''directory assistance services to allow the other carrier's customers to obtain telephone numbers'' and ''operator call completion services,'' respectively. Additionally, section 251(b)(3) of the 1996 Act imposes on each LEC ''the duty to permit all [competing providers of telephone exchange service and telephone toll service] to have nondiscriminatory access to * * * operator services, directory assistance, and directory listing, with no unreasonable dialing delays.'' Based on the Commission's review of the record it concludes that Michigan Bell offers nondiscriminatory access to its directory assistance services and operator services (OS/DA).

Other Checklist Items

10. *Checklist Item 1—Interconnection.* Based on its review of the record, the Commission concludes that Michigan Bell provides interconnection in accordance with the requirements of section 251(c)(2) and as specified in section 271 and prior Commission orders. In reaching this conclusion, the Commission examined Michigan Bell's performance with respect to collocation and interconnection trunks, as the Commission has done in prior section 271 proceedings.

11. *Checklist Item 10—Databases and Signaling.* Section 271(c)(2)(B)(x) of the 1996 Act requires a BOC to provide nondiscriminatory access to databases and associated signaling necessary for call routing and completion. Based on the evidence in the record, the Commission finds that Michigan Bell provides nondiscriminatory access to databases and signaling networks in the state of Michigan.

12. *Checklist Item 13—Reciprocal Compensation.* Section 271(c)(2)(B)(xiii) of the Act requires BOCs to enter into ''[r]eciprocal compensation arrangements in accordance with the requirements of section 252(d)(2).'' In turn, section 252(d)(2)(A) specifies the conditions necessary for a state commission to find that the terms and conditions for reciprocal compensation are just and reasonable. The Commission finds that commenters' allegations regarding Michigan Bell's reciprocal compensation policies and rate structure in Michigan do not cause Michigan Bell to fail this checklist item or the public interest standard. In addition, the Commission waives its complete-as-filed requirement on its own motion pursuant to section 1.3 of the Commission's rules to the limited extent necessary to consider Michigan Bell's revised reciprocal compensation rates. The Commission's ''complete-as-filed'' requirement provides that when an applicant files new information after the comment date, the Commission reserves the right to start the 90-day review period again or to accord such information no weight in determining section 271 compliance. In its application filed on June 19, 2003, Michigan Bell explained that it had elected to invoke the rate structure set out in the Commission's *ISP Remand Order,* and the rate structure change would be effective in Michigan on July 6, 2003–after comments were filed on Michigan Bell's application. The Commission finds that a waiver is appropriate because Michigan Bell changed its rate structure for reciprocal compensation for ISP–bound traffic to the rate caps set forth in the Commission's *ISP Remand Order,* not as part of a strategy to win approval of its application.

13. *Remaining Checklist Items (3, 5, 6, 8, 9, 11, 12 and 14).* Based on the evidence in the record, the Commission concludes that Michigan Bell demonstrates that it is in compliance with checklist item 3 (access to poles, ducts, and conduits), item 5 (unbundled transport), item 6 (unbundled switching), item 8 (white pages), item 9 (numbering administration), item 11 (number portability), item 12 (dialing parity), and item 14 (resale).

14. *Section 272 Compliance.* Based on the record, the Commission concludes that Michigan Bell has demonstrated that it will comply with the requirements of section 272. Significantly, Michigan Bell provides evidence that it maintains the same structural separation and nondiscrimination safeguards in Michigan as it does in Texas, Kansas, Oklahoma, Missouri, Arkansas, and California—states for which SBC has already received section 271 authority.

15. *Public Interest Analysis.* The Commission concludes that approval of this application is consistent with the public interest. From its extensive review of the competitive checklist, which embodies the critical elements of market entry under the Act, the Commission finds that barriers to competitive entry in the local exchange markets have been removed and the local exchange markets in Michigan today are open to competition. The Commission further finds that the record confirms its view, as set forth in prior section 271 orders, that BOC entry into the long distance market will benefit consumers and competition if the relevant local exchange market is open to competition consistent with the competitive checklist.

16. *Section 271(d)(6) Enforcement Authority.* Working with the Michigan Commission, the Commission intends to closely monitor Michigan Bell's post-approval compliance to ensure that it continues to meet the conditions required for section 271 approval. The Commission stands ready to exercise its various statutory enforcement powers quickly and decisively in appropriate circumstances to ensure that the local market remains open in Michigan.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

[FR Doc. 03–24446 Filed 9–25–03; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–2182–FN]

Medicare and Medicaid Programs; Reapproval of the Community Health Accreditation Program (CHAP) for Deeming Authority for Hospices

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Final notice.

SUMMARY: This notice announces the reapproval of the Community Health Accreditation Program (CHAP) as a national accreditation program for hospices that request participation in the Medicare or Medicaid programs.

EFFECTIVE DATE: This final notice is effective November 21, 2003 through November 21, 2009.

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

SUPPLEMENTARY INFORMATION

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a hospice, provided certain requirements are met. Section 1861(dd) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a hospice provider. The regulations at 42 CFR part 418 specify the conditions that a hospice must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for hospice care. Regulations concerning provider agreements are located in 42 CFR part 489, and regulations pertaining to activities relating to the survey and certification of facilities are located in 42 CFR part 488. Section 1905(o)(i)(A) of the Act generally extends the hospice Medicare requirements to payments for

hospice services under the Medicare program.

Generally, in order to enter into an agreement, a hospice facility must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 418 of our regulations. Then, the hospice facility is subject to regular surveys by a State survey agency to determine whether it continues to meet those 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 apply for continued approval of deeming authority every 6 years or sooner as determined by us. The Community Health Accreditation Program's (CHAP's) term of approval as a recognized accreditation program for hospice facilities expires November 20, 2003.

II. Approval Process for Deeming Applications

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 after the date of receipt of an application 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 request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** of our approval or denial of the application.

III. Provisions of the Proposed Notice

On April 25, 2003, we published a proposed notice in the **Federal Register** (68 FR 20391) announcing the CHAP's request for reapproval as a deeming organization for hospice facilities. In this notice, we specified in detail our evaluation criteria. Under section 1865(b)(2) of the Act and our regulations at § 488.4, we conducted a review of the CHAP application in accordance with the criteria specified in our regulation, which include, but are not limited to the following:

• An onsite administrative review of CHAP'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 CHAP's hospice accreditation standards to our current Medicare hospice conditions of participation.

• A documentation review of CHAP s survey processes to:

• Determine the composition of the survey team, surveyor qualifications, and the ability of CHAP to provide continuing surveyor training.

• Compare CHAP 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 CHAP's procedures for monitoring providers or suppliers found to be out of compliance with CHAP program requirements. The monitoring procedures are used only when CHAP identifies noncompliance. If noncompliance is identified through validation reviews, the survey agency monitors corrections as specified at § 488.7(d).

• Assess CHAP's ability to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

• Establish CHAP's ability to provide us with electronic data in ASCII-comparable code and reports necessary for effective validation and assessment of CHAP's survey process.

• Determine the adequacy of staff and other resources.

• Review CHAP's ability to provide adequate funding for performing required surveys.

• Confirm CHAP's policies concerning whether surveys are announced or unannounced.

• Obtain CHAP'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 CHAP's requirements met or exceeded the Medicare conditions of participation for hospice facilities. We received no public comments in response to our proposed notice.

IV. Provisions of the Final Notice

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

We compared the standards contained in CHAP's ''Standard of Excellence for Hospice'' and ''The Core Standards of Excellence'' and its survey process in the ''Reapplication for Deeming Authority For Hospice Programs'' with the Medicare hospice conditions for participation and our State and Regional Operations Manual. Our review and evaluation of CHAP's deeming application, which were conducted as described in section III of this notice yielded the following:

• CHAP agreed to add the language ''for pain control and respite purposes'' to its standard that deals with inpatient care. CHAP s standard now states: ''The general inpatient level of care is arranged when the patient requires palliation treatment for acute medical and/or psychological symptoms and/or for pain control that cannot be managed in the patient's home. Inpatient care is also available for respite purposes,'' which meets the requirements of § 418.98.

• In order to meet the requirements of the conditions of participation at § 418.94, CHAP agreed to change the term ''Home Care Aide'' to ''Home Health Aide.''

• In order to meet the requirements of § 418.204, CHAP agreed to remove the terms ''social worker'' and ''personal care'' and add the word ''homemaker'' to its standards that dealt with special coverage requirements.

• In order to meet the regulations at § 418.84, CHAP replaced the term ''professional social worker'' with ''qualified social worker.''

• In order to comply with § 418.58(b) and to clarify who is responsible for

reviewing the plan, CHAP added to its standard the wording, ''by the attending physician, the medical director or physician designee and the IDT/IDG.''

- In order to meet the requirements of § 418.22(d)(2), CHAP added certification and recertification of the terminal illness with a six-month prognosis, signed by a physician, as necessary elements that needed to be maintained in the medical record.
- The word ''paraprofessional'' was removed and replaced with the term ''Home Health Aide'' in the CHAP standard.
- CHAP agreed to change homemaker supervision from every 6 months to 1 month.
- To meet the requirements of the 2000 edition of the Life Safety Code and to comply with § 418.100, CHAP has agreed to add an additional standard that states that roller latches are not used on corridor doors.

B. Term of Approval

Based on the review and observations described in section III of this final notice, we have determined that CHAP's requirements for hospices meet or exceed our requirements. Therefore, we recognize CHAP as a national accreditation organization for hospices that request participation in the Medicare program, effective November 21, 2003 through November 21, 2009.

IV. Collection of Information Requirements

This final notice does not impose any information collection and record keeping 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.

V. 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) (September 16, 1980, Pub. L. 96–354), 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, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). This final notice recognizes CHAP as a national accreditation organization for hospices that request participation in the Medicare and Medicaid programs. 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.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any one year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this notice will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

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

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice will have no consequential effect on the governments mentioned or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this notice does not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this 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 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplemental Medical Insurance Program)

Dated: August 7, 2003.

Thomas Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 03–24547 Filed 9–25–03; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9018–N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—April 2003 Through June 2003

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

ACTION: Notice.

SUMMARY: This notice lists CMS manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published from April 2003 through June 2003, relating to the Medicare and Medicaid programs. This notice provides information on national coverage determinations affecting specific medical and health care