conflicts of interests, or unsound banking practices." Any request for a hearing on this question must be accompanied by a statement of the reasons a written presentation would not suffice in lieu of a hearing, identifying specifically any questions of fact that are in dispute, summarizing the evidence that would be presented at a hearing, and indicating how the party commenting would be aggrieved by approval of the proposal.

Comments regarding the application must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than August 22, 1985.

A. **Federal Reserve Bank of Minneapolis** (Bruce J. Hedblom, Vice President) 250 Marquette Avenue, Minneapolis, Minnesota 55480:

1. *Security State Agency of Aitkin, Inc.*, Aitkin, Minnesota; to acquire John F. Solien Agency, Aitkin, Minnesota, thereby engaging in general insurance agency activities in a place with a population not exceeding 5,000, pursuant to section 4(c)(8)(C)(i) of the Act. These activities would be conducted in the Aitkin, Minnesota, trade area.

Board of Governors of the Federal Reserve System, July 25, 1985.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 85-18088 Filed 7-30-85; 8:45 am]

BILLING CODE 6210-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Health Information Policy Council; 1984 Revision of the Uniform Hospital Discharge Data Set

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: The purpose of this notice is to announce the 1984 Revision of the Uniform Hospital Discharge Data Set (UHDDS) which has been approved by the Secretary for use within the Department of Health and Human Services (DHHS). The purposes of the 1984 revision are to update and improve the original version of the UHDDS which was promulgated by the Secretary in 1974 as a minimum, common core of data for use in programs of the Department which require data on individual hospital discharges on a continuing basis. Revisions to definitions and categories have been developed to update certain items and to improve their accuracy.

DATES: The 1984 Revision of the UHDDS will become effective on January 1, 1986.

FOR FURTHER INFORMATION CONTACT: Dr. Gooloo S. Wunderlich, Division of Data Policy, Office of the Assistant Secretary for Health, Room 717-H, Hubert H. Humphrey Building, 200 Independent Avenue, SW., Washington, D.C. 20201. Commercial Phone: (202) 245-2100.

SUPPLEMENTARY INFORMATION

Background

A Uniform Hospital Discharge Data Set was promulgated by the Secretary of the U.S. Department of Health, Education, and Welfare in 1974 as a minimum, common core of data on individual hospital discharges in the Medicare and Medicaid programs. Its purpose was to improve the uniformity and comparability of hospital discharge data. Promulgation of the UHDDS was the culmination of a number of developmental activities involving both the public and private sectors.

In the eleven years since its promulgation, the UHDDS has achieved fairly widespread use as a minimum, common core of data within the Department in programs which require data on individual hospital discharges on a continuing basis. The data set is also used within other Federal Agencies and has gained acceptance and use as a standard in the non-Federal public and private sectors, such as in the operations of hospital discharge abstracting services.

The purposes of the 1984 Revision of the UHDDS are to update and improve the original version in the light of current needs and developments. Revisions to definitions and categories have been developed to update certain items and to improve their accuracy. In keeping with the original UHDDS concept, it is emphasized that the UHDDS is a minimum, common core of data on individual hospital discharges and is not intended to serve the entire data needs of a data program or activity. Individual programs and data collectors may obtain additional data elements beyond those in the UHDDS as necessary, and may obtain additional detail within the UHDDS items, provided that the detail can be aggregated to the UHDDS items, definitions, and categories.

The 1984 Revision of the UHDDS was developed by the Health Information Policy Council of the U.S. Department of Health and Human Services. The Council is the principal internal advisory body to the Secretary on departmentwide health data policy. In developing the 1984 Revision, the Council consulted both with the National Committee on Vital and Health Statistics, the principal public advisory body to the Secretary on health statistical matters, and with a departmentwide interagency task force comprised of representatives of programs which would be affected by the revision. The Secretary has approved the revision with an effective date of implementation of January 1, 1986.

1984 Revision of the UHDDS

The 1984 Revision of the Uniform Hospital Discharge Data Set consists of the following items:

Number and item

1.—Personal Identification
2.—Date of Birth
3.—Sex
4.—Race and Ethnicity
5.—Residence
6.—Hospital Identification
7-8.—Admission and Discharge Dates
9-10.—Physician Identification: Attending and Operating
11.—Diagnoses
12.—Procedures and Dates
13.—Disposition of Patient
14.—Expected Payer for Most of This Bill (Anticipated Financial Guarantor for Services)

The following list contains an identification, definition, or subcategorization of each UHDDS element, and if appropriate, comments are given.

1. *Personal Identification.** The unique number assigned to each patient within a hospital that distinguishes the patient and his or her hospital record from all others in that institution.

2. *Date of Birth.* Month, day, and year of birth.

Comment: It is recommended that the year of birth be reported in four digits rather than usually accepted two digits. This will make the data element more accurate if dealing with persons over 100 years old.

3. *Sex.** Male or female.

4a. *Race.* White, Black, Asian or Pacific Islander, American Indian/Eskimo/Aleut, Other.

b. *Ethnicity.* Spanish origin/Hispanic. Non-Spanish origin/Non-Hispanic.

Comment: "Race" and "Ethnicity" have been separated for clarification purposes.

* Indicates no definitional change from the UHDDS recommended to the Secretary by the National Committee on Vital and Health Statistics in 1979, viz., National Committee on Vital and Health Statistics. *Uniform Hospital Discharge Data: Minimum Data Set.* DHEW Publication No. (PHS) 80-1157. U.S. Department of Health, Education and Welfare, Washington, April 1980.

5. *Residence.* Zip Code. Code for foreign residence.

Comment: A code (to be determined) has been added for foreign residence to include residences throughout the world.

6. *Hospital Identification.*[n] A unique institutional number within a data collection system.

7–8. *Admission and Discharge Dates.*[n] Month, day, and year of both admission and discharge. An inpatient admission begins with the formal acceptance by a hospital of a patient who is to receive physician, dentist, or allied services while receiving room, board, and continuous nursing service. An inpatient discharge occurs with the termination of the room, board, and continuous nursing services, and the formal release of an inpatient by the hospital.

9–10. *Physician Identification.*[n] Each physician must have a unique identification number within the hospital. The attending physician and the operating physician (if applicable) are to be identified.

9. *Attending Physician.* The clinician who is primarily and largely responsible for the care of the patient from the beginning of the hospital episode.

10. *Operating Physician.* The clinician who performed the principal procedure (see item 12 for definition of a principal procedure).

11. *Diagnoses.*[n] All diagnoses that affect the current hospital stay.

a. *PRINCIPAL DIAGNOSIS* is designated and defined as: the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

b. *OTHER DIAGNOSES* are designated and defined as: all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

12. *Procedures and Date.* All significant procedures are to be reported.

a. A significant procedure is one that is:

(1) Surgical in nature, or

(2) Carries a procedural risk, or

(3) Carries an anesthetic risk, or

(4) Requires specialized training.

b. For significant procedures, the identity (by unique number within the hospital) of the person performing the procedure and the date must be reported.

c. When more than one procedure is reported, the principal procedure is to be designated. In determining which of several procedures is principal, the following criteria apply:

> The principal procedure is one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure.

For reporting purposes, the following definitions and guidelines should be used:

(1) *Surgery* includes incision, excision, amputation, introduction, endoscopy repair, destruction, suture and manipulation.

(2) *Procedural risk.*—This term refers to a professionally recognized risk that a given procedure may induce some functional impairment, injury, morbidity, or even death. This risk may arise from direct trauma, physiologic disturbances, interference with natural defense mechanisms, or exposure of the body to infection or other harmful agents.

Traumatic procedures are those that are invasive, including nonsurgical procedures that utilize cutdowns, that cause tissue damage (e.g., irradiation), or introduce some toxic or noxious substance (e.g., caustic test reagents).

Physiologic risk is associated with the use of virtually any pharmacologic or physical agent that can affect homeostasis (e.g., those that alter fluid distribution, electrolyte balance, blood pressure levels, and stress or tolerance tests).

Any procedure in which it is obligatory (or usual) to utilize pre- or postmedications that are associated with physiologic or pharmacologic risk should be considered as having a "procedural risk," for example, those that require heavy sedation or drugs selected for their systemic effects such as alteration of metabolism, blood pressure or cardiac function.

Some of the procedures that include harmful exposures are those that can introduce bacteria into the blood stream (e.g., cardiac catheterization), those capable of suppressing the immune system, those that can precipitate idiosyncratic reactions such as anaphylaxia after the use of contrast materials, and those involving substances with known systemic toxicity.

Long-life radioisotopes pose a special kind of exposure risk to other persons as well as to the patient. Thus, these substances require special precautionary measures and the procedures using them carry procedural risk.

(3) *Anesthetic risk.*—Any procedure that either requires or is regularly performed under general anesthesia carries anesthetic risk, as do procedures under local, regional, or other forms of anesthesia that induce sufficient functional impairment necessitating special precautions to protect the patient from harm.

(4) *Specialized training.*—This criterion is important for procedures that are exclusively or appropriately performed by specialized professionals, qualified technicians, or clinical teams that are either specifically trained for this purpose or whose services are principally dedicated to carrying them out. Whenever specially trained staff resources are necessary or are customarily employed in the performance of a procedure, it is considered significant.

Comment: The categorization of procedures into classes has been eliminated. This will remove the difficulty currently being experienced in selecting the proper classification. It will also allow new procedures to be properly reported. "Special facilities" and "special equipment" have been removed as requirements for a significant procedure". It is believed that the other defined significant procedures encompass these two categories.

13. *Disposition of Patient.*

a. Discharged to home (routine discharge).

b. Left against medical advice.

c. Discharged to another short-term hospital.

d. Discharged to a long-term care institution.

e. Died.

f. Other.

Comment: "Other" has been added to this definition to make "disposition of patient" all inclusive.

14. *Expected Payer for Most of This Bill.* (Anticipated Financial Guarantor for Services).

Single major source that the patient expects will pay for his or her bill.

a. Blue Cross.

b. Other insurance companies.

c. Medicare.

d. Medicaid

e. Workers' compensation.

f. Other government payers.

g. Self-pay.

h. No charge (free, charity, special research or teaching).

i. Other.

Comment: This definition has been updated and a clarifying statement has been added.

Dated: July 25, 1985.

James O. Mason,

Acting Agency Secretary for Health, and Chairperson, DHHS Health Information Policy Council.

[FR Doc. 85-18132 Filed 7-30-85; 8:45 am]

BILLING CODE 4150-04-M

Health Care Financing Administration

[BERC-347-NR]

Medicare Program; Criteria for Medicare Coverage of Inpatient Hospital Rehabilitation Services

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

ACTION: Notice of HCFA ruling.

SUMMARY: This notice announces a HCFA ruling that restates HCFA's longstanding criteria for Medicare coverage of inpatient hospital rehabilitation services.

FOR FURTHER INFORMATION CONTACT: Tom Hoyer, (301) 594-9446.

SUPPLEMENTARY INFORMATION: We plan to compile and publish all HCFA Rulings in the "Health Care Financing Administration Rulings" booklet which will be indexed for citation purposes. When this Ruling is republished in the booklet, it will be known as HCFAR 85-2. The text of the HCFA ruling is as follows:

MEDICARE COVERAGE OF INPATIENT HOSPITAL REHABILITATION SERVICES—HCFAR 85-2

Purpose

This Ruling provides further public notice of HCFA's criteria for Medicare coverage of inpatient hospital rehabilitation services.

Citations

Sections 1812, 1814, 1861 and 1862 of the Social Security Act (the Act) (42 U.S.C. 1395d, 1395f, and 1395x, and 1395y).

Petinent History

Under the Medicare program, there has always, been a statutory exclusion of-payment for services that" . . . are not reasonable and necessary for the diagonsis or treatment of illness or injury. . . ." (section 1862 of the Act). It is this authority, taken in conjunction with the descriptions of the various benefits, that the program uses to deny payment when services required by a patient could have been appropriately provided in inpatient setting which is less intensive than the hospital setting or in an outpatient setting. (See also section 1154 of the Act.)

Rehabilitation care is furnished in a variety of settings ranging from the inpatient hospital setting, through the skilled nursing facility setting, to various outpatient settings such as, for example, home health care, and outpatient physical therapy. To determine whether inpatient hospital care is necessary for the provision of rehabilitation services, it is first necessary to determine what rehabilitation services the patient requires and then to determine whether they need to be provided in the inpatient hospital setting.

Typically, a preadmission screening is done before a patient is admitted to a rehabilitation hospital. This screening is a preliminary review of the patient's condition and previous medical record to determine if the patient is likely to benefit significantly from an intensive hospital program or extensive inpatient assessment. Further inpatient assessment of a patient's potential for rehabilitation my be done if it is reasonable and necesary to perform the assessment in the hospital.

We developed criteria early in the program to assist medical review entities in applying the basic "reasonable and necessary" test to inpatient rehabilitation services under Part A. These criteria are used to help a medical review entity determine whether rehabilitative care in a hospital, rather than in a SNF or on an outpatient basis, is reasonable and necessary. The criteria have been revised from time to time to respond to new questions of interpretation which have arisen. Section 3101.11 of the Intermediary Manual contains the current version of these criteria. The HCFA Ruling published in this notices restates the criteria set forth in that manual.

Ruling

Criteria for Medicare Coverage of Inpatient Hospital Rehabilitation Services

A. *General*—Physicians generally agree on the circumstances that justify a medical or surgical patient's hospitalization, and, in some cases, an admission to a rehabilitation hospital or to the rehabilitation service of a short-term hospital can be justified on essentially the same medical or surgical grounds. In other cases, however, a patient's medical or surgical needs alone may not warrant inpatient hospital care, but hospitalization may nevertheless be necessary because of the patient's need for rehabilitative services.

A hospital level of care is required by a patient needing rehabilitative services if that patient needs a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade his ability to function. There are two basic requirements which must be met for inpatient hospital stays for rehabilitation care to be covered:

1. The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and

2. It must be reasonable and necessary to furnish the care on the inpatient hospital basis, rather than in a less intensive facility, such as a SNF, or on an outpatient basis.

B. *Preadmission Screening*—Before a patient is admitted to a rehabilitation hospital for treatment, a preadmission screening is normally done. This screening is a preliminary review of the patient's condition and previous medical record to determine if the patient is likely to benefit significantly from an intensive hospital program or extensive inpatient assessment.

While preadmission screening is a standard practice in most rehabilitation hospitals and may provide useful information for claims review purposes, the absence of a preadmission screening in a particular case should not be the sole reason for denying a claim. However, in a case where an inpatient assessment showed a patient clearly was not a good candidate for an inpatient hospital program, then the presence or absence of preadmission screening information would be important in determining whether the inpatient assessment itself was reasonable and necessary. If preadmission screening information indicated that the patient had the potential for benefiting from an inpatient hospital program, a period of inpatient assessment could be covered, up to the point where it was determined that inpatient hospital rehabilitation was not appropriate, since preadmission screening cannot be expected to eliminate all unsuitable candidates.

C. *Inpatient Assessment of Individual's Status and Potential for Rehabilitation* 1. *General*—Coverage is available for inpatient assessment of a patient's potential for benefiting from an intensive coordinated rehabilitation program only if it was reasonable and necessary to perform the assessment in the hospital. This determination should be made on the basis of information available in the patients's medical record. It is important to note that the assessment process is not merely a paperwork review, but rather an onsite professional review of the patient's

condition by the necessary disciplines. Inpatient assessments conducted by a rehabilitation team through examination of the patient usually require between 3 to 10 calendar days, but on occasion may require more. This 3–10 day period is often one where the patient is receiving therapies rather than simple screening assessments. Where more than 10 days are required, the case should be carefully reviewed to ensure that such additional time was necessary. An inpatient assessment may be covered even if the assessment subsequently indicates that a patient is not suitable for an intensive inpatient hospital rehabilitation program, if the patient's condition on admission was such that an extensive inpatient assessment was considered reasonable and necessary for a final decision to be made on a patient's actual rehabilitation potential. Where the initial assessment has resulted in a conclusion that the individual is a poor candidate for rehabilitation care, coverage for further inpatient hospital care is limited to a reasonable number of days needed to permit appropriate placement of the patient.

The fact that an individual received therapy prior to admission to a hospital for a rehabilitation program would not necessarily mean that the initial assessment period was not reasonable and necessary. However, if during a previous hospital stay an individual completed such a program for essentially the same condition for which inpatient hospital care is now being provided, the assessment period could be covered only if:

(1) Some intervening circumstance rendered such an assessment reasonable and necessary; or

(2) The subsequent admission is to an institution utilizing techniques or technology not previously available or not available in the first institution.

2. *Specific examples:*

a. After an inpatient hospital stay for rehabilitation care which resulted in little improvement in the patient's condition, an individual who undergoes surgery for severe contractures as a result of arthritis may require a reassessment of his rehabilitation potential in light of the surgery.

b. The fact that an individual has some degree of mental impairment would not per se be a basis for concluding that a multidisciplinary team evaluation is not warranted. Many individuals who have had CVAs suffer both mental and physical impairments. The mental impairment often results in a limited attention span and reduced comprehension with a resultant problem in communication. With an intensive rehabilitation program, it is sometimes possible to correct or significantly alleviate both the mental and physical problems.

c. Absent other complicating medical problems, the type of rehabilitation program normally required by a patient with a fractured hip during or after the nonweightbearing period or a patient with a healed ankle fracture would not require an inpatient hospital stay for rehabilitation care. Accordingly, an inpatient assessment would not be warranted in such cases. On the other hand, an individual who has had a CVA which has left the individual significantly dependent in the activities of daily living (even after physical therapy in a different setting) might be a good candidate for a more extensive inpatient assessment if the patient has potential for rehabilitation and his needs are not primarily of a custodial nature.

D. *Inpatient Rehabilitation Hospital Care*—Rehabilitative care in a hospital, rather than in a SNF or on an outpatient basis, is reasonable and necessary for a patient who requires a more coordinated, intensive program of multiple services than is generally found out of a hospital. A patient who has one or more conditions requiring intensive and multidisciplinary rehabilitation care, or who has a medical complication in addition to his primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment, would probably require a hospital level of rehabilitation care. A patient in need of rehabilitation on an inpatient hospital basis requires all of the following.

1. *Close medical supervision by a physician with specialized training or experience in rehabilitation*—A patient's condition must require the 24-hour availability of a physician with special training or experience in the field of rehabilitation. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct and medically necessary physician involvement in the patient's care; i.e., at least every 2-3 days during the patient's stay. This degree of physician involvement, which is greater than would normally be rendered to a patient in a SNF, is an indicator of a patient's need for services generally available only in a hospital setting. A SNF patient's care would usually require only the general supervision of a physician, rather than the close supervision which hospital patients need.

2. *Twenty-four-hour rehabilitation nursing.*—The patient requires the 24-hour availability of a registered nurse with specialized training or experience in rehabilitation. This degree of availability represents a higher level of care than would normally be found in a SNF. While a SNF patient may require nursing care, specialized rehabilitation nursing is generally not as readily available in such a facitily.

3. *A relatively intense level of physical therapy or occupational therapy and, if needed, speech therapy, social services, psychological services, or prosthetic-orthotic services.*—The patient must require at least 3 hours a day of physical and/or occupational therapy, in addition to any other required therapies or services. In exceptional cases, an inpatient hospital stay for rehabilitation care can be covered even though the patient has a secondary diagnosis or medical complication that prevents him from participating in programs of physical or occupational therapy to the extent outlined above. Inpatient hospital care in these cases may be the only reasonable means by which even a low intensity rehabilitation program can be safely carried out. Documentation must be secured of the existance and extent of complicating conditions affecting the carrying out of a rehabilitation program to ensure that inpatient hospital care for less than intensive rehabilitation care is actually needed.

4. *A multidisciplinary team approach to the delivery of the program.*—A multidisciplinary team usually includes a physician, rehabilitation nurse, social worker and/or psychologist, and those therapists involved in the patient's care. At a minimum, a team must include a physician, rehabilitation nurse and one therapist.

5. *A coordinated program of care.*—The patient's records must reflect evidence of a coordinated program, i.e., documentation that periodic team conferences were held with a regularity of at least every *2 weeks* to: (1) Assess the individual's progress or the problems impeding progress; (2) consider possible resolutions to such problems; and (3) reassess the validity of the rehabilitation goals initially established. A team conference may be formal or informal; however, a review by the various team members of each other's notes would not constitute a team conference. The decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the clinical record.

6. *Significant practical improvement.*—Hospitalization after the initial assessment is covered only in

those cases where the initial assessment results in a conclusion by the rehabilitation team that a significant practical improvement can be necessary that there be an expectation of complete independence in the activities of daily living, but there must be a reasonable expectation of improvement that will be of practical value to the patient, measured against his condition at the start of the rehabilitation program. For example, a multiple sclerosis patient's condition may have deteriorated as a result of a secondary illness. To be restored to a level of function before the secondary illness, the patient may require an intensive inpatient hospital rehabilitation program. While such a program would not restore the level of function before multiple sclerosis developed, a return to pre-secondary illness level would be considered to be a "significant practical improvement" in the condition.

7. Realistic goals.—While there may be instances where an intense rehabilitation program may enable a Medicare patient to return to the labor market, vocational rehabilitation is generally not considered a realistic goal for most aged or severely disabled individuals. The most realistic rehabilitation goal for most Medicare beneficiaries is self-care or independence in the activities of daily living; i.e., self-sufficiency in bathing, ambulation, eating, dressing, homemaking, etc., or sufficient improvement to allow a patient to live at home with family assistance rather than in an institution. Thus, the aim of the treatment should be achieving the maximum level of function possible.

8. *Length of Rehabilitation Program.*—Coverage should stop when further progress toward the established rehabilitation goal is unlikely or it can be achieved in a less intensive setting. In deciding whether further care can be carried out in a less intensive setting, both the degree of improvement which has occurred and the type of program required to achieve further improvement must be considered. In some cases an individual may be expected to continue to improve under an outpatient program. There are other situations where further improvement in the individual's ability to function relatively independently in the activities of daily living can be expected only if a multidisciplinary team effort is continued.

While occasional home visits and other trips into the community are factors in determining whether continued stay in the hospital is necessary, such excursions would not alone be a basis for concluding that further hospital care is not required. Planned home visits and trips to the community are frequently used to test the individual's ability to function outside the institutional setting and to assist in discharge planning for the individual.

It is also important to consider how close the patient may be to the planned end of his rehabilitation hospital stay when further progress becomes unlikely. If a patient is within a few days of discharge, it would usually not be appropriate to transfer him to a less intensive setting in another facility even though further progress in the hospital setting is unlikely. However, it could be appropriate to utilize a "swing bed" arrangement, if it exists in the same facility, for rendering necessary services to the patient pending dicharge.

When discharge or transfer to another facility is appropriate, the cut-off point for coverage should not be the last day on which improvement actually occurred. Rather coverage should continue through the time it would have been reasonable for the physician, in consultation with the rehabilitation team, to have concluded that further improvement would not occur and to have initiated the patient's discharge.

Since discharge planning is an integral part of any rehabilitation program and should begin upon the patient's admittance to the facility, an extended period of time for discharge action would not be reasonable after established goals have been reached, or after a determination has been made that further progress is unlikely or that care in a less intensive setting would be appropriate.

(Secs. 1812, 1814, 1861 and 1862 of the Social Security Act, 42 U.S.C. 1395d, 1395f, 1395x, and 1395y)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare-Hospital Insurance)

Dated: July 25, 1985.

Carolyne K. Davis,

Administrator.

[FR Doc. 85-18145 Filed 7-29-85; 10:13 am]

BILLING CODE 4120-03-M

Medicaid Program; Hearings; Reconsideration of Disapproval of the Effective Date of a Pennsylvania State Plan Amendment

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing on August 29, 1985 in Philadelphia, Pennsylvania to reconsider our decision to disapprove the effective date of Pennsylvania State Plan Amendment 84-9.

Closing Date: Requests to participate in the hearing as a party must be received by the Docket Clerk [on or before August 15 1985.]

FOR FURTHER INFORMATION CONTACT: Docket Clerk, Hearing Staff, Bureau of Eligibility, Reimbursement and Coverage, 365 East High Rise, 6325 Security Boulevard, Baltimore, Maryland 21207, Telephone: [301] 594-8261.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider our decision to disapprove the effective date of a Pennsylvania State Plan Amendment.

Section 1116 of the Social Security Act and 45 CFR Parts 201 and 213 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a State plan or plan amendment. HCFA 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 which 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 Hearing Officer within 15 days after publication of this notice, in accordance with the requirements contained in 45 CFR 213.15(b)(2). Any interested person or organization that wants to participate as amicus curiae must position the Hearing Officer before the hearing begins in accordance with the requirements contained in 45 CFR 213.15(c)(1)

If the hearing is later rescheduled, the Hearing Officer will notify all participants.

The issue in this matter is whether Pennsylvania's request to establish an effective date of July 1, 1984 for State Plan Amendment 84-9 violates Federal regulations at 42 CFR 447.253 and 42 CFR 447.205.

The plan amendment defines facility location by Metropolitan Statistical Area (MSA) levels and combines certain MSA levels for purposes of computing payment ceilings in order to avoid establishing ceilings based on a relatively small number of facilities. The amenement was appoved except for the proposed effective date.

Federal regulations at 45 CFR 205.5(a) require a State plan to be amended to reflect new or revised Federal statutes or regulations or material change in any phase of State law, organization, policy,