The purpose of this notice is to notify the public of the Indian Health Service's (IHS's) request for the approval for continued recognition as a national accrediting organization for accreditation of American Indian and Alaska Native entities to furnish outpatient diabetes self-management training services. The IHS proposes to continue to adopt the National Standards for Diabetes Self-Management Education as its quality standards. This notice also solicits public comments on the ability of the IHS to develop and apply its standards to entities furnishing outpatient diabetes self-management training services.

Outpatient Diabetes Self-Management Training Services

The regulations specifying the Medicare conditions for coverage for outpatient diabetes self-management training services are specified in 42 CFR parts 410, subpart H. These conditions implement section 1861(qq) of the Act, which provides for Medicare Part B coverage of outpatient diabetes self-management training services specified by the Secretary.

Under section 1865(b)(2) of the Act and our regulations at § 410.142 (CMS process for approving national accreditation organizations) and § 410.143 (Requirements for approved accreditation organizations), we review and evaluate a national accreditation organization based on (but not necessarily limited to) the criteria specified in § 410.142(b), and we review the ongoing responsibilities of an approved accreditation organization.

We may visit the prospective organization's offices to verify information in the organization's reapplication package, including, but not limited to, review of documents, and interviews with the organization's staff. We may conduct onsite inspection of a national accreditation organization's operations and office to verify information and assess the organization's compliance with its own policies and procedures. The onsite inspection may include, but is not limited to, reviewing documents, auditing documentation from meetings concerning the accreditation process, evaluating accreditation results or the accreditation status decision making process, and interviewing the organization's staff.

Notice Upon Completion of Evaluation

Upon completion of our evaluation, including consideration of public comments received as a result of this notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation.

III. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget did not review this notice.

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb).

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program) (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: September 6, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicare Services.

[FR Doc. E7–18470 Filed 9–27–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1378–N]

Medicare Program; Medicare Provider Feedback Group Town Hall Meeting—October 16, 2007

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of meeting.

SUMMARY: This notice announces the annual Medicare Provider Feedback Group (MPFG) Town Hall meeting. This meeting is open to all Medicare fee-for-service (FFS) providers and suppliers that participate in the Medicare program, including physicians, hospitals, home health agencies, other third-party billers and other interested parties, to present their individual views and opinions on selected FFS Medicare topics. In addition, we will be soliciting input on how we can improve communications to better serve the Medicare providers and suppliers. The meeting agenda and discussion materials will be available by October 12, 2007. The public can access these materials at *http://www.cms.hhs.gov/center/provider.asp.*

The feedback provided during this meeting will assist us as we evaluate FFS Medicare policy, operational issues and CMS' provider and supplier communication activities. The meeting is open to the public, but attendance is limited to space available. Registered participants from the meeting will be included in the Medicare Provider Feedback Group and may be contacted throughout the year for follow-up meetings to solicit additional opinions and clarify any issues that may arise from the October 16, 2007 meeting.

DATES: *Meeting Date:* The Town Hall meeting announced in this notice will be held on Tuesday, October 16, 2007, from 2 p.m. to 4 p.m. e.s.t.

ADDRESSES: The Town Hall meeting will be held in the main auditorium of the central building of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

Written Questions or Statements: Any interested party may send written comments electronically. We will give consideration to feedback received on the topics discussed at the Town Hall meeting, but written responses will not be provided. We will accept and take into consideration written feedback, questions, or other statements about the town hall meeting and agenda topics before the meeting, and up until October 26, 2007. Send written feedback, questions, or other statements to Colette Shatto at *MFG@cms.hhs.gov*.

FOR FURTHER INFORMATION CONTACT: Colette Shatto, 410–786–6932. You may also send inquires about this meeting by *MFG@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

CMS has held three Medicare Provider Feedback Group Town Hall Meetings beginning in 2005. The purpose of these meetings is to capture individual provider and supplier feedback on relevant FFS Medicare policy and operational issues. As a result, we are able to further advance our efforts to strengthen the Medicare program and enhance our relationship with providers and suppliers. The Town Hall meetings also provide a venue to allow us to continue a process of communicating with individual providers and suppliers through the following year.

II. Meeting Format

The meeting will begin with an overview of the goals and objectives of the MPFG efforts to gather feedback

from individual Medicare physicians, providers, and suppliers. Topics to be discussed during the meeting include, but are not limited to, FFS Medicare implementation of the National Provider Identifier (NPI), Medicare contractor provider satisfaction survey (MCPSS): ''Relevancy of questions in the business functions of appeals and medical review'', Medicare contracting reform, and value based purchasing.

There will be a question and answer session that offers meeting attendees an opportunity to provide feedback on how CMS serves physicians, providers, and suppliers, as well as make suggestions on how this process can be improved. The time for participants to ask questions and provide feedback will be limited according to the number of registered participants; however, written submissions will be accepted. Individuals who wish to provide written feedback should e-mail Colette Shatto at MFG@cms.hhs.gov. We will give consideration to feedback received on the topics discussed at the Town Hall meeting, but written responses will not be provided.

III. Registration Instructions

The Division of Provider Relations and Evaluations, Provider Communications Group, Center for Medicare Management, is coordinating the meeting registration. While there is no registration fee, individuals, providers, and suppliers must register to participate. Individuals interested in attending the meeting in person or by teleconference must complete the on-line registration located at *http://registration.intercall.com/go/cms2*.

The on-line registration system will capture contact information and practice characteristics, such as names, e-mail addresses, and provider and supplier types. Registration will be open on September 28, 2007 and close on October 12, 2007. Registration after 5 p.m. e.s.t. on October 12, 2007 will not be accepted.

The on-line registration system will generate a confirmation page to indicate the completion of your registration. Please print this page as your registration receipt. Teleconference instructions will be issued once participants have registered by using the on-line registration tool. If seating capacity has been reached, you will be notified that the meeting has reached capacity.

Special Accommodations: Individuals requiring sign language interpretation or other special accommodations must contact Colette Shatto by e-mail at *MFG@cms.hhs.gov*.

IV. Security, Building, and Parking Guidelines

Because this meeting will be located on Federal property, for security reasons, any persons wishing to attend this meeting must register by 5 p.m. e.s.t. on October 12, 2007. Individuals who have not registered in advance will not be allowed to enter the building to attend the meeting. Seating capacity is limited to the first 250 registrants.

The on-site check-in for visitors will be held from 12:30 p.m. to 1:30 p.m. e.s.t. Please allow sufficient time to go through the security checkpoints. It is suggested that you arrive at 7500 Security Boulevard no later than 1:30 p.m. e.s.t. so that you will be able to arrive promptly at the meeting by 2 p.m. e.s.t. All items brought to the building, whether personal or for the purpose of demonstration or to support a presentation, are subject to inspection.

Security measures will include inspection of vehicles, inside and out, at the entrance to the grounds. In addition, all persons entering the building must pass through a metal detector. All items brought to CMS, including personal items such as desktops, cell phones, and palm pilots, are subject to physical inspection.

Authority: Section 1811 and 1831 of the Social Security Act (42 U.S.C. 1395c and 1395j).

Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program.

Dated: September 6, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E7–18113 Filed 9–27–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of a New System of Records

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

ACTION: Notice of a new System of Records (SOR).

SUMMARY: In accordance with the Privacy Act of 1974, we are proposing to establish a new SOR, ''Post-Acute Care Payment Reform / Continuity of Assessment Record and Evaluation Demonstration and Evaluation (PAC–CARE),'' System No. 09–70–0569. Information maintained in this system will continue to enable CMS to better understand the relationships among patient needs, post-acute care placement, patient outcomes, and post-acute care related costs in the Medicare program. Additionally, as required by Section 5008 of the Deficit Reduction Act of 2005, CMS is developing a comprehensive assessment for use at the time of hospital discharge which identifies the needs and clinical characteristics of the patient. Additionally, this standardized patient assessment instrument shall be used across post-acute care sites, including skilled nursing facilities, home health agencies, long term care hospitals and inpatient rehabilitation facilities, to measure functional status and other factors during treatment and at discharge from each provider.

CMS proposes to broaden the scope of the disclosure requirement by adding a new routine use number 6, authorizing disclosure of personal health information to providers to facilitate the proper transfer of health information for beneficiaries being discharged from their site of care to an admitting provider's care. Individuals from the admitting providers will only be granted access to personal health information, if they have the approved, authenticated, role based authority to do so, and the need to know and review the admitted patient's personal health information. Individuals will only be granted access to this information if they meet the following requirements: they must (1) provide an attestation or other qualifying information that they are providing assistance to qualified acute care or post-acute care beneficiaries admitted to their care site, (2) have physically admitted the beneficiary to their site and have initiated an assessment of the beneficiary, (3) safeguard the confidentiality of the data and prevent unauthorized access, and (4) accept an on-line statement attesting to the information recipient's understanding of and willingness to abide by these provisions. The routine uses will then be prioritized and reordered according to their usage.

The primary purpose of this proposed system is to collect and maintain, and release when appropriate, demographic, health records, and health resource use related data on the target population of Medicare and potentially, Medicaid beneficiaries who require treatment by a designated acute care or post-acute care provider. We will also collect certain identifying information on Medicare providers who provide services to such beneficiaries. Information retrieved from this system may be disclosed to: (1) Support regulatory, reimbursement, and