description of what elements the ''behavioral health services (including medication services)'' encompass, and how they are different (or the same) as services in the currently approved State plan. It is not clear whether this is an expansion of coverage or a different payment methodology for school providers. Absent such information, SPA 05–06 did not comply with the requirements of section 1902(a)(10) of the Act to provide for medical assistance as defined in section 1905(a) of the Act.

Section 1902(a)(2) of the Act provides that the State plan must assure adequate funding for the non-Federal share of expenditures from State or local sources for the amount, duration, scope, or quality of care and services available under the plan. Section 1902(a)(30)(A) of the Act requires that State plans provide for payment for care and services available under the plan that is ''consistent with economy, efficiency, and quality of care.'' In order to assess compliance with these provisions, State officials were asked to provide information related to Alaska's funding mechanisms for payments, and the net State and local expenditures that are incurred. Nor did Alaska respond to requests for any transfers of funds between providers and State or local governments, and information as to whether the providers keep 100 percent of the total computable funds given as Medicaid payments.

According to a flow chart provided by the State, the Medicaid agency pays the schools 100 percent of the claimed amount. A quarterly bill for the State match is then submitted to school providers who transfer to the Medicaid agency the State share of the services provided. This transfer of funds is made after the schools have been reimbursed for the services they provide, and is effectively a refund by the schools for part of their Medicaid payments. As a result of this refund, the net expenditure by the State Medicaid agency is wholly federally funded. In light of this refund arrangement, we cannot conclude that the proposed payment rate reflects the net expenditure by the State for Medicaid services provided by schools, and that the net non-Federal share meets the requirements of section 1902(a)(2) of the Act. Moreover, the refund is an indication that the full payment amount is not required to ensure Medicaid beneficiaries' access to the providers' services. The result is that proposed payments under this section of the plan would not be in compliance with the requirement under section 1902(a)(30)(A) of the Act that payment rates must be consistent with economy, efficiency, and quality of care.

Finally, the proposed SPA does not comply with the general provisions of section 1902(a), including section 1902(a)(4) of the Act, as implemented in part by Federal regulations at 42 CFR section 430.10. This regulation requires that States include in their State plans all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation. As discussed above, Alaska did not provide information that would more precisely identify the covered services or the non-Federal funding source. Therefore the proposed SPA does not comply with this requirement.

For the reasons cited above, and after consultation with the Secretary, as required by Federal regulations at 42 CFR 430.15(c)(2), Alaska SPA 05–06 was disapproved.

I am scheduling a hearing on your request for reconsideration to be held on August 29, 2006, at the Blanchard Plaza Building, 2201 Sixth Avenue, 11th Floor Conference Room, Seattle, WA 98121, to reconsider the decision to disapprove SPA 05–06. If this date is not acceptable, we would be glad to set another date that is mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by Federal regulations at 42 CFR part 430.

I am designating Ms. Kathleen Scully-Hayes as the presiding officer. If these arrangements present any problems, please contact the presiding officer at (410) 786–2055. In order to facilitate any communication which may be necessary between the parties to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled, and provide names of the individuals who will represent the State at the hearing.

Sincerely,
Mark B. McClellan, M.D., PhD.

Section 1116 of the Social Security Act (42 U.S.C. 1316; 42 CFR 430.18)

(Catalog of Federal Domestic Assistance Program No. 13.714, Medicaid Assistance Program)

Dated: July 14, 2006.

Mark B. McClellan,

Administrator.

[FR Doc. E6–11577 Filed 7–20–06; 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: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS).

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

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, we are proposing to establish a new system titled, ''Medicare Chiropractic Coverage Demonstration and Evaluation (MCCDE), System No. 09–70–0577.'' The demonstration entitled, ''Expansion of Coverage of Chiropractic Services Demonstration'' was established under provisions of Section 651 (d) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law (Pub. L.) 108–173). The MCCDE will focus on selected beneficiaries, residing within the four demonstration regions or their respective control regions, who have Medicare chiropractic-eligible diagnoses [i.e., neuromusculoskeletal conditions (NMS)]. The system will contain: Demographic information from Medicare enrollment files; Medicare claims data on utilization of NMS-related Medicare services with associated costs, for demonstration participants and their matched, non-participant controls; and participant satisfaction survey data for the subset randomly surveyed. The MCCDE has four goals: (1) To determine whether eligible beneficiaries who use chiropractic services under the demonstration use a lesser overall amount of items and services for which payment is made under the Medicare program than eligible beneficiaries who do not use such services; (2) to determine the cost of providing payment for chiropractic services under the Medicare program; (3) to further determine whether the demonstration achieves budget neutrality, and if not, the amount of any cost excess to be recouped by Medicare from the chiropractic profession; and (4) finally, to ascertain the satisfaction of eligible beneficiaries participating in the demonstration projects and their perceived quality of care received.

The primary purpose of the system is to collect and maintain individually identifiable information on beneficiaries, physicians, participating chiropractors, and providers of service participating in the demonstration and evaluation program. Information retrieved from this system may be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, consultant or grantee; (2) assist another Federal or state agency with information to contribute to the accuracy of CMS's proper payment of Medicare benefits, enable such agency to administer a Federal health benefits program, or to enable such agency to fulfill a requirement of Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds; (3) support an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects; (4) support litigation involving the agency; and (5) combat fraud and abuse in certain Federally-funded health benefits programs. We have provided background information about the new system in the

SUPPLEMENTARY INFORMATION section below.

Although the Privacy Act requires only that CMS provide an opportunity for interested persons to comment on the proposed routine uses, CMS invites comments on all portions of this notice. See ''Effective Dates'' section for comment period.

DATES: *Effective Date:* CMS filed a new SOR report with the Chair of the House Committee on Government Reform and Oversight, the Chair of the Senate Committee on Homeland Security & Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on July 14, 2006. To ensure that all parties have adequate time in which to comment, the new system will become effective 30 days from the publication of the notice, or 40 days from the date it was submitted to OMB and the Congress, whichever is later. We may defer implementation of this system or one or more of the routine use statements listed below if we receive comments that persuade us to defer implementation.

ADDRESSES: The public should address comment to the CMS Privacy Officer, Mail-stop N2–04–27, 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.

FOR FURTHER INFORMATION CONTACT: Carol Magee, Division of Beneficiary Research, Research and Evaluation Group, Office of Research Development and Information, CMS, Mail Stop C3–19–07, 7500 Security Boulevard, Baltimore, Maryland 21244–1849. Her telephone number is (410) 786–6611, and her e-mail is *Carol.Magee@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION: The Medicare demonstration being evaluated by MCCDE is entitled, ''Expansion of Coverage of Chiropractic Services Demonstration'' and was established under Section 651 of the of the MMA, for the purpose of evaluating the feasibility and advisability of providing additional Medicare coverage for chiropractic services, beyond the usual covered care allowed for spinal manipulation to correct spinal subluxation. The two-year demonstration, operates within four geographic regions (two rural and two urban, with one including a health professional shortage area (HPSA) and one a non-HPSA area, respectively in each). For the demonstration, CMS has approved an expanded list of NMS conditions, all typical among users of chiropractic, as well as various additional diagnostic tests, which may be billed without physician approval to Part B Medicare by participating chiropractors. Participation in this expanded payment demonstration is determined individually by chiropractic provider practices and any Medicare Advantage Plans located within the four regions. Congress has mandated budget neutrality; consequently, any overall excess costs to Medicare, within this two-year span of expanded chiropractic coverage, must be subsequently recouped by Medicare from the chiropractic profession.

The MCCDE to enable conduct of the mandated evaluation of this chiropractic demonstration will acquire and aggregate data relative to beneficiaries receiving chiropractic services. The beneficiary survey data will address patient satisfaction and quality of care issues, while the relevant abstracted Medicare claims file data elements on NMS diagnoses, services, and costs will enable determination of costs and utilization patterns, and of demonstration budget neutrality. Additionally the evaluation will address cost aspects relative to the potential for expansion of chiropractic coverage to the national Medicare program.

I. Description of the Proposed System of Records

A. Statutory and Regulatory Basis for SOR. The statutory authority for this system is given under the Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173).

B. Collection and Maintenance of Data in the System. This system will maintain individually-identifiable and other data collected by CMS and its contractors on Medicare participants and providers of service in the chiropractic coverage demonstration, and on selected beneficiaries as non-participant controls, in order to analyze relevant data for the mandated evaluation and as means to select and contact participant beneficiaries for the survey.

Information collected will include, but is not limited to, beneficiary health insurance claim number, beneficiary identification code, beneficiary name and address, race/ethnicity, gender type, date of birth, diagnostic code(s), relevant procedural codes and dates of service, dates of admissions and discharges, diagnostic review group, unique provider identification number, as well as self-reported survey information regarding health status, demographic utilization issues, and satisfaction with care relating to chiropractic services.

II. Agency Policies, Procedures, and Restrictions on the Routine Use

A. The Privacy Act permits us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a ''routine use.'' The Government will only release MCCDE information that can be associated with an individual as provided for under ''Section III. Proposed Routine Use Disclosures of Data in the System.'' Both identifiable and non-identifiable data may be disclosed under a routine use. We will only collect the minimum personal data necessary to achieve the purpose of MCCDE.

CMS has the following policies and procedures concerning disclosures of information that will be maintained in the system. Disclosure of information from the system will be approved only to the extent necessary to accomplish the purpose of the disclosure and only after CMS:

1. Determines that the use or disclosure is consistent with the reason that the data is being collected; e.g., to collect and maintain individually identifiable information on beneficiaries, physicians, participating chiropractors, and providers of service participating in the demonstration and evaluation program.

2. Determines that:

a. The purpose for which the disclosure is to be made can only be accomplished if the record is provided in individually identifiable form;

b. The purpose for which the disclosure is to be made is of sufficient importance to warrant the effect and/or risk on the privacy of the individual that additional exposure of the record might bring; and

c. There is a strong probability that the proposed use of the data would in fact accomplish the stated purpose(s).

3. Requires the information recipient to:

a. Establish administrative, technical, and physical safeguards to prevent unauthorized use of disclosure of the record;

b. Remove or destroy, at the earliest time, all patient-identifiable information; and

c. Agree to not use or disclose the information for any purpose other than the stated purpose under which the information was disclosed.

4. Determines that the data are valid and reliable.

III. Proposed Routine Use Disclosures of Data in the System

A. The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a ''routine use.'' The proposed routine uses in this system meet the compatibility requirement of the Privacy Act. We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To agency contractors, consultants, or grantees, who have been engaged by the agency to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.

We contemplate disclosing information under this routine use only in situations in which CMS may enter into a contractual or similar agreement with a third party to assist in accomplishing CMS function relating to purposes for this system.

CMS occasionally contracts out certain of its functions when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor, consultant, or grantee whatever information is necessary for the contractor, consultant, or grantee to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor, consultant, or grantee from using or disclosing the information for any purpose other than that described in the contract and requires the contractor, consultant, or grantee to return or destroy all information at the completion of the contract.

2. To another Federal or state agency to:

a. Contribute to the accuracy of CMS's proper payment of Medicare benefits;

b. Enable such agency to administer a Federal health benefits program, or, as necessary, to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds; and/or

c. Assist Federal/state Medicaid programs within the state.

Other Federal or state agencies, in their administration of a Federal health program, may require MCCDE information in order to support evaluations and monitoring of Medicare claims information of beneficiaries, including proper reimbursement for services provided.

3. To an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects.

The MCCDE data will provide for research or support of evaluation projects and a broader, longitudinal, national perspective of the status of Medicare beneficiaries. CMS anticipates that many researchers will have legitimate requests to use these data in projects that could ultimately improve the care provided to Medicare beneficiaries and the policies that govern their care.

4. To the Department of Justice (DOJ), court or adjudicatory body when:

a. The agency or any component thereof, or

b. Any employee of the agency in his or her official capacity, or

c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or

d. The United States Government is a party to litigation or has an interest in such litigation, and, by careful review, CMS determines that the records are both relevant and necessary to the litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

Whenever CMS is involved in litigation, and occasionally when another party is involved in litigation and CMS policies or operations could be affected by the outcome of the litigation, CMS would be able to disclose information to the DOJ, court or adjudicatory body involved.

5. To a CMS contractor (including, but not necessarily limited to, fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program.

We contemplate disclosing information under this routine use only in situations in which CMS may enter into a contractual, grantee, cooperative agreement or consultant relationship with a third party to assist in accomplishing CMS functions relating to the purpose of combating fraud and abuse. CMS occasionally contracts out certain of its functions or makes grants or cooperative agreements when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor, grantee, consultant or other legal agent whatever information is necessary for the agent to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the agent from using or disclosing the information for any purpose other than that described in the contract and requiring the agent to return or destroy all information.

6. To another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in, a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such programs.

Other agencies may require MCCDE information for the purpose of combating fraud and abuse in such Federally-funded programs.

B. Additional Provisions Affecting Routine Use Disclosures.

To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR parts 160 and 164, Subparts A and E) 65 FR 82462 (12–28–00). Disclosures of such PHI that are otherwise authorized by these routine uses may only be made if, and as, permitted or required by the ''Standards for Privacy of Individually Identifiable Health Information.'' (See 45 CFR 164.512(a)(1)).

In addition, our policy will be to prohibit release even of data not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that because of the small size, use of this information could allow for the deduction of the identity of the beneficiary).

IV. Safeguards

CMS has safeguards in place for authorized users and monitors such users to ensure against excessive or 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.

V. Effects of the Proposed System of Records on Individual Rights

CMS proposes to establish this system in accordance with the principles and requirements of the Privacy Act and will collect, use, and disseminate information only as prescribed therein. Data in this system will be subject to the authorized releases in accordance with the routine uses identified in this system of records.

CMS will take precautionary measures to minimize the risks of unauthorized access to the records and the potential harm to individual privacy or other personal or property rights of patients whose data are maintained in this system. CMS will collect only that information necessary to perform the system's functions. In addition, CMS will make disclosure from the proposed system only with consent of the subject individual, or his/her legal representative, or in accordance with an applicable exception provision of the Privacy Act. CMS, therefore, does not anticipate an unfavorable effect on individual privacy as a result of information relating to individuals.

Dated; July 13, 2006.

John R. Dyer,

Chief Operating Officer, Centers for Medicare & Medicaid Services.

SYSTEM NO. 09–70–0577

SYSTEM NAME:

''Medicare Chiropractic Coverage Demonstration and Evaluation (MCCDE),'' HHS/CMS/ORDI.

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive Data.

SYSTEM LOCATION:

Centers for Medicare & Medicaid Services (CMS) Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, Maryland 21244–1850 and at various co-locations of CMS agents as follows:

- Brandeis University, 415 South Street, Waltham, Massachusetts 002454–9110.
- Battelle Institute, Suite 200, 6115 Falls Road, Baltimore, Maryland 21209.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

This system will maintain individually-identifiable and other data collected by CMS and its contractors on Medicare participants and providers of service in the chiropractic coverage demonstration, and on selected beneficiaries as non-participant controls, in order to analyze relevant data for the mandated evaluation and as means to select and contact participant beneficiaries for the survey.

CATEGORIES OF RECORDS IN THE SYSTEM:

Information collected will include, but is not limited to, beneficiary health insurance claim number (HICN), beneficiary identification code, beneficiary name and address, race/ethnicity, gender type, date of birth, diagnostic code(s), relevant procedural codes and dates of service, dates of admissions and discharges, diagnostic review group, unique provider identification number (UPIN), as well as self-reported survey information regarding health status, demographic utilization issues, and satisfaction with care relating to chiropractic services.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

The statutory authority for this system is given under the Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173).

PURPOSE(S) OF THE SYSTEM:

The primary purpose of the system is to collect and maintain individually identifiable information on beneficiaries, physicians, participating chiropractors, and providers of service participating in the demonstration and evaluation program. Information retrieved from this system may be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, consultant or grantee; (2) assist another Federal or state agency with information to contribute to the accuracy of CMS's proper payment of Medicare benefits, enable such agency to administer a Federal health benefits program, or to enable such agency to fulfill a requirement of Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds; (3) support an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects; (4) support litigation involving the agency; and (5) combat fraud and abuse in certain Federally-funded health benefits programs.

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

A. The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a ''routine use.'' The proposed routine uses in this system meet the compatibility requirement of the Privacy Act. We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To agency contractors, consultants, or grantees, who have been engaged by the agency to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.

2. To another Federal or state agency to:

a. Contribute to the accuracy of CMS's proper payment of Medicare benefits;

b. enable such agency to administer a Federal health benefits program, or, as necessary, to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds; and/or

c. assist Federal/state Medicaid programs within the state.

3. To an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the

restoration or maintenance of health, or payment related projects.

4. To the Department of Justice (DOJ), court or adjudicatory body when:

a. The agency or any component thereof, or

b. any employee of the agency in his or her official capacity, or

c. any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or

d. the United States Government, is a party to litigation or has an interest in such litigation, and, by careful review, CMS determines that the records are both relevant and necessary to the litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

5. To a CMS contractor (including, but not necessarily limited to, fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program.

6. To another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud or abuse in, a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such programs.

B. Additional Provisions Affecting Routine Use Disclosures.

To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR parts 160 and 164, subparts A and E) 65 FR 82462 (12–28–00). Disclosures of such PHI that are otherwise authorized by these routine uses may only be made if, and as, permitted or required by the ''Standards for Privacy of Individually Identifiable Health Information.'' (See 45 CFR 164.512(a)(1)).

In addition, our policy will be to prohibit release even of data not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that because of the small size, use of this information could allow for the deduction of the identity of the beneficiary).

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

STORAGE:

All records will be stored electronically and on hard copy.

RETRIEVABILITY:

The collected data are retrieved by an individual identifier; e.g., beneficiary name or HICN.

SAFEGUARDS:

CMS has safeguards in place for authorized users and monitors such users to ensure against excessive or 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:

CMS will retain information for a total period not to exceed 25 years. 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:

Director, Office of Research, Development, and Information, CMS, Mail Stop C3–20–11, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

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 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 sources will include Medicare claims for beneficiaries with relevant neuromusculoskeletal conditions diagnoses, and responses from the survey instrument administered to participant beneficiaries. The collected information from Medicare claims and enrollment data and the survey instrument, will include all of the data elements that reside within the Medicare National Claims History File and the Medicare Enrollment Data Base, as well as the self-reported beneficiary survey responses.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

[FR Doc. E6–11579 Filed 7–20–06; 8:45 am]

BILLING CODE 4120–03–P