agencies to assess all costs and benefits of available regulatory alternatives and, when rules are necessary, to select regulatory approaches that maximize net benefits (including potential economic environments, public health and safety, other advantages, distributive impacts, and equity). We believe that this notice is consistent with the regulatory philosophy and principles identified in the Executive Order. The formula for the allotments is specified in the statute. Since the formula is specified in the statute, we have no discretion in determining the allotments. This notice merely announces the results of our application of this formula, and therefore does not reach the economic significance threshold of $100 million in any one year.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any one year. Individuals and States are not included in the definition of a small entity; therefore, this requirement does not apply.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

The Unfunded Mandates Reform Act of 1995 requires that agencies prepare an assessment of anticipated costs and benefits before publishing any notice that may result in an annual expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $110 million or more (adjusted each year for inflation) in any one year. Since participation in the SCHIP program on the part of States is voluntary, any payments and expenditures States make or incur on behalf of the program that are not reimbursed by the Federal government are made voluntarily. This notice will not create an unfunded mandate on States, tribal, or local governments because it merely notifies States of their SCHIP allotment for FY 2005. Therefore, we are not required to perform an assessment of the costs and benefits of this notice.

Low-income children will benefit from payments under SCHIP through increased opportunities for health insurance coverage. We believe this notice will have an overall positive impact by informing States, the District of Columbia, and U.S. Territories and Commonwealths of the extent to which they are permitted to expend funds under their child health plans using their FY 2005 allotments.

Under Executive Order 13132, we are required to adhere to certain criteria regarding Federalism. We have reviewed this notice and determined that it does not significantly affect States' rights, roles, and responsibilities because it does not set forth any new policies.

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this notice will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

(Section 1102 of the Social Security Act (42 U.S.C. 1302).) (Catalog of Federal Domestic Assistance Program No. 93.767, State Children's Health Insurance Program)

Dated: May 17, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: June 14, 2004.

Tommy G. Thompson,

Secretary.

[FR Doc. 04–19573 Filed 8–26–04; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4067–PN]

RIN 0938–ZA53

Medicare and Medicaid Programs; Application by the Utilization Review Accreditation Commission (URAC) for Deeming Authority for Medicare Advantage

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

ACTION: Proposed notice.

SUMMARY: This proposed notice announces the receipt of an application from the Utilization Review Accreditation Commission for recognition as a national accreditation program for managed care organizations that wish to participate in the Medicare Advantage program. The statute requires that within 60 days of receipt of an organization's complete application, we will announce our receipt of the accreditation organization's application for approval, describe the criteria we will use in evaluating the application, and provide at least a 30-day public comment period.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 27, 2004.

ADDRESSES: In commenting, please refer to file code CMS–4067–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By mail.* You may mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–4067-PN, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–3159 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and

retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Heidi Adams, (410) 786–1094.

SUPPLEMENTARY INFORMATION: *Submitting Comments:* We welcome comments from the public on all issues set forth in this proposed notice to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–4067–PN and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public Web site. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7195.

This **Federal Register** document is available from the Federal Register online database through *GPO Access*, a service of the U.S. Government Printing Office. The Web site address is: *http://www.gpoaccess.gov/fr/index.html*.

I. Background

[If you choose to comment on issues in this section, please include the caption ''Background'' at the beginning of your comments.]

Under the Medicare program, eligible beneficiaries may receive covered services through a managed care organization (MCO) that has a Medicare Advantage (MA) (formerly, Medicare+Choice) contract with the Centers for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met in order for an MCO to enter into an MA contract with CMS are located at 42 CFR part 422. These regulations implement part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MCO must provide and the requirements that the organization must meet to be an MA contractor. Other relevant sections of the Act are parts A and B of Title XVIII and part A of Title XI pertaining to the provision of services by Medicare certified providers and suppliers.

Generally, for an organization to enter into an MA contract, the organization must be licensed by the State as a risk bearing organization as set forth in part 422 of our regulations. Additionally, the organization must file an application demonstrating that it meets other Medicare requirements in part 422 of our regulations. Following approval of the contract, we engage in routine monitoring and oversight audits of the MA organization to ensure continuing compliance. The monitoring and oversight audit process is comprehensive and uses a written protocol that itemizes the Medicare requirements the MA organization must meet.

As an alternative for meeting some Medicare requirements, an MA organization may be exempt from CMS monitoring of certain requirements in subsets listed in section 1852(e)(4)(B) of the Act as a result of an MA organization's accreditation by a CMS-approved accrediting organization (AO). In essence, the Secretary ''deems'' that the Medicare requirements are met based on a determination that the AO's standards are at least as stringent as Medicare requirements. As we specify at § 422.157(b)(2) of our regulations, the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO will have to re-apply to CMS.

The applicant organization is generally recognized as an entity that accredits MCOs that are licensed as a health maintenance organization (HMO) or a preferred provider organization (PPO).

II. Approval of Deeming Organizations

[If you choose to comment on issues in this section, please include the caption ''Approval of Deeming Organizations'' at the beginning of your comments.]

Section 1852(e)(4)(C) of the Act requires that within 210 days of receipt of an application, the Secretary shall determine whether the applicant meets criteria specified in section 1865(b)(2) of the Act. Under these criteria, the Secretary will consider for a national accreditation body, its requirements for accreditation, its survey procedures, its ability to provide adequate resources for conducting required surveys and supplying information for use in enforcement activities, its monitoring procedures for provider entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation.

Section 1865(b)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accreditation body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from our receipt of a completed application to publish approval or denial of the application.

The purpose of this notice is to inform the public of our consideration of the Utilization Review Accreditation Commission's (URAC's) application for approval of deeming authority of MA organizations that are licensed as an HMO for the following six categories:

- Quality improvement.
- Access to services.
- Antidiscrimination.
- Information on advance directives.
- Provider participation rules.
- Confidentiality and accuracy of enrollees' records.

This notice also solicits public comment on the ability of the applicant's accreditation program to meet or exceed the Medicare requirements for which it seeks authority to deem.

III. Evaluation of Deeming Request

[If you choose to comment on issues in this section, please include the caption ''Evaluation of Deeming Request'' at the beginning of your comments.]

On June 4, 2004, URAC submitted all the necessary information to permit us to make a determination concerning its request for approval as a deeming authority for MA organizations that are licensed as an HMO. Under § 422.158(a) of the regulations, our review and evaluation of a national accreditation organization will consider, but not necessarily be limited to, the following information and criteria:

- The equivalency of URAC's requirements for HMOs to CMS' comparable MA organization requirements.
- URAC's survey process, to determine the following:
  + The frequency of surveys.
  + The types of forms, guidelines and instructions used by surveyors.
  + Descriptions of the accreditation decision making process, deficiency notification and monitoring process, and compliance

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