIES OF RECORDS IN THE SYSTEM:

The system also contains the individual's health insurance numbers, name, geographic location, race/ ethnicity, sex, and date of birth, hospice election, premium billing and collection, direct billing information, and group health plan enrollment data.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Authority for maintenance of the system is given under of §§ 1102(a), 1819(b)(3)(A), 1819(f), 919(b)(3)(A), 1919(f), and 1864 of the Social Security Act.

PURPOSE(S) OF THE SYSTEM:

The primary purpose of the system is to aid in the administration of the survey and certification, and payment of Medicare Long Term Care services, which include skilled nursing facilities (SNFs), nursing facilities (NFs) SNFs/ NFs, and hospital swing beds, and to study the effectiveness and quality of care given in those facilities. Information in this system will also be used to: (1) Support regulatory, reimbursement, and policy functions performed within the Agency or by a contractor or consultant; (2) assist

another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3) support Quality Improvement Organizations (QIO); (4) assist other insurers for processing individual insurance claims; (5) facilitate research on the quality and effectiveness of care provided, as well as payment related projects; (6) support litigation involving the Agency; (7) assist national accrediting organizations; and (8) combat fraud, waste, 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. 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 MDS 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 have provided a brief explanation of the routine uses we are proposing to establish or modify for disclosures of information maintained in the system:

1. To support Agency contractors, consultants, or grantees 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 assist 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 support Quality Improvement Organizations (QIO) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans.

4. To assist insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO), health and welfare benefit funds, managed care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, liability insurers, no-fault medical automobile insurers, workers compensation carriers or plans, other groups providing protection against medical expenses without the beneficiary's authorization, and any entity having knowledge of the occurrence of any event affecting (a) an individual's right to any such benefit or payment, or (b) the initial right to any such benefit or payment, for the purpose of coordination of benefits with the Medicare program and implementation of the MSP provision at 42 U.S.C. 1395y (b). Information to be disclosed shall be limited to Medicare utilization data necessary to perform that specific function. 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 individual's insurance claims; and

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

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

6. To assist 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 and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

7. To support a national accrediting organization whose accredited facilities are presumed to meet certain Medicare requirements for inpatient hospital (including swing beds) services; *e.g.*, the Joint Commission for the Accrediting of Healthcare Organizations (JCAHO). Information will be released to accrediting organizations only for those facilities that they accredit and that participate in the Medicare program.

8. To assist 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, waste, or abuse in such program.

9. To support 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, waste, 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, waste, or abuse in such programs.

B. Additional Circumstances Affecting Routine Use Disclosures

To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR parts 160 and 164, subparts A and E) 65 FR 82462 (12–28–00). Disclosures of such PHI that are otherwise 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.'' (See 45 CFR 164–512 (a) (1)).

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 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:

All records are stored on magnetic media.

RETRIEVABILITY:

All Medicare records are accessible by HIC number or alpha (name) search. This system supports both online and batch access.

SAFEGUARDS:

CMS has safeguards in place for authorized users and monitors such users to ensure against 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 will be retained until an approved disposition authority is obtained from the National Archives and Records Administration.''

SYSTEM MANAGER AND ADDRESS:

Director, Survey and Certification Group, Center for Medicaid and State Operations, CMS, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

NOTIFICATION PROCEDURE:

For purpose of access, the subject individual should write to the system manager who will require the system name, health insurance claim number, 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 these records are furnished by the individual, or in the case of some MSP situations, through third party contacts. There are cases, however, in which the identifying information is provided to the physician by the individual; the physician then adds the medical information and submits the bill to the carrier for payment. Updating information is also obtained from the Railroad Retirement Board, and the Master Beneficiary Record maintained by the Social Security Administration.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

[FR Doc. E7–4889 Filed 3–16–07; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Pediatric Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Pediatric Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the agency on FDA's regulatory issues. The committee also advises and makes recommendations to the Secretary of Health and Human Services under 21 CFR 50.54 and 45 CFR 46.407 on research involving children as subjects that is conducted or supported by the Department of Health and Human Services, when that research is also regulated by FDA.

Date and Time: The meeting will be held on April 11, 2007, from 4 p.m. to 6 p.m.

Location: Advisory Committee Conference Room, rm. 1066, 5630 Fishers Lane, Rockville, MD.

Contact Person: Carlos Pena, Office of Science and Health Coordination, Office of the Commissioner (HF–33), Food and Drug Administration, 5600 Fishers Lane, (for express delivery, rm. 14B–08), Rockville, MD 20857, 301–827–3340, e-mail: *Carlos.Pena@fda.hhs.gov* or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area), code 8732310001. Please call the Information Line for up to date information on this meeting.

Agenda: The Pediatric Advisory Committee will hear and discuss reports by the agency, as mandated in section 17 of the Best Pharmaceuticals for Children Act, on adverse event reports for fluvastatin (LESCOL) and octreotide (SANDOSTATIN). The committee will also receive updates to adverse event reports for orlistat (XENICAL) and oxybutynin (DITROPAN) which were requested by the Pediatric Advisory Committee when the reports were first presented.

FDA intends to make background material available to the public no later than 1 business day before the meeting. If FDA is unable to post the background material on its Web site prior to the meeting, the background material will be made publicly available at the location of the advisory committee meeting, and the background material will be posted on FDA's Web site after the meeting. Background material is available at *http://www.fda.gov/ohrms/dockets/ac/acmenu.htm*, click on the year 2007 and scroll down to the appropriate advisory committee link.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written