Purpose: This board is charged with (a) providing advice to the Secretary, HHS, on the development of guidelines under Executive Order 13179; (b) providing advice to the Secretary, HHS, on the scientific validity and quality of dose reconstruction efforts performed for this Program; and (c) upon request by the Secretary, HHS, advising the Secretary on whether there is a class of employees at any Department of Energy facility who were exposed to radiation but for whom it is not feasible to estimate their radiation dose, and on whether there is reasonable likelihood that such radiation doses may have endangered the health of members of this class.

Matters To Be Discussed: Agenda for this meeting will focus on dose reconstruction contract award information, dose reconstruction examples, site profile development, residual contamination study, Board member interaction with claimants, and the dose reconstruction workgroup report.

Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Larry Elliott, Executive Secretary, ABRWH, NIOSH, CDC, 4676 Columbia Parkway, Cincinnati, Ohio 45226, telephone 513/841–4498, fax 513/458–7125.

The Director, Management Analysis and Services Office, has been delegated the authority to sign Federal Register notices pertaining to announcements of meetings and other committee management activities for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: September 18, 2002.

John C. Burckhardt,

Acting Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 02–24303 Filed 9–24–02; 8:45 am]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Children's Hospitals Graduate Medical Education (CHGME) Payment Program: Proposed Methodology for Calculating Reconciliation Payment, Calculating Indirect Medical Education Payment, Disseminating CHGME Payment Program Data and Audit and Clarification of Policy on Hospital Eligibility

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice.

SUMMARY: This notice requests comments on proposed methodology for determining payments during the Children's Hospitals Graduate Medical Education (CHGME) Payment Program's reconciliation process, calculating indirect medical education (IME) payment, disseminating CHGME Payment Program data, and audit. The Program is authorized by section 340E of the Public Health Service Act (42 U.S.C. 256e), as amended by Pub. L. 106–310, The Children's Health Act, 2000. The notice also sets forth clarification of policies on hospital eligibility.

DATES: Interested persons are invited to comment by October 25, 2002. All comments received on or before October 25, 2002, will be considered in the development of the final notice concerning the proposed methodology. The Department will address comments individually or by group and publish a final notice on these comments in the **Federal Register**. Comments will also be available for public inspection, beginning October 25, 2002, at the address below from 8:30 a.m.–5 p.m. on weekdays, except for federal holidays.

ADDRESSES: Submit all written comments concerning this notice to Ayah E. Johnson, Ph.D., Chief, Graduate Medical Education Branch, Division of Medicine and Dentistry, Bureau of Health Professions, Health Resources and Services Administration, Room 9A–05, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857; or by e-mail to *ChildrensHospitalGME@hrsa.gov*.

FOR FURTHER INFORMATION CONTACT: Ayah E. Johnson, Ph.D., Chief, Graduate Medical Education Branch, Division of Medicine and Dentistry, Bureau of Health Professions, Health Resources and Services Administration, Room 9A–05, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857; telephone (301) 443–1058 or e-mail address *ChildrensHospitalGME@hrsa.gov*.

SUPPLEMENTARY INFORMATION: The CHGME Payment Program, as authorized by section 340E of the Public Health Service (PHS) Act (the Act) (42 U.S.C. 256e), provides funds to children's hospitals that operate graduate medical education (GME) programs. Public Law 106–310 amended the CHGME statute to continue the Program through fiscal year (FY) 2005.

Subsequent to the publication of this notice, CHGME policies will be put forth in regulations through the rulemaking procedures in accordance with Title 5 of the United States Code, as required by amendments to the CHGME statute made by Pub. L. 106–310, the Children's Health Act, 2000.

The Department wishes to provide clarification on the policy related to hospital eligibility. This policy was first described in the March 1, 2001 (66 FR 12940), and the July 20, 2001 (66 FR 37980) **Federal Register**.

The Department wishes to clarify the relationship between the list of children's hospitals published in the March 1, 2001 **Federal Register** and those hospitals eligible to participate in the CHGME Payment Program.

The March 1, 2001 **Federal Register** notice list is comprised of hospitals that the CHGME Payment Program believed at that time to be potentially eligible based upon their Medicare provider number. However, all hospitals must meet the eligibility criteria set forth in the CHGME statute and applicable policy notices.

The Department will update the list of hospitals potentially eligible to participate in the CHGME Payment Program on an annual basis. The annual update will be available on the CHGME Web site: *http://bhpr.hrsa.gov/childrenshospitalgme*. The list is not a final determination of eligibility. A hospital omitted from this list, including a new hospital, can obtain an application by downloading it from the CHGME Web site.

Provisions Proposed for Comment

The Department is soliciting comments on the following proposed provisions within these rules: (1) Methodology for determining direct and indirect medical education (DME and IME, respectively) payments during the withholding and reconciliation process stipulated in the CHGME statute—a methodology is proposed for children's teaching hospitals and ''new children's teaching hospitals'' that are eligible to participate in the CHGME Payment Program; (2) methodology for calculating IME payments; (3) dissemination of CHGME Payment Program data.

I. Proposed Methodology for Calculating Reconciliation Payments

The CHGME statute, prior to its amendment, provided for a withholding and reconciliation process designed to increase the accuracy of the DME payments made to hospitals. The amendments revised this provision to include IME payments in the withholding and reconciliation process.

As revised, the CHGME statute requires the Secretary to withhold up to 25 percent from each interim installment payment for both DME and IME as necessary to ensure that a hospital will not be overpaid on an interim basis. In accordance with the CHGME statute, the Department must determine, prior to the end of the

Federal fiscal year (FY), any changes to the number of residents reported by a hospital in its yearly initial application for CHGME Payment Program funding to determine the final amount payable to the hospital for that FY. Funding withheld will be paid to children's hospitals following the determination of changes, if any, to the number of residents initially reported by participating hospitals.

Beginning in FY2002, the Department will implement the Program's withholding process for both DME and IME payments to reduce the likelihood that a hospital is overpaid on an interim basis. The Department proposes the following methodology for the determination of revised resident counts and reconciliation processes beginning in FY2002:

Reporting Revised Resident Counts

During the third quarter of each FY (March 1—June 30) for which payments are being made, CHGME would release a reconciliation application providing hospitals the opportunity to report changes in the resident FTE counts previously reported in their initial applications. The reconciliation application would include forms HRSA–99 (Hospital Demographics), HRSA–99–1 (Reconciliation of FTE counts), HRSA–99–3 (Certification), and HRSA–99–4 (Required Data Reporting for Government Performance and Results Act). This collection of information has been approved under OMB No. 0915–0247. Hospitals would have 30 days to complete and return the reconciliation application. If a hospital fails to complete and return the reconciliation application according to the terms and conditions of the CHGME Payment Program, HHS may suspend the award, pending corrective action or may terminate the award for cause.

Several respondents to the March 1, 2001 **Federal Register** notice requested clarification on whether the reconciliation process would include only adjustments to changes in resident counts or would it include other changes. The CHGME Payment Program currently reconciles resident FTE counts only.

Hospitals that were not eligible to participate or did not apply for funding during the initial application cycle are not eligible to apply for and receive funding during the reconciliation process. These hospitals must wait until the next ''initial'' application cycle to apply.

Determining Revised Resident Counts

Hospitals must use the methodology described in the July 20 **Federal Register** notice to determine and report revised resident counts to the CHGME Payment Program. The revised resident FTE counts must be for the same Medicare cost report (MCR) period(s) identified in the hospital's initial application for CHGME Payment Program funding. For purposes of clarification, an FTE resident is measured in terms of time worked during a residency training year. It is not a measure of individual residents who are working.

Hospitals would report their updated resident counts by completing and submitting a new form HRSA 99–1. Hospitals whose resident counts have not changed are not exempt from completing and submitting a CHGME Payment Program reconciliation application. Revised resident FTE counts reported by hospitals that file a full MCR must be in accordance with CHGME rules. The resident counts reported in the reconciliation application must be consistent and attested to by the hospital's fiscal intermediary (FI) to be accepted by HRSA.

Hospitals which file a low or no-utilization MCR and report changes to the resident FTE counts reported in their initial CHGME Payment Program application must provide a detailed explanation of the revision with supporting documentation in accordance with CHGME requirements. Revised resident FTE counts that are submitted without an explanation and supporting documentation will not be accepted.

Determining Revised Resident Counts for ''New Children's Teaching Hospitals''

''New children's teaching hospitals'' would calculate resident FTE counts for the reconciliation application process in one of two ways:

1. If a hospital has filed an MCR by the CHGME Payment Program reconciliation application deadline, the hospital would report the actual number of resident FTEs trained during that cost reporting period; or

2. If a hospital has not filed an MCR by the CHGME Payment Program reconciliation application deadline, the hospital use the methodology described in the July 20 **Federal Register** notice, with an appropriate adjustment to the timeframe, to determine and report its revised resident counts. The timeframe used to determine revised resident counts for the reconciliation application process is the beginning of the FY for which payments are made up to the reconciliation application deadline date. The revised FTE resident count would equal the average number of FTE residents trained per day during this period multiplied by the total number of days the hospital will be training residents during the FY for which payments are being made. These hospitals would calculate their revised FTE resident count for reconciliation payments as follows:

a. Determine the number of days from the beginning of the FY for which payments are made to the CHGME Payment Program reconciliation application deadline date during which the hospital will be training residents.

b. Count the actual (raw) number of unweighted resident FTEs for allopathic and osteopathic residents trained during the period specified in (a).

c. Divide the total number of unweighted FTEs trained in ''(b)'' by the number of days during the eligibility period specified in ''(a)'' above. This number is the average number of unweighted FTE residents trained per day for the period between the beginning of the FY for which payments are being made and the date the CHGME Payment Program reconciliation application is due.

d. Determine the number of days the hospital will be training residents in the fiscal year for which payments are being made. Although the majority of hospitals will be likely to train residents for a full fiscal year (*i.e.*, 365 days (366 days in leap year)), it is possible that some hospitals may not train residents for an entire year. Those hospitals should determine the number of days they will be training residents and use that number in subsequent calculations.

e. Multiply the average number of unweighted resident FTE count for allopathic and osteopathic residents trained per day ''(c)'' by the number of days that your hospital will be training residents during the fiscal year in which payments are being made ''(d)''.

f. Use the same methodology (steps a through e above) to determine the weighted resident FTE count of allopathic and osteopathic residents.

g. Use the same methodology (steps a through e above) to determine the unweighted and weighted resident FTE count for dental and podiatric residents.

''New children's teaching hospitals'' would report these updated resident counts on form HRSA 99–1 of the reconciliation application.

Although this methodology delineates the method by which partial year residents are counted for ''new children's teaching hospitals'', it is important to note that all counts are subjected to the cap set by the affiliation agreement with any existing approved residency program. Since the CHGME

Payment Program is paying hospitals for training residents during the FY for which payments are being made, the Program would convert a partial training period to reflect the amount of time the hospital will be training residents during the FY for which payments are being made.

Example:

Children's Hospital A (CHA) is a ''new children's teaching hospital'' that submitted an application to the CHGME Payment Program in FY 2002. CHA intends to participate in the CHGME reconciliation process and needs to determine its revised FTE resident count. CHA would not have filed a Medicare cost report prior to the reconciliation application deadline. In order to calculate its revised FTE resident count, CHA would need to complete the following steps:

a. Calculate the number of days from beginning of FY2002 to the reconciliation application deadline (October 1, 2001 to May 1, 2002). The total number of days is 212.

b. Calculate the actual ''raw'' number of unweighted allopathic and osteopathic resident FTEs trained during this period. CHA determined that it trained 55 FTEs.

c. Determine the average number of unweighted allopathic and osteopathic residents trained per day: 55 FTEs/212 days = 0.2594 FTEs/day.

d. Determine the number of days in FY 2002 that CHA will be training residents: 365.

e. Determine the estimated number of unweighted allopathic and osteopathic residents that CHA will be training in FY 2002: 365 days × 0.2594 FTEs/day = 94.69 (rounded from 94.69339).

f. CHA would repeat the above steps to determine the estimated number of weighted allopathic and osteopathic residents as well as the weighted and unweighted dental and podiatric residents.

Determining IME Payments for ''New Children's Teaching Hospitals''

The Department wants to use the most accurate data it can obtain to calculate hospitals' payments. Therefore, the Department proposes that ''new children's teaching hospitals'' participating in the CHGME Payment Program that had not filed an MCR or completed a full Medicare cost reporting period at the time of submission of their initial CHGME Payment Program application, complete and resubmit a revised form HRSA 99–2 as part of the reconciliation application process.

''New children's teaching hospitals'' would calculate the variables initially reported on HRSA 99–2 using the methodology previously described in one of two ways:

1. If a hospital has filed an MCR or completed a full Medicare cost reporting period by the CHGME Payment Program reconciliation application deadline, the hospital would report the data requested from the completed cost reporting period; or

2. If a hospital has not filed an MCR or completed a full Medicare cost reporting period by the CHGME Payment Program reconciliation application deadline, the hospital would use the methodology described in the July 20 **Federal Register** notice, with an appropriate adjustment to the timeframe, to determine and report its revised data. The timeframe to be used for the reconciliation application process is the beginning of the FY for which payments are made until the CHGME reconciliation application deadline date.

Withholding and Reconciliation Payment

The Secretary would determine any balance due or any overpayment made to individual hospitals following the determination of changes, if any, to the number of residents reported by hospitals in their reconciliation applications. Hospitals would be notified, in writing, of the Secretary's final reconciliation payment determination during the fourth quarter (July 1—September 30) of the FY in which payments are being made.

Hospitals that have been notified of an overpayment would have 30 days to return the overpayment to the Department without accrual of interest. Hospitals that fail to return overpayments within the specified timeframe would accrue and be responsible for any interest.

Reconciliation payments would be made to individual hospitals on or before the end of the FY (September 30) in which payments are being made. The Secretary would include in the reconciliation payments funding initially withheld from the hospital as a result of withholding and underpayment based on any increase in FTEs. Also included in the payments would be each hospital's portion of any funds that are returned to the Department during the course of the FY as a result of overpayment or other hospitals' loss of eligibility.

Hospitals that report no changes to their resident FTE counts during the reconciliation process can expect changes to their final payment determination as a result of resident FTE count changes reported by other participating hospitals. This is based upon the payment methodology used to determine CHGME Payment Program funding to individual hospitals. Payments to individual hospitals are based upon the hospital's share of the total amount of DME and IME funding available for a given FY. A hospital's portion of the total IME and DME funding available is calculated based on payment variables in the CHGME Payment Program statute and regulations. This individual hospital portion (the numerator) is then divided by the sum of all hospitals' portion (the denominator) to determine its ''share'' of the available funding. Hence, although an individual hospital's FTE count and subsequent portion (numerator) may not change at the time of the reconciliation application process, the denominator of the payment calculation may change as a result of changes in FTE counts reported by other hospitals.

As provided by statute, a hospital may request a hearing on the Secretary's payment determination by the Provider Reimbursement Review Board under section 1878 of the Social Security Act (42 U.S.C. 1395oo), implemented by regulations at 42 CFR part 405, subpart R.

It should also be noted that the reconciliation process proposed does not take the place of a separate audit process to which the hospitals may be subject. Participating children's hospitals are subject to audit (other than OMB Circular 133) to determine whether the applicant hospital has complied with applicable laws and regulations in its application for funding.

Example: Assume in FY 2001 the total amount of funding available for disbursement to four children's hospitals was $5 million. Based upon this funding level and the data reported by hospitals, the following CHGME DME payments were calculated using the methodology described in the March 1 **Federal Register** notice.

Hospital	Weighted FTE rolling average	Wage index	Relative value	Hospital share of DME	DME payment
Children's Hospital A	92.19	0.9310	87.66725079	0.451948742	$2,259,743.71

Hospital	Weighted FTE rolling average	Wage index	Relative value	Hospital share of DME	DME payment
Children's Hospital B	71.50	1.1969	81.50970685	0.420204913	2,101,024.57
Children's Hospital C	25.50	0.4621	15.74760405	0.081183221	405,916.11
Children's Hospital D	6.50	1.5521	9.05153015	0.046663122	233,315.61
Total Value	195.69	N/A	193.9760918	N/A	5,000,000.00

During the reconciliation application process, Children's Hospitals B, C and D reported no changes to the resident FTE counts reported in their initial applications; however, Children's Hospital ''A'' reported a decrease in its resident count of 8.94. In accordance with CHGME Payment Program statutes, payments were recalculated based upon the changes in resident FTE counts reported by hospitals. Payment variables affected by Children's Hospital A's change in the resident FTE count reported are bolded in the chart below.

Hospital	Weighted FTE rolling average	Wage index	Relative value	Hospital share of DME	DME payment
Children's Hospital A	**83.25**	0.9310	**79.16583825**	**0.426828279**	**$2,134,141.40**
Children's Hospital B	71.50	1.1969	81.50970685	**0.439465414**	**2,197,327.07**
Children's Hospital C	25.50	0.4621	15.74760405	**0.084904333**	**424,521.67**
Children's Hospital D	6.50	1.5521	9.05153015	**0.048801972**	**244,009.86**
Sum, where applicable	**189.19**	N/A	**185.4746793**	N/A	5,000,000.00

II. Proposed Methodology for Calculation of Indirect Medical Education (IME) Payment

For the FY 2000, 2001 and 2002 funding cycles, the CHGME Payment Program used the Centers for Medicare and Medicaid Services (CMS) published wage index (WI) from FY 1999 to calculate the DME and IME payment formulas for children's hospitals. The CHGME statute requires that the FY 1999 WI be used to calculate DME payments, and the Department maintained its use in the IME payment calculations for purposes of consistency.

Beginning with FY 2003, the Department proposes to use the CMS published WI from the most recent fiscal year available for calculating IME payments. Although this would result in two different WIs being used in calculating payments received by children's hospitals, one for DME and another for IME, it would allow a calculation of IME that is more current, fair and equitable, as it would use the WI currently used by CMS in the calculation of IME payments to all Prospective Payment System (PPS) hospitals.

One potential concern in making this decision was the potential impact on funding to children's hospitals given the recent changes in methodology used to determine the WI. Beginning in FY 2000, the derivation of the WI phases out the inclusion of costs associated with teaching faculty at a rate of 20% per year—this ''phase out'' will continue over 5 years. The WI will tend to be most impacted in those areas with high numbers of teaching hospitals.

The CHGME Payment Program evaluated the resulting changes in the WI between FY 1999 and FY 2002 for the children's hospitals participating in the program in FY 2002. The analysis indicates that the majority of hospitals would experience a change in their WI, either an increase or a decrease, of less than five percent, as shown in the table below. Given this relatively small change, the Department determined that it was reasonable to use the WI from the FY for which payments are being made in the calculation of IME payments. In addition, by employing this methodology, the CHGME Payment Program would be consistent with current Medicare policy regarding use of the WI for calculation of IME payments. In the event that the CHGME Payment Program statute is amended regarding the use of WI, the program would implement the statutorily mandated changes.

Percentage change in area wage index values between FY 1999 and FY 2002	Number of and children's hospitals
Increase more than 10 percent	2
Increase more than 5 percent and less than 10 percent	9
Increase or decrease less than 5 percent	45
Decrease more than 5 percent and less than 10 percent	3
Decrease more than 10 percent	0

The Department has received inquiries related to the appropriateness of using the WI calculated by CMS, derived from PPS hospital data, as it is not necessarily well applied to children's hospitals. To determine the WI, data are gathered from non-federal, short-term, acute care hospitals from Worksheet S–3, Parts II and III of the Medicare Cost Report (Form 2552–96). Hospitals provide information on wages, employee hours and benefits including details of total salaries and the amounts for physicians and non-physicians. They must separately report contract and non-contract amounts, as well as teaching and non-teaching amounts for physicians and other employees. CMS totals the gross allowable wages of PPS-eligible hospitals within a defined labor market area and divides them by the total paid hours for the area and thereby develops an hourly wage for the area. The WI is calculated by dividing this average by the national average hourly wage.

CMS WI calculations currently include data from children's hospitals participating in the CHGME Program that file full Medicare cost reports. Given these participating hospitals' data already are captured in calculating the CMS WI, an independent WI calculation would be both administratively and fiscally burdensome. The Department considers the CMS derived WI to be the most appropriate tool for calculating payments.

III. Proposed Dissemination of CHGME Payment Program Data

Currently, any requests for program data or application information must be submitted to Steven Merrill, Freedom of Information Act (FOIA) Officer, Health Resources and Services Administration (HRSA) FOIA Office, 5600 Fishers Lane, Room 14–45, Rockville Maryland 20857.

The Department proposes that all data related to the CHGME Payment Program, including all information submitted in the program application, all information used to calculate DME and IME payments, and hospital-specific payments, be available to the public upon written request to a member of the CHGME Payment Program staff or the HRSA FOIA officer.

This information dissemination policy is similar to the one used by the Medicare program to disseminate Medicare cost report (MCR) information, 42 CFR 401.135. The MCR information is considered to be fully disclosable; that is, its release to the public poses no potential harm to the hospital(s) that originally submitted the MCR.

In addition, the Department proposes that the CHGME Payment Program follow the policies regarding fees and charges associated with release of information as stated in 45 CFR part 5, subpart D.

Other Applicable Laws, Executive Orders, and Policies

IV. Audit

In the March 1 **Federal Register** notice, the Department announced that awards under the CHGME Payment Program must be audited under OMB Circular A–133. The Department is reconsidering its position with respect to this requirement and proposes that this program not be considered Federal awards expended under OMB Circular A–133. The only compliance requirements the Department needs tested for this program are application and reconciliation application reporting. There are no other compliance requirements the Department believes need to be tested for this program under OMB Circular A–133 Audits. Since the Secretary must account for change in the number of residents prior to the close of each fiscal year, it is important to assess the accuracy of counts per the application prior to year end. The Department will establish a process to assess the accuracy of the FTE counts submitted by children's hospitals in their application for funds from the CHGME Payment Program. The process will be based on the current assessment process utilized by CMS in their review of FTE counts included on the Medicare cost reports. The process will be implemented by Department contractors familiar with both CMS procedures and CHGME Payment Program requirements. The Department will publish more details for comment about this common assessment process in the **Federal Register** at a future date. The Department believes this approach is more effective, as it provides up-front assurance on the mandated reconciliation of FTE counts which are the basis for awards. Excluding this program from the definition of Federal awards expended under OMB Circular A–133 will remove a potential duplication of the auditor testing FTE counts that the Department has already verified and in many cases will allow these audit resources to be used to test other Federal programs of higher risk. The Department proposes to make this change effective for Federal fiscal year 2003 awards.

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 a 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 on 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 the only burden this action will impose on children's hospitals is the resources required to submit an application to the CHGME Payment Program. Therefore, in accordance with the RFA and the Small Business Regulatory Enforcement Act of 1996, which amended the RFA, the Secretary certifies that this action will have a significant impact on a substantial number of small entities in that this action will provide significant funding to eligible children's hospitals. However, since this action will not impose a significant burden on a substantial number of small entities, we have not examined any alternatives for reducing the burden on children's hospitals. The Secretary has also determined that this action does not meet criteria for a major rule as defined by Executive Order 12866 and would have no major effect on the economy of Federal expenditures.

We have determined that the proposed 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, the proposed rule 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 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 CHGME Payment Program, certain information is required as set forth in this notice in order to determine eligibility for payment and amount of payment. In accordance with the PRA, we have received final OMB approval on the collection of information for the reconciliation procedures in the FY02 cycle (OMB No. 0915–0247).

Collection of Information: The Children's Hospitals Graduate Medical Education Payment 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 medical education payments to participating children's hospitals. Indirect medical education payments will also be derived from a formula that requires the reporting of discharges, beds, and case mix index information from participating children's hospitals. Hospitals will be requested to submit such information in an annual application. Hospitals will also be requested to submit data on the number of full-time equivalent residents a second time during the fiscal year to participate in the reconciliation payment process.

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 150 hours per hospital. The estimated annual burden is as follows:

Form	Number of respondents	Responses per respondent	Hours per response	Total burden hours
HRSA–99–1	54	1	99.9	5,395
HRSA 99–1 (Reconciliation of FTE counts)	54	1	8	432
HRSA 99–2	54	1	14	756
HRSA–99–4	54	1	28	1,512
Total	54			8095

National Health Objectives for the Year 2010

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 Payment 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: April 17, 2002.

Elizabeth M. Duke,

Administrator, Health Resources and Services Administration.

Dated: June 5, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02–24311 Filed 9–24–02; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Fiscal Years (FY) 2003 Funding Opportunities

AGENCY: Substance Abuse and Mental Health Services Administration, HHS.

ACTION: Fiscal year (FY) 2003–2006 allotments to States for protection and advocacy for individuals with mental illness.

SUMMARY: The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) announces the availability of FY 2003 funds for grants for the following activity. This notice is not a complete description of the activity; potential applicants must obtain a copy of the Guidance for Applicants (GFA), including Part I, *Fiscal Years (FY 2003–2006 Allotments to States for Protection and Advocacy for Individuals with Mental Illness (SM 03–F1), and* Part II, *General Policies and Procedures Applicable to all SAMHSA Applications for Discretionary Grants and Cooperative Agreements*, before preparing and submitting an application.

Activity	Application deadline	Est. Funds FY 2003	Est. number of awards	Project period (years)
FY 2003—2006 Allotments to States for Protection and Advocacy for Individuals with Mental Illness.	October 1, 2002	Formula	Formula	4

The actual amount available for these grants will depend on the amount appropriated for the program. This program is being announced prior to the annual appropriation for FY 2003 for SAMHSA's programs. Applications are invited based on the assumption that sufficient funds will be appropriated to fund the program in FY 2003. This program is being announced at this time in order to allow applicants sufficient time to plan and prepare applications. Solicitation of applications in advance of a final appropriation will also enable the award of appropriated grant funds in an expeditious manner and thus allow prompt implementation and evaluation of promising practices. All applicants are reminded, however, that we cannot guarantee sufficient funds will be appropriated to permit SAMHSA to fund any applications. This program is authorized under the Protection and Advocacy for Individuals with Mental Illness Act of 1986, 42 U.S.C. 10801, *et seq.* (as amended in 2000). SAMHSA's policies and procedures for peer review and Advisory Council review of grant and cooperative agreement applications were published in the **Federal Register** (Vol. 58, No. 126) on July 2, 1993.

General Instructions

Applicants must use application form PHS 5161–1 (Rev. 7/00). The application kit contains the two-part application materials (complete programmatic guidance and instructions for preparing and submitting