Children's Hospital Graduate Medical Education Payment Program

SUPPORTING STATEMENT

A. Justification

1. Circumstances of Information Collection

This is a request for an extension of approval to the Office of Management and Budget (OMB) from the Health Resources Services Administration (HRSA) for the Children's Hospitals Graduate Medical Education (CHGME) Payment Program application package. The CHGME Payment Program package includes application forms, instructions and guidance. The authorizing legislation for the CHGME Payment Program is as follows: Healthcare Research and Quality Act of 1999 (Public Law 106-129), The Children's Health Act of 2000 (Public Law 106-310), Amendment to Section 340E of the Public Health Service Act (Public Law 108-490), and The Children's Hospital GME Support Reauthorization Act of 2006 (Public Law 109-307). A notice announcing implementation of the CHGME Payment Program was published in the *Federal Register* on June 19, 2000. Subsequent *Federal Register* notices were published which proposed and finalized CHGME Payment Program methodologies and processes. The OMB approval (OMB No. 0915-0247) of the current application package expires on March 31, 2010.

The Healthcare Research and Quality Act of 1999 (Public Law 106-129) amended the Public Health Service (PHS) Act to establish a new program to support graduate medical education (GME) in children's hospitals. The provision authorized payments in Federal Fiscal Year (FY) 2000 and FY 2001 for expenses associated with operating approved GME programs. The Children's Health Act of 2000 (Public Law 106-310) amended Public Law 106-129 with extension of Section 340E of the PHS Act authorizing the CHGME Payment Program through FY 2005. In December 2004, Section 340E of the Public Health Service Act was amended again (Public Law 108-490) to exclude beds or bassinets assigned to healthy newborn infants when calculating case mix for CHGME Payment Program payments. In October 2006, the Children's Hospital GME Support Reauthorization Act of 2006 reauthorized the CHGME Payment Program through FY 2011. Department of Health and Human Services appropriations for the CHGME Payment Program have exceeded $2.5 billion since the CHGME Payment Program's inception in FY 2000.

The application package includes an introductory letter, overview of the CHGME Payment Program, information on the CHGME Payment Program application cycle and deadline requirements, application forms, hospital eligibility criteria, CHGME payment methodology, explanation of data needed by participating hospitals to complete the CHGME Payment Program application forms, information to assist hospitals in determining the number of resident full-time equivalents (FTEs) that can be claimed for CHGME Payment Program payment, instructions for completing the application forms, and references. Below is a discussion of the application forms and accompanying guidance and instructions (items A through F) for which continuation of

approval is requested. These include: 1) the collection of data directly related to the administration of the CHGME Payment Program, and 2) the reporting of performance measures as required by the Government Performance and Results Act (GPRA) of 1993.

A. HRSA 99: Demographic and Contact Information- This form should be completed in its entirety by the applicant children's hospital. This form is used to identify the applicant hospital's Medicare Provider Number, Tax Identification Number, DUNS number, and the appropriate hospital liaisons for application processing and auditing purposes. This form is the initial part of each application.

B. HRSA 99-1: Determination of Weighted and Un-weighted Resident Full Time Equivalent (FTE) Counts-

By statute [Section 340E(c)(1) of the Public Health Service Act (Direct Payments)], payments for direct expenses relating to the hospital's approved GME programs for a FY are equal to the product of (a) an updated national per resident amount for direct GME with wage adjustment and a labor share for each children's hospital's area applied to a standard wage-related portion, and (b) the average number of resident FTEs as determined under Section 1886(h)(4) of the Social Security Act (SSA).

In December 2003, the President signed the MMA of 2003 (also known as the Medicare Modernization Prescription Drug and Improvement Act of 2003), Public Law 108-173. §422 of the MMA, added Section 1886(h)(7) to the SSA. This provision reduced the 1996 Base Year resident counts (the 1996 cap) for certain hospitals and redistributed those positions to other hospitals that applied for and received an increase to their 1996 Base Year Cap. Hereinafter, any decreases to a hospital's 1996 Base Year Cap as a result of §422 will be referred to as the "**§422 Cap Reduction**" and any increases to the 1996 Base Year Cap as a result of §422 will be referred to as the **"§422 Cap Increase**." Authority for implementing §422 of the MMA was delegated to the Centers for Medicare and Medicaid Services (CMS). Determinations made and implemented by CMS in response to §422 are final and not subject to appeal. Under the CHGME Payment Program statute, by incorporation of the SSA provisions, the HRSA must implement the counting law and rules of Medicare, which include those related to the implementation of §422 of the MMA.

Public Law 106-310, Public Health Service Act sec. 340E(e)(3) states that the Secretary must determine any changes to the number of resident FTEs reported by a hospital in its (initial) application for CHGME Payment Program funding. This determination, by the Secretary, will be used to calculate the final amount payable to that hospital for the fiscal year. In 2003, the Secretary established the Resident FTE Assessment Program to ensure this determination is made for resident FTE counts submitted by all children's hospitals applying for CHGME Payment Program support. Beginning in FY 2003, the CHGME Payment Program contracted with its own fiscal intermediaries (hereinafter CHGME FIs) to assess the resident FTE counts submitted by participating children's hospitals in their initial applications for CHGME Payment Program funding. This assessment of resident FTE counts is performed for all children's hospitals regardless of the type of Medicare cost report (MCR) they file. The application form for determination of weighted and un-weighted resident FTE counts for the reconciliation

application cycle is the same application form for the initial application cycle.

The resident FTE counts reported by children's hospitals in their reconciliation applications must be consistent with those reported by the CHGME FIs to be accepted by the Department. Hospitals must report any changes to their resident FTE counts for those cost report years reflected in their initial applications. Prior to the end of each fiscal year, the Department will determine the final amount due to each participating children's hospital based upon the reconciliation application cycle and will pay any balance due or recoup any overpayment made to/from each children's hospital.

C. HRSA 99-2: Determination of Indirect Medical Education Data Related to the Teaching of Residents- By statute [Section 340E(d) of the PHS Act (Indirect payments)], the Secretary must also determine the amounts of indirect medical education (IME) payments by taking into account factors identified in section 340E(d)(2)(A) of the PHS Act --- variations in case mix, and the number of resident FTEs in the hospital's approved GME training programs for a fiscal year.

This form must be completed as a component of the application. Information will be requested on the hospital's number of inpatient days, number of inpatient discharges, number of available beds, case-mix index (CMI) using CMS' -- *Diagnosis Related Group* (CMS DRG) *[the version of the HCFA-DRG to be used by hospitals will be updated annually; the version of the HCFA-DRG grouper weights used to calculate the CMI for the FFY corresponding to the year end of the most recently filed (or completed cost reporting period for the majority of applicant hospitals will be used to calculate the CMI],*and intern/resident to bed (IRB) ratio for the current and previous MCR periods.

As mentioned in section B above and as mandated in Public Law 106-310, Public Health Service Act Sec. 340E(e)(3), hospitals have an opportunity to correct the resident FTE counts submitted on the initial application form for IME during the reconciliation application cycle to determine the final amount payable to the hospital for the current fiscal year. These payments will be made after the Resident FTE Assessment Program and reconciliation of resident FTE counts by the children's hospitals have been completed.

D. HRSA 99-3: Certification- This is not a form collecting information and, therefore, the annualized burden hours on the part of the applicant children's hospital are minimal. Citations within this form have been updated and approved by the Office of General Counsel (OGC). By signing the certification statement, the applicant children's hospital agrees to adhere to all conditions listed and is aware that the hospital may be denied entry to or revoked from the CHGME Payment Program if any conditions are violated.

E. HRSA 99-4: Government Performance and Results Act (GPRA) Tables- This form is required for the collection of information per the GPRA Act of 1993. It will be requested before the end of the fiscal year when the reconciliation application cycle occurs and the HRSA 99-1 and HRSA 99-2 are resubmitted reflecting changes, if any, to the resident FTE counts reported by the children's hospitals in their initial applications for CHGME Payment Program funding.

F. HRSA 99-5: Application Checklist- This is not a form collecting information and, therefore, the annualized burden hours on the part of the applicant children's hospital is minimal. This checklist was developed in response to numerous requests by participating children's hospitals to provide them with a checklist that they could use to ensure that their application for CHGME Payment Program funding was complete before submitting it to the CHGME Payment Program for consideration. The checklist identifies all required forms and supporting documentation, where appropriate, that an applicant children's hospital must submit to the CHGME Payment Program to be considered for funding.

2. Purpose and Use of Information

HRSA will use the data to determine the amount of payments to each participating children's hospital. Administration of the CHGME Payment Program relies on the reporting of the number of resident FTEs in applicant children's hospitals' training programs to determine the amount of direct and indirect expense payments to participating children's hospitals. Indirect expense payments will also be derived from a formula that requires the reporting of case mix index information, the number of inpatient discharges and the number of inpatient beds from participating children's hospitals.

Hospitals will be requested to submit information in an initial application for CHGME Payment Program funding which includes the number of resident FTEs trained by the hospital. Before the end of the fiscal year, participating hospitals will be required to complete a reconciliation application for CHGME Payment Program funding furnishing final numbers which will reflect any changes to the number of residents reported by a hospital in its initial application. Additionally, the GPRA of 1993 requires the collection of performance data from participating children's hospitals. These data will be requested when the final number of resident FTEs is reported before the end of the fiscal year.

3. Use of Improved Information Technology

The HRSA forms are currently available electronically via the CHGME Payment Program website (http://bhpr.hrsa.gov/childrenshospitalgme) to allow for the submission of the applications from the children's hospitals. Review and assessment results are recorded electronically to increase efficiency and accuracy and to reduce costs.

4. Efforts to Identify Duplication

Contract work was performed to specifically identify existing data sources and to determine their appropriateness for the administration of the CHGME Payment Program. The evaluation concluded that existing data are not currently collected by other entities for the reasons given below.

Prior to FY 2000, children's hospitals varied in the completeness and accuracy of the resident FTE count data they furnished to the CMS data systems, and only some of the eligible children's hospitals reported cost or resident FTE count data to CMS. The major issue for the CHGME

Payment Program is the reporting of resident FTE data *according to Medicare rules*. The CHGME Payment Program requires the reporting of accurate past and current resident FTE count data under these rules, in order to make accurate payments for GME under the CHGME Payment Program.

Possible alternative data sources were reviewed (as described below) and found not to be satisfactory for the purpose of the CHGME Payment Program.

- The *American Board of Pediatrics* (ABP) collects FTE counts on most of the pediatric residents training in children's hospitals. However, the weighting factors used to determine the counts are significantly different from the Medicare rules that must be used by the CHGME Payment Program. Furthermore, the ABP collects information by programs rather than by hospitals, and it does not collect counts on FTEs of other specialties. Moreover, ABP data are unlikely to include residents who rotate into the children's hospital from programs in other hospitals.

- The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) obtains resident counts from some children's hospitals for the purpose of reimbursement. However, the weighting rules and reporting periods differ from that of the Medicare and CHGME Payment Program.

- The *Association of American Medical Colleges* (AAMC) uses the GME Track system, which supplants the resident count survey previously used by the American Medical Association and AAMC. The system requests resident numbers data from teaching hospitals and programs to be furnished between July and September each year. However, these numbers are not counted or weighted according to Medicare rules. Furthermore, the system does not produce accurate counts on a timely basis, as the counts can be modified as late as March of the following year.

Based upon the justification described in the three points above, the hospital may not want to certify such alternative counts as accurate, since they are not necessarily under the hospital's control and could be difficult for the hospital to verify.

Accordingly, information collection will be required from hospitals to determine numbers that best represent the number of resident FTEs for which they are eligible to report. To reduce the burden for those children's hospitals previously not reporting resident FTE data to CMS, the *Federal Register* notice published on June 19, 2000 proposed how those hospitals could determine their current cap to avoid the burden of having to go back and reconstruct their residency programs and rotations for previous years. For hospitals that believed they may have reported to CMS resident FTE counts which were too low, it was recommended to such hospitals that they re-open their Medicare Cost Report (MCR) to correct their earlier numbers. In applying for FY 2001 and FY 2002 funding, more than 70 percent of children's hospitals sought to re-file corrected resident FTE counts or re-open MCRs in order to correct inaccurate and/or under-reported resident FTE counts from previous years.

Information collection will also be required to determine payment amounts for the indirect expenses of medical education. The Secretary is required to take into account variations in case mix and the number of resident FTEs in the hospitals approved graduate medical residency training programs for a fiscal year. All hospitals must submit a case-mix index (CMI) on all inpatients discharges using the appropriate CMS DRG version, excluding healthy newborns. This value must be reported to four decimal points. The CMS DRG version to be used is published by the Department through the electronic alert system each spring prior to the beginning of the FY for which payments will be made and can be found on the website: http://bhpr.hrsa.gov/childrenshospitalgme/.

While it is recognized that the CMS-DRG-based CMI was not designed to be used with children's hospitals, this CMI system has been proposed as the alternatives are potentially cost prohibitive and difficult to use. Currently, the most commonly-used CMI system is based on DRGs. This system, however, does not exist for outpatient services. In fiscal year 2002, the department awarded a two-phased contract to 1) explore the feasibility of developing a formula used to calculate IME payments to children's hospitals and to develop recommendations for the creation of an analytically justified formula for IME payments; and 2) implement and test recommendations for the development of an analytically justified IME payment. The CMI system is part of the equation.

Volume data are required in order to incorporate a measure of teaching intensity currently captured under Medicare determinations of the IME by obtaining data on inpatient discharges and days, outpatient services, and bed counts. The CMI and IRB cap ratio information also are a part of inpatient data. Outpatient services have increasingly become a part of GME training. Traditionally, residency training inpatient care has been the only factor involved in determining IME costs. We continue to request the numbers for ambulatory surgery, radiology, urgent care, and clinic visits because of the increasing amount of resident training occurring in the outpatient setting. Inclusion of information on emergency room visits provides data on the number of patients who receive their primary care and ambulatory services through the emergency room. Outpatient services truly reflect the changing Residency Review Committee requirements.

The March 1, 2001 *Federal Register* notice invited comments on 1) proposed continuation of the use of the Medicare IRB-based teaching intensity factor in the calculation of payments; 2) alternative teaching intensity factors, such as the Medicare resident-to-average daily census (RADC) based on teaching intensity factor (2.8 percent per 0.1 percent increase in RADC ratio) or any other analytically justified teaching intensity factor; and 3) proposed definition of bed count to be used in calculating the Medicare IRB teaching intensity factor, which is the sum of all available beds per day in the most recently completed cost report filing period, including beds and bassinets in the healthy newborn nursery, divided by the number of days in that period. This reflects the American Hospital Association's (AHA) definition of available beds, which includes nursery beds and bassinets. Nursery beds and bassinets are an important part of pediatric residency training.

As a result of comments, the Department made revisions and clarifications in a July 20, 2002 *Federal Register* notice. Beginning in FY 2001, the Department used the IRB ratio to determine

IME payments. The Department will use the same teaching intensity factor that is used by the Medicare Inpatient Prospective Payment System (PPS) in calculating its operating adjustment for the FY in which payments are made.

Beginning in FY 2002, to comply as closely as possible with Medicare rules and regulations, the Department applied a cap on the IRB ratio, similar to the cap applied by the Medicare program pursuant to regulations at 42 CFR 412.105(a)(1), whereby the ratio may not exceed the ratio for the hospital's most recent prior cost reporting period. For those hospitals whose ratio changes, there will be a one-year delay in the implementation of the revised IRB.

Beginning in FY 2001, beds included in the calculation of the hospital bed count are defined, for the purpose of the CHGME Payment Program, and the methodology is outlined in detail for children's hospitals to report the bed count to be used in calculation of the teaching intensity factor used in determining IME payments. Public Law 108-490 revised the definition of the bed count to exclude beds and bassinets in the nursery area of the hospital.

As noted above, the contract awarded by the Department assessed various teaching intensity factors and formulas designed to capture the IME costs associated with caring for more severely ill patients in a children's hospital and explore the development of other measures of teaching intensity which may be more appropriate for children's hospitals. The results were published and finalized in a subsequent *Federal Register* notice dated July 20, 2001 (66 FR 37980).

The data to be collected for performance measures are not currently collected by another entity. Performance data will be utilized in accordance with the provisions of the GPRA of 1993.

5. Involvement of Small Entities

This project does not have a significant impact on small business or other small entities.

6. Consequences if Information is Collected Less Frequently

The annual reporting of information is necessary to calculate payment amounts for the fiscal year. The number of resident FTEs, case mix, and utilization data are expected to change annually. The annual reporting of corrections to previously reported information is necessary to complete the statutorily dictated reconciliation process. GPRA also requires the annual reporting of performance data.

7. Consistency With the Guidelines in 5 CFR 1320.5(d)(2)

This collection is consistent with the guidelines under 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

The notice required in 5 CFR 1320.8(d) was published in the Federal Register on October 14, 2009 (Vol. 74, No. 197, pages 52813-52814). No comments were received.

The following CHGME Payment Program participants have reviewed the CHGME materials for the burden estimate, and for the clarity of instructions and forms:

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9. Payment to Respondents

There will be no payment or incentive to respondents.

10. Assurance of Confidentiality

No personal identifiers will be collected. The entities reporting are hospitals, not individuals. No assurances of confidentiality will be made

11. Questions of a Sensitive Nature

There are no questions of a sensitive nature.

12. Estimates of Annualized Hour Burden

The estimated burden hours are reflected in the following table:

Form Name	No. of Respondents	Responses per Respondents	Total Responses	Hrs. per Response	Total Hour Burden	Wage Rate ($/hr)	Total Hour Cost ($)
HRSA 99-1 (Initial)	60	1	60	24.67	1,480.2	$51.19	$75,771.44
HRSA 99-1 (Reconciliation)	60	1	60	6	360	$51.19	$18,428.40
HRSA 99-2 (Initial)	60	1	60	11.33	679.8	$51.19	$34,798.96
HRSA 99-2 (Reconciliation)	60	1	60	3.67	220.2	$51.19	$11,272.04
HRSA 99-3 (Initial)	60	1	60	0.5	30	$51.19	$1,535.70
HRSA 99-3 (Reconciliation)	60	1	60	0.5	30	$51.19	$1,535.70
HRSA 99-4 (Reconciliation)	60	1	60	11	660	$51.19	$33,785.40
HRSA 99-5 (Initial)	60	1	60	0.33	19.8	$51.19	$1,013.56
HRSA 99-5 (Reconciliation	60	1	60	0.33	19.8	$51.19	$1,013.56
Total	60	N/A	60	58.33	3,499.8	-	$179,154.76

Basis for estimates:

HRSA 99-1: Determination of Weighted and Un-weighted Resident FTE Counts- Each eligible hospital must complete and submit a HRSA 99-1 to apply to the Department for annual funding under the CHGME Payment Program. The number of respondents (56 -60) completing the form is based on responses from hospitals which will likely complete the HRSA 99-1 biannually. The hours per response (26 hours) for an initial application are based upon program experience working with the hospitals and discussion with hospitals (60 hospitals x 1 initial application x 24.67 hours per response = 1,480.2 total burden hours).

The hours per response (8 hours) for the reconciliation application are based upon program experience working with the hospitals and discussions with the hospitals (60 hospitals x 1 reconciliation application x 6 hours per response = 360 total burden hours).

HRSA 99-2: Determination of Indirect Medical Education Data Related to the Teaching of

Residents- Each eligible hospital must complete and submit a HRSA 99-2 to apply for annual funding under the CHGME Payment Program. The number of respondents (60) completing the form is based on responses from hospitals which will likely complete the HRSA 99-2 biannually. The hours per response (15 hours) for an initial application are based upon program experience working with the hospitals and discussion with hospitals (60 hospitals x 1 initial application x 11.33 hours per response = 679.8 total burden hours).

The hours per response (5 hours) for the reconciliation application are based upon program experience working with the hospitals and discussions with the hospitals (60 hospitals x 1 reconciliation application x 3.67 hours per response = 220.2 total burden hours).

HRSA 99-3: Certification- Each eligible hospital must complete and submit a HRSA 99-3 to apply for annual funding under the CHGME Payment Program. The number of respondents (60) completing the form is based on responses from hospital which will likely complete the HRSA 99-3 biannually. The hours per response (.25 hours) for an initial application are based upon program experience working with the hospitals and discussion with hospitals (60 hospitals x 1 initial application x .5 hours per response = 30 total burden hours).

The hours per response (.25 hours) for the reconciliation application are based upon program experience working with the hospitals and discussions with the hospitals (60 hospitals x 1 reconciliation application x .5 hours per response = 30 total burden hours).

HRSA 99-4: Government Performance and Results Act Tables- Under the GPRA of 1993 and as part of the annual application requirements, each eligible hospital must complete and submit a HRSA 99-4. The number of respondents (60) completing the form is based on responses from hospitals which will likely complete the HRSA 99-4 annually. The hours per response (14 hours) are based upon program experience working with the hospitals and discussion with hospitals (60 hospitals x 1 initial application x 11 hours per response = 660 total burden hours).

HRSA 99-5: Application Checklist- Each eligible hospital must complete and submit a HRSA 99-5 to apply for annual funding under the CHGME Payment Program. The number of respondents (60) completing the form is based on responses from hospital which will likely complete the HRSA 99-5 biannually. The hours per response (.25 hours) for an initial application are based upon program experience working with the hospitals and discussion with hospitals (60 hospitals x 1 initial application x .33 hours per response = 19.8 total burden hours).

The hours per response (.25 hours) for the reconciliation application are based upon program experience working with the hospitals and discussions with the hospitals (60 hospitals x 1 reconciliation application x .33 hours per response = 19.8 total burden hours).

Basis for Hour Costs:

Hospital finance staff is expected to complete the application forms for CHGME Payment Program funding. It has been estimated that an average wage rate for hospital finance staff is $51.19 per hour based on figures submitted by hospital staff.

Total hour costs are estimated at $179,154.76. For an eligible hospital to complete the HRSA 99-1, it is estimated to take 24.67 hours for the initial application process and 6 hours for the reconciliation application process; for the HRSA 99-2, it is estimated to take 11.33 hours for the initial application process and 3.67 hours for the reconciliation application process; for the HRSA 99-3, it is estimated to take .5 hours for the initial application process and .5 hours for the reconciliation application process; for the HRSA 99-4, it is estimated to take 11 hours for the reconciliation application process; and for the HRSA 99-5, it is estimated to take .33 hours for the initial application process and .33 hours for the reconciliation application process. This is estimated to take a total of 3,499.8 hours, at a cost of $51.19 per hour (3,499.8 hours x $51.19 per hour = $179,154.76). The estimated cost for completing the applications forms has gone down due to increased experience by staff in filling out the forms as well as electronic automation of the process.

13. Estimates of Annualized Cost Burden to Respondents

Capital costs and start-up costs are minimal since implementation of the program occurred in FY 2000. There are no operational and maintenance costs.

14. Estimates of Annualized Cost to the Government

The cost to the Federal Government is relative to the review and audit of two applications per hospital (1 initial application and 1 reconciliation application). The revised costs to the Federal Government are estimated to be **$8,307.00** as follows:

Federal Staff Time

$ Review incoming applications from the children=s hospitals to (1) ensure application packages are complete and (2) include all required forms, signatures, and supporting documentation.

[GS13/1 @ $41.65/hour X 60 applications X 15 minutes (.25 hours)

per application. **$624.75**

$ Audit complete applications from the children's hospitals to ensure that (1) the forms were completed in accordance with stated guidance and instructions and (2) data reported is logical and consistent with supporting documentation and information previously reported to the CHGME Payment Program. Communicate with hospitals and CHGME FIs, as needed, to resolve discrepancies.

[GS13/1 @ $41.65/hour X 60 applications X 2 hours per application] **$4,998.00**

$ Data entry of children=s hospitals finalized/approved applications.

[GS13/1 @ $41.65/hour X 60 applications X 30 minutes (.50 hours)

per application. **$1,249.50**

$ Notification of award to hospitals, assurance of invoice for payment and other required documentation, and rechecking of appropriate payment amount for DME and IME payments to hospitals:

[GS13/1 @ $41.65/hour X 60 applications X 15 minutes (.25 hours)

per application. **$624.75**

$ Fiscal services management, staff, and computer support.

$6.75/obligation X 60 hospitals X 2 obligations/transactions [2 transactions per hospital (1 @ initial application and 1 @ reconciliation application)]. This figure does not include additional obligations/transactions that may occur if the Department/Agency makes payments to participating children's hospitals while operating under a continuing resolution. In FY2006, the Department made four (4) payments to each participating hospital while operating under continuing resolution funding from October 2005 through January 2006. The costs incurred equaled $1,620.00 ($6.75/obligation X 60 hospitals X 4 obligations/transactions). This cost has decreased due to the streamlining of the payment process with the utilization of the ***Payment Management System (PMS).*** The PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM).

$ 810.00

15. Changes in Burden

The OMB clearance package (OMB 0915-0247), was approved with one term of clearance on March 31, 2007. The term of clearance was to display the OMB Control Number and inform respondents of its legal significance in accordance with 5 CFR 1320.5(b). HRSA has complied with that term and the OMB control number is displayed on all information collection instruments. In the previous ICR there was an estimated total of 4,140 burden hours. With the current package, we are requesting a total of 3,499.8 hours, which is a decrease in burden due to increased experience by hospital staff in filling out the forms as well as electronic automation of the process.

16. Time Schedule, Publication and Analysis Plans

Publication of information and data are not currently planned. Data will be analyzed for internal administrative purposes and for tracking the performance indicators.

17. Exemption for Display of Expiration Date

The expiration date will be displayed.

18. Certifications

This fully complies with the guidelines set forth in 5 CFR 1320.9. The certifications are included in the package.

LIST OF ATTACHMENTS

CHGME Payment Program Application Package

A. Application Guidance
B. Form 99-1 Demographic Information
C. Form 99-1-2
D. Form 99-3
E. Form 99-5

Authorizing Legislation