Oklahoma, and thereby indirectly acquire 1st Bank Oklahoma, Claremore, Oklahoma, and thereby engage in operating a savings association, pursuant to § 225.28(b)(4)(ii) of Regulation Y.

In addition, Applicant also has applied to engage *de novo* through First Trust Company of Onaga, Onaga, Oklahoma, in trust company functions, pursuant to § 225.28(b)(5) of Regulation Y.

Comments on this application must be received by September 6, 2002.

Board of Governors of the Federal Reserve System, August 19, 2002.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 02–21551 Filed 8–22–02; 8:45 am]

BILLING CODE 6210–01–U

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies; Correction

This notice corrects a notice (FR Doc. 02-20398) published on pages 52722 and 52723 of the issue for Tuesday, August 13, 2002.

Under the Federal Reserve Bank of Kansas City heading, the entry for Morrill Bancshares, Inc., Sabetha, Kansas, is revised to read as follows:

A. Federal Reserve Bank of Kansas City (Susan Zubradt, Assistant Vice President) 925 Grand Avenue, Kansas City, Missouri 64198–0001:

1. Morrill Bancshares, Inc., Sabetha, Kansas; to acquire and merge with Morrill & Janes Bancshares, Inc., Hiawatha, Kansas, Onaga Bancshares Inc., Merriam, Kansas; and thereby acquire shares of Morrill & Janes Bank & Trust Co., Hiawatha, Kansas; The First National Bank of Onaga, Onaga, Oklahoma; Century Capital Financial, Inc., Kilgore, Texas; Century Capital Financial - Delaware, Inc., Wilmington, Delaware; and City National Bank, Kilgore, Texas.

In connection with this application, Applicant also has applied to acquire FBC Financial Corporation, Claremore, Oklahoma, and thereby indirectly acquire 1st Bank Oklahoma, Claremore, Oklahoma, and thereby engage in operating a savings association, pursuant to § 225.28(b)(4)(ii) of Regulation Y.

In addition, Applicant also has applied to engage *de novo* through First Trust Company of Onaga, Onaga, Oklahoma, in trust company functions, pursuant to § 225.28(b)(5) of Regulation Y.

Comments on this application must be received by September 6, 2002.

Board of Governors of the Federal Reserve System, August 19, 2002.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 02–21552 Filed 8–22–02; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2140–FN]

RIN 0938–ZA13

Medicare and Medicaid Programs; Approval of Deeming Authority for Critical Access Hospitals by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

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

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve the Joint Commission on Accreditation of Healthcare Organization's (JCAHO's) application as a national accrediting organization for critical access hospitals (CAHs) seeking to participate in the Medicare program. Following our evaluation of the organizational and programmatic capabilities of JCAHO, we have determined that JCAHO standards for CAHs meet or exceed the Medicare conditions of participation. Therefore, CAHs accredited by JCAHO will be granted deemed status under the Medicare program.

EFFECTIVE DATE: This final notice is effective November 21, 2002 through November 21, 2008.

FOR FURTHER INFORMATION CONTACT: Cindy Melanson, (410) 786–0310.

SUPPLEMENTARY INFORMATION:

I. Background

Statutory Provisions and Regulations

Under the Medicare program, eligible beneficiaries may receive covered services in a critical access hospital (CAH), provided that the hospital meets certain requirements. Sections 1820(c)(2)(B) and 1820(e) of the Social Security Act (the Act) establish distinct criteria for facilities seeking CAH designation. Under this authority, the Secretary has set forth in regulations minimum requirements that a CAH must meet to participate in Medicare. The regulations at 42 CFR part 485, subpart F (Conditions of Participation: Critical Access Hospitals (CAHs)) determine the basis and scope of CAH-covered services. Conditions for Medicare payment for critical access services can be found at § 413.70. Applicable regulations concerning provider agreements are at 42 CFR part 489 (Provider Agreements and Supplier Approval) and those pertaining to facility survey and certification are at 42 CFR part 488, subparts A and B.

Verifying Medicare Conditions of Participation

In general, we approve a CAH for participation in the Medicare program, if it is participating as a hospital at the time it applies for CAH designation, and is in compliance with parts 482 (Conditions of Participation for Hospitals), and 485, subpart F (Conditions of Participation: Critical Access Hospitals (CAHs)). Section 403 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 expanded this criterion to allow a limited number of additional entities to become eligible for CAH designation under certain circumstances. Specifically, a rural health clinic previously downsized from an acute care hospital, or a closed hospital that requests to reopen as a CAH, need only meet the provisions of 42 CFR part 485, subpart F (at the time they apply for CAH designation) to be eligible to participate in Medicare.

For a CAH to enter into a provider agreement, a State survey agency must certify that the CAH is in compliance with the conditions or standards set forth in the statute and part 485 subpart F of our regulations. Then, the CAH is subject to ongoing review by a State survey agency to determine whether it continues meeting Medicare requirements. There is, however, an alternative to State compliance surveys. Certification by a nationally recognized accreditation program can substitute for ongoing State review.

Section 1865(b)(1) of the Act provides that, if a provider is accredited by a national accreditation body under standards that meet or exceed the Medicare conditions of participation, the Secretary can ''deem'' the provider as having met the Medicare requirements for those conditions. Accreditation is voluntary and not required for participation in Medicare; providers have the option to undergo State surveys or pursue accreditation. The American Osteopathic Association (AOA) is currently the only CMS-approved national accreditation organization for CAHs.

II. Deeming Application Approval Process

Section 1865(b)(3)(A) of the Act provides a statutory timetable to ensure that our review of deeming applications is conducted in a timely manner. The Act provides us with 210 calendar days to complete our survey activities and application review process. Within 60 days of receiving a completed application, we must publish a notice in the **Federal Register** that identifies the national accreditation body making the request, describes the nature of the request, and provides no less than a 30-day public comment period.

III. Proposed Notice

On March 22, 2002, we published a proposed notice at 67 FR 13344 announcing the JCAHO's request for approval as a deeming organization for CAHs. In the notice, we detailed our evaluation criteria. Under section 1865(b)(2) of the Act and § 488.4, we conducted a review of the JCAHO application in accordance with the criteria specified by our regulation, which includes, but is not limited to the following:

- An onsite administrative review of JCAHO's (1) corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its surveyors; (4) ability to investigate and respond appropriately to complaints against accredited facilities; and (5) survey review and decision-making process for accreditation.
- A comparison of JCAHO's CAH accreditation standards to our current Medicare CAH conditions of participation standards.
- A documentation review of JCAHO's survey processes to do the following:
- Determine the composition of the survey team, surveyor qualifications, and the ability of JCAHO to provide continuing surveyor training.
- Compare JCAHO's processes to those of State survey agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.
- Evaluate JCAHO's procedures for monitoring providers or suppliers found to be out of compliance with JCAHO program requirements. The monitoring procedures are used only when the JCAHO identifies noncompliance. If noncompliance is identified through validation reviews, the survey agency monitors corrections as specified at § 488.7(b)(2).
- Assess JCAHO's ability to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.
- Establish JCAHO's ability to provide us with electronic data in ASCII-comparable code and reports necessary for effective validation and assessment of JCAHO's survey process.
- Determine the adequacy of staff and other resources.
- Review JCAHO's ability to provide adequate funding for performing required surveys.
- Confirm JCAHO's policies with respect to whether surveys are announced or unannounced.
- Obtain JCAHO's agreement to provide us with a copy of the most current accreditation survey together with any other information related to the survey as we may require, including corrective action plans.

In accordance with section 1865(b)(3)(A) of the Act, the proposed notice also solicited public comments regarding whether JCAHO's requirements met or exceeded the Medicare conditions of participation for CAHs. We received no public comments in response to our proposed notice.

IV. Provisions of the Final Notice

A. Differences Between JCAHO and Medicare's Conditions and Survey Requirements

We compared the standards contained in the JCAHO's ''Critical Access Hospital (CAH) Manual'' and its survey process in the ''Critical Access Hospital Surveyor Handbook'' with the Medicare CAH conditions of participation and CMS's ''State and Regional Operations Manual.'' Our review and evaluation of JCAHO's deeming application, which were conducted as described in section III of this notice yielded the following:

- JCAHO provided an updated crosswalk (a table showing the match between their standards and our standards) of recommended revisions or clarifications to its requirements to ensure that the requirements meet or exceed CMS requirements.
- JCAHO adjusted language to consistently refer to CAHs as opposed to hospitals.
- JCAHO modified and adjusted its standards for CAHs to more clearly document the JCAHO standard and intent statement. The reformatted version presents the standards in their entirety and facilitates a comparison to the Medicare COPs.
- JCAHO added language to each chapter of the CAH Manual stating, ''Critical Access Hospitals going through a deemed status survey are expected to meet the standards and the full intent of the standards.'' This added language eliminates CMS's concern about JCAHO's intent statements not carrying the same weight as the Medicare standards.
- JCAHO modified its standard and intent statement to include a list of drugs and biologicals commonly used in life-saving procedures in order to meet the requirements of § 485.618.
- In order to meet the requirements of § 485.639, JCAHO added to its standard and intent statement the language that surgery can only be performed by: (1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; (2) a doctor of dental surgery or dental medicine; or (3) a doctor of podiatric medicine.
- JCAHO standards previously indicated resurvey of a CAH every 3 years. JCAHO modified its standards to indicate in the resurvey requirements that a 1-year-follow-up visit after the initial accreditation survey is required. After the 1-year-follow-up, CAHs will be resurveyed every 3 years.
- JCAHO provided a list of currently accredited facilities and schedule of surveys to be performed to meet the requirements of § 488.4(a)(9) and (10).
- JCAHO addressed our regulations at § 485.623 and specifically, § 485.623(d)(1), by recognizing that assessing compliance with the life safety code (LSC) is a JCAHO responsibility. The LSC, published on an ongoing basis by the National Fire Prevention Association, contains building and construction standards designed to promote fire-safe structures. In addition to the JCAHO requirement that the CAH complete a Statement of Conditions (SOC), which allows the CAH to report any known deficiencies in the physical plant, a JCAHO trained surveyor also surveys the CAH using the JCAHO environment-of-care standards. During the JCAHO survey process, a surveyor will conduct a building tour, including above-the-ceiling inspections, and will validate what the organization has reported on its SOC. As a result of the inspection, JCAHO findings may be cited as requirements for improvement and may impact the score and survey outcome. JCAHO requires that all findings on the SOC be remediated in the same manner as those found independently by JCAHO surveyors. The CMS Financial Report to Congress, published in 2002, includes a report on ''Medicare's Validation Program for Hospitals Accredited by the JCAHO''. This report showed a large discrepancy between the LSC survey findings made by the State survey agencies and JCAHO surveys. JCAHO regularly failed to identify LSC deficiencies. We expect

that the current JCAHO LSC survey process will be reviewed when CMS adopts the 2000 edition of the LSC, which was published as a proposed rule on October 26, 2001 (66 FR 54178). The final rule is under development. Insofar as there may be differences between state survey standards and JCAHO standards based on the 2000 LSC, we want to provide both JCAHO and the states with an opportunity to bring their procedures into alignment with the new LSC. If, after reviewing JCAHO's performance under such standards, significant discrepancies continue to occur, we will address the matter at that time.

B. Term of Approval

Based on the review and observations described in section III of this final notice, we have determined that JCAHO's requirements for CAHs meet or exceed our requirements. Therefore, we recognize the JCAHO as a national accreditation organization for CAHs that request participation in the Medicare program, effective November 21, 2002 through November 21, 2008.

V. Collection of Information Requirements

This final notice does not impose any information collection and recordkeeping requirements subject to the Paperwork Reduction Act (PRA). Consequently, it does not need to be reviewed by the Office of Management and Budget (OMB) under the authority of the PRA. The requirements associated with granting and withdrawal of deeming authority to national accreditation organizations, codified in 42 CFR part 488, (Survey, Certification, and Enforcement Procedures) are currently approved by OMB under OMB approval number 0938–0690, with an expiration date of September 30, 2002.

VI. Regulatory Impact Statement

We have examined the impact of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (Pub. L. 98–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

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 for small businesses. For purposes of the RFA, States and individuals are not considered small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any notice 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. For purposes of section 1102(b) of the Act, we consider a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

This final notice recognizes JCAHO as a national accreditation organization for CAHs that request participation in the Medicare program. There are neither significant costs nor savings for the program and administrative budgets of Medicare. Therefore, this notice is not a major rule as defined in Title 5, United States Code, section 804(2) and is not an economically significant rule under Executive Order 12866. We have determined, and the Secretary certifies, that this notice will not result in a significant impact on a substantial number of small entities and will not have a significant effect on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing analyses for either the RFA or section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice will not result in an impact of $110 million on the governments mentioned or on the private sector.

In an effort to better assure the health, safety, and services of beneficiaries in CAHs already certified as well as provide relief to State budgets in this time of tight fiscal restraints, we deem CAHs accredited by JCAHO as meeting our Medicare requirements. Thus, we continue our focus on assuring the health and safety of services by providers and suppliers already certified for participation in a cost-effective manner.

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by the Office of Management and Budget. In accordance with Executive Order 13132, we have determined that this notice will not significantly affect the rights of States, local or tribal governments.

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb).

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplemental Medical Insurance Program).

Dated: August 16, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–21372 Filed 8–22–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3098–N]

Medicare Program; Meeting of the Executive Committee of the Medicare Coverage Advisory Committee—September 25, 2002

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a public meeting of the Executive Committee (the Committee) of the Medicare Coverage Advisory Committee (MCAC). The Committee provides advice and recommendations to us about clinical issues. The Committee will act upon recommendations from the Medical and Surgical Procedures Panel of the MCAC regarding the use of deep brain stimulation for the treatment of Parkinson's disease. The Committee will also discuss approaches to assessing clinical evidence in diagnosis and treatment of rare diseases.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. App. 2, section 10(a)(1) and (a)(2)).

DATES: *The Meeting:* September 25, 2002 from 8 a.m. until 4:30 p.m., E.D.T.

Deadline for Presentations and Comments: September 12, 2002, 5 p.m., E.D.T.

Special Accommodations: Persons attending the meeting who are hearing or visually impaired, or have a condition that requires special assistance or accommodations, are asked to notify the Executive Secretary by September 4, 2002 (see **FOR FURTHER INFORMATION CONTACT**).

ADDRESSES:

The Meeting: The meeting will be held at the Baltimore Convention Center, Room 321–322, One West Pratt Street, Baltimore, MD 21201.

Presentations and Comments: Submit formal presentations and written