PART 70—[AMENDED]

1. The authority citation for Part 70 continues to read a follows:

Authority: 42 U.S.C. 7401, *et seq.*

2. Appendix A to Part 70 is amended by adding paragraph (d) to the entry for Nebraska; City of Omaha; Lincoln-Lancaster County Health Department to read as follows.

Appendix A to Part 70—Approval Status of State and Local Operating Permits Program

* * * * *

Nebraska; City of Omaha; Lincoln-Lancaster County Health Department

* * * * *

(d) The Nebraska Department of Environmental Quality submitted the following program revisions on August 20, 1999; NDEQ Title 129, Chapters 1, 2, 5, 6, 7, 8, 10, 29, and 41; City of Omaha Ordinance No. 34492, amended section 41–2, and LLCHD Articles 2–1, 2–2, 2–5, 2–6, 2–7, 2–8, and 2–15, effective February 22, 2000.

* * * * *

[FR Doc. 00–618 Filed 1–19–00; 8:45 am]

BILLIING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 412

[HCFA–1124–IFC]

RIN 0938–AJ92

Medicare Program; Medicare Inpatient Disproportionate Share Hospital (DSH) Adjustment Calculation: Change in the Treatment of Certain Medicaid Patient Days in States With 1115 Expansion Waivers

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements a change to the Medicare DSH adjustment calculation policy in reference to section 1115 expansion waiver days. This rule sets forth the criteria to use in calculating the Medicare DSH adjustment for hospitals for purposes of payment under the prospective payment system.

DATES: *Effective date:* January 20, 2000.

Applicability Date: These regulations are applicable to discharges occurring on or after January 20, 2000.

Comment date: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on March 20, 2000.

ADDRESSES: Mail an original and 3 copies of written comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1124–IFC, P.O. Box 8010, Baltimore, MD 21244–8010.

If you prefer, you may deliver an original and 3 copies of your written comments to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room C5–16–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

FOR FURTHER INFORMATION CONTACT: Kathleen Buto, Deputy Director, Center for Health Plans and Providers, (202) 205–2505.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

The Medicare disproportionate share hospital (DSH) adjustment provision under section 1886(d)(5)(F) of the Social Security Act (the Act) was enacted by section 9105 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and became effective for discharges occurring on or after May 1, 1986, as set forth in the May 6, 1986 final rule with comment period (51 FR 16772).

The size of a hospital's Medicare DSH adjustment, which is applied to the hospital inpatient prospective payment system (PPS) payment, is based on the sum of the percentage of patient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of patient days attributable to patients eligible for Medicaid but not Medicare Part A. The first computation includes days for patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding State supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A. (See 42 CFR 412.106(b)(4).) This number is divided by the total number of patient days for that same period.

Currently, hospitals whose disproportionate patient percentage exceeds a certain threshold (which varies for urban and rural areas) receive either a fixed adjustment or, in the case of large urban hospitals (100 or more beds) or large rural hospitals (500 or more beds), a variable adjustment based on a statutory formula. As of April 1, 1990, variable adjustments were made for large urban hospitals and rural referral centers. Facilities that qualify as rural referral centers as well as sole community hospitals receive the greater of a fixed adjustment or a variable adjustment based on a statutory formula. Qualifying large rural hospitals and sole community hospitals receive a fixed adjustment. Urban hospitals with 100 or more beds that receive funds from State and local governments for indigent care in excess of 30 percent of net inpatient revenues are treated separately (42 CFR 412.106(c)).

B. Section 1115 Expansion Waivers

Some States provide medical assistance under a demonstration project (also referred to as a section 1115 waiver). In some section 1115 waivers, a given population that otherwise could have been made eligible for Medicaid under section 1902(r)(2) or 1931(b) in a State plan amendment is made eligible under the waiver. These populations are referred to as hypothetical eligibles, and are specific, finite populations identifiable in the budget neutrality agreements found in the Special Terms and Conditions for the demonstrations; the patient days utilized by that population are to be recognized for purposes of calculating the Medicare DSH adjustment. In addition, the section 1115 waiver may provide for medical assistance to expanded eligibility populations that could not otherwise be made eligible for Medicaid.

Under current policy, hospitals were to include in the Medicare DSH calculation only those days for populations under the section 1115 waiver who were or could have been made eligible under a State plan. Patient days of the expanded eligibility groups, however, were not to be included in the Medicare DSH calculation.

II. Provisions of the Interim Final Rule With Comment Period

In this interim final rule with comment period, we are revising the policy, effective with discharges occurring on or after January 20, 2000, to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's

section 1115 waiver in calculating the hospital's Medicare DSH adjustment.

One purpose of a section 1115 expansion waiver is to extend Title XIX matching payments to services furnished to populations that otherwise could not have been made eligible for Medicaid. The costs associated with these populations are matched based on section 1115 authority. In fact, section 1115(a)(2)(A) of the Act states that the ''costs of such project which would not otherwise be included as expenditures under section * * * 1903 * * * shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures * * * approved under (Title XIX).'' Thus, the statute allows for the expansion populations to be treated as Medicaid beneficiaries.

In addition, at the time that the Congress enacted the Medicare DSH adjustment, there were no approved section 1115 expansion waivers. Nonetheless, we believe allowing hospitals to include the section 1115 expanded waiver population in the Medicare DSH calculation is fully consistent with the Congressional goals of the Medicare DSH adjustment to recognize the higher costs to hospitals of treating low income individuals covered under Medicaid. Therefore, inpatient hospital days for these individuals eligible for Title XIX matching payments under a section 1115 waiver are to be included as Medicaid days for purposes of the Medicare DSH adjustment calculation.

In order to provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid as described in this rule cannot be counted.

III. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, 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.

IV. Waiver of Proposed Rulemaking and 30-Day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We find that it would be contrary to the public interest to undertake prior notice and comment procedures before implementing this interim final rule with comment period. States that have approved section 1115 waivers are continually involved in critical efforts to implement, refine, and operate their Medicaid programs. For example, the States, managed care organizations, and hospitals are always considering their financial positions and the adequacy of rates paid between these critical partners. We believe this policy change impacts their financial positions. Therefore, we believe the extended period of uncertainty for hospitals and others that would result if this policy change were to go through proposed and final rulemaking could adversely affect the course of these critical efforts and thereby disrupt services to Medicaid beneficiaries and other low-income patients who are served by hospitals, especially safety net hospitals.

Moreover, because our prior guidance on certain aspects of our Medicare DSH policy was insufficiently clear, many hospitals in States with approved section 1115 expansion waivers have been receiving Medicare DSH payments reflecting the inclusion of expansion population patient days. But for an immediate effective date of this rule, these Medicare DSH payments will cease until completion of the notice and comment rulemaking process, and, as a result, many of these hospitals may experience financial difficulties that may adversely affect access to services by the low-income patients served by these safety net hospitals.

Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis. We are providing a 60-day comment period for public comment.

Also, we normally provide a delay of 30 days in the effective date of a regulation. However, if adherence to this procedure would be impracticable, unnecessary, or contrary to the public interest, we may waive the delay in the effective date. For the reasons discussed above, it is important that the provisions of this final rule with comment period have immediate effect in order to avoid a potential hardship for hospitals and a potential disruption of services for their patients.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 412.106(b)(4) (ii) and (iii) contain information collection requirements that are subject to the PRA. The requirements are as follows:

In paragraph (b)(4)(ii), effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

In paragraph (b)(4)(iii), the hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under paragraph (b)(4) and of verifying with the State that a patient was eligible for Medicaid during each claimed Medicaid day. We solicit comments on the burden

associated with these requirements. Based upon the burden estimates received from the public, HCFA will add these new requirements and associated burden to the existing information collections entitled; ''Medicaid Disproportionate Share Adjustment Procedure and Criteria'' (OMB #0938–0691, HCFA–R–194, current expiration date 9/30/2002; and/or ''Medicaid Disproportionate Share Hospital Payments—Institutions for Mental Disease'' (OMB #0938–0746, HCFA–R–0266, current expiration date 6/30/2002.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Attn: Julie Brown, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

VI. Regulatory Impact Analysis

A. Introduction

Section 804(2) of title 5, United States Code (as added by section 251 of Public Law 104–121), specifies that a ''major rule'' is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of $100 million or more.
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States based enterprises to compete with foreign based enterprises in domestic and export markets.

We estimate that the impact of this interim final rule with comment period will exceed $100 million. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2).

We have examined the impacts of this interim final rule with comment period as required by Executive Order 12866, the Regulatory Flexibility Act (RFA) (Public Law 96–354), and the Unfunded Mandates Reform Act of 1995 (Public Law 104–4). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, non-profit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by non-profit status or by having revenues of $5 million or less annually. Individuals and States are not included in the definition of a small entity.

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes being made in this rule would affect a number of hospitals, and the effects on some may be significant. Therefore, the discussion below constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation). We have concluded that this rule does not impose any mandates on State, local, or tribal governments, or the private sector that will result in an annual expenditure of $100 million or more.

B. Impact of This Interim Final Rule With Comment Period

There are currently eight States with section 1115 expansion waivers (Delaware, Hawaii, Massachusetts, Missouri, New York, Oregon, Tennessee, and Vermont). Under this interim final rule with comment period, hospitals in these eight States would be allowed to include in the Medicaid percentage portion of their Medicare DSH calculation the inpatient hospital days attributable to patients who are eligible under the State's section 1115 expansion waiver. Because our policy was that these days were not allowable prior to the effective date of this interim final rule with comment period, by allowing hospitals to begin to include these days in their Medicare DSH calculation the impact will be to increase the DSH payments these hospitals will receive compared to what they would receive absent this change.

Based on data available for the numbers of individuals covered by the expansion waiver in each of the eight States compared to the total number of individuals covered by Medicaid in each State (adjusted for utilization), we have estimated the impact of this change to be $270 million in higher FY 2000 PPS payments, (total FY 2000 DSH payments are projected to be $4.6 billion), and $370 million in FY 2001 payments. Thus the total impact of this change for the period from FY 2001 through FY 2005 is estimated to be $2.14 billion.

In accordance with the provisions of Executive Order 12866, this interim final rule with comment period was reviewed by the Office of Management and Budget.

VII. Federalism

We have reviewed this interim final rule with comment period under the threshold criteria of Executive Order 13132, Federalism. In considering this policy change, we have evaluated any potential Federalism impacts. States are already responsible as needed for providing information to hospitals and fiscal agents under current regulations. In addition, there are existing requirements for maintaining and reporting these data under the Terms and Conditions of their section 1115 demonstration agreement. Therefore, States already possess the information necessary to implement this change, and no new standards or requirements are

established as a result of this change. Indeed there may be a reduction in State responsibilities since section 1115 demonstration populations will no longer have to be treated differently from other Medicaid eligibles.

In order to assist the States in making this information available to the Medicare fiscal intermediaries so they can accurately count days related to patients eligible under an 1115 waiver, we are issuing clarifying instructions to the States specifying exactly what data are to be included in the Medicare DSH calculation, and the States' role in providing this information. In addition, we are in ongoing contact with States that have waivers in order to assist and monitor the development and implementation of their waivers.

We believe this regulation meets Federalism requirements as it does not increase the burden on States and is responsive to requests from hospitals who partner with States in providing health services to needy populations.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For reasons set forth in the preamble, 42 CFR chapter IV, part 412 is amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 412.106, republish the headings of paragraphs (b) and (b)(4), redesignate paragraph (b)(4)(ii) as paragraph (b)(4)(iii), and add a new paragraph (b)(4)(ii) to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(b) Determination of a hospital's disproportionate patient percentage. * * *

(4) Second computation. * * *

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: December 22, 1999.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Approved: December 22, 1999.

Donna E. Shalala,

Secretary.

[FR Doc. 00–1357 Filed 1–14–00; 3:09 pm]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 27

[CC Docket No. 99–168; FCC 00–5]

Service Rules for the 746–764 and 776–794 MHz Bands

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document establishes service rules governing the initial assignment of licenses, by competitive bidding, and the subsequent regulatory treatment of commercial services to be provided on the 746–764 and 776–794 MHz Bands. The service rules adopted in this document enable assignment of these bands to licensees by competitive bidding, scheduled to commence in early May in order to comply with the statutory requirement that revenues from the auction of the commercial spectrum segments be received in the U.S. Treasury by September 30, 2000.

DATES: This rule is effective January 20, 2000.

FOR FURTHER INFORMATION CONTACT: Legal Information: Stan Wiggins, 202–418–1310; Technical Information: Martin Liebman, 202–418–1310.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's First Report and Order (First R&O) in WT Docket No. 99–168, FCC 00–5, adopted January 6, 2000, and released January 7, 2000. The complete text of this First R&O is available for inspection and copying during normal business hours in the FCC Reference Information Center, Courtyard Level, 445 12th Street, S.W., Washington, DC, and also may be purchased from the Commission's copy contractor, International Transcription Services (ITS, Inc.), CY–B400, 445 12th Street, S.W., Washington, DC. The informal text of the First R&O is posted on the Commission's Internet web site, at *www.fcc.gov/Bureaus/Wireless/Orders/2000/fcc00005.txt.*

Synopsis of the First Report and Order

1. The Commission adopts a First Report and Order (First R&O) in WT Docket No. 99–168, establishing service and auction rules for the commercial licensing of 36 megahertz of spectrum, the 746–764 and 776–794 Bands, as directed by Congress in the Balanced Budget Act of 1997. The subsequent legislation, referred to as the Consolidated Appropriations enactment directs the Commission to assign these licenses by competitive bidding, and to deposit revenues from those assignments in the U.S. Treasury no later than September 30, 2000. The assignment of this spectrum to commercial licensees has the potential to expand existing wireless services, both fixed and mobile, and to introduce both new technologies and new services.

2. The First R&O divides these Bands into several sub-bands, as subsequently described in the ''band plan'' and these decisions reflect broad spectrum management considerations. The First R&O also determines the more specific service rule and auction rule issues raised with respect to the sub-bands occupying 30 of the 36 megahertz, while it defers to a subsequent R&O the comparably specific issues raised with respect to the remaining 6 megahertz, which are designated as Guard Bands and occupy spectrum adjacent to frequencies previously allocated for public safety use. Those issues are the subject of a Public Notice issued January 7, 2000, which seeks additional comment on technical and operational issues. See Public Comment Sought On Issues Related To Guard Bands In The 746–764 MHz and 776–794 MHz Spectrum Block (WT Docket No. 99–168), Public Notice (January 7, 2000). A future R&O will also adopt revisions to Form 601.

3. These spectrum Bands occupy frequencies formerly reserved for analog UHF television service, and new licenses assigned by auction on these Bands will be required to protect existing UHF television services from harmful interference. This obligation to protect existing UHF television services will continue until the termination of analog television service, as part of the scheduled transition to digital television (DTV) service. Analog television licenses may not be renewed beyond December 31, 2006, unless the Commission determines that an extension is authorized. *See* 47 U.S.C. 309(j)(14)(B).