which the Secretary may contract with eligible entities to conduct a variety of program safeguard activities, including fraud review employing equipment and software technologies that surpass the existing capabilities of FIs and carriers (42 U.S.C. 1395ddd)). The contracting entities are called Program Safeguards Contractors.

Pursuant to § 409.902, Florida Statutes (F.S.), AHCA is charged with the administration of the Medicaid program in Florida, and is the single state agency for such purpose. AHCA is required to operate a program to oversee the activities of Florida Medicaid recipients and providers to ensure that fraudulent and abusive behavior occurs to the minimum extent possible (§ 409.913, F.S.).

AHCA's disclosure of the Medicaid data pursuant to this agreement is for purposes directly connected with the administration of the Medicaid program, in compliance with 42 CFR 431.300 through 431.307. Those purposes are the detection, prosecution and deterrence of fraud and abuse (F&A) in the Medicaid program.

PURPOSE(S) OF THE MATCHING PROGRAM:

The purpose of this agreement is to establish the conditions, safeguards, and procedures under which CMS will conduct a computer matching program with AHCA to study claims, billing, and eligibility information to detect suspected instances of Medicare and Medicaid F&A in the State of Florida. CMS and AHCA will provide EDS, a CMS contractor (hereinafter referred to as the ''Custodian'') with Medicare and Medicaid records pertaining to eligibility, claims, and billing which the Custodian will match in order to merge the information into a single database. Utilizing fraud detection software, the information will then be used to identify patterns of aberrant practices requiring further investigation. The following are examples of the type of aberrant practices that may constitute F&A by practitioners, providers, and suppliers in the State of Florida expected to be identified in this matching program: (1) Billing for provisions of more than 24 hours of services in one day, (2) providing treatment and services in ways more statistically significant than similar practitioner groups, and (3) up-coding and billing for services more expensive than those actually performed.

CATEGORIES OF RECORDS AND INDIVIDUALS COVERED BY THE MATCH:

This CMP will enhance the ability of CMS and AHCA to detect F&A by matching claims data, eligibility, and practitioner, provider, and supplier enrollment records of Medicare beneficiaries, practitioners, providers, and suppliers in the State of Florida against records of Florida Medicaid beneficiaries, practitioners, providers, and suppliers in the State of Florida.

DESCRIPTION OF RECORDS TO BE USED IN THE MATCHING PROGRAM:

The data for CMS are maintained in the following Systems of Records: National Claims History (NCH), System No. 09–70–0005 was most recently published in the **Federal Register**, at 67 FR 57015 (September 6, 2002.) NCH contains records needed to facilitate obtaining Medicare utilization review data that can be used to study the operation and effectiveness of the Medicare program. Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

Carrier Medicare Claims Record, System No. 09–70–0501 was published in the **Federal Register** at 67 FR 54428 (August 22, 2002). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

Enrollment Database, System No. 09–70–0502 was published in the **Federal Register** at 67 FR 3203 (January 23, 2002). Matched data will be released to AHCA pursuant to the routine use set forth in the system notice.

Intermediary Medicare Claims Record, System No. 09–70–0503 was published in the **Federal Register** at 67 FR 65982 (October 29, 2002). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

Unique Physician/Provider Identification Number, System No. 09–70–0525, was most recently published in the **Federal Register** at 69 FR 75316 (December 16, 2004). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

Medicare Supplier Identification File, System No. 09–70–0530 was most recently published in the **Federal Register**, at 67 FR 48184 (July 23, 2002). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

Medicare Beneficiary Database, System No. 09–70–0536 was published in the **Federal Register** at 67 FR 63392 (December 6, 2001). Matched data will be released to AHCA pursuant to the routine use as set forth in the system notice.

The data for AHCA are maintained in the following data files: Claims File Layouts HIPAA Version, Download File Record File-Claims, Recipient File Layout, Provider File Layout.

INCLUSIVE DATES OF THE MATCH:

The CMP shall become effective no sooner than 40 days after the report of the Matching Program is sent to OMB and Congress, or 30 days after publication in the **Federal Register**, which ever is later. The matching program will continue for 18 months from the effective date and may be extended for an additional 12 months thereafter, if certain conditions are met.

[FR Doc. 05–17846 Filed 9–8–05; 8:45 am]

BILLING CODE 4120–03–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 create a new SOR titled, ''Data Collection Secondary to Coverage Decision (DCSCD) System, HHS/CMS/OCSQ, System No. 09–70–0547.'' National Coverage Determinations (NCDs) are determinations by the Secretary with respect to whether or not a particular item or service is covered nationally under title XVIII of the Social Security Act (the Act) § 1869(f)(1)(B). In order to be covered by Medicare, an item or service must fall within one or more benefit categories contained within Part A or Part B, and must not be otherwise excluded from coverage. Moreover, with limited exceptions, the expenses incurred for items or services must be ''reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,'' § 1862(a)(1)(A). CMS has determined that the evidence is adequate to conclude that certain identified diagnoses are reasonable and necessary in several patient groups where certain criteria for these patients have been met. The reasonable and necessary determination requires that patients meet the criteria and are consistent with the trials discussed. Collection of these data elements allows that determination to be made. We are particularly

interested in seeing evidence that would permit us to make a coverage or non-coverage decision, *i.e.*, to move a diagnostic indication from coverage under a clinical trial or study to coverage or non-coverage based on definitive evidence of benefit, no benefit, or harm. If adequate new evidence is available, the decision may be changed to either ''coverage based on evidence of benefit,'' ''limited coverage'' or ''non-coverage based on evidence of harm or no benefit.''

The purpose of this system is to collect and maintain data on patients to review determinations of ''reasonable and necessary'' with respect to whether or not a particular item or service is covered nationally under title XVIII of the Act § 1869(f)(1)(B). Information retrieved from this system will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor or consultant; (2) assist another Federal or state agency with information to 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) 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) support constituent requests made to a congressional representative; (5) support litigation involving the agency; and (6) combat fraud and abuse in certain 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.

EFFECTIVE DATES: 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 Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on 09/01/2005. We will not disclose any information under a routine use until 30 days after publication. We may defer implementation of this SOR 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 comments 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 daylight time.

FOR FURTHER INFORMATION CONTACT: Rosemarie Hakim, Epidemiologist, Office of Clinical Standards and Quality, CMS, Mail Stop C1–09–06, 7500 Security Boulevard, Baltimore, Maryland 21244–1849. Her telephone number is (410) 786–3934, or she can be reached via e-mail at *rhakim@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION: In the case of ''limited coverage'', in NCDs for which additional evidence is required, CMS has determined that the evidence is adequate to conclude that the item or service improves net health outcomes only under specific circumstances. One of these circumstances is that the service is delivered in the context of specific data being collected. Coverage may be limited to providers who participate in and beneficiaries who are enrolled in a defined prospective data collection activity, when this data collection activity constitutes part of the evidence required to ensure that the item or service provided to that patient is reasonable and necessary.

CMS is committed to ensuring that advances in medical technology are available for its Medicare beneficiaries while ensuring the care they receive is reasonable and necessary, which is a necessary condition for payment. The coverage with evidence development initiative is intended to enable Medicare to provide payment for items and services under conditions that help assure significant net benefits of the treatment for beneficiaries, and to give rise to additional information. This evidence will also assist doctors and patients in better understanding the risks, benefits and costs of alternative diagnostic and treatment options. Consequently, the linkage of coverage to data collection will also help to ensure that individual patients are receiving care that is reasonable and necessary given their specific clinical situation; systematic, protocol-driven data has the potential to increase the likelihood of improved health outcomes. Care provided under these protocols may lead to greater attention to appropriate patient evaluation and selection, as well as the appropriate application of the technology. These additional data may alter the course of patient treatment based on the best available evidence, and may lead a physician to reconsider the use of the item or service or otherwise alter a patient's management plan, potentially improving health outcomes. In addition, these additional data will be made available in some form to providers and practitioners to inform their decisions, monitor performance quality, benchmark and identify best practices. Collection of these data elements allows that determination to be made. We will also ensure that any future data collection system is consistent with the *Standards for Privacy of Individually Identifiable Health Information* and that all issues related to patient confidentiality, privacy, and compliance with other Federal laws will be resolved prior to the collection of any data.

I. Description of the Proposed System of Records

A. Statutory and Regulatory Basis for SOR

The statutory authority for linking coverage decisions to the collection of additional data is derived from Sec. 1862 (a)(1)(A) of the Act, which states that Medicare may not provide payment for items and services unless they are ''reasonable and necessary'' for the treatment of illness or injury. In some cases, CMS will determine that an item or service is only reasonable and necessary when specific data collections accompany the provision of the service. In these cases, the collection of data is required to ensure that the care provided to individual patients will improve health outcomes.

B. Collection and Maintenance of Data in the System

Information will be collected on individuals where CMS has determined that the evidence is adequate to conclude that certain identified diagnoses are reasonable and necessary in several patient groups where certain criteria for these patients have been met and the criteria are consistent with the trials reviewed. The collected information will contain, but is not limited to, name, address, telephone number, health insurance claim (HIC) number, geographic location, race/ethnicity, gender, and date of birth, as well as, background information relating to Medicare or Medicaid issues.

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

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

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 DCSCD 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 DCSCD. 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 provide reimbursement for NCDs and assist in the collection of data on patients receiving an NCD for primary prevention to a data collection process to assure patient safety and protection and to determine that the NCD is reasonable and necessary.

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 or consultants who have been engaged by the agency to assist in the performance of a service related to this system of records 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 of records.

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 or consultant whatever information is necessary for the contractor or consultant to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor or consultant from using or disclosing the information for any purpose other than that described in the contract and requires the contractor or consultant to return or destroy all information at the completion of the contract.

2. To another Federal or state agency to:

a. Assist in the review determinations of ''reasonable and necessary'' with respect to whether or not a particular item or service is covered nationally under title XVIII of the Act § 1869(f)(1)(B).

b. Contribute to the accuracy of CMS's proper payment of Medicare benefits, and/or

c. 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.

Other Federal or state agencies in their administration of a Federal health program may require DCSCD information in order to assist in the review determinations of ''reasonable and necessary'' with respect to whether or not a particular item or service is covered nationally under title XVIII of the Act § 1869(f)(1)(B).

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 DCSCD data will provide for research or in support of evaluation projects, a broader, longitudinal, national perspective of the status of Medicare beneficiaries. CMS anticipates that many researchers will have legitimate requests to use this data in projects that could ultimately improve the care provided to Medicare beneficiaries and the policy that governs the care.

4. To a member of Congress or to a congressional staff member in response to an inquiry of the congressional office made at the written request of the constituent about whom the record is maintained.

Beneficiaries sometimes request the help of a member of Congress in resolving an issue relating to a matter before CMS. The member of Congress then writes CMS, and CMS must be able to give sufficient information to be responsive to the inquiry.

5. 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.

6. 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 relationship or grant 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 and makes grants when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor or grantee whatever information is necessary for the contractor or grantee to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor or grantee from using or disclosing the information for any purpose other than that described in the contract and requiring the contractor or grantee to return or destroy all information.

7. 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 DCSCD information for the purpose of combating fraud and abuse in such Federally-funded programs.

B. Additional Provisions Affecting Routine Use Disclosures

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, 65 FR 82462 (12–28–00), subparts A and E. Disclosures of PHI 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.''

In addition, our policy will be to prohibit release even of not directly identifiable information, 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 individuals who are familiar with the enrollees could, because of the small size, use this information to deduce 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 include 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 Prescription Drug Improvement, and Modernization Act (MMA) 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; HHS Information System 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 (see item IV above) 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 the 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.

John R. Dyer,

Chief Operating Officer, Centers for Medicare & Medicaid Services.

SYSTEM NO. 09–70–0547

SYSTEM NAME:

''Data Collection Secondary to Coverage Decision (DCSCD) System, HHS/CMS/OCSQ''.

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 contractors.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Individuals where CMS has determined that the evidence is adequate to conclude that certain identified diagnoses are reasonable and necessary in several patient groups where certain criteria for these patients have been met and the criteria are consistent with the trials reviewed.

CATEGORIES OF RECORDS IN THE SYSTEM:

The data collection should include baseline patient characteristics. The collected information will contain, but is not limited to, name, address, telephone number, health insurance claim (HIC) number, geographic location, race/ethnicity, gender, and date of birth, as well as, background information relating to Medicare or Medicaid issues.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

The statutory authority for linking coverage decisions to the collection of additional data is derived from Sec. 1862(a)(1)(A) of the Social Security Act (the Act), which states that Medicare may not provide payment for items and services unless they are ''reasonable and necessary'' for the treatment of illness or injury. In some cases, CMS will

determine that an item or service is only reasonable and necessary when specific data collections accompany the provision of the service. In these cases, the collection of data is required to ensure that the care provided to individual patients will improve health outcomes.

PURPOSE(S) OF THE SYSTEM:

The purpose of this system is to collect and maintain data on patients to review determinations of ''reasonable and necessary'' with respect to whether or not a particular item or service is covered nationally under title XVIII of the Act § 1869(f)(1)(B). Information retrieved from this system will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor or consultant; (2) assist another Federal or state agency with information to 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) 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) support constituent requests made to a congressional representative; (5) support litigation involving the agency; and (6) combat fraud and abuse in certain health benefits programs.

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

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.'' We are proposing to establish the following routine use disclosures of information maintained in the system. Information will be disclosed:

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

2. To another Federal or state agency to:

a. Assist in the review determinations of ''reasonable and necessary'' with respect to whether or not a particular item or service is covered nationally under title XVIII of the Act § 1869(f)(1)(B).

b. Contribute to the accuracy of CMS's proper payment of Medicare benefits, and/or

c. 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.

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 a member of Congress or to a congressional staff member in response to an inquiry of the congressional office made at the written request of the constituent about whom the record is maintained.

5. 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.

6. 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.

7. 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.

ADDITIONAL PROVISIONS AFFECTING ROUTINE USE DISCLOSURES:

This system contains Protected Health Information (PHI) as defined by Department of Health and Human Services (HHS) regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 Code of Federal Regulations (CFR) parts 160 and 164, 65 FR 82462 (12–28–00), subparts A and E). Disclosures of PHI 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.''

In addition, our policy will be to prohibit release even of not directly identifiable information, 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 complaint population is so small that individuals who are familiar with the complainants could, because of the small size, use this information to deduce the identity of the complainant).

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

STORAGE:

All records are stored electronically.

RETRIEVABILITY:

The data is retrieved by an individual identifier *i.e.*, name of beneficiary.

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 implements 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 include 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 Prescription Drug Improvement, Modernization Act (MMA) 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; HHS Information Systems Program Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

CMS will retain information for a total period of 10 years. All claims-related records are encompassed by the document preservation order and will be retained until notification is received from the Department of Justice.

SYSTEM MANAGER AND ADDRESS:

Director, Office of Clinical Standards and Quality, CMS, Room S2–26–17, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

NOTIFICATION PROCEDURE:

For the purpose of access, the subject individual should write to the system manager who will require the system name, address, age, gender, and for verification purposes, the subject individual's name (woman's maiden name, if applicable).

RECORD ACCESS PROCEDURE:

For the purpose of access, use the same procedures outlines 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).

CONTESTING RECORDS PROCEDURES:

The subject individual should contact the system manager named above and reasonable identify the records 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).

RECORD SOURCE CATEGORIES:

Records maintained in this system are derived from Carrier and Fiscal Intermediary Systems of Records, Common Working File System of Records, clinics, institutions, hospitals and group practices performing the procedures, and outside registries and professional interest groups.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

[FR Doc. 05–17845 Filed 9–8–05; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Notice of Availability of the Biennial Report to Congress on the Status of Children in Head Start Programs

AGENCY: Administration on Children, Youth and Families (ACYF) Administration for Children and Families (ACF), Department of Health and Human Services.

ACTION: Notice.

SUMMARY: The Administration for Children and Families announces publication of the Biennial Report to Congress on the Status of Children in Head Start Programs, Fiscal Year (FY) 2003. The report is mandated under Section 650 of the Head Start Act, as amended, which requires the Secretary of Health and Human Services to submit a report to Congress at least once during every two-year period on the status of children in Head Start programs. During FY 2003 more than 909,000 children were enrolled in Head Start programs including 62,000 children in Early Head Start programs serving children between birth and three years of age.

EFFECTIVE DATE: September 9, 2005.

ADDRESSES: Persons wishing to receive a copy of the Biennial Report to Congress on the Status of Children in Head Start Programs, FY 2003 may contact the Head Start Publication Center on 866–763–6481. Copies of the report may also be obtained by accessing the Head Start Web site at *http://www.acf.hhs.gov/programs/hsb/research/index.htm.*

FOR FURTHER INFORMATION CONTACT: Frank Fuentes, Acting Associate Commissioner, Head Start Bureau, Administration on Children, Youth and Families, 330 C Street, SW., Washington, DC 20447.

SUPPLEMENTARY INFORMATION: The Head Start and Early Head Start programs are authorized under the Head Start Act (42 U.S.C. 9801 *et seq.*) It is a national program providing comprehensive developmental services to low-income preschool children, primarily age three to age of compulsory school attendance, and their families. To help enrolled children achieve their full potential, Head Start programs provide comprehensive health, nutritional, educational, social and other services. Section 650 of the Head Start Act requires that the Secretary publish a Biennial Report of the Status of Children in Head Start Programs. The FY 2003 Biennial Report provides information about children enrolled in the program and the services they receive. During FY 2003 more than 909,000 children were enrolled in Head Start programs. Head Start operated 47,000 classrooms in more than 19,000 Head Start centers at an average annual cost per child of $7,092. Over 1,428,000 volunteers contributed their services to Head Start programs.

Dated: August 30, 2005.

Joan E. Ohl,

Commissioner, Administration on Children, Youth and Families.

[FR Doc. 05–17920 Filed 9–8–05; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

National Native American Emergency Medical Services Association

AGENCY: Indian Health Service, IHS.

ACTION: Notice of Single Source Cooperative Agreement with the National Native American Emergency Medical Services Association.

SUMMARY: The Indian Health Service (IHS) announces the award of a cooperative agreement that will be funded on a competitive continuing basis to the National Native American Emergency Medical Services Association (NNAEMSA) for a demonstration project to improve emergency medical services for Native American people by improving communications between the IHS and the Native American Emergency Medical Services (EMS) providers; by improving communications and information among other federal agencies, professional organizations and Native American EMS providers; and by supporting an Annual Educational Conference.

Project Period: The cooperative agreement is for a five-year project period effective on or about September 15, 2005 to September 14, 2010.

Amount of Award(s): Total funding for the project is $450,000. Funding in the amount of $90,000.00 is available in