ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, as amended, these records may specifically be disclosed outside the Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows:

To interface with all commercial insurance carriers and parties against whom recovery has been sought by the Department of Defense Military Health System, as well as all parties involved in support of the collection activities for health care approved by the Department of Defense.

To the National Data Clearinghouse, an electronic healthcare clearinghouse, for purposes of converting the data to an industry-wide format prior to forwarding the billing information to the insurance companies for payment.

The DoD 'Blanket Routine Uses' set forth at the beginning of Office of the Secretary of Defense's compilation of systems of records notices apply to this system.

Note 1: This system of records contains individually identifiable health information. The Department of Defense Health Information Privacy Regulation (DoD 6025.18–R) issued pursuant to the Health Insurance Portability and Accountability Act of 1996, applies to most such health information. DoD 6025.18–R may place additional procedural requirements on the uses and disclosures of such information beyond what is found in the Privacy Act of 1974 or mentioned in this system of records notice.

Note 2: Personal identity, diagnosis, prognosis or treatment information of any patient maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States is, except as per 42 U.S.C. 290dd–2, treated as confidential and disclosed only for the purposes and under the circumstances expressly authorized under 42 U.S.C. 290dd–2.

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

STORAGE:

Paper file folders and electronic storage media.

RETRIEVABILITY:

Records are retrieved by the sponsor or patient name, Social Security Number, Department of Defense Benefits Number, third party payer identification number assigned to individual, family member prefix (a two-digit code identifying the person's relationship to the Military Sponsor), and/or Patient Control Number.

SAFEGUARDS:

Physical access to system location restricted by cipher locks, visitor escort, access rosters, and photo identification. Adequate locks on doors and server components secured in a locked computer room with limited access. Each system end user device protected within a locked storage container, room, or building outside of normal business hours. All visitors and other persons that require access to facilities that house servers and other network devices supporting the system that do not have authorization for access escorted by appropriately screened/cleared personnel at all times.

Access to the system is role-based and a valid user account is required. The system provides two-factor authentication, using either a Common Access Card and Personal Identification Number or a unique logon identification and password. Where a unique logon identification and password is used, passwords must be renewed every sixty (60) days. Authorized personnel must have appropriate Information Assurance training, Health Insurance Portability and Accountability Act training, and Privacy Act of 1974 training.

RETENTION AND DISPOSAL:

Records are destroyed five years after the end of the year in which the record was closed.

SYSTEM MANAGER(S) AND ADDRESS:

Program Manager, Defense Health Services Systems, Suite 1500, 5203 Leesburg Pike, Falls Church, VA 22041–3891.

NOTIFICATION PROCEDURE:

Individuals seeking to determine whether this system contains information about themselves should address written inquires to the TRICARE Management Activity, Department of Defense, ATTN: TMA Privacy Officer, Suite 810, 5111 Leesburg Pike, Falls Church, VA 22041–3206.

Request should contain participant's and/or sponsor's full name, their Social Security Number (SSN), and current address and telephone number and the names of the military treatment facility or facilities in which they have received medical treatment.

If requesting health information of a minor (or legally incompetent person), the request must be made by a custodial parent, legal guardian, or party acting in loco parentis of such individual(s). Written proof of the capacity of the requestor may be required.

RECORD ACCESS PROCEDURES:

Individuals seeking access to records about themselves contained in this system should address written inquiries to TRICARE Management Activity, Attention: Freedom of Information Act Requester Service Center, 16401 East Centretech Parkway, Aurora, CO 80011–9066.

Requests should contain participant's and/or sponsor's full name, their Social Security Number (SSN), and current address and telephone number and the names of the military treatment facility or facilities in which they have received medical treatment.

If requesting health information of a minor (or legally incompetent person), the request must be made by a custodial parent, legal guardian, or party acting in loco parentis of such individual(s). Written proof of the capacity of the requestor may be required.

CONTESTING RECORD PROCEDURES:

The Office of the Secretary of Defense rules for accessing records, for contesting contents and appealing initial agency determinations are published in Office of the Secretary of Defense Administrative Instruction 81 (32 CFR part 311) or may be obtained from the system manager.

RECORD SOURCE CATEGORIES:

Information is obtained from an automated medical records system, the Composite Health Care System (specifically, the Ambulatory Data Module), which is automatically sent to the Third Party Collection System. Other information may be obtained from the AHLTA System and the Theater Data Medical Stores System.

EXEMPTIONS CLAIMED FOR THE SYSTEM:

None.

[FR Doc. 2010–31789 Filed 12–17–10; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Office of the Secretary

TRICARE; Formerly Known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Fiscal Year 2011 Diagnosis-Related Group (DRG) Updates

AGENCY: Office of the Secretary, DoD.

ACTION: Notice of DRG revised rates.

SUMMARY: This notice describes the changes made to the TRICARE DRG-

based payment system in order to conform to changes made to the Medicare Prospective Payment System (PPS). It also provides the updated fixed loss cost outlier threshold, cost-to-charge ratios and the data necessary to update the Fiscal Year 2011 rates.

DATES: The rates, weights, and Medicare PPS changes which affect the TRICARE DRG-based payment system contained in this notice are effective for admissions occurring on or after October 1, 2010.

ADDRESSES: TRICARE Management Activity (TMA), Medical Benefits and Reimbursement Branch, 16401 East Centretech Parkway, Aurora, CO 80011–9066.

FOR FURTHER INFORMATION CONTACT: Ann N. Fazzini, Medical Benefits and Reimbursement Branch, TMA, telephone (303) 676–3803.

Questions regarding payment of specific claims under the TRICARE DRG-based payment system should be addressed to the appropriate contractor.

SUPPLEMENTARY INFORMATION: The final rule published on September 1, 1987 (52 FR 32992) set forth the basic procedures used under the CHAMPUS DRG-based payment system. This was subsequently amended by final rules published August 31, 1988 (53 FR 33461), October 21, 1988 (53 FR 41331), December 16, 1988 (53 FR 50515), May 30, 1990 (55 FR 21863), October 22, 1990 (55 FR 42560), and September 10, 1998 (63 FR 48439).

An explicit tenet of these final rules, and one based on the statute authorizing the use of DRGs by TRICARE, is that the TRICARE DRG-based payment system is modeled on the Medicare PPS, and that, whenever practicable, the TRICARE system will follow the same rules that apply to the Medicare PPS. The Centers for Medicare and Medicaid Services (CMS) publishes these changes annually in the **Federal Register** and discusses in detail the impact of the changes.

In addition, this notice updates the rates and weights in accordance with our previous final rules. The actual changes we are making, along with a description of their relationship to the Medicare PPS, are detailed below.

I. Medicare PPS Changes Which Affect the TRICARE DRG-Based Payment System

Following is a discussion of the changes CMS has made to the Medicare PPS that affect the TRICARE DRG-based payment system.

A. DRG Classifications

Under both the Medicare PPS and the TRICARE DRG-based payment system, cases are classified into the appropriate DRG by a Grouper program. The Grouper classifies each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). The Grouper used for the TRICARE DRG-based payment system is the same as the current Medicare Grouper with two modifications. The TRICARE system has replaced Medicare DRG 435 with two age-based DRGs (900 and 901), and has implemented thirty-four (34) neonatal DRGs in place of Medicare DRGs 385 through 390. For admissions occurring on or after October 1, 2001, DRG 435 has been replaced by DRG 523. The TRICARE system has replaced DRG 523 with the two age-based DRGs (900 and 901). For admissions occurring on or after October 1, 1995, the CHAMPUS grouper hierarchy logic was changed so the age split (age < 29 days) and assignments to Major Diagnostic Category (MDC) 15 occur before assignment of the PreMDC DRGs. This resulted in all neonate tracheostomies and organ transplants to be grouped to MDC 15 and not to DRGs 480–483 or 495. For admissions occurring on or after October 1, 1998, the CHAMPUS grouper hierarchy logic was changed to move DRG 103 to the PreMDC DRGs and to assign patients to PreMDC DRGs 480, 103, and 495 before assignment to MDC 15 DRGs and the neonatal DRGs. For admissions occurring on or after October 1, 2001, DRGs 512 and 513 were added to the PreMDC DRGs, between DRGs 480 and 103 in the TRICARE grouper hierarchy logic. For admissions occurring on or after October 1, 2004, DRG 483 was deleted and replaced with DRGs 541 and 542, splitting the assignment of cases on the basis of the performance of a major operating room procedure. The description for DRG 480 was changed to "Liver Transplant and/or Intestinal Transplant", and the description for DRG 103 was changed to "Heart/Heart Lung Transplant or Implant of Heart Assist System". For Fiscal Year 2007, CMS implemented classification changes, including surgical hierarchy changes. The TRICARE Grouper incorporated all changes made to the Medicare Grouper, with the exception of the pre-surgical hierarchy changes, which will remain the same as Fiscal Year 2006. For Fiscal Year 2008, Medicare implemented their Medicare-Severity DRG (MS–DRG) based payment system. TRICARE, however, continued with the Centers for Medicare and Medicaid Services DRG-based (CMS DRG) payment system for Fiscal Year 2008. For Fiscal Year 2009, the TRICARE/CHAMPUS DRG-based payment system shall be modeled on the MS–DRG system, with the following modifications.

The MS–DRG system consolidated the 43 pediatric CMS DRGs that were defined based on age less than or equal to 17 into the most clinically similar MS–DRGs. In their Inpatient Prospective Payment System final rule for MS–DRGs, Medicare stated for their population these pediatric CMS DRGs contained a very low volume of Medicare patients. At the same time, Medicare encouraged private insurers and other non-Medicare payers to make refinements to MS–DRGs to better suit the needs of the patients they serve. Consequently, TRICARE finds it appropriate to retain the pediatric CMS DRGs for our population. TRICARE is also retaining the TRICARE-specific DRGs for neonates and substance use.

TRICARE has retained the MS–DRG numbering system for Fiscal Year 2009 and those TRICARE-specific DRGs have been assigned available, blank DRG numbers unused in the MS–DRG system. We refer the reader to *http://www.tricare.mil/drgrates* for a complete crosswalk containing the TRICARE DRG numbers for Fiscal Year 2009.

For Fiscal Year 2009, TRICARE will use the MS–DRG v26.0 pre-MDC hierarchy, with the exception that MDC 15 is applied after DRG 011–012 and before MDC 24.

For Fiscal Year 2010, there are no additional or deleted DRGs.

For Fiscal Year 2011, the added DRGs and deleted DRGs are the same as those included in CMS' final rule published on August 16, 2010. That is, DRG 009 is deleted; DRGs 014 and 015 are being added.

B. Wage Index and Medicare Geographic Classification Review Board Guidelines

TRICARE will continue to use the same wage index amounts used for the Medicare PPS. TRICARE will also duplicate all changes with regard to the wage index for specific hospitals that are redesignated by the Medicare Geographic Classification Review Board. In addition, TRICARE will continue to utilize the out commuting wage index adjustment.

C. Revision of the Labor-Related Share of the Wage Index

TRICARE is adopting CMS' percentage of labor related share of the standardized amount. For wage index values greater than 1.0, the labor related portion of the Adjusted Standardized Amount (ASA) shall equal 68.8 percent.

For wage index values less than or equal to 1.0 the labor related portion of the ASA shall continue to equal 62 percent.

D. Hospital Market Basket

TRICARE will update the adjusted standardized amounts according to the final updated hospital market basket used for the Medicare PPS for all hospitals subject to the TRICARE DRG-based payment system according to CMS's August 16, 2010, final rule. For Fiscal Year 2011, the market basket is 2.6 percent. This year, Medicare applied two reductions to their market basket amount: (1) A 0.25 percent reduction due to provisions found in the Patient Protection and Affordable Care Act, and (2) a 2.9 percent reduction for documentation and coding adjustments found in Public Law 110–90. These two reductions do not apply to TRICARE.

E. Outlier Payments

Since TRICARE does not include capital payments in our DRG-based payments (TRICARE reimburses hospitals for their capital costs as reported annually to the contractor on a pass-through basis), we will use the fixed loss cost outlier threshold calculated by CMS for paying cost outliers in the absence of capital prospective payments. For Fiscal Year 2011, the TRICARE fixed loss cost outlier threshold is based on the sum of the applicable DRG-based payment rate plus any amounts payable for Indirect Medical Education (IDME) plus a fixed dollar amount. Thus, for Fiscal Year 2011, in order for a case to qualify for cost outlier payments, the costs must exceed the TRICARE DRG-based payment rate (wage adjusted) for the DRG plus the IDME payment plus $21,229 (wage adjusted). The marginal cost factor for cost outliers continues to be 80 percent.

F. National Operating Standard Cost as a Share of Total Costs

The Fiscal Year 2011 TRICARE National Operating Standard Cost as a Share of Total Costs (NOSCASTC) used in calculating the cost outlier threshold is 0.92. TRICARE uses the same methodology as CMS for calculating the NOSCASTC; however, the variables are different because TRICARE uses national cost-to-charge ratios while CMS uses hospital-specific cost-to-charge ratios.

G. Indirect Medical Education (IDME) Adjustment

Passage of the Medicare Modernization Act of 2003 modified the formula multipliers to be used in the calculation of the indirect medical education (IDME) adjustment factor. Since the IDME formula used by TRICARE does not include disproportionate share hospitals (DSHs), the variables in the formula are different than Medicare's; however, the percentage reductions that will be applied to Medicare's formula will also be applied to the TRICARE IDME formula. The new multiplier for the IDME adjustment factor for TRICARE for Fiscal Year 2011 is 1.02.

H. Expansion of the Post Acute Care Transfer Policy

For Fiscal Year 2011 TRICARE is adopting CMS' expanded post acute care transfer policy according to CMS' final rule published August 16, 2010.

I. Cost-to-Charge Ratio

While CMS uses hospital-specific cost-to-charge ratios, TRICARE uses a national cost-to-charge ratio. For Fiscal Year 2011, the cost-to-charge ratio used for the TRICARE DRG-based payment system for acute care hospitals and neonates will be 0.3664. This shall be used to calculate the adjusted standardized amounts and to calculate cost outlier payments, except for children's hospitals. For children's hospital cost outliers, the cost-to-charge ratio used is 0.3974.

J. Updated Rates and Weights

The updated rates and weights are accessible through the Internet at *http://www.tricare.osd.mil* under the sequential headings TRICARE Provider Information, Rates and Reimbursements, and DRG Information. Table 1 provides the ASA rates and Table 2 provides the DRG weights to be used under the TRICARE DRG-based payment system during Fiscal Year 2011. The implementing regulations for the TRICARE/CHAMPUS DRG-based payment system are in 32 CFR Part 199.

Dated: December 14, 2010.

Morgan F. Park,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2010–31792 Filed 12–17–10; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF EDUCATION

Notice of Submission for OMB Review

AGENCY: Department of Education.

ACTION: Comment request.

SUMMARY: The Director, Information Collection Clearance Division, Regulatory Information Management Services, Office of Management invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995 (Pub. L. 104–13).

DATES: Interested persons are invited to submit comments on or before January 19, 2011.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Education Desk Officer, Office of Management and Budget, 725 17th Street, NW., Room 10222, New Executive Office Building, Washington, DC 20503, be faxed to (202) 395–5806 or e-mailed to *oira_submission@omb.eop.gov* with a cc: to *ICDocketMgr@ed.gov.* Please note that written comments received in response to this notice will be considered public records.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. The OMB is particularly interested in comments which: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Dated: December 14, 2010.

Darrin A. King,

Director, Information Collection Clearance Division, Regulatory Information Management Services, Office of Management.

Institute of Education Sciences

Type of Review: Revision.

Title of Collection: High School Longitudinal Study of 2009 (HSLS:09) First Follow-up Field Test 2011.

OMB Control Number: 1850–0852.

Agency Form Number(s): N/A.

Frequency of Responses: Annually.

Affected Public: Individuals or household.

Total Estimated Number of Annual Responses: 6,873.

Total Estimated Annual Burden Hours: 1,161.

Abstract: The High School Longitudinal Study of 2009 (HSLS:09) is