

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Statement of Organization, Functions, and Delegations of Authority; Office of the National Coordinator for Health Information Technology

ACTION: Notice.

SUMMARY: The Office of the National Coordinator for Health Information Technology has reorganized its office in order to more effectively meet the mission outlined by The Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA). The reorganization adds the position of Principal Deputy.

FOR FURTHER INFORMATION CONTACT: Sam Shellenberger, Office of the National Coordinator, Office of the Secretary, 200 Independence Ave., SW., Washington, DC 20201, 202–690–7151.

SUPPLEMENTARY INFORMATION: Part A, Office of the Secretary, Statement of Organization, Functions and Delegations of Authority for the Department of Health and Human Services, Chapter AR, Office of the National Coordinator for Health Information Technology (ONC), as amended at 74 FR 62785–62786, dated December 1, 2009, as corrected at 75 FR 49494, dated August 13, 2010, and as last amended at 76 FR 6795, dated February 8, 2011 is amended as follows:

I. Under Part A, Chapter AR, Office of the National Coordinator for Health Information Technology, Section AR.10 Organization, insert Office of the Principal Deputy as item B as follows and renumber items B through F accordingly:

B. Office of the Principal Deputy (ARA1): The Office of the Principal Deputy works with and reports directly to the National Coordinator and will be responsible for day-to-day operations, decision making and staff management of ONC. The Principal Deputy will oversee the activities of four offices within ONC: Office of the Deputy National Coordinator for Programs and Policy; Office of the Deputy National Coordinator for Operations; Office of Economic Analysis, Evaluation and Modeling; and, Office of the Chief Scientist. One of the current ONC offices, the Office of the Chief Privacy Officer, is a position mandated by the American Recovery and Reinvestment Act of 2009, and will continue to report to the National Coordinator.

II. Under Part A, Chapter AR, Office of the National Coordinator for Health Information Technology, Section AR.10 Organization, Paragraph C, “Office of Economic Analysis, Evaluation and Modeling (ARB),” delete the first sentence in its entirety and replace with the following: “The Office of Economic Analysis, Evaluation and Modeling is headed by a Director.”

III. Delegation of Authority. Pending further delegation, directives or orders by the Secretary or by the National Coordinator for Health Information Technology, all delegations and redelegations of authority made to officials and employees of affected organizational components will continue in them or their successors pending further redelegations, provided they are consistent with this reorganization.

Authority: 44 U.S.C. 3101.

Dated: October 13, 2011.

Kathleen Sebelius,
Secretary.

[FR Doc. 2011–27116 Filed 10–19–11; 8:45 am]

BILLING CODE 4150–45–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of a New Routine Use for Selected CMS System of Records

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

ACTION: Notice of a new routine use for selected CMS system of records.

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, CMS is adding a new routine use to disclose information to Qualified Entities (QEs) for selected Centers for Medicare & Medicaid Services (CMS) systems of records. Section 10332 of the Patient Protection and Affordable Care Act (ACA) adds a new subsection to Section 1874 of the Social Security Act, requiring that the Secretary establish a process to allow for the use of standardized extracts of Medicare Parts A, B, and D claims data by QEs to evaluate and report on the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use.

New Routine Use for Qualified Entities

1. To assist a public or private entity that is qualified (as determined by the Secretary of the Department of Health

and Human Services (the Secretary)) to use Medicare claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and who agrees to meet the requirements regarding the transparency of their methods and their use and protection of Medicare data as the Secretary may specify, if CMS:

a. Determines that the use or disclosure does not violate legal limitations under which the record was provided, collected, or obtained; and
b. Secures a written statement attesting to the information recipient's understanding of and willingness to abide by these provisions. Every Qualified Entity receiving data must have an agreement with CMS in the form of an Information Exchange Agreement or contract with all security and privacy requirements included. A Data Use Agreement (DUA) (CMS Form 0235) must be completed by the person receiving CMS data in accordance with current CMS policies.

This routine use fulfills the requirement in section 1174(e) of the Social Security Act (42 U.S.C. 1395kk (e)) to make standardized extracts of claims data under Medicare Parts A, B, and D available to a Qualified Entity (QE), recognized by the Secretary to make evaluations of provider/supplier performance in accordance with that section, and that agrees to meet specific requirements regarding the transparency of their methods and their use and protection of Medicare data. The IDR, National Claims History (NCH), CCDR, and Part D data will provide QEs, a broader, longitudinal, national perspective of the performance of Medicare providers/suppliers for use in authorized QE projects that could ultimately improve the care provided to Medicare beneficiaries and the policy that governs the care.

CMS Systems of Records To Be Modified by This Routine Use

This new routine use, when published, will be added to the compatible systems of records used to disclose Medicare claims information and numbered as the next consecutive number in the order of published routine uses for the following systems of records notices:

1. “*National Claims History (NCH)*,” System No. 09–70–0558, last published at 71 FR 67137 (November 20, 2006). The primary purpose of this system is to collect and maintain billing and utilization data on Medicare beneficiaries enrolled in hospital insurance (Part A) or medical insurance (Part B) of the Medicare program for

statistical and research purposes related to evaluating and studying the operation and effectiveness of the Medicare program.

2. “*Medicare Drug Data Processing System (DDPS)*,” System No. 09–70–0553, last published at 73 FR 30943 (May 29, 2008). The primary purpose of this system is to collect, maintain, and process information on all Medicare covered, and as many non-covered drug events as possible, for people with Medicare who have enrolled into a Medicare Part D plan.

3. “*Medicare Integrated Data Repository (IDR)*,” System No. 09–70–0571, published at 71 FR 74915 (December 13, 2006). The primary purpose of this system is to establish an enterprise resource that provides one integrated view of all CMS data to administer the Medicare and Medicaid programs.

4. “*Chronic Condition Data Repository (CCDR)*,” System No. 09–70–0573, published at 71 FR 54495 (September 15, 2006). The purpose of this system is to collect and maintain a person-level view of identifiable data to establish a data repository to study chronically ill Medicare beneficiaries. This system utilizes data extraction tools to support accessing data by chronic conditions and processes complex customized research data requests related to chronic illnesses.

DATES: The Centers for Medicare & Medicaid Services (CMS) invites interested parties to submit written comments on the proposed system until November 16, 2011. As required by the Privacy Act (5 U.S.C. 552a(r)), CMS on October 17, 2011 sent a report of a new system of records to the Committee on Homeland Security and Governmental Affairs of the Senate, the Committee on Oversight and Government Reform of the House of Representatives, and the Office of Information and Regulatory Affairs of the Office of Management and Budget (OMB). The proposed action described in this notice is effective on November 26, 2011, unless CMS receives comments which result in a republication of the notice.

ADDRESSES: The public should address comments to: CMS Privacy Officer, Division of Information Security & Privacy Management, Enterprise Architecture and Strategy Group, Office of Information Services, CMS, Room N1–24–08, 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:

Chris Haffer, Ph.D., Program Manager, Data Development and Services Group, Center for Strategic Planning, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Mail-stop: C3–24–07, Baltimore, MD 21244–1850. Office: 410–786–8764, *Facsimile*: (410) 786–5515, *E-mail address*: chris.haffer@cms.hhs.gov.

SUPPLEMENTARY INFORMATION: The statute defines QEs as public or private entities that are determined by the Secretary to be qualified to use Medicare claims data to make such evaluations of provider/supplier performance, and that agree to meet specific requirements regarding the transparency of their methods and their use and protection of Medicare data. The statute requires that Medicare claims extracts be combined with other claims data, although the statute is not specific on what, or how much, other claims data should be combined with Medicare claims data. The statute requires that the only use of such data and the derived performance information about providers and suppliers be in reports in an aggregate form, released and made available to the public, after first making such reports available to any identified provider or supplier and affording an opportunity to appeal and correct errors. The statute also instructs the Secretary to take such actions as she deems necessary to protect the identity of individual beneficiaries, and authorizes her to establish additional requirements that she may specify for QEs to meet, such as ensuring the security of data. The Medicare claims extracts are to be made available to QEs at a fee equal to the cost of making such data available (the fees will be deposited into the Part B Trust Fund).

Dated: October 12, 2011.

Michelle Snyder,

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

[FR Doc. 2011–27149 Filed 10–19–11; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Statement of Organization, Functions, and Delegations of Authority

Part F of the Statement of Organization, Functions, and Delegations of Authority for the Department of Health and Human Services, Centers for Medicare &

Medicaid Services (CMS), (**Federal Register**, Vol. 70, No. 249, pp. 77160–77161, dated December 29, 2005; Vol. 75, No. 56, pp. 14176–14178, dated March 24, 2010; and Vol. 76, No. 144, pp. 44933–44934, dated July 27, 2011) are amended to: (1) Realign the survey and certification function from the Center for Medicaid, CHIP and Survey & Certification to the Office of Clinical Standards and Quality (OCSQ) and to change the organizational title for the Center for Medicaid, CHIP and Survey & Certification to the Center for Medicaid and CHIP Services (CMCS), and (2) realign the governmental relations function from the Office of Legislation (OL) to CMCS. Part F, Sections FC.10 (Organization) and FC.20 (Functions) is revised as follows:

- Section FC. 10 (Organization):
 - Office of the Administrator (FC)
 - Office of Equal Opportunity and Civil Rights (FCA)
 - Office of Legislation (FCC)
 - Office of the Actuary (FCE)
 - Office of Strategic Operations and Regulatory Affairs (FCF)
 - Office of Clinical Standards and Quality (FCG)
 - Center for Medicare (FCH)
 - Center for Medicaid and CHIP Services (FCJ)
 - Center for Strategic Planning (FCK)
 - Center for Program Integrity (FCL)
 - Chief Operating Officer (FCM)
 - Office of Minority Health (FCN)
 - Center for Medicare and Medicaid Innovation (FCP)
 - Federal Coordinated Health Care Office (FCQ)
 - Center for Consumer Information and Insurance Oversight (FCR)
 - Office of Public Engagement (FCS)
 - Office of Communications (FCT)
- Section FC.20 (Functions):

Center for Medicaid and CHIP Services (FCJ)

- Serves as CMS’ focal point for the formulation, coordination, integration, implementation, and evaluation of all national program policies and operations relating to the Medicaid and Children’s Health Insurance Program (CHIP).
- In partnership with States, evaluates the success of State agencies in carrying out their responsibilities for effective State program administration and beneficiary protection, and, as necessary, assists States in correcting problems and improving the quality of their operations.
- Identifies and proposes modifications to Medicaid and CHIP program measures, regulations, laws and policies to reflect changes or trends