enforcement process.

- Detailed information about individuals who perform accreditation surveys including—
  + Size and composition of the survey team;
  + Education and experience requirements for the surveyors;
  + In-service training required for surveyor personnel;
  + Surveyor performance evaluation systems; and
  + Conflict of interest policies relating to individuals in the survey and accreditation decision process.
- Descriptions of the organization's—
  + Data management and analysis system;
  + Policies and procedures for investigating and responding to complaints against accredited organizations; and
  + Types and categories of accreditation offered and MA organizations currently accredited within those types and categories.

In accordance with § 422.158(b) of our regulations, the applicant must provide documentation relating to—

- Its ability to provide data in a CMS-compatible format;
- The adequacy of personnel and other resources necessary to perform the required surveys and other activities; and
- Assurances that it will comply with ongoing responsibility requirements specified in § 422.157(c) of our regulations.

Additionally, the accrediting organization must provide CMS the opportunity to observe its accreditation process on site at a managed care organization and must provide any other information that CMS requires to prepare for an onsite visit to the AO's offices.

These site visits will help to verify that the information presented in the application is correct and to make a determination on the application.

IV. Response to Comments

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

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

V. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

Authority: Section 1852 of the Social Security Act (42 U.S.C. 1395w–22).

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

Dated: August 18, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–19260 Filed 8–26–04; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Minnesota's Medicaid State Plan Amendment 03–06

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing on October 21, 2004, at 10 a.m., 233 North Michigan Avenue,Suite 600; RE–6E Board Room; Chicago, Illinois 60601 to reconsider our decision to disapprove Minnesota State PlanAmendment (SPA) 03–06.

DATES: Requests to participate in the hearing as a party must be received by the presiding officer by September 13, 2004.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes; Presiding Officer,CMS,Lord Baltimore Drive,Mail Stop: LB–23–20,Baltimore, Maryland 21244,Telephone: 410–786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider our decision to disapprove Minnesota's Medicaid State Plan Amendment (SPA) 03–06. This SPA was submitted on March 31, 2003, with a proposed effective date of January 1, 2003. This amendment would modify the State's reimbursement methodology for nursing facility services. Specifically, it would increase a disproportionate share nursing facility add-on made to 14 of the State's county-owned nursing facilities. The Centers for Medicare & Medicaid Services (CMS) was unable to approve SPA 03–06 because the State did not document that the proposed payment methodology, in combination with funding requirements under section 4.19 D of the State's plan, meet the conditions specified in sections 1902(a)(2), 1902(a)(30)(A), and 1902(a)(19) of the Social Security Act (the Act) and are consistent with the overall Federal-state financial partnership under title XIX of the Act.

In formal requests for additional information and several subsequent discussions, CMS asked that the State describe any transfers of funds between providers and State or local governments, and indicate whether the providers kept 100 percent of the total computable funds given as Medicaid payments. The State did not provide the requested information on transfers of funds between providers and local governments, nor did it indicate that the providers keep 100 percent of the total computable funds given as Medicaid payments.

The State provided information about the flow of funds between the State and local governments and from the State to providers. However, the State did not provide information about the flow of funds from providers to the State or to local governments. This information is necessary in order to validate the funding sources of the non-Federal share of Medicaid payments and to determine the appropriateness of the payment levels. If providers refund part or all of the Medicaid payments to the State or its political subdivisions, the proposed payment rate would not reflect the net expenditure by the State, and the net non-Federal share would not meet the requirements of section 1902(a)(2) of the Act. Moreover, if such refunds are made by providers, it is an indication that the full payment amount is not required to ensure Medicaid beneficiaries access to the providers' services. The result is that 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 ''efficiency, economy, and quality of care.''

Since the State has not provided the necessary information regarding provider payment retention, CMS could not find that SPA 03–06 is consistent with the requirement of section 1902(a)(19) of the Act that requires that care and services will be provided consistent with ''simplicity of administration and the best interests of the recipients.'' The best interest of recipients is not served by a proposed payment structure that would divert Medicaid payments from the providers to the State and shift financial burdens from the State to the Federal

Government. The best interest of recipients requires that the full amount of Medicaid payments should be available to support access to quality care and services. Furthermore, SPA 03–06 was not consistent with the requirements for a State plan that are set forth in the regulations implementing section 1902(a) of the Act. Under 42 CFR 430.10, the State plan must contain all the information necessary for CMS to determine whether the plan can serve as a basis for Federal financial participation (FFP) availability under section 1903(a)(1) of the Act. CMS could not determine whether the proposed plan amendment sets forth a payment methodology that could be a basis for FFP without information about whether providers refund payments and, if so, whether these refunds are offset against expenditures as an applicable credit.

Moreover, absent the requested information, the State did not document whether the proposed payment methodology set forth under SPA 03–06 is consistent with the basic Federal and State financial partnership of the Medicaid program set forth by the Congress. Section 1905(b) of the Act specifies how the Federal medical assistance percentage will be calculated for states. This section clearly sets forth how the financial partnership of the Medicaid program should operate, including a definition of the required non-Federal expenditure. The requested information is necessary to determine whether the proposed payments under SPA 03–06 would accurately reflect net expenditures with a sufficient non-Federal share consistent with the Federal and State financial partnership set forth in section 1905(b) of the Act.

For these reasons, and after consultation with the Secretary as required by Federal regulations at 42 CFR 430.15, CMS disapproved this SPA.

Section 1116 of the Act and 42 CFR, part 430 establish Departmental procedures that provide an administrative hearing for reconsideration of a disapproval of a State plan or plan amendment. CMS is required to publish a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing and the issues to be considered. If we subsequently notify the agency of additional issues that will be considered at the hearing, we will also publish that notice.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants. Therefore, based on the reasoning set forth above, and after consultation with the Secretary as required under 42 CFR 430.15(c)(2), CMS disapproved Minnesota SPA 03–06.

The notice to Minnesota announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Ms. Mary Kennedy, Medical Director, Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155–3852.

Dear Ms. Kennedy: Minnesota submitted State Plan Amendment (SPA) 03–06 on March 31, 2003, with a proposed effective date of January 1, 2003. This amendment proposes to modify the State's reimbursement methodology for nursing facility services. Specifically, this amendment increases a disproportionate share nursing facility add-on made to 14 of the State's county-owned nursing facilities. The Centers for Medicare & Medicaid Services (CMS) was unable to approve SPA 03–06 because the State did not document that the proposed payment methodology, in combination with funding requirements under section 4.19 D of the State's plan, meet the conditions specified in sections 1902(a)(2), 1902(a)(30)(A), and 1902(a)(19) of the Social Security Act (the Act) and are consistent with the overall Federal-state financial partnership under title XIX of the Act.

In formal requests for additional information and several subsequent discussions, CMS asked that the State describe any transfers of funds between providers and State or local governments, and indicate whether the providers keep 100 percent of the total computable funds given as Medicaid payments. The State did not provide the requested information on transfers of funds between providers and local governments, nor did it indicate that the providers keep 100 percent of the total computable funds given as Medicaid payments.

The State provided information about the flow of funds between the State and local governments and from the State to providers. However, the State did not provide information about the flow of funds from providers to the State or to local governments. This information is necessary in order to validate the funding sources of the non-Federal share of Medicaid payments and to determine the appropriateness of the payment levels. If providers refund part or all of the Medicaid payments to the State or its political subdivisions, the proposed payment rate would not reflect the net expenditure by the State, and the net non-Federal share would not meet the requirements of section 1902(a)(2) of the Act. Moreover, if such refunds are made by providers, it is an indication that the full payment amount is not required to ensure Medicaid beneficiaries access to the providers' services. The result is that 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 ''efficiency, economy, and quality of care.''

Since the State did not provide the necessary information regarding provider payment retention, CMS could not find that SPA 03–06 is consistent with the requirement of section 1902(a)(19) of the Act that care and services are consistent with ''simplicity of administration and the best interests of the recipients.'' The best interest of recipients is not served by a proposed payment structure that would divert Medicaid payments from the providers to the State and shift financial burdens from the State to the Federal Government. The best interest of recipients requires that the full amount of Medicaid payments are available to support access to quality care and services. Furthermore, SPA 03–06 is not consistent with the requirements for a State plan that are set forth in the regulations implementing section 1902(a) of the Act. Under 42 CFR 430.10, the State plan must contain all the information necessary for CMS to determine whether the plan can serve as a basis for Federal financial participation (FFP) that would be available under section 1903(a)(1) of the Act. CMS cannot determine whether the proposed plan amendment sets forth a payment methodology that could be a basis for FFP without information about whether providers refund payments and, if so, whether these refunds are offset against expenditures as an applicable credit.

Moreover, absent the requested information, the State did not document whether the proposed payment methodology set forth under SPA 03–06 is consistent with the basic Federal and State financial partnership of the Medicaid program set forth by the Congress. Section 1905(b) of the Act specifies how the Federal medical assistance percentage will be calculated for states. This section clearly sets forth how the financial partnership of the Medicaid program should operate, including a definition of the required non-Federal expenditure. The requested information is necessary to determine whether the proposed payments under SPA 03–06 would accurately reflect net expenditures with a sufficient non-Federal share consistent with the Federal and State financial partnership set forth in section 1905(b) of the Act.

For these reasons, and after consultation with the Secretary as required by 42 CFR 430.15(c)(2), CMS disapproved Minnesota SPA 03–06.

I am scheduling a hearing on your request for reconsideration to be held on October 21, 2004, at 10 a.m., at 233 North Michigan Avenue, Suite 600, RE–6E Board Room, Chicago, Illinois 60601. 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 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. 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. The presiding officer may be reached at (410) 786–2055.

Sincerely,

Mark B. McClellan, M.D., Ph.D.

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

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

Dated: August 18, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–19574 Filed 8–26–04; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1264–N]

RIN 0938–AM78

Medicare Program; Hospice Wage Index for Fiscal Year 2005

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

ACTION: Notice.

SUMMARY: This notice announces the annual update to the hospice wage index as required by statute. This fiscal year 2005 update is effective from October 1, 2004 through September 30, 2005. The wage index is used to reflect local differences in wage levels. The hospice wage index methodology and values are based on recommendations of a negotiated rulemaking advisory committee and were originally published in the August 8, 1997 **Federal Register**.

EFFECTIVE DATE: October 1, 2004.

FOR FURTHER INFORMATION CONTACT: Terri Deutsch, (410) 786–9462.

SUPPLEMENTARY INFORMATION:

I. Background

Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms). The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, social, psychological, emotional, and spiritual services through use of a broad spectrum of professional and other caregivers, with the goal of making the individual as physically and emotionally comfortable as possible. Counseling and inpatient respite services are available to the family of the hospice patient. Hospice programs consider both the patient and the family as a unit of care.

Section 1861(dd) of the Social Security Act (the Act) provides for coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. The statutory authority for payment to hospices participating in the Medicare program is contained in section 1814(i) of the Act.

Our existing regulations under 42 CFR part 418 establish eligibility requirements and payment standards and procedures, define covered services, and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Subpart G of part 418 provides for payment to hospices based on one of four prospectively determined rates for each day in which a qualified Medicare beneficiary is under the care of a hospice. The four rate categories are routine home care, continuous home care, inpatient respite care, and general inpatient care. Payment rates are established for each category.

The regulations at § 418.306(c), which require the rates to be adjusted by a wage index, were revised in the August 8, 1997 final rule (62 FR 42860). This rule implemented a new methodology for calculating the hospice wage index based on the recommendations of a negotiated rulemaking committee. The committee reached consensus on the methodology. We included the resulting committee statement, describing that consensus, as an appendix to the August 8, 1997 final rule (62 FR 42883). The provisions of the final hospice wage index rule are as follows:

- The revised hospice wage index will be calculated using the most current available hospital wage data.
- The revised hospice wage index was phased in over a 3-year transition period.

For the first year of the transition period, October 1, 1997 through September 30, 1998, a blended index was calculated by adding two-thirds of the 1983 index value for an area to one-third of the revised wage index value for that area. During the second year of the transition period, October 1, 1998 through September 30, 1999, the calculation was similar, except that the blend was one-third of the 1983 index value and two-thirds of the revised wage index value for that area. We fully implemented the revised wage index during the third year of the transition period,October 1, 1999 through September 30, 2000.

Payments to hospices under the wage index (as published in the August 8, 1997 final hospice wage index rule) are subject to a budget-neutrality adjustment to ensure that aggregate adjustments to payment using the new wage index, irrespective of other payment adjustments, are not greater than they would have been had the original 1983 wage index been applied. To achieve this budget neutrality, the hospice wage index is multiplied by a budget-neutrality factor. The budget-neutrality factor is computed and applied annually. The hospice budget-neutrality adjustment is not applied uniformly to all providers in calculating payments. Based on the methodology developed and signed by the negotiated rulemaking committee and adopted by CMS, a hospice's area wage index is adjusted using either the budget-neutrality factor or the hospice wage index floor described below.

Hospice wage index values of 0.8 or greater are multiplied by the budget-neutrality factor.

Hospice wage index values below 0.8 are adjusted by the greater of: (1) The hospice budget-neutrality factor; or (2) the hospice wage index floor (a 15 percent increase, subject to a maximum wage index value of 0.8).

The wage index is to be updated annually, in the **Federal Register**, based on the most current available hospital wage data. These data will include any changes to the definitions of Metropolitan Statistical Areas (MSAs). We acknowledge that on June 6, 2003, the Office of Management and Budget (OMB) issued an OMB Bulletin(No. 03–04) announcing revised definitions for MSAs, new definitions for Micropolitan Statistical Areas and Combined Statistical Areas, and guidance on using the statistical definitions. A copy of the Bulletin may be obtained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/b03–04.html*. These new definitions will not apply to the 2005 fiscal year (FY) wage index used in this **Federal Register** notice because we use the FY 2004 hospital wage index that does not reflect these revisions. The new definitions will be addressed in the FY 2006 wage index.

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) amended