

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