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

STORAGE:

All records are stored on electronic media.

RETRIEVABILITY:

The collected data are retrieved by the name or other identifying information of the participating provider or beneficiary, and may also be retrieved by a distinct identifier such as the Health Insurance Claim Number (HICN), at the individual beneficiary level.

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 may apply 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 National Institute of Standards and Technology publications; the HHS Information Systems Program Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

Records will be retained for a period of 6 years and 3 months. All claims-related records are encompassed by the document preservation order and will be retained until notification is received from DOJ.

SYSTEM MANAGER AND ADDRESS:

Division of State Health Insurance Program Relations, Strategic Research & Campaign Management Group, Office of External Affairs, Mail Stop S1–13–05, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1849.

NOTIFICATION PROCEDURE:

For purpose of access, the subject individual should write to the system manager who will require the system name, employee identification number, tax identification number, national provider number, and for verification purposes, the subject individual's name (woman's maiden name, if applicable), HICN, and/or 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).

RECORDS SOURCE CATEGORIES:

Data will be collected from Medicare and SHIP administrative records.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

[FR Doc. E7–12680 Filed 6–29–07; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities Under Emergency Review for the Office of Management and Budget (OMB)

The Health Resources and Services Administration (HRSA) has submitted the following request (see below) for emergency OMB review under the Paperwork Reduction Act (44 U.S.C. Chapter 35). OMB approval has been requested within 20 days of publication of this notice. To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, call the HRSA Reports Clearance Officer on (301) 443–1129.

Written comments and recommendations should be sent within 14 days of publication of this notice to the desk officer for HRSA, either by e-mail to *OIRA_submission@omb.eop.gov* or by fax to 202–395–6974. Please direct all correspondence ''to the attention of the desk officer for HRSA.''

Proposed Project: Ryan White HIV/AIDS Program Core Medical Services Waiver Application Requirements (NEW)

Title XXVI of the Public Health Service (PHS) Act, as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) requires that grantees expend 75 percent of Parts A, B, and C funds on core medical services, including antiretroviral drugs, for individuals with HIV/AIDS identified and eligible under the legislation, effective Fiscal Year (FY) 2007. In order for grantees under Parts A, B, and C to be exempted from the 75 percent core medical services requirement, they must request and receive a waiver from HRSA, as required in the Act. HRSA has developed a process for waiver request submission, review, and notification. The core medical services waiver uniform standard and waiver request process will apply to Ryan White HIV/AIDS Program grant awards under Parts A, B, and C of Title XXVI of the PHS Act beginning FY 2008. Core medical services waivers will be effective for a one-year period consistent with the grant award period.

Grantees must submit a waiver request with the annual grant application containing the following certifications and documentations which will be utilized by HRSA in making determinations regarding waiver requests. The waiver must include:

1. Certification from the Part B state grantee that there are no current or anticipated ADAP services waiting lists in the state for the year in which such waiver request is made. This certification must also specify that there are no waiting lists for a particular core class of antiretroviral therapeutics established by the Secretary, e.g., fusion inhibitors;

2. Certification that all core medical services listed in the statute (Part A section 2604(c)(3), Part B section

2612(b)(3), and Part C section 2651(c)(3)), regardless of whether such services are funded by the Ryan White HIV/AIDS Program, are available within 30 days for all identified and eligible individuals with HIV/AIDS in the service area;

3. Evidence that a public process was conducted to seek public input on availability of core medical services;

4. Evidence that receipt of the core medical services waiver is consistent with the grantee's Ryan White HIV/AIDS Program application (e.g., ''Description of Priority Setting and Resource Allocation Processes'' and ''Unmet Need Estimate and Assessment'' sections of the application for Parts A, ''Needs Assessment and Unmet Need'' section of the application under Part B, and ''Description of the Local HIV Service Delivery System,'' and ''Current and Projected Sources of Funding'' sections of the application under Part C).

The estimated annual burden is as follows:

Application	Number of respondents	Responses per respondent	Total responses	Hours per response	Total burden hours
Waiver Request	20	1	20	6.5	130
Total	20		20		130

Dated: June 27, 2007.

Alexandra Huttinger,

Acting Director, Division of Policy Review and Coordination.

[FR Doc. 07–3219 Filed 6–27–07; 3:32 pm]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Reimbursement Rates for Calendar Year; Correction

AGENCY: Indian Health Service, HHS.

ACTION: Notice; correction.

SUMMARY: The Indian Health Service published a document **Federal Register** on June 20, 2007, concerning rates for inpatient and outpatient medical care provided by Indian Health Service facilities for Calendar Year 2007 for Medicare and Medicaid beneficiaries of other Federal Programs. The document contained five incorrect rates.

FOR FURTHER INFORMATION CONTACT: Mr. Elmer Brewster, Special Assistant, Office of Resource Access and Partnerships, Indian Health Service, 801 Thompson Avenue, Suite 360, Rockville, MD 20852, Telephone 301–443–2419. (This is not a toll-free number.)

Corrections

In the **Federal Register** of June 20, 2007, in FR Doc. 07–3037, on page 34018, in the third column, under the heading ''Inpatient Hospital Per Diem Rate (Excludes Physician/Practitioner Services)'' ''Lower 48 States: $1725. Alaska: $2,208.'' should read ''Lower 48 States: $1726. Alaska: $2215.'' Under the heading, ''Outpatient Per Visit Rate (Excluding Medicare)'' ''Alaska: $398.'' should read ''Alaska: $405.'' Under the heading, ''Outpatient Per Visit Rate (Medicare)'' ''Alaska: $356.'' should read ''Alaska: $354.'' Under the heading, ''Medicare Part B Inpatient Ancillary Per Diem Rate'' ''Alaska: $613.'' should read ''Alaska: $625.''

Dated: June 25, 2007.

Phyllis Eddy,

Deputy Director for Management Operations, Indian Health Service.

[FR Doc. 07–3203 Filed 6–29–07; 8:45 am]

BILLING CODE 4165–16–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under the Office of management and Budget's (OMB) review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Project Substance Abuse Prevention and Treatment (SAPT) Block Grant Uniform Application Guidance and Instructions FY 2008–2010 and Regulations (OMB No. 0930–0080)—Revision.

Sections 1921 through 1935 of the Public Health Service Act (U.S.C. 300x–21 to 300x–35) provide for annual allotments to assist States to plan, carry out and evaluate activities to prevent and treat substance abuse and for related activities. Under the provisions of the law, States may receive allotments only after an application is submitted and approved by the Secretary, DHHS. For the Federal fiscal year (FY) 2008–2010 Substance Abuse prevention and Treatment (SAPT) Block Grant application cycles, SAMHSA will provide States with revised application guidance and instructions to implement changes made in accordance with the recommendations of OMB's Program Assessment Rating Tool (PART) analysis. In addition, SAMHSA has incorporated recommendations from the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and their member States in the revisions and clarification of data reporting requirements and instructions.

During the negotiations with the States resulting in agreement on the National Outcome Measures (NOMs) for substance abuse treatment and prevention, SAMHSA pledged to the States to:

1. Reduce respondent burden;

2. work with the States to improve performance management of the SAPT Block Grant;

3. improve the availability, timeliness, and quality of data available to Federal, State, and provider administrators of block grant funded programs.

This revision of the Uniform Application and Regulation for the SAPT Block Grant takes initial steps toward implementing these commitments. Individual States may reduce their respondent burden by selecting the option of using SAMHSA pre-populated tables for Section IVa and b. The data for these tables would be drawn from SAMHSA data sets known as Drug and Alcohol Services Information System (DASIS) Treatment Episode Data Set (TEDS) and National Survey on Drug Use and Health (NSDUH) by SAMHSA and provided to the States. SAMHSA is providing the States with the option of reporting on prevention expenditures utilizing the six prevention strategies or utilizing the Institute of Medicine classification of