DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Health Resources and Services Administration (HRSA) publishes abstracts of information collection requests under review by the Office of Management and Budget, in compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). To request a copy of the clearance requests submitted to OMB for review, call the HRSA Reports Clearance Office on (301) 443–1129.

The following request has been submitted to the Office of Management and Budget for review under the Paperwork Reduction Act of 1995:

Proposed Project: The Health Education Assistance Loan (HEAL) Program: Forms—(OMB No. 0915–0043)—Revision

This clearance request is for a revision of the approval for three HEAL forms: the HEAL Repayment Schedule, Fixed and Variable (provides the borrower with cost of a HEAL loan, the number and amount of payments, and the Truth-in-Lending disclosures); and the Lender's Report on HEAL Student Loans Outstanding, Call Report (provides information on the status of loans outstanding by the number of borrowers whose loan payments are in various stages of the loan cycle, such as student education and repayment, and the corresponding dollar amounts). These forms are needed to provide borrowers with information on the cost of their loan(s) and to determine which lenders may have excessive delinquencies and defaulted loans.

The estimate of burden for the forms is as follows:

Form and number	Number of respondents	Responses per respondent	Total responses	Hours per responses	Total burden hours
Disclosure: Repayment Schedule HRSA 502–1, 2	15	666	9,990	.5	4995
Reporting: Call Report, HRSA 512	20	4	80	.75	60
Total Reporting and Disclosure	20		10,070		5,055

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to: John Morrall, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: October 15, 2003.

Jane M. Harrison,

Director, Division of Policy Review and Coordination.

[FR Doc. 03–26573 Filed 10–21–03; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Children's Hospitals Graduate Medical Education Payment Program: Final Policies on Withholding and Reconciliation Process and Methodology for Calculating Reconciliation Payments, Use of Wage Index in Calculating Indirect Medical Education Payments, Dissemination of Program Data, and Audit; Updates on Calculation of National Per Resident Amount and Government Performance and Results Act Measures

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Final notice.

SUMMARY: This notice adopts policies for the Children's Hospitals Graduate Medical Education Payment Program (CHGME PP) regarding the CHGME PP withholding and reconciliation process and calculation of reconciliation payments, use of the wage index to calculate CHGME PP indirect medical education (IME) payments, dissemination of CHGME PP data, and audits. This notice also provides updates and clarification on the CHGME PP calculation of a national per resident amount and CHGME PP compliance with Government Perfornance and Results Act (GPRA) measures.

DATES: This notice is effective November 21, 2003. See discussion under Supplemental Information.

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

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

On September 25, 2002, the Secretary published a notice in the **Federal Register** (67 FR 60241) clarifying hospital eligibility criteria for the CHGME PP. That notice also sought public comments on proposals for (1) establishing a methodology to determine direct medical education (DME) and IME payments during the withholding and reconciliation processes stipulated in the CHGME PP statute; (2) updating the wage index used in the calculation of IME payments; (3) disseminating CHGME PP data; and (4) auditing.

During the comment period, the Department received comments from six interested parties, including hospitals and professional associations. The Secretary thanks the respondents for the quality and thoroughness of their comments. As a result of these comments, the Department has made revisions and clarifications in this final notice. The comments and Department's responses to the comments, as well as the final rules are set forth below. Subsequent to the publication of this notice, CHGME PP policies will be codified.

As indicated in the September 25 **Federal Register** notice, an updated listing of children's hospitals potentially eligible to participate in the CHGME PP will be posted on the CHGME PP Web site (*http://bhpr.hrsa.gov/childrenshospitalgme*), during the third quarter of each year.

Effective dates. To the extent this notice reiterates or clarifies past practices of the CHGME program, those policies continue in effect. To the extent

this notice creates new duties and obligations which cannot be directly drawn from the statute, the effective date shall be November 21, 2003.

Final Provisions

The Department is finalizing the following provisions: (1) Methodology for withholding DME and IME payments and determining reconciliation payments as stipulated in the CHGME PP statute; (2) updating of the wage index used in calculating lIME payments; (3) dissemination of CHGME PP data; and (4) audit.

In its September 25, 2002 **Federal Register** notice, the Department proposed for public comment its methodology for the withholding and reconciliation of CHGME PP payments as stipulated by statute. The Department proposed to withhold up to 25% of both DME and lIME payments to ensure that hospitals did not receive overpayment. It also proposed a methodology to determine reconciliation payments using changes in FTE resident counts that occur during the Federal fiscal year (FFY) for which payments are being made.

In the same **Federal Register** notice, the Department also proposed that the most recently available wage index (WI) be used in the determination of IME payments. To date, the Department had been using the FY 1999 WI published by the Centers for Medicare and Medicaid Services (CMS) to determine IME since its use is statutorily mandated in the determination of DME.

The Department also proposed that each hospital could request its own information (*i.e.*, its application information and information used to determine payments) from the CHGME PP but would need to request all other information (*e.g.*, information for other hospitals or for all hospitals) through the HRSA Freedom of Information Act (FOIA).

Finally, the Department proposed that the 0MB A–133 review requirements originally imposed on hospitals participating in the CHGME PP be replaced with an assessment conducted by an outside contractor familiar with Medicare policies of the FTE resident counts.

A description of the Department's final policies on these issues as well as the public comments and the Department's response is included in the following sections.

I. Withholding and Reconciliation Processes and Methodology for Calculating Reconciliation Payments

The Department is finalizing the methodology for withholding children's hospitals DME and IME payments to reduce the likelihood that a hospital is overpaid on an interim basis, determining revised full time equivalent (FTE) resident counts, and calculating reconciliation payments described in the September 25, 2002 **Federal Register** notice. The CHGME PP began implementing this methodology beginning with the payments it awarded to children's hospitals issued in Federal Fiscal Year (FFY) 2002.

Withholding Process

The CHGME PP statute, as amended, states that ''the Secretary shall withhold up to 25% from each interim (payment) installment for direct and indirect graduate medical education * * * as necessary to ensure a hospital will not be overpaid on an interim basis.'' The statute also indicates that, prior to the end of each FFY, the Secretary must determine any changes to the number of FTE residents reported by a hospital in its annual initial application for CHGME PP funding. This determination by the Secretary will be used to calculate the final amount payable to that hospital for the FFY. Funding withheld during the interim period will be allocated to children's hospitals following the determination by the Secretary of any changes to the number of FTE residents reported by participating hospitals. The Secretary has statutory authority to reconcile FTE resident counts only. It should be noted, however, that the Secretary does have the discretion to audit any and all variables used to determine CHGME PP payments to children's hospitals.

Reporting Revised Resident Counts

To assess the impact of payment resulting from the FTE assessment process, during the third quarter (March 1–June 30) of each FFY for which payments are being made, the CHGME PP will release a reconciliation application for use by participating hospitals to report changes in the FTE resident counts reported in their initial applications. The reconciliation application will include forms HRSA–99 (Hospital Demographics), HRSA–99–1 (Reconciliation of FTE resident counts), HRSA 99–2 (Determination of Indirect Medical Education Data), HRSA–99–3 (Certification), and HRSA–99–4 (Required Data Reporting for Government Performance and Results Act). This collection of information has been approved under 0MB Information Collection No. 09 5–0247. Hospitals will have 30 days to complete and return the reconciliation application. If a hospital fails to complete and return the reconciliation application according to the terms and conditions of the CHGME PP, the Department may suspend the award, pending corrective action, or may terminate the award for cause.

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

Determining Changes in FTE Resident Counts

Hospitals will report revised FTE resident counts to the CHGME PP by submitting a complete reconciliation application. Any changes to resident FTE counts reported on the reconciliation application must be for the same Medicare cost report (MCR) period(s) identified in the hospital's initial application for the FFY. Hospitals whose resident counts have not changed are not exempt from completing and submitting a CHGME PP reconciliation application. For purposes of clarification, an FTE resident is measured in terms of time worked during a residency training year. It is not a measure of individual residents who are working.

Prior to FFY 2003, assessment of FTE resident counts was done by the Medicare fiscal intermediaries (FIs) for the subset of children's hospitals that filed full MCRs. The Secretary has established an assessment process that will ensure this determination is made for FTE resident counts submitted by all children's hospitals. Beginning in FFY 2003, the CHGME PP is contracting with FIs to assess the FTE resident counts submitted by participating hospitals in their FFY 2003 initial CHGME PP application. This assessment of FTE resident counts will be performed for all hospitals regardless of the type of MCR they file (*e.g.*, full, low or no utilization). This process is designed to assess FTE resident counts for all children's hospitals within the CHGME PP time constraints in an equitable fashion. The resident FTE counts reported by the hospitals in their reconciliation application must be consistent with those reported by the hospital's CHGME FI to be accepted by the Department. The Department will provide final review and determination of the hospitals' FTE counts. The reconciliation process requires that participating hospitals comply with requests from the CHGME PP FI. The CHGME PP has placed a guidance document providing further information about the FTE resident count assessment on the program's Web site

(*http://bhpr.hrsa.gov/childrenshospitalgme*).

Comment: One respondent noted that the Department should seek FI review of hospitals' resident counts and reporting of those counts consistent with the review for a given point in time and that the FIs should not be required to attest to hospitals' resident counts. The respondent noted that such an attestation suggests that the FI could be held legally liable for a hospital's error in resident counts even though the FI is not responsible for the maintenance and accuracy of the hospital's records. In addition, the review of resident counts reflects those counts at a point in time: The counts may be subject to change over time due to a variety of factors such as a cost report re-opening.

Response: The Department will not require the CHGME FIs to attest to a hospital's FTE resident count but instead will require a review of the FTE resident counts. This review will be based on the FTE resident counts submitted by the hospitals with their initial application for funding in a particular FFY. It will reflect the hospitals' FTE resident counts at a point in time just prior to the submission of the hospitals' reconciliation application. The hospital's reconciliation application must be consistent with the results of this CHGME PP FI FTE resident count assessment. The Department also recognizes that these FTE resident counts may change over time.

Comment: One respondent commented that although the Department should contract with FIs to provide independent review of resident counts for the CHGME PP, the hospitals should be able to have the same FI providing both the review and processing of their MCR and the assessment of resident FTE counts for their CHGME PP application.

Response: In developing a contract with the FIs to assess the FTE resident counts training in children's hospitals, the Department made every effort to ensure that the same FI would work with the hospital on both their MCR and their CHGME PP application. However, not all FIs chose to participate in the CHGME PP FTE resident assessment contract and, as a result, some hospitals will have different FIs reviewing their MCR and their CHGME PP application. It is important to note that the prime contractor for Medicare and the CHGME PP is the same. As a result, communications are facilitated between the Medicare and CHGME PP FIs in instances where the two are different entities. In those instances where a children's hospital has one FI for Medicare and one for CHGME PP, information and FTE assessment results will be shared between both FIs.

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

New children's teaching hospitals'', as defined by the CHGME PP in its July 20, 2001 **Federal Register** notice, do not include those hospitals with a newly approved residency training program as described in 42 CFR 413.86(g)(6)(i). These ''new children's teaching hospitals'' will calculate FTE resident counts for the reconciliation application process using the methodology proposed in the September 25 **Federal Register** notice. This proposed methodology provides that the hospital would calculate its FTE resident counts in one of two ways:

1. If a hospital has filed a Medicare cost report (MCR) by the CHGME PP reconciliation application deadline, the hospital would report the actual number of resident FTEs trained during that cost reporting period;

2. If a hospital has not filed an MCR by the CHGME PP reconciliation application deadline, the hospital would determine the FTE residents training at the hospital from the beginning of the FFY for which payments are being made up to the reconciliation application deadline. The revised FTE resident count will equal the average number of FTE residents trained per day during this period multiplied by the total number of days the hospital will be training residents during the FFY for which payments are being made. In the event that a ''new children's teaching hospital'' counts residents in excess of its FTE resident cap as a result of an affiliation agreement with one or more other hospitals, it is important to note that the total number of FTE residents counted by members of the affiliated group cannot exceed the aggregate FTE cap for member hospitals. ''New children's teaching hospitals'' will report these updated FTE resident counts on form HRSA 99–1 of the reconciliation application.

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

All hospitals, including ''new children's teaching hospitals,'' must submit a complete reconciliation application. In completing form HRSA 99–2 (Indirect Medical Education) in the reconciliation application, ''new children's teaching hospitals'' will use the methodology described in the September 25 **Federal Register** notice. Those hospitals that have not filed an MCR or completed a full Medicare cost reporting period will use the timeframe from the beginning of the FFY for which payments are being made up to the reconciliation application deadline date to determine the estimates needed to complete the form.

Reconciliation Payment Process

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

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

Reconciliation payments will be made to individual hospitals on or before the end of the FFY (September 30) in which payments are being made. The Secretary will include in the reconciliation payments all funding initially withheld from the hospital as a result of withholding required by statute. At the end of the FFY, the CHGME PP may make a final payment to distribute any remaining funds, including those funds that have been returned to the Department during the course of the FFY as a result of overpayment or hospitals' loss of eligibility.

All hospitals, whether or not they report changes to their resident FTE resident counts during the reconciliation process, can expect changes to their final payment determination as a result of FTE resident count changes reported by other participating hospitals. This is due to the methodology used to determine CHGME PP payments. Payments to individual hospitals are based upon the hospital's share of the total amount of DME and IME funding available for a given FFY. A hospital's portion of the total DME and IME funding available is calculated based on payment variables in the CHGME PP statute and regulations. This individual hospital portion (the numerator) is then divided by the sum of all hospitals' portions (the denominator) to determine the share of the total available funding to be distributed to the hospital. Hence, although an individual hospital's FTE resident count and subsequent portion (numerator) may not change at the time

of the reconciliation application process, the denominator of the payment calculation may change as a result of changes in FTE resident counts reported by other hospitals. More detailed information is available on the CHGME PP payment formulas in the June 19, 2000 **Federal Register** notice (DME payment formula) and the July 20, 2001 **Federal Register** notice (IME payment formula). Information on the payment formulas is also available on the CHGME PP Web site *http://bhpr.hrsa.gov/childrenshospitalgme/.*

As provided by statute, for disputes greater than $10,000, a hospital may request a hearing on the Secretary's payment determination by the Provider Reimbursement Review Board under section 1878 of the Social Security Act (42 U.S.C. 1395oo), implemented by regulations at 42 CFR part 405, subpart R.

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

Comment: One respondent requested that the interest rate charged by the Government be published.

Response: Interest will be accrued at a rate set on a quarterly basis by the Secretary of the Treasury pursuant to 45 CFR 30.13.

II. Updating the Wage Index in Calculation of Indirect Medical Education Payment

The Department has determined that it will continue to use the wage index (WI) determined by the Centers for Medicare and Medicaid Services (CMS) for fiscal year (FY) 1999 to calculate the indirect medical education (IME) payment for children's hospitals. In its September 25, 2002 **Federal Register** notice, the CHGME PP proposed that the wage index (WI) from the most recent fiscal year available be used to calculate IME payments. Although the CHGME PP statute states that the factor applied under section 1886(d)(3)(E) of the Social Security Act (*i.e.*, the wage index calculated by the Centers for Medicare and Medicaid Services) for discharges occurring during fiscal year 1999 for the hospital's area be used in the calculation of direct medical education (DME) payments, the Secretary has discretion to choose the WI used in the calculation of IME payments. Since the statute specifies the use of the FY 1999 WI to determine DME, however, the use of the WI from the most recent fiscal year available to calculate IME payments would result in two different WI being used to determine the CHGME PP payments to children's hospitals. After consideration of the public comments on this topic, the Department has determined that it will continue to use the wage index (WI) determined by the Centers for Medicare and Medicaid Services (CMS) for fiscal year (FY) 1999 to calculate the indirect medical education (IME) payment for children's hospitals. In using the WI to determine CHGME PP payments for both DME and IME, the Secretary will use the most recently available Medicare PPS labor-related (and non-labor-related) share; currently, the PPS labor-related share is 71.1%.

Comment: Several respondents expressed concern regarding use of the updated CMS WI because of current Congressional efforts to make substantive changes in the determination of the CMS WI. As the outcome of these efforts (*i.e.*, if and when a bill is passed) and the resulting implications for recalculation of the WI by CMS are not clear, the respondents encouraged the CHGME PP to postpone implementation of this policy.

Response: Since its inception, determination of the WI has been subject to change both at the Congressional and Department level. Given this ongoing iterative process and the lack of statutory directive regarding the use of WI in the calculation of IME, the Department has determined that it will continue to use the WI from FY 1999 to calculate the IME payment.

Comment: One respondent was concerned about the potential confusion that could result from using two different WI values, one for DME and one for lIME, to determine payments for the participating hospitals.

Response: The Department recognizes the potential confusion that using two different WI values could create among hospitals participating in the CHGME PP. In order to prevent such confusion, the WI from FY 1999 will continue to be used to calculate IME.

Comment: One respondent commented that it may be more appropriate to postpone the implementation of the proposed WI policy until it could be assessed in light of the findings of the ongoing analytic activities related to the CHGME PP IME payment formula.

Response: The Department agrees that it may be best to introduce any changes to the IME payment formula simultaneously and not in an incremental fashion. It should be noted, however, that the payment formulas used by the program may be subject to statutory amendment.

III. Dissemination of CHGME PP Data

The Department considers all CHGME PP information obtained by the program in hospital applications and generated by the program to determine payments to be fully disclosable; that is, its release to the public poses no potential harm to the hospital(s) that originally submitted the Program application. The Department is finalizing the following procedure for the dissemination of information related to the CHGME PP.

Each hospital participating in the CHGME PP may request its own hospital-specific data related to the CHGME PP through a written request to the CHGME PP. Contact information is provided earlier in this notice.

All other requests for information (*e.g.,* information requested about another participating hospital or all participating hospitals) must be submitted to the Freedom of Information Act (FOIA) Officer for the Health Resources and Services Administration (HRSA). The HRSA FOIA Office address is 5600 Fishers Lane, Room 14–45, Rockville Maryland 20857.

In addition, the CHGME PP will follow the policies regarding fees and charges associated with release of information as stated in 45 CFR part 5, subpart D.

IV. Audit

In the March 1, 2001 **Federal Register** notice, the Department announced that awards under the CHGME PP must be audited under Office of Management and Budget (OMB) Circular A–133. The Department has reconsidered its position with respect to this requirement, and is making final the policy proposed in the September 25 **Federal Register** notice that CHGME PP awards are not subject to review/audit under OMB Circular A–133. This policy will be in effect beginning with the FFY 2003 CHGME PP application.

The relevant compliance requirements that the Department needs for the CHGME PP are the FTE resident counts reported on the initial and reconciliation applications for the Program. Since the Secretary must account for change in the number of FTE residents prior to the close of each FFY, the Department is required to assess FTE resident counts per the applications prior to the end of each FFY for all CHGME PP participating hospitals. The Department has established a process to assess the FTE resident counts submitted by children's

hospitals in their applications for funds from the CHGME PP. The process is based on the assessment process utilized by CMS in their review of FTE resident counts submitted on MCR. The process will be implemented by Department contractors familiar with both CMS procedures and CHGME PP requirements.

The Department believes this approach is more effective than an audit/review under OMB Circular A–133, as it provides the Department up-front assurance on the reconciliation of FTE resident counts as mandated in statute. Excluding the CHGME PP from the definition of Federal awards expended under OMB Circular A–133 removes a potential duplication of effort that would result from an auditor testing FTE counts that the Department has already verified, and may allow these audit resources to be used to test other Federal programs of higher risk.

Comment: Several respondents commented that the elimination of the requirement for compliance with OMB Circular A–133 should be made retroactive.

Response: The compliance reviews under OMB Circular A–133 will have been initiated and/or completed for FFYs 2000–2002 prior to the finalization of the Department's policy on this issue. As a result, the Department is not in a position to make the elimination of this compliance requirement retroactive. The Department policy will become effective with the FFY 2003 funding cycle. Furthermore, the comprehensive FTE resident count assessment process undertaken by the Department was not in place prior to FFY 2003.

Clarification of Provisions

The Department wishes to clarify its current rules related to the calculation of a national per resident amount for determining CHGME PP payments and the measures used by the CHGME PP to be in compliance with the Government Performance and Results Act (GPRA).

V. Calculation of National Per Resident Amount

The CHGME PP statute specifies the calculation of a baseline national per resident amount (NPRA) using FFY 1997 data. As amended, the statute also specifies that this baseline amount should be updated annually using the estimated percentage increase in the consumer price index (CPI) for all urban consumers during the period beginning October 1997 and ending with the midpoint of the federal fiscal year for which payments are made. The NPRA is used in the calculation of DME payments.

The March 1, 2001 **Federal Register** notice indicated that the NPRA for cost reporting periods ending in FFY 1997, using the methodology prescribed by the CHGME PP statute, is $67,688. This amount has only been updated by the program once to date. As published in the March 1, 2001 **Federal Register** notice, the updated amount for FFY 2000 was estimated at $71,709. Since the NPRA appears as the same number in both the individual hospital portion (numerator) and the sum of all hospitals' portions (denominator) used to determine DME payments, it doesn't affect the calculation of payments; as a result, the update has not been performed annually.

Beginning with FFY 2002, the NPRA will be updated annually using the methodology included in the statute. The updated amount will be posted on the CHGME PP Web site (*http://bhpr.hrsa.gov/childrenshospitalgme*) in the third quarter of each year. For FFY 2002, the updated NPRA is estimated at $74,890—determined by applying the percent increase in CPI from October 1997 to April 2002 to the baseline NPRA from FFY 1997.

VI. Government Performance and Results Act (GPRA) Measures

In order to be in compliance with the GPRA, the CHGME PP collects information on a series of measures determined by the Department in its annual performance plan. These performance measures are developmental and are subject to periodic modification. In the future, the CHGME PP will post annual updates of its GPRA performance measures on the CHGME PP Web site (*http://bhpr.hrsa.gov/childrenshospitalgme*).

The following measures are being used by the Department to evaluate the performance of the CHGME PP for FFY 2003: (1) Maintain the number of FTE residents in training in eligible children's teaching hospitals; (2) Report the percentage of hospitals funded by the program with negative total margins; and (3) Report the proportion of hospitals' gross revenue from patient care attributed to public insurance (Medicaid, Medicare, SCHIP) and uninsured patients.

Other Applicable Laws, Executive Orders, and Policies

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

Executive Order 12866 requires that all regulations reflect consideration of alternatives of costs, benefits, incentives, equity, and 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.

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 effect on a substantial number of small entities, in that this action will provide significant funding to eligible children's hospitals. The Department has determined that the only burden this action will impose on children's hospitals is the allocation of resources required to submit an application to the CHGME PP. Since this action will not impose a significant burden on a substantial number of small entities, the Department has not examined any alternatives for reducing the burden on children's hospitals. The Secretary has also determined that this action does not meet criteria for a major rule as defined by Executive Order 12866 and would have no major effect on the economy or Federal expenditures.

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

Further, Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a rule that imposes substantial direct compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. The Department has reviewed this action under the threshold criteria of Executive Order 13132, Federalism, and has 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 0MB approval on collections of information. In order to implement the CHGME PP, certain information is required, as set forth in this notice, in order to determine eligibility for payment and amount of payment. In accordance with the PRA, we have received final 0MB approval on the collection of information for the reconciliation procedures beginning in the FFY 2002 cycle (0MB No. 0915–0247).

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

Description: Data is collected on the number of full-time equivalent residents in applicant children's hospitals' training programs to determine the amount of direct and indirect medical education payments to be distributed to participating children's hospitals. Indirect medical education payments will also be derived from a formula that requires the reporting of discharges, beds, and case mix index information from participating children's hospitals. Hospitals will be requested to submit such information in an annual application. Hospitals will also be requested to submit data on the number of full-time equivalent residents a second time during the Federal fiscal year to participate in the reconciliation payment process.

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

Estimated Annual Reporting: The estimated average annual reporting for this data collection is approximately 150 hours per hospital. The estimated annual burden is as follows:

Form	Number of respondents	Responses per respondent	Hours per response	Total burden hours
HRSA–99–1	54	1	99.9	5,395
HRSA99–1 (Reconciliation of FTE counts)	54	1	8	432
HRSA99–2	54	1	14	756
HRSA–99–4	54	1	28	1,512
Total	54			8,095

Education and Service Linkage: As part of its long-range planning, HRSA will be targeting its efforts to strengthen linkages between Department education programs and programs that 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 Pub. L. 103–227, the ProChildren 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: September 2, 2003.

Elizabeth M. Duke,

Administrator, Health Resources and Services Administration.

Dated: October 16, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–26626 Filed 10–21–03; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Advisory Committee on Infant Mortality; Notice of Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), notice is hereby given of the following meeting:

Name: Advisory Committee on Infant Mortality (ACIM).

Dates and Times: November 12, 2003, 9 a.m.—5 p.m.; November 13, 2003, 8:30 a.m.—3 p.m.

Place: The Washington Marriott Hotel, 1221 22nd Street, NW., Washington, DC 20037, (202) 872–1500.

Status: The meeting is open to the public.

Purpose: The Committee provides advice and recommendations to the Secretary of Health and Human Services on the following: Department programs that are directed at reducing infant mortality and improving the health status of pregnant women and infants; factors affecting the continuum of care with respect to maternal and child health care, including outcomes following childbirth; strategies to coordinate the variety of Federal, State, local and private programs and efforts that are designed to deal with the health and social problems impacting on infant mortality; and the implementation of the Healthy Start initiative and infant mortality objectives from *Healthy People 2010.*

Agenda: Topics that will be discussed include the following: Low-Birth Weight and Preterm Birth, Racial Disparities, Border Health, and the Healthy Start Program. Agenda items are subject to change as priorities are further determined.

For Further Information Contact: Anyone requiring information regarding the Committee should contact Peter C. van Dyck, M.D., M.P.H., Executive Secretary, ACIM, Health Resources and Services Administration (HRSA), Room 18–05, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857, telephone (301) 443–2170.

Individuals who are interested in attending any portion of the meeting or who have questions regarding the meeting should contact Ann M. Koontz, C.N.M., Dr.P.H., HRSA, Maternal and Child Health Bureau, telephone (301) 443–6327.

Dated: October 15, 2003.

Jane M. Harrison,

Director, Division of Policy Review and Coordination.

[FR Doc. 03–26572 Filed 10–21–03; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration National Advisory Council on Nurse Education and Practice; Notice of Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), notice is hereby given of the following meeting:

Name: National Advisory Council on Nurse Education and Practice (NACNEP).