assertion that their conduct was legitimate ''messengering'' of health plan contract offers. The prohibition on using the same agent as any other physician in connection with health plan contracting would not apply where respondents are obtaining bona fide legal services (that is, activities undertaken by an attorney that constitute the practice of law as defined by New Mexico law).

As in other orders addressing providers' collective bargaining with health care purchasers, certain kinds of agreements are excluded from the general bar on joint negotiations.

First, respondents would not be precluded from engaging in conduct that is reasonably necessary to form or participate in legitimate joint contracting arrangements among competing physicians, whether a ''qualified risk-sharing joint arrangement'' or a ''qualified clinically-integrated joint arrangement.''

As defined in the proposed order, a ''qualified risk-sharing joint arrangement'' possesses two key characteristics. First, all physician participants must share substantial financial risk through the arrangement, such that the arrangement creates incentives for the participants to control costs and improve quality by managing the provision of services. Second, any agreement concerning reimbursement or other terms or conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

A ''qualified clinically-integrated joint arrangement,'' on the other hand, need not involve any sharing of financial risk. Instead, as defined in the proposed order, physician participants must participate in active and ongoing programs to evaluate and modify their clinical practice patterns in order to control costs and ensure the quality of services provided, and the arrangement must create a high degree of interdependence and cooperation among physicians. As with qualified risk-sharing arrangements, any agreement concerning price or other terms of dealing must be reasonably necessary to achieve the efficiency goals of the joint arrangement.

Second, because the order is intended to reach agreements among horizontal competitors, Paragraph II would not bar agreements that only involve physicians who are part of the same medical group practice (defined in Paragraph I.E).

Paragraph III, which applies only to CPA, provides for the dissolution of the organization following the expiration or termination of all payor contracts, and in the interim requires that CPA cease all activities except those necessary to comply with the order and the winding down of its affairs. Further, Paragraph III.B requires CPA to distribute the complaint and order to all physicians who have participated in CPA, to payors that negotiated contracts with CPA or indicated an interest in contracting, and to the Carlsbad Medical Center. Paragraph III.C requires CPA, at any payor's request and without penalty, to terminate its current contracts with respect to providing physician services.

In the event that CPA fails to comply with the requirement to send out the notices set forth in Paragraph III.B, Paragraph IV requires Mr. Moore to do so.

Paragraphs V through IX of the proposed order impose various obligations on respondents to report or provide access to information to the Commission to facilitate monitoring respondents' compliance with the order.

The proposed order will expire in 20 years.

By direction of the Commission.

**Donald S. Clark,**

*Secretary.*

[FR Doc. 03–11721 Filed 5–9–03; 8:45 am]

**BILLING CODE 6750–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Indian Health Service

### Delegations of Authority

Notice is hereby given that I have delegated to the Director, Indian Health Service, with authority to redelegate, all the authorities vested in the Secretary of Health and Human Services under Pub. L. 107–63, the Interior and Related Agencies Appropriations Act for Fiscal Year 2002, 115 Stat. 458, to accept land donated by the Tanadgusix Corporation.

This delegation is effective upon date of signature. In addition, I hereby ratify and affirm any actions taken by the Director, Indian Health Service, or his subordinates which involved the exercise of the authorities delegated herein prior to the effective date of this delegation.

Dated: May 2, 2003.

**Tommy G. Thompson,**

*Secretary.*

[FR Doc. 03–11685 Filed 5–9–03; 8:45 am]

**BILLING CODE 4160–16–M**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

### Privacy Act of 1974; Report of a Modified or Altered System of Records

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

**ACTION:** Notice of a modified or altered System of Records (SOR).

**SUMMARY:** In accordance with the requirements of the Privacy Act of 1974, we are proposing to modify or alter an SOR, ''1–800 Medicare + Choices Helpline (HELPLINE), System No. 09–70–0535.'' We are proposing to amend the purpose of the HELPLINE to include maintaining utilization and bill processing data and change the name to read the ''1–800–Medicare Helpline'' to reflect this amended purpose. Information collected will also be used to update the Enrollment Data Base, System No. 09–70–0502, which is now used to maintain enrollment-related data. The HELPLINE will retrieve utilization data used for bill payment record processing maintained in the ''Common Working File,'' System No. 09–70–0526.

CMS proposes 6 new routine uses to permit release of information to: (1) Another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (2) providers and suppliers of services for administration of Title XVIII of the Social Security Act (the Act); (3) third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs; (4) other insurers, third party administrators (TPA), employers, self-insurers, managed care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, group health plans (*i.e.*, health maintenance organizations (HMOs) or a competitive medical plan (CMP) with a Medicare contract, or a Medicare-approved health care prepayment plan (HCPP)), directly or through a contractor, and other groups providing protection for their enrollees to assist in the processing of individual insurance claims; and (5) combat fraud and abuse in certain health benefits programs.

We are modifying the language in the remaining routine uses to provide an easy to read format to CMS's intention to disclose individual-specific