ANNUAL BURDEN ESTIMATES

Instrument	Number of Respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Application	500	1	20	10,000
Estimated Total Annual Burden Hours				10,000

In compliance with the requirements of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Dated: June 13, 2000.

Bob Sargis,

Reports Clearance Officer.

[FR Doc. 00–15339 Filed 6–16–00; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: Uniform Project Description for Discretionary Grant Application Form

OMB No. 0970–0139

Description: ACF has more than forty discretionary grant programs. The proposed information collection form would be a uniform discretionary application form usable for all of these grant programs to collect the information from grant applicants needed to evaluate and rank applicants and protect the integrity of the grantee selection process. All ACF discretionary grant programs would be eligible but not required to use this application form. The application consists of general information and instructions; the Standard Form 424 series that requests basic information, budget information and assurances; the Program Narrative requesting the applicant to describe how these objectives will be reached; and certifications. Guidance for the content of information requested in the Program Narrative is found in OMB Circulars A–102 and A–110.

Respondents: Applicants for ACF Discretionary Grant Programs.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
UPD	4,133	1	4	16,532
Estimated total annual burden hours				16,532

In compliance with the requirements of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Information Services, 370 L'Enfant Promenade, S.W., Washington, D.C. 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Dated: June 13, 2000.

Bob Sargis,

Reports Clearance Officer.

[FR Doc. 00–15340 Filed 6–16–00; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Children's Hospitals Graduate Medical Education Payment Program: Proposed Eligibility and Funding Criteria and List of Eligible Hospitals

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice.

SUMMARY: The Health Resources and Services Administration (HRSA) announces the Children's Hospitals Graduate Medical Education (CHGME) Payment Program, authorized under section 340E of the Public Health Service (PHS) Act (the Act) (42 U.S.C. 256e), as added by the Healthcare Research and Quality Act of 1999 (Public Law 106–129), enacted December 6, 1999. This notice requests comments on proposed eligibility criteria, funding factors and methodology, and performance measures for participating hospitals for the CHGME program. It includes a list of hospitals meeting these proposed eligibility criteria. In compliance with the Paperwork Reduction Act of 1995, the Department will obtain prior Office of Management and Budget clearance to any data collections imposed on the public.

DATES: Interested persons are invited to comment by July 19, 2000. All comments received on or before July 19, 2000 will be considered in the development of the criteria and methodology for the CHGME program. Comments will be addressed individually or by group in the final notice published in the **Federal Register**.

ADDRESSES: All written comments concerning this notice should be submitted to F. Lawrence Clare, Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration, Room 9A–21, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857; or by e-mail to: ChildrensHospitalGME@hrsa.gov.

FOR FURTHER INFORMATION CONTACT: F. Lawrence Clare, Division of Medicine; telephone (301) 443–7334.

SUPPLEMENTARY INFORMATION:

Purpose

The Children's Hospitals Graduate Medical Education Payment Program provides funds to children's hospitals to support the training of pediatric and other residents in graduate medical education programs (GME). Since Federal financial support of graduate medical education is extensively supported by the Medicare system, this program compensates for the disparity in the level of Federal funding for teaching hospitals for pediatrics versus other types of teaching hospitals. For example, on average a freestanding children's hospital receives $374 per resident in Medicare funds versus an average of $87,034 per resident for a non-children's hospital.

The CHGME program is an interim measure to assist children's hospitals to continue their teaching programs while Congress examines the medical education funding system. The Secretary of HHS (the Secretary) has delegated the authority for the administration of the CHGME program to HRSA which redelegated it to the Bureau of Health Professions (BHPr).

Available Funds

The Act authorizes $280 million for fiscal year (FY) 2000 and $285 million for FY 2001. Under the FY 2000 appropriations law, $40 million has been appropriated for this program. The Act directs the Secretary to make payments for both direct and indirect expenses to each eligible children's hospital.

I. Dividing the CHGME Appropriation Between Direct and Indirect Medical Education

The Act requires the Secretary to make payments to children's hospitals for both direct and indirect medical education expenses (DME and IME). Although the Act authorizes funds for FY 2000 and FY 2001 in specific amounts for each, the Appropriation Act does not similarly divide the appropriation between DME and IME.

In FY 2000, section 340E(f) authorizes the appropriation of $90 million for DME and $190 million for IME. To conform with the allocation of funds indicated in the Act, the Secretary will divide the amount appropriated between DME and IME based on the ratio set forth in the authorizing statute, approximately one-third of the funds to DME and two-thirds to IME.

II. Proposed Hospital Eligibility Criteria

The Act requires HHS to make payments to ''children's hospitals that operate graduate medical education programs.'' A children's hospital is defined as a hospital in which more than 50 percent of its patients are under the age of 18, referencing the definition of children's hospital contained in section 1886(d)(1)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww). Regulations at 42 CFR 412.23(d) use this definition in the Prospective Payment Systems (PPS) for Inpatient Hospital Services. The Department proposes to define a children's hospital eligible for funding by adopting this definition of children's hospital from the PPS regulations as follows:

A children's hospital must-

(1) Have a provider agreement with a unique Medicare provider number as a hospital, under Section 1886(d)(1)(B)(iii) of the Social Security Act;

(2) Be engaged in furnishing services to inpatients who are predominantly individuals under the age of 18; and

(3) Participate in an accredited graduate medical education program.

The Congressional intent of the CHGME program is to provide funds only to children's hospitals that do not have access to Medicare payments under the PPS system to achieve some degree of parity in support. Fifty-nine was the number of teaching hospitals certified by Medicare as children's hospitals at that time.

Accordingly, the proposed eligibility criteria exclude children's hospitals which are part of a hospital system, rather than freestanding. Even if a children's hospital is separately identified in the AMA Directory but shares a Medicare provider number as part of a health system, it still would not be considered to be an eligible children's hospital under these criteria. Since these hospitals have access to Medicare direct and indirect GME funding as part of the PPS, they are able to receive the higher levels of Medicare GME paid to PPS hospitals, by being able to (1) factor a higher Medicare patient proportion into the direct GME funding formula, and (2) receive, as part of a PPS hospital system, indirect GME funds. Thus, these hospitals are not within the universe of intended beneficiaries of the CHGME program.

The physical characteristics or location of a children's hospital are irrelevant to eligibility. Even if a children's hospital is separated physically from its adult hospital partner, sharing a Medicare provider number makes the children's hospital ineligible because it then qualifies for Medicare GME funds for its pediatric or other residents under the PPS as part of the adult hospital partner.

Payments made to a children's hospital will have no effect on payments received under the Medicare or Medicaid programs. The intent of the CHGME program is to create a degree of parity between children's hospitals and adult hospitals. Accordingly, the CHGME program will operate independently from the Medicare and Medicaid programs.

Based on the proposed eligibility criteria, the Department has identified the following-listed hospitals potentially eligible for this program as of December 6, 1999. Any hospitals meeting the proposed criteria which are not included on the list may inform the Department of their eligibility during the comment period for this notice. The Secretary will then publish a revised list

of eligible hospitals for FY 2000 in the final **Federal Register** notice.

Medicare Provider Number	Facility name	City	State
01–3300	Children's Hospital of Alabama	Birmingham	AL
04–3300	Arkansas Children's Hospital	Little Rock	AR
05–3300	Valley Children's Hospital	Madera	CA
05–3301	Children's Hospital Medical Center	Oakland	CA
05–3302	Children's Hospital of Los Angeles	Los Angeles	CA
05–3303	Children's Hospital and Health Center	San Diego	CA
05–3304	Children's Hospital of Orange County	Orange	CA
05–3305	Lucile Salter Packard Children's Hospital	Palo Alto	CA
06–3301	The Children's Hospital	Denver	CO
07–3300	Connecticut Children's Medical Center	Hartford	CT
08–3300	Alfred I Dupont Institute	Wilmington	DE
09–3300	Children's Hospital National Medical Center	Washington	DC
10–3300	All Children's Hospital	Saint Petersburg	FL
10–3301	Miami Children's Hospital	Miami	FL
11–3300	Egleston Children's Hospital at Emory	Atlanta	GA
12–3300	Kapiolani Women's & Children's Medical Center	Honolulu	HI
14–3300	Children's Memorial Hospital	Chicago	IL
14–3301	Larabida Children's Hospital	Chicago	IL
15–3300	St. Vincent's Children's Specialty Hospital	Indianapolis	IN
19–3300	Children's Hospital	New Orleans	LA
21–3301	Kennedy Krieger Institute	Baltimore	MD
22–3300	Franciscan Children's Hospital & Rehabilitation Center	Brighton	MA
22–3302	The Children's Hospital	Boston	MA
23–3300	Children's Hospital of Michigan	Detroit	MI
24–3300	Gillette Children's Hospital	Saint Paul	MN
24–3301	Children's Health Care—Saint Paul	Saint Paul	MN
24–3302	Children's Health Care—Minneapolis	Minneapolis	MN
26–3301	St. Louis Children's Hospital	Saint Louis	MO
26–3302	Children's Mercy Hospital	Kansas City	MO
28–3300	Boys Town National Research Hospital	Omaha	NE
28–3301	Children's Memorial Hospital	Omaha	NE
31–3300	Children's Specialized Hospital	Mountainside	NJ
32–3307	Carrie Tingley Hospital	Albuquerque	NM
33–3301	Blythdale Children's Hospital	Valhalla	NY
36–3300	Children's Hospital Medical Center	Cincinnati	OH
36–3302	Rainbow Babies and Children's Hospital	Cleveland	OH
36–3303	Children's Hospital Medical Center	Akron	OH
36–3304	Cleveland Clinic Children's Rehabilitation Hospital	Cleveland	OH
36–3305	Children's Hospital	Columbus	OH
36–3306	Children's Medical Center	Dayton	OH
36–3307	Northside and Tod Children's Hospital	Youngstown	OH
37–3301	Children's Medical Center	Tulsa	OK
39–3307	St. Christopher's Hospital for Children	Philadelphia	PA
39–3302	Children's Hospital of Pittsburgh	Pittsburgh	PA
39–3303	Children's Hospital of Philadelphia	Philadelphia	PA
40–3301	University Pediatric Hospital	San Juan	PR
44–3302	St. Jude Children's Research Hospital	Memphis	TN
44–3303	East Tennessee Children's Hospital	Knoxville	TN
45–3300	Cook Ft. Worth Children's Medical Center	Fort Worth	TX
45–3301	Driscoll Children's Hospital	Corpus Christi	TX
45–3302	Children's Medical Center of Dallas	Dallas	TX
45–3304	Texas Children's Hospital	Houston	TX
45–3305	Santa Rosa Children's Hospital	San Antonio	TX
46–3301	Primary Children's Medical Center	Salt Lake City	UT
49–3301	Children's Hospital—King's Daughters	Norfolk	VA
50–3300	Children's Hospital & Regional Medical Center	Seattle	WA
50–3301	Mary Bridge Children's Health Center	Tacoma	WA
52–3300	Children's Hospital of Wisconsin	Milwaukee	WI

Changes in Eligibility Status

For each fiscal year, the Secretary will publish a **Federal Register** notice inviting applicants for the CHGME program and listing the eligible children's hospitals. Since HHS calculates the payments for each fiscal year by dividing the available funds by the resident count data submitted by the eligible hospitals, additional hospitals cannot be included for funding for that fiscal year after the allocation has been made. Newly-qualifying institutions must notify HHS as soon as possible to be added to the list of eligible hospitals for the next fiscal year.

A children's hospital which loses its eligibility during the course of a fiscal year must notify HHS immediately of the change in status. The Department will then declare the hospital to be

ineligible and terminate its payments under the CHGME program. The hospital will remain liable for the reimbursement, with interest, of any money received during a period of ineligibility.

Funds that are returned to the Department during a fiscal year by the termination of hospitals from the CHGME program will be distributed as follows: (1) Direct GME funds will be 8 placed in the direct GME withholding account and distributed to the remaining children's hospitals as part of the reconciliation process; and (2) the IME funds will be distributed to the remaining children's hospitals during the fiscal year based on the IME formula. The latter approach is necessary because IME funding has no reconciliation process.

III. Determining Resident Counts in the CHGME Program

Definition. Section 340E(c)(1) of the Act provides that the amount of the payment to a children's hospital for direct medical expenses is equal to the product of the amount per resident as determined under paragraph (2) of that section and—

> the average number of full-time equivalent (FTE) residents in the hospital's approved graduate medical residency training programs, as determined under section 1886(h)(4) [42 U.S.C. 1395ww(h)(4)] of the Social Security Act during the fiscal year.

Section 340E(g)(1) of the Act defines the term ''approved graduate medical residency training program'' by reference to section 1886(h)(5)(A) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(A)). Regulations at 42 CFR 413.86 implement these provisions.

Accordingly, the term ''approved graduate medical residency training program'' means a residency or other postgraduate medical training program in allopathic medicine, osteopathic medicine, dentistry, and podiatry approved by the indicated accrediting body in which participation may be counted toward certification in a specialty or subspecialty. Only residents in allopathic medicine, osteopathic medicine, dentistry, and podiatry will be counted to determine the amount of direct and indirect medical expenses paid to children's hospitals.

Residency FTE Reporting Period

The Act requires the Secretary to make CHGME payments ''for each of fiscal years 2000 and 2001,'' (emphasis added). ''Fiscal Year'' means the Federal Fiscal Year from October 1 of each year through September 30 of the following year, not to be confused with the hospital cost-reporting periods used for Medicare GME purposes. The CHGME statute distinguishes ''fiscal year'' from a hospital's ''cost reporting period.'' ''Cost reporting period'' is used in two provisions to differentiate specific time periods from the Federal fiscal year. Accordingly, the Secretary is interpreting ''fiscal year'' to mean ''Federal fiscal year.'' To receive CHGME funds, a hospital must submit the number of FTE residents at the hospital during the Federal fiscal year for which payments are being made.

Counting FTE Residents

Section 340E(c)(1)(B) requires that the average number of FTE residents in the hospital's approved residency programs be determined according to section 1886(h)(4)(42 U.S.C. 1395ww(h)(4)) of the Social Security Act. This section is implemented by regulations at 42 CFR 413.86(f), (g), (h), and (i). These provisions indicate: How to determine the total and weighted numbers of FTE residents; the required documentation and certification for purposes of application for Medicare payments by hospitals for cost reporting periods; and the application of the ''caps'' (described in sec. 1886(h)(4)(f) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(f))) and ''rolling averages'' (described in sec. 1886(h)(4)(g) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(g))) to FTE resident counts prior to weighting. Hospitals must certify the accuracy of their FTE resident counts and apply the Medicare cap and rolling average to this count.

Because these requirements are closely tied to Medicare, the Department will be using Medicare data to assist in verifying the submitted counts. Comment is solicited on whether the program should require the standardized reporting of resident counts currently required in the Medicare Intern and Resident Information System (IRIS).

The cap requires an accurate count for the last hospital cost reporting year ending on or before December 31, 1996. The Department will rely on the resident counts reported on Medicare cost reports to verify each hospital's count. Some hospitals may have previously undercounted their residents in their Medicare cost reports due to the insignificance of their Medicare payments. Because of the cap, hospitals that underreported that number should consider requesting the Department to reopen their Medicare cost reports, pursuant to 42 CFR 405.1885, to revise the numbers submitted for cost reports that are subject to reopening.

The regulations at 42 CFR 413.86 do not apply to a hospital which had not previously submitted Medicare cost reports but had been operating a residency training program. Hospitals must determine their resident counts in the cost-reporting year ending in 1996. In cases where this is very difficult to establish from existing records, it is necessary to propose an FTE counting methodology addressing this situation.

For most hospitals, program size and resident rotations among the participating institutions are relatively stable from year to year. Therefore, a hospital could address missing FTE counts for earlier years by starting with the assumption that these counts would be the same as the FY 1999 count in the absence of changes in the residency programs after 1996. The incremental effect of any changes could be estimated by adjusting the FY 1999 and FY 2000 counts to determine resident FTE counts for FY 1996 through FY 1998. Examples of adjustments for incremental changes in FTE counts follow:

Example A: The children's hospital has 24 residents in a pediatric residency program. The residents spend 90 percent of their time at the children's hospital and 10 percent rotating to other hospitals. The hospital's *unweighted* FTE count for its cost reporting period beginning in FY1999 is 21.6 (the unweighted FTE count is the FTE number of residents *prior* to weighting the residents who have exceeded the number of years of formal training necessary to satisfy the requirements of the appropriate approving body related to board certification or 5 years, whichever is less, by 0.5). The unweighted FTE count for its cost reporting period ending in calendar year 1996 is deemed to be 21.6. This becomes the cap, which applies to Federal fiscal years 2000 and beyond.

Example B: The children's hospital had 24 residents in its pediatric residency program (8 in each of 3 residency years) until the program year beginning July 1, 1999, when the number of first year residents was increased to 10. The residents spend all their time at the children's hospital. The hospital's unweighted FTE count for its cost-reporting period ending 12/31/99 is 25, because the additional first year residents added 1.0 to the FTE resident count (two residents for 6 months each). The count for its cost reporting period ending in calendar year 1996, and the hospital's cap from that point on, is deemed to be 24.

Example C: The children's hospital is a major participating institution for five residency programs. During its cost-reporting period ending 6/30/99, 100 residents rotated from other hospitals for rotations of 1 to 6 months. The hospital's unweighted FTE count was 25. The same affiliation agreements have been in effect since before 1996 and there were no significant changes in the size of the residency programs or rotation schedules. The hospital's unweighted count for its cost reporting period ending in calendar year 1996 (which ended 6/30/96), and therefore its cap for future years, is deemed to be 25.

Example D: The children's hospital is a major participating institution for five residency programs. During its cost-reporting period ending 6/30/99, 100 residents rotated from other hospitals for rotations of 1 to 6 months. The hospital's unweighted FTE count was 25. During the program year beginning in 1997, the hospital started serving as a training site for the first time for a family practice program which sends three residents for 3 months each for a continuity clinic in each of the first two family practice program years. The residents count as 1.5 FTE in the hospital's FTE count for its FY ending 6/30/99 (0.75 FTE for 1st year residents and 0.75 for 2nd year residents). The hospital's count for its cost reporting period ending in calendar year 1996 (FY ending 6/30/96), and therefore its cap, is deemed to be 23.5.

If no prior counts were reported, it would then only be necessary to determine the 1996-based cap from the FY1999 and FY2000 actual counts if the number of residents had increased after 1996. The cap would not be operative if there had been no change or a decrease since 1996.

Similarly, Medicare applies a ''rolling average'' to resident counts (42 CFR 413.86(g)(5)). Unlike the cap, the rolling average is applied to weighted FTE resident counts. For the hospital's first cost reporting period beginning on or after October 1, 1997, the weighted FTE count equals the average of the weighted count for that period and the preceding cost reporting period. For cost reporting periods beginning on or after October 1, 1998, the hospital's weighted FTE count equals the average of that reporting year and the two preceding cost reporting years.

For the weighted FTE resident count for Federal fiscal years 2000 and 2001, the hospital must determine the weighted FTE resident count for each Federal fiscal year beginning October 1, 1997 (which is also the effective date of the caps). The FTE resident counts for these years are needed to determine the cap and the rolling average for Federal fiscal years 1999 and 2000.

IV. Determining Direct Medical Education Payments

Section 340E(a) requires the Secretary to make payments for direct and indirect expenses associated with operating approved graduate medical residency training programs for each of fiscal years 2000 and 2001. Section 340E(b) describes direct expenses as covering the costs of 13 operating approved graduate medical residency training programs. Subsection (e)(1) requires the Secretary to determine the amount of direct and indirect payments for each hospital before the beginning of each fiscal year for which payments are made and to make these payments to each hospital in 26 equal installments during the fiscal year. If the Secretary determines that the funds appropriated for the CHGME program for a fiscal year are insufficient to provide the total payments due to hospitals for that fiscal year, the Secretary will reduce the amount of payments to each hospital on a pro-rata basis.

The Act also provides a method for refining the accuracy of the direct payments made to each hospital. Under subsection (e)(2), the Secretary must withhold up to 25 percent from each direct medical education interim installment payable to hospitals to permit the final adjustment and reconciliation of the number of FTE residents for whom direct payments are being made. At the end of that fiscal year, each participating hospital must submit information to enable the Secretary to determine the percentage (if any) of the total amount withheld that is due each hospital for the fiscal year. The hospital may request a hearing on the Secretary's payment determination. The Secretary pays each hospital any balance due or recoups any overpayments made.

Due to the time limitations in establishing a new program and the one year availability of the $40 million appropriated in FY 2000, for the CHGME program, the Secretary will obligate the entire CHGME appropriation in FY 2000, without the withholding of direct payments.

Determination of the Amount of Direct Medical Education Payment

Section 340E(c)(1) requires that the payments to a children's hospital for direct medical education expenses for a fiscal year equal the product of:

- The updated per resident amount as determined under subsection (c)(2); and
- The average number of FTE residents in the hospital's graduate approved medical residency program as determined under section 1886(h)(4) of the Social Security Act during the fiscal year.

Section 340E(c)(2) determines the updated per resident amount for direct medical education using the following methodology. The Secretary will:

(1) *Determine the hospital's single per resident amount:* Compute for each of every (not just children's) teaching hospital a single per resident amount computed equal to the weighted average of the primary care per resident amount and the non-primary care per resident amount computed under 1886(h)(2) of the Social Security Act for cost reporting periods ending during FY 1997;

(2) *Determine the wage and non-wage-related proportion of the single per resident amount:* Estimate the average proportion of the single per resident amount that is attributable to wages and wage-related costs;

(3) *Standardize per resident amounts:* Establish a standardized per resident amount for each children's hospital that is adjusted for wages;

(4) *Determine a national average per resident amount:* Compute a national average per resident amount equal to the average of the standardized amounts computed above weighted by the average number of FTE residents at the children's hospitals; and

(5) *Apply factors 1–4 to each hospital:* Compute for each children's hospital the national average per resident amount after adjustment for wage-related costs.

Updating the Per Resident Amount

The legislation provides for updating the per resident amount for each hospital by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning October 1997 and ending with the midpoint of the hospital's cost reporting period that begins in FY 2000. Since the CHGME will operate on a fiscal rather than a cost reporting year basis, it is inappropriate to end the adjustment period with the midpoint of the cost reporting year. To do so would create inconsistent and inequitable results, rendering the provision ineffective. To give effect to the intent of updating the per resident amount, the Secretary will update the per resident amounts to a common date, the midpoint of the current fiscal year.

Determining the Single Per Resident Amounts

The Secretary proposes to use the Health Care Financing Administration's (HCFA's) Hospital Cost Report Information System (HCRIS), an electronic reporting system, to determine the hospitals single per resident amounts. HCRIS is organized by the cost reporting period beginning dates. The data base for determining the per resident amounts paid to children's hospitals is from all teaching hospitals, not just children's teaching hospitals. HCRIS files are updated quarterly as the cost reports move through the cost report settlement process. The September 30, 1999, HCRIS update file has 1206 hospitals reporting residents for cost reporting periods ending in FY 1997.

Wage Adjustment in Standardizing Per Resident Amounts

Section 340E states that the Secretary—

shall establish a standardized per resident amount for each such hospital by—

(i) Dividing the single per resident amount computed under subparagraph (A) into a wage-related and non-wage related portion by applying the proportion determined under subparagraph (B);

(ii) Dividing the wage-related portion by the factor applied under section 1886(d)(3)(E) of the Social Security Act for discharges occurring during fiscal year 1999 for the hospital's area; and

(iii) Adding the non-wage-related portion to the amount computed under clause (ii).

Subparagraph (B) requires the Secretary to:

[E]stimate the average proportion of the single per resident amounts computed under subparagraph (A) that is attributable to wages and wage-related costs.

Under the Medicare program, direct GME expenses include intern and resident salaries and fringe benefits; compensation to teaching physicians for the teaching and supervision of residents; and other, allocated hospital costs. Earlier HCRIS public use files indicate that the labor-related share of the PPS rate for inpatient operating costs is at 71.1 percent. However, this figure may not be appropriate for the per resident amount since it includes direct patient care costs, such as drugs and room and board costs.

The Department is analyzing the Medicare cost reports to develop a more accurate estimate of the labor-related share of the per resident amount. HHS intent is to complete this analysis in time for the final **Federal Register** notice. Until the analysis is completed, the Secretary proposes that the PPS labor-related share be used to standardize wages in determining the national standard per resident amount.

Determining Payments

Each hospital will be requested to submit an annual application containing the number of weighted FTE residents in all its graduate training programs. Using this data, the Secretary will calculate the hospital's direct GME payment using the following formula:

$$Y_i = \left(X * .711 * WI_i + X * .289\right) * FTE_i$$

Where—

X = national average per resident amount

X_z = national pro-rata average per resident amount (based on funds available)

WI = wage index (for the area in which the hospital is located)

FTE = weighted number of FTE residents working at the hospital

Y = direct GME payment to a hospital

i = indicates an individual hospital

n = the number of children's hospitals participating in the program

Σ = sum of (the following)

Z = the total funds available for direct payments

The total direct GME payments to all children's teaching hospitals equal the sum of payments to all individual hospitals:

$$Y_{total} = \sum_{i=1}^{n} X\left(.711 * WI_i + .289\right) * FTE_i$$

To calculate the *pro rata* average per resident amount based on the funds available (X_z) without knowing the national average per resident amount (X), the Secretary will use the following equation:

$$X_Z = Z / \sum_{i=1}^{n}\left(.711 * WI_i + .289\right) * FTE_i$$

The final **Federal Register** notice will contain a computed national per resident amount.

V. Determining Indirect Medical Education Payments

Sections 340E(a) and (b)(1)(B) require the Secretary to make payments for indirect expenses associated with operating approved graduate medical residency training programs for each of fiscal years 2000 and 2001. Section 340E(b)(1) requires that the payments be made for an approved program ''for a fiscal year,'' and section 340E(b)(1)(B) describes indirect payments as covering ''expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs.''

Subsection (e)(1) requires the Secretary to determine the amount of both direct and indirect payments for each hospital before the beginning of each fiscal year for which payments are made and to make these payments to each hospital in 26 equal installments during the fiscal year. Subsection (d)(2)(B) provides that the indirect payments are equal to the amount appropriated for such expenses for the fiscal year under subsection (f)(2), but unlike the DME payment, there is no provision for withholding a portion of IME payments or making a final reconciliation after the close of the fiscal year.

Section 340E(d)(2) requires the Secretary to determine the appropriate amount of indirect medical education payments for expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs to a children's hospital by considering:

- Variations in case mix among children's hospitals; and
- The hospitals' number of FTE residents in approved training programs.

Determination of Case Mix

The statute provides no guidance on the case mix measure to be used for determining indirect payments. Hence, the Secretary is seeking comments on this issue.

Case mix information for hospitals is typically generated as a by-product of a billing or administrative reporting system. Children's hospitals currently use various DRG systems and weights. These include the HCFA Diagnosis-Related Group (DRG); the All-Payer DRG (AP-DRG); and the All-Payer Refined DRG (APR-DRG) systems. To require a hospital to report its case mix index using a different classification system from its current system would create an administrative burden.

Accordingly, the Secretary proposes to:

(1) Identify the case-mix indexes that are commonly used by children's hospitals; and

(2) Explore the feasibility of adjustment factors derived from comparative studies that allow for approximate equilibration of the various case mix indexes that may be used.

Determining the Number of FTE Residents

Section (d)(2)(A) states that in determining the amount of payments to a children's hospital for indirect medical education expenses, the Secretary shall take into account '' * * * the number of full-time equivalent residents'' in the hospital's approved residency programs. Unlike direct payments, it does not specify that the FTE residents be counted as determined under section 1886(h)(4) of the Social Security Act. FTE residents under Medicare are also counted differently for direct (sec. 1886(h)(4)) of the Social Security Act) and indirect (42 CFR 412.105(a)(1)) payments. Under the latter, ''full-time equivalent residents'' are counted without the weighting applied to the count for direct payment determination.

The Secretary will use the number of FTE residents during the fiscal year as determined under 42 CFR 412.105(a)(1) to determine indirect payments to a hospital.

Factoring in Teaching Intensity

The statute does not specify a factor for determining teaching intensity. Traditionally, the indirect expenses associated with teaching activity are based on costs per case. Teaching hospitals tend to have higher costs per case relative to other hospitals in the same area with a comparable case mix. The higher costs are generally associated with treating a more critically ill patient population than non-teaching hospitals and with the use of more resources, such as diagnostic tests, when residents are involved in the care of patients. A close relationship exists between higher costs and teaching intensity as measured by the ratio of either interns/residents-to-beds, or the ratio of residents to the average daily census of the hospital.

The Secretary proposes to determine teaching intensity using one of the following factors derived from the Medicare formula:

- The ratio of residents to average daily census; or
- The ratio of residents to beds.

In summary, the Secretary proposes to calculate IME payments for a hospital using the number of FTE residents; a case mix index; a case mix adjustment factor to correlate hospitals' case mix information to the case mix index selected for the CHGME program; a teaching intensity adjustment; and volume. Due to the time required to statistically model and analyze the various alternatives, the case mix index, case mix adjustment factor, and the teaching intensity adjustment are not currently available. The Secretary will include a detailed methodology for distribution of the IME funds in the final **Federal Register** notice to be published in July. Although FY 2000 IME funds must be distributed this fiscal year based on the IME formula published in the July notice, we will solicit comments and change the distribution formula for subsequent cycles if appropriate.

VI. Evaluation Criteria

The CHGME program is subject to the Government Performance and Results Act of 1993 (GPRA), Public Law 103–62. GPRA provides Congress with information on whether and in what respects a program is working well or poorly to support its oversight of Federal agencies and their budgets. Therefore, GPRA requires each Federal agency to prepare an annual performance plan covering each program activity set forth in the budget of the agency. The Department must evaluate all programs for effectiveness, efficiency, and continuous improvement. To measure effectiveness, it must obtain performance information from recipients of HHS funds.

Performance Goals

The performance goals described below are those included in the President's FY 2001 GPRA performance plan. These goals are still formative because HHS is unable to set targets until it obtains the necessary data. The Department requests public comment on the appropriateness and feasibility of these performance measures. The Department is particularly interested in receiving comments on the feasibility of each goal, in terms of the hospitals' ability to both provide data and measure the success of the program.

Goals I and II listed below take into consideration that some information requirements may be more easily obtained for residents in programs sponsored by the children's hospital than for residents who rotate in from programs sponsored by another teaching hospital. Comments are requested on the practicality and value of reporting this information on residents who rotate in from programs sponsored by other hospitals, as well as those from residency programs sponsored by the children's hospital.

Proposed Goal I: Eliminate Barriers to Care

A. Maintain the number of FTE residents supported by the children's hospitals receiving funds under the program. The health care workforce environment requires that sufficient numbers and types of physicians be appropriately and adequately trained to care for pediatric populations. Financial pressures common to the academic health center community may raise interest in reducing or eliminating training programs. These hospitals and their training programs provide a significant service to the local, regional, and sometimes national community. A reduction in training programs could impair the provision of those services as well as the production of one-quarter of the Nation's pediatricians and a majority of pediatric specialists. The following data elements provide an accurate accounting of and trends in the number of resident FTEs training in children's hospitals, and are fundamental in determining payments under the program.

Proposed Required Data: While the number of trainees in a given hospital's training program is currently collected by the Health Care Financing Administration (HCFA) for freestanding children's hospitals that request reimbursement from Medicare, not all freestanding children's hospitals that are eligible for participation in the CHGME Program have submitted this information to HCFA. Generally, each hospital has a fairly good accounting of the number of trainees in residency programs sponsored directly by the hospital; but, accounting for the number of trainees rotating to a freestanding children's hospital for a portion of their training is more complicated. Not all children's hospitals have quantified the FTE residents rotating to their hospital from other training programs.

To receive CHGME payments, hospitals must accurately report trainees' numbers. HHS proposes to require each hospital to submit on an annual application the aggregate number of FTE residents, by program, who are:

- In the recipient children's hospital and sponsored by the hospital;
- Rotating into the recipient hospital from residency programs sponsored by other institutions; and
- Sponsored by the hospital and rotating to other hospitals.

These data should already be available now from children's hospitals that furnish Medicare cost report resident data and submit reports under the IRIS. As noted above, comment is being solicited on whether the program should require the standardized reporting of resident counts that is currently required by Medicare in cost reports and IRIS.

B. Increase the percentage of residents' training that is supported in rural and underserved areas. Research on access to health care services has focused on the contribution of physicians treating the underserved. Residency training programs located in rural areas and medically underserved communities (MUCs) (as defined in sec. 799B(6) of the PHS Act; 42 U.S.C. 295p(6)) provide much needed care in their communities while residents learn the knowledge, skills and attitudes necessary to adequately and appropriately care for these rural and underserved populations.

Proposed Required Data: The Department proposes to require each hospital to submit on an annual application the FTE count for resident time spent in training in MUCs and rural areas. The definition for the designation of rural areas will be taken from the United States Department of Agriculture's Urban-Rural County Continuum Code classification system.

Proposed Goal II: Improve Public Health and Health Care Systems.

A. Monitor financial status of hospitals' total and operating margins.

B. Monitor the proportion of uncompensated care patients.

C. Monitor the proportion of Medicaid patients. Children's hospitals have a very high portion of Medicaid patients, at 40 percent of gross patient revenues. Another 4 percent represent charity and bad debt. Children's hospitals also have on average poorer financial status than other teaching hospitals. In 1995, 58 percent of children's hospitals had negative operating margins. This may have been aggravated by major changes in the health care system, including the expansion of managed care and increased enrollments in Medicaid managed care, and increased efforts to constrain health care costs. These changes in the health care system put health facilities that train physicians at a competitive disadvantage. A negative operating margin could affect the long-term viability of children's hospitals and their ability to continue providing a high proportion of care to children covered by Medicaid and uncompensated care. It may also affect their ability to continue training a high proportion of the nation's general and subspecialty pediatric and other residents, since, in the competitive marketplace, payers of health care services have few if any incentives to pay higher costs to sites that train health professionals.

Proposed Required Data: The Department proposes to require each hospital to submit on an annual application the following:

- Total and operating margins;
- Percentage of patients served who are enrolled in Medicaid; and
- Percentage of uninsured patients and uncompensated care.

Economic and Regulatory Impact

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when rulemaking is necessary, to select regulatory approaches that provide the greatest net benefits (including potential economic, environmental, public health, safety distributive and equity effects). In addition, under the Regulatory Flexibility Act (RFA) of 1980, if a rule has a significant economic effect on a substantial number of small entities, the Secretary must specifically consider the economic effect of the rule on small entities and analyze regulatory options that could lessen the impact of the rule.

Executive Order 12866 requires that all regulations reflect consideration of alternatives, of costs, of benefits, of incentives, of equity, and of available information. Regulations must meet certain standards, such as avoiding an unnecessary burden. Regulations which are ''significant'' because of cost, adverse effects of the economy, inconsistency with other agency actions, effects on the budget, or novel legal or policy issues, require special analysis.

The Department has determined that resources to implement this rule are required only of the children's hospitals in submitting their applications and of the Department in reviewing them. Therefore, in accordance with the RFA of 1980, and the Small Business Regulatory Enforcement Fairness Act of 1996, which amended the RFA, the Secretary certifies that this rule will not have a significant impact on a substantial number of small entities. The Secretary has also determined that this rule does not meet the criteria for a major rule as defined by Executive Order 12866 and would have no major effect on the economy or Federal expenditures.

We have determined that the rule is not a ''major rule'' within the meaning of the statute providing for Congressional Review of Agency Rulemaking, 5 U.S.C. 801. Similarly, it will not have effects on State, local, and tribal governments and on the private sector such as to require consultation under the Unfunded Mandates Reform Act of 1995.

Further, Executive Order 13132 establishes certain requirements that an agency must

meet when it promulgates a rule that imposes substantial direct compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed action under the threshold criteria of Executive Order 13132, Federalism, and, therefore, have determined that this action would not have substantial direct effects on the rights, roles, and responsibilities of States.

Paperwork Reduction Act of 1995

In accordance with section 3507(a) of the Paperwork Reduction Act (PRA) of 1995, the Department is required to solicit public comments, and receive final Office of Management and Budget (OMB) approval, on collections of information. As indicated, in order to implement the Children's Hospital Graduate Medical Education Payment Program (CHGME), certain information is required as set forth in this notice in order to determine eligibility for payment.

In accordance with the PRA, we are submitting to OMB at this time the following requirements for seeking emergency review of these provisions. HRSA has requested an emergency review because the data collection and reporting of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR part 1320, to ensure the timely availability of data as necessary to ensure payment to eligible children's hospitals. A 30-day notice was published in the **Federal Register** on May 15, 2000 to provide for public comment and to request an expedited review of the information collection associated with the CHGME. Delaying the data collection would delay implementation of the statutory purpose of providing payments by the end of the fiscal year to children's hospitals that support training of residents in graduate medical education programs.

Collection of Information: The Children's hospital Graduate Medical Education Program.

Description: Data is collected on the number of full-time equivalent residents in applicant children's hospital training programs to determine the amount of direct and indirect expense payments to participating children's hospitals. Indirect expense payments will also be derived from a formula that requires the reporting of case mix index information from participating 25c children's hospitals. Hospitals will be requested to submit such information in an annual application.

Description of Respondents: Children's Hospitals operating approved graduate medical residency training programs.

Estimated Annual Reporting: The estimated average annual reporting for this data collection is approximately 138 hours per hospital. The estimated annual burden is as follows:

Form name	No. of respondents	Responses per respondent	Total responses	Hours per response	Total hour burden
Form E (Short)	42	1	42	99.9	4,194
Form E (Long)	12	1	12	46.7	560
Form F (Short)	42	1	42	8	336
Form F (Long)	12	1	12	8	96
IME Data	54	1	54	14	756
Required GPRA Tables	54	1	54	28	1,512
Total	54				7,454

National Health Objectives for the Year 2000

The Public Health Service is committed to achieving the health promotion and disease prevention objectives of Healthy People 2000, and its successor, Healthy People 2010. These are Department-led efforts to set priorities for national attention. The CHGME program is related to the priority area 1 (Access to Quality Health Services) in Healthy People 2010, which is available online at http://www.health.gov/healthypeople/.

Education and Service Linkage

As part of its long-range planning, HRSA will be targeting its efforts to strengthening linkages between Department education programs and programs which provide comprehensive primary care services to the underserved.

Smoke-Free Workplace

The Department strongly encourages all award recipients to provide a smoke-free workplace and promote abstinence from all tobacco products, and Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities that receive Federal funds in which education, library, day care, health care, and early childhood development services are provided to children.

This program is not subject to the Public Health Systems Reporting Requirements.

Dated: May 17, 2000.

Claude Earl Fox,

Administrator, Health Resources and Services Administration.

Dated: April 11, 2000.

Donna E. Shalala,

Secretary.

[FR Doc. 00–15332 Filed 6–16–00; 8:45 am]

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DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4564–N–04]

Notice of Proposed Information Collection: Healthy Homes Initiative

AGENCY: Office of Lead Hazard Control

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

DATES: *Comments Due Date:* August 18, 2000.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Ms. Gail Ward, Reports Liaison Officer, Department of Housing and Urban Development, 451 7th St., SW, Room P3206, Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Ellen R. Taylor (202) 755–1785 ext. 116 (this is not a toll free number), for copies of the proposed forms and other available documents.

SUPPLEMENTARY INFORMATION: The Department will submit the proposed information collection to OMB for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended).

The Notice is soliciting comments from members of the public and affected agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) Enhance