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 is disapproving New Jersey SPA 02–10.

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

Ms. Kathryn A. Plant
Director, Division of Medical Assistance and Health Services, Department of Human Services, P.O. Box 712. Trenton, NJ 08625–0712.

Dear Ms. Plant: I am responding to your request for reconsideration of the decision to disapprove New Jersey State Plan Amendment (SPA) 02–10.

In the SPA, New Jersey proposes to establish a new target group for case management services for youth and young adults under the age of 21 who are in the care of the Juvenile Justice Commission as a result of a commitment order. The SPA further specifies that the target group is limited to youth and young adults who reside in their own homes, the homes of relatives, community-based residences or residential group centers, or other community-based living arrangements as a result of their original placement or conditional release from a public institution.

At issue is whether the Centers for Medicare & Medicaid Services (CMS) properly concluded as a basis for disapproving the amendment that: (1) The State had not demonstrated that the proposed services were within the statutory definition of case management services found in section 1915(g)(2) of the Social Security Act (the Act); (2) the proposed services are available without charge to the user and thus payment under the amendment is not reasonable and necessary and would duplicate payment under other program authorities; and (3) the amendment would restrict beneficiary freedom of choice by limiting providers to employees of New Jersey's Juvenile Justice Commission.

Medicaid coverage of targeted case management is authorized by section 1915(g) of the Act, which defines case management services as services that assist beneficiaries in gaining access to needed services and does not include the direct provision of those services. Because the services proposed as Medicaid targeted case management are segments of the State's juvenile justice program, CMS believes they are integral components of the direct services and administrative functions of that juvenile justice program. In this instance, Medicaid payment for portions of the juvenile justice program would duplicate payment under other programs that are the responsibility of the State Government.

During CMS' conversation with the State, section 8435 of the Technical and Miscellaneous Revenue Act of 1988, Public Law Number 100–647 was discussed. In this section, Congress clarified that the Secretary may not deny approval of either an SPA or a claim on the basis that the state is required to provide such services under state law, or is or was otherwise, paying for the services using non-Federal funds. However, section 8435 also expressly states that this was not to be construed to require the Secretary to make payment for case management services that are provided without charge to the users of such services. Approval of this amendment, therefore, would be contrary to this express statutory provision, since this SPA seeks payment from the Medicaid program for services that are available without charge to the users.

In addition, while states are free to set qualifications for providers, a state must comply with Medicaid law and regulations concerning freedom of choice at section 1902(a)(23) of the Act and the implementing regulation at 42 CFR 431.51. These provisions require that a state plan permit beneficiaries to obtain services from any qualified provider that undertakes to provide the services. Section 1915(g)(1) of the Act states, ''The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23).'' The proposed SPA restricts beneficiary choice of case managers by imposing standards that are not reasonably related to the qualifications of providers, but instead limits available providers to employees of the Juvenile Justice Commission.

This notice announces an administrative hearing to be held on February 4, 2003, at 10 a.m., Centers for Medicare & Medicaid Services, New York Regional Office, 26 Federal Plaza, Room 38–110A; New York, New York 10278–0063.

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

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: December 19, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–32654 Filed 12–26–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers For Medicare & Medicaid Services

[CMS–4055–N]

Medicare Program: National Medicare+Choice Risk Adjustment Public Meeting—February 3, 2003

AGENCY: Centers for Medicare & Medicaid Services (CMS), Health and Human Services.

ACTION: Notice of meeting.

SUMMARY: This notice announces a national Medicare+Choice risk adjustment public meeting for Medicare+Choice organizations, Medicare capitated demonstration projects, PACE plans, Evercare plans, Social Health Maintenance Organizations, Wisconsin Partnership program, Minnesota Senior Health Options, providers, practitioners, and other interested parties. The public meeting will provide updated information on the final CMS-HCC (Hierarchical Condition Category) risk adjustment model and risk adjustment data processing. This public meeting builds on information provided at the January 16, 2002 public meeting held at CMS, the draft model released on March 29, 2002, and the regional training sessions held in June 2002.

DATES: The public meeting is scheduled for February 3, 2003 from 9 a.m. until 5 p.m., e.s.t.

ADDRESSES: The public meeting will be held in the CMS Auditorium, 7500 Security Boulevard, Baltimore, Maryland, 21244–1850.

FOR FURTHER INFORMATION CONTACT: Bobbie Knickman at (410) 786–4161 or *bknickman@cms.hhs.gov.* To submit public comments no later than February 18, 2003, 5 p.m., e.s.t., e-mail Angela Porter at *aporter@cms.hhs.gov* or fax to (410) 786–1048.

SUPPLEMENTARY INFORMATION:

Background

The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) expanded the Medicare+Choice (M+C) program for

Medicare beneficiaries. Under the BBA, the Secretary of Health and Human Services (the Secretary) was required to implement a risk adjustment methodology that adjusts M+C payments to account for variations in per capita costs based on health status and other demographic factors. The BBA also gave the Secretary the authority to collect inpatient hospital data for discharges on or after July 1, 1997, and additional data for other services occurring on or after July 1, 1998. The Secretary developed an initial risk adjustment methodology that incorporated only inpatient hospital data. As required by the BBA, this methodology was implemented beginning on January 1, 2000. Currently, only 10 percent of the M+C payment rate is risk adjusted under the existing risk adjustment methodology, with the other 90 percent subject only to demographic adjustments. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), enacted in December 2000, stipulates that the risk adjustment methodology for 2004 and succeeding years should be based on data from inpatient hospital and ambulatory settings. The BIPA also contains a provision that phases in future risk adjusted payments as follows: 30 percent in 2004; 50 percent in 2005; 75 percent in 2006; and 100 percent in 2007.

The collection of physician encounter data, which began on October 1, 2000, and hospital outpatient encounter data, which began on April 1, 2001, was suspended from May 25, 2001 through July 1, 2002. The Secretary suspended the submission of physician and hospital outpatient encounter data in May 2001 and directed us to develop a risk adjustment approach that balanced payment accuracy with data burden. We worked with M+C organizations, their associations, and other interested parties to develop a risk adjustment approach that significantly reduced the burden of data collection for M+C organizations compared to the approach that was suspended in May of 2001. The result of this effort was to reduce burden by approximately 98 percent. The reduction in burden was accomplished by decreasing the number of data elements submitted (from 50 to 5 elements), only requiring submission of diagnoses that are needed for calculating payments, and creating a simplified data submission format and processing system. The draft CMS–HCC risk adjustment payment model was released on March 29, 2002. The CMS–HCC risk adjustment payment model is a 61 disease group selected significant disease model. Also released on March 29, 2002, was a file of ICD–9–CM codes required to group diagnosis codes for risk adjustment. On April 15, 2002, a reduced set of ICD–9–CM codes were released to further simplify the collection of diagnoses. The Risk Adjustment Processing System (RAPS) became operational on October 1, 2002. Submission of ambulatory risk adjustment data (physician and hospital outpatient) resumed on October 1, 2002 for dates of service beginning July 1, 2002. On March 28, 2003 we will announce the proposed final version of the CMS–HCC risk adjustment payment model that affects risk adjustment payment beginning January 2004 and incorporates hospital inpatient, hospital outpatient and physician data.

This public meeting will cover proposed changes to the draft version of the CMS–HCC risk adjustment model released on March 29, 2002. These changes include proposed adjustments to account for higher costs for community-based enrollees, as well as proposed implementation approaches for 2004. The meeting will focus on the risk adjustment model and data collection and include the following topics:

- Proposed final version of the CMS-HCC risk adjustment payment model.
- Frailty adjuster (soliciting public comment).
- Elimination of the lag between the data collection period and payment (soliciting public comment).
- Risk adjustment data processing.
- Risk adjustment schedule.

A copy of the public meeting agenda is available at: http://*www.aspenxnet.com/meetingagenda.htm.*

The agenda will include presentations by CMS staff, Aspen training staff, as well as question and answer sessions. Written public comments are preferred following the meeting and will be accepted until February 18, 2003, 5 p.m., e.s.t.

Registration

Registration for this public meeting is required and will be on a first-come, first-serve basis, limited to three attendees per organization.

This public meeting is intended for Medicare+Choice organizations, Medicare capitated demonstration projects, PACE plans, Evercare plans, Social Health Maintenance Organizations, Wisconsin Partnership program, Minnesota Senior Health Options, providers, practitioners, and other interested parties. A waiting list will be available for additional requests. The registration deadline is January 29, 2003 at 5 p.m., e.s.t. Registration must be completed via the Internet at the following Web site: http://*www.aspenxnet.com/registration.* A confirmation notice with specific meeting location information will be sent to attendees upon finalization of registration.

Persons who are not registered in advance will not be permitted into the Federal Building and thus not be able to attend the public meeting. Persons attending the public meeting will be required to show photographic identification, preferably a valid driver's license, before entering the building. Please note that if the public meeting is cancelled, then a notice will be posted on our Web site (http://*www.cms.hhs.gov).*

Attendees will be provided with meeting materials at the time of the meeting. Meeting materials will be available at http://*www.mcoservice.com* after February 3, 2003.

Written questions about meeting logistics or requests for meeting materials after February 3, 2003 must be directed to: Kim Slaughter, Aspen Systems Corporation, Telephone Number: (301) 519–5388, Fax Number: (301) 519–6360, e-mail: *encounterdata@aspensys.com.*

Written public comments will be accepted until February 18, 2003, 5 p.m., e.s.t. Written public comments should be sent to Angela Porter at *aporter@cms.hhs.gov* or fax to (410) 786–1048.

(Authority: Sections 1851 through 1859 of the Social Security Act (42 U.S.C. 1395w–21 through 1395w–28)) (Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare— Supplementary Medical Insurance Program**)**

Dated: December 4, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–31410 Filed 12–26–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1202–CN]

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Correction Notice

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