unused resident slots; *Form Number:* CMS–2552–96 (OMB# 0938–0050); *Frequency:* Annually; *Affected Public:* Business or other for-profit, Not-for-profit institutions, and State, Local or Tribal Government; *Number of Respondents:* 6,111; *Total Annual Responses:* 6,111; *Total Annual Hours:* 4,046,782.

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Application Template for Health Insurance Flexibility and Accountability (HIFA) Section Demonstration Proposal; *Use:* The HIFA Initiative affords states an opportunity to expand coverage to the uninsured under Social Security Act Section 1115 demonstrations authority. States will be able to use Medicaid and State Child Health Insurance Program funds in concert with private insurance options to expand coverage to low-income uninsured individuals with a focus on those with income at or below 200 percent of the Federal poverty level. The model demonstration application will facilitate State efforts in designing programs to cover the uninsured; *Form Number:* CMS–10048 (OMB# 0938–0848); *Frequency:* Other: renewal every 5 yrs.; *Affected Public:* State, Local or Tribal Government; *Number of Respondents:* 10; *Total Annual Responses:* 9; *Total Annual Hours:* 42.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site address at *http://www.cms.hhs.gov/regulations/pra/*, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office on (410) 786–1326.

Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the CMS Paperwork Reduction Act Reports Clearance Officer designated at the address below: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Melissa Musotto, Room C5–14–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: December 3, 2004.

John P. Burke, III,

CMS Paperwork Reduction Act Reports Clearance Officer, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group.

[FR Doc. 04–27145 Filed 12–9–04; 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 Oklahoma State Plan Amendment (SPA) 03–26

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing on January 14, 2005, at 10 a.m., 1301 Young Street, Room 1113, Dallas, Texas 75202, to reconsider our decision to disapprove Oklahoma's Medicaid State Plan Amendment (SPA) 03–26.

DATES: Requests to participate in the hearing as a party must be received by the presiding officer by December 27, 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 CMS' decision to disapprove Oklahoma's Medicaid State Plan Amendment (SPA) 03–26.

Oklahoma submitted SPA 03–26 on January 2, 2004. This SPA would modify language regarding the rate-setting process for inpatient and outpatient hospital services. Specifically, this SPA would provide for supplemental payments to hospitals located in hospital districts pursuant to the Oklahoma Hospitals Public Trust and Authority Act.

The Centers for Medicare & Medicaid Services (CMS) was unable to approve SPA 03–26 because the SPA did not comply with sections 1902(a), 1902 (a)(19), 1903(w), and 1905(b) of the Social Security Act (the Act).

The payments proposed under SPA 03–26 would be funded through transfers from the Tulsa Hospital Public Trust Authority (THPTA) that CMS has determined are not consistent with the provisions of sections 1903(w)(1) and 1902(a) of the Act. Although the State has indicated that State law recognizes any such entity as a ''government entity * * * with powers of government,'' State law specifically withholds the governmental powers that are characteristic of a unit of government. THPTA is an association of hospitals (formed by the action of hospitals and with a board controlled by hospitals) that has no powers of taxation, or police or business regulation, and is not a sub-unit of the State government or any other local government that exercises such powers. While it has the power to impose assessments on member hospitals, the State has indicated that Oklahoma law specifically indicates that this power is not taxation. THPTA more closely resembles a private association that collects dues from its members. As a result, CMS has concluded that THPTA is not within the scope of a ''unit of government,'' and its assessments are not within the scope of ''state or local taxes'' as those terms are used under section 1903(w)(6) of the Act. Transfers of funds made by THPTA would thus not qualify for protected status under section 1903(w)(6)of the Act. Absent protected status, THPTA is within the definition of a provider-related entity under section 1903(w)(7) of the Act. As such, the transfers are subject to the provider-related donation requirements in section 1903(w)(l) of the Act and the implementing regulations in 42 CFR Part 433. Under those provisions, because payment of supplemental payments to member hospitals (the provider class) is contingent upon the receipt of donations from a provider-related entity, there is a hold harmless arrangement and the donation is not ''bona fide,'' as set forth in 42 CFR 433.54. Under section 1903(w)(l) of the Act, a donation that is not bona fide cannot be recognized as the non-Federal share of Medicaid expenditures that is required under section 1902(a) of the Act.

Nor is SPA 03–26 consistent with the requirement of section 1902(a)(19) of the Act 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 payment structure that is designed primarily to divert Medicaid payments from the providers to the State, and to shift financial burdens from the State to the Federal Government. The best interest of recipients requires that the full amount of Medicaid payments should be available to support access to quality care and services.

Finally, section 1905(b) of the Act specifies how the Federal medical assistance percentage (FMAP) will be calculated for states. This section clearly illustrates Congress' intentions as to how the financial partnership of the Medicaid program should operate. The formula in this cite clearly and explicitly states that the FMAP for any state shall be 100 per centum less the state percentage, and then further

defines how the state percentage is to be determined. Any creative funding mechanism that effectively increases the FMAP would undermine the clear direction of Congress. Since Oklahoma proposes to claim Federal matching funds for payments that are funded through impermissible donations, CMS must conclude that effective FMAP being paid to Oklahoma is not consistent with section 1905(b) of the Act, and that the funding of payments under Oklahoma's Attachments 4.19-A and 4.19-B of its Medicaid State plan does not uphold the basic Federal and state financial partnership.

For these reasons, and after consulting with the Secretary as required by 42 CFR 430.15, CMS disapproved this SPA.

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. 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 Oklahoma announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Mr. Jim Hancock,

Director, Health Policy Division, Oklahoma Health Care Authority, 4545 North Lincoln Blvd., Suite 124, Oklahoma City, OK 73105.

Dear Mr. Hancock: I am responding to your request for reconsideration of the decision to disapprove Oklahoma State Plan Amendment (SPA) 03–26, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on January 2, 2004, with a proposed effective date of January 19, 2004. This SPA would modify language regarding the rate-setting process for inpatient and outpatient hospital services. Specifically, this SPA would provide for supplemental payments to hospitals located in hospital districts pursuant to the Oklahoma Hospitals Public Trust and Authority Act. CMS reviewed this proposal, and for the reasons set forth below, was unable to approve SPA 03–26.

The CMS was unable to approve SPA 03–26 because the SPA did not comply with sections 1902(a), 1902(a)(19), 1903(w), and 1905(b) of the Social Security Act (the Act).

The payments proposed under SPA 03–26 would be funded through transfers from the Tulsa Hospital Public Trust Authority (THPTA) that CMS has determined are not consistent with the provisions of sections 1903(w)(1) and 1902(a) of the Act. Although the State has indicated that State law recognizes any such entity as a ''government entity * * * with powers of government,'' State law specifically withholds the governmental powers that are characteristic of a unit of government. THPTA is an association of hospitals (formed by the action of hospitals and with a board controlled by hospitals) that has no powers of taxation, or police or business regulation, and is not a sub-unit of the State government or any other local government that exercises such powers. While it has the power to impose assessments on member hospitals, the State has indicated that Oklahoma law specifically indicates that this power is not taxation. THPTA more closely resembles a private association that collects dues from its members.

As a result, CMS has concluded that THPTA is not within the scope of a ''unit of government,'' and its assessments are not within the scope of ''state or local taxes'' as those terms are used under section 1903(w)(6) of the Act. Transfers of funds made by THPTA would thus not qualify for protected status under section 1903(w)(6) of the Act. Absent protected status, THPTA is within the definition of a provider-related entity under section 1903(w)(7) of the Act. As such, the transfers are subject to the provider-related donation requirements in section 1903(w)(l) of the Act and the implementing regulations in 42 CFR Part 433.

Under those provisions, because payment of supplemental payments to member hospitals (the provider class) is contingent upon the receipt of donations from a provider-related entity, there is a hold harmless arrangement and the donation is not ''bona fide,'' as set forth in 42 CFR 433.54. Under section 1903(w)(l) of the Act, a donation that is not bona fide cannot be recognized as the non-Federal share of Medicaid expenditures that is required under section 1902(a) of the Act.

Nor is SPA 03–26 consistent with the requirement of section 1902(a)(19) of the Act 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 payment structure that is designed primarily to divert Medicaid payments from the providers to the State, and to shift financial burdens from the State to the Federal Government. The best interest of recipients requires that the full amount of Medicaid payments should be available to support access to quality care and services.

Finally, section 1905(b) of the Act specifies how the Federal medical assistance percentage (FMAP) will be calculated for states. This section clearly illustrates Congress' intentions as to how the financial partnership of the Medicaid program should operate. The formula in this cite clearly and explicitly states that the FMAP for any state shall be 100 per centum less the state percentage, and then further defines how the state percentage is to be determined. Any creative funding mechanism that effectively increases the FMAP would undermine the clear direction of Congress. Since Oklahoma proposes to claim Federal matching funds for payments that are funded through impermissible donations, CMS must conclude that effective FMAP being paid to Oklahoma is not consistent with section 1905(b) of the Act, and that the funding of payments under Oklahoma's Attachments 4.19-A and 4.19-B of its Medicaid State plan does not uphold the basic Federal and state financial partnership. For these reasons, and after consulting with the Secretary as required by 42 CFR 430.15, CMS disapproved this SPA.

I am scheduling a hearing to be held on January 14, 2005, at 10:00 a.m., 1301 Young Street, Room 714, Dallas, Texas 75202, to reconsider our decision to disapprove Oklahoma SPA 03–26. 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,

Mark B. McClellan, M.D., Ph.D.

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 3, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–27144 Filed 12–9–04; 8:45 am]

BILLING CODE 4120–03–P