Dated: July 30, 1999.

W.B. Hathaway,

Acting Regional Administrator, Region 6.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[HCFA–1001–IFC]

RIN 0938–AI27

Medicare Program; Graduate Medical Education (GME): Incentive Payments Under Plans for Voluntary Reduction in the Number of Residents

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements section 1886(h)(6) of the Social Security Act, as added by section 4626(a) of the Balanced Budget Act (BBA) of 1997. Section 4626(a) of the BBA allows qualifying hospitals to receive incentive payments over a 5-year period for voluntarily reducing the size of their residency programs. A hospital seeking incentive payments must submit, to HCFA and its Medicare intermediary, an application that specifies reductions in its number of residents by 20 to 25 percent.

DATES: *Effective date:* This interim final rule with comment period is effective September 17, 1999.

Comment Period: Comments will be considered if we receive them at the appropriate address, as provided in the **ADDRESSES** section, no later than 5 p.m. on October 18, 1999.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1001–IFC, P.O. Box 9010, Baltimore, MD 21244–9010.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room C5–16–03, Central Building, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

For comments that relate to information collection and recordkeeping requirements, mail copies of comments directly to the following:

Health Care Financing Administration, Office of Information Services, Security Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850; and the

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

FOR FURTHER INFORMATION CONTACT: Rebecca Hirshorn, (410) 786–3411.

SUPPLEMENTARY INFORMATION:

Comments

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1001–IFC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

I. Background

Since the inception of Medicare in 1965, the program has shared in the costs of educational activities incurred by participating providers. Our regulations at 42 CFR 413.85(b) define approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities include approved training programs for physicians, nurses, and certain allied health professionals. Medicare makes payments for both the direct and indirect costs of graduate medical education (GME). Under section 1886(h) of the Social Security Act (the Act) and 42 CFR 413.86, Medicare pays hospitals for the costs of direct GME. Under 1886(d)(5)(B) of the Act and 42 CFR 412.105, Medicare pays hospitals for the costs of indirect medical education (IME).

A. Direct Graduate Medical Education

Under sections 1886 (a)(4) and (d)(1)(A) of the Act and 42 CFR 412.113, direct GME costs are excluded from the definition of a hospital's operating costs and, accordingly, are not included in the calculation of payment rates under the hospital inpatient prospective payment system or in the calculation of the rate-of-increase limit for hospitals excluded from the prospective payment system. Under section 1886(h) of the Act and 42 CFR 413.86, hospitals are paid for direct GME costs based on Medicare's share of a hospital-specific per resident amount multiplied by the number of full-time equivalent (FTE) residents.

B. Indirect Medical Education (IME)

Medicare has made payments to short-term acute care hospitals under section 1886(d) of the Act on the basis of the prospective payment system since 1983. Under the prospective payment system, hospitals receive a predetermined payment for each Medicare discharge. Section 1886(d)(5)(B) of the Act specifically directs the Secretary to provide an additional payment under the inpatient operating prospective payment system to hospitals for IME costs. This additional payment, which reflects the higher operating costs associated with GME, is based in part on the applicable IME adjustment factor. The adjustment factor is calculated by using a hospital's ratio of residents-to-beds in the formula set forth at section 1886(d)(5)(B)(iii) and specified in regulations at § 412.105.

Psychiatric and rehabilitation hospitals and units as well as long-term care, cancer, and children's hospitals are excluded from the prospective payment system and are paid on a reasonable cost basis under section 1861(v)(1)(A) of the Act, subject to a rate-of-increase limit. Payments to excluded hospitals for their IME costs are included in their payments for operating costs and are therefore subject to the rate-of-increase limit.

Under section 1886(g) of the Act and § 412.322 of the existing regulations, we also make capital GME payments to hospitals on the basis of each respective hospital's ratio of residents to average daily census.

C. The Balanced Budget Act of 1997

Section 4626(a) of the Balanced Budget Act (BBA) of 1997, Public Law 105–33 (enacted on August 5, 1997), added section 1886(h)(6) to the Act to set forth provisions that allow Medicare participating hospitals to receive incentive payments over a 5-year period under approved plans for voluntarily reducing the number of residents that are in their approved medical residency training programs. Section 1886(h)(6)(C) of the Act defines the entities that may qualify for incentive payments under a voluntary reduction plan and section 1886(h)(6)(B) of the Act sets forth

participation and reduction criteria that the plan applications must meet for approval.

Section 1886(h)(6)(B)(i) of the Act specifies that the application for a voluntary resident reduction plan must be submitted in a form and manner specified by the Secretary and must be received no later than November 1, 1999. Section 1886(h)(6)(B)(ii) of the Act specifies that the application must provide for the operation of a plan for reducing the number of FTE residents in approved medical residency training programs consistent with the requirements of section 1886(h)(6)(D) of the Act.

Sections 1886(h)(6)(B)(iii) and (iv) of the Act provide that the applying entity—

- Must elect in the application the period of residency training years (not greater than 5) over which the reduction will occur; and
- Must not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion in effect as of the applicable time described in section 1886(h)(6)(D)(v) of the Act.

The statute directs the Secretary to determine whether the application, the entity, and plan meet such other requirements as the Secretary specifies in regulations.

Sections 1886(h)(6) (D) and (E) of the Act specify the requirements for percentage reductions in the number of residents and the manner in which the reductions are to take place. Section 1886(h)(6)(F) provides for a penalty for noncompliance with approved voluntary residency reduction plans. Section 1886(h)(6)(G) specifies that the Secretary shall establish rules regarding the treatment of rotating residents as it relates to providers participating in the voluntary residency reduction plan.

II. Provisions of the Interim Final Regulations

We are establishing interim final regulations under a new § 413.88 under 42 CFR Part 413, to incorporate requirements for incentive payments under voluntary residency reduction plans to implement section 1886(h)(6) of the Act, as added by section 4626(a) of the BBA. The specific statutory provisions and the corresponding regulatory provisions are described below.

A. Participation Criteria

Participation in the residency reduction program under section 1886(h)(6) of the Act is voluntary. Section 1886(h)(6)(A) of the Act specifies that each hospital that is part of a ''qualifying entity'' may receive incentive payments. Section 1886(h)(6)(C) defines a ''qualifying entity'' as—

- An individual hospital that operates one or more approved residency training programs;
- Two or more hospitals that operate one or more approved residency training programs and apply for treatment as a single qualifying entity; or
- A qualifying consortium as described in section 4628 of BBA. Section 4628(b) of the BBA defines a consortium as an entity that consists of a teaching hospital with one or more approved medical residency training programs and one or more of the following:

—A school of allopathic or osteopathic medicine.
—Another teaching hospital, which may be a children's hospital.
—A Federally qualified health center.
—A medical group practice.
—A managed care entity.
—An entity furnishing outpatient services.
—Any other entity that the Secretary determines to be appropriate.

The members of the consortium must have agreed to participate in the GME programs that are operated by the entities in the consortium, and have agreed on a method of allocating the payments among the members. The consortium must meet such additional requirements as the Secretary may establish as necessary.

We are incorporating the provision of section 1886(h)(6)(C) of the Act in the regulations at § 413.88(b). Any hospital that is entitled to receive direct or indirect medical education payments, or both, from Medicare may participate in the voluntary reduction plan as an individual hospital. In addition, two or more hospitals that receive direct or indirect medical education payments, or both, from Medicare may participate as a single entity (joint applicant) and apply for a collective annual resident reduction target.

Section 1886(h)(6)(C)(iii) of the Act cross refers the description of a qualifying consortium for purposes of making voluntary residency reduction incentive payments to the description specified in section 4628 of the BBA. Section 4628 requires the Secretary to establish a demonstration project under which, instead of making GME payments to individual teaching hospitals, under section 1886(h) of the Act, the payments would be made to each consortium.

At this time, we are in the initial phase of developing the demonstration project on the use of consortia and have not yet established the criteria that a qualifying consortium will have to meet beyond that described under section 4628(b) of the BBA. Therefore, we have not included in this interim final regulation provisions related to consortia and we will not be accepting applications for voluntary residency reduction plans from entities that may be qualifying consortia until we have established these additional criteria. If qualifying entities express an interest in participating as a consortia, when the criteria for consortia are finalized for the demonstration project, we will publish a regulation outlining how consortia qualify for the voluntary residency reduction plan. However, until we have established these additional criteria, we are allowing a multihospital entity, that may later qualify as a consortium, to apply as a joint applicant. In addition, we are allowing an individual hospital that may later qualify to participate as a member of a consortium to apply as an individual applicant. In both cases, participation of an individual hospital or a multihospital entity in the voluntary reduction plan does not preclude the entity from later applying to participate as a member(s) of a consortium once the consortia demonstration criteria have been finalized. We are considering whether to allow these applicants to modify their applications so that they can be treated as a consortium for the remainder of their individual or joint voluntary residency reduction plans once the consortium definition is finalized. If we were to allow this alternative, a qualifying entity that is interested in downsizing its resident numbers in accordance with the percentages required under section 1886(h)(6) of the Act would be able to participate and establish its base number of residents prior to knowing whether it would qualify as a consortium.

B. Submission of Applications and Effective Date of Plans

Section 1886(h)(6)(B)(i) of the Act, as added by the BBA, specifies that the application must be submitted ''in a form and manner specified by the Secretary and by not later than November 1, 1999.'' We are requiring each qualifying entity to sign a statement indicating voluntary participation in the residency reduction plan (§ 413.88(d)(8)). We will accept applications from qualifying entities at least one day prior to the first day of the period over which voluntary reduction will occur but in no case later than the November 1, 1999 application date specified in the statute (§ 413.88(e)). We

believe that allowing plan applications to be submitted during this period will ensure that qualifying entities can apply for incentive payments for voluntary reduction plans applicable to residency training programs that begin as early as July 1, 1999.

We also are specifying in § 413.88(e) that each qualifying entity must submit its application to its Medicare fiscal intermediary for review. A copy of the application must also be sent to the HCFA Central Office at the following address: Voluntary Residency Reduction Plan, Health Care Financing Administration, Plan and Provider Purchasing Policy Group, Division of Acute Care, Room C4–07–07, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Interested entities may contact the Division of Acute Care at (410) 786–3411 for questions on the application process.

Accordingly, we are specifying under § 413.88(f) that residency reduction plans that are submitted to the fiscal intermediary on or after September 17, 1999 but on or before November 1, 1999, may be effective for portions of cost reporting periods beginning no earlier than the day after the date of the application. In other words, as long as the application is submitted on or before November 1, 1999, the entity can choose the effective date of the plan to be as early as the day after the date of application.

C. Contents and Format of Applications

In accordance with section 1886(h)(6)(B) of the Act, we are specifying in § 413.88(d) that the qualifying entity must submit an application that contains the statutorily specified information and agreements. In addition, under the authority of section 1886(h)(6)(B)(v) of the Act, we are establishing additional requirements for submittal of data to enable verification of compliance with the percentage reduction requirements of the statute by the fiscal intermediary and for annual monitoring and audit purposes.

Under § 413.88(d)(1), we require an application to include a description of the operation of a plan for reducing the FTE residents in the qualifying entity's approved medical residency training programs, consistent with the percentage reduction requirements specified in section 1886(h)(6)(D) of the Act and described under section II.E. of this preamble. To ensure that we have sufficient data and information to ascertain that the voluntary reduction plan meets the percentage reductions specified in the statute, under § 413.88(d)(3) we further require the qualifying entity to submit FTE counts for its base number of residents (as defined in section II.D. of this preamble), with a breakdown of the number of primary care residents compared to the total number of residents. A primary care resident is defined in the existing Medicare regulations at § 413.86(b) as a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice. We also are requiring the entity to submit its direct and indirect FTE counts as of June 30, 1997. For joint applicants, these counts must be provided individually and collectively. This information will be verified by the fiscal intermediary.

In addition, in § 413.88(d)(4) we are requiring the qualifying entity to submit, with the application, data on the annual and cumulative targets for reducing the number of FTE residents and the ratios of the number of primary care residents to the total number of residents for the year used to determine the base number and for each year in the 5-year reduction period. For joint applicants, these data must be provided individually and collectively. In the case of joint applicants, the group of participating hospitals will be held to a collective target. None of the participating hospitals will receive incentive payments unless the collective target is met.

In accordance with section 1886(h)(6)(D)(iii) of the Act, the application must include an election of the period of residency training years during which the reductions will occur (§ 413.88(d)(2)). The reductions must be fully implemented by not later than the fifth residency training year in which the plan is effective.

Under § 413.88(d)(5) and in accordance with section 1886(h)(6)(B)(iv) of the Act, we are requiring the qualifying entity in its application to agree to not reduce the proportion of its primary care residents to its total number of residents below the proportion that exists in the residency training program year that the entity used to determine the base number of residents, as described in section II.D. of this preamble.

Under the Secretary's authority under section 1886(h)(6)(B)(v) of the Act to determine other requirements for voluntary reduction plans and entities as necessary, we are requiring under § 413.88(d)(7) that for a qualifying entity that is also member of an affiliated group as defined in § 413.86(b), a statement be submitted along with the application that all members of the affiliated group (that are not a part of the qualifying entity) agree to an aggregate FTE cap that reflects the resident count during each year of the qualifying entity's plan and the 1996 FTE count of the other hospital(s) in the affiliated group. In addition, we are requiring under § 413.88(d)(6) that the qualifying entity, in its application, agree to comply with data submission requirements deemed necessary by HCFA to make annual incentive payments during the 5-year residency reduction plan, and to fully cooperate with additional audit and monitoring activities deemed necessary by HCFA.

D. Definition of the Base Number of Residents

Under section 1886(h)(6)(D), the residency reduction requirement for a qualifying entity depends on the entity's base number of residents. Section 1886(h)(6)(D)(vi) of the Act, as added by section 4626(a) of the BBA, defines the term ''base number of residents'' to mean—

* * * with respect to a qualifying entity (or its participating hospitals) operating approved medical residency training programs, the number of full-time equivalent residents in such an entity's programs (before application of weighting factors) of the entity as of the most recent residency training year ending before June 30, 1997 or, if less, for any subsequent residency training year that ends before the date the entity makes application under this paragraph.

Under § 413.88(g)(1) of these interim final regulations, we define the base number of residents using the counting rules for determining a hospital's direct GME FTE count under existing § 413.86 with two changes to reflect the provisions of section 4626 of the BBA. First, consistent with section 1886(h)(6)(D)(vi), we specify that the base number of residents will be determined on the basis of a July 1 to June 30 ''residency training year,'' rather than the hospital's cost reporting period. Second, under existing § 413.86(g), a weighting factor is applied to each resident included in a hospital's direct GME FTE count. Residents within an initial residency period are weighted at 1.0 FTE and residents beyond the initial residency period are weighted at 0.5 FTE. However, consistent with section 1886(h)(6)(D)(vi) of the Act, in determining the base number of residents for voluntary residency reduction plans, we are requiring under § 413.88(g)(1)(i) that FTEs be counted ''before application of weighting factors,'' so that each resident will be weighted at 1.0 FTE.

In summary, we are specifying in § 413.88(g)(1)(i) that the base number of residents means the lesser of (1) The number of FTE residents in all approved medical residency training programs of the qualifying entity (before application of weighting factors under § 413.86(g)) for the most recent residency training year ending June 30, 1996; or (2) the number of FTE residents in all approved medical residency training programs of the qualifying entity (before application of weighting factors under § 413.86(g)) for any subsequent residency training year that ends before the date the entity submits its plan to the fiscal intermediary and HCFA. The residency training year used to determine the base number of residents is the ''base year'' for determining residency reduction requirements described under section II.E. of this preamble.

E. Residency Reduction Requirements

Section 1886(h)(6)(D) of the Act, as added by the BBA, specifies the methodology for determining the number of FTE residents in all of the qualifying entity's approved medical residency training programs that must be reduced in order for each type of qualifying entity to receive incentive payments.

1. Qualifying Entities That Are Individual Hospitals

a. *Hospitals with a base number of residents that is greater than 750.* If an individual hospital's base number of residents exceeds 750 residents, the voluntary plan must specify a reduction in the base number of residents by at least 20 percent.

b. *Hospitals with a base number of residents between 601 and 750.* If an individual hospital's base number of residents exceeds 600 but is not in excess of 750, the voluntary plan must specify a reduction in the base number of residents by at least 150 residents. Alternatively, the plan may specify a reduction of at least 20 percent if the base number of residents in primary care is increased during the plan by at least 20 percent.

c. *Hospitals with a base number of residents that is 600 or fewer.* Hospitals with a base number of residents of 600 or less have the option of reducing the base number of residents by at least 25 percent. Alternatively, the plan may specify a reduction of at least 20 percent if the number of primary care residents is increased by at least 20 percent.

We have incorporated these provisions at § 413.88(g)(2).

2. Qualifying Entities With Two or More Hospitals (Joint Applicants)

Joint applicants must reduce their combined base number of residents by 25 percent; or if there is an increase in the combined base number of primary care residents of at least 20 percent, by at least 20 percent. Section 413.88(g)(3) contains this provision.

3. Consortia Applicants

The statute specifies that consortia applicants must reduce the combined base number of residents by at least 20 percent. As indicated earlier, we are not accepting applications from consortia until we have established criteria for consortia under section 4628 of the BBA and have some experience with the demonstration project. Therefore, this interim final rule does not contain provisions relating to consortia. However, until we have issued these criteria, a qualifying entity that may later qualify as a consortium may apply in the interim as an individual hospital or multihospital joint applicant as described above.

Under section 1886(h)(6)(B)(iv) of the Act, a qualifying entity applicant may not reduce the base year proportion of its primary care residents to its total number of residents below the proportion that exists in the residency training program year used to determine the base number of residents. In other words, the proportion of residents in primary care at the end of the plan must be at least the same as or greater than the proportion of total residents in primary care in the base number of residents. We have incorporated these provisions at § 413.88(g)(2)(ii)(B), (g)(2)(iii)(B) and (g)(3)(ii).

Section 1886(h)(6)(D)(iv) of the Act specifies that voluntary residency reductions in the base number of residents must be fully effective no later than the fifth residency training year in which the application is effective. The following table illustrates the resident reduction options under the voluntary plans for the different types of qualifying entity applicants:

Type of applicant	Reduction option (5 year plan)
Individual Hospitals:	
More than 750 Residents	≥20%.
601 to 750 Residents	≥150 Residents or ≥20% if primary care residents increase by ≥20%.
600 or fewer Residents	≥25% or ≥20% if number of primary care residents increased by ≥20%.
Joint Applicants	≥25% or ≥20% if number of primary care residents increased by ≥20%.
Consortia Applicants	≥20%.
All Applicants	May Not Reduce Primary Care/Total Resident Ratio.

F. Incentive Payments

Sections 1886(h)(6)(A) and (E) of the Act prescribe the formula for calculating the amount of incentive payments. Although hospitals may participate as a joint applicant (or later as a consortium, as discussed earlier in this preamble), incentive payments will be made to individual hospitals through the regular Medicare payment process via cost reports.

Incentive payments will be made on the basis of a cost reporting period even though residency reductions under the plan are made on a July 1 to June 30 medical residency program year. If a hospital cost reporting period coincides with a residency program training year, incentive payments may begin at the beginning of the first cost reporting period in which resident reductions are made under the voluntary residency reduction plan. For instance, if a hospital chooses to participate in the voluntary residency reduction plan for the residency training year July 1, 2000 to June 30, 2001 and the hospital has a July 1 to June 30 cost reporting period, the first year in which Medicare may make incentive payments for voluntary residency reductions would be the hospital's July 1, 2000 to June 30, 2001 cost reporting period. If a hospital's cost reporting period does not coincide with a residency training year, the first year in which incentive payments may be made under the voluntary residency reduction plan would be the hospital's cost reporting period that overlaps the July 1, 2000 beginning date of the voluntary residency reduction plan. For instance, if a hospital participates in the residency reduction plan effective July 1, 2000, and the hospital has a January 1 to December 31 cost reporting period, incentive payments may be made under the voluntary residency plan beginning

in the hospital's January 1, 2000 to December 31, 2000 cost reporting period. If the hospital's cost reporting period does not coincide with a July 1 to June 30 residency training year, the applicable hold-harmless percentages described earlier would be prorated accordingly over the respective cost reporting period(s). In addition, if the hospital's cost reporting period does not coincide with a July 1 to June 30 residency training year, for purposes of calculating the number of residents in each plan year, the number of FTE residents would be prorated over the respective cost reporting periods.

In § 413.88(j), we specify that annual incentive payments through cost reports will only be made to hospitals that are or are part of qualifying entities over the 5-year reduction period if the qualifying entity meets specified annual residency reduction goals. An incentive payment will be made for any given year only when the participant meets or exceeds the cumulative annual target applicable to that year. Consistent with section 1886(h)(6)(F) of the Act, if a participating entity fails to comply with its residency reduction plan by the end of the fifth residency training year, the hospitals that comprise the qualifying entity will be liable for repayment of all incentive payments.

We will allow an entity to update its annual targets as specified in its plan only under limited circumstances. If the entity has failed to meet any of its annual targets in a plan year, it will not receive incentive payment for that particular plan year. To be eligible for future incentive payments for the duration of the plan, the entity may update future annual targets for the remaining years of the plan in order to comply with its cumulative target. We would require the updated plan to be submitted prior to the beginning of each July 1 medical residency training year during the plan years.

In accordance with section 1886(h)(6)(A) of the Act, each individual entity participating in the plan will receive incentive payments based on the following calculation (as specified under § 413.88(h)): The sum of the entity's direct and indirect GME payment based on 95 percent of the total number of weighted residents in the approved medical residency training programs of the qualifying entity on June 30, 1997 subtracted by the sum of the qualifying entity's direct and indirect GME payment based on 100 percent of the number of weighted FTE residents in each of the 5 plan years. This difference will be multiplied by a decreasing hold-harmless percentage for the given plan year, to arrive at an individual hospital's incentive payment.

In accordance with section 1886(h)(6)(E) of the Act, the applicable hold-harmless percentages are as follows (as specified under § 413.88(i)):

Plan year	Percentage
1	100
2	100
3	75
4	50
5	25

As stated above, the applicable hold-harmless percentages must be prorated over two hospital cost reporting periods if the hospital's cost reporting period does not coincide with the residency training program year. For instance, a hospital participating in the voluntary plan will be making reductions on the basis of a July 1 to June 30 program year. If the hospital has a January 1 to December 31 cost reporting period, the applicable hold-harmless percentages will change on July 1 of each year, which is in the middle of the hospital's cost reporting period. For this reason, the applicable hold-harmless percentage for the cost reporting period will reflect a weighted average of the residency reductions in each portion of the cost reporting period. In addition, in calculating the incentive payments we will apply weighting factors to the total resident count as of June 30, 1997 and for each plan year. This is consistent with our existing policy under § 413.86(g) of applying weighting factors to resident FTE counts.

We are providing the following simplified example to illustrate application of the incentive payment calculation.

Assume a hospital's resident program year is the same as its cost reporting year, and that it receives $10 million for direct and indirect GME based on 100 FTE residents as of June 30, 1997. Also assume that the hospital's average payment per resident for indirect and direct GME of $100,000 (derived from $10 million/100 residents) does not change from June 30, 1997 to the end of the 5-year reduction plan. If the hospital agrees to reduce its FTE count by 5 residents per year and 25 residents over 5 years, it would be paid as follows:

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	Resident Reduction Plan Year					Total Payment (in millions)
	1st	2nd	3rd	4th	5th	
FTEs on June 30, 1997 *(a)*	100	100	100	100	100	-----
Cumulative FTE resident reduction *(b)*	5	10	15	20	25	-----
FTE residents in each plan year *(c)* *(c= a-b)*	95	90	85	80	75	-----
Adjusted June 30, 1997 FTEs *(d)* *(d= a (0.95))*	95	95	95	95	95	-----
FTE loss applied to incentive calculation *(e)* *(e= c-d)*	0	5	10	15	20	-----
Total direct & indirect GME payments for residents in each plan year *(f)* (in millions) *(f= c ($100,000))*	$9.5	$9.0	$8.5	$8.0	$7.5	$ 42.5
Total direct & indirect GME loss relative to June 30, 1997 FTE count *(g)* (in millions) *(g= b ($100,000))*	$0.5	$1	$1.5	$2.0	$2.5	------
Total direct & indirect GME loss applied to incentive calculation *(h)* (in millions) *(h= e ($100,000))*	$0	$0.5	$1.0	$1.5	$2.0	-----
Hold-Harmless percentage *(i)*	1.0	1.0	0.75	0.50	0.25	-----
Incentive payment *(j)* (in millions) *(j= h (i))*	$0	$0.5	$0.75	$0.75	$0.5	$ 2.5
Grand Total Payments *(k)*	-----	-----	-----	-----	-----	$ 45.0

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As depicted in the preceding chart, in any year of the residency reduction plan, the hospital receives incentive payments based on 95 percent of its number of residents on June 30, 1997. In each year of the plan, the incentive payment is based on a declining percentage (hold-harmless percentage, line (i) in the preceding chart) of the hospital's direct and indirect GME payment loss associated with residency reduction below 95 percent of its base number of residents line (h). In this example, the hospital's revenues for indirect and direct GME would have declined by a total of $7.5 million ($50 million-$42.5 million) over a 5-year period if the hospital did not reduce the number of residents according to the plan. A hospital participating in the voluntary plan, however, received $2.5 million in incentive payments. Of the $5 million difference ($7.5 million-$2.5 million), $2.5 million is due to the hold-harmless percentage (i) and the remaining $2.5 million is due to the 5-percent adjustment to the number of residents on June 30, 1997.

Under section 1886(h)(6)(A) of the Act, the determination of the incentive payments for any year must be made on the basis of the Medicare payment provisions ''in effect on the application deadline date for the first calendar year to which the reduction plan applies.'' Thus, the amount of the incentive payment depends on the Medicare provisions in effect on the application deadline date (§ 413.88(h)(2)). As specified earlier, applications must be filed at least one day prior to the effective date of the plan but no later than November 1, 1999. For example, if a hospital wants the reduction plan provision to go into effect on September 1, 1999, the deadline for the application would be August 31, 1999. Therefore, the Medicare payment provisions in effect on August 31, 1999, would be used to calculate the amount of the incentive payment. The latest date for applying for incentive payments is November 1, 1999.

G. Repayment Penalty Provision

Section 1886(h)(6)(F)(ii) of the Act, as added by the BBA, sets forth a repayment penalty following a qualifying entity's completion of a voluntary residency reduction plan in which the entity received incentive payments if the entity exceeds the number of residents that it has agreed to in its plan. We are specifying in § 413.88(k) that the entity is liable for repayment for the total amount of the incentive payments if the number of FTE residents increases above the number of such residents permitted under the reduction plan after the completion of the plan. If the number of FTE residents increases above the number of residents permitted under the voluntary reduction plan, the following provisions of repayment apply:

- In any postplan year, a qualifying entity that successfully completed the reduction plan either as an individual hospital or a member of a joint applicant is subject to the total repayment provisions if its resident count exceeds the number of residents specified in the voluntary residency reduction plan.
- As contained in § 413.88(l)(1), the end-of-plan residency cap will equal the unweighted FTE count used for direct medical education payments for the last residency training program year in which a qualifying entity participates in a plan. For each subsequent cost reporting year that ends after the end of the reduction plan, the unweighted direct FTE resident count will be compared to the unweighted direct GME FTE resident count for the last residency training program year. If the unweighted direct GME FTE resident count for a cost reporting period post plan exceeds the resident count specified in the voluntary residency reduction plan, the qualifying entity is subject to the total repayment provision.
- The repayment provision applies until such time when a full credit has been made against the total amount of incentive payments made to the qualifying entity. For individual hospitals, the total incentive payment amount equals all of the incentive payments made to the hospital. For joint participants, the total payment amount equals the sum of all incentive payments made to the individual hospitals that make up the membership of the joint participant.
- For the purpose of calculating the credit amount in each postplan year to which the total repayment provision applies, an individual hospital's direct and indirect GME payments will be calculated based on the hospital's actual FTE resident counts in that year. Payments are made to the hospital up to the amount that applies to the end-of-plan FTE resident count. The remainder is credited against the total repayment amount. The total repayment amount is equal to the actual annual incentive payments made during the voluntary reduction plan years. An example would be a hospital that had a base number of 200 FTE residents and by the end of the plan reduces its FTE count to its cumulative target of 160 FTE residents. If, at a later date after the completion of the plan, the entity increases its FTE count from 160 FTEs to 161 FTEs, the repayment penalty provision would be in effect. The entity would be required to repay the entire amount it received as incentive payments during the plan years. However, the method of repayment is limited to the direct and indirect payments the entity would have received for the 161st resident. These direct and indirect GME payments are credited against the total repayment amount the entity is required to repay.
- Once the total penalty is repaid, the qualifying entity's adjusted FTE cap reverts back to its original 1996 FTE cap, since effectively all benefits of participating in the plan will have been eliminated (§ 413.88(l)(2)(ii)).

H. Related BBA Provisions and Their Effect on Voluntary Plan Reduction Provisions

Several other provisions of the BBA that were implemented in the **Federal Register** on August 29, 1997 (62 FR 46003 through 46007), and on May 12, 1998 (63 FR 26318) have an effect on incentive payments under the voluntary residency reduction plan.

1. Reduction in the Indirect Medical Education Adjustment

Section 4621 of the BBA revised section 1886(d)(5)(B) of the Act to reduce the level of the IME adjustment in effect prior to the enactment of the BBA (approximately 7.7 percent for every 10-percent increase in the resident-to-bed ratio) over several years. The schedule for the IME adjustment is as follows: 7.0 percent for discharges during FY 1998; 6.5 percent during FY 1999; 6.0 percent during FY 2000; and 5.5 percent during FY 2001 and thereafter. In determining the voluntary residency reduction incentive payment calculation, the respective IME adjustment factors will apply for the number of FTE residents in each of the 5 plan years and to the number of FTE residents as of June 30, 1997.

2. Caps on the Number of FTEs

Sections 4621 and 4623 of the BBA amended section 1886 of the Act to limit the number of residents that a hospital can count for purposes of determining payment for indirect and direct GME costs. For cost reporting periods beginning on or after October 1, 1997, the total number of allopathic and osteopathic medical residents that a hospital may include in its FTE count in either a hospital or nonhospital setting for IME payments is limited to the total number of such resident FTEs included in the hospital's most recent cost reporting period ending on or before December 31, 1996. Similarly, for direct GME payments, the number of

allopathic and osteopathic medical residents that a hospital may include in its unweighted direct medical education FTE count for cost reporting periods beginning on or after October 1, 1997, is limited to the number included in the hospital's most recent cost reporting period ending on or before December 31, 1996. The August 29, 1997 final rule with comment period and the May 12, 1998 final rule amended §§ 412.105 and 413.86 of the regulations to implement these provisions for indirect and direct GME, respectively.

Since the counting rules for indirect and direct GME in hospital cost reports ending on or before December 31, 1996 were different, the FTE caps may also be different. Prior to enactment of the BBA, a hospital's IME FTE count could only include residents working in inpatient areas of the hospital subject to the prospective payment system and hospital outpatient departments. Residents in nonhospital settings and areas of the hospital not subject to the prospective payment system could not be counted. For direct GME, a hospital could include residents in all areas of the hospital complex (including areas not subject to the prospective payment system) and nonhospital settings (if the criteria of § 413.86(f)(1)(iii) are met). However, residents in subspecialty training and residents otherwise beyond the initial residency period included in a hospital's direct GME FTE count are weighted at 0.5 FTE under § 413.86(g).

The BBA limits the FTE caps to allopathic and osteopathic medical residents and does not apply FTE caps to podiatry and dentistry residents. For purposes of the voluntary residency reduction plans, the base number of residents under section 1886(h)(6)(D)(vi) of the Act includes all of a hospital's residents (including residents in dentistry and podiatry). Therefore, we will determine whether a hospital is eligible for incentive payments under the voluntary residency reduction plan by counting all residents participating in approved medical residency training programs. Accordingly, a hospital that receives incentive payments under the voluntary residency reduction plan remains subject to the indirect and direct GME FTE caps mandated under sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act and §§ 412.105 and 413.86 of the regulations.

3. Counting Residents Based on a 3-Year Average in the Plan Year

Section 1886(d)(5)(B)(vi)(II) of the Act, as amended by section 4621 of the BBA, provides that a hospital's IME FTE resident count for a cost reporting period beginning during FY 1998 will be based on the average of the number of residents for the cost reporting period and the prior cost reporting period. The hospital's IME FTE count for cost reporting periods beginning in FY 1999 and subsequent years will be based on an average of the FTE count for the cost reporting period and the prior two cost reporting periods. Similarly, section 1886(h)(4)(G) of the Act, as amended by section 4623 of the BBA, provides that a hospital's direct GME FTE resident count for a cost reporting period beginning during FY 1998 will be based on the average of number of residents for the cost reporting period and the prior cost reporting period. The hospital's direct GME FTE count for cost reporting periods beginning in FY 1999 and subsequent years will be based on an average of the FTE count for the cost reporting period and the prior two cost reporting periods.

We determine the level of payments for the cost reporting period using the number of residents as of June 30, 1997 without regard to averaging rules. However, the averaging rules described above are applicable when determining incentive payments for the hospital's actual residents in a voluntary plan year.

4. Capital IME Payment

Section 1886(h)(6)(A) of the Act limits the incentive payments to direct GME payments and operating IME payments. However, under section 1886(g) of the Act and § 412.322 of the existing regulations, we also make capital IME payments on the basis of the hospital's ratio of residents to average daily census. Since capital IME payments are also a function of the number of residents in approved programs, we believe we have discretion to provide incentive payments for capital IME using a methodology similar to the one used for determining operating IME payments under this interim final rule. We are including language in § 413.88(h)(1)(iii) that will allow hospitals participating in voluntary residency reduction plans to receive incentive payments for capital IME.

5. Counting FTEs in Nonhospital Settings

Under § 413.86(f)(1)(iii), on or after July 1, 1987 and before January 1, 1999, a resident may be included in a hospital's direct GME FTE count if the resident spends time in patient care activities outside of the hospital and there is a written agreement between the hospital and the nonhospital entity that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital. Section 4621(b)(2) of the BBA amended section 1886(d)(5)(B)(v) of the Act to allow all the time spent by residents in patient care activities under an approved medical residency training program in a nonhospital setting to be counted towards the determination of FTEs for IME, if the hospital incurs all, or substantially all, of the costs for the training program in the nonhospital setting. In accordance with section 1886(h)(4)(E) of the Act, we are currently using the same criteria for determining whether a hospital may include a resident in its FTE count for direct GME. However, in the July 31, 1998 **Federal Register** (63 FR 41005), we revised the definition of ''all or substantially all of the costs'' in order to implement section 4625 of the BBA, which permits payment to certain nonhospital providers. The revised rule requires the written agreement to indicate that the hospital will incur the costs of the resident's compensation in the nonhospital site and provide reasonable compensation to the nonhospital site for supervisory teaching activities. If a hospital includes residents in nonhospital settings in its IME FTE count, consistent with section 1886(d)(5)(B)(v) of the Act, the hospital must include those residents in determining whether it has exceeded its IME FTE cap. In addition, if a hospital included residents in nonhospital settings in its direct GME FTE count, the hospital must include these residents in determining whether it has exceeded its direct GME FTE cap.

A hospital that incurs ''all or substantially all of the costs'' and is counting the FTE for the time a resident spends in a nonhospital site for purposes of direct and indirect GME payments must also include the FTE in the nonhospital site for purposes of counting the FTE in making the target reductions under the plan. In other words, qualifying entities that include the FTE in nonhospital sites for GME payment must also include it when making the target reductions.

6. New Medical Residency Training Programs

Section 1886(h)(5)(H) of the Act permits special rules in the case of medical residency training programs established on or after January 1, 1995. Under a final rule published in the **Federal Register** on May 12, 1998 (63 FR 26333) such new medical residency training programs are permitted to have an adjustment to the FTE cap. (We have proposed to further clarify the requirements for receiving an adjustment to the FTE cap for new medical residency training programs in

a notice of proposed rulemaking published in the **Federal Register** on May 7, 1999 (64 FR 24735)).

For purposes of this interim final rule with comment period, however, since section 1886(h)(6) of the Act does not provide for adjustments to the FTE counts, we will not adjust a hospital's base number of residents for adjustments that may be otherwise made to hospital FTE caps for new medical residency training programs. For example, a hospital that had a 100 FTE cap that qualifies for a new medical residency training program adjustment to raise its FTE cap to 120 FTE residents would not be able to count the 20 FTE adjustment for purposes of calculating the base number of residents for the voluntary residency reduction plan.

7. Hospitals That Meet the Definition of Affiliated Groups

Section 1886(h)(5)(H)(ii) of the Act allows the Secretary to prescribe rules that allow institutions that are members of the same affiliated group to elect to apply the FTE caps on an aggregate basis. In the May 12, 1998 final rule (63 FR 26358), an affiliated group is defined as follows:

- Two or more hospitals located in the same urban or rural area (as those terms are defined in § 412.62(f)) or in contiguous areas if individual residents work at each of the hospitals during the course of the program; or
- If the hospitals are not located in the same or contiguous rural and urban areas, hospitals that are jointly listed—

++ As sponsor, primary clinical site, or major participating institution for one or more of the programs as those terms are used in the *Graduate Medical Education Directory*, 1997–1998; or

++ As the sponsor or under affiliations and outside rotations for one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs*; or

- Hospitals that are under common ownership.

For purposes of this interim final rule with comment period, we will permit applications from one or more hospitals that qualify as an affiliated group under § 413.86. A qualification that must be met for affiliated groups that involve one or more member hospitals participating in the voluntary residency reduction plan is that all members of the affiliated group agree to an aggregate FTE cap that reflects the resident count during each plan year of the hospital that is in the voluntary reduction plan.

As stated earlier, section 1886(h)(6)(F)(ii) of the Act requires a qualifying entity to refund all incentive payments if it has more residents after the end of the plan than it was permitted under the plan. Affiliated groups that include hospitals in the voluntary residency reduction plan that have successfully completed the plan must also agree to an aggregate cap based on the 1996 FTE count of each hospital in the affiliated group, adjusted for the participating hospital's final FTE count under the voluntary residency reduction plan. However, in the event that a qualifying entity increases its FTE count above its target reduction and has refunded all incentive payments received under the plan (since effectively all benefits of participation in the plan will have been eliminated), the aggregate FTE cap would include that entity's FY 1996 FTE cap.

In accordance with the requirement established under § 413.88(g)(4), a hospital participating in the voluntary residency reduction plan and is a member of an affiliated group, may not achieve its residency reduction goals by rotating residents to other members of the affiliated group that are not participating in the voluntary residency reduction plan.

8. Payments to Hospitals for Indirect and Direct GME Costs Associated with Medicare+Choice Enrollees

Section 4622 of the BBA added section 1886(d)(11) to the Act to provide for IME payments to teaching hospitals for discharges associated with Medicare+Choice enrollees for portions of cost reporting periods occurring on or after January 1, 1998. The additional payment is equal to an applicable percentage of the estimated average per discharge amount that would have been made for the discharge for IME if the beneficiary were not enrolled in managed care. The applicable percentage set forth in section 1886(h)(3)(D)(ii) of the Act is equal to 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent in 2002 and subsequent years.

Section 4624 of the BBA amended section 1886(h)(3) of the Act to provide a 5-year phase-in of the payments to teaching hospitals for direct GME costs associated with services to Medicare+Choice discharges for portions of cost reporting periods occurring on or after January 1, 1998. The amount of payment is equal to the product of the per resident amount, the total weighted number of FTE residents working in all areas of the hospital (and nonhospital settings in certain circumstances) subject to the limit on the number of FTE residents under section 1886(h)(4)(F) of the Act and the averaging rules under section 1886(h)(4)(G) of the Act, the ratio of the total number of inpatient bed days that are attributable to Medicare+Choice enrollees to total inpatient days and an applicable percentage. The applicable percentages are 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent in 2002 and subsequent years.

The effect of this provision for qualifying entities participating in voluntary residency reduction plans is that the level of payments for the cost reporting period will be determined using the actual number of residents reflective of the additional indirect and direct GME payments associated with Medicare+Choice discharges. The difference between the hospital's payments using the number of residents as of June 30, 1997, and the actual number of residents in a voluntary residency reduction plan year, including the effect of adjustments for payments associated with Medicare+Choice discharges, will be the basis for the incentive payment calculation.

I. Other Issues

1. Mergers, Acquisitions, and Related Changes

We recognize that hospitals participating in an approved voluntary residency reduction plan may undergo hospital mergers, acquisitions, or related changes (for example, system dissolution) that may affect the qualifying entity. We invite comments on how we can most appropriately address such situations.

2. Evaluation

We do not have specific plans to evaluate the impact of the voluntary residency reduction plans at this time. However, we may request information from entities approved for participation in a voluntary residency reduction plan. If a full evaluation is conducted, cooperation will be voluntary.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act (PRA) of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Section 413.88(d) of this document contains information collection requirements. However, given that we anticipate the submission of less than 10 applications on an annual basis, these collection requirements are not subject to the PRA. Therefore, at this time we are not submitting a copy of this document to OMB for its review of these information collection requirements. If we determine, at a later date, that we will receive more than 10 applications prior to the November 1, 1999 application submission deadline, we will submit these information collection requirements to the OMB, as required by section 3504(h) of the PRA.

Although we believe that these information collection requirements are not subject to the PRA, we still welcome public comment on each of the following issues for the section of this document that contains information collection requirements:

Section 413.88(d) requires that a qualified entity must submit a voluntary residency reduction plan application that contains the following information or documents:

(1) A description of the operation of a plan for reducing the FTE residents in its approved medical residency training programs, consistent with the percentage reduction requirements described under section II.E. of this preamble.

(2) An election of the period of residency training years during which the reductions will occur;

(3) FTE counts for the base number of residents, with a breakdown of the number of primary care residents compared to the total number of residents; and the direct and indirect GME FTE counts for the entity on June 30, 1997. For joint applicants, these counts must be provided individually and collectively;

(4) Data on the annual and cumulative targets for reducing the number of FTE residents and the ratios of the number of primary care residents to the total number of residents for the base year and for each year in the 5-year reduction period. For joint applicants, these data must be provided individually and collectively;

(5) An agreement to not reduce the proportion of its primary care residents to its total number of residents below the proportion that exists in the base year;

(6) An agreement to comply with data submission requirements deemed necessary by HCFA to make annual incentive payments during the 5-year residency reduction plan, and to fully cooperate with additional audit and monitoring activities deemed necessary by HCFA; and

(7) For a qualifying entity that is also member of an affiliated group as defined in § 413.86(b), a statement that all members of the affiliated group—that are not part of the qualifying entity—agree to an aggregate FTE cap that reflects the resident count during each year of the qualifying entity's plan and the 1996 FTE count of the other hospital(s) in the affiliated group; and

(8) A statement indicating voluntary participation in the plan under the terms of this section, signed by each hospital that is part of the applying entity.

Each applicant will determine its own annual and cumulative targets for the number of FTE reductions. Annual and collective targets must be included in the application. In the case of a joint applicant, the group of participating hospitals will be held to a collective target. None of the participating hospitals will receive incentive payments unless the collective target is met.

Qualifying entities with approved voluntary resident reduction plans will be required to submit data on annual and cumulative targets deemed necessary by HCFA. Qualifying entities will also be required to submit update plan if annual targets are not met and if the qualifying entities wish to request that future annual targets be adjusted to comply with their cumulative targets.

We anticipate that on average it will require 15 hours for an applicant to complete and submit the required information.

Organizations and individuals that wish to submit comments on the information collection and recordkeeping requirements set forth in this interim final rule should direct them to HCFA and OMB officials whose names appear in the **ADDRESSEES** section of this preamble.

IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. Under the Administrative Procedure Act (APA), however, this procedure can be waived if an agency finds good cause that prior notice-and-comment procedures are impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rule. As explained below, we find for good cause that it would be impracticable to undertake prior notice-and-comment procedures with respect to this rule before the provisions of the rule take effect.

The BBA was enacted on August 5, 1997. In section 4626(c), the Congress specifically authorized (but did not require) the Secretary to promulgate interim final rules ''by not later than 6 months after the date of the enactment of [the BBA].'' Thus, if the Secretary had published this document by February 5, 1998, the Secretary could have issued this rule on an interim final basis by exercising the specific authority in section 4626(c) of the BBA, rather than waiving notice-and-comment procedures in accordance with the APA.

Because of the numerous obligations imposed by the BBA, we were not able to promulgate this rule by February 5, 1998. The BBA required development of complex regulations establishing, among other things: hospital specific FTE caps; aggregate FTE caps in affiliated group arrangements; GME payments to nonhospital providers; and adjustment to FTE caps for new residency programs. Each of these represented a significant and complex change affecting Medicare payment for indirect and direct GME.

Nevertheless, we believe that the Congress' grant of specific authority to issue interim final rules evinces an intent to allow hospitals to begin participating in the voluntary residency reduction plans at the earliest practicable date; if we undertook prior notice-and-comment procedures now, we would have to allow for a 60 day comment period before publishing final regulations, and this would further delay the effective date of this rule.

We also find good cause to waive the prior notice of proposed rulemaking with respect to the provisions of this document concerning capital IME. Capital IME payments—like operating IME and direct GME payment—are a function of the number of residents in approved programs. Consistent with our broad authority to implement the capital prospective payment system, this interim final rule with comment period provides that the amount of incentive payments reflects the effect of the residency reduction on capital IME. Given that we find good cause to waive prior notice and comment procedures with respect to the other provisions of this rule, and given our interest in

promoting uniformity and consistency, we believe it would be impracticable to conduct prior notice and comment procedures for the provisions of this document concerning capital IME payments.

For all these reasons, as well as the statutory requirement that applications for incentive payments must be received no later than November 1, 1999, we find good cause to waive the prior notice of proposed rulemaking and to issue this final rule on an interim basis. We invite written comments on this interim final rule and will consider comments we receive by the date and time specified in the **DATES** section of this preamble.

V. Response to Comments

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

VI. Impact Analysis

A. Background

We have examined the impacts of this interim final rule with comment period as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). The RFA requires agencies to analyze options for regulatory relief for small businesses. For purposes of the RFA, most hospitals, and most other providers, physicians, and health care suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually.

B. Executive Order 12866 and RFA Analysis

Without knowing the number of applications that we will receive and the characteristics of the hospitals that will apply, we believe it is difficult to assess the impact of this interim final rule with comment period. However, we do believe that few hospitals will apply for the voluntary residency reduction plan. As stated earlier, section 4623 of the BBA requires the Secretary to determine incentive payment based on an average of the hospital's FTE count for the cost reporting period and the prior two cost reporting periods (the prior one cost reporting period for the hospital's first cost reporting period beginning on or after October 1, 1997). Using the 3-year averaging rule, Medicare makes a partial payment for each resident eliminated and no longer included in a hospital's resident FTE counts by phasing in the reduction over 3 years. Therefore, the 3-year averaging rule provides similar incentives to those available under the voluntary residency reduction plan without requiring a permanent minimum reduction of either at least 25 percent or, with an increase in primary care residents of at least 20 percent, at least 20 percent. Further, under the 3-year averaging rules, the regulations do not mandate the hospital to maintain the proportion or increase the number of residents in primary care. Finally, hospitals participating in the voluntary plan will be subject to repayment of all incentive funds if they subsequently increase the number of residents. Hospitals that receive additional payments by downsizing residents under the 3-year averaging rules are not subject to a similar refund provision. We are providing the following hypothetical examples that illustrate how hospitals could potentially be affected under the voluntary residency reduction plan.

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Example 1--A Hospital Participates in the Voluntary Residency Reduction Plan (20% Reduction)							
Year	**FTEs**	**3-Year Rolling Avg. FTE**	**Per Resident Payment**	**Direct GME Payments**	**Hold-Harmless Percentage**	**Incentive Payments**	**Total Payments**
Base Year[2]	200	200.00	$ 50,000.00	$10,000,000.00	--	--	--
95% of Base	190	190.00	$ 50,000.00	$ 9,500,000.00	--	--	--
Year 1	192	197.33[1]	$ 50,000.00	$ 9,866,500.00	100		$9,866,500.00
Year 2	184	192.00	$ 50,000.00	$ 9,600,000.00	100	--	$9,600,000.00
Year 3	176	184.00	$ 50,000.00	$ 9,200,000.00	75	$225,000.00	$9,425,000.00
Year 4	168	176.00	$ 50,000.00	$ 8,800,000.00	50	$350,000.00	$9,150,000.00
Year 5	160	168.00	$ 50,000.00	$ 8,400,000.00	25	$275,000.00	$8,675,000.00
5 Year Total				$45,866,500.00		$850,000.00	$46,716,500.00

[1] Assumes that the 3-year Rolling Average FTE = ((200+200+192)/3)
[2] Base year = number of FTE residents on June 30, 1997

Example 2--Hospital Does Not Participate in the Voluntary Residency Reduction Plan (20% Reduction)				
Year	**FTEs**	**3-Year Rolling Avg. FTE**	**Per Resident Payment**	**Total Payments**
Base Year[2]	200	200	$ 50,000.00	--
Year 1	192	197.33[1]	$ 50,000.00	$9,866,500.00
Year 2	184	192	$ 50,000.00	$9,600,000.00
Year 3	176	184	$ 50,000.00	$9,200,000.00
Year 4	168	176	$ 50,000.00	$8,800,000.00
Year 5	160	168	$ 50,000.00	$8,400,000.00
5 Year Total				$45,866,500.00

[1] Assumes that the 3-year Rolling Average FTE = ((200+200+192)/3)
[2] Base year = number of FTE residents on June 30, 1997

Example 3--Hospital Does Not Participate in the Voluntary Residency Reduction Plan (19% Reduction)				
Year	**FTEs**	**Average FTE**	**Per Resident Payment**	**Total Payments**
Base Year[2]	200	200.00	$ 50,000.00	--
Year 1	192	197.33[1]	$ 50,000.00	$9,866,500.00
Year 2	184	192.00	$ 50,000.00	$9,600,000.00
Year 3	176	184.00	$ 50,000.00	$9,200,000.00
Year 4	168	176.00	$ 50,000.00	$8,800,000.00
Year 5	162	168.67	$ 50,000.00	$8,433,500.00
5 Year Total				$45,900,000.00

[1] Assumes that the 3-year Rolling Average FTE = ((200+200+192)/3)
[2] Base year = number of FTE residents on June 30, 1997

Example 4--Hospital Does Not Participate in the Voluntary Residency Reduction Plan (15% Reduction)				
Year	**FTEs**	**Average FTE**	**Per Resident Payment**	**Total Payments**
Base Year[2]	200	200.00	$ 50,000.00	--------
Year 1	194	197.33[1]	$ 50,000.00	$9,990,000.00
Year 2	188	192.00	$ 50,000.00	$9,700,000.00
Year 3	182	184.00	$ 50,000.00	$9,400,000.00
Year 4	176	176.00	$ 50,000.00	$9,100,000.00
Year 5	170	168.67	$ 50,000.00	$8,800,000.00
5 Year Total	-----	--------	---------	$46,850,000.00

[1] Assumes that the 3-year Rolling Average FTE = ((200+200+192)/3)
[2] Base year = number of FTE residents on June 30, 1997

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These examples are simplified but do illustrate the impact on hospital revenues from various reduction options assuming fixed Medicare per resident payment amounts under several reduction options. The examples do not take into account any changes in IME payments, updates to the per resident amounts, changes in Medicare utilization or other factors that affect Medicare payment for direct and indirect GME. However, generally IME payments are twice the amount of direct GME payments for the average hospital. In each of these examples, the hospital's payments under current law are based on a 3-year average of the FTEs. The hospital's Medicare direct GME payments are equal to the product of the average FTEs and the Medicare per resident payment amount. The difference between the payments based on the number of residents on June 30, 1997 and plan year payments are multiplied by the hold-harmless percentage to determine incentive payments. The incentive payments are added to the hospital's Medicare direct GME payments to determine total payments.

In example 1, the hospital participates in the voluntary residency reduction plan under the 20-percent option (this option would also require an increase in the number of primary care residents by 20 percent which is not illustrated). The hospital achieves its residency reduction under the plan by reducing 4 percent per year from the base number of residents. The incentive payments are based on the difference in payments using 95 percent of the count of residents as of June 30, 1997, and rate year payments using the 3-year average count of residents. In example 1, the hospital does not receive an incentive payment during the first 2 years of the plan because its average count of FTEs is more than 95 percent of its number of residents as of June 30, 1997. The hospital receives incentive payments for the remaining 3 years of the voluntary plan and its total incentive payments are $850,000. Its total direct GME payments over the 5 plan years are $46.72 million. If the hospital increases residents above the level it has at the end of the plan, the hospital will be required to refund $850,000. Although the hospital could receive higher incentive payments by making larger reductions in year 1 and year 2 of the plan, our experience indicates that hospitals are actually planning smaller reductions in the first 2 years of the plan because of prior commitments made to residents. In fact, we believe this example may actually present a larger resident reduction in the first 2 years of the plan than hospitals are likely to make.

In example 2, all of the variables are the same as example 1 except the hospital does not participate in the voluntary plan. Since the hospital does not participate in the voluntary plan, it does not receive incentive payments and its total payments are $850,000 less over 5 years than the hospital in example 1. This hospital can subsequently increase its residents to its FTE caps and will not be liable for any refunds.

In example 3, all of the variables are the same as example 2 except the hospital reduces its number of residents from the count as of June 30, 1997 by 19 percent. In this example, the hospital receives slightly higher payments than the hospital in example 2 because it has more residents over 5 years. Its payments are $816,500 lower than the hospital that participated in the voluntary plan. Again, this hospital can increase its residents to its FTE cap level without being liable for refunds of incentive payments to Medicare.

In example 4, the hospital does not participate in the voluntary plan and reduces its number of residents from the count on June 30, 1997 by 15 percent. In this example, the hospital actually receives higher total payments than the hospital in any of the previous examples, including the hospital participating in the voluntary residency reduction plan because of Medicare revenues associated with a higher count of residents.

We recognize that there are many factors that may induce a hospital to participate in the voluntary residency reduction plan. Medicare direct and indirect medical education revenues are only one factor in deciding whether to participate. We urge hospitals to carefully consider all factors before deciding whether to participate in the voluntary plans. However, we believe Medicare incentive payments for resident reductions made under this provision may not provide a strong incentive to participate in the voluntary plan unless a hospital is already planning permanent residency reductions of 20 to 25 percent even in the absence of the voluntary residency reduction plan. Even if the hospital is planning residency reductions of 20 to 25 percent, it may be reluctant to participate in the plan because of the requirement that the hospital refund all incentive funds if the hospital increases its residents higher than the level permitted under its voluntary residency reduction plan.

In summary, we do not believe many hospitals are likely to participate in the voluntary residency reduction plans because the 3-year average count provides similar incentives without mandating reductions of 20 to 25 percent, non-receipt of incentive payments for the first 5 percent of resident reduction, and full refund of all incentive payments if a hospital ever increases its number of residents in training. We believe that only hospitals that anticipate making reductions of 20 to 25 percent over the next 5 years are likely to consider participating.

C. Rural Hospital Impact

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any interim final rule with comment period that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the R.F.A. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 50 beds.

We are not preparing a rural hospital impact statement since we have determined, and certify, that this interim final rule with comment period will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this interim final rule with comment period was reviewed by the Office of Management and Budget.

We have reviewed this interim final rule with comment period under the threshold criteria of Executive Order 12612. We have determined that it does not significantly affect States' rights, roles, and responsibilities.

List of Subjects in 42 CFR Part 413

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

42 CFR Part 413 is amended as set forth below:

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

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

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

2. A new § 413.88 is added to subpart F to read as follows:

§ 413.88 Incentive payments under plans for voluntary reduction in number of medical residents.

(a) *Statutory basis.* This section implements section 1886(h)(6) of the Act, which establishes a program under which incentive payments may be made to qualifying entities that develop and implement approved plans to voluntarily reduce the number of residents in medical residency training.

(b) *Qualifying entity defined.* ''Qualifying entity'' means:

(1) An individual hospital that is operating one or more approved medical residency training programs as defined in § 413.86(b) of this chapter; or

(2) Two or more hospitals that are operating approved medical residency training programs as defined in § 413.86(b) of this chapter and that submit a residency reduction application as a single entity.

(c) *Conditions for payments.* (1) A qualifying entity must submit an application for a voluntary residency reduction plan that meets the requirements and conditions of this section in order to receive incentive payments for reducing the number of residents in its medical residency training programs.

(2) The incentive payments will be determined as specified under paragraph (g) of this section.

(d) *Requirements for voluntary plans.* In order for a qualifying entity to receive incentive payments under a voluntary residency reduction plan, the qualifying entity must submit an application that contains the following information, documents, and agreements—

(1) A description of the operation of a plan for reducing the full-time equivalent (FTE) residents in its approved medical residency training programs, consistent with the percentage reduction requirements specified in paragraphs (g)(2) and (g)(3) of this section;

(2) An election of the period of residency training years during which the reductions will occur. The reductions must be fully implemented by not later than the fifth residency training year in which the plan is effective;

(3) FTE counts for the base number of residents, as defined in paragraph (g)(1) of this section, with a breakdown of the number of primary care residents compared to the total number of residents; and the direct and indirect FTE counts of the entity on June 30, 1997. For joint applicants, these counts must be provided individually and collectively;

(4) Data on the annual and cumulative targets for reducing the number of FTE residents and the ratios of the number of primary care residents to the total number of residents for the base year and for each year in the 5-year reduction period. For joint applicants, these data must be provided individually and collectively;

(5) An agreement to not reduce the proportion of its primary care residents to its total number of residents below the proportion that exists in the base year, as specified in paragraph (g)(1) of this section;

(6) An agreement to comply with data submission requirements deemed necessary by HCFA to make annual incentive payments during the 5-year residency reduction plan, and to fully cooperate with additional audit and monitoring activities deemed necessary by HCFA;

(7) For a qualifying entity that is a member of an affiliated group as defined in § 413.86(b), a statement that all members of the group agree to an aggregate FTE cap that reflects—

(i) The reduction in the qualifying entity's FTE count as specified in the plan during each year of the plan; and

(ii) The 1996 FTE count of the other hospital(s) in the affiliated group.

(8) A statement indicating voluntary participation in the plan under the terms of this section, signed by each hospital that is part of the applying entity.

(e) *Deadline for applications.* A qualifying entity must submit an application that meets the requirements of paragraph (d) of this section at least one day prior to the first day of the period to which the plan would be effective but no later than November 1, 1999. The application must be submitted to the fiscal intermediary, with a copy to HCFA.

(f) *Effective dates of plans.* Residency reduction plans that are submitted to the fiscal intermediary on or after September 17, 1999 but on or before November 1, 1999, may be effective for portions of cost reporting periods beginning no earlier than the day after the date of the application.

(g) *Residency reduction requirements*—(1) *Base number of residents defined.* (i) ''Base number of residents'' means the lesser of—

(A) The number of FTE residents in all approved medical residency training programs of the qualifying entity (before application of weighting factors under § 413.86(g)) for the most recent residency training year ending June 30, 1996; or

(B) The number of FTE residents in all approved medical residency training programs of the qualifying entity (before application of weighting factors under § 413.86(g)) for any subsequent residency training year that ends before the date the entity submits its plan to the fiscal intermediary and HCFA.

(ii) The residency training year used to determine the base number of residents is the ''base year'' for determining reduction requirements.

(iii) The qualifying entity's base number of residents may not be adjusted to reflect adjustments that may otherwise be made to the entity's FTE caps for new medical residency training programs.

(2) *Qualifying entity consisting of individual hospital.* The base number of FTE residents in all the approved medical residency training programs operated by or through a qualifying entity consisting of an individual hospital must be reduced as follows:

(i) If the base number of residents exceeds 750, residents, by at least 20 percent of the base number.

(ii) If the base number of residents exceeds 600 but is less than or equal to 750 residents—

(A) By 150 residents; or

(B) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number by at least 20 percent.

(iii) If the base number of residents is 600 or less residents—

(A) By 25 percent; or

(B) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number of residents by at least 20 percent.

(3) *Qualifying entity consisting of two or more hospitals.* The base number of FTE residents in the aggregate for all the approved medical residency training programs operated by or through a qualifying entity consisting of two or more hospitals must be reduced—

(i) By 25 percent; or

(ii) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number of residents by at least 20 percent.

(4) *Treatment of rotating residents.* A qualifying entity will not be eligible for incentive payments for a reduction in the base number of residents if the reduction is a result of the entity rotating residents to another hospital that is not a part of its voluntary residency reduction plan.

(5) *Updates to annual and cumulative targets.*—(i) Except as provided in paragraph (g)(5)(ii) of this section an entity with an approved voluntary residency reduction plan may not change the annual and cumulative reduction targets that are specified in its plan in accordance with paragraphs (g)(2) and (g)(3) of this section.

(ii) An entity may update annual reduction targets specified in its plan only if—

(A) It has failed to meet a specified annual target for a plan year in the 5-year period; and

(B) It wishes to adjust future annual targets for the remaining years of the plan in order to comply with its cumulative target.

(iii) An updated plan allowed under paragraph (g)(5)(ii) of this section must be submitted prior to the beginning of each July 1 medical residency training year during the plan years.

(h) *Computation of incentive payment amount.* (1) Incentive payments to qualifying entities that meets the requirements and conditions of paragraphs (d) and (g) of this section will be computed as follows:

(i) *Step 1.* Determine the amount (if any) by which the payment amount that would have been made under § 413.86(d) if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the amount of payment that would have been made under § 413.86(d) in each year under the voluntary residency reduction plan, taking into account the reduction in the number of FTE residents under the plan.

(ii) *Step 2.* Determine the amount (if any) by which the payment amount that would have been made under § 412.105 of this chapter if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the payment amount made under § 412.105 of this chapter in each year under the voluntary residency reduction plan, taking into account the actual reduction in the number of FTE residents.

(iii) *Step 3.* Determine the amount (if any) by which the payment amount that would have been made under § 412.322 of this chapter if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the payment amount made under § 412.322 of this chapter in each year under the voluntary residency reduction plan, taking into account the actual reduction in the number of FTE residents.

(iv) *Step 4.* Multiply the sum of the amounts determined under paragraph (h)(i), (ii), and (iii) of this section by the applicable hold harmless percentages specified in paragraph (i) of this section.

(2) The determination of the amounts under paragraph (h)(1) of this section for any year is based on the applicable Medicare statutory provisions in effect on the application deadline date for the voluntary reduction plan specified under paragraph (e) of this section.

(i) *Applicable hold-harmless percentage.* The applicable hold-harmless percentages for each year in which the residency reduction plan is in effect are as follows:

(1) 100 percent for the first and second residency training years;

(2) 75 percent for the third year;

(3) 50 percent for the fourth year; and

(4) 25 percent for the fifth year.

(j) *Payments to qualifying entities.* Annual incentive payments through cost reports will be made to each hospital that is or is part of a qualifying entity over the 5-year reduction period if the qualifying entity meets the annual and cumulative reduction targets specified in its voluntary reduction plan.

(k) *Penalty for noncompliance*—(1) *Nonpayment.* No incentive payment may be made to a qualifying entity for a residency training year if the qualifying entity has failed to reduce the number of FTE residents according to its voluntary residency reduction plan.

(2) *Repayment of incentive amounts.* The qualifying entity is liable for repayment of the total amount of incentive payments it has received if the qualifying entity—

(i) Fails to reduce the base number of residents by the percentages specified in paragraphs (g)(2) and (g)(3) of this section by the end of the fifth residency training year; or

(ii) Increases the number of FTE residents above the number of residents permitted under the voluntary residency reduction plan as of the completion date of the plan.

(l) *Postplan determination of FTE caps for qualifying entities*—(1) *No penalty imposed.* Upon completion of a voluntary residency reduction plan, if no penalty is imposed, the qualifying entity's 1996 FTE count is permanently adjusted to equal the unweighted FTE count used for direct GME payments for the last residency training year in which a qualifying entity participates.

(2) *Penalty imposed.* Upon completion of the voluntary residency reduction plan—

(i) *During repayment period.* If a penalty is imposed under paragraph (k)(2) of this section, during the period of repayment, the qualifying entity's FTE count is as specified in paragraph (l)(1) of this section.

(ii) *After repayment period.* Once the penalty repayment is completed, the qualifying entity's FTE reverts back to its original 1996 FTE cap.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: July 7, 1999.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: July 27, 1999.

Donna E. Shalala,

Secretary.

[FR Doc. 99–21322 Filed 8–17–99; 8:45 am]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR PART 73

[MM Docket No. 97–234, GC Docket No. 92–52, and GEN Docket No. 90–264; FCC 99–201]

Implementation of Competitive Bidding for Commercial Broadcast and Instructional Television Fixed Service Licenses

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document concludes that it is appropriate for the Federal Communications Commission to attribute the mass media interests of investors holding more than a 33% equity and/or debt interest in a broadcast auction bidder claiming a New Entrant Bidding Credit, even if such an interest is non-voting.

DATES: The effective date is August 18, 1999.

FOR FURTHER INFORMATION CONTACT: Shaun Maher, Video Services Division, Mass Media Bureau at (202) 418–1600.

SUPPLEMENTARY INFORMATION: This item contains information collections requirements for which we have received OMB approval, OMB Control Number 3060–0896. This *Memorandum Opinion and Order* concludes that it is