which requires that payments under the plan be ''consistent with efficiency, economy and quality of care.''

The proposed SPA would increase the Medicaid payment rate for inpatient and outpatient services at facilities paid as Indian Health Service (IHS) facilities (including tribal facilities operated under contracts or compacts pursuant to Public Law 93–638). The IHS sets Medicaid billing rates for inpatient and outpatient services furnished by Alaska IHS facilities, which are announced in the **Federal Register**. Alaska's proposed rates would substantially exceed the IHS published rates, and Alaska provided no analysis of why it would be consistent with efficiency, economy, and quality of care to pay rates higher than the rate authorized by IHS. Absent any such analysis, the CMS found that the proposed rates were not consistent with efficiency, economy, and quality of care as required under section 1902(a)(30)(A) of the Act. 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 Alaska SPA 01–009.

Section 1116 of the Act and 42 CFR, part 430, establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a state plan or plan amendment. The 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.

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

Mr. Robert Labbe,
Director, Division of Medical Assistance,
Department of Health and Social Services,
P.O. Box 110601, Juneau, AK 99811–0601.

Dear Mr. Labbe: I am responding to your request for reconsideration of the decision to disapprove Alaska State Plan Amendment (SPA) 01–009. Alaska submitted SPA 01–009 on December 27, 2001. This SPA would increase the Medicaid payment rate for inpatient and outpatient services at facilities paid as Indian Health Service (IHS) facilities (including tribal facilities operated under contracts or compacts pursuant to Public Law 93–638). The IHS sets Medicaid billing rates for inpatient and outpatient services furnished by Alaska IHS facilities, which are announced in the **Federal Register**. Alaska's proposed rates would substantially exceed the IHS published rates, and Alaska provided no analysis of why it would be consistent with efficiency, economy, and quality of care to pay rates higher than the rate authorized by IHS. Absent any such analysis, CMS found that the proposed rates were not consistent with efficiency, economy, and quality of care as required under section 1902(a)(30)(A) of the Act. 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 Alaska SPA 01–009.

I am scheduling a hearing on your request for reconsideration to be held at 10:00 a.m., October 24, 2002, Seattle Regional Office; 2201 Sixth Avenue; Room 1206; Seattle, Washington 98121, to reconsider our decision to disapprove Alaska SPA 01–009.

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,

Thomas A. Scully.

Authority: 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: October 11, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–26904 Filed 10–22–02; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Virginia State Plan Amendment 01–14

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing to be held on December 11, 2002, 10 a.m., Suite 216, The Public Ledger Building, 150 S. Independence Mall West; Philadelphia, Pennsylvania 19106, to reconsider our decision to disapprove Virginia State Plan Amendment 01–14.

CLOSING DATE: Requests to participate in the hearing as a party must be received by the presiding officer by November 7, 2002.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS, 2520 Lord Baltimore Drive, Suite L, Baltimore, Maryland 21244–2670, Telephone: (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider our decision to disapprove Virginia State Plan Amendment (SPA) 01–14. Virginia submitted SPA 01–14 on December 14, 2001. The amendment would revise the State's payment methodology to provide for supplemental payments for inpatient and outpatient services furnished by non-state government owned or operated facilities.

The issue is whether this SPA sets out a definite payment methodology for supplemental payments for inpatient and outpatient services furnished by non-state government owned or operated facilities in compliance with the requirements of the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 430.10 and 447.252(b). First, the methodology set out in the proposed plan amendment is contingent on unexplained factors including size criteria and Medicaid participation criteria that are not described, and the hospital's acceptance of an intergovernmental transfer agreement that is not described. As a result, the proposed State plan amendment does not ''comprehensively'' describe the State Medicaid program, and does not contain ''all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation'' consistent with

these regulatory requirements. Second, the State was on notice that CMS would review this proposed state plan amendment with heightened scrutiny because of CMS'' concern that the payment level was not consistent with efficiency, economy, and quality of care. During a portion of the period covered by this amendment, the methodology would result in total aggregate payments at the level of 150 percent of the amount that would be paid for the services under Medicare payment principles. In a State Medicaid Director's letter dated November 23, 2002, CMS informed states of the intention not to approve amendments submitted after the November 23, 2001, issuance of a notice of proposed rulemaking that would lower the permissible aggregate payment level from 150 percent to 100 percent of the amount that would be paid for the services under Medicare payment principles.

Section 1116 of the Social Security Act (the Act) and 42 CFR, part 430 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a state plan or plan amendment. The 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 Virginia SPA 01–14.

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

Mr. Patrick W. Finnerty,

Director, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23119.

Dear Mr. Finnerty: I am responding to your request for reconsideration of the decision to disapprove Virginia State Plan Amendment (SPA) 01–14. Virginia submitted SPA 01–14 on December 14, 2001. The amendment would revise the State's payment methodology to provide for supplemental payments for inpatient and outpatient services furnished by non-state government owned or operated facilities.

The issue is whether this SPA sets out a definite payment methodology for supplemental payments for inpatient and outpatient services furnished by non-state government owned or operated facilities in compliance with the requirements of the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 430.10 and 447.252(b). First, the methodology set out in the proposed plan amendment is contingent on unexplained factors including size criteria and Medicaid participation criteria that are not described, and the hospital's acceptance of an intergovernmental transfer agreement that is not described. As a result, the proposed state plan amendment does not ''comprehensively'' describe the state Medicaid program, and does not contain ''all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation'' consistent with these regulatory requirements. Second, the State was on notice that CMS would review this proposed state plan amendment with heightened scrutiny because of CMS'' concern that the payment level was not consistent with efficiency, economy, and quality of care. During a portion of the period covered by this amendment, the methodology would result in total aggregate payments at the level of 150 percent of the amount that would be paid for the services under Medicare payment principles. In a State Medicaid Director's letter dated November 23, 2002, CMS informed states of the intention not to approve amendments submitted after the November 23, 2001, issuance of a notice of proposed rulemaking that would lower the permissible aggregate payment level from 150 percent to 100 percent of the amount that would be paid for the services under Medicare payment principles.

Based on the reasoning set forth above, and after consultation with the Secretary as required under 42 CFR 430.15(c)(2), CMS disapproved Virginia SPA 01–14.

I am scheduling a hearing on your request for reconsideration to be held on December 11, 2002, at 10 a.m., Suite 216, The Public Ledger Building, 150 S. Independence Mall West; Philadelphia, Pennsylvania 19106 to reconsider our decision to disapprove Virginia SPA 01–14.

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,
Thomas A. Scully.

Authority: 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: October 11, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–26905 Filed 10–22–02; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of South Carolina State Plan Amendment 01–14(A)

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing to be held on December 2, 2002, at 10 a.m., Atlanta Federal Center, 61 Forsyth Street, SW., Suite 4T20, Executive Conference Room, Atlanta, Georgia 30303–8909, to reconsider our decision to disapprove South Carolina State Plan Amendment 01–14 (A).

CLOSING DATE: Requests to participate in the hearing as a party must be received by the presiding officer by November 7, 2002.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS, 2520 Lord Baltimore Drive, Suite L, Baltimore, Maryland 21244–2670, Telephone: (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider our decision to disapprove South Carolina State Plan Amendment (SPA) 01–14(A). South Carolina submitted SPA 01–014(A) on December 21, 2001. In this amendment, South Carolina proposed to revise the methodology for calculating supplemental payments for inpatient and outpatient services furnished by non-state government owned or operated facilities.

The issue is whether the State's proposed revised methodology for calculating supplemental payments for inpatient and outpatient services furnished by non-state government owned or operated facilities was consistent with the requirements of