of 1988 (CLCIA) Criteria for Waiver,'' device safety alerts, **Federal Register** reprints, information on premarket submissions (including lists of approved applications and manufacturers' addresses), small manufacturers' assistance, information on video conferencing and electronic submissions, mammography matters, and other device-oriented information. The CDRH home page may be accessed at http://www.fda.gov/cdrh. ''Guidance for Clinical Laboratory Improvement Amendments of 1988 (CLIA) Criteria for Waiver'' is available at http://www.fda.gov/cdrh.

IV. Comments

Interested persons may submit to the Dockets Management Branch (address above) written comments regarding this draft guidance by May 30, 2001. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. The draft guidance and received comments may be seen in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

Dated: February 14, 2001.

Linda S. Kahan,

Deputy Director for Regulations Policy, Center for Devices and Radiological Health.

[FR Doc. 01–4963 Filed 2–28–01; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–265]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Health Care Financing Administration, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Type of Information Collection Request: Extension of a currently approved collection;

Title of Information Collection: Independent Renal Dialysis Facility Cost Report Form and Supporting Regulations 42 CFR 413.24, 413.20;

Form No.: HCFA–265 (OMB# 0938–0236);

Use: The Medicare Independent Renal Dialysis Facility Cost Report provides for determinations and allocation of costs to the components of the Renal Dialysis facility in order to establish a proper basis for Medicare payment;

Frequency: Annually;

Affected Public: Business or other for-profit, not-for-profit institutions, and State, Local, or Tribal Government;

Number of Respondents: 3,085;

Total Annual Responses: 3,085;

Total Annual Hours: 604,660.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access HCFA's Web Site address at *http://www.hcfa.gov/regs/prdact95.htm*, or E-mail your request, including your address, phone number, OMB number, and HCFA document identifier, to *Paperwork@hcfa.gov*, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Attention: Melissa Musotto, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: February 14, 2001.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 01–4987 Filed 2–28–01; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Children's Hospitals Graduate Medical Education (CHGME) Payment Program: Final Eligibility and Funding Criteria and List of Eligible Hospitals and Proposed Methodology for Determining FTE Resident Count, Treatment of New Children's Teaching Hospitals, and Calculating Indirect Medical Education Payment

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Final notice and additional provisions proposed for comment.

SUMMARY: This notice sets forth final eligibility, funding criteria, payment methodology and performance measures for the Children's Hospitals Graduate Medical Education Payment (CHGME) program, authorized by section 340E of the Public Health Service Act (42 U.S.C. 256e), amended by Pub. L. 106–310, The Children's Health Act, 2000. It includes a list of hospitals potentially eligible for the CHGME program. The notice also requests comments on proposed criteria for: determining FTE resident count, the treatment of new children's teaching hospitals, and the methodology for indirect medical education (IME) payments. In compliance with the Paperwork Reduction Act of 1995, the Department obtained Office of Management and Budget (OMB) approval on an emergency clearance to any data collections imposed on the public (OMB No. 0915–0247). The Department has requested approval for extension of OMB clearance to any data collections imposed on the public by this notice. Any changes to this collection will not become effective until approved by OMB.

DATES: Interested persons are invited to comment by April 2, 2001. All comments received on or before April 2, 2001 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**.

ADDRESSES: Submit all written comments concerning this notice to Barbara Brookmyer, Division of Medicine and Dentistry, Bureau of Health Professions, Health Resources and Services Administration, Room 9A–27, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857; or by

e-mail to *ChildrensHospitalGME@hrsa.gov.*

FOR FURTHER INFORMATION CONTACT: Barbara Brookmyer, Division of Medicine and Dentistry; telephone (301) 443–1058.

SUPPLEMENTARY INFORMATION: The CHGME 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 to address disparity in the level of Federal funding for children's hospitals that result from Medicare funding for graduate medical education (GME). Pub. L. 106–310 amended the CHGME statute to extend the program through Federal fiscal year (FFY) 2005.

On June 19, 2000, the Secretary published a notice in the **Federal Register** (65 FR 37985) setting forth proposed rules to implement the CHGME Program. During the comment period, the Department received 21 comments from hospitals, hospital and professional associations, Medicare counseling companies, other Federal agencies, and individuals.

The Secretary thanks the respondents for the quality and the thoroughness of their comments. As a result of these comments, the Department has made numerous revisions and clarifications in this final notice. The comments and the Department's responses to the comments are discussed below. This Notice also reflects amendments to the CHGME statute made by Pub. L. 106–310, the Children's Health Act, 2000, enacted on October 17, 2000. As required by these amendments, subsequent to the publication of this notice, the Department will promulgate them as codified regulations through additional rulemaking procedures in accordance with Title 5 of the United States Code.

Provisions Proposed for Comment

The Department is soliciting comments on the following proposed provisions within these rules: (1) The criteria for FTE resident count; (2) the treatment of new children's teaching hospitals with respect to resident count; and (3) the methodology for IME payments. The first and second issues result from amendments made to the CHGME statute. The third proposal relating to IME payments were not addressed in the Department's June 19, 2000, **Federal Register** notice.

I. Funding

The Department will make CHGME program payments in FFY 2001 as payments were made in FFY 2000, dividing the available funding based on the CHGME authorization statute with approximately one-third of the funds for direct medical education (DME) payments and two-thirds to IME payments. Should a FY 2001 appropriation act alter this plan, the CHGME program will revise the payment plan accordingly.

The CHGME statute, as amended, sets forth the following funding process for DME and IME payments:

1. *Calculation of payments:* The Secretary must determine the amounts to be paid for DME and IME before the beginning of each fiscal year for which payments will be made.

2. *Withholding:* the Secretary must withhold up to 25 percent from each interim installment for DME and IME as necessary to ensure that a hospital will not be overpaid on an interim basis.

3. *Revised Counts:* The Secretary must determine, prior to the end of the fiscal year, any changes to the number of residents reported by a hospital in its application for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both DME and IME payments.

4. *Reconciliation:* The Secretary then must pay any balance due or recoup any overpayments made to each hospital.

II. Withholding and Reconciliation

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.

In FFY 2000, the Department did not implement the withholding and reconciliation process for DME payments provided for in the CHGME program statute due to inadequate time and restrictions in the FFY 2000 Appropriations Act. The FFY 2000 Appropriations Act required all appropriated funds to be obligated in FFY 2000, thus prohibiting carryover funds to be awarded to hospitals in FFY 2001. To the extent possible, the Department will implement the CHGME program's withholding and reconciliation process for both DME and IME payments beginning in FFY 2001.

As revised, the CHGME statute requires the Secretary to withhold up to 25 percent from each installment payment for both DME and IME as necessary to ensure that a hospital will not be overpaid on an interim basis. To distribute the funds withheld, prior to the end of the fiscal year the Secretary must determine any changes to the number of residents reported by a hospital in its application for the current fiscal year in order to determine the final amount payable to the hospital for the current fiscal year for both DME and IME payments. Then, the Secretary must pay any balance due or recoup any overpayments made to each hospital.

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 subpart R.

The Secretary will include in the reconciliation process funds that are returned to the Department during a fiscal year by the termination of hospitals from the CHGME program. These funds will be distributed to the remaining children's hospitals as part of reconciliation payments.

III. Eligible Hospitals

Pub. L. 106–310 amended the CHGME statute to revise the definition of an eligible hospital, effective October 17, 2000. As revised, a ''children's hospital'' eligible to participate in the CHGME program meets the following criteria:

1. It participates in an approved GME program;

2. It has a Medicare provider agreement;

3. It is excluded from the Medicare inpatient prospective payment system (PPS) under section 1886(d)(1)(B)(iii) of the Social Security Act and its accompanying regulations; and

4. It is a ''freestanding'' children's hospital.

Several respondents indicated that the Department may have omitted additional potentially eligible hospitals from the list included in the June 19, 2000, **Federal Register** notice due to the proposed eligibility requirement published in that notice that a hospital have a provider agreement with a unique Medicare provider number as a ''children's hospital'' under section 1886(d)(1)(B)(iii) of the Social Security Act.

The Department agreed with the respondents and for FFY 2000, used the following eligibility for the CHGME program;

A ''children's hospital'' eligible to apply for CHGME funds in FFY 2000 was a hospital that met all of the following criteria:

1. More than 50% of its inpatients were individuals under 18 years of age;

2. It participated in an approved GME program;

3. It is excluded from the Medicare PPS under section 1886(d)(1)(B) of the Social Security Act; and

4. It was a ''freestanding'' children's hospital. For purposes of the CHGME

program, the term ''freestanding'' excludes a hospital that shares a Medicare provider number with a health care system. Although an independent listing in the American Medical Association Directory or being separated physically from an adult hospital affiliate may be indicative of ''freestanding,'' for the purposes of the CHGME program, they do not alone make a hospital ''freestanding.''

Several respondents indicated a concern with the term ''hospital system'' and suggested clarifying the definition of a ''freestanding'' hospital.

The Department recognizes the ambiguity of the terms ''hospital system'' and ''freestanding,'' particularly in today's rapidly changing world of health care delivery. Some ''freestanding'' hospitals also may be affiliated with or are part of larger systems. For purposes of eligibility in the CHGME program, the Department intends to exclude those children's hospitals that operate under a Medicare hospital provider number assigned to a larger health care entity that would allow the children's hospital to receive Medicare GME payments as part of the larger health care entity. The Department will maintain its definition of ''freestanding'' as stated in the eligibility criteria.

A number of respondents asserted that other entities such as children's units within PPS hospitals and, in some cases, PPS hospitals themselves should be eligible for CHGME funds, if they meet the other eligibility criteria, since they also may suffer from the allegedly inequitable internal distribution of GME funds under 1886(h) of the Social Security Act.

The Department does not agree with these comments. The intent of the CHGME Act is to create parity in GME payments among all hospitals providing GME. It is clear that primarily two factors cause this disparity in children's hospitals: (1) low Medicare utilization; and (2) PPS-exempt status. While there may be some GME payment disparity among PPS hospitals that serve children and among children's units within PPS hospitals, unlike ''freestanding'' children's hospitals which are only eligible to receive DME payments, they are eligible to receive both DME and IME payments.

One respondent requested the Department to clarify how waiver from the PPS system by a State would affect eligibility. Currently, Maryland is the only PPS-waivered State. A State's PPS status has no effect on the CHGME eligibility criteria. Hospitals in PPS-waivered States must still meet all the eligibility criteria of the CHGME program.

Two respondents brought to the Department's attention the inconsistency in using the term ''accredited'' instead of the term ''approved'' to refer to a GME training program. The Department agrees with this comment and will consistently refer to these training programs as ''approved'' in accordance with the Medicare program's definition of hospitals eligible to receive funds for GME, 42 U.S.C. 256e(b)(1); 42 CFR 413.86.

Based on the revised eligibility criteria, the Department has identified the below-listed hospitals as potentially eligible for participation in the CHGME program and will send these hospitals applications for FFY 2001 through FFY 2005. This list is not a final determination of eligibility. A hospital omitted from this list, including a new hospital, can obtain an application by download form the CHGME Web Site: http://bhpr.hrsa.gov/childrenshospitalgme.

CHGME HOSPITALS

Medicare provider No.	Facility name	City	State
01–3300	Children's Hospital of Alabama	Birmingham	AL
03–3301	Los Ninos Hospital	Phoenix	AZ
04–3300	Arkansas Children's Hospital	Little Rock	AR
05–3300	Valley Children's Hospital, California	Madera	CA
05–3301	Children's Hospital Medical Center	Oakland	CA
05–3302	Children's Hospital of Los Angeles	Los Angeles	CA
05–3303	Children's Hospital and Health Center	San Diego	CA
05–3304	Children's Hospital of Orange County	Orange	CA
05–3305	Lucile Salter Packard Children's Hospital	Palo Alto	CA
05–3306	Children's Hospital at Mission	Mission Viejo	CA
05–3307	Children's Recovery Center of Northern California	Campbell	CA
05–3308	Healthbridge Children's Rehab Hospital	Orange	CA
06–3301	The Children's Hospital	Denver	CO
07–3300	Connecticut Children's Medical Center	Hartford	CT
08–3300	Alfred I. Dupont Institute	Wilmington	DE
09–3300	Children's Hospital National Medical Center	Washington	DC
10–3300	All Children's Hospital	St. Petersburg	FL
10–3301	Miami Children's Hospital	Miami	FL
11–3300	Egleston Children's Hospital at Emory	Atlanta	GA
11–3301	Scottish Rite Medical Center—Atlanta	Atlanta	GA
12–3300	Kapiolani Women's & Children's Medical Center	Honolulu	HI
14–3300	Children's Memorial Hospital	Chicago	IL
14–3301	Larabida Children's Hospital	Chicago	IL
15–3300	St. Vincent's Children's Specialty Hospital	Indianapolis	IN
17–3300	Children's Mercy Hospital South	Overland Park	KS
19–3300	Children's Hospital	New Orleans	LA
21–3300	Mt. Washington Pediatric Hospital	Baltimore	MD
21–3301	Kennedy Krieger Institute	Baltimore	MD
22–3300	Franciscan Children's Hospital & Rehabilitation Center	Brighton	MA
22–3302	The Children's Hospital	Boston	MA
23–3300	Children's Hospital of Michigan	Detroit	MI
24–3300	Gillette Children's Hospital	Saint Paul	MN
24–3301	Children's Hospitals and Clinics—Saint Paul	Saint Paul	MN
24–3302	Children's Hospitals and Clinics—Minneapolis	Minneapolis	MN
26–3301	St. Louis Children's Hospital	Saint Louis	MO

CHGME HOSPITALS—Continued

Medicare provider No.	Facility name	City	State
26–3302	Children's Mercy Hospital	Kansas City	MO
28–3300	Boys Town National Research Hospital	Omaha	NE
28–3301	Children's Memorial Hospital	Omaha	NE
31–3300	Children's Specialized Hospital	Mountainside	NJ
32–3307	Carrie Tingley Hospital	Albuquerque	MN
33–3301	Blythdale Children's Hospital	Valhalla	NY
36–3300	Children's Hospital Medical Center	Cincinnati	OH
36–3301	Convalescent Hospital for Children	Cincinnati	OH
36–3302	Rainbow Babies and Children's Hospital	Cleveland	OH
36–3303	Children's Hospital Medical Center	Akron	OH
36–3304	Cleveland Clinic Children's Rehabilitation Hospital	Cleveland	OH
36–3305	Children's Hospital	Columbus	OH
36–3306	Children's Medical Center	Dayton	OH
36–3307	Tod Children's Hospital	Youngstown	OH
39–3300	J.D. McCarty Center for Children with Developmental Disabilities	Norman	OK
37–3301	Children's Medical Center	Tulsa	OK
39–3302	Children's Hospital of Pittsburgh	Pittsburgh	PA
39–3303	Children's Hospital of Philadelphia	Philadelphia	PA
39–3304	Children's Home of Pittsburgh	Pittsburgh	PA
39–3306	Temple University	Philadelphia	PA
39–3307	St. Christopher's Hospital for Children	Philadelphia	PA
40–3301	University Pediatric Hospital	San Juan	PR
44–3302	St. Jude Children's Research Hospital	Memphis	TN
44–3303	East Tennessee Children's Hospital	Knoxville	TN
45–3300	Cook Ft. Worth Children's Medical Center	Fort Worth	TX
45–3301	Driscoll Children's Hospital	Corpus Christi	TX
45–3302	Children's Medical Center of Dallas	Dallas	TX
45–3304	Texas Children's Hospital	Houston	TX
45–3305	Christus Santa Rosa Children's Hospital	San Antonio	TX
45–3306	Coveneant Children's Hospital	Lubbock	TX
45–3308	Pediatric Center for Restorative Care	Dallas	TX
45–3309	Beacon Health Westchase	Houston	TX
46–3301	Primary Children's Medical Center	Salt Lake City	UT
49–3300	Cumberland Hospital—The Brown Schools of Virginia	New Kent	VA
49–3301	Children's Hospital—King's Daughters	Norfolk	VA
49–3302	Children's Hospital	Richmond	VA
50–3300	Children's Hospital & Regional Medical Center	Seattle	WA
50–3301	Mary Bridge Children's Health Center	Tacoma	WA
52–3300	Children's Hospital of Wisconsin	Milwaukee	WI

IV. Loss of Eligibility

Several respondents noted that there should be a distinction preserved between hospitals that lose their eligibility to participate in the CHGME program and hospitals that retain their eligibility, but for some defined period have no residents rotating through the hospitals.

The Department agrees with the need to clarify the definition of loss of eligibility for the CHGME program. A hospital is eligible to participate in the CHGME program if it trains residents as a freestanding children's hospital in the FFY for which the CHGME payments are being made. Reporting residents on Medicare cost reports is irrelevant to the eligibility of the hospital. Hospitals that do not report residents to Medicare remain eligible for the CHGME program if they continue to train residents as a freestanding children's hospital in the FFY for which the payment amounts are established.

Any hospital which loses its eligibility during the course of a FFY must notify HRSA immediately of the change in status and the date on which it became ineligible. The Department will then terminate the hospitals payments under the CHGME program. The hospital will be liable for the reimbursement, with interest, of any funds received during a period after it became ineligible.

Several respondents questioned the Department's legal authority to collect interest from ineligible institutions during a reimbursement process. They requested clarification on the applicability of interest to amounts paid to hospitals later deemed to be ineligible as opposed to overpayments to eligible hospitals that may be required to reimburse the Department after a reconciliation process for the DME and IME payments.

The Federal Debt Collection Act requires the Department to collect interest on the recovery of CHGME funds, just as on any debt owed to the Federal Government. There is no interest due on payments recovered under the reconciliation process because this is not a debt owed to the government.

V. Determining FTE Resident Counts for DME

Residency FTE Reporting Period

As amended, the CHGME statute provides that the Secretary make interim payments to hospitals ''based on the number of residents reported in the hospital's most recently filed Medicare cost report prior to the application date for the FFY for which the interim payment amounts are established. In the case of a hospital that does not report residents on a Medicare cost report, such interim payments shall be based on the number of residents trained during the hospital's most recently completed cost report filing period.'' For hospitals that report resident counts to Medicare, the most recently filed cost

report reflects the average of the actual FTE resident count for that filing period and the prior two cost report filing periods.

Hospitals that do not report resident counts to Medicare are to report the number of FTE residents trained during their most recently completed Medicare cost report filing period. This number reflects the average of the actual FTE residents trained during the most recently completed Medicare cost report filing period and the prior two cost report filing periods.

If the cost reporting period ends less than 5 months prior to the CHGME program's application deadline, hospitals that do not report residents to Medicare may use either the FTE resident count in the most recently completed cost report year or the FTE resident count in the previous cost report year. The determination of the 5-month period is based on the Medicare program's policy that hospitals have 5 months from the completion of the cost report year to file the Medicare cost report.

Several respondents objected to the use of the FFY for calculating the FTE resident count in the FFY 2000 CHGME application process. They asserted that most hospitals use either an academic year (7/1–6/30) or the Medicare cost reporting period.

Prior to amendment, the CHGME statute required the Secretary to make CHGME payments ''for each of *fiscal years* 2000 and 2001'' (emphasis added). For FFY 2000, the Department interpreted ''fiscal year'' to mean that payments were to be based on the FTE resident counts for FFYs (from October 1 of each year through September 30 of the following year), rather than the hospital cost reporting period or the hospital academic year.

To assist hospitals in determining FTE resident counts based on the FFY required in the FFY 2000 CHGME application, tables contained in the application materials instructed hospitals on how to convert their data to the applicable FFY. In addition, the Department presented four technical assistance workshops to hospitals and related association staff to give advice on how to complete the necessary application forms and how to convert an academic/hospital accounting period to a FFY.

Counting FTE Residents in FFY 2000

The methodology described by the Department in its June 19, 2000, **Federal Register** notice regarding the determination of a hospital's FTE resident count, generated considerable comment. Some respondents felt that it was unfair to allow hospitals that had not previously filed Medicare cost reports to recreate their resident count. Some respondents felt that all hospitals should be allowed to recreate their resident count because of the significant inaccuracies in the previously filed Medicare cost reports. Other respondents questioned the Department's proposed adoption of the Medicare GME resident counting methodology. Simpler methods were suggested that would eliminate the use of ''caps'', or ''rolling averages.''

Section 340E(c)(1)(B) of the CHGME statute requires that the average number of FTE residents in the hospital's approved residency programs be determined according to section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) of the Social Security Act. This section is implemented by regulations at 42 CFR 413.86(f), (g), (h), and (i). These provisions indicate: how to determine the total and weighted numbers of FTE residents; the required documentation and certification for purposes of application for Medicare payments by hospitals for cost reporting periods; and the application of the ''caps'' (described in sec. 1886(h)(4)(f) of the Social Security Act; 42 U.S.C. sec. 1395ww(h)(4)(f)) and ''rolling averages'' (described in sec. 1886(h)(4)(g) of the Social Security Act; 42 U.S.C. sec. 1395ww(h)(4)(g)) to FTE resident counts prior to weighting. The Department notes that dental and podiatric residents are not included in the resident FTE cap. Hospitals must certify the accuracy of their FTE resident counts and apply the Medicare cap and rolling average to this count. Since the Act specifically references use of caps and rolling averages for DME, the Department does not have discretion to accept the respondents' suggestion.

For FFY 2000 applications, the Department was more flexible in the FTE resident counts accepted due to the short time frame hospitals had from publication of the June 19, 2000, **Federal Register** notice to the application deadline. Most respondents agreed with the Department's requirement that resident counts from Medicare hospital cost reports determine the CHGME resident counts. However, some objected because they may have under reported their resident counts on their past Medicare cost reports. Since the Medicare utilization and reimbursement was so low among the children's hospitals, many Fiscal Intermediaries (FIs) and hospitals paid little attention to the counts submitted or to correcting and auditing the counts.

According to regulations, the FIs have 180 days from the reopening request and submission of all supporting data to finalize a cost report. Several hospitals wanted the Department to instruct Medicare FIs to respond quickly to their requests to reopen cost reports and adjust resident counts to more accurately reflect the actual training programs.

The Department contacted the majority of hospitals' FIs, and, in accordance with existing rules and regulations, many of the CHGME program applicant hospital's FIs were able to expedite the review and revision process for new FTE resident counts. On average, these reviews were completed within a one-week period.

Clearly, hospitals that have never submitted Medicare cost reports have no comparable validated counts to submit on their CHGME program applications. Therefore, these hospitals must determine FTE resident counts through the methodology described in the application. The accuracy of the resident counts, as all information filed by hospitals, is subject to audit by the Department and the General Accounting Office.

Several respondents requested clarification on counting time spent by a resident on required research. The Department is using the Medicare regulation 42 CFR 413.86(f) to apply to counting research time. In brief, the research conducted by the resident must be part of the residency program and the resident must carry out the research in either:

1. The children's hospital (clinical or bench research); or

2. In a nonhospital site where the research involves direct patient care and the salaries of both the resident and the supervising faculty are paid by the children's hospital.

Respondents were concerned that the CHGME program could inadvertently cause a shift in the primary care focus of pediatric GME. General pediatrics residency training programs require a significant amount of training (at least 50%) to occur in ambulatory care settings such as freestanding clinics and physicians' offices. Respondents asserted that the CHGME program payments should reflect the cost of training in both inpatient and outpatient settings.

The Department recognizes the important of the primary care focus in general pediatrics residency training, which implements the Department's own goal of improving public access to primary care. All resident training in ambulatory care settings may be included in the resident FTE resident count as long as the hospital funds the faculty and resident cost of this training

through a written agreement between the hospital and the ambulatory care setting, according to 42 CFR 413.86(f)(3) and (4).

One respondent requested that the Department provide a waiver of the requirement to obtain written agreements with participating ambulatory care sites. They contend that since children's hospitals were not able to claim significant GME payments, many failed to obtain written agreements with their participating ambulatory care sites.

Hospitals will not be required to submit such written agreements to the Department with their annual applications to the CHGME program. Hospitals should be prepared to produce such agreements in any subsequent audit carried out by the Department.

One respondent was concerned about what they perceived as the ''arbitrary 5-year limit'' for the initial residency periods.

The Department follows Medicare rules regarding the use of the initial residency period. The Medicare rules reduce counts for all hospitals that train residents beyond their initial residency period (i.e., fellows) with regard to the DME and IME portions of the GME reimbursement. In addition, this 5-year limit is not arbitrary, but rather reflective of the minimum number of years required for the resident to reach initial board eligibility.

Several respondents suggested that the Department require that hospitals submit their Intern and Residents Information System (IRIS) diskettes as the primary source of data for validating their resident counts. This source would then provide a consistent method for verifying submitted counts. Another respondent indicated that the data on the IRIS diskettes are rarely completed correctly, frequently contained inaccurate data and duplicated resident counts between two hospitals.

The department recognizes that the submission of IRIS diskettes by hospitals to the CHGME program may potentially reduce the administrative burden of reporting among those hospitals that submit IRIS diskettes for Medicare. There are several reasons, however, that the use of the IRIS diskettes as the primary source of data for the CHGME program would not be feasible: (1) Not all hospitals participating in the CHGME program submit IRIS diskettes to Medicare so there would not be a consistent source of information for all hospitals participating in the program; (2) information required by the CHGME program in its FFY 2000 applications included some information not available on the IRIS diskettes—the ''conversion'' of FTE resident counts based on the Medicare cost reporting period to an FTE resident count based on the FFY; (3) the CHGME program will not have access to the IRIS diskettes from those hospitals that may potentially be double counting residents so there would be no way to validate the IRIS data from hospitals participating in the program.

One respondent commented that the Medicare provision for FTE adjustments in the context of an affiliated group cap requires a retroactive adjustment to account for situations in which the group remains under its aggregate cap, but individual hospitals exceed their individual caps (allowable under Medicare rules, so long as the aggregate cap is not exceeded). This respondent proposed that the FFY 2000 and 2001 counts would need to be adjusted after audits of the respective hospital cost reports. The respondent stated that since the Department proposed no reconciliation for FFY 2000, the hospital might be disadvantaged.

The Department is aware that it would be difficult for hospitals to estimate adjustments to their aggregate cap. In FFY 2000, there were no children's hospitals claiming an adjustment to their cap based on a written affiliation agreement. Given the recent legislative changes, hospitals will no longer have to estimate adjustments to their aggregate cap. Hospitals will report the actual adjustment made to the aggregate cap as reported on their Medicare cost reports.

One respondent questioned the accuracy of examples B and D on page 37988 of the **Federal Register** notice of June 19, 2000. The Department clarifies these examples as follows:

Example B: One respondent questioned the accuracy of the 1999 resident count. This example is correct as written. The two residents added to the hospital count for the period 7/1/99 to the end of the cost reporting year 12/31/99 would add 1.0 FTE to the count because the residents only were counted for one-half of the cost reporting year. One-half of two FTEs equals one FTE.

Example D: The respondent stated that the 1999 resident count would not be reduced if the hospital is incurring all or substantially all of the training costs for the three residents in the continuity clinic. The Department agrees with the respondent's observation; however, this example demonstrates how to estimate the number of FTEs in 1996, when there was a substantial change to the number of FTEs trained. To determine the number of FTEs trained during the 1996 cost report year, subtract the 1.5 FTEs which were added to the program in 1997 from the 1999 number of 25 FTEs to arrive at the cap of 23.5 FTEs.

Proposed Criteria for Determining FTE Resident Counts Beginning in FFY 2001

The Department invites comments on the following proposed criteria for determining FTE resident counts. The comments will be considered by the Department in developing final criteria for determining FTE resident counts to be used for the purposes of the CHGME program in determining payment to eligible hospitals. These final criteria will be published in a subsequent **Federal Register** notice and applied to the CHGME program beginning in FFY 2001.

The Department wants to use the most accurate and valid data it can obtain on a hospital's resident counts. Beginning in FFY 2001, for hospitals that report residents to Medicare, the application requirement will be as follows:

1. For the most recent cost reports ending on or before December 31, 1996, a hospital must report the latest settled FTE resident count or a preliminary FI determined resident count. All preliminary FI determined counts must be determined according to HCFA and Medicare criteria. Hospitals may not use the ''preliminary'' numbers that were used for the FFY 2000 CHGME program unless those FTE resident counts have since become finalized or are validated according to HCFA and Medicare standards.

2. For all other settled cost reports, a hospital must report the latest settled count. For a settled report that has been reopened, a hospital must report the latest settled count or, if available, the most recent ''preliminary'' FI determined FTE count.

3. For cost reports which have never been settled, a hospital must report, in order of decreasing priority:

a. The most recent ''preliminary'' FI determined FTE resident count;

b. The ''amended'' FTE resident count; or

c. The ''as filed'' FTE resident count.

Resident count requirements remain unchanged for hospitals that do not report residents to Medicare but have been operating a residency training program. If these hospitals wish to revise their FTE resident counts, they must submit a detailed explanation of the revision with supporting documentation. For hospitals that have previously filed Medicare cost reports, the Department will use the cost reports filed with the FIs to verify the resident counts submitted.

Proposed Criteria for ''New Children's Teaching Hospitals''

Because of the amendment revising the reporting of residents using the most recently filed Medicare cost report, the Department will need to propose a method for ''new children's teaching hospitals'' to report residents for application for funding under the CHGME program. Accordingly, the Department invites comments on the proposed criteria for reporting FTE residents by new children's teaching hospitals. The comments will be considered by the Department in developing final criteria for determining FTE resident counts in ''new children's teaching hospitals''. These final criteria will be published in a subsequent **Federal Register** notice and applied to the CHGME program beginning in FFY 2001.

The Department defines a ''new children's teaching hospital'' as a children's hospital that began training residents from an already existent residency training program, less than three cost report periods prior to the FFY in which CHGME payments are being made. In order to participate in the CHGME program, a ''new children's teaching hospital'' must meet all necessary eligibility criteria.

These ''new children's teaching hospitals'' are distinct from those teaching hospitals that are participating in a new medical residency training program, defined under 42 CFR 413.86(g)(9) as ''a medical residency that receives initial accreditation by the apporpriate accrediting body or begins training residents on or after January 1, 1995.'' Medicare regulations at 42 CFR 413.86(g)(6)(i) and (g)(7) set forth criteria for applying the ''caps and rolling averages'' in these teaching hospitals with new residency training programs.

Establishing the Cap

''New children's teaching hospitals'' that did not train residents during the most recent cost report period ending on or before December 31, 1996, would have a cap of zero. These hospitals may receive an adjustment to their cap through an affiliation agreement specifying an aggregate cap as described in 63 FR 26338, published May 12, 1998, which establishes the process for application of an aggregate FTE cap in accordance with section 1886(h)(4)(H) of the Social Security Act.

To the extent that it is reasonable and feasible, the CHGME program will implement the HCFA final rule cited above. If a ''new children's teaching hospital'' elects to establish the cap through an affiliation agreement, it must comply with 63 FR 26338, published May 12, 1998, in accordance with section 1886(h)(4)(H) of the Social Security Act. For purposes of the CHGME program, however, the following exceptions to the HCFA final rule are proposed; these exceptions would be in effect only during the first year of a hospital's application for the CHGME program.

(1) For the first year of the affiliation agreement, an effective date must be specified for purposes of the CHGME program. The effective date does not need to be July 1 for purposes of the CHGME program. However, for the first year of the agreement, an effective date of July 1 will apply for purposes of the Medicare program (63 FR 26338, published May 12, 1998, in accordance with section 1886(h)(4)(H) of the Social Security Act.). Subsequent to the first year of the affiliation agreement, the effective date must comply with the above cited **Federal Register** final rule which specifies a date for all affiliation agreements.

(2) The affiliation agreement must be for a minimum of 1 year and must include a full academic year (July 1–June 30 period).

(3) The effective date and length of the affiliation agreement for an aggregate cap must be clearly documented in the agreement.

(4) The affiliation agreement must be filed with all the necessary HCFA fiscal intermediaries and HRSA.

''New children's teaching hospitals'' will calculate their FTE resident count using the full value of the cap as determined by the affiliation agreement. The Department recognizes that the cap in ''new children's teaching hospital's'' first Medicare cost report may not agree with the cap specified by the affiliation agreement as Medicare does not apply an affiliation agreement for an aggregate cap until July 1 (63 FR p. 26338, published May 12, 1998, in accordance with section 1886(h)(4)(H) of the Social Security Act.) As a children's hospital's cost report period may not be July 1–June 30, it may potentially receive a prorated cap for its first Medicare cost reporting period.

Establishing FTE Resident Counts and Payments

In general, the FTE resident count from each hospital reflects the residents trained during the Medicare cost report period, limited by the unweighted FTE resident count from the most recent cost report period ending on or before December 31, 1996 (the cap). Payments to each hospital are based on the average of the FTE resident count for the Medicare cost report and the prior two cost reports (3-year rolling average). The Department proposes that the ''new children's teaching hospitals'' training residents who were originally trained in a program that received and will continue to receive funds under the CHGME program wait until they have completed a Medicare cost report period before applying for payments from the CHGME program. These hospitals would also need to apply the 3-year rolling average consistent with Medicare regulations. Over a 3-year period, the ''new children's teaching hospital'' will gradually increase the number of FTE residents that can be claimed on the CHGME application as the children's hospital that previously received during for those FTE residents gradually decreases its resident count.

The Department proposes the following methodology for determining FTE resident counts and payment for ''new children's teaching hospitals'' training residents that were never previously claimed for CHGME payment:

1. Since payments under the CHGME program are based on FTE resident counts from a completed cost report filing period, ''new children's hospitals'' training residents never previously claimed for CHGME payment that have not completed a cost report filing period at the time of the CHGME program application would not have an FTE resident count to report to the program. The Department proposes that these ''new children's teaching hospitals'' submit FTE resident counts to the CHGME program according to the following methodology in their initial application:

a. Divide the number of FTE residents trained from the effective date, specified for purposes of the CHGME program, of the affiliation agreement to the application deadline by the number of days during this period to produce the average number of FTEs per day.

b. Multiply the average number of FTEs per day by the number of days the hospital will train residents during the FFY in which payments are being made.

2. After the initial application year, a ''new children's teaching hospital'' training residents that were never previously claimed for CHGME payment will submit its actual FTE resident count from the most recently completed Medicare cost report period rather than using the 3-year rolling average. Once these hospitals have completed three Medicare cost report periods, the 3-year rolling average will apply.

Hospitals eligible for the CHGME program participating in a new medical residency training program, defined

under 42 CFR 413.86(g)(9), will follow Medicare regulations regarding the determination of their cap and 3-year rolling average (42 CFR 413.86(g)(6)(i) and (g)(7)). If the hospital has not completed a Medicare cost report period to submission of the CHGME application, it will follow the methodology described above for ''new children's teaching hospitals'' training residents not previously claimed by the CHGME program in the calculation of its FTE resident count.

VI. Determining Direct Medical Education Payments

Wage Adjustment in Standardizing Per Resident Amounts

The per resident amount applicable to a specific children's teaching hospital (prior to pro-rata reduction) is determined by multiplying the Medicare PPS labor-related share of the per resident amount by the FY 1999 hospital wage index and adding the non-labor related share to the result. Respondents expressed concern regarding use of the PPS labor-related share to standardize wages in determining the national standard per resident amount because the pediatric population is not represented in the wage index calculations. They asserted that since children's hospitals are PPS exempt and are not required to complete the wage index portion of the Medicare cost report, this factor does not reflect the children's hospital population.

The Secretary recognizes that the wage data used to develop the PPS labor-related share is based on PPS hospitals which would not include information from PPS-exempt hospitals. Accordingly, the Department analyzed Medicare cost reports to develop a more accurate estimate of the labor-related share of the per resident amount. As the analytically derived labor-related share does not vary significantly from the Medicare labor-related share, for FFY 2000 the Department used the Medicare PPS labor-related share of 71.1 percent in the calculation of direct medical education payments. In FFY 2001 and beyond, the Secretary will use the most recent Medicare PPS labor-related share calculation.

The **Federal Register** notice published in June 19, 2000, for the CHGME program announced that the Secretary would publish a computed national per resident amount in the final notice. The Secretary has determined that the national average per resident amount for cost reporting periods ending in FFY 1997 is $67,688. After updating for inflation as specified in the statute, the FFY 2000 national average per resident amount is $71,709.

VII. Determining Indirect Medical Education Payments

The **Federal Register** notice of June 19, 2000, sought comments on the case mix measure to be used for determining IME payments. Due to lack of time, this notice omitted a detailed methodology for distribution of the IME funds. The Secretary also stated that this final **Federal Register** notice would include this methodology for public comment subject to revision in another final **Federal Register** notice.

After considering suggestions submitted by respondents, the Department is proposing IME payment methodology for FFY 2001 organized by: (1) The purpose and use of payments under the program, (2) case mix, (3) number of FTE residents, (4) teaching intensity factor, (5) patient volume, (6) outpatient services, and (7) determination of payments. Interested parties are invited to submit comments on the proposed rules for a 30-day period. After consideration of the comments, the Department will publish the final IME methodology in the **Federal Register** and apply it to the determination of IME payments beginning in FFY 2001.

Purpose and Use of IME Payments

The CHGME statue requires the Secretary to make payments for IME associated with operating approved graduate medical residency training programs for each of fiscal years 2000 through 2005. Section 340E(b)(1)(B) describes IME payments as covering ''expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs.''

Section 340E(d)(2) of the Act requires the Secretary to determine IME payments by considering:

1. Variations in case mix among children's hospitals; and

2. The hospitals' number of FTE residents in approved training programs.

One respondent commented that the educational purposes of the CHGME program take precedence over what he described as imitation of the Medicare system in developing the payment methodologies. This commenter recommended that the calculation for IME payments incorporate the costs associated with providing training opportunities in rural and underserved areas.

The Department agrees that the CHGME program's purpose is to provide reimbursement to children's hospitals for costs associated with training residents.

Although the CHGME statute describes factors that the Secretary must consider in developing payment methodology, the statute does not reference the type of training, such as training in rural and underserved areas. Nevertheless, the CHGME payment methodology which incorporates the Medicare FTE resident count does allow for an adjustment to the FTE resident cap for residents training in rural areas (42 CFR 413.86(g)(4) and (11)).

One respondent expressed concern that the CHGME program payments would be disbursed only for inpatient training. The respondent stated it was essential for payments to be disbursed to children's hospitals to defray the costs of training in both inpatient and outpatient settings. The respondent cited the pediatrics Residency Review Committee of the Accreditation Council for Graduate Medical Education's requirements that at least 50 percent of resident training take place in ambulatory settings and the recommendation of the Council on Graduate Medical Education that clinical education should occur in settings representative of the environment in which graduates will eventually practice.

These payments do reflect the cost of training residents in outpatient facilities in the hospital calculation of FTE resident count. Hospitals may include residents rotating through outpatient facilities and in ambulatory outpatient clinics, as provided in 42 CFR 413.86(f)(3) and (4). However, the CHGME program has no statutory authority to prescribe how hospitals are to use the funds received from the program.

One respondent indicated that the **Federal Register** notice of June 19, 2000, did not state that the IME payments will be wage-adjusted, whereas Medicare DME and IME payments are both wage-adjusted.

The Department agrees with this comment and revised the IME calculation used in FFY 2000 and proposed for FFY 2001, accordingly. For FFY 2000, the Department incorporated a wage adjustment into the formula for calculating IME payments by adjusting the labor-related share of the hospital operating cost for geographic differences by using the hospital wage index for FFY 1999. In FFY 2001, the Department will incorporate the same wage adjustment in its calculation of IME payments.

Determination of Case Mix

Two respondents suggested that the case mix index (CMI) be excluded from the formula for distributing FFY 2000 funds because no standardized CMI and Diagnosis Related Group (DRG) weights exist for children's hospitals nationwide.

The Department does not have the discretion to exclude the CMI from the IME formula because the CHGME statute explicitly requires the use of case-mix in determining IME payments under the program.

The Department received several comments on the development and utilization of a uniform CMI for all hospitals applying for funding from the CHGME program, as follows:

1. Five respondents supported the use of one CMI system for determining the IME payments to eliminate inconsistency among hospitals by using a variety of case mix index systems.

2. One respondent stated that ''converting'' CMIs derived from different CMI systems, such as HCFA–DRG and All-Payer Refined DRG systems, was not possible.

3. Four respondents recommended the use of the HCFA–DRG CMI system; one respondent suggested that version 15 of the HCFA–DRG system, with appropriate Medicare weights, should be used as the standard.

4. One respondent suggested providing a default value for hospitals that cannot provide a HCFA–DRG CMI.

The Department agrees that CMIs must be based on one system to assure equitable distribution of IME funds to hospitals. Due to insufficient implementation time, the Department could not establish a single CMI requirement for FFY 2000. Nevertheless, all but five of the 56 children's hospitals applying for FFY 2000 CHGME program funds were eventually able to furnish one of three versions of a HCFA–DRG CMI (versions 15, 16 or 17).

One respondent commented that case mix methodologies to be employed in determining IME payments should include both inpatient and outpatient care delivered by the hospital as well as factor in costs associated with providing residency training in rural and urban underserved areas, to avoid creating financial incentives that reduce education in primary care pediatrics.

The Department agrees that payment systems should not produce incentives that reduce education in primary care pediatrics. However, all current case-mix systems rely totally on hospital inpatient data based on reporting for the Uniform Hospital Discharge Data System which includes only inpatient data. No present CMI reflects both inpatient and outpatient care.

For FFY 2000, the Secretary used the average of all CMIs from the 27 hospitals that furnished a CMI based on HCFA–DRG version 15 as a default CMI for those hospitals unable to furnish a HCFA–DRG CMI. For the hospitals that supplied a CMI from version 16 or 17 of the HCFA–DRGs, the Secretary adjusted the version 16 or 17 reported by the hospital by the percentage difference in the CMI between the HCFA–DRG version 15 and the reported HCFA–DRG version according to the following table.

	Average FFY 1998 relative weight (HCFA v.15)	Average FFY1999 relative weight (HCFA v. 16)	Average FFY2000 relative weight (HCFA v. 17)
All cases excluding newborn	0.9711	1.0005	0.9639
Percent change from v. 15		[1]3.03	[1] – 0.74

[1] percent.

For FFY 2000, hospitals were asked to remove DRG 391, newborn births, from the calculation of their CMI. Given the time frame for CHGME program implementation in FFY 2000, it was difficult to create an accurate conversion factor including DRG 391 due in part to variability in hospitals reporting a CMI including DRG 391.

Beginning in FFY 2001, all applicant hospitals must submit a CMI, based on the discharges from the most recently completed cost report period, using HCFA–DRG Version 17 with the appropriate HCFA Version 17 weights reported to the ten-thousandth decimal place; all DRGs must be included in the calculation of this CMI. In subsequent years, the version of the HCFA–DRG to be used by hospitals will be updated annually.

If a children's hospital eligible to participate in the CHGME program has not completed a Medicare cost report period prior to submission of an application to the CHGME program, it would base its CMI on discharges from the day it became eligible for the CHGME program until the CHGME application deadline.

While the Department recognizes that the HCFA–DRG based CMI was not designed to be used with children's hospitals, this CMI system has been proposed as the most reasonable choice. Currently, the most commonly used case mix index system is based on CMIs. This system, however, does not exist for outpatient services. For future use, the Department intends to investigate the feasibility of developing a case mix index that is more reflective of the relative resource utilization experienced by children's hospitals in both an inpatient and an outpatient setting.

Determining the Number of FTE Residents for IME Payments

One respondent stated that resident counts should not be used as a separate factor because it is already included in the measure of teaching intensity, and the purpose of IME payments is to compensate for higher patient care costs, not the number of residents.

The Department agrees that resident counts should be incorporated only in the teaching intensity measure in the IME formula. The IME formula used in FFY 2000 and proposed for FFY 2001 and future years include the resident count only in the teaching intensity measure.

Many respondents provided comments concerning the difficulty hospitals anticipated in reopening their Medicare cost reports and making any necessary corrections to their FTE resident counts used to develop caps and rolling averages.

The June 19, 2000, **Federal Register** notice proposed using an unweighted FTE resident count for the IME portion of the payment and to apply the caps and rolling averages to the IME resident count, consistent with Medicare's application to its IME count. However, during the application process, the administrative difficulty of obtaining an unweighted FTE count from October 1, 1997, to September 30, 2000, became clear. The unweighted resident FTE count was not reported on the HCFA–2552, E–3, Part IV worksheet until the Medicare cost report period beginning on or after October 1, 1997. For some hospitals, this occurred as late as their 1999 Medicare cost report. While it would have been possible to eventually determine the unweighted count for all

the years necessary in order to calculate a 3-year rolling average, it would have been additionally administratively burdensome to children's hospitals, fiscal intermediaries and HRSA. As a result, the payments for FFY 2000 would have been delayed.

To resolve these difficulties, for FFY 2000, the Department did not apply either the caps or the rolling averages to the unweighted resident FTE count in calculating the IME payments. Since the CHGME statute does not require application of ''caps and rolling averages'' to the FTE resident count for IME payment (as it does for the DME payment), the Department calculated the unweighted FTE resident count from the application forms and the cost reports.

In addition, the Department's June 19, 2000, **Federal Register** notice stated that the resident count for the IME portion would be based upon 42 CFR 412.105(a)(1). That regulation was cited in error because it refers to the determination of a ratio rather than an actual number.

For FFY 2001, the Secretary believes that hospitals will have had sufficient notice and time to adjust their unweighted FTE counts from 1996 through 1999 and to obtain their unweighted numbers from their FIs. Therefore, beginning with FFY 2001, the Secretary will apply the ''caps and rolling averages'' consistent with Medicare regulation 42 CFR 412.105(f), with the exception of 42 CFR 412.105(f)(1)(ii)(A) as it refers to the ''PPS sections'' of the hospital, in calculating IME payments.

Factoring in Teaching Intensity

The **Federal Register** notice of June 19, 2000, proposed the addition of a teaching intensity factor to the statutorily required case-mix and FTE resident count in determining IME payments. The Secretary used the current Prospective Payment System (PPS) operating teaching intensity factor of 6.5 percent per 0.1 interns and residents-to-bed ratio (IRB) to determine IME payments for FFY 2000.

The Department calculated the IRB using the unweighted FTE resident count and the number of beds reported by each hospital to Medicare for the most recently completed fiscal year. For those hospitals that did not report this information to Medicare, the Department used the number of available beds on July 1, 2000. According to Medicare regulations at 42 CFR 412.105(b), the Department defined ''hospital beds'' as ''available beds,'' which are beds that are permanently maintained for inpatients in rooms and wards, excluding beds and bassinets in the healthy newborn nursery.

Several respondents suggested measures of teaching intensity in the formula for determining IME payments to hospitals. Two recommended using a resident-to-bed ratio, and two recommended a resident-to-average daily census (RADC) ratio. One respondent recommended a resident-to-bed ratio, stating that either ratio was feasible but noted that Medicare uses a resident-to-bed ratio. One respondent recommended the RADC ratio stating that, the ADC is more appropriate because it measures actual activity, while the number of beds might not change even when the patient volume changes.

For FFY 2001, the Department invites comment on:

1. The proposed continuation of the use of the Medicare IRB-based teaching intensity factor in the calculation of IME payments. The CHGME program would use the most current PPS IRB in its calculation of IME payments;

2. Application of a cap on the IRB ratio, similar to the cap applied by the Medicare program, 42 CFR 412.105(a)(1), whereby the ratio may not exceed the ratio for the hospital's most recent prior cost reporting period. Application of this cap will not be initiated until FFY 2002 due to the proposed change in the definition of bed count;

3. Suggestions on alternative teaching intensity factors, such as the Medicare RADC-based teaching intensity factor (2.8 percent per 0.1 percent increase in RADC ratio) or any other analytically justified teaching intensity factor; and

4. The proposed definition of ''bed count'' to be used in calculating the Medicare IRB teaching intensity factor—the sum of all available beds per day in the most recently completed cost report filing period, including beds and bassinets in the healthy newborn nursery, divided by the number of days in that period. If a children's hospital eligible to participate in the CHGME program has not completed a Medicare cost report period prior to submission of an application to CHGME program, it would base its ''bed count'' on the sum of all available beds per day, including beds and bassinets in the healthy newborn nursery, in the period from the day it became eligible for the CHGME program until the CHGME application deadline, divided by the number of days in that period.

In addition, the Department intends to explore for future proposal the development of other measures of teaching intensity which may be more appropriate for children's hospitals.

Patient Volume

Since the IME payment is cover ''expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs,'' the patient volume in a particular hospital is an important factor in its calculation. For FFY 2000, the Department used inpatient discharges from the hospital's most recently completed fiscal year as the measure of patient volume for IME payments. Beginning in FFY 2001, the Department will use inpatient discharges for the hospital's most recently completed Medicare cost report filing period as the measure of patient volume for IME payments.

If a children's hospital eligible to participate in the CHGME program has not completed a Medicare cost report period prior to submission of an application to the CHGME program, its patient volume will be calculated by the following methodology:

a. Divide the number of inpatient discharges from the date the hospital became eligible to the CHGME application deadline by the number of days during this period to produce the average number of discharges per day.

b. Multiply the average number of discharges per day by the number of days the hospital will provide inpatient care as a hospital eligible to participate in the CHGME program during the FFY in which payments are being made.

Outpatient Services

Since a large component of training programs in children's hospitals involves training in ambulatory outpatient settings, the Department will explore the development of a factor to indicate the resources associated with training in outpatient settings. Any such factor will be proposed for comment in a subsequent **Federal Register** notice.

Determining IME Payments to Hospitals

For FFY 2000, the Department used the following formula to calculate IME payments:

$$\text{IME Pay}_i = Z * \frac{\text{NoD}_i * \text{CMI}_i * \left(\text{WI}_i * .711 + .289\right) * 1.6 \left(\left(1 + \text{residents}_i\text{-to-bed}_i \text{ ratio}\right)^{.405} - 1\right)}{\sum_{i=1}^{n} \text{NoD}_i * \text{CMI}_i * \left(\text{WI}_i * .711 + .289\right) * 1.6 \left(\left(1 + \text{residents}_i\text{-to-bed}_i \text{ ratio}\right)^{.405} - 1\right)}$$

Where:
i = individual hospital
n = the total number of hospitals participating in the CHGME program
WI = area wage index for hospital$_i$
NoD = number of discharges for hospital$_i$
CMI = average case mix index for hospital$_i$
IME Pay = IME payment to individual hospital$_i$ for the CHGME program
Z = total funds available for IME

The Department used the current Medicare teaching intensity factor of $1.6((1 + \text{residents-to-bed ration})^{.405} - 1)$. Residents indicated the unweighted actual FTE resident count during FFY 2000 without application of the cap. The bed count was based on the number of beds reported on a hospital's most recently filed Medicare cost report or the number of available beds on July 1, 2000. The bed count did not include bassinets.

This FFY 2000 IME payment formula used by the CHGME program was derived from the following basic formula:

$Y_i = X\ (.711 * WI_i + .289) * NoD_i * CMI_i * IME_i$

Where:
X = national average cost per case
i = individual hospital
WI = area wage index for hospital$_i$
NoD = number of discharges for hospital$_i$
CMI = average case mix index for hospital$_i$
IME = IME educational adjustment factor for hospital$_i$
Y = IME payment to individual hospital$_i$

Because the CHGME program has a filed appropriation, a hospital's individual payment reflects its share of the sum of IME payments to all hospitals, multiplied by the total funds available for IME, as in the following formula:

$$\text{IME Pay}_i = Z * \frac{X * \left(.711 * \text{WI}_i + .289\right) * \text{NoD}_i * \text{CMI}_i * \text{IME}_i}{\sum_{i=1}^{n} X * \left(.711 * \text{WI}_i + .289\right) * \text{NoD}_i * \text{CMI}_i * \text{IME}_i}$$

Since the national average cost per case appears in both the numerator and denominator of the formula, it does not impact the calculation of a hospital's IME payment and may be removed from the final formula.

For FFY 2001, the CHGME program will use the same formula that was used in FFY 2000. If the PPS IRB teaching intensity factor to be used in FFY 2001 is different from 6.5 percent to .1 interns and residents-to-bed ratio, the teaching intensity factor in the equation to calculate IME payments would be altered accordingly.

Children's Hospitals With Average Lengths of Stay Greater Than or Equal to 30 Days

In calculating IME payments for FFY 2000, it became apparent that certain hospitals with lengths of stay greater than or equal to 30 days were significantly disadvantaged by the formula utilized to calculate the IME payments. These hospitals provided a variety of services, including rehabilitative services, that required their patients to remain as inpatients for a prolonged period of time. The Department proposes to apply an adjustment factor in the calculation of IME payments for children's hospitals with average lengths of stay greater than or equal to 30 days.

The Department found that when using the HCFA–DRG based CMI to measure relative resource allocation in the IME payment formula, it did not adequately account for the resources required to treat patients in children's hospitals with significantly long lengths of stay because the HCFR–DRG was developed based on different classes of patients in hospitals with shorter lengths of stay. For example, functional status, which is not measured by the DRG system, accounts for systematic differences in the cost of rehabilitation stays for the same diagnosis.

Since the length of stay is a major factor in determining the relative costliness of an inpatient stay, the Department proposes an adjustment factor based on the average length of stay (ALOS) to more adequately reflect the relative costliness of patients treated by the children's hospitals with significantly long lengths of stay. For hospitals with ALOS greater than or equal to 30 days, the adjustment factor is the ALOS for the individual hospital divided by the average ALOS for all hospitals with ALOS less than 30 days.

The IME calculation will use one formula to calculate IME payments for hospitals with an average length of stay less than 30 days and a second formula to calculate payments for hospitals with an average length of stay greater than or equal to 30 days, as follows:

Where:
NoD=number of discharges for hospital
CMI=average case mix index for hospital using HCFA v. 17
LOSadj=average length of stay (ALOS) per hospital with ALOS > or = 30 days/ALOS for all hospitals with ALOS < 30 days)
WI=area wage index for hospital
IME=IME adjustment factor for hospital
Z=total dollars available for CHGME program IME payments
IME Pay=total IME payments to hospital
i=individual hospital with ALOS < 30 days
j=individual hospital with ALOS > or = 30 days
m=total number of hospitals with ALOS > or = 30 days participating in the CHGME program
n=total number of hospitals with ALOS < 30 days participating in the CHGME program
residents=average number of unweighted FTE residents in the most recently completed cost reporting period with application of the cap.
beds=sum of available beds, including beds and bassinets in the healthy newborn nursery, in the most recently completed cost report filing period, divided by the number of days in that period.

For children's hospitals with ALOS < 30 days, the following formula will be used in FY 2001 to calculate the IME payment.

$$\text{IME Pay}_i = Z * \frac{\text{NoD}_i * \text{CMI}_i \left(\text{WI}_i * .711 + .289\right) * 1.6 \left(\left(1 + \text{residents}_i\text{-to-bed}_i \text{ ratio}\right)^{.405} - 1\right)}{\sum_{j=1}^{n} \text{NoD}_i * \text{CMI}_i * \left(\text{WI}_i * .711 + .289\right) * 1.6 \left(\left(1 + \text{residents}_i\text{-to-bed}_i \text{ ratio}\right)^{.405} - 1\right) + \sum_{j=1}^{m} \text{NoD}_j * \text{LOSadj}_j * \text{CMI}_j * \left(\text{WI}_j * .711 + .289\right) * 1.6 \left(\left(1 + \text{residents}_j\text{-to-bed}_j \text{ ratio}\right)^{.405} - 1\right)}$$

For children's hospitals with ALOS > or = 30 days, the following formula will be used in FY 2001 to calculate the IME payment:

$$\text{IME Pay}_j = Z * \frac{\text{NoD}_j * \text{LOSadj}_j * \text{CMI}_j * \left(\text{WI}_j * .711 + .289\right) * 1.6 \left(\left(1 + \text{residents}_j\text{-to-bed}_j \text{ ratio}\right)^{.405} - 1\right)}{\sum_{i=1}^{n} \text{NoD}_i * \text{CMI}_i * \left(\text{WI}_i * .711 + .289\right) * 1.6 \left(\left(1 + \text{residents}_i\text{-to-bed}_i \text{ ratio}\right)^{.405} - 1\right) + \sum_{j=1}^{m} \text{NoD}_j * \text{LOSadj}_j * \text{CMI}_j * \left(\text{WI}_j * .711 + .289\right) * 1.6 \left(\left(1 + \text{residents}_j\text{-to-bed}_j \text{ ratio}\right)^{.405} - 1\right)}$$

VIII. Evaluation Criteria

General Comments on Reporting

Respondents generally supported the collection of some performance data, although a number of respondents raised concerns about the potential reporting burden. Most respondents favored the use of existing hospital data systems for the reports, whenever possible. Two respondents asserted that these performance measures are unnecessary.

The Government Performance and Results Act (GPRA) requires the Department to collect, analyze and submit reports on the performance of its legislative programs. Therefore, the Department must collect information on performance measures for the CHGME program. To the extent the CHGME program is successful, aggregated hospital data reported should reflect this success. The reports will not affect the specific payment amounts made to participating hospitals.

The Department will reduce this reporting burden by eliminating the requirement for reporting rotations to rural and underserved areas. However, the Department will continue to request data on the number of FTE residents participating in children's hospital approved residency training program; the percentage of gross revenue associated with patient care; hospital total and operating margins; and patient-related operating costs. The period for which the performance goals are measured is the most recently filed Medicare cost report. Hospitals that do not file Medicare cost reports should submit data from the most recently completed Medicare cost reporting period.

GPRA Performance Measures for CHGME Program

Beginning in FFY 2001, the CHGME program will use the following GPRA performance measures:

- Maintain the number of FTE residents receiving training in the hospitals funded by the program;
- Maintain the number of FTE residents sponsored by hospitals funded by the program;
- Monitor the proportion of the hospital's gross revenue from patient care attributed to public insurance (Medicaid, Medicare, State Children's Health Insurance Program (SCHIP)), uncompensated care, and uninsured patients;
- Monitor the percentage of hospitals, funded by the program, with negative total margins; and
- Monitor the hospital's allowable operating costs.

Some respondents requested clarification of performance elements and necessary data requirements. These data requirements are described below:

1. A ''sponsoring institution'' is an institution that assumes the ultimate responsibility for a graduate medical education program. According to the Accreditation Council for Graduate Medical Education (ACGME), the following are the institutional requirements for a sponsoring institution: (1) A residency program must operate under the authority and control of a sponsoring institution; (2) there must be a written statement of institutional commitment to GME that is supported by the governing authority, the administration, and the teaching staff; (3) sponsoring institution must be in a substantial compliance with the Institutional Requirements and must ensure that their ACGME-accredited programs are in substantial compliance with the Program Requirements; and (4) an institution's failure to comply substantially with the Institutional Requirements may jeopardize the accreditation of all of its sponsored residency programs.

2. Medicaid refers to any funding provided by Title XIX including that from Medicaid HMOs. Payments for Disproportionate Share Hospitals (DSH) are also included in gross revenue for Medicate patient care.

3. State Children's Health Insurance Program (SCHIP) refers to funding provided under Title XXI.

4. ''Uncompensated Care'' means bad debt and charity. ''Uncompensated care'' does not include contractual allowances. The definition of ''uncompensated care'' is to be used for purposes of the CHGME program only. ''Uninsured patients'' means those patients that are self-pay.

For hospitals which do not file Medicare cost reports—(a) operating margin is net income from service to patients (net patient revenues − total operating expenses)/net patient revenues (total patient revenues − contractual allowances) * 100; and (b) total margin is net income from all sources (net patient revenue + all other income − total operating-other expenses)/total hospital revenues (net patient revenues + total other income) * 100.

For hospitals completing Medicare cost reports (HCFA–2552–96), the

margins should be calculated from Worksheet G–3:

Operating margin = (Line 5/Line 3) * 100

Total margin = (Line 31/(Line 3 + Line 25)) * 100

In calculating hospital operating costs, hospitals should include allowable operating costs based on Medicare cost reports.

IX. Other Laws Applicable to the CHGME Program

HHS is responsible to Congress and the U.S. taxpayers for carrying out its mission in compliance with applicable rules and regulations. HHS seeks to ensure integrity and accountability in its financial assistance programs. Applicants for and recipients of HHS funds are responsible for and must adhere to all applicable Federal statutes, regulations, and policies.

Legal Implication of Application

To be considered for support, an applicant must be an eligible entity and must submit a complete application in accordance with the established deadline. The application must be signed by an authorized representative of the applicant organization. This person is the designated representative of the hospital in matter related to the award of HHS financial assistance. HHS does not specify the organizational location of the applicant's representative; however, it requires the designation of such an official as the focal point for the organization's responsibilities as the recipient of HHS funds.

The signature of an authorized representative of the applicant on the application attests that:

1. All information contained in the application is true and complete, and in conformance with Federal requirements and the organization's own policies and requirements; and

2. The applicant organization's intent to comply with all assurances and certifications referenced in the application.

Civil and criminal penalties apply to any certification, assurance or submission made to HHS made in connection with any program administered by HHS. Even if the application for funding is not granted, the applicant may be subject to penalties if the information contained in it, including its assurances, is found to be false, fictitious, or fraudulent. The applicable provisions are summarized below:

The Program Fraud and Civil Remedies Act of 1986, 31 U.S.C. 3801, provides for the administrative imposition by HHS of civil penalties and assessments against persons who knowingly make false, fictitious, or misleading claims to the Federal Government for money, including money representing grants, loans, or benefits. A civil penalty of not more than $5,000 may be assessed for each such claim. If a grant is awarded and payment is made on a false or fraudulent claim, an assessment of not more than twice the amount of the claim may be made in lieu of damages, up to $150,000. Regulations at 45 CFR Part 79 specify the process for imposing civil penalties and assessments, including hearing and appeal rights.

The Criminal False Claims Act, 18 U.S.C. 287 and 1001, provides for criminal prosecution of a person who knowingly makes or presents any false, fictitious, or fraudulent statements or representations or claims against the United States. Such person may be subject to imprisonment of not more than 5 years and a fine.

The Civil False Claims Act, 31 U.S.C. 2739, provides for imposition of penalties and damages by the United States, through civil litigation, against any person who knowingly makes a false or fraudulent claim for payment, makes or uses a false record or false statement to get a false claim paid or approved, or conspires to defraud the Government to get a false claim paid. A ''false claim'' is any request or demand for money or property made to the United States or to a contractor, grantee, or other recipient, if the Government provides or will reimburse any portion of the funds claimed. Civil penalties of $5,000 to $10,000 may be imposed for each false claim, plus damages of up to three times the amount of the false claim.

45 CFR Part 74 authorizes HHS to recover funds administratively.

Record Retention and Access

Financial and programmatic records, supporting documents, statistical records, and all other records of a participating hospital that are required by the terms of the award or may reasonably be considered pertinent to the award, must be retained for the time period specified in 45 CFR Part 74, Subpart D. Access to these records is also governed by the provisions of 45 CFR Part 74, Subpart D.

Audit

HHS, or any other authorized Federal agency, may conduct an audit to determine whether the applicant hospital has complied with all governing laws and regulations in its application for funding. Any and all information submitted to HHS by an applicant or participating hospital during or after the award of funds is subject to review in an audit.

Hospitals must comply with OMB requirements for audits. OMB Circulars explain the scope, frequency, and other aspects of the audit. OMB Circular A–128, Audits of State and Local Governments, contains the requirements for audits of governmental hospitals. OMB Circular A–133, Audits of Institutions of Higher Education and Other Nonprofit Institutions, issued March 8, 1990, establishes the audit requirements for institutions of higher education and other nonprofit institutions receiving Federal awards. The main features of this Circular are as follows:

1. Nonprofit institutions receiving Federal awards of:

a. $100,000 or more a year shall have an audit made in accordance with the Circular. However, if the awards are under one program, the institution can have either an audit made in accordance with the Circular or have an audit made of the one program only. Individual program audits must conform to the reporting requirements set forth in General Accounting Office publication, government Auditing Standards, 1988 revision.

b. At least $25,000 but less than $100,000 a year must have an audit made in accordance with the Circular or the requirements of each Federal award.

c. Less than $25,000 a year are exempt from Federal audits but must have their records available for review by Federal agencies.

An audit made in accordance with OMB Circular A–133 will be in lieu of any financial audit required under individual Federal awards. However HHS will perform any additional audits necessary to carry out its responsibilities under Federal law or regulation.

Hospitals must submit a copy of audit reports to the National External Audit Resources, HHS Office of Audit Services, 323 West 8th Street, Lucas Place, Room 514, Kansas City, MO 64105.

Suspension, Termination, and Withholding of Support

If a hospital has failed to materially comply with the terms and conditions of the CHGME program, HHS may suspend the award, pending corrective action, or may terminate the award for cause.

Suspension: Temporary withdrawal of a hospital's authority to obligate funds, pending either corrective action by the

hospital, as specified by HHS, or a decision by HHS to terminate the award.

Termination: Permanent withdrawal by HHS of a hospital's authority to obligate previously awarded funds before that authority would otherwise expire. HHS regulations at 45 CFR Part 76 provide for the debarment and suspension of individuals and institutions from eligibility to receive grants and other forms of financial assistance under HHS discretionary programs. (Also see Executive Order 12549, Debarment and Suspension.)

Fraud, Waste and Abuse

HHS encourages anyone who becomes aware of the existence or apparent existence of fraud, abuse, and waste of HHS financial assistance to report this to the HHS Inspector General's Office in writing or on the Inspector General's Hotline. The toll-free number is 1–800–368–5779. All telephone calls will be confidential. Address written complaints to Inspector General, HHS, Room 5250, 200 Independence Avenue SW, Washington, D.C. 20201.

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 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 with 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 States, 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 Children's Hospital Graduate Medical Education Payment Program (CHGME), certain information is required as set forth in this notice in order to determine eligibility for payment. In accordance with the PRA, we are submitting to OMB at this time the following requirement for seeking review of these provisions. A 30-day notice was published in the **Federal Register** on November 7, 2000, to provide for public comment and to request a review of the information collection associated with CHGME.

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

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

Description of Respondents: Children's hospitals operating approved graduate medical residency training operations.

Estimating 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 name	Number of respondents	Responses per respondent	Total responses	Hours per response	Total hour burden
HRSA–99–1:					
(Annual)	54	1	54	99.9	5,395
(Reconciliation)	54	1	54	8	432
HRSA–99–2 (IME)	54	1	54	14	756
HRSA–99–4 (Required GPRA tables)	54	1	54	28	1,512
Total	54	1	54		8095

National Health Objectives for the Year 2000

The Public Health Service is committed to achieving the health promotion and disease prevention objectives of Healthy People 2000, and its successor, Healthy People 2010. These are Department-led efforts to set priorities for national attention. The CHGME program is related to the priority area 1 (Access to Quality Health Services) in Health 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: February 6, 2001.

Claude Earl Fox,

Administrator.

Tommy G. Thompson,

Secretary.

[FR Doc. 01–5008 Filed 2–28–01; 8:45 am]

BILLING CODE 4160–15–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Drug Abuse; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Program Project.

Date: March 16, 2001.

Time: 9:00 a.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Bethesda Marriott, 5151 Pooks Hill Rd., Bethesda, MD 20814.

Contact Person: Rita Liu, PhD, Health Scientist Administrator, Office of Extramural Affairs, National Institute on Drug Abuse, National Institutes of Health, DHHS, 6001 Executive Boulevard, Room 3158, MSC 9547, Bethesda, MD 20892–9547, (301) 443–2620.

(Catalogue of Federal Domestic Assistance Program Nos. 93.277, Drug Abuse Scientist Development Award for Clinicians, Scientist Development Awards, and Research Scientist Awards; 93.278, Drug Abuse National Research Service Awards for Research Training; 93.279, Drug Abuse Research Programs, National Institutes of Health, HHS)

Dated: February 21, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–4906 Filed 2–28–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of General Medical Sciences Special Emphasis Panel.

Date: March 26, 2001.

Time: 11 a.m. to 12 p.m.

Agenda: To review and evaluate grant applications.

Place: Natcher Building, Room 1AS–13, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Arthur L. Zachary, PhD, Scientific Review Administrator, Office of Scientific Review, National Institute of General Medical Sciences, National Institutes of Health, Natcher Building, Room 1AS–13H, Bethesda, MD 20892, (301) 592–2886, zacharya@nigms.nih.gov.

(Catalogue of Federal Domestic Assistance Program Nos. 93.375, Minority Biomedical Research Support; 93.821, Cell Biology and Biophysics Research; 93.859, Pharmacology, Physiology, and Biological Chemistry Research; 93.862, Genetics and Developmental Biology Research; 93.88, Minority Access to Research Careers; 93.96, Special Minority Initiatives, National Institutes of Health, HHS)

Dated: February 20, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–4907 Filed 2–28–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CO–14000–01–1220–AF]

Shooting Closure Order on North Hardscrabble Access Road in Glenwood Springs Field Office; CO

AGENCY: Bureau of Land Management, Department of the Interior.

ACTION: Shooting closure order.

SUMMARY: This order, issued under the authority of 43 CFR 8364.1 closes public lands along the North Hardscrabble Access Road to recreational target shooting for the purpose of enhancing public safety. For this closure order, recreational target shooting is defined as the discharge of any weapon for any purpose other than the lawful taking of a game animal recognized by the State of Colorado. This order applies to public land administered by BLM in Township 5 South, Range 85 West, Section 10, Tract 80 and Lot 7, and in Section 15, Lot 2 and Lot 3, 6th Principal Meridian; Eagle County. The affected public land is generally located east and south of the Town of Gypsum, CO, off of Eagle County Spring Creek Road, 102A.

This action is in accordance with the Glenwood Springs Resource Management Plan, Record of Decision (BLM, 1984). This order, issued under the authority of 43 CFR 8364.1, is established to protect persons, property, public lands and resources.

EFFECTIVE DATES: The restriction shall be effective upon publication until rescinded or modified by the Authorized Officer.

SUPPLEMENTARY INFORMATION: Federal Register Notice CO–070–4333–13–241A,