SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of West Virginia is hereby amended to include the following areas among those areas determined to have been adversely affected by the catastrophe declared a major disaster by the President in his declaration of June 3, 2001:

Greenbrier and Nicholas Counties for Individual and Public Assistance.

(The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 83.537, Community Disaster Loans; 83.538, Cora Brown Fund Program; 83.539, Crisis Counseling; 83.540, Disaster Legal Services Program; 83.541, Disaster Unemployment Assistance (DUA); 83.542, Fire Suppression Assistance; 83.543, Individual and Family Grant (IFG) Program; 83.544, Public Assistance Grants; 83.545, Disaster Housing Program; 83.548, Hazard Mitigation Grant Program)

Joe M. Allbaugh,

Director.

[FR Doc. 01–20072 Filed 8–9–01; 8:45 am]

BILLING CODE 6718–02–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisition of Shares of Bank or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the office of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than August 27, 2001.

A. Federal Reserve Bank of Chicago (Phillip Jackson, Applications Officer) 230 South LaSalle Street, Chicago, Illinois 60690–1414:

1. John Gary Rosholt, Stevens Point, Wisconsin; to acquire additional voting shares of Rosholt Bancorporation, Inc., Rosholt, Wisconsin, and thereby indirectly acquire additional voting shares of Community First Bank, Rosholt, Wisconsin.

B. Federal Reserve Bank of Minneapolis (JoAnne F. Lewellen, Assistant Vice President) 90 Hennepin Avenue, Minneapolis, Minnesota 55480–0291:

1. Davis Bancshares Limited Partnership, Rapid City, South Dakota; to retain voting shares of Belle Fourche Bancshares, Inc., Belle Fourche, South Dakota, and thereby indirectly retain voting shares of Pioneer Bank & Trust, Belle Fourche, South Dakota.

Board of Governors of the Federal Reserve System, August 7, 2001.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 01–20146 Filed 8–9–01; 8:45 am]

BILLING CODE 6210–01–S

FEDERAL RESERVE SYSTEM

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

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at www.ffiec.gov/nic/.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than September 4, 2001.

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

1. State Bank of Winfield Employee Stock Ownership Plan & Trust, Winfield, Kansas; to become a bank holding company by acquiring 32.45 percent of the voting shares of State Financial Investments, Inc., and thereby indirectly acquiring an interest in The State Bank, both of Winfield, Kansas.

2. Team Financial Acquisition Subsidiary, Inc., Paola, Kansas; to acquire 100 percent of the voting shares of Post Bancorp, Inc., and thereby indirectly acquiring Colorado Springs National Bank, both of Colorado Springs, Colorado.

B. Federal Reserve Bank of Dallas (W. Arthur Tribble, Vice President) 2200 North Pearl Street, Dallas, Texas 75201–2272:

1. BOTH, Inc., Kerrville, Texas; to become a bank holding company by acquiring 100 percent of the voting shares of BOTH of Delaware, Inc., Wilmington, Delaware, and thereby indirectly acquiring Bank of the Hills, N.A., Kerrville, Texas.

In connection with this application, BOTH of Delaware, Inc., Wilmington, Delaware; to become a bank holding company by acquiring 100 percent of the voting shares of Bank of the Hills, N.A., Kerrville, Texas.

Board of Governors of the Federal Reserve System, August 6, 2001.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 01–20056 Filed 8–9–01; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[CMS–1107–N]

Medicare and Medicaid Programs; Notice for the Solicitation of Proposals for the Private, For-Profit Demonstration Project for the Program of All-Inclusive Care for the Elderly (PACE)

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

ACTION: Notice for solicitation of proposals.

SUMMARY: This notice solicits proposals from private, for-profit organizations for a fully capitated joint Medicare and Medicaid demonstration program. The purpose of this demonstration is to determine whether the risk-based long-term care model employed by the nonprofit Programs of All-Inclusive Care for the Elderly (PACE) can be replicated successfully by for-profit organizations

in various communities nationwide with comparable costs, quality, and access to services. The PACE model focuses on frail community dwelling elderly, most of whom are dually eligible for Medicare and Medicaid, and all of whom are assessed as being eligible for nursing home placement according to their State's standards. The program of care includes as core services the provision of adult day care and case management through which a multidisciplinary team coordinates all health and long-term care services for a participant. This demonstration will include a maximum of 10 for-profit demonstration sites.

DATES: *Letters of Intent:* We will begin accepting letters of intent from interested private, for-profit organizations beginning on August 10, 2001. *Proposals:* We will accept proposals beginning December 10, 2001. An unbound original and 10 copies must be submitted.

ADDRESSES: Letters of intent and proposals should be mailed to the following address: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Attention: Michael Henesch, Project Officer, Center for Health Plans and Providers, Room C4–17–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

FOR FURTHER INFORMATION CONTACT: Michael Henesch at (410) 786–6685, or by e-mail at *mhenesch@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative History

On Lok Senior Health Systems, located in San Francisco's Chinatown, began operating in 1971. The intent of the program was to enable the frail elderly to remain in the community and live at home. Participants were transported to an adult day care center a few times a week where they visited their physicians, received supportive services, and socialized with other elderly community members.

Under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509), the Congress authorized a demonstration program of all-inclusive care for the frail elderly for nonprofit entities that sought to replicate the model developed by On Lok in various communities nationwide. The demonstration came to be known as the Program of All-Inclusive Care for the Elderly (PACE) demonstration. The On Lok protocol was used as the guiding principle for creating new PACE sites, and the demonstration eventually grew to 26 sites, including On Lok, in 14 States.

Section 4801 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) authorized coverage of PACE under the Medicare program. It amended title XVIII of the Social Security Act (the Act) by adding section 1894, which addresses Medicare payment to, and coverage of benefits under, PACE. Section 4802 of the BBA authorized the establishment of PACE as a State option under Medicaid. It amended title XIX of the Act by adding section 1934, which directly parallels the provisions of section 1894. Section 4803 of the BBA addresses implementation of PACE under both Medicare and Medicaid, the effective date, timely issuance of regulations, priority and special consideration in processing applications, and transition from PACE demonstration project status. On November 24, 1999, we published an interim final rule with comment period, ''Program of All-Inclusive Care for the Elderly (PACE)'' (64 FR 66234) that establishes the nonprofit PACE demonstration as a permanent provider program under Medicare and Medicaid. These PACE regulations appear at 42 CFR Part 460—Programs of All-Inclusive Care for the Elderly.

B. Nonprofit Program Versus For-Profit Demonstration

Section 4804(a)(2) of the BBA requires us to conduct a study to compare the costs, quality, and access to services provided by for-profit entities to those of nonprofit PACE providers. The for-profit entities must operate under demonstration project waivers granted under sections 1894(h) and 1934(h) of the Act.

The protocol developed by On Lok contained the program's guiding principles and was used to review the proposals for nonprofit PACE demonstrations. Section 4801(h)(2)(A) of the BBA states that the terms and conditions for the for-profit PACE program must be the same as those for PACE providers that are nonprofit, private organizations except that only 10 waivers may be granted (section 4801(h)(2)(B) of the BBA). Under the demonstration for for-profit entities, the existing PACE regulations at part 460 for nonprofit, private entities, will be the primary standard against which proposals will be reviewed.

C. Program Regulations for Nonprofit Entities

The description below summarizes key components of the November 24, 1999 final rule for the nonprofit organization PACE program.

- State's Role

An interested organization should contact the State Administering Agency in coordination with the State Medicaid Agency about applying to participate in the PACE demonstration. The PACE demonstration is intended to be a three-way partnership between us, the States, and the PACE organizations. The State plays an integral role in not only the process for reviewing a proposal, but in the monitoring of an organization and the annual certification of a participant's eligibility. We will review a proposal after we receive an assurance from the State Administering Agency indicating that it considers the applicant qualified to be a PACE organization and that the State is willing to enter into a PACE Program Agreement with the applicant.

- General

A PACE participant must meet the State's nursing facility eligibility criteria, be 55 years of age or older, be a resident of the PACE organization's service area, and be assessed by the PACE organization's multidisciplinary team. The multidisciplinary team must consist of a primary care physician, registered nurse, social worker, physical therapist, occupational therapist, dietitian, home care coordinator, PACE center manager, recreational therapist or activity coordinator, driver, and personal care attendant. Except for the physical therapist, occupational therapist, driver, and dietitian, the members of the multidisciplinary team must be employed by the PACE organization. A waiver may be granted by the State Administering Agency and us as specified in § 460.102(g). The multidisciplinary team assesses each participant during the intake process, and develops a plan of care tailored to that individual's needs as specified in §§ 460.104 and 460.106. On at least a semi-annual basis, the multidisciplinary team must reassess the participant and reevaluate the participant's plan of care, including defined outcomes, and make changes as necessary.

A PACE organization must operate at least one PACE center and should either own or contract with at least one hospital, nursing home, and transportation service. The PACE organization must provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, and meals at the PACE center. A PACE participant must be able to access services 24 hours a day, 365 days a year. The PACE organization's responsibility for the participant extends beyond the PACE

center. If the participant requires help cooking, cleaning, bathing, *etc.,* a home visit must be arranged by the PACE organization. If the center's physicians are unable to treat a participant for a particular condition, the organization must pay for treatment by an outside specialist or provider. In addition to the provision of all Medicare and Medicaid services, without the usual limitations and conditions, the PACE service package must include all primary, acute, and long-term care necessary to improve or maintain the participant's health status with the exceptions specified in §§ 460.94 and 460.96. Section 1894(b)(1)(A) of the Act prohibits the use of deductibles, copayments, coinsurance, or cost sharing in this program. The capitation rate covers all of the costs related to the participant's care.

The PACE program seeks to enhance the quality of life and autonomy of the participant, while maximizing the dignity of, and respect for, older adults and elderly persons. A PACE program's success hinges on conscientious preventative care to avoid costly hospital and nursing home stays. It is the attentiveness of the multidisciplinary team and the preventative care and social interaction at the PACE center that helps participants to avoid acute and long-term care settings.

- Payment

The nonprofit entities are currently paid the Medicare+Choice rate (§ 460.180) multiplied by a frailty adjuster of 2.39 for all PACE participants except those diagnosed with end-stage renal disease (ESRD). Payments for persons with ESRD are paid the ESRD statewide rate book amount multiplied by PACE specific adjustors of 1.46 for part A and 1.36 for part B. At the present time, we are developing a specific risk adjustment methodology to apply to the PACE program that is expected to change the payment methodology in the future.

States that elect PACE set Medicaid rates subject to Federal regulations. Each State develops a payment amount based on the cost of comparable services for the State's nursing-facility-eligible population. The amount is generally based on a blend of the cost of nursing home and community-based care for the frail elderly. The monthly capitation payment amount is negotiated between the PACE organization and the State Administering Agency and must be less than the amount that is paid under the State plan if the participant is not enrolled in the PACE program.

II. Provisions of This Notice

A. Purpose

This notice solicits proposals from for-profit entities to demonstrate that they can successfully provide comprehensive coordinated care for the frail elderly under a prepaid fully capitated payment system.

B. Duration of the Demonstration

The demonstration will operate for 3 years. There is no authority for payment to for-profit entities outside of this demonstration, absent a change in the law. Participating programs must be prepared to disenroll participating beneficiaries at that time subject to the requirements of §§ 460.166 and 460.168. Under section 4804(b)(2) of the BBA, an evaluation of the demonstration comparing the for-profit entities to the nonprofit entities must be conducted. A CMS contractor will design and conduct an evaluation of the demonstration.

C. Requirements for Proposal Submission

We will only consider proposals from for-profit organizations. Interested applicants must submit a proposal that provides a comprehensive array of benefits and must be willing to assume full financial risk for all primary, acute, and long-term care. A PACE organization must accept both Medicare and Medicaid capitation to participate, although individual participants who are not eligible for Medicare or Medicaid may enroll in the program. We will consider only one site per proposal and define a site as one contiguous service area.

D. Proposal Process

Proposals will be accepted until we choose 10 sites. After we have chosen 10 sites, we will notify the organization that submits a letter of intent that the limit of approved sites has been reached. We recommend the following steps to expedite a proposal submission:

Step One

An organization that wishes to apply to participate in the demonstration should review the PACE program regulations for nonprofit organizations at Part 460 (Programs of All-Inclusive Care for the Elderly), which can be accessed from various sources including websites *www.jcfa.gov/medicare (or Medicaid)/PACE/pacehmpg.htm* or *www.access.gpo.gov/mara/index.html,* or by calling 1–888–293–6498. These regulations should serve as the organization's guiding principles during the development of a demonstration proposal for a PACE program. A successful proposal will be one that satisfies the requirements of the PACE program regulations.

Step Two

An applicant interested in pursuing participation should send a letter of intent to us and to their State Medicaid Agency. An applicant should collaborate with the State in developing its proposal. The for-profit organization should submit a complete proposal, along with 6 copies, to its State Medicaid Agency.

Step Three

Once the State agrees to enter into a PACE program agreement with the for-profit organization, the applicant should submit a proposal to us. In addition, the applicant should include a letter obtained from the State indicating that the State considers the applicant qualified to be a PACE organization and that it is willing to participate in the demonstration.

III. Final Selection

A review panel will perform an independent review of proposals and will make recommendations based on organizational capabilities, fiscal soundness, service delivery, quality improvement plan, and data collection and record maintenance capabilities.

Our Administrator will make a final decision on awards taking into consideration proposals that observe the following priority areas:

1. An applicant should be able to serve the frail elderly in geographical areas that are currently not being served. Sections 1894(e)(2)(B) and 1934(e)(2)(B) of the Act state that we may exclude from designation an area that is already covered under another PACE program agreement. This is to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program. The organization's State Administering Agency will also be able to provide technical assistance on this issue.

2. We would prefer to have a rural site participate to determine if these sites are viable and how the sites differ from existing nonprofit entities.

3. We would prefer to limit sites to one for-profit organization per State.

4. We encourage for-profit entities of all organizational types to apply. We would prefer to have a variety of sites with differing organizational structures and backgrounds to participate in the demonstration.

5. Finally, considering that this program grew out of a community's interest in enabling its elderly members to age in a community-based setting,

and the program's emphasis on community involvement, we would prefer for-profit organizations that have a longstanding relationship with the community they serve to participate in the demonstration.

In reviewing the proposals, we will give greatest consideration to an organization's development of policies and procedures. Due to the short time frame of this demonstration and the frailty of the population, we need to be certain that the organization can anticipate potential problems and is prepared to handle the problems efficiently and effectively. In addition, these policies and procedures will increase quality by providing safeguards to protect the beneficiaries.

We reserve the right to conduct site visits to the awardee's location before making awards. An independent contractor, selected and funded by us, will design and conduct an evaluation. The awardee will be required to cooperate with the contractor conducting the evaluation.

IV. Collection of Information Requirements

As referenced in this notice, we will award up to 10 sites. However, given that we expect less then 10 proposals on an annual basis and the proposals are not standardized, the requirements referenced in this notice do not meet the definition of an information collection, as defined under 5 CFR 1320.3(c) and as such are not subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Authority: Sections 1894(h) and 1934(h) of the Social Security Act (42 U.S.C. 1395eee and 1396u–4)

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

Dated: August 6, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 01–20049 Filed 8–9–01; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of New York State Plan Amendment (SPA) 96–40a

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing on October 3, 2001; 10 a.m.; Room 38–110a; Thirty-Eighth Floor; Jacob Javits Federal Building; 26 Federal Plaza; New York, New York 10278, to reconsider our decision to disapprove New York SPA 96–40a.

CLOSING DATE: Requests to participate in the hearing as a party must be received by the presiding officer by August 27, 2001.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS C1–09–13, 7500 Security Boulevard, Baltimore, Maryland 21244; Telephone: (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider our decision to disapprove New York SPA 96–40a. New York submitted this SPA on September 30, 1996. The issue is whether the effective date of a change in the method of Medicaid payment that increases Medicaid payments to hospitals may be earlier than the first day of the calendar quarter in which New York submitted a SPA for approval by the Secretary. This amendment proposes to increase payments under the Medicaid State plan by reclassifying certain amounts, originally paid outside the scope of the Medicaid program by State contractors for the cost of care for persons eligible for the State Home Relief program, as Medicaid disproportionate share hospital (DSH) payments. As the State's public notice made clear, the proposed change in Medicaid payment methodology was not simply to use an intermediary to make payments already authorized under the existing State plan, but would increase Medicaid payments by adding to the DSH payments to certain hospitals. Federal regulations at 42 CFR 447.256(c) and 430.20(b), however, preclude the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, from approving a SPA that changes the method of payment prior to the first day of the calendar quarter in which the SPA was submitted. In addition, Federal regulations at 42 CFR 447.205(a) require a State to provide public notice of any significant proposed change in its methods and standards for setting payment rates for services. Federal regulations at 42 CFR 447.205(d) require that the notice be published before the proposed effective date of the change. Therefore, the earliest permissible effective date for this amendment based on the date of public notice (i.e., September 25, 1996) and on the calendar quarter in which the SPA was submitted (i.e., September 30, 1996), was September 26, 1996. After consulting with the Secretary as required by 42 CFR 430.15(c), CMS informed New York of its decision to disapprove this amendment. SPA 96–40a was originally submitted as SPA 96–40, which affected DSH payments beginning on July 1, 1994. CMS suggested the State split the original amendment into two separate amendments to allow payments beginning on September 26, 1996, to be approved. The State agreed to this suggestion. The first amendment, 96–40a, affects Medicaid payments from July 1, 1994, through September 25, 1996, and was disapproved by CMS on May 14, 2001, after consultation with the Secretary as required under 42 CFR430.15(c)(2). The second amendment, 96–40b, affecting Medicaid payments from September 26, 1996, forward, was approved.

The notice to New York announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Dr. Antonia C. Novello,

Commissioner, New York State Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237.

Dear Dr. Novello: I am responding to your request for reconsideration of the decision to disapprove New York State Plan Amendment (SPA) 96–40a. This SPA was submitted on September 30, 1996.

The issue is whether the effective date of a change in the method of Medicaid payment that increases Medicaid payments to hospitals may be earlier than the first day of the calendar quarter in which New York submitted a SPA for approval by the Secretary. This amendment proposes to increase payments under the Medicaid State plan by reclassifying certain amounts, originally paid outside the scope of the Medicaid program by State contractors for the cost of care for persons eligible for the State Home Relief program, as Medicaid disproportionate share hospital (DSH) payments. As the State's public notice made clear, the proposed change in Medicaid payment methodology was not simply to use an intermediary to make payments already authorized under the existing State plan, but would increase Medicaid payments by adding to the DSH payments to certain hospitals.