permit under 40 CFR part 70 or 40 CFR part 71" until the final reconsideration rule is published in the **Federal Register**.

III. What are the major comments and responses to those comments?

We received five comments in support of the proposed stay. In addition, four of the commenters also provided comments objecting to EPA finalizing the title V permit requirement as part of our reconsideration. Because we received no adverse comment on the proposed stay of the title V permitting requirement, we are taking final action to extend the stay until the final reconsideration rule is published in the **Federal Register**. This action deals only with the stay. We will discuss and request comment on the title V permitting issue in the forthcoming reconsideration notice.

IV. What are the changes since proposal?

No changes have been made to the proposed stay (75 FR 77799). Thus, the final rule is identical to the proposed rule.

V. What are the impacts of the final rule?

The stay will not change the estimated environmental and cost impacts of the rule because it does not apply to the control requirements in the rule. However, the burden associated with conducting activities related to preparing permit applications will, at a minimum, be delayed for the duration of the stay.

VI. Statutory and Executive Order Reviews

A. General Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), and Executive Order 13563 (76 FR 3821, January 21, 2011), this action is not a "significant regulatory action," and, therefore, is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, "Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use" (66 FR 28355, May 22, 2001). In addition, this action does not impose any enforceable duty or contain any unfunded mandate as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), or require prior consultation with State officials, as specified by Executive Order 12875 (58 FR 58093, October 28, 1993), or involve special consideration of environmental justice related issues, as required by Executive Order 12898 (59 FR 7629, February 16, 1994). Pursuant to the Regulatory Flexibility Act, I certify that this action will not have a significant economic impact on a substantial number of small entities. This final rule will not impose any new requirements on small entities. This action also does not have Tribal implications because it will not have a substantial direct effect on one or more Indian Tribes, on the relationship between the Federal government and Indian Tribes, or on the distribution of power and responsibilities between the Federal government and Indian Tribes, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This action also does not have Federalism implications because it does not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). This action also is not subject to Executive Order 13045 "Protection of Children from Environmental Health Risks and Safety Risks" (62 FR 19885, April 23, 1997). The requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This action does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, *et seq.*). EPA's compliance with these statutes and Executive Orders for the underlying rule is discussed in the October 29, 2009, **Federal Register** document.

B. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801, *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that, before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this notice and other required information to the United States Senate, the United States House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. The stay of these particular provisions in 40 CFR part 63, subpart VVVVVV is not a "major rule" as defined by 5 U.S.C. 804(2). This rule will be effective March 14, 2011.

List of Subjects in 40 CFR Part 63

Environmental protection, Administrative practice and procedure, Air pollution control, Reporting and recordkeeping requirements.

Dated: March 8, 2011.

Lisa P. Jackson,

Administrator.

For the reasons stated in the preamble, title 40, chapter I of the Code of Federal Regulations is amended as follows:

PART 63—[AMENDED]

■ 1. The authority citation for part 63 continues to read as follows:

Authority: 42 U.S.C. 7401, *et seq.*

§ 63.11494 [STAYED IN PART]

■ 2. In § 63.11494, paragraph (e) is stayed from March 14, 2011, until further notice.

[FR Doc. 2011–5778 Filed 3–11–11; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS–1430–IFC]

RIN 0938–AQ92

Medicare Program; Revisions to the Reductions and Increases to Hospitals' FTE Resident Caps for Graduate Medical Education Payment Purposes

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements section 203 of the Medicare and Medicaid Extenders Act of 2010 relating to the treatment of teaching hospitals that are members of the same Medicare graduate medical education affiliated groups for the purpose of determining possible full-time equivalent resident cap reductions.

DATES: *Effective Date:* These regulations are effective on March 14, 2011.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on April 13, 2011.

ADDRESSES: In commenting, please refer to file code CMS–1430–IFC. Because of staff and resource limitations, we cannot

accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed)

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1430–IFC, P.O. Box 8013, Baltimore, MD 21244–8013.

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

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1430–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201

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

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

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

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Tzvi Hefter, (410) 786–4487.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

A. Statutory Authority

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and as currently implemented in the regulations at 42 CFR 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act sets forth a methodology for the determination of a hospital-specific base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable direct costs of GME in a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, October 1, 1983 through September 30, 1984). The base year PRA is updated annually for inflation. In general, Medicare direct GME payments are calculated by multiplying the hospital's updated PRA by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (and at nonprovider sites, when applicable), and the hospital's Medicare share of total inpatient days.

Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the hospital inpatient prospective payment system (IPPS) for hospitals that have residents in an approved GME program in order to account for the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at 42 CFR 412.105. The hospital's IME adjustment applied to the DRG payments is calculated based on the ratio of the hospital's number of FTE residents training in either the inpatient or outpatient departments of the IPPS hospital to the number of inpatient hospital beds.

The Balanced Budget Act of 1997 (Pub. L. 105–33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its FTE resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997.

The recently enacted Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively referred to in this document as the Affordable Care Act) made a number of statutory changes relating to the determination of a hospital's FTE resident count for direct GME and IME payment purposes and the manner in which FTE resident limits are calculated and applied to hospitals under certain circumstances. Section 5503 of the Affordable Care Act added a new section 1886(h)(8) to the Act to provide for the reduction in FTE resident caps for direct GME under Medicare for certain hospitals, and to authorize the "redistribution" of the estimated number of FTE resident slots to other qualified hospitals. In addition, section 5503 amended section 1886(d)(5)(B)(v) of the Act to require the application of section 1886(h)(8) of the Act provisions "in the same manner" as the FTE resident caps for IME. The regulations implementing section 5503 of the Affordable Care Act were included in the Outpatient Prospective Payment System (PPS) Final Rule, published on November 24, 2010 in the **Federal Register** (75 FR 72147). The section below summarizes the provisions of section 5503 of the Affordable Care Act as implemented in

the November 24, 2010 **Federal Register**.

B. Reductions and Increases to Hospitals' FTE Resident Caps for GME Payment Purposes Under Section 5503 of the Affordable Care Act

As previously discussed, the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes. Dental and podiatric residents are not included in this statutorily mandated cap. Some hospitals have trained a number of allopathic and osteopathic residents in excess of their FTE resident caps, while other hospitals have reduced their FTE resident counts to some level below their FTE resident caps. Section 5503 of the Affordable Care Act added a new section 1886(h)(8) to the Act to provide for reductions in the statutory FTE resident caps for direct GME under Medicare for certain hospitals, and authorizes a "redistribution" to hospitals of the estimated number of FTE resident slots resulting from the reductions. Section 5503 of the Affordable Care Act also amended section 1886(d)(5)(B)(v) of the Act to require application of the provisions of 1886(h)(8) of the Act "in the same manner" to the FTE resident caps for IME.

The new section 1886(h)(8)(A) of the Act provides that, effective for portions of cost reporting periods occurring on or after July 1, 2011, a hospital's FTE resident cap will be reduced if its "reference resident level" is less than its "otherwise applicable resident limit," as these terms are described below. Section 1886(h)(8)(A)(ii) of the Act and the November 24, 2010 **Federal Register** (75 FR 72147) describes which hospitals are exempt from a cap reduction under section 5503 of the Affordable Care Act. Included in that group are rural hospitals with fewer than 250 acute care inpatient beds. For other hospitals, any such reduction will be equal to 65 percent of the difference between the hospital's "otherwise applicable resident limit" and its "reference resident level."

Under section 1886(h)(8)(B) of the Act, the Secretary is authorized to increase the FTE resident caps for certain categories of hospitals for portions of cost reporting periods occurring on or after July 1, 2011, by an aggregate number that does not exceed the estimated overall reduction in FTE resident caps for all hospitals under section 1886(h)(8)(A) of the Act. A single hospital may receive an increase in its FTE resident cap of no more than 75 additional FTEs. That is, a hospital would be allowed to receive up to 75 additional slots for direct GME and up to 75 additional slots for IME. In determining which hospitals would receive an increase in their FTE resident caps, sections 1886(h)(8)(C) through 1886(h)(8)(E) of the Act directs us to do all of the following:

- Take into account the demonstrated likelihood of the hospital filling the additional positions within the first three cost reporting periods beginning on or after July 1, 2011.
- Take into account whether the hospital has an accredited rural training track program.
- Distribute 70 percent of the resident slots to hospitals located in States with resident-to-population ratios in the lowest quartile.
- Distribute 30 percent of the resident slots to hospitals located in a State, a territory of the United States, or the District of Columbia that are among the top 10 States, territories, or Districts in terms of the ratio of the total population living in an area designated as a health professional shortage area (HSPA), as of March 23, 2010, to the total population, and/or to hospitals located in rural areas.

A comprehensive description of the rules implementing the cap slot redistribution under section 1886(h)(8) of the Act can be found in the November 24, 2010 **Federal Register** (75 FR 72168).

C. Treatment of Affiliated Groups Under Section 5503 of the Affordable Care Act

A previous redistribution of "unused" FTE resident slots was performed in 2005 under section 422 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108–173). Section 422 of the MMA provided for the redistribution of unused residency positions effective for portions of cost reporting periods beginning on or after July 1, 2005. While the redistribution under section 5503 of the Affordable Care Act as initially enacted is similar to the previous redistribution under section 422 of MMA, there are substantive differences between the two provisions. One of those differences involves the treatment of hospitals that were members of the same Medicare GME affiliated groups for purposes of determining whether a hospital should receive a cap reduction. The regulations governing Medicare GME affiliated groups and Medicare GME affiliation agreements are at 42 CFR 413.75(b) and 413.79(f), respectively. Medicare GME affiliation agreements allow teaching hospitals to temporarily transfer cap slots to other hospitals in order to facilitate the cross training of residents. The duration of the temporary cap slots transfer is a minimum of 1 year beginning on July 1 of a year, per the Medicare GME affiliation agreement.

Under section 422 of MMA, the statute explicitly directed the Secretary to apply the provisions to hospitals that were members of the same Medicare GME affiliated group as of July 1, 2003. Specifically, section 1886(h)(7)(A)(iii) of the Act states "The provisions of clause (i) shall be applied to hospitals which are members of the same Medicare GME affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) as of July 1, 2003." Therefore, in implementing section 422 of MMA, we based the FTE resident cap reductions for hospitals that were participating in a Medicare GME affiliated group on the aggregate cap and count data from all hospitals participating in the same Medicare GME affiliated group(s). If a hospital was training a number of residents below its FTE resident cap for the reference cost reporting period but the hospital was part of a Medicare GME affiliated group for some or all of that reference cost reporting period, the Medicare contractor determined if the aggregate affiliated count for all hospitals in the Medicare GME affiliated group was greater than the aggregate affiliated cap. If the aggregate affiliated count was greater than the aggregate cap, then there was no reduction made to the FTE caps of any hospital in the Medicare GME affiliated group (even for the hospital that was part of the Medicare GME affiliated group, but was training below its cap).

However, as we noted in the November 24, 2010 **Federal Register** (75 FR 72161), in contrast to section 422 of MMA, section 5503 of the Affordable Care Act as initially enacted did not include language specific to Medicare GME affiliated groups as was included in section 422 of MMA under section 1886(h)(7)(A)(iii) of the Act. Thus, section 5503 of the Affordable Care Act as initially enacted did not provide for determinations based on the aggregate experience of a Medicare GME affiliated group. Therefore, we stated in the November 24, 2010 **Federal Register** (75 FR 72161), that the determination of whether a hospital would receive a cap reduction based on that individual

hospital's experience and not the aggregate experience of the Medicare GME affiliated group.

D. Section 203 of the Medicare and Medicaid Extenders Act of 2010 (P.L. 111–309)

Section 203 of the Medicare and Medicaid Extenders Act of 2010 (MMEA) further amended section 1886(h)(8) of the Act by adding the following new subparagraph:

(I) Affiliation.—The provisions of this paragraph shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and the reference resident level for each such hospital shall be the reference resident level with respect to the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit.

This paragraph refers to the treatment of hospitals that are members of the same Medicare GME affiliated groups, as described in section C of this interim final rule for purposes of determining a hospital's possible cap reductions under section 1886(h)(8)(A) of the Act. Similar to section 422 of MMA, this amendment to the language at section 1886(h)(8) of the Act allows us to consider hospitals that are members of the same Medicare GME affiliated group in the aggregate, rather than only on an individual basis, for the purposes of determining a GME FTE cap reduction.

Although this amendment allows us to implement section 5503 of the Affordable Care Act in a manner similar to section 422 of MMA, a key difference in implementation remains. One point of note is that section 422 of MMA, (section 1886(h)(7)(A)(ii)(I) of the Act) refers to the most recent cost reporting period ending on or before September 30, 2002 as the reference cost reporting period. However, as stated in the August 11, 2004 **Federal Register** (69 FR 49125), if a hospital was a member of a Medicare GME affiliated group for the academic year beginning July 1, 2003, then its reference cost reporting period was the cost reporting period that included July 1, 2003. This differs from section 5503 of the Affordable Care Act which instructs the Secretary to choose the reference cost reporting period out of the hospital's three most recent cost reporting periods ending before March 23, 2010 for which a cost report has been settled or has been submitted to the Medicare contractor by March 23, 2010, that has the highest FTE resident count section 1886(h)(8)(H)(i)) of the Act.

For hospitals that were members of the same Medicare GME affiliated groups, the MMEA now allows us to determine the reference cost reporting period as the cost reporting period out of the hospitals three most recent cost reporting periods ending before March 23, 2010 for which a cost report has been settled or has been submitted to the Medicare contractor by March 23, 2010 with the smallest difference between the reference resident level and the otherwise applicable resident limit (section 1886)(h)(8)(I) of the Act). Therefore based on the amendment made to section 1886(h)(8) of the Act by section 203 of the MMEA adding subparagraph (I), we are establishing in this interim final rule with comment period, a methodology to determine whether a hospital is subject to a cap reduction under section 5503 of the Affordable Care Act based on that hospital's participation in a Medicare GME affiliated group(s) or an emergency Medicare GME affiliated group under 42 CFR 413.79(f). Although the MMEA provision applies to both regular Medicare GME affiliation agreements and emergency Medicare GME affiliation agreements, for ease of reference, we will refer in this discussion to both with the term Medicare GME affiliation agreements. We believe the purpose of section 203 of MMEA is to amend section 1886(h)(8) of the Act in order to implement section 5503 of the Affordable Care Act in a manner that is similar to section 422 of MMA with regard to treatment of hospitals that are members of the same Medicare GME affiliated group. Accordingly, we are implementing section 203 of the MMEA in a manner similar to the way in which section 422 of MMA was implemented. The methodology used to determine a cap reduction for hospitals which are members of the same affiliated group is as follows:

Part 1: Determine the "Reference Cost Reporting Period"

The Medicare contractor will assess each hospital on an individual basis. First, the Medicare contractor will determine whether a hospital was a member of a Medicare GME affiliated group at any point during any of the hospital's three most recent cost reporting periods ending before March 23, 2010 for which a cost report has been settled or has been submitted to the Medicare contractor by March 23, 2010. That is, the Medicare contractor will determine whether the caps during any of those three cost reporting periods were revised because the hospital was a member of a Medicare affiliation agreement. If a hospital was not a member of a Medicare GME affiliated group during any of those three cost reporting periods, then the Medicare contractor will determine if and by how much that hospital's FTE resident caps should be reduced in accordance with the policy established in the November 24, 2010 final rule (75 FR 72155 through 72168).

If the Medicare contractor determines that a hospital was a member of a Medicare GME affiliated group at any point during any of the three most recent cost reporting periods ending before March 23, 2010 for which a cost report has been settled or has been submitted to the Medicare contractor by March 23, 2010, then subparagraph (I) applies, and the Medicare contractor will determine a hospital's reference cost reporting period by determining the cost reporting period from the three most recent cost reporting periods ending before March 23, 2010 for which a cost report has been settled or has been submitted to the Medicare contractor by March 23, 2010, that results in the smallest difference between the reference resident level and the otherwise applicable resident limit. For example, a hospital with a FYE of December 31 may not be a member of a Medicare GME affiliated group for the academic years beginning July 1, 2006, 2007, or 2008, but it may be a member of a Medicare GME affiliated group for the academic year beginning July 1, 2005. In the cost reporting period ending December 31, 2006, the months of January through June 2006 would be affected by the July 1, 2005 Medicare GME affiliation agreement. Therefore, in this example, the hospital is indeed a member of a Medicare GME affiliated group at some point, albeit for only a portion of a cost reporting period, during its three most recent cost reporting periods ending before March 23, 2010 for which a cost report has been settled or has been submitted to the Medicare contractor by March 23, 2010 (in this case, these cost reporting periods would include FYE 12/31/08, FYE 12/31/07, and FYE 12/31/06), and as such its reference cost reporting period would be determined as the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit. As previously discussed, section 422 of the MMA specified a single time period that would be used for all hospitals that were members of a Medicare GME affiliated group; that is as of July 1, 2003. However, section 5503 of the Affordable Care Act does not specify one cost reporting period, but rather it specifies that the reference cost

reporting period is one out of three possible cost reporting periods. For a hospital that was a member of a Medicare GME affiliated group at any point during any of the three applicable cost reporting periods, after determining the cost report that is a hospital's reference cost reporting period based on the cost report that results in the smallest difference between the reference resident level and the otherwise applicable resident limit, to determine whether there are any excess slots we believe it is appropriate to consider whether a hospital was a member of a Medicare GME affiliated group as of July 1 of that reference cost reporting period. The hospital may or may not have been a member of a Medicare GME affiliated group during that reference cost reporting period. We do not believe that section 1886(h)(8)(I) of the Act, as added by section 203 of the MMEA, requires that a hospital must be a member of a Medicare GME affiliated group during all 3 cost reporting periods, nor during the year determined to be the reference cost reporting period. Rather, being a member of a Medicare GME affiliated group at some point in just one of the three cost reporting periods warrants that a hospital's reference cost reporting period be determined based on which cost report has the smallest difference between the reference resident level and the otherwise applicable resident limit. To determine if an FTE resident cap reduction is appropriate, if the hospital was a member of a Medicare GME affiliated group as of July 1 in the reference cost reporting period, we will look at the Medicare GME affiliated group in the aggregate, when we determine if the subject hospital has excess capacity for purposes of a reduction under sections 5503 and 203. If the hospital was not a member of a Medicare GME affiliated group as of July 1 in the reference cost reporting period, excess FTEs training at other members of the affiliated group will not be considered for the purposes of a reduction under sections 5503 and 203 and that hospital's FTE resident caps should be reduced in accordance with the policy established for hospitals that are not members of Medicare GME affiliated groups in the November 24, 2010 final rule (75 FR 72155 through 72168). The nature of this determination underscores the fact that reductions to the FTE resident caps of hospitals that are members of Medicare GME affiliated groups must still be made on an individual hospital basis. The following is an example of a reference cost reporting period determination. (For ease of illustration, this example focuses on reductions to the IME FTE resident caps only, but the methodology is the same for reductions to the direct GME FTE resident caps):

Hospital A has a FTE resident cap of 10 FTE residents. Hospital A's three most recent cost reports that have been settled or submitted to the Medicare contractor by March 23, 2010 include cost reporting periods with FYE 12/31/2006, 12/31/2007, and 12/31/2008. During these three cost reporting periods, Hospital A trained 8, 9, and 9 FTE residents, respectively. For the academic years beginning July 1, 2006 and July 1, 2007, Hospital A was not a member of a Medicare GME affiliated group. However, for the academic year beginning July 1, 2008, Hospital A is affiliated with Hospital B and Hospital C. As a result of its Medicare GME affiliation agreement with Hospitals B and C, Hospital A's adjusted cap or otherwise applicable resident limit is 12 for the academic year beginning July 1, 2008. Thus, when determining the reference cost reporting period for Hospital A, the Medicare contractor would compare the resident level for Hospital A with its otherwise applicable resident limit for each of the cost reporting period as indicated below:

- Cost Reporting Period 1 (01/01/2006–12/31/2006): 10 (FTE Resident Cap) − 8 (FTE Resident Count) = 2.
- Cost Reporting Period 2 (01/01/2007–12/31/2007): 10 (FTE Resident Cap) − 9 (FTE Resident Count) = 1.
- Cost Reporting Period 3 (01/01/2008–12/31/2008): 11 (Adjusted FTE Resident Cap) − 9 (FTE Resident Count) = 2.

(Note that although Hospital A received an increase of 2 FTEs, from 10 to 12, under the Medicare GME affiliation agreement for the academic year beginning July 1, 2008, since Hospital A has a 12/31 fiscal year end, the actual cap adjustment is prorated to half of 2, for an increase to its FTE resident cap of 1, equaling 11). In this example, the smallest difference between the reference resident level and the otherwise applicable resident limit for Hospital A is 1, which occurs in the cost reporting period with FYE 12/31/2007. Thus, Hospital A's reference cost reporting period is 01/01/2007–12/31/2007. Note that Hospital A is not a member of a Medicare GME affiliated group during FYE 12/31/07. The implications of this are discussed below.

Part 2: Determine the Applicable Reductions

For a hospital that was a member of a Medicare GME affiliated group at any point during any of its three most recent cost reporting periods ending before March 23, 2010 for which a cost report has been settled or has been submitted to the Medicare contractor by March 23, 2010, once the Medicare contractor determines that hospital's reference cost reporting period (that is, the cost report with the smallest difference between the hospital's FTE resident cap and FTE resident count), the Medicare contractor must then determine if the hospital was a member of a Medicare GME affiliated group as of the July 1 that occurs during that reference cost reporting period. If not, and the hospital's FTE resident count was equal to or exceeded its FTE resident cap in that reference cost report, then no reduction to its FTE resident cap is made and no further steps are necessary. If that hospital's FTE resident count was less than its FTE resident cap during that reference cost report, then the Medicare contractor would reduce the FTE resident cap by 65 percent of the difference between the FTE resident cap and the FTE resident count.

If the hospital was a member of a Medicare GME affiliated group as of the July 1 that occurs during that reference cost reporting period, the Medicare contractor will look at the members of the Medicare GME affiliated group for that period in the aggregate, for the purpose of determining a reduction to the particular hospital's FTE resident cap. In other words, assuming the Medicare contractor is assessing Hospital X, once it is determined that Hospital X was training residents below its adjusted FTE resident cap as part of a Medicare GME affiliation agreement occurring during Hospital X's reference cost reporting period, the Medicare contractor will treat the hospitals in the Medicare GME affiliated group in the aggregate, but only for the purpose of determining the reduction to Hospital X's FTE resident cap. The Medicare contractor would not actually reduce the FTE resident caps of the other hospitals that were affiliated with Hospital X in that year, since each hospital is evaluated separately, and it may be that the reference cost reporting periods for the other hospitals may not be the same as Hospital X's reference cost reporting period. (It may be that the reference cost reporting period for another hospital is one in which that hospital was not part of a Medicare GME affiliated group, in which case, treatment as a group is not warranted when determining that hospital's FTE cap reduction).

For the hospital that was a member of a Medicare GME affiliated group as of the July 1 that occurs during that

reference cost report, the Medicare contractor will determine for each hospital in the Medicare GME affiliated group respectively its FTE resident cap and FTE resident count (IME and direct GME separately). The Medicare contractor will add each hospital's FTE resident caps (IME and direct GME separately) to determine the aggregate affiliated FTE resident cap. The contractor will then add each hospital's FTE resident count (IME and direct GME separately) to determine the aggregate affiliated FTE resident count. If the aggregate FTE resident counts are equal to or exceed the aggregate FTE resident caps, then no reductions would be made to that particular hospital's FTE resident cap under section 5503 of Affordable Care Act, and no further steps are necessary for that hospital. We emphasize that at this point, it has only been determined that the particular hospital will not be subject to an FTE resident cap reduction—as the FTE resident cap reduction determination is ultimately one that is done on an individual hospital basis, at this point the contractor has not made any determinations regarding the status of the other hospitals that are in the same Medicare GME affiliated group as the particular hospital under review.

However, where the aggregate FTE resident count is below the aggregate FTE resident cap (IME and direct GME separately), a reduction to the particular hospital's FTE resident cap would be necessary. In these cases, for each hospital that is a member of the same Medicare GME affiliated group, the Medicare contractor will determine the following FTE information from the cost report that includes July 1 of the particular hospital's reference cost reporting period:

(1) The "1996" FTE resident cap (as adjusted by new programs, if applicable) for the hospital under review— For IME from Worksheet E, Part A of the Medicare cost report, the sum of lines 3.04 and 3.05. If the hospital's IME FTE resident cap was reduced under section 422 of the MMA, subtract from this sum the amount reported on Worksheet E–3, Part VI, line 13. For direct GME from Worksheet E–3, Part IV of the Medicare cost report, the sum of lines 3.01 and 3.02. If the hospital's direct GME FTE resident cap was reduced under section 422 of the MMA, subtract from this sum the amount reported on Worksheet E–3, Part VI, line 2.

(2) The "affiliated" FTE resident cap for the hospital being assessed—For IME, line 3.07. For direct GME, line 3.04.

(3) The total number of allopathic and osteopathic FTE residents for the hospital being assessed—For IME, line 3.08. For direct GME, line 3.05.

(4) The difference between the aggregate "affiliated" FTE resident cap and the total FTE resident counts for all of the affiliated hospitals—For IME, Σ line 3.08 minus Σ (lines 3.04 + 3.05 − applicable section 422 reduction amount). For direct GME, Σ line 3.05 minus Σ (lines 3.01 + 3.02 − applicable section 422 reduction amount).

(5) For IME, for those hospitals whose FTE resident count from line 3.08 is greater than the "affiliated" FTE resident cap on line 3.07, indicate "zero." For direct GME, for those hospitals whose FTE resident count from line 3.05 is greater than the "affiliated" FTE resident cap on line 3.04, indicate "zero." For IME, for those hospitals whose FTE resident count from line 3.08 is less than the "affiliated" FTE resident cap on line 3.07, determine the difference between the hospital's "affiliated" FTE resident cap and the hospital's FTE resident count, line 3.08 minus line 3.07. For direct GME, for those hospitals whose FTE resident count from line 3.05 is less than the "affiliated" FTE resident cap on line 3.04, determine the difference between the hospital's "affiliated" FTE resident cap and the hospital's FTE resident count, line 3.05 minus line 3.04.

(6) For IME and direct GME separately, to determine the total amount by which the FTE resident counts are below the "affiliated" FTE resident caps and add the amounts determined under step 5 for each hospital that trained fewer residents than its "affiliated" FTE resident caps.

(7) For IME and direct GME separately, determine a pro rata cap reduction for the hospital being assessed by dividing the hospital-specific amount in step 5 by the total amount for all of those hospitals in step 6, and multiply by the amount in step 4. (that is, (step5/step6) × step 4).

(8) For IME and direct GME separately, determine the actual cap reduction for the hospital being assessed by multiplying the pro rata cap reduction from step 7 by 0.65.

(9) For IME and direct GME separately, determine the reduced FTE resident cap for the hospital being assessed by subtracting the actual cap reduction from step 8 from the "1996" FTE resident cap from step 1. This is the hospital's FTE resident cap effective July 1, 2011.

The following is an example of how the reductions to the FTE resident caps will be determined where the FTE resident counts in the aggregate for hospitals that were affiliated as of July 1 of the reference cost reporting period for a particular hospital are below the hospitals' FTE resident caps in the aggregate. For ease of illustration, this example focuses on reductions to the IME caps only, but the methodology is the same for reductions to the direct GME caps.

In this example, the Medicare contractor has determined, using the methodology from Step 1, that the reference cost reporting period (the period with smallest difference between the reference resident level and the otherwise applicable resident limit) for Hospital D is January 1, 2007 to December 31, 2007. The academic year that occurs in this reference cost reporting period begins July 1, 2007. Hospitals D, E, and F are members of a Medicare GME affiliated group for the academic year that begins July 1, 2007. Hospital D is also separately affiliated with Hospitals G and H for the academic year that begins July 1, 2007. Thus, the affiliated group for GME payment purposes, and for purposes of determining possible FTE cap reductions for Hospital D under subparagraph (I) consists of Hospitals D, E, F, G, and H. Hospital E's cost report that includes July 1, 2007 is FYE June 30, 2008. Hospital D's, F's, and G's cost report that includes July 1, 2007 is their FYE December 31, 2007, and Hospital H's cost report that includes July 1, 2007 is its FYE September 30, 2007. Using steps 1 through 9 above, the reduction to the FTE resident caps for Hospital D is determined in the table below.

Hospital	1996 FTE Caps (Step 1)	"Affiliated" FTE cap (Step 2)	FTE Count (Step 3)	Number of FTEs below the "Affiliated" Cap (Step 5)	Pro rate reduction (Step 7)	Actual Cap Reduction (Step 8)	Final FTE Cap (Step 9)
D	115	90	75	−15	−8	−5.2	109.8
E	80	100	125	0	N/A	N/A	N/A
F	120	10	10	0	N/A	N/A	N/A

Hospital	1996 FTE Caps (Step 1)	"Affiliated" FTE cap (Step 2)	FTE Count (Step 3)	Number of FTEs below the "Affiliated" Cap (Step 5)	Pro rate reduction (Step 7)	Actual Cap Reduction (Step 8)	Final FTE Cap (Step 9)
G	95	115	125	0	N/A	N/A	N/A
H	30	125	65	−60	N/A	N/A	N/A
Totals	440	440 Step 4→	400 −40	−75 Step 6↑	N/A	N/A	N/A

In this example, Hospital D's FTE resident count of 75 was 15 less than its "affiliated" FTE resident cap of 90, and Hospital H's FTE resident count of 65 was 60 less than its "affiliated" FTE resident cap of 125 (as determined under step 5). Hospital F's "affiliated" FTE resident cap equaled its FTE resident count. Under this methodology, the fact that Hospitals E and G exceeded their respective "affiliated" FTE resident caps minimizes the reductions to Hospital D's "1996" FTE resident caps through the calculation of a pro rata reduction under step 7.

We note that although Hospital H is also under its cap; its cap is not reduced in this exercise. Under section 5503, the cap reduction determination is calculated individually for each hospital based on its individual reference cost reporting period, so each hospital would be evaluated for a possible reduction separately. Hospital H will be evaluated separately, and it may be that Hospital's H reference cost report may not be its FYE September 30, 2007 cost report, and ultimately, Hospital H may or may not be subject to an FTE resident cap reduction. Thus, under step 8, the actual cap reduction of 5.2 FTEs for Hospital D is determined by taking 65 percent of 8 (rather than 65 percent of 15). As a result, under step 9, Hospital D's final FTE resident cap effective on July 1, 2011 is determined to be 109.8 FTEs.

We also note that the reduction to Hospital D's "1996" FTE resident caps was minimized only because Hospitals E and G exceeded their "affiliated" FTE resident caps. If all hospitals in the Medicare GME affiliated group had trained residents below their "affiliated" FTE resident caps, then a pro rata reduction would not benefit Hospital D. In that case, the "1996" FTE resident caps of Hospital D in the Medicare GME affiliated group would be reduced by 65 percent of the difference between its "affiliated" FTE resident cap and FTE resident count.

We believe this final policy is similar to the method used to implement section 422 of the MMA with regard to hospitals that were members of the same Medicare GME affiliated group in that, as under section 422 of the MMA, we are only treating a hospital as part of a group if the hospital was a member of a Medicare GME affiliation agreement during its reference cost reporting period under section 1886(h)(8) of the Act. In implementing section 203 of the MMEA in this manner, we believe we have addressed the concerns raised by commenters in response to the CY 2011 Outpatient PPS proposed rule (75 FR 46395 August 3, 2010) in that this policy could protect hospitals from a loss of slots if the aggregate counts equal to or exceed the "affiliated" FTE resident caps, and could limit the loss of slots in the instance where a hospital is a member of a Medicare GME affiliated group and the aggregate counts are below the "affiliated" FTE resident caps.

II. Provisions of the Interim Final Rule

As part of the CY 2011 Hospital Outpatient PPS final rule published in the November 24, 2010 **Federal Register** (75 FR 71800), we implemented section 5503 of the Affordable Care Act, which added a new section 1886(h)(8) to the Act. Section 5503 of the Affordable Care Act provides for reductions in the statutory FTE resident caps for direct GME under Medicare for certain hospitals, and authorizes a "redistribution" to hospitals of the estimated number of FTE resident slots resulting from the reductions. Section 5503 of the Affordable Care Act also amended section 1886(d)(5)(B)(v) of the Act to require application of the provisions of 1886(h)(8) of the Act "in the same manner" to the FTE resident caps for IME. Section 1886(h)(8) of the Act requires that any such reduction to the FTE resident caps will be equal to 65 percent of the difference between the hospital's "otherwise applicable resident limit" and its "reference resident level." Section 5503 of the Affordable Care Act as initially enacted did not include language specific to Medicare GME affiliated groups and did not provide for FTE resident cap reduction determinations based on the aggregate experience of a Medicare GME affiliated group. Accordingly, section 203 of the MMEA further amended section 1886(h)(8) of the Act to specify that the provisions of section 1886(h)(8) of the Act shall be applied to hospitals which are members of the same Medicare GME affiliated group, and the "reference resident level" for each such hospital is the FTE resident count from the cost reporting period that results in the smallest difference between the FTE resident count and the FTE resident cap. We are revising § 413.79(m)(7) to reflect the changes made by section 203 of the MMEA.

III. Response to Comments

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

IV. Waiver of Proposed Rulemaking, 60-Day Comment Period, and Delay of Effective Date

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (APA), we are required to publish a notice of proposed rulemaking (NPRM) in the **Federal Register**. Section 1871(b)(1) of the Act imposes a similar requirement: that the Secretary publish a **Federal Register** notice with not less than 60 days for public comment. In addition, both authorities mandate a 30-day delay in effective date.

Section 553(b)(B) of the APA provides for an exception from these APA requirements; in cases in which this exception applies, section 1871(b)(2)(C) of the Act provides an exception from the notice and delayed effective date requirements of the Act as well. Section 553(b)(B) of the APA authorizes an agency to dispense with normal rulemaking requirements for good cause if the agency makes a finding that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest. In addition, both section 553(d)(3) of APA and section 1871(e)(1)(B)(ii) of the Act allow the agency to avoid the 30-day delay in

effective date where such delay is contrary to the public interest and an agency includes a statement of support.

Here, section 203 of the MMEA amends section 1886(h)(8) of the Act. Regulations implementing section 5503(a) of the ACA were published in the November 24, 2010 **Federal Register**. The amendment made by section 203 of the MMEA is effective as if included in the enactment of section 5503(a) of the Affordable Care Act. Specifically the amendments apply to portions of cost reporting periods occurring on or after July 1, 2011. As a result, given the December 15, 2010 enactment of the MMEA, there was and there is a finite and, under the circumstances, highly compressed window of opportunity to complete implementation before the statutory deadline. Time pressure is acute because the agency must commence implementation substantially in advance of its July 1, 2011 deadline or risk a cascade of missed deadlines and failed intermediate steps, jeopardizing the program. Binding instructions must be given to Medicare contractors and hospitals as soon as possible to enable them to undertake critical first steps in a tight chain of business decisions that must precede implementation of the new provision.

As we indicate in section VI.C., the effect of section 203 of the MMEA is that it benefits member hospitals of Medicare GME affiliated groups by protecting them from or mitigating their loss of residency slots. Prior implementation of section 422 of the MMA, which similarly redistributed unused FTE resident cap slots to other qualifying hospitals, suggests that significant time is required to implement this type of provision. The MMA was passed in December 2003, and was effective on July 1, 2005. Unlike section 5503 of the ACA, section 422 of the MMA, as originally enacted, already included language giving special consideration to the treatment of members of Medicare GME affiliated groups. We published final regulations implementing the process for reducing the FTE resident caps of certain teaching hospitals, both members of Medicare GME affiliated groups and those that were not affiliated, by August 1, 2004 (69 FR 49111). Since section 422 of the MMA was effective on July 1, 2005, the agency had 11 months between August 2004 and July 1, 2005 to implement section 422 of the MMA.

In this case, the statutory deadline provides the agency with significantly less time to implement section 5503 of the ACA and section 203 of the MMEA than it had to implement section 422 of the MMA. The ACA was passed on March 23, 2010, and we included the proposal for section 5503 of the ACA in the CY 2011 OPPS proposed rule; the final rule was not issued until November 1, 2010 (75 FR 72133). Since section 5503 of the ACA must be implemented to be effective on July 1, 2011, this means that we have only 8 months (as compared to the 11 months under section 422 of the MMA) to implement section 5503. Moreover, because the language regarding special treatment of hospitals that are members of Medicare GME affiliated groups was not passed as part of the MMEA until December 15, 2010, yet it has the same effective date of July 1, 2011 as section 5503 of ACA, the amount of time available to implement the provision by July 1, 2011 has been further reduced to approximately 4 months. Facing this comparatively brief window, and based on historical experience, we find that it would be impracticable for us and our contractors to perform enough GME audits to assure the validity of as-submitted cost report data that are necessary for implementation—especially while simultaneously reviewing for regulatory compliance many hundreds of applications requesting additional slots.

The implementation of section 5503 of ACA and section 203 of the MMEA, as we learned when implementing section 422 of the MMA, requires significant planning, coordination, and investment of time and audit resources. There are approximately 1,100 teaching hospitals and more than 300 of them are members of Medicare GME affiliated groups. Many of these teaching hospitals have hundreds of residents, and it can take a Medicare contractor many weeks or months to audit the data on each as-submitted cost report. On January 7, 2011, we issued instructions to the contractors instructing them to begin audits for the purpose of implementing section 5503 of ACA. In those instructions, and in the CY 2011 OPPS final rule (75 FR 72153), we stated that the contractors are required to submit their estimates of each teaching hospital's FTE resident cap reduction, if any, to CMS by May 16, 2011. This would allow us to create the "pool" of slots available for redistribution, and to start assigning those slots to qualifying hospitals based on applications we reviewed between January 21, 2011 and May 2011. Even prior to May 16, 2011, the Medicare contractors will need time to notify hospitals of their tentative findings and allow hospitals to react to the potential FTE resident cap reductions. Unfortunately, many audits have yet to begin, as the Medicare contractors have been waiting for instructions regarding treatment of hospitals that are members of Medicare GME affiliated groups.

For these reasons, that is, because we face an extremely compressed timeframe; because Medicare contractors and hospitals need to make critical business decisions and systems changes far in advance, each constituting a material change of position that would be costly and impracticable to reverse; because historical evidences suggests that even a slight delay could prevent timely implementation of this Congressionally mandated policy change; and because it is therefore probable that failing to act early would have adverse financial impacts for teaching hospitals and the Federal government—we have concluded that there is good cause to waive ordinary rulemaking provisions as they are impracticable and contrary to the public interest in this case, and issue interim final regulations as soon as possible, that being necessary to implementing section 203 of the MMEA in an accurate, comprehensive, and timely manner. We are providing a 30-day public comment period.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995. (44 U.S.C. Chapter 35)

VI. Regulatory Impact Statement

A. Statement of Need

Section 5503 of the Affordable Care Act provides for reductions in the statutory FTE resident caps under Medicare for certain hospitals and authorizes a "redistribution" of the FTE resident slots resulting from the reduction in the FTE resident caps to other hospitals. The purpose of section 5503 is to allow hospitals in certain states that wish to start new or expand existing programs in primary care or general surgery but are already training residents at or above their FTE resident caps to use slots from other hospitals that have not been using all of their slots. Section 203 of the Medicare and Medicaid Extenders Act of 2010 amended section 1886(h)(8) of the Act (as added by section 5503 of the Affordable Care Act) to specify that the provisions of section 1886(h)(8)(A) of the Act shall be applied to hospitals

which are members of the same Medicare GME affiliated group, and the "reference resident level" for each hospital is the FTE resident count from the cost reporting period that has the smallest difference between the FTE resident count and the FTE resident cap. The purpose of section 203 is to take into account the unique situation of hospitals that are members of the same Medicare GME affiliated group in that they share FTE resident cap slots, and that FTE resident cap reduction determinations of hospitals should consider the shared nature of those slots.

B. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

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 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

In the November 24, 2010 final rule which implemented section 5503 of the Affordable Care Act (75 FR 72239), we mentioned that we were unable to project how many FTE resident slots will be available for redistribution under section 5503 of the Affordable Care Act. Unlike section 422 of the MMA, which also provided for a redistribution of FTE resident slots but provided that the redistributed slots will be paid using the national average per resident amount (PRA) for direct GME payment purposes, section 5503 of the Affordable Care Act requires that hospitals be paid for their additional FTE resident slots using the hospitals' specific PRAs. Because we were unable to determine the number of FTE resident slots that will be redistributed under section 5503 of the Affordable Care Act or which hospitals will be receiving additional FTE resident slots, we could not calculate a direct GME impact for section 5503 of the Affordable Care Act. Similarly, we cannot calculate a direct GME dollar impact for section 203 of the MMEA.

Although the general effect of section 203 of the MMEA is to protect from loss or mitigate the loss of slots of hospitals that are members of a Medicare GME affiliated group, there could be fewer direct GME and IME slots available for redistribution to other hospitals. For several reasons, we are unable to compute a dollar impact on the redistribution of those slots to other hospitals. First, although there are currently 307 hospitals that are members of a Medicare GME affiliated group, these hospitals were not necessarily members of Medicare GME affiliated groups during the reference cost reporting periods specified by section 5503 of the Affordable Care Act. Second, we do not know which hospitals, that are members of a Medicare GME affiliated group, will be at risk for losing direct GME and/or IME FTE resident cap slots under section 5503 of the Affordable Care Act, as revised by section 203 of the MMEA. Third, we do not know the PRAs and Medicare utilization rates of hospitals that will be receiving additional FTE resident slots. With respect to determining an impact for IME payment purposes, section 5503 of the Affordable Care Act requires us to use an IME multiplier of 1.35; however, we do not know the intern-to-bed ratio and resident-to-bed ratio for the hospitals that will receive additional FTE resident slots or the volume or case mix of Medicare discharges at those hospitals. Therefore, we cannot determine a financial impact for purposes of direct GME and IME for this provision. We solicit comment on our analysis.

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most physician practices, hospitals and other providers are small entities, either by nonprofit status or by qualifying as small businesses under the Small Business Administration's size standards (revenues of less than $7.0 to $34.5 million in any 1 year). States and individuals are not included in the definition of a small entity. For details, see the Small Business Administration's Web site at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2465b064ba6965cc1fbd2eae60854b11&rgn=div8&view=text&node=13:1.0.1.1.16.1.266.9&idno=13)*

Individuals and States are not included in the definition of a small entity. The Regulatory Flexibility Act requires an agency to prepare an initial regulatory flexibility analysis when they issue a general notice of proposed rule-making. However, HHS has maintained a long-standing policy of voluntarily preparing initial regulatory flexibility analyses for all rule-making. The Secretary has determined that this interim final rule 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 for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this interim final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2011, that threshold is approximately $136 million. This rule will have no consequential effect on State, local, or tribal governments 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 regulation does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

C. Anticipated Effects

We believe the general effect of section 203 of the MMEA is that it could protect from loss or mitigate the loss of slots for hospitals that are members of a Medicare GME affiliated group, and therefore, there could be fewer direct

GME and IME slots available for redistribution to other hospitals.

D. Alternatives Considered

Although there may be alternatives, the method we are finalizing in this interim final rule is the most consistent with that of a similar provision for hospitals that are members of Medicare GME affiliated groups implemented as part of section 422 of the MMA.

E. Conclusion

The analysis above, together with the remainder of this preamble, provides a Regulatory Flexibility Analysis as well as a Regulatory Impact Analysis. For the reasons outlined in the RIA, we are not preparing an analysis for either the RFA or section 1102(b) of the Act because we have determined that this interim final rule with comment would not have a direct significant economic impact on a substantial number of small entities or a direct significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

■ 1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332).

■ 2. Section 413.79 is amended by revising paragraph (m)(7) to read as follows:

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

(m) * * *

(7) *Consideration for members of Medicare GME affiliated groups.* For a hospital that is a member of a Medicare GME affiliated group at any point during any of the hospital's three most recent cost reporting periods ending before March 23, 2010 for which a cost report has been settled or has been submitted to Medicare contractor by March 23, 2010, in determining whether a hospital's otherwise applicable resident FTE resident cap is reduced under paragraph (m) of this section, the Medicare contractor determines a hospital's reference cost reporting period by finding the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit.

(i) If the reference resident level is less than the otherwise applicable resident limit in that reference cost reporting period, the Medicare contractor must then determine if the hospital was a member of a Medicare GME affiliated group as of the July 1 that occurs during that reference cost reporting period.

(ii) If the hospital was a member of a Medicare GME affiliated group as of the July 1 that occurs during that reference cost report, the Medicare contractor does all of the following:

(A) Treat the members of the Medicare GME affiliated group as a group for that reference cost reporting period, for the purpose of determining a reduction to the particular hospital's FTE resident cap.

(B) Determine for each hospital in the Medicare GME affiliated group respectively the FTE resident cap and FTE resident count (IME and direct GME separately).

(C) Add each hospital's FTE resident caps (IME and direct GME separately) to determine the aggregate FTE resident cap.

(D) Add each hospital's FTE resident count (IME and direct GME separately) to determine the aggregate FTE resident count.

(iii) If the aggregate FTE resident count is equal to or exceeds the aggregate FTE resident cap, then the Medicare contractor would make no reduction to the particular hospital's otherwise applicable FTE resident cap under paragraph (m) of this section, and no further steps are necessary for that hospital.

(iv) If the hospitals' aggregate FTE resident count is less than the aggregate FTE resident cap, then the Medicare contractor would determine on a hospital-specific basis whether the particular hospital's FTE resident count is less than its otherwise applicable FTE resident cap (as adjusted by affiliation agreement(s)) in the hospital's reference cost report.

(v) If the hospital's FTE resident count exceeds its otherwise applicable FTE resident cap, the hospital will not have its otherwise applicable FTE resident cap reduced under paragraph (m) of this section.

(vi) If the particular hospital's FTE resident count is less than its otherwise applicable FTE resident cap, the Medicare contractor determines a pro rata cap reduction amount that is equal, in total, to 65 percent of the difference between the aggregate FTE resident cap and the aggregate FTE resident count for the Medicare GME affiliated group.

(A) The pro rata cap reduction to the particular hospital's otherwise applicable FTE resident cap is calculated by dividing the difference between the hospital's otherwise applicable FTE resident cap and the hospital's FTE resident count, by the total amount by which all of the hospitals' individual FTE resident counts are below their affiliated FTE resident caps, multiplying the quotient by the difference between the aggregate FTE resident cap and the aggregate FTE resident counts for the Medicare GME affiliated group, and multiplying that result by 65 percent.

(B) The final reduction takes into account the hospital's FTE resident cap as reduced under the provisions of paragraph (c)(3) of this section.

* * * * *

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

Dated: February 10, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: March 1, 2011.

Kathleen Sebelius,

Secretary.

[FR Doc. 2011–5960 Filed 3–11–11; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[DA 11–324; MB Docket No. 10–189; RM–11611]

Radio Broadcasting Services; Willow Creek, CA

AGENCY: Federal Communications Commission.

ACTION: Final rule.