special interest in ensuring that women, minority groups, and physically challenged individuals are adequately represented on the MCAC. Therefore, we encourage nominations of qualified candidates from these groups.

All nominations must be accompanied by curricula vitae. Nomination packages must be sent to Michelle Atkinson at the address listed in the **ADDRESSES** section.

Criteria for Members

Nominees for voting membership must have expertise and experience in one or more of the following fields: clinical medicine of all specialties, administrative medicine, public health, patient advocacy, epidemiology and biostatistics, methodology of trial design, biologic and physical sciences, health care data and information management and analysis, the economics of health care, medical ethics, and other related professions.

We are also seeking nominations for nonvoting consumer and industry representatives. Nominees for these positions must possess appropriate qualifications to understand and contribute to the MCAC's work.

The nomination letter must include a statement that the nominee is willing to serve as a member of the MCAC and appears to have no conflict of interest that would preclude membership. We are requesting that all curricula vitae include the following: Date of birth, place of birth, social security number, title and current position, professional affiliation, home and business address, telephone and fax numbers, e-mail address, and list of areas of expertise. In the nominations letter, we are requesting that the nominee specify whether applying for voting member, Industry Representative, or Consumer Representative. Potential candidates will be asked to provide detailed information concerning such matters as financial holdings, consultancies, and research grants or contracts in order to permit evaluation of possible sources of conflict of interest.

Members are invited to serve for overlapping 4-year terms. A member may serve after the expiration of the member's term until a successor takes office. Any interested person may nominate one or more qualified persons. Self-nominations are also accepted.

Authority: 5 U.S.C. App. 2, section 10(a)(1) and (a)(2).

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

Dated: September 14, 2004.

Sean R. Tunis,

Director, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services.

[FR Doc. 04–21200 Filed 9–23–04; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2204–PN]

RIN 0938–ZA61

Medicare and Medicaid Programs; Application by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for Home Health Agencies

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of an application from the Joint Commission on Accreditation of Healthcare Organizations for continued recognition as a national accreditation program for Home Health Agencies that wish to participate in the Medicare or Medicaid programs. The statute requires that within 60 days of receipt of an organization's complete application, we will publish a notice that will announce our receipt of the accreditation organization's application for approval, describe the criteria we will use in evaluating the application, and provide at least a 30-day public comment period.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 25, 2004.

ADDRESSES: In commenting, please refer to file code CMS–2204–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2204–PN, P.O. Box 8017, Baltimore, MD 21244–8017.

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

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

SUPPLEMENTARY INFORMATION:

I. Background

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

Under the Medicare program, eligible beneficiaries may receive covered services in a Home Health Agency (HHA) provided certain requirements are met. Sections 1861(o) and 1891 of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as an HHA. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at 42 CFR 484 specify the conditions that an HHA must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for Home Health care.

Generally, to enter into an agreement, an HHA must first be certified by a State survey agency as complying with the conditions or requirements set forth in

part 484 of our regulations. Then, the HHA is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(b)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accreditation organization that all applicable Medicare conditions are met or exceeded, we would ''deem'' those provider entities as having met the requirements. Accreditation by an accreditation organization is voluntary and is not required for Medicare participation.

If an accreditation organization is recognized by the Secretary as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accreditation organization applying for approval of deeming authority under part 488, subpart A must provide us with reasonable assurance that the accreditation organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning reapproval of accrediting organizations are set forth at § 488.4 and § 488.8(d)(3). The regulations at § 488.8(d)(3) require accreditation organizations to reapply for continued approval of deeming authority every 6 years or sooner as determined by CMS. The JCAHO's term of approval as a recognized accreditation program for HHAs expires March 31, 2005.

II. Approval of Deeming Organizations

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

Section 1865(b)(2) of the Act and our regulations at § 488.8(a) require that our findings concerning review and reapproval of a national accrediting organization's requirements consider, among other factors, the reapplying accreditation organization's: Requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide us with the necessary data for validation.

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

The purpose of this proposed notice is to inform the public of our consideration of JCAHO's request for approval of continued deeming authority for HHAs. This notice also solicits public comment on the ability of JCAHO requirements to meet or exceed the Medicare conditions for participation for HHAs.

III. Evaluation of Deeming Authority Request

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

On June 30, 2004, JCAHO submitted all the necessary materials to enable us to make a determination concerning its request for reapproval as a deeming organization for HHAs. Under section 1865(b)(2) of the Act and our regulations at § 488.8 (Federal review of accreditation organizations), our review and evaluation of JCAHO will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of JCAHO standards for an HHA as compared with our comparable HHA conditions of participation.
- JCAHO's survey process to determine the following:

+ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

+ The comparability of JCAHO processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

+ JCAHO's processes and procedures for monitoring providers or suppliers found out of compliance with JCAHO program requirements. These monitoring procedures are used only when JCAHO identifies noncompliance. If noncompliance is identified through validation reviews, the survey agency monitors corrections as specified at § 488.7(d).

+ JCAHO's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

+ JACAHO's capacity to provide us with electronic data in ASCII comparable code, and reports necessary for effective validation and assessment of the organization's survey process.

+ The adequacy of JCAHO's staff and other resources, and its financial viability.

+ JCAHO's capacity to adequately fund required surveys.

+ JCAHO's policies with respect to whether surveys are announced or unannounced.

+ 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).

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Upon completion of our evaluation, including evaluation of comments received as a result of this notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation.

V. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866, this proposed notice was not reviewed by the Office of Management and Budget.

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)

Dated: September 10, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–21193 Filed 9–23–04; 8:45 am]

BILLING CODE 4120–01–P