When Disaster Strikes a Residency Program

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When a disaster such as a hurricane or flood temporarily shuts down a teaching hospital it wreaks havoc on residency programs as the hospital works to train continuously its residents and struggles to rebuild its program. Loss of a residency program, even temporarily, can put a hospital in the red as its census lowers, its Graduate Medical Education (GME) funding decreases, and its medical professionals relocate while it still needs to cover residency training expenses.[1] Residents may be sent to another part of the country. Teaching hospitals produce the majority of physicians providing medical services in their communities; so when physicians leave an area due to a disaster, the residency program is crucial for a community to rebuild its health system.[2]

On August 19, 2008, the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) published its final rules on Payments for Graduate Medical Education for Affiliated Teaching Hospitals in Certain Emergency Situations. While HHS is commended for responding to teaching hospitals' needs in Louisiana and Texas by issuing interim final rules in 2006 and in 2007 immediately effective retroactive to August 29, 2005, the agency may not have provided enough timely relief to hospitals struggling to maintain and rebuild their residency programs. This article describes the effect of a disaster on residency programs, examines CMS' response, and highlights policy considerations for GME funding for residency programs affected by disasters.

Hurricane Katrina's Effect on Residency Programs in Louisiana

One of the many lessons of Hurricane Katrina was its effect on the residency programs in Louisiana. Seventy percent of Louisiana's healthcare workforce graduate from Louisiana State University School of Medicine in New Orleans.[3] Before Hurricane Katrina, Louisiana ranked second in the nation for retaining physicians to practice medicine in the state after training there.[4] Louisiana residency programs trained 55% of the physicians in Louisiana.[5] Moreover, pre-Hurricane Katrina Louisiana had 220 physicians per 100,000 people as opposed to 245 physicians per 100,000 people on the national level.[6] As physicians left the region devastated by Hurricane Katrina, there was a dearth of physicians to provide healthcare services to its citizens who remained. In fact, the percentage of physicians leaving the area was higher than the general population.[7] Forty of six hundred physicians at Ochsner's Hospital in New Orleans resigned after Katrina.[8] Louisiana already had fewer physicians than the national average and suffered a disproportionate loss of physicians due to the disaster. Residency programs, the primary source of physicians for the community, were the life line to rebuilding Louisiana's health system.

Yet, the residency programs suffered greatly in Louisiana as hospitals lost inpatients, lost revenue, and had ongoing expenses such as resident salaries. Hospitals needed external funding to cover their expenses. Fortunate for those training at Tulane University Hospital, the Hospital Corporation of America, an 80% owner of Tulane University Hospital, sustained resident salaries while GME funds were tied up with CMS.[9] Not all residency programs were so fortunate. While most of the residents at University or Charity hospitals, members of Louisiana State University Health Sciences Center (LSUHSC), were relocated to in-state teaching hospitals or in-state private hospitals, LSUHSC encountered financial

difficulty when its GME funding was disrupted while the institution continued to pay residents' salaries.[10] Given the high percentage of Louisiana residents being trained by LUSHSC,[11] the lack of funding for residents had a devastating effect on the state's largest residency program. Although CMS ultimately provided retroactive relief, teaching hospitals and residency programs were forced to find alternative resources or sustain an economic loss in the interim.

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Section 1135 Powers

Section 1135 of the Social Security Act empowers the Secretary of HHS to ensure Medicare, Medicaid, and State Children's Health Insurance Program recipients have sufficient healthcare services and items in an emergency. When the President declares an emergency or disaster pursuant to the National Emergencies Act[12] or the Robert T. Stafford Disaster Relief and Emergency Assistance Act,[13] and the Secretary of HHS declares a public health emergency pursuant to Section 319 of the Public Health Service Act, then Section 1135 empowers the Secretary to waive or modify temporarily regulatory requirements during an emergency period to ensure the distribution of sufficient healthcare items and services to federal healthcare program recipients.

On August 27, 2005, President Bush declared an emergency in Louisiana, and Secretary Leavitt declared a public health emergency on September 5, 2005. CMS refers to the disaster as the 1135 emergency and the disaster area as the 1135 emergency area.[14] Subsequently, Secretary Leavitt revised certain rules pertaining to GME funding to teaching hospitals given the effect of the 1135 emergency on the residency programs.

Medicare Payments for Graduate Medical Education

CMS compensates teaching hospitals for the direct and indirect costs of educating residents, through GME payments. Direct costs or direct GME include expenses such as resident salaries, fringe benefits, and teaching physician costs. CMS determines GME allocation by the product of Medicare patient load (percentage of Medicare inpatient days), hospital per resident payment, and the weighted number of full time equivalent (FTE) residents.[15]

Indirect costs or IME is the additional indirect costs attributable to teaching such as more technologically advanced treatments for sicker populations and inefficiencies from having residents provide services such as additional tests and having support staff to supervise residents. IME payments are a percentage add on adjustment to the per discharge Hospital Inpatient Prospective Payment System payment, and CMS calculates the payment based on the hospital's ratio of FTE to available beds.[16]

With the 1997 Balanced Budget Act, Congress limited the number of residents for which a teaching hospital may receive direct GME and IME FTE reimbursement. The policy underlying such caps is to limit the potential for increases in GME spending.[17] The FTE cap discourages an oversupply of physicians, redistributes residents around the country so that rural areas have residents as well as urban areas, and dissuades the narrow focus on inpatient training.[18] In 2005, Congress issued a one-time redistribution of caps to alleviate some of the financial pressure the caps cause teaching hospitals.[19]

Department of Health and Human Services' Response

Closed Hospitals

GME funds significantly impact hospitals' bottom line. Before Hurricane Katrina, all Medicare GME funding was estimated to be $7.4 billion nationally with $65 million for Louisiana.[20] When New Orleans hospitals closed their residency programs, they lost GME funds associated with those programs. They scrambled to redistribute residents to residency programs at other hospitals so that education could continue. Louisiana lost 300 residents and fellows to out-of-state residency and fellowship programs between 2005 and 2006.[21]

At first, CMS directed Louisiana teaching hospitals affected by Hurricane Katrina to follow existing rules for closed hospitals.[22] When a hospital residency program closes, hospitals that are members of the same affiliated group may aggregate their direct GME and IME FTE resident caps through existing Medicare GME affiliation agreements. Through Medicare GME affiliation agreements, hospitals may send displaced residents to hospitals in the contiguous area, under common ownership or jointly listed as sponsors or major participating institutions in the same program.[23] CMS defines closed hospital residency programs as those programs at hospitals that cease to offer training for residents in a particular approved medical residency training program.[24] The hospital accepting displaced residents temporarily may adjust its IME and direct GME caps for each displaced resident it accepts from a closed hospital residency program. There is a corollary decrease in the closed hospital's IME and direct GME cap and increase in the IME and direct GME cap of the hospital accepting the displaced residents. CMS ties the adjustment directly to the resident actually displaced by the closure. As soon as the displaced resident completes her or his training or returns to the original hospital or the original hospital residency program reopens, the temporary adjustment in IME and direct GME caps ceases.[25] Also, there is no adjustment for the accepting hospital for the direct GME and IME FTE if the displaced resident FTE is above the closed hospital's resident FTE cap.[26]

Another requirement for the redistribution of direct GME and IME FTE caps is that within 60 days after the hospital begins to train the displaced residents, both of the hospitals must file detailed documentation with fiscal intermediaries to accomplish this adjustment.[27] CMS extended the documentation deadline to the end of the 1135 emergency or June 30, 2006, whichever was earlier. The 1135 emergency ended on January 31, 2006, but no hospitals could comply with such documentation requirements by the extended deadline.[28]

April 12, 2006 Interim Final Rules

CMS' policy in its response to when a disaster strikes a residency program is twofold: (1) facilitate the continuity of GME by minimizing the disruption to training; and (2) facilitate the rebuilding of home hospitals devastated by disaster.[29] Many of the hospitals in the 1135 area after Hurricane Katrina devastated New Orleans indicated that their training programs were closed, necessitating that the hospitals send their residents to hospitals all around the country.[30] However, CMS found that existing rules for closed hospital residency programs did not address the complexity of issues being faced by these hospitals. Medicare GME affiliation agreements must be in effect as of July 1 of the academic year so there can be no adjustment of resident FTEs for hospitals that were not already in a Medicare GME affiliation agreement. Moreover, given the sheer number of residents affected, New

Orleans hospitals sent their residents across the country to continue training. As a result, Medicare GME affiliation agreements did not exist because the new affiliations were with hospitals not in the same contiguous area. New Orleans hospitals' residency programs were not always fully closed. If the program was partially open, there could be no adjustment of direct GME and IME FTE caps between the hospitals.[31] The accepting hospital was put in the position of training additional residents, thereby incurring increased training costs, with no mechanism for relief in the way of enhanced GME funding.

To address such issues, on April 12, 2006, CMS issued interim final rules with comment period, immediately effective retroactive to August 29, 2005,[32] allowing hospitals in the 1135 area with a 20% drop in inpatient bed occupancy to enter into emergency Medicare GME affiliation agreements retroactive to the date of the initiation of the 1135 emergency. CMS measures the 20% drop by comparing inpatient bed occupancy one week before the 1135 emergency or the date of the evacuation to the inpatient bed occupancy one week after the 1135 emergency occurs.[33] Not all teaching hospitals in the 1135 area with closed residency programs qualified for an emergency Medicare GME affiliation agreement under the interim rules. There were hospitals with less than a 20% decrease in their census or an increased census that had closed their residency programs because they could not train residents amid the devastation.

Emergency Medicare GME affiliations could be with host hospitals anywhere in the country and in effect for the remainder of the academic year plus two additional academic years. The host and home hospitals (defined herein) in the emergency Medicare GME affiliation agreement have until the end of the academic year to adjust their FTE counts. The home hospital is the hospital in the 1135 area whose inpatient bed occupancy decreased by 20% or more due to the 1135 emergency so that it is unable to train the number of residents it originally intended to train during the academic year and needs to send its displaced residents to train at another hospital.[34] The host hospital is the hospital that accepts such displaced residents.[35]

Unlike with Medicare GME affiliation agreements, hospitals in emergency Medicare GME affiliation agreements must adjust the FTEs based upon the aggregate cap existing prior to the 1135 emergency.[36] With multiple Medicare GME affiliation agreements, hospitals have complex adjustments to their FTE counts as residents rotate among the institutions. Accordingly, CMS finds it important to have documentation to ensure the correct reimbursement to the hospitals. CMS extended the timeframe for both host and home hospitals to submit documentation of the emergency Medicare GME affiliation agreement to 180 days after the first day of the 1135 emergency or June 30, whichever is later.[37] Such documentation must include a copy of the emergency Medicare GME affiliation agreement, a list of each participating hospital with its provider number, specification of the effective period for the emergency agreement, list of each participating hospital's IME and direct GME FTE caps in effect before the emergency affiliation (as already adjusted by any existing affiliation), specification of the total adjustment to the host hospital's direct and indirect FTE caps that is offset by a negative adjustment to the home hospital, and documentation of any displaced resident FTE (name, social security number, name of original sponsor, copies of all existing GME agreements).

In addition, CMS determined that hospitals participating in emergency Medicare GME affiliation agreements would not need to have shared rotation whereby residents rotate among the affiliated hospitals. This is in contrast to such a requirement for hospitals participating in Medicare GME affiliation agreements. Hospitals in emergency Medicare GME affiliation agreements are not necessarily in close geographic proximity and may be spread around the country. CMS reasoned the hospitals recouping from a disaster may not have the funds to cover travel around the country for rotating residents.[38]

Moreover, in recognition of host hospitals' expectation that they receive GME funds immediately to cover the added expense of training displaced residents,

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from August 29, 2005 through June 30, 2006, CMS exempted displaced resident FTEs from the host hospitals' three-year rolling average calculation of resident FTEs.[39] CMS averages the current resident FTE count with those of the proceeding two years so that changes in the count are felt one-third in the first year, two-thirds in the next year, and fully in the third year, assuming no other changes in the FTE count. Without the time limited exception, host hospitals would not have received full GME funds for the displaced residents for three years. CMS did not want to penalize host hospitals for meeting the immediate needs of displaced residents.

November 27, 2007 Interim Final Rules

Despite CMS' revisions, affected hospitals found they needed additional GME funding relief as their residency programs reopened at different rates as accreditation required amendment to programs and the need to adjust locations for training continued to fluctuate. Accordingly, on November 27, 2007, CMS issued interim final rules with comment period immediately retroactively effective to August 29, 2005.[40] Given that residency programs remain in fluctuation until hospitals have permanent structures and permanently can restore their residency programs, CMS allowed emergency Medicare GME affiliation agreements to continue with out-of-state host hospitals up to four academic years after the affected academic year and apply to residents actually displaced by the 1135 emergency. This change reflects a two-year increase in duration of an emergency Medicare affiliation agreement, but it still only applies to residents actually displaced by the disaster. In the case of in-state host hospitals, emergency Medicare GME affiliation agreements may continue up to four academic years after the affected academic year, but the application of the agreements is to displaced residents ***and*** new residents not in training at the time of the disaster. The CMS policy goal is to balance the home hospital's desire to return residents to their original training sites and to rebuild residency programs. Given that the majority of residents remain in the community, CMS policy increases the likelihood that residents will stay in the area and help rebuild the local health system. CMS believes it facilitates the regrowth of residency programs in the 1135 region by allowing for reallocation of FTE slots to include those residents new to the program.[41]

August 19, 2008 Final Rules

In the August 2008 final rules, CMS describes additional issues raised by commenters. If a home hospital was over its cap at the time of the 1135 emergency, then the home hospital could only redistribute direct GME and IME FTE slots that were under its cap to host hospitals. This leaves the host hospital, accepting displaced residents from a home hospital's residency program that is already above its cap, in the position of not being able to receive direct GME and IME FTE funding for those displaced residents who were over the cap. CMS did not resolve the problem of the cap, stating that its authority is limited to facilitating the redistribution of funding under the cap. CMS acknowledges that many hospitals operate programs over the cap and posits that these hospitals must have a benefit to the training of residents above government funding. It points out that "[t]he Conference Report for the BBA of 1997 indicated that 'the Secretary's flexibility is limited by the conference agreement that the aggregate number of FTE residents should not increase over current levels.' (H. Conf. Rept. No. 105-217, p. 822)."[42] CMS continues "the aggregate total number of FTE residents counted by all the hospitals participating in a Medicare GME affiliation agreement cannot exceed the aggregate total of the hospitals' direct GME and IME FTE resident caps."[43]

Accordingly, CMS argues that it cannot authorize redistribution of GME funding above the aggregate total cap for hospitals participating in emergency Medicare GME affiliation agreements as well. "These provisions are not intended to provide increased flexibility to shift FTE resident caps slots to other hospitals in the country simply to maximize Medicare IME and direct GME payments."[44]

While some commenters to the interim rules argue that the caps no longer have a purpose given that oversupply of physicians is no longer an issue, CMS posits that the maldistribution of physicians across the country and the narrow focus on inpatient training settings are still concerns. Therefore, CMS believes that caps still serve a purpose with GME funding. CMS emphasizes that there was a one-time redistribution of caps in 2005; so there has been relief on the cap issue for teaching hospitals. CMS concludes that it cannot provide

relief other than to allow hospitals to aggregate resident funding under the cap through the emergency Medicare GME affiliation agreements and it cannot authorize additional slots above the aggregate cap.[45]

Another issue that home hospitals had with the revised rules was that CMS was not accounting for the fact that, for a time after the hurricane hit, the region's hospitals were not training residents and residents were not transferred. For about a month the hospitals were flooded, medical professionals had limited resources, and there was no training. Hospitals requested that CMS allow them to annualize their 11-month FTE count so they could be paid for the ongoing expense of training costs even though no training could occur. While CMS acknowledges the abrupt loss of funding would adversely affect teaching hospitals, it argues that GME payments may only be attributed to actual time spent training at hospitals. CMS suggests that hospitals seek other types of grants and relief payments to cover these costs.[46] Given CMS' purpose to help home hospitals rebuild so they can provide Medicare services, it seems that the annualizing of the 11 months of resident FTEs would have been a good compromise to accomplish CMS' goal and not leave hospitals looking for relief for its residency programs from other sources.

In addition, a significant issue is the three-year rolling average count of resident FTEs designed to "distribute the impact of increasing or decreasing the number of residents at a hospital over 3-year period."[47] As noted above, CMS averages the current resident FTE count with those of the preceding two years so that changes in the count are felt one-third in the first year, two-thirds in the next year, and in full in the third year, assuming no other changes in the FTE count. Commenters to the interim CMS rule noted that the three-year rolling average does not protect home hospitals from sudden loss of GME funding when a hospital residency program closes due to disaster.[48] A hospital, abruptly closed, does not have any Medicare patient load. Accordingly, it cannot receive GME reimbursement.

One commenter suggested that CMS count FTE residents in a manner similar to the calculation of residents in a new program so that the three-year rolling average would not count while home hospitals rebuild.[49] With new teaching hospitals, "the hospital's per resident amount is established based on the lower of the hospital's direct GME costs per resident in its base year, or the updated weighted mean value of the per resident amounts of all hospitals located in the same geographic area."[50] CMS responded that the three-year rolling average applies to existing programs.[51]

CMS' view is that the rolling three-year average works in a home hospital's favor as the effect from the decrease after closure is spread over three years.[52] It notes the statute does not allow for an exception to the three-year rolling average. However, CMS does acknowledge that there has to be a significant Medicare inpatient utilization for the three-year rolling average to have a graduated effect. CMS again suggests the hospitals utilize alternative funding available during disasters to address significant drops in GME funding after a closure.[53]

As noted above, the 2006 interim rule did allow host hospitals to exclude displaced FTE residents in their rolling average count for the period August 29, 2005 through June 30, 2006. This allowed host hospitals not to have to wait to receive payments for displaced residents. CMS understood that host hospitals taking in displaced residents expected immediate relief for the additional training costs.[54] Yet, in its August 2008 final rule, CMS declined to extend this exception beyond the initial period of displacement in the first academic year.[55] CMS did not find it appropriate to make an exception beyond the immediate academic year.

Finally, CMS extended the revisions pertaining to emergency Medicare GME affiliation agreements to all future 1135 emergencies,[56] such as Hurricane Ike that recently wreaked havoc on Texas' residency programs.

Summary Policy Considerations

Given the level of devastation to hospitals in New Orleans from Hurricane Katrina, CMS' amended regulations do allow some affected hospitals the flexibility to affiliate with hospitals not in the contiguous area and aggregate direct GME and IME FTEs under the cap so that residents receive continuous training and host hospitals receive some reimbursement. Congress has not authorized CMS to increase the cap, but only to aggregate caps. There is a future policy consideration as to whether caps should be increased given that the oversupply

of physicians is not as much of a concern as in the past. However, the real issue behind CMS' decision not to provide cap relief to residency programs in 1135 areas most likely is lack of funding. Unfortunately, host hospitals accepting residents over the home hospital's cap are left with no additional funding. This may lead potential host hospitals not to accept displaced residents, resulting in disruption of the training of residents after disasters.

Also, while CMS allowed home hospitals in the 1135 area, with a 20% decrease in inpatient bed capacity and with a need to transfer residents, to enter into the emergency Medicare GME affiliation agreements, it did not provide such relief for all hospitals in the 1135 area. Some hospitals in the 1135 area actually had an increase in inpatient bed capacity as they absorbed patients from hospitals that closed, but they were not able to continue resident education in the midst of the devastation.[57] Any residency training program that could not continue in the 1135 area and sent its residents to another setting for training should have the flexibility to aggregate its direct GME and IME FTEs with other hospitals. This flexibility allows all host hospitals taking in displaced residents to receive increased GME funding. CMS states that it would dissuade the effort to rebuild residency training if it extended the emergency Medicare GME affiliation agreements to other hospitals in the 1135 area,[58] but that argument seems counter intuitive. If a hospital in the 1135 area cannot continue its residency program, then efforts to allow it to provide training for its residents and rebuild its program seem to encourage the re-establishment of the local health system. There seems to be no more of a disincentive for hospitals with more than a 20% decrease in bed capacity than hospitals with less than a 20% decrease in bed capacity to rebuild if residents temporarily are sent to other areas to train. The common thread is that these hospitals are in the 1135 area and their residency programs cannot continue. Both need to rebuild.

CMS did exempt host hospitals from having to include displaced residents in their FTE count for the three-year rolling average during the first academic year in recognition of the immediate financial burden the additional residents placed upon host hospitals. Given the continuing financial burden the displaced residents have on host hospitals and that it takes more than an academic year to re-stabilize residency programs after a disaster, CMS should reconsider extension of the exemption from the three-year rolling average as long as the host hospitals have the actual displaced residents.

CMS does encourage the rebuilding of home hospital residency programs by allowing them to include new residents in aggregate FTE counts in emergency Medicare GME affiliation agreements with in-state hospitals. Yet, CMS does not address the burden to the home hospitals through the application of the three-year rolling average, given the dramatic loss of census immediately following the disaster. CMS states that it does not have authority to grant relief to the home hospitals, but it also seems contrary to CMS' policy to assist home hospitals with rebuilding if home hospitals must turn to alternative resources to cover ongoing training costs. While the application of the three-year rolling average does graduate the effect of the dramatic loss over a three-year period, such relief seems inadequate amid a disaster.

In conclusion, CMS should be commended for applying immediately retroactive rules to provide relief to residency programs after a disaster, but the relief may not have been enough to achieve CMS' goals to provide continuous training to residents and to facilitate the rebuilding of residency programs in 1135 areas. Given the critical role residency programs play in building community health systems, we need to further examine support to residency programs as future disasters affect them.

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Endnotes

1 *New Orleans Institutions Face Post Katrina Challenges*, AAMC Reporter (Mar. 2006).
2 *Id.*
3 *Id.*
4 Richard Streiffer, M.D., Bridget Lavin, M.S., Anthony E. Keck, M.P.H., Fred Cerise, M.D., M.P.H., *Impact of Hurricane Katrina on Graduate Medical Education in the New Orleans Area and Implications for National GME Policy*, Louisiana Department of Health and Hospitals, Tulane University School of Medicine, Tulane University School of Public Health and Tropical Medicine.
5 *Id.*
6 *Id.*
7 Fran Simon, *Resuscitation*, TULANE UNIV. MAGAZINE (Winter 2007).
8 Ruth E. Berggren, M.D., and Tyler J Curiel, M.D., M.P.H., *After the Storm – Health Care Infrastructure in Post-Katrina New Orleans*, 354 NEW ENGLAND J. MED. at 1550 (Apr. 13, 2006).
9 *Id.* at 1552.
10 AAMC Reporter, *supra* note 1.
11 Sixty-one percent of residents in Louisiana were trained through LSUHSC, while Tulane trained 26%, Ochsner trained 11%, and East Jefferson General Hospital and Baton Rouge General Medical Center trained the remaining 2% of residents. Streiffer, Lavin, Keck, and Cerise, *supra* note 4.
12 Pub. L. No. 94-412.
13 Pub. L. No. 93-288.
14 42 C.F.R. § 413.75(b).
15 42 C.F.R. § 413.76; 71 Fed. Reg. 18655.
16 42 C.F.R. 412.105; 71 Fed. Reg. 18655-18656.
17 Social Security Act §§ 1186(h)(4)(F) and 1886(d)(5)(B)(v); 73 Fed. Reg. 48642.
18 73 Fed. Reg. 48642.
19 *Id.*
20 *See* Streiffer, Lavin, Keck, and Cerise, *supra* note 4.
21 *Id.*
22 *See* http://questions.cms.hhs.gov.
23 42 C.F.R. § 413.75(b).
24 42 C.F.R. § 413.79(h)(1).
25 71 Fed. Reg. 18656.
26 *See* http://questions.cms.hhs.gov.
27 42 C.F.R. § 413.79(h).
28 71 Fed. Reg. 18657.
29 *Id.*
30 71 Fed. Reg. 18656.
31 *Id.*
32 While the Administrative Procedure Act requires a 30-day delay in the effective date of a final rule, it allows waiver of such delay if the agency finds good cause that the delay is impractical, unnecessary, or contrary to public interest. Secretary Leavitt found that delay in the effective date of the interim final rule would be against public interest given the urgent need to address the disruption of residency training programs due to Hurricanes Katrina and Rita. The Secretary made such a finding as well when the November 27, 2007 interim final rules were issued.
33 71 Fed. Reg. 18658.
34 71 Fed. Reg. 18656.
35 *Id.*
36 71 Fed. Reg. 18658-9.
37 CMS further extended the deadline to October 9, 2006. 72 Fed. Reg. 66895.
38 71 Fed. Reg. 18661.
39 71 Fed. Reg. 18661-2.
40 72 Fed. Reg. 66580.
41 72 Fed. Reg. 66896.
42 73 Fed. Reg. 48642.
43 *Id.*
44 *Id.*
45 73 Fed. Reg. 48642-48643.
46 73 Fed. Reg. 48644.
47 73 Fed. Reg. 48643.
48 *Id.*
49 *Id.*
50 71 Fed. Reg. 18661.
51 73 Fed. Reg. 48643.
52 *Id.*
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54 71 Fed. Reg. 18662-3.
55 73 Fed. Reg. 48644.
56 73 Fed. Reg. 48650.
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