* * * * *

[FR Doc. 00–25599 Filed 10–6–00; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[HCFA–1883–F2]

RIN 0938–AI80

Medicare Program; Revision of the Procedures for Requesting Exceptions to Cost Limits for Skilled Nursing Facilities and Elimination of Reclassifications; Correction

AGENCY: Health Care Financing Administration (HCFA) HHS.

ACTION: Technical corrections.

SUMMARY: In the August 5, 1999 issue of the **Federal Register** (64 FR 42610), we published a final rule addressing the procedures for granting exceptions to the Medicare skilled nursing facility (SNF) routine service cost limits, and we removed the provision allowing for reclassification for SNFs and home health agencies. This document amends the regulations text to make technical corrections to those parts of the regulation unrelated to the SNF exception procedures that were inadvertently changed.

EFFECTIVE DATE: September 7, 1999.

FOR FURTHER INFORMATION CONTACT: Julie Stankivic, (410) 786–5725.

SUPPLEMENTARY INFORMATION:

Background

In the August 5, 1999 final rule (64 FR 42610), we amended the regulations to allow the fiscal intermediaries to make final determinations on requests by skilled nursing facilities (SNFs) for exceptions to the Medicare routine service cost limits under 42 CFR § 413.30(f). In the preamble to both the proposed and final rules (63 FR 42797 and 64 FR 42610, respectively), we specifically stated that the changes are limited to our procedures regarding SNF exceptions. We did not intend to change the new provider exemption under § 413.30(e) or any other provision relating to home health agencies (HHAs). The changes in § 413.30 as set forth in the final rule, however, have raised questions as to whether policy changes had been made in these unrelated areas.

The New Provider Exemption

The preamble to the proposed and final rules (63 FR 42797 and 64 FR 42610, respectively) discussed the three types of relief available to SNFs that exceed the SNF routine service cost limits found in § 413.30. In the preamble concerning § 413.30(c), we indicated that a provider may seek relief from the effects of applying the cost limits, either by requesting an exemption from its limits as a new provider of inpatient services, by requesting a reclassification of its provider status, or by requesting an exception to the cost limit. Of these three types of relief, the proposed and final rules focused solely on the exception process and our proposal to revise the approval process for granting exceptions to the cost limits for SNFs and to remove the provision for obtaining a reclassification for a SNF or an HHA. We did not make changes to the exemption requirements for a new provider. However, the recently promulgated changes to § 413.30(c)(2), with regard to the processing of SNF exception requests, may have created confusion with regard to the processing of new provider exemption requests. In addition, editorial changes to § 413.30(d), meant to clarify which provisions applied to which provider type may have created an impression that a policy change has occurred; no policy changes were intended. The only two provider types subject to the regulations found in § 413.30 at present are SNFs and HHAs. We did not propose any changes to our existing policies with regard to the new provider exemption provision or the processing of new provider exemption requests. The intermediary makes a recommendation to HCFA, and HCFA makes the final determination on requests by SNFs for a new provider exemption under § 413.30(d) as redesignated.

Home Health Agencies

In the preamble to the proposed and final rules (63 FR 42797, 64 FR 42610), we clearly stated that we are retaining the current procedures for HHA exception requests and that these provisions would remain unchanged. We modified § 413.30 (in its entirety), in an attempt to clarify which provisions applied to which provider type. The only two provider types subject to § 413.30 at present are SNFs and HHAs. HHAs, however, have never been eligible to receive an exception for ''areas with fluctuating populations,'' an impression that may have been created by these editorial changes.

Provisions of the Rule

For the reasons discussed above, we are making the necessary technical corrections to restore the regulations to conform with our longstanding and unchanged policies for both the new provider exemption for SNFs, and the procedures for exceptions to the cost limits for HHAs.

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

Accordingly, 42 CFR part 413 is corrected by making the following correcting amendments:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 13951, 13951(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

2. In § 413.30, the following changes are made:

§ 413.30 [Corrected]

A. In paragraph (a) introductory text, at the end of the second sentence after the word ''situations'', the phrase ''of particular providers'' is added.

B. In paragraph (a)(2), at the beginning of the first sentence, the words ''Payable SNF and HHA'' are removed, and the words ''Reimbursable provider'' are added in their place.

C. In paragraph (c) introductory text, in the last sentence, the words ''intermediary's notice of program pay'' are removed, and the words ''intermediary's notice of program reimbursement'' are added in their place.

D. In paragraph (c)(2), the heading is corrected to read ''Skilled nursing facility exception''; and in the first sentence, the word ''exception'' is added between the words ''SNFs'' and ''request''.

E. In paragraph (d), add the sentence ''The intermediary makes a recommendation on the provider's request to HCFA, which makes the decision.'' after the first sentence; and remove the words ''the type of'' from the first sentence and add the word ''a'' in their place.

F. In paragraph (e)(3) introductory text, the words ''or HHA'' are removed; and in paragraph (e)(3)(ii), the word ''similar'' is added before each occurrence of the word ''services'', and the words ''or HHA'' are removed.

(Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance)

Dated: September 21, 2000.

Brian P. Burns,

Deputy Assistant Secretary for Information Resources Management.

[FR Doc. 00–25497 Filed 10–6–00; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 440 and 441

[HCFA–2010–FC]

RIN 0938–AI67

Medicaid Program; Home and Community-Based Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period expands State flexibility in providing prevocational, educational, and supported employment services under the Medicaid home and community-based services waiver provisions currently found in section 1915(c) of the Social Security Act (the Act); and incorporates the self-implementing provisions of section 4743 of the Balanced Budget Act of 1997 that amends section 1915(c)(5) of the Act to delete the requirement that an individual have prior institutionalization in a nursing facility or intermediate care facility for the mentally retarded before becoming eligible for the expanded habilitation services. In addition, we are making a number of technical changes to update or correct the regulations.

DATES: Effective date: October 1, 1997. We will consider written comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on or before December 11, 2000.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Health Care Financing Administration, U.S. Department of Health and Human Services, P.O. Box 9010, Attention: HCFA–2010–FC, 7500 Security Boulevard, Baltimore, MD 21244–9010.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept audio, visual, or facsimile (FAX) copies of comments. In commenting, please refer to file code HCFA–2010–FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in room 443–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

FOR FURTHER INFORMATION CONTACT: Mary Jean Duckett, (410) 786–3294.

SUPPLEMENTARY INFORMATION:

I. Background

The Medicaid program is a Federally supported, State-administered program that provides medical assistance to individuals that meet eligibility criteria. It was established in 1965 as title XIX of the Social Security Act (the Act).

Section 1915(c) was added to title XIX of the Act by the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981) (Public Law 97–35) to encourage the provision of cost-effective services to Medicaid recipients in noninstitutional settings. Before the enactment of OBRA 1981, the Medicaid program provided limited coverage for long-term care services in noninstitutional settings.

Section 1915(c) of the Act authorizes the Secretary to waive certain Medicaid statutory requirements to enable a State to cover a broad array of home and community-based services that are not otherwise available under a State's Medicaid program. These services must be furnished in accordance with an individually written plan of care that is subject to approval by the State Medicaid agency, and may be furnished only to persons who, but for the provision of the services, would otherwise require the level of care provided in a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF/MR). Coverage of these services enables elderly, disabled, and chronically ill persons, who would otherwise be institutionalized, to live in the community.

Under section 1915(c) of the Act, a State could receive Federal financial participation (FFP) for the following services as home and community-based services: case management services, homemaker and home health aide services, personal care services, adult day health services, habilitation services, respite care, and ''other'' services as requested by the State and approved by HCFA. Section 9502(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272) revised section 1915(c) of the Act to explicitly include certain prevocational, educational, and supported employment services as expanded habilitation services under home and community-based services for those individuals who receive waiver services after discharge from an NF or ICF/MR. Section 1915(c)(4) of the Act authorizes the provision of habilitation services, and section 1915(c)(5) of the Act defines habilitation services as services to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Section 1915(c)(5) of the Act was further amended by section 4743(a) of the Balanced Budget Act of 1997 (BBA) (Public Law 105–33), which deleted the requirement that an individual have prior institutionalization in either an NF or ICF/MR before becoming eligible for habilitation services. The regulations at § 440.180(c)(1) applied this prior institutionalization requirement to expanded habilitation services. Thus, effective October 1, 1997, if a State chooses to provide these expanded habilitation services under its home and community-based waiver, it may provide these services to all individuals eligible for these services without regard to whether the individuals had a prior institutional stay in an NF or ICF/MR.

II. Provisions of the Final Rule With Comment Period

Before the enactment of the BBA, section 1915(c)(5) of the Act specified that the term ''habilitation services'' applies to individuals who receive services after discharge from an NF or ICF/MR. Section 4743 of the BBA amended section 1915(c)(5) of the Act, effective October 1, 1997, to remove the requirement that an individual be institutionalized before receiving habilitation services.

To implement the provisions of section 4743 of the BBA, we are revising parts 440 and 441. We are also making a number of technical changes to update or correct the regulations.