DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 413

[CMS-1069-F]

RIN 0938-AJ55

Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule establishes a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital. It implements section 1886(j) of the Social Security Act (the Act), as added by section 4421 of the Balanced Budget Act of 1997 and as amended by section 125 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Section 1886(j) of the Act authorizes the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units of hospitals. This section also

authorizes the Secretary to require rehabilitation hospitals and rehabilitation units to submit data as the Secretary deems necessary to establish and administer the prospective payment system. The prospective payment system described in this final rule replaces the reasonable cost-based payment system under which rehabilitation hospitals and rehabilitation units of hospitals are paid under Medicare.

EFFECTIVE DATE: These regulations are effective on January 1, 2002.

APPLICABILITY DATE: The provisions of this final rule are effective for cost reporting periods beginning on or after January 1, 2002.

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

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Alphabetical List of Acronyms Appearing in the Final Rule

ADL Activities of Daily Living

BBA	Balanced Budget Act of 1997, Public Law 105-33
BBRA	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106-113
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106-554
CMGs	Case-mix groups
CMI	Case-mix index
CMS	Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration)
COS	Clinical Outcomes Systems
DRGs	Diagnosis-related groups
FIM	Functional independence measure
FRG	Function-related group
FY	Federal fiscal year
HCFA	Health Care Financing Administration (now the Centers for Medicare & Medicaid Services)
HIPAA	Health Insurance Portability and Accountability Act of 1996, Public Law 104-191
HHAs	Home health agencies
HMO	Health maintenance organization

IRFs	Inpatient rehabilitation facilities
MDCN	Medicare Data Collection Network
MDS-PAC	Minimum Data Set for Post-Acute Care
MedPAC	Medicare Payment Advisory Commission
MedPAR	Medicare Provider Analysis and Review File Tool
OASIS	Outcome and Assessment Information Set
ProPAC	Prospective Payment Assessment Commission
RAPs	Resident assessment protocols
RICs	Rehabilitation impairment categories
SNFs	Skilled nursing facilities
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248
UDSmr	Uniform Data Set for medical rehabilitation

I. Background

A. General

On November 3, 2000, we published a proposed rule in the **Federal Register** (65 FR 66304, HCFA-1069-P) to announce, and solicit public comments on, our proposed plans to establish a prospective payment system under Medicare for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit of a hospital. (The proposed rule and all other important

information regarding the proposed IRF prospective payment system is contained on our website at www.hcfa.gov/medicare/irfpps.htm.) Section 1886(j) of the Social Security Act (the Act), as added by section 4421 of the Balanced Budget Act of 1997 (BBA)(Public Law 105-33) and as amended by section 125 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA) (Public Law 106-113) and section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Public Law 106-554), authorizes the implementation of such a prospective payment system. Below we provide a history of Medicare payments for inpatient rehabilitation services and a discussion of the legislative changes that have affected these payments.

When the Medicare statute was originally enacted in 1965, Medicare payment for hospital inpatient services was based on the reasonable costs incurred in furnishing services to Medicare beneficiaries. The statute was later amended by section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) to limit payment by placing a limit on allowable costs per discharge. Section 601 of the Social Security Amendments

of 1983 (Public Law 98-21) added a new section 1886(d) to the Act that replaced the reasonable cost-based payment system for most hospital inpatient services. Section 1886(d) of the Act provides for a prospective payment system for the operating costs of hospital inpatient stays effective with hospital cost reporting periods beginning on or after October 1, 1983.

Although most hospital inpatient services became subject to a prospective payment system, certain specialty hospitals were excluded from that system. Inpatient rehabilitation hospitals and distinct part rehabilitation units in hospitals were among the excluded facilities. We refer to these inpatient rehabilitation hospitals and units as "inpatient rehabilitation facilities" or "IRFs" throughout this rule.

Subsequent to the implementation of the hospital inpatient prospective payment system, both the number of excluded IRFs, particularly distinct part units, and Medicare payments to these facilities grew rapidly. In order to control escalating costs, the Congress, through enactment of section 4421 of the BBA, section 125 of the BBRA, and section 305 of the BIPA, provided for the implementation of a prospective payment system for IRFs.

Section 4421 of the BBA amended the Act by adding section 1886(j), which authorizes the implementation of a prospective payment system for inpatient rehabilitation services. Section 125 of the BBRA amended section 1886(j) of the Act (as added by the BBA) to require the Secretary to use the discharge as the payment unit for inpatient rehabilitation services under the prospective payment system and to establish classes of patient discharges by functional-related groups. Section 305 of the BIPA further amended section 1886(j) of the Act to allow rehabilitation facilities to elect to be paid the full Federal prospective payment rather than the blended payments otherwise specified in the Act. This final rule implements the Medicare prospective payment system for IRFs, as authorized by section 1886(j) of the Act, as amended.

The statute provides for the prospective payment system for IRFs to be implemented for cost reporting periods beginning on or after October 1, 2000. However, because of the extensive changes required by the statute to change the payment systems for IRFs as well as the demands of simultaneously implementing new prospective payment systems for outpatient hospital and home health services, we determined, in the proposed rule, that it was not

feasible to implement the IRF prospective payment system as of October 1, 2000. The creation of each new payment system or modification to an existing payment system requires an extraordinary amount of lead-time to develop and implement the necessary changes to our existing computerized claims processing systems. In addition, it requires additional time after implementation to ensure that these complex changes are properly administered. Therefore, in the November 3, 2000 proposed rule, we indicated our belief that the earliest feasible date to implement the IRF prospective payment system was for cost reporting periods beginning on or after April 1, 2001.

We have evaluated the changes that will be necessary in our various systems for the IRF prospective payment system in order to accommodate suggestions made in the comments (such as developing and administering a revised patient assessment instrument described in section IV. of this preamble) along with changes to other Medicare payment systems required by the BBA, the BBRA, and the BIPA. After an extensive analysis of the changes required to both the providers' and our systems, we have now determined that the earliest feasible date to implement the IRF prospective payment system in this final rule is for cost reporting

periods beginning on or after January 1, 2002. We believe that this is the earliest feasible date given the scope and magnitude of the implementation and administrative requirements, including provider training, associated with the IRF prospective payment system and other mandated payment systems.

B. Summary of the Statutory Provisions Governing the IRF Prospective Payment System

Section 4421(a) of the BBA amended the Act by adding a new section 1886(j) to the Act that provides for the implementation of a Medicare prospective payment system for inpatient hospital rehabilitation services furnished in all IRFs. Under the prospective payment system, IRFs will be paid based on predetermined amounts. These prospective payments will encompass the inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IRF prospective payment system. Covered rehabilitation services include services for which benefits are provided under Part A (the Hospital Insurance Program) of the Medicare program.

Section 1886(j)(1)(A) of the Act provides that, notwithstanding section 1814(b) of the Act and subject to the provisions of section 1813 of the Act regarding beneficiary deductibles and coinsurance responsibility, the amount of payment for inpatient rehabilitation hospital services equals an amount determined under section 1886(j) of the Act. Sections 1886(j)(1)(A)(i) and (j)(1)(A)(ii) of the Act, as in effect prior to the enactment of sections 305(b)(1)(A), (B), and (C) of the BIPA, provide for a transition period covering cost reporting periods that begin during FYs 2001 and 2002 under the prospective payment system. During this transition period, IRFs would receive a payment rate comprising a blend of the “TEFRA percentage” of the amount that would have been paid under Part A with respect to those costs if the prospective payment system had not been implemented, and the “prospective payment percentage” of payments using the IRF prospective payment system rate. The applicable transition percentages are described in section 1886(j)(1)(C) of the Act. Sections 305(b)(1)(A) and (C) of the BIPA amended section 1886(j)(1)(A) and added a new subparagraph (F) to section 1886(j)(1) of the Act, respectively, to allow an IRF to elect to be paid the full Federal prospective

payment rather than a payment determined under the transition period methodology described in detail below. The provisions of section 305(b) of the BIPA take effect as if included in the enactment of the BBA.

Section 1886(j)(1)(B) of the Act, in effect prior to the enactment of section 305 of the BIPA, sets forth a requirement applicable to all IRFs for the payment rates under the fully implemented prospective payment system. Notwithstanding section 1814(b) of the Act and subject to the provisions of section 1813 of the Act regarding beneficiary deductibles and coinsurance responsibility, the amount of the payment for the operating and capital costs of an IRF for a payment unit (as defined in section 1886(j)(1)(D) of the Act) in a cost reporting period beginning on or after October 1, 2002 (FY 2003), will be equal to the per unit payment rate established under the prospective payment system for the fiscal year in which the payment unit of service occurs. Section 305(b)(1)of the BIPA amended section 1886(j)(1)(B) of the Act and added a new subparagraph (F) to section 1886(j)(l) to make the provisions of section 1886(j)(1)(B) of the Act applicable to an IRF that elects, not later than 30 days before its first cost reporting period for which it is subject to the

payment methodology of section 1886(j)(1) of the Act, to be paid the full Federal prospective payment rather than a payment determined under the transition period methodology.

Sections 1886(j)(1)(C)(i) and (ii) of the Act set forth the applicable TEFRA and prospective payment rate percentages during the transition period. The two sections specify that, for a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001 (FY 2001), the "TEFRA percentage" is 66 2/3 percent and the “prospective payment percentage" is 33 1/3 percent; and on or after October 1, 2001, and before October 1, 2002 (FY 2002), the "TEFRA percentage" is 33 1/3 percent and the "prospective payment percentage" is 66 2/3 percent. (As explained earlier in section I.A. of this final rule, we are implementing the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002. See section VI.H. of this final rule for a discussion of the implementation of the transition period methodology.)

Section 1886(j)(1)(D) of the Act contains the definition of "payment unit." Until the passage of the BBRA, "payment unit" was defined by the statute as "a discharge, day of inpatient hospital services, or other

unit of payment defined by the Secretary." Section 125(a)(1) of the BBRA amended section 1886(j)(1)(D) of the Act by striking "day of inpatient hospital services, or other unit of payment defined by the Secretary." Accordingly, the payment unit utilized in the IRF prospective payment system will be a discharge.

Section 125(a)(3) of the BBRA amended the Act by adding a new section 1886(j)(1)(E) to the Act that states: “Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.” Our transfer policy is discussed in section VI.B. of this preamble.

Section 305(b)(1)(C) of the BIPA amended the Act by adding section 1886(j)(1)(F) to provide that an IRF may elect, not later than 30 days before its first cost reporting period for which the payment methodology applies to the facility, to have payment made to the facility under the provision of section 1886(j)(1)(B) of the Act (the fully implemented prospective payment system) rather than section 1886(j)(1)(A) of the Act (payment under the

transition methodology) for each cost reporting period to which the payment methodology applies.

Section 1886(j)(2)(A) of the Act, as added by section 4421 of the BBA, directed the Secretary to establish case-mix groups (CMGs) based on the factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient. This section also requires the Secretary to establish a method of classifying specific patients in IRFs within these groups. Section 125(a)(2) of the BBRA amended section 1886(j)(2)(A)(i) of the Act to establish classes of patient discharges by functional-related groups. Section 1886(j)(2)(A)(i) of the Act reads: "classes of patient discharges of rehabilitation facilities by functional-related groups (each . . . referred to as a 'case mix group'), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups."

Section 1886(j)(2)(B) of the Act provides that the Secretary must assign each case-mix group a weighting factor that reflects the relative facility resources used

for patients classified within the group as compared to patients classified within other groups.

Section 1886(j)(2)(C)(i) of the Act directs the Secretary to adjust "from time to time" the case-mix classifications and weighting factors "as appropriate to reflect changes in treatment patterns, technology, case-mix, number of payment units for which payment is made . . . and other factors which may affect the relative use of resources." Such periodic adjustments must be made in a manner so that changes in aggregate payments are a result of real changes in case-mix, not changes in coding that are unrelated to real changes in case-mix. Section 1886(j)(2)(C)(ii) of the Act provides that, if the Secretary determines that adjustments to the case-mix classifications or weighting factors resulted in (or are likely to result in) a change in aggregate payments that does not reflect real changes in case-mix, the Secretary must adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of the coding or classification changes.

Section 1886(j)(2)(D) of the Act authorizes the Secretary to require rehabilitation facilities that provide inpatient hospital services to submit such data as the

Secretary deems necessary to establish and administer the IRF prospective payment system.

Section 1886(j)(3)(A) of the Act describes how the prospective payment rate will be determined. A prospective payment rate must be determined for each payment unit for which an IRF is entitled to payment under the prospective payment system. The payment rate will be based on the average payment per payment unit for inpatient operating and capital costs of IRFs, using the most recently available data, and adjusted by the following factors:

- Updating the per-payment unit amount to the fiscal year involved by the applicable percentage increase (as defined by section 1886(b)(3)(B)(ii) of the Act) covering the period from the midpoint of the period for such data through the midpoint of FY 2000 and by an increase factor specified by the Secretary for subsequent fiscal years.
- Reducing the rates by a factor that is equal to the proportion of Medicare payments under the prospective payment system as estimated by the Secretary based on prospective payment amounts that are additional payments relating to outlier and related payments.
- Accounting for area wage variations among IRFs.
- Applying the case-mix weighting factors.

- Adjusting for such other factors as the Secretary determines necessary to properly reflect variations in necessary costs of treatment among IRFs.

Until the passage of the BIPA, section 1886(j)(3)(B) of the Act directed the Secretary to establish IRF prospective payment system payment rates during FYs 2001 and 2002 at levels so that, in the Secretary's estimation, total payments under the new system will equal 98 percent of the amount of payments that would have been made for operating and capital costs in those years if the IRF prospective payment system had not been implemented. In establishing these payment amounts, the Secretary must consider the effects of the prospective payment system on the total number of payment units from IRFs and other factors. Section 305(a) of the BIPA amended section 1886(j)(3)(B) of the Act by striking “98 percent” and adding “98 percent for fiscal year 2001 and 100 percent for fiscal year 2002”. The heading for section 305(a) of BIPA is “Assistance with administrative costs associated with the completion of patient assessment." In addition, section 305(b)(2) amended section 1886(j)(3)(B) of the Act to clarify that in establishing the levels of the payment rates under section 1886(j)(3)(B) of the Act, the Secretary

is not to account for any payment adjustment for IRFs electing not to be paid under the transition period methodology as allowed under section 1886(j)(1)(F) of the Act as added by section 305(b)(1)(C) of the BIPA. Section VI.E. of this final rule contains a further discussion of the development of payment rates under section 1886(j)(3)(B) of the Act.

Section 1886(j)(3)(C) of the Act provides for an annual increase factor. This factor must be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under section 1886(j) of the Act (which may be the market basket percentage increase described in section 1886(b)(3)(B)(iii) of the Act).

Under section 1886(j)(4)(A) of the Act, the Secretary is authorized, but not required, to provide for an additional payment to a rehabilitation facility for patients in a case-mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary. The amount of the additional payment must approximate the marginal cost of care above what otherwise would be paid and must be budget neutral. The total amount of the

additional payments to IRFs under the prospective payment system for a fiscal year may not be projected to exceed 5 percent of the total payments based on prospective payment rates for payment units in that year.

Section 1886(j)(4)(B) of the Act establishes that the Secretary is authorized but not required to provide for adjustments to the payment amounts under the prospective payment system as the Secretary deems appropriate to take into account the unique circumstances of IRFs located in Alaska and Hawaii.

Section 1886(j)(5) of the Act provides for the Secretary to publish in the **Federal Register**, on or before August 1 before each fiscal year, the classifications and weighting factors for the IRF case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

Section 1886(j)(6) of the Act provides that the Secretary must adjust the proportion (as estimated by the Secretary from time to time) of IRFs' costs that are attributable to wages and wage-related costs, of the prospective payment rates for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the

geographic area of the IRF compared to the national average wage level for such facilities. Additionally, the Secretary is required to make a budget-neutral update to the area wage adjustment factor no later than October 1, 2001, and at least once every 36 months thereafter. The budget neutral update is based on information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services.

Sections 1886(j)(7)(A), (B), (C), and (D) of the Act establish that there shall be no administrative or judicial review, under sections 1869 and 1878 of the Act or otherwise, of the establishment of case-mix groups, the methodology for the classification of patients within these groups, the weighting factors, the prospective payment rates, outlier and special payments and area wage adjustments.

Section 125(b) of the BBRA provides that the Secretary shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the IRF prospective payment system. A report on the study must be submitted to the Congress not later than 3 years after

the date the IRF prospective payment system is first implemented.

C. Summary of the November 3, 2000 Proposed Rule

In the November 3, 2000 proposed rule, we proposed to establish a new subpart P under 42 CFR Part 412 of the Medicare regulations to implement the IRF prospective payment system and to make technical and conforming changes to other appropriate sections under Parts 412 and 413.

In the proposed rule, to support and explain our proposed policies, we presented the following:

? An overview of the reasonable cost-based payment system that would be replaced by the IRF prospective payment system.

? An extensive discussion of past research on IRF patient classification systems and prospective payment systems, including earlier research performed by the RAND Corporation that supported a per discharge based prospective payment system using a patient classification system known as Functional Independence Measures-Functional Related Groups (FIM-FRGs).

? A discussion of the following policy objectives we identified to evaluate the relative merits of the various policy options considered:

– The creation of a beneficiary-centered payment system that promotes quality of care, access to care, and continuity of care and is administratively feasible while controlling costs.

– The provision of incentives to furnish services as efficiently as possible without diminishing the quality of the care or limiting access to care.

– The creation of a payment system that is fair and equitable to facilities, beneficiaries, and the Medicare program.

– The development of an IRF prospective payment system that has the capability to recognize legitimate cost differences among various settings furnishing the same service; and a patient classification system used to group patients and services that is based on clinically coherent categories and, at the same time, reflects similar resource use. This would limit opportunities to "upcode" or "game" the system.

? A discussion of options considered for the following major components of the proposed IRF prospective payment system: the patient assessment instrument; the patient classification system; the unit of payment; and the data used to construct the payment rates.

? A discussion of the proposed requirement that IRFs complete the Minimum Data Set for Post-Acute Care (MDS-PAC) (a patient assessment instrument) as a part of the data collection deemed necessary by the Secretary to implement and administer the IRF prospective payment system. (As explained in section IV. of this final rule, we are adopting a revised patient assessment instrument.)

? A discussion of the proposed IRF patient classification system using CMGs and the prospective payment system supported by RAND's research using 1996 and 1997 data. The results of this research were released in a report by RAND in July 2000. (This report is contained on our website: www.hcfa.gov/medicare/irfpps.htm.)

? A discussion of the impact of the proposed IRF prospective payment system on the Medicare program and on IRFs.

D. General Overview of the IRF Prospective Payment System

In accordance with the requirements of section 1886(j) of the Act, and following issuance of the November 3, 2000 proposed rule and consideration of public comments, we are implementing a prospective payment system for IRFs that replaces the current reasonable cost-based payment system. The new prospective payment system utilizes information

from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group with additional case-level and facility-level adjustments applied.

We are requiring IRFs to complete the patient assessment instrument described in section IV. of this preamble, for all Medicare Part A fee-for-service patients admitted or discharged on or after January 1, 2002.

Data from the patient assessment instrument will be used to--

? Determine the appropriate classification of a Medicare patient into a CMG for payment under the prospective payment system (using data from only the initial patient instrument completed after admission, as described in section IV. of this preamble);

? Implement a system to monitor the quality of care furnished to Medicare patients; and

? Ensure that appropriate case-mix and other adjustments can be made to the patient classification system.

Further details of the CMG classification system are discussed in section V. of this preamble.

IRFs are required to input the patient assessment data into a computerized data system. In general, this system consists of a computerized patient grouping software program (GROUPER software) and data transmission software.

Upon the discharge of a Medicare patient, the GROUPER software will determine the appropriate CMG classification number. IRFs must enter the CMG classification number onto the Medicare claim form in accordance with Medicare claims processing procedures. The operational aspects and instructions for completing and submitting Medicare claims under the IRF prospective payment system will be addressed in a Medicare program memorandum issued prior to the effective date of this final rule. We are aware that, beginning October 16, 2002, the submission of electronic claims must be in compliance with the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as specified in the Standards for Electronic Transactions final rule published in the **Federal Register** on August 17, 2000 (65 FR 50312). We will be taking the necessary steps in the future to ensure compliance with this provision of the HIPAA.

The payment unit for the IRF prospective payment system for Medicare patients will be a discharge. The payment rates will encompass inpatient operating and capital costs of furnishing covered inpatient rehabilitation hospital services, including routine, ancillary, and capital costs, but not the costs of bad debts or approved educational activities. (A detailed description of the payment policies, including the transition period methodology, appears in section VI. of this final rule.)

E. Summary of Public Comments Received on the November 3, 2000 Proposed Rule

The November 3, 2000 proposed rule provided for a 60-day comment period ending January 2, 2001. We extended this initial comment period an additional 30 days, until February 1, 2001, through the publication of a notice in the **Federal Register** on December 27, 2000 (65 FR 81813).

We received a total of 399 timely items of correspondence containing multiple comments on the November 3, 2000 proposed rule. Major issues addressed by commenters included the use of the MDS-PAC as the patient assessment instrument; various aspects of the CMG classification system, including the recognition of

comorbidities; various aspects of the facility and case level payment adjustments; and the requirements to be classified as an IRF.

Summaries of the public comments received and our responses to those comments are set forth below under the appropriate subject heading.

II. Requirements and Conditions for Payment Under the Prospective Payment System for IRFs

In the November 3, 2000 proposed rule, we proposed the conditions that an IRF must meet to be paid under the IRF prospective payment system (proposed §412.604). In general, if the conditions are not met, we may reduce or withhold Medicare payments or may classify the IRF as a hospital that is paid under the acute care hospital prospective payment system (proposed §412.604(a)(2)).

A. Classification Criteria for IRFs

1. Provisions of Proposed Rule

In the November 3, 2000 proposed rule, we stated that we were not proposing to change the existing criteria for a hospital or hospital unit to be classified as a rehabilitation hospital or a rehabilitation unit that is excluded from the acute care hospital prospective payment systems under sections 1886(d) and 1886(g) of the Act, that

are codified in regulations in 42 CFR Part 412. In addition, we indicated that we were not proposing to revise the survey and certification procedures applicable to entities seeking this classification.

Under §412.604(b), we proposed that, to be classified as a rehabilitation hospital or rehabilitation unit, an IRF must meet the criteria set forth in existing §§412.23(b), 412.25, and 412.29 for exclusion from the inpatient hospital prospective payment system. Existing §412.23(b) provides that a rehabilitation hospital must--

? Have a provider agreement under Part 489 to participate as a hospital;

? Except for a newly participating hospital seeking exclusion for its first 12-month cost reporting period, show that during its most recent 12-month cost reporting periods, it served an inpatient population of whom at least 75 percent required intensive rehabilitation services for one or more of 10 conditions specified in the regulations;

? Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program or assessment;

? Ensure that patients receive close medical supervision and furnish rehabilitative nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social or psychological services, and orthotic and prosthetic services, through the use of qualified personnel;

? Have a director of rehabilitation who meets the criteria specified in the regulations;

? Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and

? Use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient in the manner specified in the regulations.

Existing §412.25 provides that a rehabilitation unit must--

? Be part of an institution that has in effect an agreement under part 489 of this chapter to participate as a hospital; is not excluded in its entirety from the prospective payment systems; and has enough beds that are not excluded from the prospective payment systems to permit

the provision of adequate cost information, as required by §413.24(c);

? Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients;

? Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available;

? Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit;

? Meet applicable State licensure laws;

? Have utilization review standards applicable for the type of care offered in the unit;

? Have beds physically separate from (that is, not commingled with) the hospital's other beds;

? Be serviced by the same fiscal intermediary as the hospital;

? Be treated as a separate cost center for cost finding and apportionment purposes;

? Use an accounting system that properly allocates costs;

? Maintain adequate statistical data to support the basis of allocation;

? Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital;

? As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient rehabilitation care regardless of whether there are any inpatients in the unit on that date.

In addition, existing §412.25 contains requirements on changes in hospital size and existing §412.29 includes specific requirements for new and converted units (as specified in §412.30), preadmission screening, staffing, plans of treatment, a coordinated multidisciplinary team approach as documented in clinical records, and administration.

2. Public Comments and Departmental Responses

Comment: Many commenters suggested that we update the 10 conditions specified in §412.23(b)(2) that are used to determine if at least 75 percent of facility’s patients require intensive rehabilitative services. One commenter recommended completely eliminating the “75 percent” rule to classify a facility or unit as an IRF because we proposed

to use the 21 rehabilitation impairment categories (RICs) as defined in the proposed rule.

Response: Currently, hospitals or hospital units that meet the requirements at existing §§412.23(b), 412.25, and 412.29 are eligible to be classified as rehabilitation hospitals or rehabilitation units that are excluded from the acute care inpatient hospital prospective payment systems established under sections 1886(d) and 1886(g) of the Act. Section 1886(j) of the Act was added to implement the prospective payment system described in this final rule for excluded hospitals and hospital units that are classified as rehabilitation hospitals and rehabilitation units. As we noted in the proposed rule, we were not proposing changes to the existing requirements for classification under §412.23(b)(2). We believe that the existing requirements are appropriate in classifying a hospital or unit as an IRF that is paid under section 1886(j) of the Act. Accordingly, for this final rule, we are not revising the existing requirements at §§412.23(b), 412.25, and 412.29. However, as more data, including patient data associated with the RICs, become available after we initially implement the IRF prospective payment system, we may reconsider whether it would be appropriate

to revisit the requirement regarding the "75 percent" rule in the future.

Comment: Several commenters suggested that we amend §412.30 to clarify that hospitals seeking to convert skilled nursing facility (SNF) beds to excluded inpatient rehabilitation beds must wait for 12 months before being excluded from the acute care hospital prospective payment system (and be paid under the IRF prospective payment system) just as acute care hospitals must do if they convert medical-surgical beds to excluded inpatient rehabilitation beds.

Response: Currently, the 12-month delay for the conversion of beds under §412.30 to IRF beds does not apply to SNF beds. For this final rule, as stated in the proposed rule, we are not changing the existing criteria for a hospital or hospital unit to be classified as a rehabilitation hospital or a rehabilitation unit that is excluded from the acute care inpatient hospital prospective payment system. We believe that the existing requirements are appropriate in classifying a hospital unit as an IRF that is paid under section 1886(j) of the Act. In accordance with section 125(b) of the BBRA, we indicated that we will be conducting a study of the impact on

utilization and beneficiary access to services of the implementation of the IRF prospective payment system. If this study shows the need to change this requirement to include converted SNF beds, we will propose to do so in the future. Accordingly, we are not making any changes to the existing §412.30 as the commenters suggested.

3. Provisions of the Final Rule

Under §§412.604(a) and (b) of the final regulations, we are specifying that, for cost reporting periods beginning on or after January 1, 2002, hospitals or hospital units that are classified as rehabilitation hospitals or rehabilitation units will be paid under the IRF prospective payment system (except for IRFs that are paid under the special payment provisions at §412.22(c) of the regulations) as described below.

? Requirements for IRFs. The IRF prospective payment system will apply to inpatient rehabilitation services furnished by Medicare participating entities that are classified as rehabilitation hospitals or rehabilitation units under §§412.23(b), 412.25, and 412.29. In addition, we are adopting as final the proposed technical changes to

§§412.22, 412.23, 412.25, and 412.29 to reflect the application of the classification criteria to IRFs under the IRF prospective payment system.

? Location of IRFs outside the 50 States. IRFs that meet the requirements of §§412.22, 412.23, 412.25, 412.29, and 412.30 that are located in Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Mariana Islands, and the District of Columbia will be subject to the IRF prospective payment system.

? Hospitals Not Subject to the IRF Prospective Payment System. The following hospitals are paid under special payment provisions described in §412.22(c) and, therefore, are not subject to the IRF prospective payment system rules:

- Veterans Administration hospitals.

- Hospitals that are reimbursed under State cost control systems approved under 42 CFR Part 403.

- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)).

? Other Technical Changes. In addition to the technical changes to §§412.22, 412.23, 412.25, and 412.29

cited above, we are adopting as final the proposed technical changes to §§412.1, 412.20, 412.116, 412.130, 413.1, 413.40, and 413.64 to reflect payment for inpatient rehabilitation services furnished by IRFs under the IRF prospective payment system, effective January 1, 2002.

B. Completion of Patient Assessment Instrument

Proposed §412.604(c) provided that, for each Medicare patient admitted or discharged on or after April 1, 2001, the IRF must complete a patient assessment instrument. In the proposed rule under §412.606(b), we had proposed the use of the MDS-PAC as the patient assessment instrument. However, as discussed in detail in section IV.D. of this preamble, we are replacing the MDS-PAC with our inpatient rehabilitation facility patient assessment instrument. Under §412.604(c) of this final rule, we are requiring an IRF to complete our inpatient rehabilitation facility patient assessment instrument for each Medicare Part A fee-for-service patient admitted to or discharged from the IRF on or after January 1, 2002.

C. Limitation on Charges to Beneficiaries

Proposed §412.604(d) specified that an IRF may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of

furnishing services to that beneficiary are greater than the amount the facility is paid under the IRF prospective payment system. Proposed §412.604(d) further specified that an IRF receiving a prospective payment for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§409.82, 409.83, and 409.87 of the regulations.

We did not receive any comments on proposed §412.604(d) and are adopting it as final with one modification. In the proposed rule, we inadvertently did not specify that, in addition to the applicable deductible and coinsurance amounts, a facility is limited to its charges to beneficiaries and other individuals on their behalf under existing §489.20(a) of the regulations.

D. Furnishing of Inpatient Hospital Services Directly or Under Arrangement

Proposed §412.604(e) specified that an IRF must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements. The IRF prospective payments are payment in full for all inpatient hospital services, as defined in §409.10. We proposed that

we would not pay any provider or supplier other than the IRF for services furnished to a Medicare beneficiary who is an inpatient of the IRF, except for physicians' services reimbursable under §405.550(b) and services of an anesthetist employed by a physician reimbursable under §415.102(a) of the regulations.

We did not receive any comments on proposed §412.604(e) and are adopting it as final with two conforming changes:

We are revising proposed paragraph (e)(1) to conform it to the provisions of existing §412.50, which lists the types of services that are not included as inpatient hospital services. Section 412.50 was revised on April 7, 2000 (65 FR 18537). However, we inadvertently did not include the revised list in the proposed rule.

Proposed §412.622(b) (which we are adopting as final) specifies that payments for approved educational activities, bad debts, and per units for blood clotting factor are separate payments made outside the scope of the full prospective payment to IRFs for inpatient rehabilitation services. We are including in §412.604(e)(l) a citation to §412.622(b) to clarify that payment for these three types of services are not included

in the full prospective payment for all inpatient IRF services.

E. Reporting and Recordkeeping Requirements

Under proposed §412.604(f), we specified that all IRFs participating in the IRF prospective payment system must meet the recordkeeping and cost reporting requirements of §§413.20 and 413.24 of the regulations.

We did not receive any comments on proposed §412.604(f) and, therefore, are adopting it as final without modification.

III. Research To Support the Establishment of the IRF Prospective Payment System

A. Overview of Research for the Proposed Rule

In 1995, the Rand Corporation (RAND) began extensive research, sponsored by us, on the development of a per discharge based prospective payment system using a patient classification system known as Functional Independence Measures-Functional Related Groups (FIM-FRGs) using 1994 data. The results of RAND's earliest research were released in September 1997 and are contained in two reports available through the National Technical Information Service (NTIS). The reports are--

? Classification System for Inpatient Rehabilitation Patients--A Review and Proposed Revisions to the Function Independence Measure-Function Related Groups, **NTIS order number PB98-105992INZ**; and

? Prospective Payment System for Inpatient Rehabilitation, **NTIS order number PB98-106024INZ**.

These reports can be ordered toll-free by calling the NTIS sales desk at 800-553-6847 or by e-mail at www.orders@ntis.fedworld.gov.

In summarizing these reports, RAND found in the research based on 1994 data that, with limitations, the FIM-FRGs were effective predictors of resource use based on the proxy measurement: length of stay. FRGs based upon FIM motor scores, cognitive scores, and age remained stable over time (prediction remained consistent between 1990 and 1994 data). Researchers at RAND developed, examined, and evaluated a model payment system based upon FIM-FRG classifications that explains approximately 50 percent of patient costs and approximately 60 to 65 percent of costs at the facility level. Based on this earlier analysis, RAND concluded that an IRF prospective payment system using this model is feasible.

In July 1999, we contracted with RAND to update their earlier research. The update included an analysis of FIM data, the FRGs, and the model **rehabilitation** prospective payment system using more recent data from a greater number of IRFs. The purpose of updating the earlier research was to develop the underlying data necessary to support the Medicare IRF prospective payment system based on case-mix groups for the proposed rule. RAND expanded the scope of their earlier research to include the examination of several payment elements, such as comorbidities, f**acility**-level adjustments, and implementation issues, including evaluation and monitoring.

Specifically, as described in the proposed rule (65 FR 66313), RAND performed the following tasks:

? Constructed a data file, using 1996 and 1997 FIM data from the Uniform Data Set for medical rehabilitation (UDSmr) and the Clinical Outcomes System (COS). Our files and other sources were used to obtain data on Medicare beneficiaries and IRFs for 1996 and 1997.

? Determined that the FIM data from UDSmr and COS data are representative of the Medicare population.

? Identified factors or variables that were used to design the proposed prospective payment system.

? Developed data on the elements of the proposed prospective payment system regarding RICs, the CMGs, relative weights and payment rates for each CMG, **facility**-level adjustments, and patient-level adjustments.

? Developed data to examine the joint performance of all of the payment system elements by simulating **facility** payments for our analysis of the impact of implementing the payment system.

? Developed data to assist in identifying specific issues in connection with implementing the payment system.

? Presented options regarding the design and development of a system to monitor the effects of the payment system and other changes in the health care market on IRFs and on other post-acute care providers, including home health agencies and skilled nursing facilities, by measuring factors such as access, utilization, quality, and cost of care.

RAND issued a report on the findings on its analysis of the 1996 and 1997 data in July 2000. We have made the report available on our web site at www.hcfa.gov/medicare/irfpps.htm.

B. Updated Research for the Final Rule

In the November 3, 2000 proposed rule, we indicated we would refine some of the patient CMGs and corresponding weights and rates if further analysis of the data file and consideration of the comments that we received in response to the **proposed** rule warranted such refinements.

RAND has updated their research, as discussed below, to include patient assessment data and Medicare beneficiary data from more recent years than the data used to develop the provisions of the proposed rule. RAND's analysis of the later data assisted us in developing responses to comments on the proposed rule and identifying aspects of the patient classification and payment systems where refinements were justified or where further research was necessary. We discuss the details of refinements that we believe are necessary in section V. (Case-Mix Group Patient Classification System) and in section VI. (Payment Rates) of this final rule.

1. Sources and Description of More Recent Data

We used 1996 and 1997 Medicare program data and patient assessment data to develop the provisions of the proposed rule. For this final rule, we used 1998 and 1999

Medicare program data and patient assessment data as follows:

? Medicare Program Data - Calendar year 1998 and 1999 Medicare Provider Analysis and Review (MedPAR) files were used in RAND's updated research. The MedPAR file contains the records for all Medicare hospital **inpatient** discharges (including discharges for **rehabilitation** facilities). The data in the MedPAR file include patient demographics (age, gender, race, residence zip code), clinical characteristics (diagnoses and procedures), and hospitalization characteristics (admission date, discharge date, days in intensive care wards, charges by department, and payment information).

The Medicare cost report data are contained in the Health Care Provider Cost Report Information System (HCRIS). The cost report files contain information on **facility** characteristics, utilization data, and cost and charge data by cost center. For RAND's updated research, we obtained the HCRIS data from the most current available cost data for cost reports (FYs 1998, 1997, and/or 1996). Supplementary information to this file includes: (1) the wage data for the area in which an IRF is located; (2) data on teaching hospitals, including the number of residents

assigned to **rehabilitation** units and the distribution of resident time across **inpatient** and outpatient settings; (3) data on the number of Medicare cases at each IRF that represent Supplemental Security Income (SSI) beneficiaries; and (4) information about payments under the existing reasonable cost payment system.

? Patient Assessment Data - We entered into an agreement with the University at Buffalo Foundation Activities, Inc. to obtain 1998 and 1999 UDSmr patient assessment data. For the proposed rule, we entered into an agreement with Caredata.com, Inc. to retrieve COS patient assessment data. However, as mentioned in the proposed rule, the COS has been discontinued as of July 2000. COS patient assessment data for 1998 and 1999 were available though, for a majority of COS providers that operate under the HealthSouth Corporation. Accordingly, we entered into an agreement with the HealthSouth Corporation to retrieve patient assessment data for 1998 and 1999. Collectively, we will refer to the patient assessment data from the UDSmr (1996 through 1999), the COS (1996 and 1997), and the HealthSouth Corporation (1998 and 1999) as FIM data throughout this final rule.

The FIM data include demographic descriptions of the

patient (birth date, gender, zip code, ethnicity, marital status, living setting), clinical descriptions of the patient (condition requiring **rehabilitation**, ICD-9-CM diagnoses, functional independence measures at admission and discharge) and the hospitalization data (encrypted hospital identifier, admission date, discharge date, charges, payment source, and an indicator of whether this is the first **rehabilitation** hospitalization for this condition, a readmission, or a short stay for evaluation).

2. Description of the Methodology Used to Construct the Data File

In the proposed rule (65 FR 66314), we described the methodology that RAND used to construct the data file that formed the basis of the proposed CMG patient classification system and the resulting payment weights, rates, and payment adjustments using 1996 and 1997 data. RAND updated and expanded the data file to include the 1998 and 1999 data as follows:

RAND linked the 1998 and 1999 FIM patient records with patient records on the respective MedPAR files that describe the same discharge. RAND determined the Medicare provider number(s) that correspond to each **facility** code in

the FIM data. Next, RAND matched the FIM patients and MedPAR patients within the paired facilities.

Because of the proprietary and sensitive nature of the FIM patient records, certain data fields that specifically identify the patient and the servicing IRF were encrypted. Therefore, as in RAND's previous research, it was necessary to subject the FIM and MedPAR records to a sophisticated and complex matching probability technique. The result produces the most statistically valid match of patient/**facility** records and a data file that contains the characteristics of each Medicare beneficiary and his or her servicing IRF.

Because of the complex scope and nature of the matching technique used, we have included in Appendix A of this final rule a technical discussion of each step taken to create the updated data file. The tables contained in Appendix A show the actual effects of applying the matching technique on both the patient and **facility** records for 1996 through 1999.

3. Representativeness of the Updated Data File

It is extremely important to examine the quality of the resulting match, including the extent to which the linked MedPAR and FIM records are representative of the

MedPAR universe. We believe that the updated data file described in Appendix A, contains the best available and most representative data to construct a prospective payment system for all IRFs within the parameters of the statutory requirements. Our analysis of the updated data file allows us to develop the CMG patient classification and payment system, described in sections V. and VI. of this final rule.

C. Research on the Patient Assessment Instrument for the Final Rule

In the proposed rule (65 FR 66315), we set forth the proposed requirements regarding the completion of the MDS-PAC rather than the FIM patient assessment instrument. We stated that we would test further whether the MDS-PAC results in patient classifications that are equivalent to the classifications that occurred with the FIM (that is, the assessment instruments that were used to design the prospective payment system).

We expanded RAND's scope of work under the 1999 contract to include a study of the MDS-PAC and FIM instruments to answer the following questions:

? How accurate is the MDS-PAC for use in classifying

cases into CMGs for the proposed IRF prospective payment system?

? How do the validity, reliability, and consistency of the FIM and the MDS-PAC elements compare?

? What are the costs associated with the data collection on the FIM and MDS-PAC instruments?

? Are comorbidities being coded accurately on the FIM and the MDS-PAC instruments?

? Does the additional data in the MDS-PAC provide an opportunity for better groupings in the future?

Work on this project was performed by the Harvard Medical School under the RAND contract. The design and results of this study are discussed in detail in section IV. of this final rule.

D. Analyses to Support Future Adjustments to the IRF Prospective Payment System

The principal goal of the analysis described in section III.B. of this final rule is to determine the extent to which measurable patient characteristics, as reported on a patient assessment instrument, permit classification of patients into identifiable groups that accurately reflect the use of resources in IRFs. The research to date indicates that CMGs are effective

predictors of resource use as measured by proxies such as length of stay and cost. The use of these proxies is necessary because data that measure actual nursing and therapy time spent on patient care, and other resource use data, are not available. The collection of data on patient characteristics and patient-specific resource use may enhance our ability to refine the CMGs in a manner that supports our policy objectives for future refinement of the IRF prospective payment system. Accordingly, we have contracted with Aspen Systems Corporation to collect actual resource use data in a sample of IRFs. The data collected by Aspen will be submitted to RAND for analysis to determine if the data can be used to support future refinements to the CMGs.

IV. The IRF Patient Assessment

A. Implementation of a Patient Assessment Instrument

1. Statutory Authority and Proposed Rule

Under section 1886(j)(2)(D) of the Act, "The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection." The collection of patient data is indispensable for the

successful development and implementation of the IRF prospective payment system. A comprehensive, reliable system for collecting standardized patient assessment data is necessary for: (a) the objective assignment of Medicare beneficiaries to appropriate IRF CMGs; (b) the development of a system to monitor the effects of an IRF prospective payment system on patient care and outcomes; (c) the determination of whether future adjustments to the IRF CMGs are warranted; and (d) the development of an integrated system for post-acute care in the future.

2. Proposed Rule--Patient Assessment Instrument

In the November 3, 2000 proposed rule (65 FR 66315), we proposed to use the MDS-PAC as the standardized patient assessment instrument under the IRF prospective payment system (§§412.604(c) and 412.606). We acknowledged that the nature of the patient data we would collect may evolve over time. We stated our belief that the present structure of independent Medicare post-acute benefits, which includes payment systems, coverage requirements, and quality assessment instruments based primarily on site of care, may provide incentives that result in reduced access and choice for beneficiaries and may contribute to inappropriate care.

We are continuing to reevaluate the methods we use to pay for the delivery of post-acute services, with the objective of developing an integrated approach. The use of post-acute care patient assessment instruments is one way to operationally advance an integrated approach. We believe that MedPAC recognized the integrating function that post-acute care patient assessment instruments can play when, in its 1999 Report to Congress, MedPAC recommended that the Secretary collect a core set of patient assessment information across all post-acute care settings (Recommendation 5A).

As we strive to develop an integrated approach to the delivery of post-acute services, we are trying to implement MedPAC's March 2001 Report to Congress recommendation that the Secretary: (1) minimize reporting burden and needless complexity; and (2) assure that only the data necessary for payment and quality monitoring are collected (Recommendation 6B). We believe that the revised IRF patient assessment instrument contained in this final rule meets this MedPAC recommendation.

In the November 3, 2000 proposed rule, we proposed that only the IRF clinicians that we specified assess Medicare patients in IRFs using the MDS-PAC as the patient

assessment instrument. We proposed that an IRF clinician assess a Medicare IRF patient on Day 4, Day 11, Day 30, and Day 60 of the patient's IRF stay, and also when the patient was discharged. We proposed that the patient assessment data for each of these assessments would be transmitted to us. In addition, we proposed to impose penalties on the IRF based on late completion of the MDS-PAC and late transmission of the MDS-PAC data.

As discussed in detail in section IV.B. of this preamble, based on the public comments received, we have decided to use a patient assessment instrument that is different from the MDS-PAC and is more similar to the UDSmr patient assessment instrument.

3. Public Comments Received on Proposed Use of MDS-PAC as the Patient Assessment Instrument

In the November 3, 2000 proposed rule, we sought public comment on the use of MDS-PAC as the assessment instrument for the IRF prospective payment system, including: comments and supporting data regarding the additional burden and cost, if any, associated with this instrument; the suitability of the instrument for the rehabilitation setting and as a model for other post-acute care settings; views on whether the instrument has been

properly tested and validated for industry-wide use; and the utility and reliability of the quality data items contained in the instrument.

We received numerous comments regarding our proposal to use the MDS-PAC as the patient assessment instrument. In general, the commenters stated that--

? We should use the UDSmr patient assessment instrument, commonly referred to as the "FIM," instead of the MDS-PAC as the patient assessment instrument for the IRF prospective payment system;

? The MDS-PAC consisted of too many items;

? The reliability and validity of the items associated with monitoring quality of care had not been appropriately demonstrated;

? The FIM is as appropriate as the MDS-PAC to both classify patients into CMGs and monitor quality of care;

? The number of proposed patient assessments was excessive;

? The MDS-PAC item scoring scales for the FIM-like motor and cognitive items would contribute to errors scoring these items;

? The inconsistency of the item assessment time periods would detract from the accuracy of the assessment;

? An IRF's accreditation by JCAHO and CARF would be jeopardized or made unnecessarily burdensome and complicated if an IRF had to use the MDS-PAC;

? Clinicians other than those listed in the proposed rule should be allowed to certify that the assessment instrument had been properly completed;

? The list of the types of clinicians who could complete portions of the assessment should be expanded;

? The penalties associated with late completion or transmission of the MDS-PAC were too harsh;

? The policies for the IRF prospective payment system should only apply to patients admitted to an IRF after the system's implementation date; and

? More specifics regarding the assessment instrument test transmission should be given.

Below we give an overview of the patient assessment policies specified in the proposed rule, followed by a discussion of the public comments received and our response to those comments.

We have by no means abandoned our goal of ultimately establishing a common system to assess patient characteristics and care needs for all post-acute care services and pursing more integrated approaches to their

payment and delivery. As we stated earlier, that goal was endorsed by MedPAC in its March 1999 Report to the Congress, in which MedPAC recommended that the Secretary collect a core set of patient assessment information across all post-acute care settings (Recommendation 5A).

In its March 2001 Report to Congress, MedPAC recommends that "The Secretary should develop for potential implementation a patient classification system that predicts costs within and across post-acute settings" (Recommendation 6C). We continue to share MedPAC's view of the utility of implementing a common patient assessment data system and a common patient classification system across post-acute settings. The implementation of these common systems would facilitate across post-acute settings consistency of payments, consistency of patient assessment burden, and consistency of quality of care monitoring. We believe that the assessment instrument set forth in this final rule will help achieve these goals.

The patient assessment instrument adopted in this final rule supports both our payment and quality objectives. In addition, we note that section 545 of BIPA requires the Secretary to report to Congress by January 1, 2005, on the development of standard instruments

for the assessment of the health and functional status of patients, for items and services offered in all settings and to include in the report a recommendation on the use of such standard instruments for payment purposes. We believe that as a result of the study necessary to develop the report, we will make refinements in the design and application of our IRF patient assessment instrument. The refinements will provide us with even more essential information on which to base policy decisions related to post-acute care and its characteristics, including the quality of care furnished and our payment methods. We note that only Medicare Part A fee-for-service (original Medicare) IRF patients must be assessed by an IRF clinician using the patient assessment instrument.

In the proposed rule, we discussed our premise that the implementation of the per-case prospective payment system based on the "functional-related group" methodology requires the use of a standardized data collection instrument that contains the elements required to classify a patient into a distinct CMG. To classify a patient into a distinct CMG, the data collection instrument must first assign the patient into one of the various high level categories that are based principally on ICD-9-CM diagnoses

plus some additional patient information. These high level categories are called Rehabilitation Impairment Categories (RICs). After that initial classification step, the level of the patient's impairment, as determined by the patient's motor and cognitive function scores, and the age of the patient are used to classify a patient into a distinct CMG within the higher level RIC. How a patient's comorbidities may affect a patient's CMG is discussed in section VI. of this preamble. Additional data elements are required to identify the patient and for monitoring the quality of care furnished to patients in IRFs.

In the proposed rule, we indicated that we had explored several available approaches to the collection of the required data elements: These included: (a) the development of a new data collection instrument, the MDS-PAC (as discussed in the proposed rule); (b) the adoption of an instrument closely modeled on the UDSmr and the COS instrument; and (c) the incorporation verbatim into a new instrument (MDS-PAC) of the UDSmr/COS data elements that are relevant to payment. We indicated in the proposed rule that we proposed to use the first option, the MDS-PAC. We are referring readers to the November 3, 2000 proposed rule

for a detailed description of the MDS-PAC instrument (65 FR 66304).

Comment: We received many comments stating that the proposed MDS-PAC assessment instrument was too long and too complex. The commenters stated that the length and complexity of the patient assessment instrument create an unreasonable time burden in terms of performing the patient assessment. The unreasonable time burden in turn translated into excessive IRF patient assessment costs. The commenters urged us to use the FIM as the patient assessment instrument.

Response: Our goal was to collect comprehensive patient assessment data, with that data being used to classify patients into payment groups and for quality of care purposes. However, after analysis of the public comments, we have decided to reconsider the number and complexity of patient assessment items and, therefore, are adopting in this final rule the use of a modified version of the UDSmr patient assessment instrument (FIM) as our patient assessment instrument (§§412.604(c) and 412.606(b)) rather than the MDS-PAC. We have decreased the number of assessment items and changed some of the FIM items in an effort to make them easier to understand and complete.

We recognized that many rehabilitation hospitals already use the FIM. Another organization known as Caredata.com used to market a patient assessment instrument that is very similar to the UDSmr patient assessment instrument. (We have been notified that, as of July 2000, Caredata.com discontinued the part of its business operations related to patient data analysis and reporting that was similar to the function UDSmr continues to perform for IRFs.) The FIM assessment system has been under development since the mid-1980s. The FIM was developed by researchers who were funded by a consortium of rehabilitation professional associations and the Department of Education at the State University of New York (SUNY) at Buffalo in the 1980s. The FIM is marketed by the UDSmr, maintained by SUNY/Buffalo, and is proprietary. There has been extensive training in and experience with the data elements, particularly the functional components, that enter into the construction of the CMGs. We believe that with a few modifications it can be the basis for a valid and reliable instrument to measure impairments in IRFs. The reliability and validity of using the FIM to assess IRF patients have been documented by a substantial list of publications produced both in the United States and

overseas (for example, Sweden and Japan), by the developers of the system and by independent investigators. We also conducted a study of the FIM. We discuss the results of that study concerning the reliability and validity of the patient assessment instrument in section IV.E. of this preamble.

Many rehabilitation providers are clients of UDSmr. Our 1997 data show that approximately 68 percent of Medicare patients had a UDSmr or COS data file, indicating that these patients were assessed with the FIM. (We received comments indicating that currently approximately 85 percent of IRFs use the FIM. UDSmr also indicated that approximately 85 percent of IRFs currently use the FIM.)

The developers of the FIM offer a certification course to train assessors in the use of the instrument. This results in high rates of intrarater and interrater reliability, with Cronbach alpha coefficients of more than 0.9 for both the motor and cognitive subscores. The Cronbach alpha coefficient is a statistical measure of interrater reliability with perfect reliability equal to 1.0. Therefore, a score of 0.9 indicates a very high level of interrater reliability.

The principal objective of the FIM is to assess person-level disability in the inpatient medical rehabilitation setting. FIM data are collected at admission and discharge, and, when possible, 6 months after discharge. The strength of the FIM assessment instrument is that it is a well-evolved and extensively tested approach to the assessment of the critical components of care provided by IRFs and the measurement of patient improvement in functional capacity. The variations among facilities in the difference between the observed and expected improvement in function are used as indicators of the quality and the effectiveness of the facilities. UDSmr analyzes FIM data for providers and generates benchmark data that allow IRFs to compare the outcome of their performance on the functional independence measures relative to other providers participating in the system.

In sections VIII. and IX. of this final rule, we discuss in detail the burden of the use of a modified version of the FIM patient assessment instrument that we will use under the IRF prospective payment system.

Comment: Many commenters stated that the item scoring scales for the FIM-like motor and cognitive items would cause errors in scoring these items, because the scoring

scales were different from the FIM motor and cognitive items.

Response: We have incorporated the actual FIM motor and cognitive items into our revised patient assessment instrument. Therefore, the scoring of these items will be exactly as currently done for these FIM items. In addition, in consultation with UDSmr staff, we made the coding of some other items on our patient assessment instrument as similar as possible to how the FIM motor and cognitive items are coded.

Comment: One commenter requested a patient assessment item that would be used to collect speech-language data that are more descriptive of speech-language problems the patient may have.

Response: Our patient assessment instrument is now a slightly modified version of the UDSmr patient assessment instrument. Consequently, we will be using the UDSmr assessment items to assess a patient's communication ability. As we state repeatedly in this preamble, we want to limit the burden on IRFs. Therefore, we are being parsimonious in what items are added to the UDSmr instrument, and are only adding items that clearly increase the capability of our instrument to classify a patient into

a CMG or items that clearly collect needed and proven quality of care data. At this time, we do not have data that clearly indicate the value of changing the UDSmr communication assessment category of items.

Comment: Several commenters stated that the inconsistency of assessment time periods for different patient assessment instrument items would detract from the accuracy of the patient assessment. The different item assessment time periods would create confusion about how to perform the assessment and create an additional assessment burden.

Response: In the proposed rule, we specified that the item we proposed to use to assess "Indicators of Delirium-Periodic Disordered Thinking/Awareness" requires an assessment time period that is 7 calendar days in length. We also specified that the items we proposed to use to assess "Bladder Continence" and "Bowel Continence" each requires an assessment time period that is 7 to 14 calendar days in length. We stated that we would conduct additional testing of the MDS-PAC to determine if the assessment time period for these items should be changed. In addition, we stated that, if the additional testing indicated that the assessment time periods for these items should not be

changed, we would make appropriate changes to the patient assessment schedule.

We conducted testing of both the MDS-PAC and the UDSmr patient assessment instrument. Our additional testing confirmed that the assessment time periods for the bowel and bladder items should, in some cases, remain as long as 14 calendar days in length. In addition, we consulted with UDSmr staff regarding the assessment time period for the bladder and bowel items in the FIM, because the algorithms for these items indicate an assessment time period as long as 14 days. UDSmr staff recommended that the assessment time period for the bladder and bowel items remain as long as 14 days.

Our patient assessment instrument is a slightly modified version of the UDSmr patient assessment instrument, and contains all 18 of the UDSmr patient assessment instrument functional independence measures that are used to measure both motor and cognitive functioning. Therefore, in accordance with the public comments that recommended we make the assessment time periods for our patient assessment instrument items consistent, and in recognition of the assessment time periods used for the items in the UDSmr patient assessment instrument, in this

final rule we are requiring that the assessment time period for all of our patient assessment instrument items is 3 calendar days, except for some items as discussed below. We are not including in our assessment instrument the MDS-PAC item "Indicators of Delirium-Periodic Disordered Thinking/Awareness." Our additional testing did not confirm that this MDS-PAC item was as valid or reliable as our earlier testing indicated.

In general, the proposed rule specified an admission assessment time period that covers calendar days 1 through 3 of the patient's current IRF hospitalization, and an assessment reference date that is the third day of the admission assessment time period. These 3 calendar days are the days during which the patient's clinical condition would be assessed so that the clinical, as opposed to demographic, data that are required on the patient assessment instrument can be collected. In addition, these 3 calendar days must be days during which the patient was furnished Medicare Part A fee-for-service inpatient rehabilitation services. In this final rule, for the admission assessment, we are retaining the general guideline that the assessment reference date is the third calendar day of the admission assessment time period.

However, we believe that it may be necessary to allow additional time to assess certain items in order to most appropriately capture patient information to facilitate the payment and quality of care monitoring objectives of our IRF patient assessment instrument. Our item-by-item guide will provide specific guidelines on the observation period for individual items. We note that the UDSmr coding manual allows for an admission assessment time period for some items that is longer than 3 calendar days.

Specifically, clinical experience may indicate the optimal clinical assessment of the activity covered by an item would be more accurately obtained by using a longer assessment time period. Consequently, for a given patient assessment item, the item-by-item guide may specify an assessment time period that is longer than the general guideline of the first 3 calendar days of the patient's current hospitalization. In that situation, the IRF may use information from a variety of sources to assess the patient's clinical condition for the time period that is prior to the patient's current IRF hospitalization. The other sources could be one or more of the following: (1) the patient's physician; (2) the patient's clinical record if the patient is coming directly from an acute care

hospital or a SNF; (3) the medical record maintained by an HHA if the patient was being furnished services by an HHA immediately prior to the IRF hospitalization; (4) information obtained from the patient's family or someone who has personal knowledge of the patient's clinical condition; or (5) information obtained from the patient. For example, in order to perform the optimal clinical assessment for item "X", the admission assessment time period may need to be 7 calendar days. Therefore, in this example, the IRF would assess that item using data collected during the first 3 calendar days of the patient's current IRF hospitalization, and for the other 4 calendar days preceding the admission use data gathered from one or more of the specified other sources.

We believe that only one set calendar day should be the assessment reference date. In the example situation above, in order to have only one assessment reference date, the assessment reference date would remain being the third calendar day of the patient's current IRF hospitalization, but the span of calendar days for the admission assessment time period would be 7 calendar days with respect to that item.

The discharge assessment may also have items that require an assessment time period longer than 3 calendar days. If the patient has not been an IRF patient during the time period covered by this longer assessment time period, the IRF may obtain the data for these items using one of more of the sources specified above.

In this final rule, we are adopting the proposed provision that, for the discharge assessment, the assessment reference date is the day that the first of either of the two following events occurs: (1) the patient is discharged from the IRF; or (2) the patient stops being furnished Medicare Part A inpatient rehabilitation services, which includes the situation when a patient dies. In general, we are adopting the proposed rule provision that the assessment time period will be the 3 calendar days immediately prior to the assessment reference date. However, similar to the admission assessment, the assessment time period for some items for the discharge assessment will be different than the 3 calendar days prior to the assessment reference date. In addition, for the discharge assessment, in no case will the discharge assessment time period include a calendar day(s) prior to the admission assessment reference calendar date or the

admission assessment reference calendar date itself. For example, a patient admitted on July 1, 2002, will have an admission assessment reference date of July 3, 2002. If that patient is either discharged from the IRF or stops being furnished Medicare Part A inpatient rehabilitation services on July 12, 2002, the discharge assessment reference date is July 12, 2002. In this case, the discharge assessment time period for any of the items will not be the time period prior to or include July 3, 2002. Otherwise, we would be capturing data already recorded on the admission assessment. The goal of the discharge assessment is to obtain motor and cognitive data for the time period between the admission assessment and the discharge assessment.

In the final rule, for admission assessments, we are adopting the proposed assessment completion date of 1 calendar day after the assessment reference date. For discharge assessments, the completion date is the 5th calendar day in the period beginning with the assessment reference date. Charts 1, 2, and 3 and the accompanying discussion of the charts in section IV.D. of this preamble further illustrate the application of the assessment

reference date and other associated patient assessment schedule dates.

Comment: Several commenters stated that they used the FIM to comply with the accreditation process administered by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF). These commenters believed that substituting the MDS-PAC for the FIM as the patient assessment instrument would jeopardize their accreditation that was based on use of the FIM. The commenters stated it would be burdensome if they had to use the MDS-PAC and the FIM to satisfy both our requirements and the requirements of JCAHO and CARF.

Response: The patient assessment instrument that we are adopting in this final rule incorporates the majority of the UDSmr patient assessment instrument items. Therefore, we believe that use of our assessment instrument contains the same motor and cognitive items that IRFs need to maintain their JCAHO or CARF accreditation.

Comment: Several commenters stated that our proposed list of clinicians who would be authorized to sign the patient assessment instrument attesting to the completion and accuracy of the data recorded in the assessment

instrument was too restrictive. They believed that additional types of clinicians should be authorized. However, the commenters believed that no clinician should have to attest to the accuracy of the data recorded for each item, because it would normally be difficult or impossible for a clinician to verify the accuracy of the data recorded by one or more other clinicians during the time period we proposed to allow for completion of the assessment instrument.

Several commenters stated that the type of clinician who was authorized to complete a portion of our assessment instrument should be expanded to include several other types of clinicians.

Response: In this final rule, we are using a patient assessment instrument that is a modified version of the UDSmr patient assessment instrument. The UDSmr patient assessment instrument does not have an attestation section. Therefore, we are not including the attestation section in our patient assessment instrument in order to increase the similarity between the two assessment instruments. We are revising proposed §412.606 in these final regulations to remove the attestation provisions.

In addition, because we are using a slightly modified version of the UDSmr patient assessment instrument, we will follow UDSmr's item coding format. The data for the UDSmr patient assessment instrument items can be collected and recorded on the instrument by any clinician trained in how to collect and record the data. Therefore, we have decided to allow any clinician who is employed by the IRF or is a contract clinician of the IRF, and who has been trained in how to perform a patient assessment using our assessment instrument, to perform a patient assessment and record data for any item on the patient assessment instrument. Similar to UDSmr, we believe that any clinician who has been properly trained in collecting the patient assessment data is capable of satisfactorily collecting the data. The IRF will be responsible for ensuring that the data recorded by any clinician of the IRF on the patient assessment instrument are accurate and complete and in accordance with the policies contained in these final regulations (§412.606(c)(1) and (2)).

B. The Patient Assessment Process

As discussed in section IV.A. of this preamble, we are requiring that IRFs use our IRF patient assessment instrument to collect data on Medicare patients being

furnished care in IRFs. In the proposed rule, we did not state specifically that Medicare Part A fee-for-service patients are the only Medicare patients that must be assessed using the CMS patient assessment instrument. Therefore, in this final rule, for clarity we are stating that Medicare Part A fee-for-service patients are the only Medicare patients that must be assessed using our IRF patient assessment instrument. Our IRF patient assessment instrument consists of nine sections, each to collect different categories of patient information. These categories include identification and demographic information about the patient, medical information, and information related to quality of care and basic patient safety. Appendix B of this final rule contains the CMS IRF patient assessment instrument. However, our IRF patient assessment instrument must be approved by the Office of Management and Budget (OMB) prior to its use. Therefore, we may be required to make changes to the patient assessment instrument while the instrument is undergoing the OMB approval process. After the patient assessment instrument is approved by OMB, we will make it available on the IRF prospective payment system website (www.hcfa.gov/medicare/irfpps.htm). (In the proposed rule,

we included an item-by-item guide for the proposed MDS-PAC patient assessment instrument. Because we are changing the patient assessment instrument from the proposed MDS-PAC to a modified version of the UDSmr patient assessment instrument, we will need to develop additional instructions to supplement the UDSmr guide.)

The additional instructions supplementing the UDSmr guide will, in effect, be our draft item-by-itself guide to the IRF patient assessment instrument. Once the IRF patient assessment instrument is approved by OMB, we will submit the draft item-by-item guide to OMB for public review and comment, in compliance with the Paperwork Reduction Act of 1995 (PRA). When we submit the draft item-by-item guide to OMB for public review and comment, we will place it on the IRF prospective payment system website specified above. We anticipate that this draft item-by-item guide will be available for review and comment beginning September 2001. We will be providing appropriate training on the IRF patient assessment instrument and the item-by-item guide, after both the issuance of this final rule and OMB approval of the patient assessment instrument and the item-by-item guide.

IRFs must computerize and electronically report the patient assessment data (§412.614). Each year tens of thousands of Medicare patients are treated in IRFs. As discussed in more detail later in section IV.D. of this preamble, each Medicare Part A fee-for-service patients will be assessed two times by an IRF clinician using our inpatient rehabilitation facility patient assessment instrument. Therefore, there will be a large quantity of data collected and submitted to us each year. As a result, it would be unrealistic for us to perform a meaningful analysis of this large amount of data for payment, medical review, and quality monitoring purposes in the absence of the capability to use automated data collection. An analysis of IRF patient assessment data would allow us to use the data in a manner similar to how we use SNF patient assessment data. (See 42 CFR 413.343 and 483.20 and the July 30, 1999 SNF prospective payment system final rule (64 FR 41644).)

One use of SNF patient assessment data is to support quality of care monitoring. The SNF patient assessment data is reliable and effective in supporting early identification of potential quality of care problems.

Early identification, in turn, helps to focus the survey process on these identified problem areas.

Using SNF patient assessment data, we have developed indicators of the quality of care in SNFs. These quality of care indicators are used for internal quality improvement and public reporting to help beneficiaries make more informed decisions. The quality of care indicators are also used to support analytical evaluations of the quality of services that SNFs furnish. For example, we use MDS data to provide us with objective and detailed measures of the clinical status and care outcomes of residents in a SNF. In addition, quality of care indicators can be used to analyze the relationship between Medicare policy changes and quality of care.

Computerization of the IRF patient assessment data makes it easier and more practical for an IRF to use the patient assessment data to classify a patient into a CMG. Electronic transmission of the patient assessment data by the IRF makes the creation of an IRF patient assessment database feasible. That database, in turn, permits the data to be accessed easily in various formats for different analytical purposes, which can be used to support the Medicare program's fraud and abuse efforts, for medical

review purposes, and for uses similar to how the SNF MDS data are used.

Beginning on January 1, 2002, for Medicare Part A fee-for-service patients, IRFs must collect patient assessment data using the CMS IRF patient assessment instrument as part of the IRF's inpatient assessment process. This data collection requirement applies to Medicare beneficiaries who are already inpatients as of January 1, 2002, as well as beneficiaries admitted as inpatients on or after January 1, 2002 (§412.606(b)). In addition, IRFs must use our patient assessment instrument to assess inpatients in accordance with the assessment schedule discussed in section IV.D. of this preamble and specified in §412.610(c).

The IRFs must encode the patient assessment data by entering the data into a computer software program that we will provide at no charge to IRFs (§412.614(a)). The patient assessment data records will be considered "locked" when they have passed all of our specified edits and are accepted by the IRF patient assessment database to which the IRF transmitted its records.

IRFs also must maintain all completed Medicare patient assessments that were performed using the CMS IRF patient

assessment instrument for the previous 5 years, either in a paper format in the patient's clinical record or in an electronic computer file format that can be easily obtained (§412.610(f)). We are imposing this requirement because the assessments may be needed as part of a retrospective review conducted at the IRF for various purposes (for example, as part of the documentation that the IRF used to determine the medical necessity of the Medicare-covered services the IRF furnished). Also, completed patient assessments that are available at the IRF could be beneficial to other entities that appropriately have access to these records (for example, a State or Federal agency conducting an investigation due to a complaint of patient abuse or a suspicion of fraud). In addition, retention of the patient assessment instrument by the IRF will provide a backup to the electronic database.

We will use data from the initial patient assessment to classify patients into a CMG (§412.620(a)(3)). The CMG determines the base payment rate that the IRF receives for the Medicare-covered Part A services furnished by the IRF during the Medicare beneficiary's episode of care.

IRFs must complete a successful transmission of test patient assessment data to us by a date that we will

specify in program instructions. A successful transmission by the IRFs of test data to us is necessary to determine connectivity with the system and to identify any transmission problems. Our system will transmit a test data feedback report to each IRF indicating that the test data transmission was either completely successful or experienced problems. Problems will be specified in the test data transmission report.

We will provide training and technical support to the IRFs on administering and completing our IRF patient assessment instrument, as well as transmitting the data.

C. Documentation Requirements for the Patient Assessment

The admission patient assessment will be used to classify each Medicare Part A fee-for-service patient into a CMG, and the CMG will be used to determine the IRF payment. While the admission assessment is used to place a patient in a CMG, the discharge assessment is used to determine the relevant weighting factors, if applicable, associated with comorbidities. Section VI. of this preamble discusses comorbidities. One principle governing appropriate Medicare payment and utilization of Medicare inpatient services is that there must be documentation establishing that the inpatient services furnished to a

patient meet the requirements set forth in section 1862(a) of the Act (for example, are reasonable and necessary for the diagnosis or treatment of illness or injury) (§412.606(a) and (c)).

When the data recorded on the patient assessment instrument accurately reflect the patient's clinical status, they form the basis for documenting that services furnished to the IRF Medicare inpatient are reasonable and necessary. There may be cases in which we raise questions about the accuracy of the recorded patient assessment items and, by extension, the associated medical necessity of the services that the IRF furnished. In these cases, other provider documentation may be examined to verify the information recorded on the patient assessment instrument. Other documentation that will support the accuracy of the recorded data (and the medical necessity for the services furnished to the inpatient) must be recorded in the patient's medical record and could include, but is not limited to: (1) physician's orders; (2) physician's notes; (3) nursing notes; (4) notes from therapists; (5) diagnostic tests and their results; and (6) other associated information, such as social worker or case manager notes.

A patient's clinical status for a given time period, as indicated by the completed patient assessment instrument, must be verifiable and consistent with the clinical information independently or separately recorded in the patient's clinical record. Otherwise, inaccurately completed patient assessments might be used to classify patients into CMGs that would, in turn, form the basis for Medicare payment for medically inappropriate or unnecessary services.

Facilities must transmit each Medicare inpatient's patient assessments to us, and submit claims for Medicare payment to the fiscal intermediary, in accordance with the Medicare Part A claims processing procedures. Payment to the IRF will be made according to the CMG recorded on the claim sent to the fiscal intermediary.

D. Patient Assessment Schedule and Data Transmission

In the November 3, 2000 proposed rule, we discussed our proposal to implement the patient assessment instrument as part of the IRF prospective payment system. We included a discussion of the patient assessment schedule; what assessment items would be collected on each assessment; the penalties for late completion of assessments; the computerization of the patient assessment data; the

transmission of the patient assessment data, including the late transmission penalty; and the patient assessment instrument computer software that would be required to be used.

1. Assessment Schedule

In the proposed rule, we stated that we were proposing to require that a Medicare patient be assessed at Day 4, Day 11, Day 30, and Day 60 of his or her IRF stay, and also when the patient either is discharged from the IRF or stops receiving Medicare Part A inpatient rehabilitation services (65 FR 66325 and 66326 and proposed §412.610(c)). Given that the mean length of stay in an IRF is 15.81 days (median length of stay is 14 days), we solicited comments in the November 3, 2000 proposed rule on the benefits of mid-stay assessments, that is, the Day 11, Day 30, and Day 60 assessments. We noted that the IRF stay of a small percentage of patients is over 30 days, and an even smaller percentage of patients stay over 60 days.

In proposed §412.602, we proposed that an interrupted stay is one in which an IRF patient is discharged from the IRF and returns to the same IRF within 3 consecutive calendar days. In counting the 3 calendar day time period to determine the length of the interruption of the stay,

the first day of the start of the interruption of the stay is counted as "day 1," with midnight of that day serving as the end of that calendar day. The 2 calendar days that immediately follow would be days 2 and 3. If the patient returns to the IRF by midnight of the third calendar day, the patient would be determined to have had an interrupted stay of 3 calendar days or less. We are adopting as final the definition of interrupted stay as proposed, with further clarification that an interruption is 3 consecutive calendar days that begins with the day of discharge and ends on midnight of the third day.

We indicated that when a patient has an interrupted stay, the interrupted stay must be documented on the assessment instrument interrupted stay tracking form. The data recorded on the interrupted stay tracking form must be transmitted to our patient data system within 7 calendar days of the date the patient returns to the IRF.

We proposed that when an interruption of a patient's IRF stay occurs, it may affect the assessment reference dates, completion dates, encoding dates, and transmission dates.

Comment: We received numerous comments stating that the proposed number of assessments was excessive and

created an undue burden on the IRF. The commenters stated that they believed that assessing patients only upon the patient's admission and discharge to the IRF was sufficient to fulfill our payment classification and quality of care monitoring goals. Some of the commenters emphasized that the UDSmr patient assessment system requires patient assessment only upon the patient's IRF admission and discharge.

Response: As described more fully in the proposed rule, we believe that a patient assessment at one or more points between a patient's admission and discharge would yield valuable quality of care monitoring data. However, after analyzing the public comments that stated that our proposed method was an undue time burden, we are making changes to reduce the burden associated with our proposed assessment schedule. In this final rule, we are requiring the completion of the patient assessment instrument only upon the patient's admission and discharge, for a total of two assessments (§412.610(c)).

In addition to requiring the completion of the patient assessment instrument upon only the patient's admission and discharge, in section IV.D.2. of this final rule, we are specifying that patient assessment data for both the

admission and discharge assessment are to be transmitted only once and at the same time (§412.614(c)). Thus, there will be only one transmission of all of the patient assessment data. To be consistent with the time requirement for transmission of the patient admission and discharge assessment data, we also are requiring that the interruption in stay data be transmitted only at the same time that the admission and discharge assessment data is transmitted (§412.618).

We agree with the commenters who stated that, by collecting IRF patient assessment data only upon the patient's admission and discharge (as approximately 85 percent of IRFs that subscribe to the UDSmr patient assessment system currently do), we can achieve our goals of appropriately classifying a patient into a CMG, and at the same time monitor the quality of care furnished to the IRF patient. In our proposed rule, we stated that we believed that in order to monitor the quality of care furnished to a patient, we needed patient data collected between the admission and discharge assessments. However, we agree with the commenters that obtaining data for quality of care monitoring, using the method employed by approximately 85 percent of IRFs that our data indicate

subscribe to the UDSmr patient assessment system, will be sufficient to meet our quality of care monitoring goal. We note that the IRF prospective payment system is a discharge-based system that pays based on the entire episode of the IRF stay. That is in contrast to the SNF prospective payment system which, because it is a per-diem based payment system, needs to have more frequent patient assessment data in order to evaluate if the prior per-diem payment rate that was previously determined based on patient assessment data is still appropriate.

Patient Assessment Instrument Dates Associated with the Admission Assessment. The following Charts 1 and 2 and the accompanying discussion illustrate application of the final patient assessment schedule and associated assessment reference date, assessment instrument completion date, assessment instrument encoding date, and assessment instrument transmission date to the admission assessment.

CHART 1.--PATIENT INSTRUMENT ADMISSION ASSESSMENT SCHEDULE AND ASSOCIATED DATES

Assessment Type	Hospitalization Time Period and Observation Time Period	Assessment Reference Date	Patient Assessment Instrument Must Be Completed By:	Payment Time Covered By This Assessment:	Patient Assessment Data Must Be Encoded By:	Patient Assessment Instrument Data Must Be Transmitted By: **
Admission Assessment	First 3 Days	Day 3*	Day 4	Entire Medicare Part A Stay Time Period	Day 10	See ** below for how to calculate this date.

*Except for some items, as discussed previously in section IV.A.3. of this preamble.
**Because all the assessment data for admission and discharge assessments must be transmitted together after the patient is discharged or stops receiving Medicare Part A services, the admission assessment data must be transmitted at the same time the discharge data are transmitted. That transmission date is by the 7th calendar day in the period beginning with the last permitted discharge patient assessment instrument "encoded by" date.

CHART 2.--EXAMPLE APPLYING THE PATIENT ASSESSMENT INSTRUMENT ADMISSION ASSESSMENT SCHEDULE AND ASSOCIATED DATES

Assessment Type	Hospitalization Time Period and Observation Time Period	Assessment Reference Date	Patient Assessment Instrument Must Be Completed By:	Patient Assessment Instrument Data Must Be Encoded By:	Patient Assessment Instrument Data Must Be Transmitted By:**
Admission Assessment	First 3 days (Patient admitted on 7/3/02)	7/5/02*	7/6/02	7/12/02	See ** below for how to calculate this date.

*Except for some items, as discussed previously in section IV.A.3. of this preamble.
**If the patient is discharged on 7/16/02, the last permitted discharge patient assessment instrument encoding date is 7/26/02, and the admission and discharge assessment data must be transmitted by 8/01/02. See Chart 3 that illustrates how to apply the patient assessment instrument discharge dates. Note that the span of time to complete the admission assessment is different from the time to complete the discharge assessment as discussed in this section IV.D. of the preamble.

Each Medicare Part A fee-for-service patient must be assessed by a clinician(s) using our IRF patient assessment

instrument to perform a comprehensive assessment according to the schedule specified above. More than one clinician may contribute to the completion of the patient assessment instrument. We believe that the accuracy of the assessment would be enhanced if the data collected for a patient assessment item were collected by a clinician with specialized training and experience in the area of the data being collected. For example, although a registered nurse could fully assess all aspects of a patient and collect all the patient assessment instrument data, a physical therapist or an occupational therapist has the specialized training that may contribute to a more accurate assessment of some neuromuscular items. Our objective is to have data collected that would best reflect the patient's unique circumstances and clinical status during the assessment observation period, considering the accuracy of patient assessment is contingent on the training and experience of the clinician assessor.

In Chart 6.--Critical Patient Assessment Items in section V.D. of this preamble, we specify the patient assessment instrument items that will be used to classify a patient into a specific CMG.

If an interruption of 3 calendar days or less occurred for the admission assessment observation time period (for example, the days specified in the "Hospitalization Time Period and Observation Time Period" column in Charts 1 and 2 illustrated previously), the associated assessment reference date, patient assessment instrument completion date, patient assessment instrument encoded by date, and patient assessment instrument transmitted by date for the admission assessment would be shifted forward by the number of days that the patient was not an inpatient of the IRF. We refer to Chart 2 to help guide the reader during our discussion of the shifting forward of dates. With regard to the admission assessment, assume that the patient's stay began with admission to the IRF on July 3, 2002, but was interrupted on July 4, 2002, which would be day 2 of the patient's IRF hospitalization. The patient returned to the same IRF prior to midnight of July 6, 2002, and had an interrupted stay of 3 calendar days. The assessment reference date observation time period for the admission assessment would be shifted to July 6, 7, and 8. (Without the interrupted stay, the admission assessment reference date observation time period would have been July 3, 4, and 5, with the assessment reference date being July 5, 2002.)

Because of the interruption in stay, the admission assessment reference date would be reset to July 8, 2002. The admission assessment completion date would be reset to July 9, 2002. The admission assessment "patient assessment instrument must be encoded by" date would be reset to July 15, 2002. The admission assessment "patient assessment instrument must be transmitted by" date would be reset to a date calculated according to the footnote for the "patient assessment instrument must be transmitted by" column in Chart 2.

In the final rule, we are revising proposed §412.610 to specify under paragraph (c)(1) the admission assessment reference dates and the admission assessment completion dates.

Patient Assessment Instrument Dates Associated with the Discharge Assessment. In this final rule, we are revising proposed §412.610(c) to specify under paragraph (2) that the assessment reference date for the discharge assessment is the actual day that one of two events occurs first: (1) the day on which the patient is discharged from the IRF; or (2) the day on which the patient ceases to receive Medicare-covered Part A inpatient rehabilitation services. Note that the day the patient ceases to receive

Medicare-covered Part A inpatient rehabilitation services includes a situation when a patient dies. The discharge assessment is performed only at the first point in time that either of these events occurs. There may be cases when a patient ceases receiving Medicare Part A inpatient rehabilitation services, but is not discharged from the IRF.

After the assessment reference date for the discharge assessment is determined, the completion date for the discharge assessment must be set. We are revising proposed §412.610(c) to include under paragraph (2)(i)(B) that the completion date for the discharge assessment is the 5th calendar day that follows the discharge assessment reference date with the discharge assessment reference date itself being counted as the first day of the 5 calendar day time period. To determine the 5th calendar day, the discharge assessment reference date is counted as day 1 of the 5 calendar days. For example, if the assessment reference date is July 16, 2002, the completion date would be July 20, 2002.

We are not using the method used to determine the completion date for the admission assessment to determine the completion date for the discharge assessment.

The reason for using a different method to determine the discharge completion date is because of the definition of an interrupted stay. Previously, we specified that, after the patient returns to the IRF after an interrupted stay, another admission assessment is not performed, and the CMG into which the patient classified prior to starting the interrupted stay is still in effect. Therefore, in order to ensure that a clinician does not perform a discharge assessment on a patient who meets the criteria of an interrupted stay, it is necessary to make the completion date of the discharge assessment a date that exceeds the interrupted stay defined time period. This safeguard prevents the performance of unnecessary discharge assessments by the IRF.

In addition, any discharge assessment that is transmitted to the CMS patient data system is used by the system to indicate that a patient is no longer hospitalized in the IRF. Therefore, if a discharge assessment that is associated with an interrupted stay is transmitted to our patient data system, it would result in our patient data system rejecting the subsequent true discharge assessment that would be transmitted when the patient is actually

discharged or stops being furnished Medicare Part A inpatient rehabilitation services.

We are revising proposed §412.610 to remove the contents of paragraph (d) that reference penalties for late completions (as discussed in section IV.D.4. of this preamble); to remove from paragraph (e) the provisions on assessment completion dates (which are now under paragraph (c)); and to specify under new paragraph (d) only encoding dates. (As conforming changes, proposed paragraphs (f) and (g) are redesignated as paragraphs (e) and (f), respectively.)

We are providing that the discharge assessment "must be encoded by date" is the 7th calendar day in the period beginning with the determined discharge completion date. To determine the 7th calendar day, count the discharge assessment completion date as day 1 of the 7 calendar days. For example, if the discharge assessment completion date is July 20, 2002, the assessment must be encoded by date would be July 26, 2002.

In this final rule, we also are revising proposed §412.614(c) to specify that the discharge assessment "must be transmitted by date" is the 7th calendar day in the period beginning with the discharge assessment "must be

encoded by date". To determine the 7th calendar day, count the discharge assessment "must be encoded by date" as day 1 of the 7 calendar days. For example, if the discharge assessment "must be encoded by date" is July 26, 2002, the assessment "must be transmitted by date" would be August 1, 2002.

Chart 3 below illustrates the discharge assessment dates discussed above:

CHART 3.--EXAMPLE APPLYING THE PATIENT ASSESSMENT INSTRUMENT DISCHARGE ASSESSMENT DATES

Assessment Type	Discharge Date*	Assessment Reference Date	Assessment Instrument Must Be Completed On:	Assessment Instrument Data Must Be Encoded By:	Assessment Instrument Data Must Be Transmitted By:
Discharge Assessment	7/16/02*	7/16/02**	7/20/02	7/26/02	8/01/02

*This is either: (1) the day the patient is discharged from the IRF; or (2) the day the patient ceases receiving Medicare-covered Part A inpatient rehabilitation services.
**Except for some items, as discussed previously in section IV.A.3. of this preamble.

Comment: Some commenters believed that the IRF prospective payment system policies should only apply to patients admitted to an IRF on or after the implementation date of the IRF prospective payment system. They did not believe that the IRF prospective payment system policies should apply to patients who were admitted prior to implementation of IRF prospective payment system, and are

still patients on the day the IRF prospective payment system is effective.

Response: Because the IRF prospective payment system is a discharge-based system, payment is made to the IRF based on the entire episode of stay of the patient in the IRF. Therefore, any IRF that discharges any patient after the IRF prospective payment system is implemented must be paid according to the IRF prospective payment system policies. Consequently, we are adopting as final the "Assessment Rule to Use if Medicare Beneficiaries Are Receiving IRF Services on the Effective Date of the Regulation" policy (65 FR 66328) we proposed in the proposed rule.

2. Data Items to be Collected

In the proposed rule, we specified a list of data items that we were proposing to be collected for Day 4, Day 11, Day 30, and Day 60 of an admission and at discharge (65 FR 66328-66330).

Comment: As stated previously, many commenters urged us to use the FIM as the patient assessment instrument. In addition, the commenters urged us to collect the patient assessment data according to the same schedule as the UDSmr uses for the FIM.

Response: In sections IV.A. and B. of this preamble, we state that the patient assessment instrument we are adopting in this final rule is more similar to the UDSmr patient assessment instrument. We also state under this final rule that we are requiring IRFs to collect patient assessment data in a manner similar to how the UDSmr patient assessment data are collected, that is, only upon the admission and discharge of the patient. However, as we specified in the proposed rule (under proposed §412.610(c)(5)) and as we are adopting in this final rule under §412.610(c)(2)(ii), if the patient stops receiving Medicare Part A inpatient rehabilitation services before being discharged from the hospital, for purposes of the discharge assessment, the day that the patient stops receiving Medicare Part A services becomes the discharge day. In other words, in this situation the day that the patient stops receiving Medicare Part A services is the day to use as the discharge day. The net effect is that the patient is still only assessed twice during the patient's IRF stay. We note that the IRF is only required to collect patient assessment data on Medicare Part A fee-for-service patients.

The IRF must record the items in the identification information, admission information, and payer information sections of the patient assessment instrument only once on the assessment instrument, and must transmit these items to the CMS patient data system when all of the admission and discharge assessment data are completed. Once entered into the computerized version of the assessment instrument, that data will be retained in the computerized version, negating the need to enter the same information again. Data for the other sections of the patient assessment instrument will be collected only upon the patient's admission or discharge as appropriate; the patient assessment instrument clearly delineates which items are collected upon admission and which are collected upon discharge.

The proposed rule contained a table entitled "Table 7C.--MDS-PAC ITEMS REQUIRED BY TYPE OF ASSESSMENT". That table specified the data items that would be collected during the admission, update, or discharge assessment. Chart 4 below (a replacement for proposed Table 7C) is a category, sub-category, item name, and item number specification of the data items that are to be collected for the admission assessment and the discharge assessment. As would be expected, the data for all of the items will be

recorded during the admission assessment, with the logical exception of the items for which data can only be recorded upon the patient's discharge. The "X" in the admission or discharge column indicates if that item is collected upon the admission or discharge assessment. Chart 4 takes into account that the admission assessment items associated with the patient assessment instrument categories of data related to patient identification, admission information, payer information, medical information, medical needs, function modifiers, FIM instrument, and quality indicators will be retained in the data fields of the computerized version (software) of the patient assessment instrument. Therefore, there are many data items that are not collected during the discharge assessment, but because the data items are retained in the patient assessment software, will also be transmitted when the discharge assessment items are completed and the entire assessment instrument is transmitted.

CHART 4.--PATIENT ASSESSMENT ITEMS

BY TYPE OF ASSESSMENT

ITEM CATEGORY, ITEM SUB-CATEGORY, ITEM NAME, ITEM NUMBER	ADMISSION ASSESSMENT	DISCHARGE ASSESSMENT
IDENTIFICATION INFORMATION*		
1. Facility Information		
A. Facility Name	X	
B. Facility Medicare Provider Number	X	
2. Patient Medicare Number	X	
3. Patient Medicaid Number	X	
4. Patient First Name	X	
5. Patient Last Name	X	
6. Birth Date	X	
7. Social Security Number	X	
8. Gender	X	
9. Race/Ethnicity (Check all that apply):		
American Indian or Alaska Native	X	
Asian	X	
Black or African American	X	
Hispanic or Latino	X	
Native Hawaiian or Other Pacific Islander	X	
White	X	
10 Marital Status	X	
11. Zip Code of Patient's Pre-Hospital Residence:	X	
ADMISSION INFORMATION*		
12. Admission Date	X	
13. Assessment Reference Date	X	
14. Admission Class	X	
15. Admit From	X	
16. Pre-Hospital Living Setting	X	
17. Pre-Hospital Living With	X	
18. Pre-Hospital Vocational Category	X	
19. Pre-Hospital Vocational Effort	X	
PAYER INFORMATION*		
20. Payment Source		
A. Primary Source	X	
B. Secondary Source	X	
MEDICAL INFORMATION*		

ITEM CATEGORY, ITEM SUB-CATEGORY, ITEM NAME, ITEM NUMBER	ADMISSION ASSESSMENT	DISCHARGE ASSESSMENT
21. Impairment Group	X	X
22. Etiologic Diagnosis:	X	
23. Date of Onset of Etiologic Diagnosis	X	
24. Comorbid Conditions:		
A.	X	X
B.	X	X
C.	X	X
D.	X	X
E.	X	X
F.	X	X
G.	X	X
H.	X	X
I.	X	X
J.	X	X
MEDICAL NEEDS		
25. Is patient comatose at admission?	X	
26 Is patient delirious at admission?	X	
27. Swallowing Status:	X	X
28. Clinical signs of dehydration	X	X
FUNCTION MODIFIERS*		
29. Bladder Level	X	X
30. Bladder Freq.	X	X
31. Bowel Level	X	X
32. Bowel Freq.	X	X
33. Tub Transfer	X	X
34. Shower Transfer	X	X
35. Distance Walked (feet)	X	X
36. Distance Traveled in Wheelchair (feet)	X	X
37. Walk	X	X
38. Wheelchair	X	X
FIM INSTRUMENT*		
SELF-CARE		
A. Eating	X	X
B. Grooming	X	X
C. Bathing	X	X
D. Dressing – Upper	X	X
E. Dressing – Lower	X	X
F. Toileting	X	X
SPHINCTER CONTROL		
G. Bladder	X	X
H. Bowel	X	X
TRANSFERS		
I. Bed, Chair, Wheelchair	X	X
J. Toilet	X	X
K. Tub, Shower	X	X
LOCOMOTION		
L. Walk/Wheelchair	X	X

ITEM CATEGORY, ITEM SUB-CATEGORY, ITEM NAME, ITEM NUMBER	ADMISSION ASSESSMENT	DISCHARGE ASSESSMENT
M. Stairs	X	X
COMMUNICATION		
N. Comprehension	X	X
O. Expression	X	X
SOCIAL COGNITION		
P. Social Interaction	X	X
Q. Problem Solving	X	X
R. Memory	X	X
DISCHARGE INFORMATION*		
40. Discharge Date		X
41 Patient discharge against medical advice:		X
42. Program Interruptions		X
43. Program Interruption Dates		
A. 1st Transfer Date		X
B. 1st Return Date		X
C. 2nd Transfer Date		X
D. 2nd Return Date		X
E. 3rd Transfer Date		X
F. 3rd Return Date		X
44A. Discharge to Living Setting:		X
44B. Was patient discharged with Home Health Services?		X
45. Discharge to Living With:		X
46. Diagnosis for Transfer or Death:		X
47. Complications during rehabilitation stay		
A.		X
B.		X
C.		X
D.		X
E.		X
F.		X
QUALITY INDICATORS		
RESPIRATORY STATUS		
48. Shortness of breath with exertion	X	X
49. Shortness of breath at rest	X	X
50. Difficulty coughing	X	X
PAIN		
51. Rate the highest level of pain reported by the patient within the assessment period	X	X
PUSH SCALE		
Pressure Ulcers		
52A. Highest current pressure ulcer stage	X	X

ITEM CATEGORY, ITEM SUB-CATEGORY, ITEM NAME, ITEM NUMBER	ADMISSION ASSESSMENT	DISCHARGE ASSESSMENT
pressure ulcer stage		
52B. Number of current pressure ulcers	X	X
52C. Length multiplied by width (open wound surface area)	X	X
52D. Exudate amount	X	X
52E. Tissue type	X	X
52F. Total Push Score	X	X
SAFETY		
53. Total number of falls during the rehabilitation stay		X
54. Balance problem	X	X

* The FIM data set, measurement scale and impairment codes incorporated or referenced herein are the property of U B Foundation Activities, Inc. ©1993, 2001 U B Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.

The IRF must collect the patient assessment data upon admission and discharge, but must transmit the patient assessment data only one time to our patient data system. This transmission will contain all the admission data and the discharge data.

In the proposed rule, we named the patient data system to which the IRF would transmit its patient assessment data the "HCFA MDS-PAC system". Because we are using a patient assessment instrument that is different from the MDS-PAC, we are renaming the HCFA MDS-PAC system "the CMS Patient Data System." The IRF will still encode the patient data into a computerized version of the patient assessment instrument. Also, the computer program will use the

encoded admission assessment data to classify a patient into a CMG.

3. Data Transmission

a. Computerization of Patient Assessment Data

In the proposed rule, we specified that the data for all MDS-PAC specified assessments must be encoded. Encoding the data means entering the data into the IRF's computer using appropriate software, including performing data edits. In §412.610(e)(3), we proposed that IRFs encode and edit the data for Medicare patients within 7 calendar days of the date that the MDS-PAC is completed. We proposed to specify a maximum of 7 calendar days because we believed that this is a reasonable amount of time for IRFs to complete these tasks (65 FR 66330).

In §412.610(f) we proposed that the encoded data must accurately reflect the patient's status at the time the data are collected. Because the patient's clinical status may change over time, the data must accurately represent a patient's clinical status as of a particular assessment reference date. Before transmission, the IRF must ensure that the data items on the paper copy match the encoded data that are sent to our patient data system. We also proposed to require that once the clinician(s) complete the

assessment using either a paper copy of the instrument or an electronic version, the IRF must ensure that the data encoded into the computer and transmitted to our system accurately reflect the data collected by the clinician.

b. Transmission of Data

The IRF must have a system that supports dial-up communication for the transmission of the patient assessment instrument data to our system. The patient assessment data will be submitted to our system via the Medicare Data Collection Network (MDCN). The MDCN is a secured private network. Specific instructions and telephone numbers will be provided to the IRFs in order for the IRFs to be able to access the MDCN.

We will utilize the most current technology capable of maintaining the security of the patient data (for example, encryption technology) in order to ensure the security of the information transmitted to and from our system. For security purposes, there are two levels of user authentication required. For the first level, to obtain access to the MDCN, the IRF must obtain an individual network-identification code for each person submitting the data to our system. The CMS system administrator or our agents distribute this identification code. Then, to

obtain access to our data system, an IRF must also obtain a facility-identification code from our system administrator. The IRF must transmit the patient assessment data via the MDCN secured lines to our data system. At that time, the data will be checked to ensure it complies with our system data formatting specifications.

In §412.614, we proposed to require that the IRF electronically transmit to our patient data system accurate, complete, and encoded data for each Medicare patient. We also proposed that the data must be transmitted in a format that meets the general requirements specified in §412.614. We believed that once the patient assessment data are encoded and edited, it is a relatively simple procedure to complete the preparation of the data for transmission to our system. Therefore, we proposed that encoded and edited data that have not previously been transmitted, must be transmitted within 7 calendar days of the day by which the data must be encoded as specified in the assessment schedule and associated dates (Charts 1 and 3 in section IV.D. of this preamble). In addition, we proposed that the data must be transmitted in a manner that meets the locked data criteria specified in the proposed rule. At the end of the transmission file, an entry

concerning the number of records being transmitted is required to complete the transmission process.

As specified in section IV.D.2. of this preamble, we are changing the proposed patient assessment schedule so that a patient is now assessed only at admission and upon discharge. As a result of this revision, in this final rule we are revising proposed §412.614(c) to reflect transmission dates that conform to the schedule admission and discharge assessment and encoding dates.

c. Patient Instrument Computer Software

In the proposed rule under §412.614(c), we proposed that the IRF encode and transmit the MDS-PAC data using the software available from us or other software that conforms to our standard data specifications, data dictionary, and other data requirements specified by us, and that includes the data items that match the most updated version of the patient assessment instrument. We indicated that our Minimum Data Set for Post-Acute Care Tool (MPACT) software would be able to be used for several purposes, such as to encode data, to maintain IRF and patient-specified information, to create export files to submit data, and to test alternative software. The MPACT software would provide comprehensive on-line help to users in encoding,

editing, and transmitting the data. Additionally, there would be a toll-free hotline to support this software product.

Comment: Several commenters requested more information regarding the IRF patient assessment data test transmission that we will conduct.

Response: Because we were not able to publish a final rule prior to February 1, 2001, we were not able to have IRFs conduct a patient data test transmission during February 2001 as stated in the proposed rule. At this time, we have not finalized when the test transmission time period will occur. We will train the IRFs on the CMS IRF patient assessment instrument and the patient assessment process. During that time, we will provide the IRFs with specifics about the patient data test transmission process.

4. Penalties for Late Assessments

In the proposed rule, we proposed that the assessment is late if the assessment is not in accordance with the assessment reference date specification for the Day 4 assessment and outlined the penalties (65 FR 66330; §412.614(d)). We stated that, if the IRF transmits the patient assessment data late, the IRF would be paid either a reduced CMG-determined payment or no CMG-determined

payment. We proposed that the CMG-determined payment be reduced by 25 percent if the IRF transmitted the patient assessment data 10 or less calendar days late. We also proposed that if the IRF transmitted the patient assessment data more than 10 calendar days late, the IRF receives no payment for the Medicare Part A services the IRF furnished.

Comment: Several commenters stated that the penalties associated with late completion and late transmission of the patient assessment data were too harsh.

Response: In the proposed rule, we proposed a penalty for late completion of the MDS-PAC assessment. As specified in section IV.D.2. of this preamble, we are changing the assessment schedule so that the patient is only assessed upon admission and discharge. In addition, in this final rule, we are specifying that both the admission and discharge patient assessment data must be transmitted together. Because of these changes the focus of our patient assessment data monitoring will be the assessment reference date and the data transmission date, instead of the instrument completion date. In addition, as stated previously, we are deleting the proposed assessment attestation section of the patient assessment instrument. The attestation section was the basis for the completion

penalty, because it contained the date on the assessment instrument form that specified when the data for all of the assessment instrument items had been recorded on the patient assessment instrument. Thus, the date on the proposed attestation section was the basis for determining the date when the assessment instrument had been completed. The result of eliminating the proposed attestation section is that the completion date that the IRF would record on the assessment instrument form that indicated when all of the assessment items had been completed is also eliminated. In order to have a completion penalty, there must be a completion date specified on the assessment form. For these reasons the completion penalty is eliminated. However, the IRF must still complete the CMS IRF patient assessment instrument in accordance with the calendar date specifications contained in this final rule.

After analysis of the public comments we received, we have decided to revise the transmission penalty. In the proposed rule, we proposed that "late transmission" meant the IRF did not transmit MDS–PAC data in accordance with the transmission timeframes specified in Table 4C of section III. of the proposed rule. The payment penalties we proposed are described above under item 4.

As specified in section IV.D.2. of this preamble, we are changing the patient assessment schedule so that a patient is now assessed only at admission and upon discharge. In addition, we are specifying that for each IRF stay, the patient assessment data will be transmitted only once. Because of the change in the patient assessment schedule, we no longer need the data to be transmitted more frequently. This less frequent assessment of the patient and transmission of the patient assessment data will reduce the time burden associated with the assessment process as requested by many commenters. Because of the changes to the patient assessment schedule, we are revising the specifications of what constitutes a late transmission. In this final rule, "late transmission" means the IRF did not transmit the patient assessment data in accordance with the transmission timeframes specified in Charts 1, 2, and 3 of section IV.D. of this final rule. In addition, we are persuaded by the commenters that the transmission penalty as proposed in the proposed rule, and described above under item 4, is too harsh. It is appropriate for the IRF to be paid some amount for the treatment the IRF furnished to the patient. To address the commenters' concern, we are reducing the amount of the penalty so that the IRF is paid

some of the CMG associated payment for the patient care the IRF furnished (§412.614(d)).

In this final rule under §412.614(d)(2), we are specifying that if the IRF transmits the patient assessment data more than 10 calendar days late, the IRF will be paid a CMG-determined payment that will be reduced by 25 percent. There will not be any other penalty associated with late transmission.

E. Quality Monitoring

Before we present our specific strategies for quality monitoring in IRFs, we want to discuss our conceptual framework for understanding and advancing quality in the setting of IRFs, as well as other post-acute care settings.

The degree of efficiency of any process that produces a service is measured by the span of time, the amount of resources, and the type of resources consumed to produce the service. The degree of effectiveness of the service is measured by the change that occurs when that service process is applied. The concept "quality of care" refers to the relationship between patient treatment (a service) efficiency and the resulting effect of that treatment process. Therefore, to measure the relationship (quality of care), we must collect and quantify both before and

after treatment patient assessment data so that the correlation or consequences due to the efficiency (time, amount and type of resources used) and the effectiveness (outcomes) of the patient treatment process can be evaluated.

To help promote efficiency in the rehabilitation treatment process, the IRF prospective payment system methodology uses historical data to determine a payment amount that, given the patient's clinical status, is representative of what we consider to be an appropriate use and mix of available treatment resources. To measure the relationship (that is, the quality of the care furnished) between the IRF treatment process resources used (and paid by Medicare) and the effects of the treatment process, we need to use generally acknowledged measures that indicate the results that are due to the treatment the patient was furnished. At a minimum, these measures must indicate that the patient's health and safety are being fostered. In addition, the measures should reveal changes in the patient's capabilities, with the changes reflecting the impact of the treatment process. The changes can be measured by changes in the patient's functional (motor), cognitive, and emotional status.

The CMS IRF patient assessment instrument can be used to record (code) the patient's diseases and injuries. The patient assessment instrument focuses on generalized changes in a patient's functional, cognitive, and emotional status in response to the treatment furnished, as opposed to focusing on the impact of the application of a specific disease or injury treatment process. We note that we are exploring the potential for developing disease-specific quality of care measures.

When measuring changes in the patient's functional, cognitive, emotional, or lifestyle status, a determination must be made if the changes reflect good or bad patient care. Therefore, the changes must be compared to either a predetermined standard or, because we believe that facility comparison promotes competitiveness which leads to enhanced quality, to similar patients treated in other but similar treatment facilities.

Determining if a predetermined generally accepted standard of good care has been met means that the quality of care indicators must demonstrate that the patient care techniques used promoted a positive change in the patient's health. Examples of such patient care techniques include ensuring that the patient consumes appropriate amounts and

types of food and fluid, the prevention of patient injury (for example, falls and pressure ulcers), the prevention of the exacerbation of existing injuries (for example, pressure ulcers), or enhancing the caliber of patient's lifestyle (for example, by preventing or mitigating pain). Therefore, to measure the relationship (quality of the care furnished) between the treatment resources used and resulting patient outcomes, we need to: (1) be able to compare similar patients in similar facilities; and (2) have the ability to determine if some basic patient care, patient safety, and lifestyle enhancement measures are being implemented during the patient's treatment.

From the above discussion, it is clear that quality of care is complex, sometimes difficult to define, and is multidimensional in nature. One dimension is that the care achieve its intended result, which in the context of the IRF setting is most often to improve the patient's functioning in order to foster more independent living. A second dimension of quality is the prevention of avoidable complications or other adverse events and minimizing the effects of adverse events. A third related dimension is to improve management of the patient's medical impairments, with the goal being to promote "improved" health as well as

function, or at least to improve the management of the patient's medical conditions. In addition, it is important to use data to identify other sentinel events. Identifying these potentially negative impacts to care allows us to perform root cause analysis and determine solutions to prevent them from reoccurring. Our specific quality monitoring processes should be developed in a way that supports this multidimensional view of quality.

The consequences of detecting possible quality of care problems through IRF data are varied and could include--(a) increasing educational efforts to beneficiaries to help them make better informed selections of providers; and (b) improving the survey and oversight of IRFs and accrediting organizations. An IRF's staff may use quality of care information from our patient assessment instrument for their own quality assurance and, ultimately, quality improvement activities. We also have the potential to develop refinements to the case-mix methodology which provide incentives for improving quality.

As our payment policies continue to evolve, our objective is to move forward with a quality assessment and improvement agenda that is based on standardized data, beneficiaries' clinical characteristics, and patient care

outcomes. To achieve that objective, we need to collect common data elements and develop standardized assessment tools that will enable us to focus on beneficiary care needs rather than the characteristics of the provider. We believe that the most important short-term goal of post-acute care quality monitoring is to assess the effects of implementing the changes in the payment system on the quality of care furnished in post-acute care settings.

We are aware of MedPAC's concern that we may have only a limited ability to assess the impact of Medicare payment changes that either have been implemented or will soon be initiated--for example, the IRF prospective payment system. There is a need to enhance our ability to assess this impact in order to improve the policies associated with our Medicare prospective payment systems.

In its March 2000 Report to Congress, MedPAC states that "Quality monitoring systems could help ensure that payment systems are designed correctly and that providers are responding appropriately to the systems' incentives, and could also be used to accomplish several other important objectives." (page 62) MedPAC believes that such information "could assist in tracking trends over time, or provide an early warning of impending problems in quality",

and further indicated that "Attaining any of these ends requires routine, systematic measurement of health care quality." (page 62) We believe that our current patient assessment instrument is another step in the development of the process for monitoring quality of care in IRFs.

The nonpayment-related items in our instrument are necessary to provide an inventory of patient factors that are necessary to monitor quality and assess risk. These data can be used by facilities to identify patients at risk for adverse outcomes. In addition, our patient assessment instrument data may contribute to development of the patient care plan. Information collected can identify patients at risk for adverse outcomes, such as weight loss, aspiration, or pressure ulcers, and support the monitoring of these patients to prevent outcomes that might negatively impact patients' likelihood of optimal rehabilitation.

We believe that the data collected by our patient assessment instrument can be used to monitor the impact of the IRF prospective payment system upon IRFs and beneficiaries, including beneficiary access to care. Section 125 of the BBRA directs the Secretary to conduct a monitoring study, and to submit a report to the Congress no later than 3 years from the date that the IRF prospective

payment is implemented. To both monitor the impact of the IRF prospective payment system on IRFs and beneficiaries, and support this BBRA-mandated report to the Congress, we need a data-driven monitoring system that will give us the capability to acquire objective (as opposed to anecdotal) data for analysis.

The discharge assessment will provide data about a patient's clinical status at discharge and give us the ability to compare a patient's clinical status at discharge with the patient's clinical status at the admission assessment. Comparison of the patient's clinical status at admission and at discharge will give us the data to analyze the relationship between any changes in the patient's clinical status and the quantity and effectiveness of the services the IRF furnished to the patient. That comparison will provide us with data that will indicate the quality of the IRF services furnished, and if an IRF was not furnishing the level of Medicare-covered services the patient needed.

Many studies have examined overall and condition-specific functional gain from admission to discharge as a measure of the effectiveness of a rehabilitation program. National benchmarks of functional gain have been used by

providers to measure their performance relative to other facilities. In addition, some work has also been devoted to understanding providers' efficiency by linking measures of length of stay and functional gain.

The data associated with each patient assessment item will enhance our ability to monitor and, thus, safeguard the quality of care that beneficiaries receive. A quality of care improvement monitoring system that is based on our IRF patient assessment instrument data is consistent with other information-based quality monitoring programs, such as the ORYX process used by the JCAHO.

While only some assessment items will be used to determine the CMG, we believe that the data provided by all assessment items are an essential first step in developing the type of quality monitoring system that both MedPAC and our favor. Possible uses of the data include: (1) strengthening existing quality assurance mechanisms; (2) generating indicators that will allow providers to assess their performance, and to compare it against benchmarks derived from standards of care or the performance of peers; and (3) creating a system that assists beneficiaries in making informed decisions when choosing among providers. In addition, the patient assessment items may be useful in

developing core measures that provide meaningful information on patient characteristics and outcomes across post-acute care settings.

1. Monitoring the IRF Prospective Payment System

We are planning a system that can be used to monitor access to rehabilitation facilities as well as to monitor the quality of the care delivered in these facilities. This will be done through the monitoring of payment for the care and the associated cost of the delivered care. Monitoring will include variables such as length of IRF stay, percent of IRF discharges to SNF, long-term care hospital, or intensive outpatient rehabilitation programs, change in motor function between admission and discharge, and the case-mix distribution of the facility. We plan to examine changes within "market areas" as well as individual facilities.

In addition, we will be developing a variety of methods for monitoring the impact of the IRF prospective payment system. Monitoring may describe changes in access to rehabilitation, in payments to rehabilitation facilities, in quality of care, and in the cost of rehabilitation care. This monitoring will also help to identify unintended changes in the operations of providers,

and help to identify refinements needed in the IRF prospective payment system. In addition, because the IRF prospective payment system may have effects on non-IRF providers, and because changes in the payment systems for other providers may affect IRFs once common core data elements are required across post-acute care providers and linked with other data, the monitoring system could also describe changes in access, utilization, quality, and cost of care in different types of post-acute care sites, including, but not limited to HHAs and SNFs. We could start these activities in approximately 2 years.

2. Quality Indicators

Quality indicators are markers that indicate either the presence or absence of potentially poor facility care practices or outcomes. The development of quality indicators depends on the collection and analysis of sufficient patient assessment data from a representative national sample. We are attempting to design a monitoring system that would not only describe quality indicators, but also show how they can be used together to obtain a clear description of access, outcomes, and cost in IRFs. Quality indicators will be developed around the different dimensions of quality discussed earlier in this section.

We believe that quality indicators developed for individual IRFs would help identify the IRFs that require attention because they may be coding incorrectly or providing lower quality care. Analysis of the distribution of hospital indicators within specific classes of hospitals (for example, teaching hospitals and rural hospitals) will help us to evaluate whether facility level adjustments are warranted.

We will decide which quality indicators we will use to evaluate IRF quality of care outcomes based on the results of a contractor's analysis of patient assessment instrument data. Quality indicators are not direct measures of quality but rather point towards potential areas that require further investigation. Quality indicators identify the percent of a patient population with a certain condition and compare this percent to a state level and a national level. If a facility "flags" for scoring "high" on a particular quality indicator, this does not necessarily mean that the facility has a quality of care problem but simply that further focused review of care practices may be required. Quality indicators have already been developed by the University of Wisconsin for use in SNFs and are being effectively used by State surveyors to

target facilities for closer onsite review of care practices as well as by some nursing homes to identify potential problems within their facility.

We have already begun consideration of quality indicators that may be created from IRF patient assessment data to evaluate care delivered in IRFs. However, we note that, due to the quality monitoring developmental process and the time needed to develop quality indicators and benchmarking information, quality monitoring based on the patient assessment instrument will not be implemented for at least 2 years. We agree with MedPAC's view that quality monitoring efforts be closely coordinated across different types of post-acute care providers. We expect to develop measures to be applied across different settings. We anticipate that measures of functional improvement from admission to discharge will be examined. In addition, during calendar year 2001, the infrastructure to collect the data to identify quality indicators for IRFs will be under development. Field validation of these indicators is expected to begin in FY 2003. Once the indicators have been field tested, we can begin to utilize these data to monitor quality. The next step will be validation of the assessment data. Piloting the reporting of data will be

ongoing during this time period. "Tool kits" will be developed for targeted interventions to address common quality issues in IRFs. Examples of quality indicators currently being considered for IRFs are described below.

a. Functional Independence

The main goal of an IRF is to assist the patient in regaining his or her prior level of functional ability. A measure of the quality of a rehabilitation program is the patient's ability to function independently upon discharge to the community. Using our IRF patient instrument assessment data, we believe it will be possible to measure the percent of all cases discharged to the community who are functionally independent or whose functional status has improved at the time of discharge.

Functional independence on the patient assessment instrument would be measured using the functional modifiers and FIM instrument sections of the instrument. A patient's progress can be evaluated with respect to thresholds or milestones, developed after analysis of data collected during rehabilitation stays rather than based upon theoretical assumptions. The data also will assist in the development of quality indicators to predict the types of patients who have the best prognosis for improvement in

rehabilitation programs. In addition, this information may encourage referrals to IRFs for patients who might otherwise not have been referred. The data derived from functional information may also serve to better match patients with program characteristics to "fine tune" the delivery of rehabilitation services.

Additional items on our patient assessment instrument will allow the facility to consider factors that may affect a patient's ability to return to his or her previous level of functional ability or live independently in the community. Indicators based on functional gain will be useful in public reporting to help beneficiaries make more educated decisions about the facility from which they choose to receive care. In addition, PROs may be able to use the data from successful IRFs to identify factors that are better at assisting patients in achieving functional independence and returning to the community. This information can be shared with other IRFs to help improve their success rate as well.

b. Incidence of Pressure Ulcers

Pressure ulcers (also known as decubitus ulcers) are a problem in IRFs as well as in other post-acute care and acute care settings. Pressure ulcers will be documented

using the PUSH scale developed by the National Ulcer Advisory Panel. Many facilities are already using this scale and laud its ability to present a true picture of the pressure ulcer status in a facility. In some situations, the patient is admitted with these ulcers. IRFs cannot be held responsible for ulcers that were present upon admission, but if these ulcers increase in size or grade, or if new ulcers develop, this can be an indicator of poor quality of care. Information about pressure ulcers would be collected in the quality indicators section of our patient assessment instrument. Information about bed mobility and transfer ability, bladder incontinence, and nutritional status is useful in identifying patients at high risk for developing new pressure ulcers. A pressure ulcer quality indicator could be used by the facility to institute such measures as staff training or more attention to techniques and equipment intended to prevent the development of pressure ulcers (such as frequent change of position of patients unable to move themselves and use of pressure relieving devices). In addition, quality indicators at the facility and State level can be compared to national averages for a better understanding of a facility's performance relative to its peers. Focused review will

help identify which factors are contributing to the higher incidence of pressure ulcers. Analysis of patient assessment data can also be used to identify facilities that are successful in resolving and treating existing pressure ulcers. These facilities may have effective pressure ulcer reduction programs in place that can be shared with other facilities that are experiencing difficulty treating and reducing the incidence of pressure ulcers. Public reporting of the rate of pressure ulcers based on quality indicator information may help consumers make more informed choices when choosing a facility.

c. Falls Prevention

Falls prevention is an important component of a rehabilitation program and is critical to avoiding repeat hospitalizations which, in turn, delay return to independence. Items in our patient assessment instrument such as balance, dizziness, and falls provide critical information regarding fall risk to help facilities identify patients who may be at risk for falls. This indicator may also be used to identify facilities with poorer track records in fall avoidance. Information about falls prevention also provides information so that facilities serving different types of patients can be distinguished.

PROs may also use these data to teach facilities how to better identify patients at risk for falls and set up programs to reduce the incidence of falls through such methods as low beds or better monitoring of at-risk patients.

As illustrated by these examples, there are several ways the quality information gathered through our patient assessment instrument may be used. As noted, quality indicator data do not necessarily illustrate that a facility is providing a lower level of care, but this information can be useful in targeting facilities for closer review of their patient care practices and facility layout. Quality indicators can also be used to identify facilities with best practices. Identifying how these facilities maintain a high-quality level of care may provide valuable information to assist facilities.

3. Quality Improvement

Quality assurance involves the establishment of standards and having a system to enforce compliance with these standards. Quality improvement fosters and facilitates continuous enhancement of whatever service or product an organization is engaged in or produces. The JCAHO require facilities to have quality improvement

programs. Currently, the Medicare conditions of participation require hospitals to do quality assurance, which we believe can be supported with the information obtained from the IRF patient assessment instrument. The proposed change in these conditions for hospitals would require hospitals, including IRFs, to have quality improvement programs (62 FR 66726, December 19, 1997). Also, we are identifying opportunities in which PROs can use their expertise and skill mix to provide valuable information on quality improvement to post-acute care providers. For example, PROs have been working with SNFs for the past year, and feedback from the SNFs has indicated that the information shared by the PRO in a penalty-free environment has been valuable in helping the SNFs learn how to use the MDS to identify their own opportunities for quality improvement. In addition, many IRFs already have data-based quality improvement systems addressing some aspects of quality. PROs may build on their experience in SNFs and on the experience of IRFs and become a resource on how to use information derived from our patient assessment instrument to identify potential quality concerns. Quality improvement activities may include providing each facility with information derived from its submissions of its

patient assessment data for use in self-monitoring, providing facilities with information comparing their performance with that of their peers, and maintaining a clearinghouse of "best practices" that can be used by facilities to improve the quality of care they deliver.

IRFs may also use data from our patient assessment instrument to generate quality indicators on their own, and use this information to help them target specific problems within their facility, or identify areas where quality improvement projects may be most effective. IRFs can also use the data from our patient assessment instrument to perform their own monitoring of changes in quality of care within the facility.

Comment: Many commenters questioned the reliability and validity of the patient assessment items that we had proposed to use for quality of care monitoring.

Response: The patient assessment items that we had proposed for monitoring quality of care in IRFs were (1) being used by us to monitor quality of care in other post-acute settings; (2) the items that resulted from our extensive MDS-PAC pilot and field testing; or (3) the result of the consensus of the Technical Expert Panel. However, in accordance with our statement in the proposed

rule that we would conduct further study of the patient assessment instrument, after publishing the proposed rule we conducted additional field testing of all the MDS-PAC items.

In order to reduce the burden imposed by our patient assessment instrument, we have greatly decreased the number of items. The CMS IRF patient assessment instrument is now very similar to the UDSmr patient assessment instrument, because we used the UDSmr patient assessment instrument as the foundation for our assessment instrument. Our data indicate that approximately 85 percent of IRFs currently use the UDSmr patient assessment instrument to assess their patients.

As stated in the proposed rule, an independent panel of technical experts highlighted areas of concern regarding the FIM's accuracy in predicting costs for patient care. Panelists were concerned that the scoring of some items, such as cognitive functioning, gave raters a great deal of discretion in determining what evidence was used in the assessment and how often the behavior had occurred. These technical experts also agreed that a functional status assessment for payment purposes should be based on clinical observation of performance rather than on the rater's

assessment of the patient's capacity to perform the task.

In order to address these and other concerns, a special study was completed to assess the validity and reliability of the MDS-PAC and the FIM instruments. This special study was also completed in accordance with our statement in the proposed rule that we would be conducting additional testing of the MDS-PAC and the FIM.

In the proposed rule, we proposed to use the MDS-PAC as the patient assessment instrument for payment purposes. We qualified our proposal by indicating that we were in the process of performing a special study to assess the reliability and validity of both these instruments. We further indicated that the findings of this study would inform our final decisionmaking process regarding the instrument of choice for implementing the inpatient rehabilitation payment system.

Our study was in a sample of facilities that are currently using UDSmr's FIM patient assessment instrument. These facilities completed the UDSmr instrument and the MDS-PAC on the same patient at the same time. We then compared the results of this paired assessment to determine the capability of the MDS-PAC instrument to accurately and

consistently assign CMGs and whether the MDS-PAC assigns the same CMGs as the UDSmr instrument would.

The purpose of this study was not only to assess the accuracy of the MDS-PAC for classifying cases into CMGs, but also to determine the time it would take clinicians to administer the FIM and the MDS-PAC, the accuracy of coding of comorbidities, and a comparison of the validity, reliability, and consistency of the FIM and the MDS-PAC. The following summarizes the findings from this study:

? Interrater reliabilities were higher on the FIM than on the MDS-PAC.

? The FIM and MDS-PAC functional and cognitive scores were able to produce the same case-mix groups 53 percent of the time and a comparison of a more FIM-like version of the MDS-PAC and the FIM increased the case-mix group match to 57 percent.

? The study found that payment differences between the two instruments varied by RIC. While overall the payment differences (using the two instruments) were small, 20 percent of the hospitals could see revenue differences of 10 percent or more depending on which instrument was used.

? The administrative burden associated with the MDS-PAC, that is, 120 minutes compared with 23 minutes to complete the FIM, was found to be substantial.

As stated in the proposed rule, if the tests showed that patients are classified differently using the MDS-PAC, we would incorporate the phrasing and definitions of the FIM to replace sections of the MDS-PAC. This would meet our objective to field a more extensive instrument to provide a more complete picture of the condition of the patient and of the care provided in the IRF, while also retaining confidence in the validity of the CMG classification of the patient. Using the phrasing and definitions of many of the UDSmr patient assessment instrument items will minimize the effect on reliability and validity inherent in the design of new data collection instruments. Based upon our study findings, the comments received on the proposed rule, the earlier research and analysis supporting the design of the prospective payment system for inpatient rehabilitation facilities, and after conferring with UDSmr staff, we decided to use a majority of the UDSmr patient assessment instrument items and some other quality of care items to collect the information

needed for implementation of the IRF prospective payment system.

Comment: Many commenters indicated that they believed that using only the items on the UDSmr patient assessment instrument could fulfill our goals to classify patients into payment groups and monitor quality of care.

Response: We believe that, in order to adequately monitor quality of care, we need to add quality items to the UDSmr patient assessment instrument. Therefore, we have added to the basic UDSmr patient assessment instrument a few items we believe are critical to monitor quality of care. Also, in response to the recommendations following additional data analysis by our contractor, RAND, and in consultation with and with the agreement of UDSmr, we have added functional independence measure modifiers to our patient assessment instrument. We will use the functional independence measure modifiers, and other items as specified in Chart 7--Critical Patient Assessment Items in section V.E. of this preamble, to classify patients into CMG payment groups. We also will use the functional independence measure modifiers items and some other items as specified in the "Critical Items" chart to monitor quality of care.

We used items similar to MDS-PAC items to modify the UDSmr patient assessment instrument because the MDS-PAC covers several topics, such as nutrition, swallowing, and pain, that are either not included in the FIM or not covered in sufficient detail in the FIM for clinical assessment purposes. Therefore, we decided to retain some of the nonpayment items from the MDS-PAC. The MDS-PAC items that we have chosen to retain in our patient assessment instrument are the items that we believe will yield significant quality of care data and will be used to direct and define development of quality indicators for use in IRFs.

4. Consumer Information

We plan to use the quality information derived from our patient assessment instrument in our public reporting strategy. Our patient assessment data, after appropriate evaluation and validation, can be used to inform consumers about the performance of facilities in their area so that they can make informed decisions when selecting a rehabilitation facility. In addition, information derived from our patient assessment instrument and the comparable information available in SNFs and other settings will help us understand which patients fare better in which types of

post-acute care settings, or even within subsets of IRFs, thus informing and shaping future long-term care quality initiatives.

As part of our efforts in designing a monitoring system, in the November 3, 2000 proposed rule we solicited comments on whether we should also collect data related to medications and medication administration.

Comment: One commenter stated that because data related to medications and medication administration will have no bearing on how the CMG is determined, collecting this information would be an unnecessary burden on the IRF.

Response: Considering the consequences of both medication administration errors and the incorrect prescribing of medications, we believe that data on these issues are of benefit in monitoring quality of care. However, these data are contained in the patient's clinical record or in some other documentation maintained about the patient. Therefore, at this time we will not use the IRF patient assessment instrument to collect these data.

F. Training and Technical Support for IRFs

We will provide educational and technical resources to IRFs to support both implementation of the CMS IRF patient assessment instrument and the computerization and

transmission of the patient assessment data. We will provide training and technical support on the use of our patient assessment instrument by clinical staff and on the use of software to encode and transmit the patient assessment data.

Although we will be providing both initial and ongoing training and technical support, IRFs will probably find it advantageous to designate a staff member as an IRF trainer, in order to have in-house capability both to train newly hired staff, and to have a designated person who can serve as the in-house resource for other staff.

We will train and support the IRFs in the implementation of the IRF prospective payment system and automation of our patient assessment instrument by--

? Training IRFs on our patient assessment data set;

? Answering questions on the clinical aspects of our patient assessment instrument and providing information to IRFs on the use of the instrument to determine CMGs;

? Providing training to State agency staff in using our patient assessment data for survey activities;

? Training IRFs in interpreting validation reports;

? Providing information relative to hardware and software requirements; and

? Providing support for transmission of test data, supporting callers who request technical assistance, providing passwords to IRFs, and answering questions about the computer edits and reports.

Comment: One commenter stated that having an IRF clinician that we [CMS] have trained to be the trainer of other clinicians at an IRF may lead to incorrect information being disseminated, because the clinician that we have trained might unintentionally distort the information when that clinician trains other clinicians. Other commenters stated that we underestimated the time needed to train clinicians, and the number of clinicians that need to be trained. One commenter indicated that only 5 to 6 hours are needed by UDSmr to train IRF clinicians in how to perform a patient assessment using the UDSmr patient assessment instrument.

Response: We, along with other organizations, have successfully used the "train the trainer" technique, in which the person trained then trains others. We acknowledge that there is the possibility that an IRF staff member trained by us might inadvertently train another IRF staff member incorrectly in some aspect of the IRF patient assessment process that is specified in our final rule.

However, we note that all IRF staff will have the patient assessment instrument item-by-item guide available to them as a resource in how to perform the patient assessment. In addition, all staff members may refer to this final rule and call our contractors or us if they have questions about the patient assessment process.

We are still in the process of finalizing our plans for training IRFs on the patient assessment process. However, we are aware that UDSmr estimates that it only takes a day to train IRF clinicians in how to perform a patient assessment using the UDSmr patient assessment instrument. We believe that "a day" means approximately 8 hours. Our patient assessment instrument is a slightly modified version of the UDSmr patient assessment instrument. Therefore, we believe that our estimate of 16 hours of initial training, in order to train the IRF lead clinician on our patient assessment instrument and assessment process, is a reasonable estimate. We believe that our estimate of 12 hours of initial training to train the nonlead IRF clinicians also is a reasonable estimate. In addition, we believe that 5 hours to initially train clerical personnel is reasonable, because their tasks under the IRF patient assessment process are not as complicated

as the tasks that the clinicians must perform. We note that the training hours specified in the rule, both for the initial training and for ongoing training, are estimates, and we will adjust the hours as needed when we finalize our training plans and schedules. In addition, due to the wide variety of the sizes of IRFs, we have no way of knowing how many clinicians are employed by an IRF. Therefore, we could only give estimates of how many clinicians would need to be trained. When we have a final training schedule, we will publish it on our IRF prospective payment system website.

G. Release of Information Collected Using the Patient Assessment Instrument

As in the proposed rule under §412.616, in this final rule we are providing that the IRF and its agents must ensure the confidentiality of the information collected using the assessment instrument in the same manner as all other information in the medical record, in accordance with the hospital conditions of participation at §482.24(b)(3). While the conditions of participation include confidentiality requirements that apply broadly to all patient information used and disclosed by the IRF, in this final rule we are establishing additional requirements that

apply specifically to data collected using the patient assessment instrument. Specifically, we are establishing a requirement to inform patients of their rights regarding collection of the patient assessment (§412.608), as well as requirements governing release of patient-identifiable information to IRF agents (§412.616(b)). The facility must ensure that information may be released only to authorized individuals and must ensure that unauthorized individuals cannot gain access to or alter patient records. The original medical record must be released by the facility or its agent only in accordance with Federal or State laws, court orders or subpoenas. In addition, we are providing that an agent acting on behalf of an IRF in accordance with a written contract with that IRF may only use the information for the purposes specified in the contract. We believe that these provisions will ensure that access to patient assessment data (paper copy as well as electronic data) is secured and controlled by the IRF, in accordance with Federal and State laws.

On December 28, 2000, the Department of Health and Human Services published a final rule adopting standards for the privacy of certain individually identifiable health information (65 FR 82462) (Privacy Rule). The Privacy Rule

is the second in a series of rules mandated by provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191. In part, the Privacy Rule establishes a new Subpart E under 45 CFR Part 164. Subpart E establishes standards that entities covered by the statute--health plans, health care clearinghouses, and certain health care providers--are required to comply with in order to protect the privacy of certain individually identifiable health information. The standards establish requirements relating to the use and disclosure of protected health information, the rights of individuals with respect to that information, and the procedure for exercising those rights.

On February 26, 2001, the Department published a final rule (66 FR 12434) correcting the effective date of the December 28, 2000 final rule. The new effective date is now April 14, 2001. In accordance with the requirements set forth in the Privacy Rule, we are proceeding with an implementation plan that will result in full compliance with these standards on or before April 14, 2003. This plan includes compliance with the standards as they relate to information collected as part of the IRF patient assessment instrument set forth in this final rule.

Accordingly, as we proceed with its compliance efforts associated with the Privacy Rule, we may be making future changes in the regulations adopted in this final rule.

In the proposed rule, we indicated that, as with other regulations that result in the creation of a new system of records, we are in the process of developing a notice describing the new system of records that is unique to MDS-PAC. We have typically issued notices describing new systems of records in conjunction with the issuing of a final rule. The notices, required by the Privacy Act of 1974, describe both the entities to whom identifiable and nonidentifiable data can be routinely disclosed, as well as the safeguards that will protect the privacy and the security of the data. While each system of records notice is unique to the system and the data instrument, readers interested in understanding a recent approach are referred to the notice of the new system of records published June 18, 1999 (64 FR 32992) for the "Home Health Agency Outcome and Assessment Information Set (OASIS)."

We solicited comments on issues germane to the notice that we would develop for the patient assessment records.

Comment: Several commenters believed that the great number of items in the MDS-PAC are not necessary to

determine that a payment is excessive. In the commenters' view, the excessive number of these nonpayment items is both of dubious value in monitoring quality of care and amount to a violation of the patient's privacy.

Response: Our patient assessment instrument is now closely modeled on the UDSmr patient assessment instrument. The items that we have added to the UDSmr instrument either improve the capability of the instrument to determine a patient's CMG or collect quality of care data. We believe that the number of items we have added to the basic UDSmr patient assessment instrument is not excessive, especially considering the vital data these items will yield. The quality of care data items are few, especially when the number of these items are compared to all the nonpayment items in the MDS-PAC. In addition, the quality of care items now in our instrument collect basic data that we have found to be of significant value in monitoring quality of care. Therefore, we are only collecting data needed to appropriately classify a patient into a CMG and data that benefit the patient by helping monitor the quality of the services furnished. We will be publishing a system of records notice in the **Federal Register** that will detail our efforts to safeguard the privacy of the data that we

collect using our inpatient rehabilitation facility patient assessment instrument in this final rule.

H. Patient Rights

We are adopting the provision of the proposed rule under §412.608 that in order to receive payment for the Medicare IRF services furnished, a clinician must inform the Medicare inpatient of the following rights with respect to the assessment prior to performing the assessment. These rights include--

? The right to be informed of the purpose of the patient assessment data collection;

? The right to have any patient assessment information that is collected remain confidential and secure;

? The right to be informed that the patient assessment information will not be disclosed to others except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

? The right to refuse to answer patient assessment data questions; and

? The right to see, review, and request changes on the patient assessment instrument.

We are requiring the IRF to ensure that a clinician documents in the Medicare patient's clinical record that the patient has been informed of the above patient rights. IRFs should note that the above patient rights are in addition to the patient rights specified under the conditions of participation for hospitals in §482.13.

Our statements of patient rights with regard to the IRF patient assessment instrument will be available via our Inpatient Rehabilitation Facility Prospective Payment System website. These statements may be revised in accordance with the Office of Management and Budget Paperwork Reduction Act reapproval process. Future revisions to these statements will be available via our Inpatient Rehabilitation Facility Prospective Payment System website, and in other instructional materials that we issue.

Comment: Commenters asked what the IRF should do if the patient refuses to answer questions when the IRF clinician tries to collect patient assessment data, and how this would be indicated on the electronic version of the patient assessment instrument.

Response: In the proposed rule, we proposed that data that are not obtained by direct observation by an IRF

clinician of an activity performed by the patient can be obtained from the patient, the patient's clinical record, other patient documents or the patient's family. In addition to the patient's family, we are including in this final rule the provision that the data can be obtained from someone personally knowledgeable about the patient's clinical conditions or capabilities. Data that are obtained from the patient's clinical record, other patient documents, the patient's family, or someone personally knowledgeable about the patient's clinical conditions or capabilities do not have to be specially indicated or annotated on the paper or electronic version of the patient assessment instrument. However, the clinician has the discretion to note in the patient's clinical record that the information recorded for an item was obtained from one of these other sources, and not directly from the patient.

We believe that the data for the items associated with observation by the clinician of a particular activity performed by the patient will always be recorded on the patient assessment instrument, because these items allow for the recording of the data in different ways, including recording that the activity did not occur. We reiterate that, for the patient assessment observational items, the

clinician assessor should not require a patient to perform an activity that, in the clinician's professional judgment, is clinically contraindicated or hazardous to the patient.

I. Medical Review Under the IRF Prospective Payment System

Under a discharge-based prospective payment system, IRFs might have financial incentives to miscode information on the patient assessment instrument in order to gain a higher CMG and, therefore, payment (that is, case-mix upcoding for payment). Data analysis may be conducted to identify program payment vulnerabilities or areas of risk, and medical review may be conducted to ensure that appropriate payment is being made for services furnished by IRFs.

V. Case-Mix Group Patient Classification System

A. Background

1. Statutory Authority for the Establishment of a Patient Classification System

Section 1886(j)(2)(A)(i) of the Act, as amended by section 125 of the BBRA, requires the Secretary to establish “classes of patient discharges of rehabilitation facilities by functional-related groups (each referred to . . . as a ‘case mix group’), based on impairment, age, comorbidities, and functional capability of the patient,

and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups." In addition, the Secretary is required to establish a method of classifying specific patients in IRFs within these groups. (These provisions are implemented in §412.620 of this final rule.)

2. Development of the Proposed Case-Mix Groups

In the November 3, 2000 proposed rule, we proposed a methodology to establish a patient classification system using case-mix groups called CMGs (65 FR 66337). The proposed CMGs are based on the FIM-FRG methodology and reflect refinements to that methodology. In addition, we described in the proposed rule the process to classify a patient into a CMG.

In general, a patient is first placed in a major group called a RIC based on the patient’s primary reason for inpatient rehabilitation, such as a stroke or a hip fracture. Next, the patient is placed into a CMG within the RIC, based on the patient's ability to perform specific activities of daily living, and sometimes the patient's cognitive ability and/or age. Other special circumstances, such as the occurrence of very short stays or cases where

the patient expired, would be considered in determining the appropriate CMG.

In the proposed rule, we stated that our analysis of 1996 and 1997 FIM and Medicare data validated our proposal to establish 21 RICs and 92 CMGs based on the FIM-FRG methodology. The data also supported the establishment of five additional special CMGs that improved the explanatory power of the FIM-FRGs. That is, we proposed to establish one additional special CMG to account for very short stays and four additional special CMGs to account for cases where the patient expired. In addition, we proposed to pay an additional amount with the presence of at least one relevant comorbidity for certain CMGs.

Comment: Several commenters suggested that we use the term "FIM-FRGs" rather than "CMGs" to describe the patient classification groupings.

Response: The FIM-FRGs' ability to predict resource use has been improved since their original development with the recognition of comorbidities and other special circumstances. We believe that identifying the groups as CMGs avoids any confusion that the basis of the CMGs is not only the original FIM-FRG methodology, but that it also includes improvements to that methodology. In addition, we

believe that the statutory language also recognized that improvements have been made and may be made in the future to the original FIM-FRG methodology by referring to the groups as “case mix groups.” Accordingly, the patient classification system that we are implementing under §412.620(a) of these final regulations will classify patients into case-mix groups called CMGs.

3. Refinements to the Proposed CMGs

We explained in the proposed rule that further analysis of FIM and Medicare data and our review of the comments received may result in refinements to some proposed CMGs. For this final rule, we use the most recent FIM and Medicare data from 1998 and 1999 as described in section III. of this preamble. Developing the CMGs with the 1998 and 1999 data results in 95 CMGs based on the FIM-FRG methodology rather than the 92 CMGs described in the proposed rule. In addition, in the following subsections, we will describe the results of analyzing these later data that validate the use of the same 21 RICs and five special CMGs as proposed.

B. Description of Methodology Used to Develop the CMGs Based on the FIM-FRG Methodology for the Final Rule

1. Rehabilitation Impairment Categories

In the first step to develop the CMGs, the FIM data from 1998 and 1999 were used to group patients into RICs. Specifically, the impairment code from the assessment instrument used by clients of UDSmr and Healthsouth indicates the primary reason for the inpatient rehabilitation admission. This impairment code is used to group the patient into a RIC. Chart 5 below (a replacement for Table 1D in the proposed rule) shows each RIC and its associated impairment code.

The earlier RAND research using 1994 data resulted in 20 RICs. We initially used RAND’s statistical analysis of 1997 data which showed that the 1997 data generally performed as well as the 1994 data in predicting resource use in RICs 01 through 20. Based on this analysis, the impairment code 14.9 "Status post major multiple fractures" appeared to fit more appropriately into RIC 17. Also, based on the 1997 data, we created a separate RIC for burn cases.

For this final rule, we will continue to use the 21 RICs described in the proposed rule and shown in Chart 5 below.

Chart 5.--Rehabilitation Impairment Categories (RICs) and Associated Impairment Group Codes

Rehabilitation Impairment Category	Associated Impairment Group Codes
01 Stroke (Stroke)	01.1 Left body involvement (right brain) 01.2 Right body involvement (left brain) 01.3 Bilateral Involvement 01.4 No Paresis 01.9 Other Stroke
02 Traumatic brain injury (TBI)	02.21 Open Injury 02.22 Closed Injury
03 Nontraumatic brain injury (NTBI)	02.1 Non-traumatic 02.9 Other Brain
04 Traumatic spinal cord injury (TSCI)	04.210 Paraplegia, Unspecified 04.211 Paraplegia, Incomplete 04.212 Paraplegia, Complete 04.220 Quadriplegia, Unspecified 04.2211 Quadriplegia, Incomplete C1-4 04.2212 Quadriplegia, Incomplete C5-8 04.2221 Quadriplegia, Complete C1-4 04.2222 Quadriplegia, Complete C5-8 04.230 Other traumatic spinal cord dysfunction

Rehabilitation Impairment Category	Associated Impairment Group Codes
05 Nontraumatic spinal cord injury (NTSCI)	04.110 Paraplegia, unspecified 04.111 Paraplegia, incomplete 04.112 Paraplegia, complete 04.120 Quadriplegia, unspecified 04.1211 Quadriplegia, Incomplete C1-4 04.1212 Quadriplegia, Incomplete C5-8 04.1221 Quadriplegia, Complete C1-4 04.1222 Quadriplegia, Complete C5-8 04.130 Other non-traumatic spinal cord dysfunction
06 Neurological (Neuro)	03.1 Multiple Sclerosis 03.2 Parkinsonism 03.3 Polyneuropathy 03.5 Cerebral Palsy 03.8 Neuromuscular Disorders 03.9 Other Neurologic
07 Fracture of LE (FracLE)	08.11 Status post unilateral hip fracture 08.12 Status post bilateral hip fractures 08.2 Status post femur (shaft) fracture 08.3 Status post pelvic fracture
08 Replacement of LE joint (ReplLE)	08.51 Status post unilateral hip replacement 08.52 Status post bilateral hip replacements 08.61 Status post unilateral knee replacement 08.62 Status post bilateral knee replacements 08.71 Status post knee and hip replacements (same side) 08.72 Status post knee and hip replacements (different sides)

Rehabilitation Impairment Category	Associated Impairment Group Codes
09 Other orthopedic(Ortho)	08.9 Other orthopedic
10 Amputation, lower extremity (AMPLE)	05.3 Unilateral lower extremity above the knee (AK) 05.4 Unilateral lower extremity below the knee (BK) 05.5 Bilateral lower extremity above the knee (AK/AK) 05.6 Bilateral lower extremity above/below the knee (AK/BK) 05.7 Bilateral lower extremity below the knee (BK/BK)
11 Amputation, other (AMP-NLE)	05.1 Unilateral upper extremity above the elbow (AE) 05.2 Unilateral upper extremity below the elbow (BE) 05.9 Other amputation
12 Osteoarthritis (OsteoA)	06.2 Osteoarthritis
13 Rheumatoid, other arthritis (RheumA)	06.1 Rheumatoid Arthritis 06.9 Other arthritis
14 Cardiac (Cardiac)	09 Cardiac
15 Pulmonary (Pulmonary)	10.1 Chronic Obstructive Pulmonary Disease 10.9 Other pulmonary
16 Pain Syndrome (Pain)	07.1 Neck pain 07.2 Back pain 07.3 Extremity pain 07.9 Other pain
17 Major multiple trauma, no brain injury or spinal cord injury (MMT-NBSCI)	08.4 Status post major multiple fractures 14.9 Other multiple trauma
18 Major multiple trauma, with brain or spinal cord injury (MMT-BSCI)	14.1 Brain and spinal cord injury 14.2 Brain and multiple fractures/amputation 14.3 Spinal cord and multiple fractures/amputation
19 Guillian Barre (GB)	03.4

Rehabilitation Impairment Category	Associated Impairment Group Codes
20 Miscellaneous (Misc)	12.1 Spina Bifida 12.9 Other congenital 13 Other disabling impairments 15 Developmental disability 16 Debility 17.1 Infection 17.2 Neoplasms 17.31 Nutrition (endocrine/metabolic) with intubation/parenteral nutrition 17.32 Nutrition (endocrine/metabolic) without intubation/parenteral nutrition 17.4 Circulatory disorders 17.51 Respiratory disorders-Ventilator Dependent 17.52 Respiratory disorders-Non-ventilator Dependent 17.6 Terminal care 17.7 Skin disorders 17.8 Medical/Surgical complications 17.9 Other medically complex conditions
21 Burns (Burns)	11 Burns

In the proposed rule, we stated in the footnote to Table 1D that we were analyzing the effect of moving the few cases with an impairment code of 12.1 (Spina Bifida) to one of the other spinal cord RICs (RIC 05 or 04). Based on our analysis of the 1998 and 1999 data, there were a combined total of 45 cases with an impairment code for Spina Bifida for both years. With such a small sample of

cases, the results of our analysis of the effects of moving these cases to another RIC were inconclusive. Therefore, in this final rule, we are retaining the 12.1 impairment code in RIC 20 (Miscellaneous). We will continue our analysis of these cases in the future with later data to determine if moving them to another RIC would be appropriate.

2. Functional Status Measures and Age

After using the RIC to define the first split among the inpatient rehabilitation groups, we used functional status measures and age to partition the cases further. For this final rule, we used more recent data (1998 and 1999 Medicare bills with corresponding FIM data) to create the CMGs and more thoroughly examine each item of the motor and cognitive measures. Based on this analysis, we found that we could improve upon the CMGs by making a slight modification to the motor measure. We modify the motor measure by removing the transfer to tub/shower item because we found that an increase in a patient's ability to perform functional tasks with less assistance for this item is associated with an increase in cost, whereas an increase in other functional items decreases costs. We describe below the statistical methodology (Classification and Regression

Trees (CART)) that we used to incorporate a patient's functional status measures (modified motor score and cognitive score), and age into the construction of the CMGs in this final rule.

We used the CART methodology to split the rehabilitation cases further within each RIC. In general, CART can be used to identify statistical relationships among data and, using these relationships, construct a predictive model for organizing and separating a large set of data into smaller, similar groups. Further, in constructing the CMGs, we analyzed the extent to which the independent variables (motor score, cognitive score, and age) help predict the value of the dependent variable (the log of the cost per case).

The CART methodology creates the CMGs that classify patients with clinically distinct resource needs into groups. CART is an iterative process that creates initial groups of patients and then searches for ways to split the initial groups to decrease the clinical and cost variances further and to increase the explanatory power of the CMGs. (Further information regarding this methodology can be found in the seminal literature on CART (Classification and Regression Trees, Leo Breiman, Jerome Friedman, Richard

Olshen, Charles Stone, Wadsworth Inc., Belmont CA, 1984: pp. 78-80).)

As a result of this analysis, Chart 6 lists 95 CMGs and their respective descriptions, including the motor and cognitive scores and age that will be used to classify discharges into CMGs in the IRF prospective payment system.

Comment: One commenter suggested that spinal cord injury (SCI) patients who are ventilator-dependent should have their own CMG and an associated payment. The commenter stated that, under the proposed CMGs, an SCI ventilator-dependent patient would always result in an outlier payment. The commenter further noted that while there is not a large number of these patients, the outlier payment could result in a large financial loss to providers.

Response: We are not including a separate CMG for ventilator-dependent, spinal cord injury patients in this final rule. We will consider analyzing this group of patients for future refinements. Our current CMGs are based on historical data. In order to develop a separate CMG, we need to have data on a sufficient number of cases to develop coherent groups. As the commenter noted, the data that RAND analyzed did not have a sufficiently large

number of these patients. The cost of caring for ventilator-dependent spinal cord injury patients is reflected in the relative weights for the CMGs in which these cases fall. Ventilator-dependent spinal cord injury cases will be classified to comorbidity tier 1. We grouped these types of cases only with other very expensive spinal cord injury patients, and the relative weights set forth in this final rule reflect the average cost for these cases. Therefore, we believe that the standard IRF prospective payment plus the outlier payment (which addresses the marginal cost of care beyond the applicable threshold) will pay adequately for these cases. It is certainly possible that, for a given case, the total payment for the case might be lower than the cost for the case, but for other cases, the total payment might be higher than costs.

Comment: A few commenters believed that payment for burns was insufficient.

Response: For the proposed rule, we created one case-mix group, CMG 2101, for all burn cases. For CMG 2101, we calculated an average length of stay of 18.5 days and a relative weight of 1.2863 as described in the proposed rule. However, for the CMGs set forth in this final rule, we use the latest available data as described in Appendix

A. These data include more burn cases compared to the data used to create the CMGs in the proposed rule. We created two CMGs with the more recent data using the CART methodology described earlier in this preamble. The costs of providing care for patients with the lowest motor scores (those patients needing more assistance with tasks such as transferring, bathing, and dressing) are more on average than the costs for patients with higher motor scores. When we use the most recent data, we find that the CMG for a burn patient with the lower motor score, from 12 to 45 (CMG 2102 with no comorbidities) has an average length of stay of 29 days and a relative weight of 1.8226. The CMG for a burn patient with a higher motor score of 46 to 84 (CMG 2101) who can perform self-care task with less assistance reflects the lower costs of caring for these patients. The average length of stay for patients classified to CMG 2101 with no comorbidities is 16 days and the relative weight is .8387. It is possible that, for a given case, the total payment for a burn case might be lower than the costs for the case, but for other burn cases, the total payment might be higher than costs. For burn cases with extremely high costs, outlier payments may

be made as well. Therefore, we believe payment for burn cases will be sufficient.

3. Comorbidities

A comorbidity is considered in the context of the principal diagnosis. That is, a comorbidity is a specific patient condition that is secondary to the patient's principal diagnosis or impairment that is used to place a patient into a RIC. A patient could have more than one comorbidity present during the inpatient rehabilitation stay.

Our analysis found that the presence of a comorbidity could have a major effect on the cost of furnishing inpatient rehabilitation care. For the proposed rule, we found that the effect of comorbidities varied across RICs, significantly increasing the costs of patients in some RICs, while having no effect in others.

We linked frequently occurring comorbidities to impairment categories in order to ensure that all of the chosen comorbidities are not an inherent part of the diagnosis that assigns the patient to the RIC. For example, providing rehabilitation services to a beneficiary with a total hip replacement can become both more complex and more costly if the beneficiary also has pneumonia. In

contrast, hemiparesis paralysis of one side of the body would not have an impact on patients in RIC 01, stroke.

In the proposed rule, we found comorbidities to affect cost per case for some of the CMGs, but not all. When comorbidities substantially increased the average cost of the CMG and were determined to be clinically relevant (not inherent in the diagnosis in the RIC), we developed CMG relative weights adjusted for comorbidities (§412.620(b)).

In this final rule (as we had proposed in the November 3, 2000 proposed rule), we are specifying that a payment adjustment will be made if one of the comorbidities listed in Appendix C of this final rule is present during the patient's stay.

Comment: We received a number of comments suggesting that we take into account the existence of multiple comorbidities.

Response: We have completed considerable analysis on how to account for the severity of each comorbidity that may be present during an inpatient rehabilitation stay. Further discussion of the results of this analysis appears in section VI. of this final rule.

C. Description of Methodology Used to Develop CMGs for Special Cases for the Final Rule

As we did with the proposed rule, for this final rule, we analyzed the payment-to-cost ratios for special types of cases that were not typical cases to determine if costs could be predicted. (We define typical cases as those that stay more than 3 days, receive a full course of inpatient rehabilitation care, and are discharged to the community.) From this analysis, we believe that IRFs would be paid substantially more for cases in which the patient expires and cases with a length of stay of 3 days or less (not including transfer cases) than for the costs of these cases if facilities received the full CMG payment. To improve the explanatory power of the groups, we added four CMGs to account for cases in which the patient expires and one CMG for all cases that have a length of stay of 3 days or less (not including transfer cases). We explain these five types of special cases in greater detail in section VI. of this final rule.

D. Final Set of CMGs

Chart 6 below shows the final set of 95 CMGs based on the FIM-FRG methodology and 5 special CMGs and their description. In section V.E. of this preamble, we discuss

the process of how to classify a patient into a RIC and a CMG.

Chart 6.--Definition of Case Mix Groups (CMGs)

CMG Number*	CMG Description
0101	Stroke with motor score from 69-84 and cognitive score from 23-35
0102	Stroke with motor score from 59-68 and cognitive score from 23-35
0103	Stroke with motor score from 59-84 and cognitive score from 5-22
0104	Stroke with motor score from 53-58
0105	Stroke with motor score from 47-52
0106	Stroke with motor score from 42-46
0107	Stroke with motor score from 39-41
0108	Stroke with motor score from 34-38 and patient is 83 years old or older
0109	Stroke with motor score from 34-38 and patient is 82 years old or younger
0110	Stroke with motor score from 12-33 and patient is 89 years old or older
0111	Stroke with motor score from 27-33 and patient is between 82 and 88 years old
0112	Stroke with motor score from 12-26 and patient is between 82 and 88 years old
0113	Stroke with motor score from 27-33 and patient is 81 years old or younger
0114	Stroke with motor score from 12-26 and patient is 81 years old or younger
0201	Traumatic brain injury with motor score from 52-84 and cognitive score from 24-35
0202	Traumatic brain injury with motor score from 40-51 and cognitive score from 24-35
0203	Traumatic brain injury with motor score from 40-84 and cognitive score from 5-23
0204	Traumatic brain injury with motor score from 30-39
0205	Traumatic brain injury with motor score from 12-29
0301	Non-traumatic brain injury with motor score from 51-84
0302	Non-traumatic brain injury with motor score from 41-50
0303	Non-traumatic brain injury with motor score from 25-40

CMG Number*	CMG Description
0304	Non-traumatic brain injury with motor score from 12-24
0401	Traumatic spinal cord injury with motor score from 50-84
0402	Traumatic spinal cord injury with motor score from 36-49
0403	Traumatic spinal cord injury with motor score from 19-35
0404	Traumatic spinal cord injury with motor score from 12-18
0501	Non-traumatic spinal cord injury with motor score from 51-84 and cognitive score from 30-35
0502	Non-traumatic spinal cord injury with motor score from 51-84 and cognitive score from 5-29
0503	Non-traumatic spinal cord injury with motor score from 41-50
0504	Non-traumatic spinal cord injury with motor score from 34-40
0505	Non-traumatic spinal cord injury with motor score from 12-33
0601	Neurological with motor score from 56-84
0602	Neurological with motor score from 47-55
0603	Neurological with motor score from 36-46
0604	Neurological with motor score from 12-35
0701	Fracture of lower extremity with motor score from 52-84
0702	Fracture of lower extremity with motor score from 46-51
0703	Fracture of lower extremity with motor score from 42-45
0704	Fracture of lower extremity with motor score from 38-41
0705	Fracture of lower extremity with motor score from 12-37
0801	Replacement of lower extremity joint with motor score from 58-84
0802	Replacement of lower extremity joint with motor score from 55-57
0803	Replacement of lower extremity joint with motor score from 47-54
0804	Replacement of lower extremity joint with motor score from 12-46 and cognitive score from 32-35
0805	Replacement of lower extremity joint with motor score from 40-46

CMG Number*	CMG Description
	and cognitive score from 5-31
0806	Replacement of lower extremity joint with motor score from 12-39 and cognitive score from 5-31
0901	Other orthopedic with motor score from 54-84
0902	Other orthopedic with motor score from 47-53
0903	Other orthopedic with motor score from 38-46
0904	Other orthopedic with motor score from 12-37
1001	Amputation, lower extremity with motor score from 61-84
1002	Amputation, lower extremity with motor score from 52-60
1003	Amputation, lower extremity with motor score from 46-51
1004	Amputation, lower extremity with motor score from 39-45
1005	Amputation, lower extremity with motor score from 12-38
1101	Amputation, non-lower extremity with motor score from 52-84
1102	Amputation, non-lower extremity with motor score from 38-51
1103	Amputation, non-lower extremity with motor score from 12-37
1201	Osteoarthritis with motor score from 55-84 and cognitive score from 34-35
1202	Osteoarthritis with motor score from 55-84 and cognitive score from 5-33
1203	Osteoarthritis with motor score from 48-54
1204	Osteoarthritis with motor score from 39-47
1205	Osteoarthritis with motor score from 12-38
1301	Rheumatoid, other arthritis with motor score from 54-84
1302	Rheumatoid, other arthritis with motor score from 47-53
1303	Rheumatoid, other arthritis with motor score from 36-46
1304	Rheumatoid, other arthritis with motor score from 12-35
1401	Cardiac with motor score from 56-84
1402	Cardiac with motor score from 48-55
1403	Cardiac with motor score from 38-47

CMG Number*	CMG Description
1404	Cardiac with motor score from 12-37
1501	Pulmonary with motor score from 61-84
1502	Pulmonary with motor score from 48-60
1503	Pulmonary with motor score from 36-47
1504	Pulmonary with motor score from 12-35
1601	Pain syndrome with motor score from 45-84
1602	Pain syndrome with motor score from 12-44
1701	Major multiple trauma without brain or spinal cord injury with motor score from 46-84
1702	Major multiple trauma without brain or spinal cord injury with motor score from 33-45
1703	Major multiple trauma without brain or spinal cord injury with motor score from 12-32
1801	Major multiple trauma with brain or spinal cord injury with motor score from 45-84 and cognitive score from 33-35
1802	Major multiple trauma with brain or spinal cord injury with motor score from 45-84 and cognitive score from 5-32
1803	Major multiple trauma with brain or spinal cord injury with motor score from 26-44
1804	Major multiple trauma with brain or spinal cord injury with motor score from 12-25
1901	Guillian Barre with motor score from 47-84
1902	Guillian Barre with motor score from 31-46
1903	Guillian Barre with motor score from 12-30
2001	Miscellaneous with motor score from 54-84
2002	Miscellaneous with motor score from 45-53
2003	Miscellaneous with motor score from 33-44

CMG Number*	CMG Description
2004	Miscellaneous with motor score from 12-32 and patient is 82 years old or older
2005	Miscellaneous with motor score from 12-32 and patient is 81 years old or younger
2101	Burns with motor score from 46-84
2102	Burns with motor score from 12-45
5001	Short-stay cases, length of stay is 3 days or fewer
5101	Expired, orthopedic, length of stay is 13 days or fewer
5102	Expired, orthopedic, length of stay is 14 days or more
5103	Expired, not orthopedic, length of stay is 15 days or fewer
5104	Expired, not orthopedic, length of stay is 16 days or more

*The first two digits of the CMG number from 01 to 21 correspond with a specific RIC number shown on Chart 5.

E. Methodology to Classify Patients into CMGs

Data from the patient assessment instrument, described in section IV.A. of this preamble and specified in §412.620(a)(3) of the final regulations, will be used to classify a patient into a RIC and CMG. In Chart 7, we have identified the impairment code needed to classify a patient into a RIC and specific items that must be completed on the instrument in order to classify a patient into a CMG. The items from the instrument will be used to establish a motor score, a cognitive score, and age of the patient that corresponds with a specific CMG description.

Chart 7. --CRITICAL PATIENT ASSESSMENT ITEMS

ITEM CATEGORY, ITEM SUB-CATEGORY, ITEM NAME, ITEM NUMBER	ADMISSION ASSESSMENT	DISCHARGE ASSESSMENT
IDENTIFICATION INFORMATION*		
1. Facility Information		
A. Facility Name	X	
B. Facility Medicare Provider Number	X	
2. Patient Medicare Number	X	
3. Patient Medicaid Number	X	
4. Patient First Name	X	
5. Patient Last Name	X	
6. Birth Date **	X	
7. Social Security Number	X	
8. Gender	X	
9. Race/Ethnicity (Check all that apply)		
American Indian or Alaska Native	X	
Asian	X	
Black or African American	X	
Hispanic or Latino	X	
Native Hawaiian or Other Pacific Islander	X	
White	X	
10 Marital Status	X	
11. Zip Code of Patient's Pre-Hospital Residence:	X	
ADMISSION INFORMATION*		
12. Admission Date	X	
13. Assessment Reference Date	X	
14. Admission Class	X	
15. Admit From	X	
16. Pre-Hospital Living Setting	X	
17. Pre-Hospital Living With	X	
18. Pre-Hospital Vocational Category	X	
19. Pre-Hospital Vocational Effort	X	
PAYER INFORMATION*		
20. Payment Source		
A. Primary Source	X	
B. Secondary Source	X	
MEDICAL INFORMATION*		
21. Impairment Group **	X	X
22. Etiologic Diagnosis:	X	
23. Date of Onset of Etiologic Diagnosis	X	
24. Comorbid Conditions: **		
A.	X	X
B.	X	X
C.	X	X
D.	X	X
E.	X	X
F.	X	X
G.	X	X
H.	X	X

ITEM CATEGORY, ITEM SUB-CATEGORY, ITEM NAME, ITEM NUMBER	ADMISSION ASSESSMENT	DISCHARGE ASSESSMENT
I.	X	X
J.	X	X
MEDICAL NEEDS		
25. Is patient comatose at admission?	X	
26 Is patient delirious at admission?	X	
27. Swallowing Status:	X	X
28. Clinical signs of dehydration	X	X
FUNCTION MODIFIERS*		
29. Bladder Level **	X	X
30. Bladder Freq. **	X	X
31. Bowel Level **	X	X
32. Bowel Freq. **	X	X
33. Tub Transfer **	X	X
34. Shower Transfer **	X	X
35. Distance Walked (feet) **	X	X
36. Distance Traveled in Wheelchair (feet) **	X	X
37. Walk **	X	X
38. Wheelchair **	X	X
FIM INSTRUMENT*		
SELF-CARE		
A. Eating **	X	X
B. Grooming **	X	X
C. Bathing **	X	X
D. Dressing - Upper **	X	X
E. Dressing - Lower **	X	X
F. Toileting **	X	X
SPHINCTER CONTROL		
G. Bladder **	X	X
H. Bowel **	X	X
TRANSFERS		
I. Bed, Chair, Wheelchair **	X	X
J. Toilet **	X	X
K. Tub, Shower	X	X
LOCOMOTION		
L. Walk/Wheelchair **	X	X
M. Stairs **	X	X
COMMUNICATION		
N. Comprehension **	X	X
O. Expression **	X	X
SOCIAL COGNITION		
P. Social Interaction **	X	X
Q. Problem Solving **	X	X
R. Memory **	X	X
DISCHARGE INFORMATION*		
40. Discharge Date		X
41 Patient discharge against medical advice:		X
42. Program Interruptions		X
43. Program Interruption Dates		
A. 1st Transfer Date		X
B. 1st Return Date		X
C. 2nd Transfer Date		X

ITEM CATEGORY, ITEM SUB-CATEGORY, ITEM NAME, ITEM NUMBER	ADMISSION ASSESSMENT	DISCHARGE ASSESSMENT
D. 2nd Return Date		X
E. 3rd Transfer Date		X
F. 3rd Return Date		X
44A. Discharge to Living Setting:		X
44B. Was patient discharged with Home Health Services?		X
45. Discharge to Living With:		X
46. Diagnosis for Transfer or Death:		X
47. Complications during rehabilitation stay **		
A.		X
B.		X
C.		X
D.		X
E.		X
F.		X
QUALITY INDICATORS		
RESPIRATORY STATUS		
48. Shortness of breath with exertion	X	X
49. Shortness of breath at rest	X	X
50. Difficulty coughing	X	X
PAIN		
51. Rate the highest level of pain reported by the patient within the assessment period	X	X
PUSH SCALE		
Pressure Ulcers		X
52A. Highest current pressure ulcer stage	X	X
52B. Number of current pressure ulcers	X	X
52C. Length multiplied by width (open wound surface area)	X	X
52D. Exudate amount	X	X
52E. Tissue type	X	X
52F. Total Push Score	X	X
SAFETY		
53. Total number of falls during the rehabilitation stay		X
54. Balance problem	X	X

* The FIM data set, measurement scale, and impairment codes incorporated or referenced herein are the property of UB Foundation Activities, Inc. ©1993, 2001 UB Foundation Activities, Inc. The FIM mark is owned by UBFA, Inc.

** Denotes the items from the patient assessment instrument that must be recorded by item number to classify a patient into a CMG. All other items in this Chart will be used to administer, monitor, and analyze possible refinements to the IRF prospective payment system. The items identified will be further explained and may be refined in the manual associated with our patent assessment instrument.

Case Example

The following is an example of how data from the admission patient assessment will be used to code the functional independence measure items of the IRF patient assessment instrument.

Note: This is a fictitious patient.

Martin P. is an 84-year-old left-handed male who was admitted to an acute care hospital at 11:00 A.M. An initial medical history was obtained from his wife. He is English speaking. Martin is retired and lives with his 72-year-old wife in a townhouse with three levels. He has been an adult-onset diabetic for 10 years, who has been treated with oral medication which provides adequate control of his blood glucose. He has a history of hypertension. He has, nevertheless, been actively traveling with his wife and actively involved with his daughter and her family who live a few blocks away. His wife explained that Martin complained of heaviness in his right arm and an overall tired or weak feeling prior to the onset and asked his wife to call the doctor. When his speech was affected, she called an ambulance.

On admission to the hospital, Martin's speech was garbled, but he was able to follow simple commands. His right arm and leg were weak with diminished sensation.

Diagnosis on admission: Ischemic stroke involving the left middle cerebral artery.

Four days after admission to an acute care hospital, Martin was medically stable. He was alert, cooperative, and had the support of his family. He was transferred to an IRF for intensive inpatient rehabilitation. Functional assessment during the first 3 days after admission to the rehabilitation unit is as follows:

Eating

Martin eats by himself after the helper provides setup assistance, such as opening milk and juice containers and cutting meat.

Grooming

Martin performs grooming activities at the sink. He washes his face, combs his hair, rinses his dentures, and shaves himself after the helper provides setup assistance.

Bathing

Martin washes, rinses, and dries just less than half of his body while sitting on a tub bench. Specifically, he bathes his chest, abdomen, and his left and right thighs. The helper then bathes Martin's arms, lower legs, buttocks, and perineal area.

Dressing - Upper Body

Martin typically wears a sweatshirt to therapy. The helper threads the left and right sleeves of the sweatshirt. Martin pulls the shirt over his head and down over his trunk. Martin performs just over half of the effort.

Dressing - Lower Body

Martin typically wears underwear, sweatpants, antiembolic stockings, and shoes on his lower body. The helper performs most of the lower body dressing tasks, with Martin performing just over one-fourth of the effort.

Toileting

Martin uses a urinal to void and the toilet for bowel movements. The helper manages his clothing before and after using the toilet or urinal. Martin cleanses himself after voiding and moving his bowels. Martin performs approximately one-third of the toileting effort.

Bladder Management

Martin uses a urinal to void. The helper places the urinal within reach on the bedside table and empties it for Martin. He has had two bladder accidents during the past week.

Bowel Management

Martin has not had any episodes of bowel incontinence. He does not use any assistive devices related to bowel management, but does take a stool softener every day.

Transfers: Bed, Chair, Wheelchair

The helper provides lifting assistance to transfer Martin from the wheelchair to the bed. Although Martin assists during the transfer, he performs less than half of the effort.

Transfers: Toilet

The helper provides lifting assistance to get Martin from a sitting position in the wheelchair to a standing

position. Although Martin assists during the transfer, he performs less than half of the effort.

Locomotion: Walk/Wheelchair

The therapist expects Martin to be ambulating at discharge. At admission, Martin travels in the wheelchair over 150 feet requiring supervision and cueing only. He walks only 15 feet at a time in therapy with one person assisting. Note: Since patient is expected to walk at discharge, record walking score.

Locomotion: Stairs

Martin has not attempted going up or down stairs.

Comprehension

Martin understands directions and questions about his daily activities. Martin indicates food and beverages preferences when someone reads the hospital menu. He does not understand more abstract information such as humor or discharge planning. Overall, Martin understands just over 90 percent of the basic information presented to him.

Expression

During the day, Martin expresses basic daily information such as asking for pain medication and food preferences. His speech is slurred, but understandable. He does not express more complex information.

Social Interaction

Martin interacts appropriately with the hospital staff, other patients and family members.

Problem Solving

Martin recognizes and solves basic problems as he performs his daily activities such as asking for help as he tries to thread his shirt without success, and asking for assistance to wash his lower body. He has more trouble with unfamiliar tasks. For example, he is unable to solve more complex problems such as managing his medications.

Memory

Martin recognizes people frequently encountered, and remembers his daily therapy schedule and directions in most situations. He has difficulty remembering under stressful situations, and requires prompting less than 10 percent of the time.

In order to classify a patient into a CMG, the IRF will use the IRF patient assessment instrument admission assessment data to score a patient's functional independence measures that consist of what are termed "motor" items and the "cognitive" items. In addition to the functional independence measures, the patient's age will also influence the CMG into which the patient is

classified. The motor items are generally indications of the patient's physical functioning level. The cognitive items are generally indications of the patient's mental functioning level, and are related to the patient's ability to process and respond to empirical factual information, use judgment, and accurately perceive what is happening. The motor items are eating, grooming, bathing, dressing upper body, dressing lower body, toileting, bladder management, bowel management, transfer to bed/chair/wheelchair, transfer to toilet, walking or wheelchair use, and stair climbing. The cognitive items are comprehension, expression, social interaction, problem solving, and memory. (The CMS IRF patient assessment instrument manual will include more information on these items.) Each item is generally recorded on our patient assessment instrument and scored on a scale of 1 to 7, with a 7 indicating complete independence in this area of functioning, and a 1 indicating that a patient is very impaired in this area of functioning.

Under the current instructions for completing the FIM instrument, a 1 is recorded if an activity did not occur indicating that the patient needs total assistance to perform the activity. For our patient assessment

instrument, an 8 will be recorded to indicate that the activity did not occur. This will enable us to distinguish between patients who needed total assistance from patients who did not perform an activity. However, for the purpose of classifying a patient into a CMG, a recorded score of 8 will be recoded as a 1. This scoring methodology will then be consistent with the scoring methodology for the FIM data used to construct the CMGs in this final rule. The methodology to determine the score will be further explained in the manual associated with our patient assessment instrument.

The coding of this patient's functional independence measures on the IRF patient assessment instrument is reflected in the chart below:

Item	**Rating**	**Rationale***
Eating	5	The helper provides assistance such as opening containers - Setup.
Grooming	5	The helper provides setup assistance - Setup.
Bathing	2	Martin washes less than half of his body – Maximal Assistance.
Dressing-Upper Body	3	The helper threads both sweatshirt sleeves. Martin threads his neck through the sweatshirt and pulls

Item	Rating	Rationale*
		the sweatshirt over his trunk – Moderate Assistance.
Dressing-Lower Body	2	Martin performs just over one-fourth of the effort - Total Assistance.
Toileting	2	Martin does his own perineal hygiene. The helper manages Martin's clothing before and after toilet/urinal use – Maximal Assistance.
Bladder Management	3	Martin has had two bladder accidents (wetting linen/clothing) during the past week (level 3). The helper provides setup assistance for bladder management. Record the lower rating – Moderate Assistance.
Bowel Management	6	Martin is not incontinent of stool (level 7) and does not use any assistive devices. He takes a stool softener (medication - level 6) - Record the lower rating – Modified Independence.
Transfer: Bed, Chair, Wheelchair	2	Martin performs between 25 and 49 percent of the effort – Maximal Assistance.
Transfer: Toilet	2	Martin performs between 25 and 49 percent of the effort – Maximal Assistance.
Walk/Wheelchair	1	Martin travels in a wheelchair more than 150 feet with supervision

Item	Rating	Rationale*
		(level 5), but is expected to walk by discharge. Record the rating based on Martin's walking: Level 1 - Total Assistance.
Stairs	1	Martin has not attempted stairs. Activity Did Not Occur - Code 8 on form, and recode to 1 for CMG assignment.
Comprehension	5	Martin understands over 90 percent of the basic information presented to him, but not complex information – Standby Prompting.
Expression	5	Martin expresses basic information, not complex information – Standby Prompting.
Social Interaction	7	Martin interacts approximately with the staff – Complete Independence.
Problem Solving	5	Martin recognizes and solves routine problems only (not complex) - Supervision
Memory	5	Martin remembers more than 90 percent of the time. He only has difficulty during stressful situations - Supervision.

* The use of the rationale and the methodology to determine the rating (score) will be further explained in the manual associated with the patient assessment instrument.

The patient's motor score (the sum of the scores for eating; grooming; bathing; dressing; toileting; bladder and bowel management; transfer: bed, chair, wheelchair; transfer: toilet; locomotion: walk/wheelchair; and locomotion: stairs) equals 34. The patient's cognitive score (the sum of comprehension; expression; social interaction; problemsolving; and memory) equals 27. Based on this patient's reason for rehabilitation (ICD-9 coding: Cerebral artery occlusion - 434.91, hemiplegia - 342.9, aphasia - 784.3), he is first classified into RIC 01 for stroke. He is then classified into CMG 0108 because his motor score is between 34-38 and he is more than 83 years old. (The cognitive score does not affect this CMG assignment.)

F. Adjustment to the CMGs

In accordance with §412.620(c) of the final regulations and section 1886(j)(2)(C)(i) of the Act, we adjust the CMGs periodically to reflect changes in treatment patterns, technology, number of discharges, and other factors affecting the relative use of resources.

VI. Payment Rates

The IRF prospective payment system in this final rule utilizes Federal prospective payment rates across 100 distinct CMGs. The Federal payment rates are established using a standard payment amount (referred to as the budget neutral conversion factor). A set of relative payment weights that account for the relative difference in resource use across the CMGs is applied to the budget neutral conversion factor and, finally, a number of facility-level and case-level adjustments may apply. The facility-level adjustments include those that account for geographic variation in wages (wage index), disproportionate share hospital (DSH) percentages, and location in a rural area. Case-level adjustments include those that apply for interrupted stays, transfer cases, short-stays, cases in which patients expire, and outlier cases, as described later in this section.

The budget neutral conversion factor provides the basis for determining the CMG-based Federal payment rates. It is a standardized payment amount that is based on average costs from a base period and also reflects the combined aggregate effects of the payment weights, various facility-level and case-level adjustments, and other

policies discussed in this section. Consequently, in discussing the methodology for development of the Federal payment rates, we begin by describing the various adjustments and factors that serve as the inputs used in establishing the budget neutral conversion factor.

We developed prospective payments for IRFs using the following major steps:

? Develop the CMG relative weights.

? Determine the payment adjustments.

? Calculate the budget neutral conversion factor.

? Calculate the Federal CMG prospective payments.

A description of each step and a discussion of our final policies follow.

A. Development of CMG Relative Weights

Section 1886(j)(2)(B) of the Act requires that an appropriate relative weight be assigned to each CMG. Relative weights are a primary element of a case-mix adjusted prospective payment system that account for the variance in cost per discharge and resource utilization among the payment groups. The establishment of relative weights will help ensure that beneficiaries have access to care and receive the appropriate services that are commensurate to other beneficiaries that are classified to

the same CMG. In addition, prospective payments that are based on relative weights encourage provider efficiency and, hence, help ensure a fair distribution of Medicare payments. Accordingly, under §412.620(b)(1) of the final regulations, we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1. We discuss the details of developing the relative weights below.

As indicated in section III. of this final rule, we believe that the RAND analysis has shown that CMGs based on functional-related groups (adjusted for comorbidities) are effective predictors of resource use as measured by proxies such as length of stay and costs. The use of these proxies is necessary in developing the relative weights because data that measure actual nursing and therapy time spent on patient care, and other resource use data, are not available. Throughout this section of the final rule, we describe how we used these proxy measures of resource use to develop the relative weights for each CMG and the specific case-level adjustments.

1. Overview of Development of the CMG Relative Weights

To calculate the relative weights, we estimate operating (routine and ancillary services) and capital costs of IRFs. For the payment rates set forth in this final rule, we use the same method for calculating the cost of a case as we did for the proposed rule; however, we have used the most recent data available. Specifically, for the relative weights set forth in this final rule, we obtained cost-to-charge ratios for ancillary services and per diem costs for routine services from the most recent available cost report data (FYs 1998, 1997, and/or 1996). We obtained charges from calendar year 1999 Medicare bill data and derived corresponding functional measures from the FIM data. We omitted data from rehabilitation facilities that are classified as all-inclusive providers from the calculation of the relative weights, as well as from the parameters that we use to define transfer cases, because these facilities are paid a single, negotiated rate per discharge and they do not maintain a charge structure.

For ancillary services, we calculate both operating and capital costs by converting charges from Medicare claims into costs using facility-specific, cost-center specific cost-to-charge ratios obtained from cost reports.

Our data analysis showed that some departmental cost-to-charge ratios were missing or found to be outside a range of statistically valid values. For anesthesiology, a value greater than 10, or less than 0.01, was found not to be statistically valid. For all other cost centers values greater than 10 or less than 0.5 were found not to be statistically valid. As with the proposed rule, we replace individual cost-to-charge ratios outside of these thresholds. The replacement value that we use for these aberrant cost-to-charge ratios is the mean value of the cost-to-charge ratio for the cost-center within the same type of hospital (either freestanding or unit).

For routine services, per diem operating and capital costs are used to develop the relative weights. In addition, per diem operating and capital costs for special care services are used to develop the relative weights. (Special care services are furnished in intensive care units. We note that fewer than 1 percent of rehabilitation days are spent in intensive care units.) Per diem costs are obtained from each facility's Medicare cost report data. We use per diem costs for routine and special care services because, unlike for ancillary services, we cannot obtain cost-to-charge ratios for those services from the

cost report data. To estimate the costs for routine and special care services included in developing the relative weights, we sum the product of routine cost per diem and Medicare inpatient days and the product of the special care per diem and the number of Medicare special care days.

In this final rule, we use a hospital-specific relative value method to calculate relative weights as described in the proposed rule. We use the following basic steps to calculate the relative weights for this final rule:

The first step in calculating the CMG weights is to estimate the effect that comorbidities have on costs. The second step is to adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step. In the third step, the adjusted costs from the second step are used to calculate “relative adjusted weights” in each CMG using the hospital-specific relative value method. The final steps are to calculate the CMG relative weights by modifying the “relative adjusted weight” with the effects of the existence of the comorbidity tiers (explained below) and normalize the weights to 1.

We describe each of these steps in greater detail below.

2. Steps for Calculating the Relative Weights

Step 1--Estimate the effect of comorbidities on costs.

We use regression analyses to determine if we should establish a separate relative weight for cases in a CMG with comorbidities meeting the appropriate criteria described in section V.B. of this preamble. In the proposed rule, we indicated that a higher payment would be made for cases that have at least one relevant comorbidity from the list included in Appendix C of the proposed rule. Under the proposed policy, payment for a case with one relevant comorbidity would be the same as a case with multiple relevant comorbidities.

Comment: Several commenters suggested that additional payments should be made for more than one comorbidity. Further, some commenters suggested that payment for comorbidities should be based on a tiered approach. Specifically, a tiered approach provides for different payments based on the cost of the comorbidity.

Response: In response to these comments, for this final rule we analyzed the use of a tiered approach that consists of three weighting levels that account for

variations in severity of relevant comorbidities. The data indicate that arraying comorbidities into three categories based on whether the costs associated with the comorbidities are considered high, medium, or low improves the extent to which payment matches cost. As described later in this final rule, separate relative weights for three tiers will now be calculated for each CMG using the weighting methodology. Then, separate payment rates will be calculated by multiplying the relative weights by a standardized payment amount which is also discussed later in this final rule. The result is variations in payment for CMGs based on differences in costs among relevant comorbidities for each tier. When a case has more than one comorbidity, the applicable CMG payment rate will be determined by the comorbidity that results in the highest payment. We believe the use of this 3-tiered approach will improve the extent to which the IRF prospective payments accurately reflect case costs. Therefore, we will use the 3-tiered approach for the payment rates set forth in this final rule.

Comment: Several commenters suggested that the list of comorbidities in the proposed Appendix C should be expanded to include specific diagnoses. In contrast, some

commenters recommended that certain diagnoses should be excluded from the list of comorbidities because they suggested these codes were inappropriate for care furnished in an inpatient rehabilitation setting.

Response: We analyzed the comorbidities listed in Appendix C in the proposed rule extensively to determine the appropriateness of the diagnoses and improve the list. Based on the results of the analyses described below, we are modifying the list of comorbidities in Appendix C of this final rule. Specifically, we applied the following general criteria to refine the comorbidity list further: We deleted codes that we found to be irrelevant to the inpatient rehabilitation population and added codes that we found to be associated with higher costs in the inpatient rehabilitation population. We removed from the list those comorbidities that we determined to be preventable by good medical care. An example would be not to pay extra for urinary tract infections, many of which can be prevented by removing unnecessary Foley catheters. In addition, as we proposed, conditions that we determined to be inherent to a specific RIC were excluded from the list of relevant comorbidities for that RIC.

We will continue to examine the appropriateness of the comorbidities and may refine the list in the future if warranted. We used the final list of comorbidities in Appendix C of this final rule to construct the payment rates effective with this final rule. This list of comorbidities will help determine which comorbidity tier may be appropriate for payment.

To compute payments for the comorbidity tiers, we performed a regression analysis to determine if the comorbidity tiers affect costs per case by RIC. In the analysis, we found that each comorbidity tier does not have the same effect on each RIC. Therefore, if coefficients by RIC are positive and significant and the comorbidity is deemed to be relevant clinically to the CMG, we calculate separate relative weights for cases for each comorbidity tier in Step 3 below.

Comment: One commenter requested clarification regarding why the CMGs that depicted expired patients were not affected by comorbidities.

Response: The process of determining the effects of comorbidities excludes cases that end in death. The number of cases used to calculate the relative weights for cases that end in death is too small to develop different

payments based on comorbidities. However, the effects of comorbidities are still accounted for in the payments. To the extent that comorbidities occur with cases ending in death, the costs of comorbidities are included in the average cost and, thus, the relative weight for these cases reflects comorbidities for these cases.

Step 2--Adjust the costs of each discharge for the effects of comorbidities.

The second step in the calculation of the weights is to adjust the resource use for each case to eliminate the effect of comorbidities. The adjusted cost (A) for a discharge is calculated as follows: Let x be a vector (a quantity completely specified by a magnitude and a direction) with three elements, one for each comorbidity tier. Each element of x will be 1 if the case is in that tier and 0 otherwise. The a is the transposed vector of coefficients corresponding to each tier in the RIC for the case. Then A = cost per discharge/exp(a*x). These adjusted costs for each discharge are then used to calculate the adjusted relative weight for each CMG, thereby eliminating the effect of comorbidities from the weight (signified by wk in the formula described in step 3 below).

Step 3--Calculate the CMG relative weights adjusted for comorbidity tiers, on an iterative basis.

The process of calculating the CMG relative weights is iterative. First, we give an initial case-mix index (CMI) value of 1 to each facility. Then, for each case, we calculate a facility-specific relative value by dividing the comorbidity-adjusted cost of the case by the average comorbidity-adjusted cost of all cases at the facility, and multiplying the result by the facility's CMI. We then set the CMG-adjusted weights in proportion to the average of the facility-specific relative values. The result is a new CMI for each facility and, therefore, new facility-specific, relative values. The process continues until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001. After the first iteration, we remove statistical outlier--cases that differ from the CMG mean by more than three standard deviations in the log scale of standardized cost. We believe this method is a reasonable statistical approach to remove aberrant values that could skew the remainder of the data. We treat discharges that meet the definition of a transfer case as a fraction of a case. (See discussion of transfers in section VI.B. of

this preamble.) We calculate relative weight for each relevant combination of CMG "without comorbidity", "tier 1", "tier 2", and "tier 3", using the following formula:

$$W(k,x) = \exp(a*x)w_k$$

where x and a are the vectors described in step 2 (all elements of x are 0 if no comorbidities were present, so exp(a*x) = 1 when no comorbidities are present). The variable (w_k) equals the comorbidity adjusted weight. If the coefficient (a) is not positive and significant as previously discussed in Step 1, then (a) will be set to equal 0 in the formula. This results in exp(a*x), in the formula, to equal 1 and the weight (W) will equal (w_k).

Step 4--Calculate the weight by modifying the relative adjusted weight with the effects of comorbidity and normalizing the weights to 1.0.

This step entails calculating a relative weight for each relevant combination of CMG and comorbidity tier. In this step, we determine the average cost per discharge for all the cases and use that value as the divisor to calculate the relative weights. For example, if the average cost per discharge across all discharges is $12,000, then the relative weight for a CMG with an average cost of $12,000 is 1, and the relative weight for a CMG

with an average cost per discharge of $20,000 is 1.67. If "r" is the relative adjusted weight for a case in a CMG with a comorbidity given by:

$$w = k\ r\ \exp(a*x),$$

then k is determined so that the average value of w is 1.

Table 1 in the Addendum to this final rule lists the CMGs, the comorbidity tiers, and their respective relative weights. The relative weights reflect the inclusion of cases with a very short interruption (return on day of discharge or either of the next 2 days). Information obtained from the first assessment will be used to determine the appropriate CMG and corresponding payment.

Comment: A few commenters suggested that additional payments should be made if the comorbidity develops at any time during the course of the inpatient stay, rather than only if the condition is recorded on the admission assessment.

Response: For the proposed rule, we stated that we proposed to pay an additional amount with the presence of a relevant comorbidity based on the initial assessment. In this final rule, we are using a modified version of the UDSmr patient assessment instrument, the FIM. For the FIM instrument, comorbidity data are not coded until the

discharge assessment. Because we are modifying our patient assessment instrument to reflect more closely the items and data collection methods from the FIM, we will obtain information regarding comorbidities from the discharge assessment. However, we will not use any comorbidities identified on the day prior to the day of discharge or the day of discharge to determine a comorbidity tier. We believe increasing payment for comorbidities that occur at the end of a beneficiary's stay is inappropriate because these comorbidities have less effect on the resources consumed during the entire stay. Often, the occurrence of a comorbidity at the end of the stay may be part of the reason the rehabilitation stay was ended. Comorbidities that are identified on the day prior to the day of discharge or the day of discharge should not be listed on the discharge assessment; we will reevaluate the appropriateness of this type of coding in the future. Therefore, in order to determine the appropriate comorbidity, we will use the ICD-9-CM codes (item 24 on the patient assessment instrument) obtained from the discharge assessment.

If a relevant comorbidity is indicated on the discharge assessment, payment will be based on the relative

weight from the appropriate comorbidity tier column in Table 1 in the Addendum to this final rule.

Comment: Several commenters expressed concern regarding relative weight compression in the proposed classification system.

Response: Subsequent to issuance of the proposed rule our analysis showed that the proposed CMG relative weights exhibited weight compression and suggested a methodology for addressing it. Weight compression may exist when payment for "high weighted" cases is less than the cost of the case and payment for "low weighted" cases is more than the cost of the case. Similarly, CMI compression may exist when facilities with high CMIs have higher standardized costs relative to their CMG than facilities with low CMIs.

To measure compression, we use regression analysis to assess the relationship of the log of the average cost minus outlier payments at a facility and the log of the CMI. The coefficient on the CMI illustrates how much cost increases with increasing the CMI. If the weights are neither compressed or decompressed, the coefficient will be 1. A value greater than 1 indicates compression. The relative weights computed for this final rule also exhibited CMI compression with a coefficient of about 1.10.

In other words, a facility with a case-mix index that is 10 percent higher than another facility will, on average, cost about 11.0 percent more.

In light of the coefficient, we explored possible reasons for compression. Analysis of the data supports an assumption that the use by IRFs of a single uniform per diem charge for routine services may be a major cause of the observed compression. This results in data on IRF claims that may not fully reflect the relative resource requirements for nursing and other routine services. Further analysis also indicates that the likely causes for the compression may be due to the bundling of ancillary services into routine costs and varying nursing intensity across CMGs. However, at the present time, there is a lack of data to resolve these issues directly. When staff time measurements become available in the future (as discussed in section III. of this final rule), we will analyze these data in terms of potential explanation of compression and modify the relative weights or payment methodologies, if warranted.

We believe it is important to alleviate compression to the extent that payment for higher cost cases is lower than costs, and payment for lower cost cases is higher than

costs. If the weights are not adjusted, inappropriate incentives will exist to admit the lower cost cases. Limiting access to higher cost cases is not a desirable outcome. In order to adjust the relative weights for this final rule, we developed an algorithm using the relationship of IRF average costs and CMI. We believe that using this algorithm to adjust the relative weights will, to the extent possible, eliminate CMI compression and result in weights that are a better measure of costs than the compressed weights. Therefore, we adjust the relative weights using the following basic formula:

$$nw(i) = w(i) + 0.10(w(i)-1)$$

where nw(i) is the new relative weight and w(i) is the relative weight prior to the adjustment.

The adjusted relative weights result in average payments per IRF that vary directly with average costs at the IRF. Although this formula is used to adjust the relative weights for each CMG, we do not apply it to the short-stay CMG because the result would be a negative relative weight. Instead, we reduce the case weight by 15 percent, which we believe based on our analysis is an appropriate amount to offset the increase in the relative weights at the high end (that is, over 1.0) and results in

weights that we find are a better measure of costs than the compressed weights.

B. Transfer Payment Policy

1. Background

In the November 3, 2000 proposed rule, we proposed a transfer policy under §412.624(f) to provide for payments that more accurately reflect facility resources used and services delivered. This reflected our belief that it is important to minimize the inherent incentives specifically associated with the early transfer of patients in a discharge-based payment system. Discharging patients early can be profitable in that IRFs can receive the full CMG payment without providing a complete course of treatment. As we previously stated, length of stay has been shown to be a good proxy measure of costs. Thus, in general, reducing lengths of stay will be profitable under the IRF prospective payment system. We are concerned that incentives might exist for IRFs to discharge patients prematurely, as well as to admit patients that may not be able to endure intense inpatient therapy services. Even if patients were transferred before receiving the typical, full course of inpatient rehabilitation, the IRF could still be paid the full CMG payment rate in the absence of a

transfer policy. Accordingly, we proposed a transfer policy that reduces the full CMG payment rate when a Medicare beneficiary is transferred.

2. Definition of Site of Care

In the proposed rule, for the purposes of our transfer policy, we proposed to define site of care as an "institutional site", although we were considering the option to extend the definition of site of care to the "provider site" definition. In addition, we solicited comments regarding the inclusion of nursing homes in the definition of site of care.

3. Criteria for Defining Transfer Cases

In the proposed rule, we proposed that in order for a discharge from an IRF to be classified as an early transfer, the length of stay for the discharge must be less than the average length of stay for the given CMG (as shown in section XII. of the proposed rule), and the patient must be discharged to another rehabilitation facility, a long-term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program or the Medicaid program, or both (65 FR 66346).

Comment: Some commenters suggested that we limit or completely eliminate the transfer policy. Specifically,

some commenters noted that a prospective payment system, by design, is based on averages, making adjustments for transfer cases unnecessary. Other commenters suggested that nursing homes be removed from the definition of transfer cases. Another commenter focused on potential access barriers for patients who use a nursing home as their residence.

Response: With the development of each new prospective payment system, analysis of the inherent incentives is necessary to determine what factors will motivate providers to optimize their payments inappropriately. As we stated in the proposed rule, a discharge-based payment system based on national average costs contains the inherent incentive to discharge patients prematurely and admit patients inappropriately. If these incentives are not addressed, Medicare funds will not be distributed in the most equitable manner possible or, more specifically, to those IRFs that are providing the full course of rehabilitative services. We note that a transfer policy for IRFs is contemplated under the statute. Specifically, section 1886(j)(1)(E) of the Act states: "Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment

to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care."

Some commenters suggested that applying our transfer policy to cases discharged to nursing homes will pose access barriers to patients whose permanent residence is a nursing home because discharge prior to the average length of stay for a CMG will always involve a transfer payment. Thus, IRFs may decide to not admit nursing home patients because they want to avoid the risk of receiving a transfer payment for their services. We believe that payments for such cases (which include an additional half day payment for the first day) are adequate to cover costs of care and should mitigate any potential incentives not to admit these patients (see comment and response regarding increasing payment for transfer cases). Accordingly, we are not adopting the commenters' recommendation to eliminate or narrow the focus of the transfer policy.

In the November 3, 2000 proposed rule, we stated that we were analyzing claims data to determine the extent to which we could distinguish among services that could be considered a substitution of care rather than an extension of the normal progression for inpatient rehabilitation

care, and to determine the frequency and intensity of both home health and outpatient therapy services. We noted that estimating the potential substitution of home health therapy services was made more challenging because we had just developed the HHA prospective payment system, and it was difficult to anticipate how therapy services would be delivered after implementation of that system.

We indicated in the proposed rule that we were not proposing to include home health services, outpatient therapy, and “day programs” in our transfer policy. However, we were considering including these services to the extent that we could distinguish when home health and outpatient therapy services are more intensive and used as a substitution for inpatient rehabilitation care. We proposed that if we could determine that the care is used as a substitution rather than just the normal progression of care, then we believed that these types of intensive home health and outpatient therapy services should be included as part of the transfer policy. We specifically solicited comments on this option.

Comment: Several commenters recommended that the transfer policy should not be extended to include home health and outpatient rehabilitation services.

Specifically, the commenters noted that many Medicare beneficiaries need and benefit from some short-term home health or outpatient therapy following discharge from an IRF. They also observed that home health and outpatient therapy services are the most appropriate and cost effective way to continue their care.

Response: To date, claims data are not available to determine the extent to which we can distinguish those services that represent a substitution of care rather than an extension of the normal progression for inpatient rehabilitation care, and to determine the frequency and intensity of both home health and outpatient therapy services. Therefore, we believe it would be inappropriate to expand the transfer policy at this time to include discharges of patients who will receive home health and outpatient therapy services. We acknowledge that many patients will require some form of therapy after discharge from the IRF. However, we remain concerned about incentives to discharge patients prematurely under the IRF prospective payment system, and as part of the monitoring system we will analyze data to compare practice patterns prior to and after its implementation. Based on future

analysis of practice patterns, we may refine payments in the future, if warranted.

In the November 3, 2000 proposed rule, we also solicited comments on a monitoring system that includes transfers or discharges from an IRF to “provider sites." This would have included transfers or discharges from an IRF to a SNF, a long-term care facility, an HHA, or an inpatient hospital. The monitoring system would include discharges and transfers from one IRF to a different IRF, including situations where the transfer occurs between organizations of common ownership. We indicated that although it does not currently appear that this type of transfer occurs frequently, further analysis of data regarding this type of transfer between IRFs may warrant an adjustment to payments. We did not receive any comments in response to our solicitation, and we will continue to develop a monitoring system that will allow us to assess the impact of the IRF prospective payment system on these types of situations.

4. Transfer Case Payment

For the November 3, 2000 proposed rule, we proposed to compute the per diem-based payment for a transfer case as follows: first, calculate the unadjusted per diem amount

for each CMG (except the short-stay CMG) by dividing the average length of stay for nontransfer cases (those cases discharged to the community with a length of stay exceeding 3 days) in the CMG into the Federal prospective payment (with or without comorbidities) for that CMG. Next, multiply the CMG per diem payment from the first step by the number of days that the beneficiary was in the IRF prior to his or her transfer. The result equals the proposed unadjusted Federal prospective payment for the transfer case. We solicited comments on the appropriateness of our proposed methodology for computing payments for transfer cases.

Comment: Several commenters suggested that there are additional costs associated with the initial day in comparison to each additional day a patient is in the IRF, and therefore recommended that we pay transfer cases at a higher rate. Further, the commenters noted the additional costs of the initial day are related to: processing the patient through the admissions department; integrating the patient into the facility; assessing the patient; and providing appropriate diagnostic tests, pharmaceuticals, and supplies. Most of the commenters recommended an additional half day payment for the first day to account

for the higher costs incurred at the beginning of the stay. Some commenters recommended a transfer payment methodology similar to the acute transfer payment methodology, where the initial day is paid two times the per diem and each additional day at the per diem.

Response: In light of these comments, we analyzed cost data for each day of stay to determine if per diem costs were significantly higher for the first day relative to subsequent days. The data support the commenters' recommendations to include an additional half day payment for the first day of a stay for transfer cases. However, the data do not support payment at two times the per diem for the first day. Therefore, under §412.624(f) of these final regulations, we will pay transfer cases a per diem amount and include an additional half day payment for the first day. As with other adjustments, this payment will be made in a budget neutral manner. We are concerned that this more precise matching of payment to average historical costs has the potential to provide an incentive for IRFs to admit patients who are not appropriate for an intensive inpatient rehabilitation program. These patients may be less expensive to care for than patients requiring intensive rehabilitation and, thus, may be more profitable

to hospitals even though these patients are soon transferred to another setting. We will monitor the appropriateness of admissions for patients who have shorter than average stays and are then transferred to another setting. We may make future payment refinements based on the extent to which this type of case increases.

Comment: Several commenters suggested that the proposed payments did not account for long–stay transfers. The commenters stated that long-stay transfers would not receive adequate payments and suggested an increase in payment for these cases.

Response: Based on the comments received, we believe it is necessary to clarify which cases were included in the construction of the CMGs, and also to identify the types of cases that were included in the construction of the relative weights for the CMGs. The cases included in the construction of the CMGs were those cases in which the patient returned home and had a length of stay greater than 3 days (short-stay and expired CMGs were created based on the remainder of the cases). For the proposed rule, we also used these data to determine the average length of stay for the groups based on these cases. Once we constructed the CMGs for the proposed rule, we then

calculated the relative weights for each group using cases in which the patient returned home and had a length of stay greater than 3 days in addition to the long-stay transfer cases. Therefore, long-stay transfer cases were included for cases other than short stays and expired cases in the construction of the relative weights for the CMGs.

For this final rule, we calculate the average length of stay for the CMGs which included those cases in which the patient returned home and had a length of stay greater than 3 days as well as long-stay transfer cases. We calculate the average length of stay in this manner so that the inputs are consistent with those used to develop the relative weights. For CMGs that have a very small number of cases (less than 10 cases), we use a model to estimate the average length of stay for that CMG. To do this, we estimate the average length of stay from an analysis of variance using the log of the length of stay as the dependent variable. The independent variables are the CMG and the comorbidity tier coefficient for each RIC. It is possible that payment for an individual case might be lower than the cost of the case, but for other cases, the total payment might be higher than costs.

C. Special Cases That Are Not Transfers

Section 1886(j)(3)(A)(v) of the Act permits us to adjust the payment rates by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. There are three types of special cases that are not transfers. The special cases include short-stay outliers, cases in which the patient expires, and interrupted stays.

1. Short-Stay Outliers

We proposed under §412.620(b)(2) of the proposed rule to develop separate weighting factor(s) for patients who are discharged (and not transferred) within a specified number of days after admission. We proposed to define a short-stay outlier as a case that has a length of stay of 3 days or less (regardless of the CMG) and that does not meet the definition of a transfer (as discussed in section VI.B. of this final rule). Payment-to-cost ratios for these cases show that, if facilities received a full CMG payment, the payment would substantially exceed the resources the IRF had expended.

We proposed to pay short-stay outliers a relative weight of 0.1908. We computed this relative weight for short-stay outlier discharges by identifying all cases in

which the length of stay is 3 days or less and the discharge does not meet the policy criteria to be considered a transfer. In the proposed rule, we calculated the relative weight for short-stay cases using the hospital-specific relative value methodology. For this final rule, we will pay short-stay cases a relative weight of 0.1651. This amount also was derived using the hospital-specific relative value method. However, we use the most recent data available (calendar year 1999 Medicare bills with corresponding FIM data) and we adjust the weight due to the results of the regression analyses described earlier in this preamble which measured the extent to which the relative weights reflect case costs.

In addition, in the proposed rule we specifically solicited comments on the appropriate time period for our short-stay criteria. We proposed that the considerations underlying the short-stay policy might also apply to cases with a length of stay greater than 3 days. More specifically, we noted that some beneficiaries may have longer lengths of stay, and yet may not require intensive inpatient rehabilitative care, or may lack the capacity to participate in an intensive rehabilitation program. Thus, we were also considering a short-stay policy that could

encompass certain cases with a length of stay longer than 3 days. We indicated that we were in the process of further analyzing claims data for Medicare beneficiaries to determine the most appropriate number of days to use in the definition of a short-stay case. We stated that if analysis of the data supported increasing the number of days for the short-stay criteria, we might adopt in the final rule a definition covering a longer timeframe than the 3-day period.

Comment: One commenter suggested that adjustments for short-stay outliers are unnecessary, because the prospective payment system is based on averages; some patients have a longer length of stay, while others have a shorter length of stay.

Response: Section 1886(j)(3)(A)(v) of the Act provides us with broad authority to adjust the payment rates under the IRF prospective payment system by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. Because the prospective payment system is based on a system of averages, certain cases could be paid significally more than their cost if the facility receives the full CMG payment. Due to the

budget neutrality provision, excessive payment for short-stay outlier cases that do not actually entail the full course of rehabilitative care results in reducing payment for those cases that warrant full payment based on the rehabilitation services delivered. Adjusting for short-stay outlier cases is a means of matching payment as closely to cost as possible. Therefore, we are not adopting the suggestion to eliminate the short-stay outlier policy.

Comment: Some commenters maintained that the time period used to define the short-stay outlier policy (3 days or less) is appropriate. Other commenters disagreed with increasing the short-stay outlier policy to encompass cases with a length of stay of longer than 3 days.

Response: In developing the short-stay CMG for the proposed rule, we performed extensive analyses using the frequency distribution of existing claims data to determine the most appropriate length of stay for the short-stay CMG. Specifically, we found that a length of stay of 3 days or less will capture the majority of those cases in which the beneficiary is unlikely to receive and benefit from a full course of rehabilitative treatment. Further, based on consultation with clinical experts, we determined the

minimum length of time needed to acclimate a beneficiary to an IRF before intensive rehabilitation can begin. In view of administrative processes and the initial assessment activities, we believe that 3 days is appropriate. Based on these analyses, we are not expanding the 3-day period for the short-stay outlier policy. However, we will monitor the extent to which practice patterns change as a result of implementing this policy, and we may make refinements in the future, if warranted.

2. Cases in Which the Patient Expires

In general, payment for cases that end in death might substantially exceed the costs if facilities received the full CMG payment for these cases. Even excluding all of the

short-stay cases with a length of stay of 3 days or fewer, payment for the remaining expired cases as a whole would still be substantially more than the costs.

In the proposed rule, we indicated that we had analyzed payment-to-cost ratios and found that we could improve the accuracy of the payments if we split expired cases into two categories based on the RIC--one for orthopedic cases and one for all other types of RICs. We further found that splitting these cases based on length of

stay also improves the accuracy of the payment system. Therefore, under proposed §412.620(b)(3), we proposed to determine weighting factor(s) for patients who expired within a specified number of days after admission. We proposed that expired cases in which a beneficiary dies within 3 days after admission are classified into the short-stay CMG. Expired cases with a length of stay greater than 3 days are classified into one of four CMGs, based on length of stay and whether the discharge falls within an orthopedic RIC (RICs 07, 08, and 09). More specifically, one group includes orthopedic discharges with a length of stay of more than 3 days but less than or equal to the average length of stay for expired cases classified within the orthopedic RIC. The second group includes orthopedic discharges with a length of stay greater than the average length of stay for expired cases classified within the orthopedic RIC. The third group includes nonorthopedic discharges with a length of stay of more than 3 days but less than or equal to the average length of stay of expired cases that are not classified within the orthopedic RIC. The fourth group includes nonorthopedic discharges with a length of stay greater than the average length of stay of expired cases that are not classified

within the orthopedic RIC. We calculated the proposed relative weights for each expired CMG using the hospital-specific relative value methodology discussed previously in this preamble.

Comment: A few commenters suggested that adjustments for cases that end in death are not necessary in the IRF prospective payment system. Specifically, one commenter indicated that, since the system is based on averages, it should account for atypical cases.

Response: Section 1886(j)(3)(A)(v) of the Act permits us to adjust the payment rates by such factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities. In the proposed rule, we noted that certain cases (such as cases in which the patient expires) that receive less than the full course of treatment for a specific CMG would be paid inappropriately if the facility received the full CMG payment. In general, cases in which the patient expires might be paid substantially more than costs if we did not create separate CMGs for these cases. Further, other cases that warrant full payment because they receive the full course of rehabilitative care would instead receive reduced payments,

due to the budget neutrality provision of the statute. Adjusting for cases in which the patient expires is a means of matching payment more closely to the cost of the case. Expired cases may also warrant additional outlier payments if the estimated cost of the case exceeds the adjusted CMG payment amount and the adjusted loss threshold amount. Therefore, in this final rule we are adopting as final the provision at proposed §412.620(b)(3), which provides for the development of weighting factor(s) for cases in which patients expire within the number of days after admission that we specify.

3. Interrupted Stay

In proposed §412.602, we proposed to define an interrupted stay as a stay in which the beneficiary is discharged and returns to the same IRF within 3 consecutive calendar days. We proposed to pay one discharge payment for these cases. The assessment from the initial stay would be used to determine the appropriate CMG.

Comment: Several commenters expressed concern about the proposed interrupted stay policy. Some commenters recommended that the interrupted stay policy be eliminated or limited to a 24-hour time period.

Response: We believe that, in the absence of an interrupted stay policy, incentives might exist for facilities to attempt to inappropriately receive more than one CMG payment for the same patient by moving the patient out of the IRF, only to return the patient to the same IRF, solely to maximize payments. We believe this would be an undesirable outcome of the IRF prospective payment system. Therefore, we are not adopting the recommendation to eliminate or reduce the interrupted stay policy. In addition, in this final rule, we are clarifying in §412.602 that the duration of the interruption of stay of 3 consecutive calendar days begins with the day of discharge from the IRF and ends on midnight of the third day.

Comment: One commenter suggested that we include the interrupted stay policy in the codified regulations text.

Response: In response to this comment, we are adding language to the regulation text at §412.624(g).

Comment: Other commenters requested clarification regarding how services during the interruption of the IRF stay would be paid.

Response: As stated above, in this final rule we are adding a paragraph (g) to proposed §412.624 to specify special payment provisions for interrupted stays when a

beneficiary is discharged from the IRF to an acute care hospital. Under §412.624(g), there will be no separate DRG payment to the acute care hospital when the beneficiary is discharged and returns to the same IRF on the same day. However, if a beneficiary receives inpatient acute care hospital services, the acute care hospital can receive a DRG payment if the beneficiary is discharged from the IRF and does not return to that IRF by the end of that same day.

D. Adjustments

Section 1886(j)(6) of the Act requires an adjustment to the Federal prospective payments to account for geographic area wage variation. Section 1886(j)(3)(A)(v) of the Act confers broad discretion on the Secretary to adjust prospective payments "by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." Section 1886(j)(4) of the Act authorizes (but does not require) the Secretary to make specified payment adjustments (including an adjustment for outlier cases).

Consistent with what we proposed in the November 3, 2000 proposed rule, in this final rule we will

adjust payments for facilities located in rural areas, in addition to the geographical wage adjustment. Further, we will adjust payments to reflect the percentage of low-income patients. We discuss these adjustments and the final payment methodologies below.

1. Area Wage Adjustment

Section 1886(j)(6) of the Act specifies that payment rates under the IRF prospective payment system must be adjusted to account for geographic area wage variation. The statute requires the Secretary to adjust the labor-related portion of the prospective payment rates for area differences in wage levels by a factor reflecting the relative facility wage level in the geographic area of the rehabilitation facility compared to the national average wage level for these facilities. In accordance with §412.624(e)(1) of this final rule, we will adjust payment rates for geographic wage variations using the following methodology:

To account for wage differences, we first identify the proportion of labor and nonlabor components of costs. In general, the labor-related share is the sum of relative importance of wages, fringe benefits, professional fees, postal services, labor-intensive services, and a portion of

the capital share from an appropriate market basket. We use the excluded hospital market basket with capital costs to determine the labor-related share. The excluded hospital market basket with capital costs is derived from available cost data for rehabilitation hospitals, long-term care hospitals, psychiatric hospitals, cancer hospitals, and children's hospitals. In the proposed rule, we estimated the labor-related share for FY 2001. However, because implementation of the IRF prospective payment system is effective with cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, we are now estimating the labor-related share for FY 2002.

The labor-related share is the sum of the weights for those cost categories contained in the excluded hospital with capital market basket that are influenced by local labor markets. These cost categories include wages and salaries, employee benefits, professional fees, labor-intensive services and a 46-percent share of capital-related expenses. The labor-related share for FY 2002 is the sum of the FY 2002 relative importance of each labor-related cost category, and reflects the different rates of price change for these cost categories between the base year and FY 2002. The sum of the relative importance for

FY 2002 for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) is 68.821 percent, as shown in the chart below. The portion of capital that is influenced by local labor markets is estimated to be 46 percent, which is the same percentage used for the hospital inpatient capital-related prospective payment system. Because the relative importance for capital is 7.770 percent of the excluded hospital with capital market basket in FY 2002, we take 46 percent of 7.770 percent to determine the labor-related share for FY 2002. The result is 3.574 percent, which we add to 68.821 percent for operating cost to determine the total labor-related share for FY 2002. Thus, the labor-related share that we will use for rehabilitation facilities in FY 2002 is 72.395 percent, as show in the chart below.

Total Labor-Related Share

Cost Category	**Relative Importance (Percent) FY 2002**
Wages and salaries	50.038
Employee benefits	11.285

Professional fees	2.045
Postal services	0.245
All other labor intensive services	5.208
SUBTOTAL	**68.821**
Labor-related share of capital costs	3.574
TOTAL	**72.395**

Comment: A few commenters requested clarification of references to different labor-related shares in the proposed rule.

Response: In the proposed rule, we described the methodology for computing the labor-related share for FY 2001 (71.301 percent). We proposed a wage adjustment using an estimated FY 2001 labor-related share which was appropriate given that the IRF prospective payment system was proposed to be implemented on or after April 1, 2001. However, in this final rule, we use the estimated FY 2002 labor-related share of 72.395 to develop the impacts among the various classes of IRFs, as well as for determining the payment rates set forth in this final rule. We use the estimated FY 2002 labor-related share for these purposes

because the payment system will be implemented during FY 2002, and we updated the payments used in the impact analysis in section VIII. of this final rule to the midpoint of FY 2002.

In the proposed rule as well as in this final rule, we apply an estimated labor-related share of 70.5 percent (FY 1998) in order to determine the facility-level adjustments other than the wage adjustment. For purposes of determining facility-level adjustments (other than the wage adjustment), the FY 1998 labor-related share continues to be appropriate, given that, for the proposed rule, the labor-related share was applied to FY 1998 cost report and cost per case data. Although we obtained more recent Medicare bill and FIM data in developing the payment rates set forth in this final rule, the cost report data are still primarily from FY 1998. Therefore, we believe the estimated labor-related share for FY 1998 remains most appropriate to apply to the data used in the regression analyses to determine the facility-level adjustments other than the wage adjustment.

The labor-related portion of the unadjusted Federal payment is multiplied by a wage index value to account for

area wage differences. We use inpatient acute care hospital wage data to compute the wage indices.

The inpatient acute care hospital wage data that we use include the following categories of data associated with costs paid under the inpatient acute care hospital prospective payment system (as well as outpatient costs): salaries and hours from short-term, acute care hospitals, home office costs and hours, certain contract labor costs and hours, and wage-related costs. The wage data exclude the wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare Part B, because these services are not covered under the IRF prospective payment system.

Consistent with the wage index methodologies in other prospective payment systems, we divide hospitals into labor market areas. For purposes of defining labor market areas, we define an urban area as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget. We define a rural area as any area outside an urban area. For the purposes of computing the wage index for IRFs, we determine the wage index values for urban and rural areas

without regard to geographic reclassification under section 1886(d)(8) or 1886(d)(10) of the Act.

Comment: One commenter questioned how we would compute the wage index for providers with more than one MSA. Also, a few commenters requested that we use "post-reclassification" wage data, that is, wage data that reflects any geographic reclassification, to compute the IRF wage index.

Response: We believe the actual location of an IRF as opposed to the location of affiliated providers is most appropriate for determining the wage adjustment because the data support the premise that the prevailing wages in the area in which a facility is located influence the cost of a case. Further, IRFs provide services that are considered part of the post-acute continuum of care. In order to be consistent with the area wage adjustments made to other post-acute care providers (that is, under the existing SNF and HHA prospective payment systems), we are using the inpatient acute care hospital wage data without regard to any approved geographic reclassifications under section 1886(d)(8) or 1886(d)(10) of the Act. Therefore, we are not adopting the use of "post-reclassification" wage data and the wage index used by an IRF will be based on the

facility’s actual location, as shown in Tables 3A and 3B in the Addendum to this final rule, without regard to the urban or rural designation of any affiliated or related providers.

In the November 3, 2000 proposed rule, we proposed to use an IRF wage index that was based on FY 1996 inpatient acute care hospital wage data (65 FR 66349). These data were also used to compute the FY 2000 hospital inpatient prospective payment system wage indices. In the proposed rule, we also indicated that we proposed to use FY 1997 inpatient acute care hospital wage data to develop the wage index for IRFs for this final rule. Because these are the most recent final data available, for this final rule, we used the FY 1997 inpatient acute care hospital wage data to develop the wage index for the IRF prospective payment system.

Comment: Some commenters recommended that we research the development of a separate wage index for rehabilitation facilities. Further, commenters stated that the acute care hospital wage structure and labor classification are not necessarily representative of rehabilitative staffing and wages.

Response: At this time, we are unable to develop a separate wage index for rehabilitation facilities. There is a lack of specific IRF wage and staffing data necessary to develop a separate IRF wage index accurately. Further, in order to accumulate the data needed for such an effort, we would need to make modifications to the cost report. In the future, we will continue to research a wage index specific to IRF facilities. Because we do not have an IRF specific wage index that we can compare to the hospital wage index, we are unable to determine at this time the degree to which the acute care hospital data fully represent IRF wages. However, we believe that a wage index based on acute care hospital wage data is the best and most appropriate wage index to use in adjusting payments to IRFs, since both acute care hospitals and IRFs compete in the same labor markets.

The final IRF wage indices are computed as follows:

- Compute an average hourly wage for each urban and rural area.
- Compute a national average hourly wage.
- Divide the average hourly wage for each urban and rural area by the national average hourly wage--the result is a wage index for each urban and rural area.

To calculate the adjusted facility payments for the payment rates set forth in this final rule, the prospectively determined Federal prospective payment is multiplied by the labor-related percentage (72.395) to determine the labor-related portion of the Federal prospective payments. This labor-related portion is then multiplied by the applicable IRF wage index shown in Table 3A for urban areas and Table 3B for rural areas in the Addendum to this final rule.

The resulting wage-adjusted labor-related portion is added to the nonlabor-related portion, resulting in a wage-adjusted payment. The following example illustrates how a Medicare fiscal intermediary would calculate the adjusted facility Federal prospective payment for IRF services with a hypothetical Federal prospective payment of $10,000 for services provided in the rehabilitation facility located in Heartland, USA. The rehabilitation wage index value for facilities located in Heartland, USA is 1.0234. The labor-related portion (72.395 percent) of the Federal prospective payment is $7,239.50 = ($10,000*72.395 percent), and the nonlabor related portion (27.605 percent) of the Federal prospective payment is $2,760.50 = ($10,000*27.605 percent). Therefore,

the wage-adjusted payment calculation is as follows:

$10,169.40 = ($7,239.50*1.0234) + $2,760.50

2. General Specifications to Determine Other Adjustments

As indicated earlier, section 1886(j)(3)(A)(v) of the Act confers broad authority on the Secretary to adjust prospective payments “by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." To determine whether other payment adjustments are warranted for the IRF prospective payment system, we conducted extensive regression analyses of the relationship between IRF costs (including both operating and capital costs per case) and several facility characteristics such as percentage of low-income patients, geographic location, and other factors that may affect costs. The appropriateness of potential payment adjustments is based on both cost effects estimated by regression analysis and other factors, including simulated payments that we discuss in section VIII.B.2. of this final rule.

Our analyses for developing the payment adjustments set forth in this final rule included 714 facilities for which cost and case-mix data were available. We estimated

costs for each case by taking facility specific, cost-center specific cost-to-charge ratios and multiplying them by charges. We obtained cost-to-charge ratios from FYs 1996, 1997, and/or 1998 cost report data, and obtained charges from the calendar years 1998 and 1999 Medicare claims data. We calculated the cost per case by summing all costs and dividing by the number of equivalent full cases. After calculating the cost per case for both years, we combined the number of cases and total costs for both years. For this final rule, we did not adjust the 1998 cost per case by the case-weighted average change in cost per case between 1998 and 1999 because the difference is less than 0.2 percent and adjusting the 1998 costs would have such a small effect. Using the data from both years should provide more stability in the payment adjustments than would using data for a single year. When data for only one year are available, we use the costs and number of equivalent cases for that year.

Multivariate regression analysis is a standard way to examine facility cost variation and analyze potential payment adjustments. We looked at two standard models: (1) fully specified explanatory models to examine the impact of all relevant factors that might potentially

affect facility cost per case; and (2) payment models that examine the impact of those factors specifically used to determine payment rates. The general specification for the multi-variate regression is that the estimated average cost per case (the dependent variable) at the facility can be explained or predicted by several independent variables, including the CMI, the wage index for the facility, and a vector of additional explanatory variables that affect a facility's cost per case, such as its teaching program or the proportion of low-income patients. The CMI is the average of the CMG weights derived by the hospital-specific relative value method for each facility. We give transfer cases a partial weight based on the ratio of the length of stay for the transfer to the average length of stay for the CMG, in addition to an increase to account for the half-day payment for the first day. We count interrupted stay cases as a single stay. Using the regression coefficients, we then simulated payments and calculated payment-to-cost ratios for different classes of hospitals, for specific combinations of payment policies.

For the proposed rule, we used payment variables from the hospital inpatient prospective payment system, including DSH patient percentage, both capital and

operating teaching variables (resident-to-average daily census and resident-to-bed ratios, respectively) as well as the teaching variable (resident-to-adjusted average daily census ratio) used in the analyses for the hospital outpatient prospective payment system, and variables to account for location in a rural or large urban area.

For this final rule, we updated the variables described above based on the availability of more recent data and refined some of the independent variables based on suggestions from the comments received. A discussion of the major payment variables and our findings for this final rule appears below.

3. Adjustments for Rural Location

We examined costs per case for both large urban and rural IRFs. In the regression models, both explanatory and payment, the variable for rural IRFs was positive and significant ($p<0.05$). The standardized cost per case for rural IRFs is almost 16 percent higher than the national average. On average, rural IRFs tend to have fewer cases, a longer length of stay, and a higher average cost per case. The difference in costs becomes more evident when the average cost per case is standardized for the CMI and the wage index. In the regression models, large urban IRFs

were not significantly different from other urban facilities. Under §412.624(e)(3) of this final rule, we adjust for rural IRFs by multiplying the payment by 1.1914. This adjustment was determined by using the coefficients derived from the regressions.

Comment: Two commenters suggested that we consider the patient's residence to determine eligibility for the rural adjustment, as opposed to the physical location of the IRF.

Response: Our analysis of the IRF data has shown that the physical location of IRFs corresponds with the cost of a case, with rural IRFs experiencing higher costs other things being equal. Rural IRFs have higher costs because they exhibit practice patterns that contribute to increased expense relative to other facilities, such as lower transfer rates for longer lengths of stay. Further, if any effects in costs are associated with beneficiaries who reside in rural locations, the relative weights should address these differences. The purpose of the relative weights is to account for the level of severity of a given case. If beneficiaries who reside in rural locations require more costly care, the relative weights should account for these costs. Therefore, we are not adopting

the recommendation to consider the beneficiary's place of residence to determine eligibility for the rural adjustment.

4. Adjustments for Indirect Teaching Costs

In general, facilities with major teaching programs tend to be located in large urban areas and have more cases, a higher case mix, and a higher proportion of low-income patients. For the proposed rule, we found that when the regression models used only the payment variables that might warrant an adjustment under the prospective payment system (that is, percentage of low-income patients or rural/urban status, rather than for-profit and not for-profit), the indirect teaching cost variable was not significant. Accordingly, we did not propose an adjustment for indirect teaching costs.

For the proposed rule, we looked at different specifications for the teaching variable. We used a resident-to-average daily census ratio and a resident-to-bed ratio that we based on the estimated number of residents assigned to the inpatient area of the rehabilitation facility. We also used a resident-to-adjusted average daily census ratio based on the total number of residents at the hospital complex and outpatient as well as inpatient volume.

For this final rule, we assessed the extent to which we could improve the variable used to measure indirect

teaching intensity in order to reassess the appropriateness for an adjustment. However, developing an appropriate measure is complicated by differences in reporting resident counts for freestanding rehabilitation hospitals and units.

To determine if an adjustment for indirect teaching costs is warranted for this final rule, we use the same approach that we used in the proposed rule to calculate the number of full-time equivalent (FTE) residents. That is, we use the number of residents reported for the rehabilitation units of acute care hospitals. For freestanding hospitals, we estimate the number of residents assigned to the routine area (that is, room and board and direct nursing care) based on the ratio of resident salaries apportioned to those areas to total resident salaries for the facility. We define teaching intensity as the ratio of FTE residents-to-average daily census. As in the proposed rule, the indirect teaching variable was insignificant in the payment regressions. Therefore, we will not adjust payments for costs associated with indirect teaching.

Comment: A few commenters requested that we reconsider an adjustment for costs associated with indirect teaching.

Response: As we previously stated, the results of the regression analyses for the proposed rule showed that the indirect teaching variable was significant only with the fully specified regression, and not with the payment regression. However, in the analyses conducted for this final rule, the indirect teaching variable was not significant for either the fully specified regression or the payment regression. Also, the impacts among the various classes of facilities reflecting the fully phased-in IRF prospective payment system in section VIII. of this final rule illustrate that IRFs with the highest measures of indirect teaching lose approximately 2 percent of estimated payments under the IRF prospective payment system. Further, these impacts among the various classes of facilities do not account for changes in behavior that facilities will likely adopt in response to the inherent incentives of the IRF prospective payment system. Accordingly, IRFs can change their behavior in ways to mitigate any potential losses. In considering the impacts among these types of facilities and the results of the regression analyses, we will not adjust payments for indirect teaching because we believe that this type of

adjustment is not supported by our regression analyses or impact analyses.

5. Adjustments for Low-Income Patients

We assessed the appropriateness of adjustments for facilities serving low-income patients. For the proposed rule, we limited our analysis to the effects of serving low-income patients on costs per case rather than a subsidy for uncompensated care.

Also, in the proposed rule, we evaluated a facility-level adjustment that takes into account both the percentage of Medicare patients who are receiving Supplemental Security Income (SSI) and the percentage of Medicaid patients who are not entitled to Medicare. We proposed to use the same measure of the percentage of low-income patients currently used for the acute care hospital inpatient prospective payment system, which is the DSH variable. The low-income payment adjustment we chose improves the explanatory power of the IRF prospective payment system because as a facility's percentage of low-income patients increases, there is an incremental increase in a facility's costs. We proposed to adjust payments for each facility to reflect the facility’s percentage of low-income patients using the DSH measure.

Comment: One commenter suggested that the payment for the percentage of low-income patients adjustment should reflect all low-income patients, including uninsured patients.

Response: While we recognize that an adjustment accounting for the costs of serving uninsured patients may be desirable, we do not currently have access to data that would allow us to measure uncompensated care. However, we analyzed the performance of other measures of low-income patients, in addition to DSH, such as the SSI ratio, dual eligibles (Medicare beneficiaries entitled to Medicaid), and self-pay/charity cases (determined by UDSmr non-Medicare data by primary and secondary payer) in order to determine the measure that most accurately matches payment to costs. To do this, we used data for the IRFs for which we had all payer information. These data indicate that the DSH variable improves the explanatory power of the groups better than the other measures, with an r-squared of .0529. The measure of dual eligibles, self-pay/charity, and the SSI ratio did not predict costs as well as DSH. Further, the SSI ratio measure was not significant in our regression analyses. After examining the use of these alternative low-income measures, we found the DSH variable explained

costs more fully than the other variables that we examined. Therefore, we are not adopting the commenter's suggestion and will use the DSH variable as the basis of the adjustment for low-income patients.

Comment: A few commenters noted that the adjustment for low-income patients was not consistent with the name of the adjustment, "disproportionate" share adjustment. In general, one commenter stated that if all IRFs are eligible to receive this adjustment, then the adjustment is not applicable only to those IRFs that treat a "disproportionate" share of low-income patients.

Response: In response to this comment, in this final rule, we will refer to the adjustment for low-income patients as the LIP adjustment. However, we will use the term DSH when we refer to the measure used to compute IRF's percentage of low-income patients because it is the same measure used to measure low-income patients in acute care hospitals.

Comment: Some commenters suggested that the LIP adjustment have a threshold similar to the inpatient acute care hospital prospective payment system.

Response: We analyzed different specifications for the LIP adjustment. One option had a threshold of 5

percent. In general, under this option, a facility would not be allowed to receive the LIP adjustment unless its DSH was greater than 5 percent. Although we considered this option, we favored the use of a LIP adjustment that matches payment as closely to cost as possible. The LIP adjustment we chose improves the explanatory power of the IRF prospective payment system because as a facility's percentage of low-income patients increases, there is an incremental increase in a facility's cost. It is also important to note that the thresholds established under the inpatient acute care hospital prospective payment system were statutorily mandated. Thus, we have decided to adjust the IRF payments set forth in this final rule for the percentage of low-income patients, but the adjustment does not have a threshold amount.

As we stated in the proposed rule, section 4403(b) of the BBA requires us to develop a Report to the Congress containing a formula for determining additional payment amounts to hospitals under section 1886(d)(5)(F) of the Act. In light of our current study of a new payment formula for determining adjustments for hospitals serving low-income patients and MedPAC's related recommendation, in the November 3, 2000 proposed rule, we indicated that we

would consider these study results and other information as they become available and potentially refine the LIP adjustment in the future to ensure that we pay facilities in the most consistent and equitable manner possible.

Comment: One commenter requested clarification of whether all facilities will receive a LIP adjustment.

Response: All IRFs are eligible to receive a LIP adjustment. There is not a required threshold for a minimum number of beds or a minimum amount of DSH in order to receive the adjustment.

In accordance with proposed §412.624(e)(2), which we are adopting as final, for the payment rates set forth in this final rule, we multiply each IRF's payment by the following formula to account for the cost of furnishing care to low-income patients:

(1+DSH) raised to the power of .4838

$$\text{Where DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

Comment: One commenter stated that the calculation of the LIP adjustment should exclude the data that we imputed for 46 IRFs. The commenter indicated that the regressions are extremely sensitive to these imputed values.

Response: In light of this comment, we analyzed the data to assess the extent to which the results of the multivariate regressions are sensitive to the imputed DSH values used to calculate the proposed adjustments. For the proposed rule, we used a 2-step process to impute missing values for our low-income patient measures: (1) For rehabilitation units where we were missing only the Medicaid days, we estimated the Medicaid rehabilitation days by applying the ratio of Medicaid acute care days to total acute care inpatient days to the total inpatient rehabilitation days. (2) If we were missing the SSI days or if we were also missing Medicaid days for the hospital, we imputed low-income variable values by assigning the State average DSH percentage for large urban and other facilities as appropriate. Our regression analyses indicated that the facilities with missing values were significantly different from other facilities. The findings indicate that the results are sensitive to the imputation methodology described above.

In this final rule, we have modified the imputation methodology for imputing DSH values for the LIP adjustments. To impute, we estimate the proportion of non-Medicare days in the rehabilitation facility that are

attributable to Medicaid patients as a function of two variables: the facility's percentage of Medicare patients who are entitled to SSI and the State in which the facility is located. The results of the regressions are not sensitive to this methodology (r-squared = .4159). We believe the value of including the imputations is that it allows us to address other concerns the industry expressed in its comments. Specifically, these concerns referred to the number of facilities used to calculate the payment rates. Using an imputation method allows us to include more facilities than we could have otherwise if we had not imputed DSH values for this final rule. In order for an IRF to be included in the analysis for the facility-level adjustment, all values of the independent variables examined under the regression must exist. For example, if we are missing the DSH value for certain facilities, even if we know the remainder of the independent variables (such as the wage index), we cannot include these facilities in the regression. Therefore, in this final rule we use an improved imputation methodology for the DSH variable that does not influence the results of the adjustments.

Comment: Several commenters expressed concern about the data used to measure DSH for purposes of calculating

the LIP adjustment. Specifically, some commenters preferred the use of a DSH measure that better reflected the inpatient rehabilitation units, while others preferred the use of the overall acute care hospital DSH measure for the units.

Response: We constructed the DSH variable, as described above, using the latest data available at the time that we developed the proposed rule. Specifically, we used

the ratio of Medicaid days to total days specific to the rehabilitation unit when the facility identified this information on its cost report. When the unit-specific information was unavailable, we used the overall Medicaid days and total days for the entire facility. For the SSI portion of the DSH variable, we used the acute care hospitals' ratio of SSI days to total Medicaid days for the rehabilitation units.

For purposes of constructing the LIP adjustment for this final rule, we obtained unit specific measures of the ratio of the SSI days to the total number of Medicare days. Further, we used the ratio of Medicaid (non-Medicare days) to total days when this information was available on the cost reports, in addition to the improved imputation

methodology described above. Therefore, to the extent possible, the LIP adjustment set forth in this final rule is based on data specific to inpatient rehabilitation units, as well as freestanding inpatient rehabilitation hospitals. We believe data that are most reflective of the characteristics of the inpatient rehabilitation setting are most appropriate in determining payments under the IRF prospective payment system.

Comment: Some commenters suggested that differences in Medicaid coverage rules would disadvantage IRFs in certain States because of the LIP adjustment.

Response: In order to evaluate these concerns, we examined the feasibility of making an adjustment for the percentage of low-income patients using only the ratio of SSI to Medicare days. The results of this analysis indicated that the ratio of SSI to Medicare days would not predict the cost of a case as well as using the DSH variable. Specifically, the r-square value for the DSH variable is .0609 compared to the r-square value of .0525 for the SSI variable. Therefore, using the DSH variable enables us to develop a payment system that better predicts IRF costs compared to using the SSI variable. We acknowledge that Medicaid coverage rules may vary from

State to State. However, based on considerable analysis, we believe that the DSH variable is the best current predictor of costs associated with treating low-income patients in IRFs. In addition, it is unclear whether certain IRFs in States are disadvantaged in the context of the entire payment (reflecting all adjustments). Further, analysis of the "new payment to current payment ratios" illustrated in Table II of section VIII. of this final rule indicates that the IRFs with the lowest DSH percentages gain approximately 2 percent of estimated payments under the IRF prospective payment system, while IRFs with moderate levels of DSH lose approximately 1 or 2 percent of estimated payments under the IRF prospective payment system. Therefore, if an IRF has a DSH amount that is lower than average due to Medicaid coverage rules for its State, the IRF may still experience a gain in payments under the IRF prospective payment system. In the future, we will assess the extent to which DSH continues to measure the percentage of low-income patients adequately. This future analysis may include the effect of the LIP adjustment on IRFs in various States.

Comment: Some commenters requested clarification of how new providers would receive DSH payment adjustments.

Response: New providers will receive a LIP adjustment when cost report data are available to determine a DSH amount. Until information from the cost report is available, the information used to calculate DSH is unknown and we will not be unable to determine the LIP adjustment. Once we have the information from the cost report, we will make final payments for the previous appropriate year in a lump sum and we will use these data in the calculation of future interim payments. We will issue further instructions in a Medicare program memorandum regarding the details of implementing this policy.

Comment: One commenter suggested that the LIP adjustment is beyond our legislative authority and stated that the LIP adjustment fulfills no policy objectives.

Response: Section 1886(j)(3)(A)(v) of the Act gives the Secretary broad authority to adjust the prospective payment rates by "such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." Through the multivariate regression analyses described above, we found that providing a LIP adjustment would allow us to match payment more closely to cost. Therefore, as a matter of policy, the purpose of the LIP

adjustment for the payment rates set forth in this final rule is to pay IRFs more accurately for the incremental increase in Medicare costs associated with the facility's percentage of low-income patients.

6. Adjustments for Alaska and Hawaii

Section 1886(j)(4)(B) provides that the Secretary is authorized, but not required, to take into account the unique circumstances of IRFs located in Alaska and Hawaii. There are currently three IRFs in Hawaii and one in Alaska. However, for the proposed rule, we had cost and case-mix data for only one of the facilities in Hawaii (982 cases) and the facility in Alaska (117 cases). Due to the small number of cases, analyses of the simulation results were inconclusive regarding whether a cost-of-living adjustment would improve payment equity for these facilities. Therefore, we did not propose to make an adjustment for rehabilitation facilities located in Alaska and Hawaii.

Comment: A few commenters suggested that a cost-of-living adjustment for Hawaii and Alaska should be revisited.

Response: As with the proposed rule, in determining the adjustments for the final rule, we had cost and case-mix data for only one of the facilities in Hawaii and the

facility in Alaska. Further, the total number of cases in the 1999 data (783) is smaller. Due to the small number of cases, analyses of the simulation results were inconclusive regarding whether a cost-of-living adjustment would improve payment equity for these facilities. Therefore, we are not making an adjustment under section 1886(j)(4)(B) of the Act for rehabilitation facilities located in Alaska and Hawaii for the payment rates set forth in this final rule.

7. Adjustments for Cost Outliers

Section 1886(j)(4) of the Act specifies that the Secretary is authorized, but not required, to provide for additional payments for outlier cases. Further, section 1886(j)(4)(A)(iii) of the Act specifies that the total amount of the additional payments for outliers cannot be projected to exceed 5 percent of the total Medicare payments to IRFs in a given year. Providing additional payments for costs that are beyond a facility's control can strongly improve the accuracy of the IRF prospective payment system in determining resource costs at the patient and facility level. In general, outlier payments reduce the financial risk that would otherwise be substantial due to the relatively small size of many rehabilitation facilities. These additional payments reduce the financial

losses caused by treating patients who require more costly care and, therefore, will reduce the incentives to underserve these patients.

In the November 3, 2000 proposed rule (65 FR 66357), we considered various outlier policy options. Specifically, we examined outlier policies using 3, 4, and 5 percent of the total estimated payments. In order to determine the most appropriate outlier policy, we analyzed the extent to which the various options reduce financial risk, reduce incentives to underserve costly beneficiaries, and improve the overall fairness of the system. We proposed an outlier policy of
3 percent of total estimated payments because we believed this option would optimize the extent to which we could protect vulnerable facilities, while still providing adequate payment for all other cases.

We proposed under §412.624(e)(4) to make outlier payments for discharges whose estimated cost exceeds an adjusted threshold amount ($7,066 multiplied by the facility's adjustments) plus the adjusted CMG payment. We would adjust both the loss threshold and the CMG payment amount for wages, rural location, and disproportionate share. We proposed to calculate the estimated cost of a

case by multiplying an overall facility-specific cost-to-charge ratio by the charge. Based on analysis of payment-to-cost ratios for outlier cases, and consistent with the marginal cost factor used under section 1886(d) of the Act, we proposed to pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the CMG payment and the loss amount of $7,066, as adjusted). We calculated the outlier threshold by simulating aggregate payments with and without an outlier policy, and applying an iterative process to determine a threshold that would result in outlier payments being equal to 3 percent of total payments under the simulation.

Comment: Some commenters suggested that adjusting the outlier threshold by the rural adjustment and the LIP adjustment would be inappropriate.

Response: In the proposed rule, we stated that the outlier threshold of $7,066 was to be multiplied by the facility-level adjustments reflecting facility characteristics such as geographic location and LIP. Before the above calculation can be done, we must first determine if any facility characteristics affect the cost of a case. Then we determine adjustments for these

characteristics. As we previously discussed, the data showed that wage variation, IRFs located in rural areas, and the percentage of low-income patients affect case costs. Further, we calculate an IRF standardized budget neutral conversion factor that eliminates the effects of the IRF adjustments. We then determine the appropriate outlier percentage based on analyses of the data. As in the proposed rule, in this final rule we calculate the standardized threshold amount by eliminating the effects of the various adjustments. The standardized outlier threshold for the payment rates set forth in this final rule is $11,211. In this final rule, as with the proposed rule, the standardized outlier threshold is then adjusted for each IRF to account for its wage adjustment, its LIP adjustment, and its rural adjustment, if applicable. Using this facility-specific adjusted threshold amount to determine eligibility for outlier payments results in facility payments that do not unduly harm any particular class of IRFs and appears to distribute payments more equitably among the various cases as shown in section VIII. of this final rule. Therefore, we believe applying the facility-level adjustment to the threshold amount is appropriate.

Comment: Some commenters, including MedPAC, suggested increasing the outlier provision from the proposed 3 percent to the full 5 percent allowed under the BBA. One commenter suggested that if we address the issue of compression with the relative weights (which we discuss in response to an earlier comment in this section VI. of this final rule), the increase to 5 percent may not be necessary.

Response: Since outlier payments are a redistribution of payment, it is important to set the outlier percentage so that it maximizes resources available for all types of cases while still protecting a facility from the financial risk associated with extremely high-cost cases. As we stated earlier, section 1886(j)(4) of the Act authorizes, but does not require, us to provide for additional payments for outlier cases. Further, section 1886(j)(4)(A)(iii) of the Act provides that the total amount of the additional payments cannot be projected to exceed 5 percent of the total payments projected or estimated to be made to prospective payment units in a given year. The outlier policy options specified in the proposed rule were evaluated by analyzing financial risk, accuracy of payment

at the case level, and accuracy of payment at the hospital level.

We measure financial risk of an IRF using the standard deviation of annual profit as a fraction of expected annual revenue. The outlier payment decreases the financial risk of an IRF as the outlier percentage increases. However, financial risk decreases at a declining rate of improvements as the outlier percentage increases. These results indicate that an outlier percentage lower than the statutory maximum amount of 5 percent of total estimated payments would allow us to pay more appropriately for both outlier and
nonoutlier cases.

Increasing the percentage of the outlier policy would leave less payments available to cover the costs of nonoutlier cases, due to the budget neutral provision of the statute. Specifically, an increase in the outlier percentage would decrease the budget neutral conversion factor and reduce payment for all nonoutlier cases. Although the purpose of outlier payments is to funnel more payments to high-cost cases in which the IRF prospective payment system payment would be substantially less than the cost of the case, it is possible that in some instances the

IRF total prospective payment, including the outlier payment, will exceed the cost of the case. Paying cases more than costs may occur with outlier payments because an IRF's overall cost-to-charge ratio, which is used to derive the estimated cost of the case to determine if the case is an outlier may differ substantially from an actual department (for example, a physical therapy cost center) cost-to-charge ratio in which the services are delivered. Specifically, analysis of the various outlier percentage options for the proposed rule illustrated that the amount by which payment is more than cost increases substantially as the outlier percentage increases. Simulating payments using the 1997 data, the 1-percent outlier payment policy option resulted in an estimated total "overpayment" of approximately $300,000. When we simulated a 3-percent outlier percentage, estimated "overpayments" were at $1.0 million, and when we simulated outlier payments at 5 percent, "overpayments" almost doubled to $1.9 million.

Outlier payments funnel more resources to the most costly cases, which improves accuracy of payment at the case level. This is evident in the analysis of r-squared values, a statistical measure of how well the outlier payment matches the costs of the case. The percent

improvement of the predictive r-squared value decreases as the outlier payment percentage increases. Using the 1997 cost data, going from the "no outlier" policy option to setting the outlier policy at 1 percent increases the r-squared value by 30.7 percent, while going from a 4-percent to a 5-percent outlier payment percentage increases the r-squared value by only 4.2 percent.

To evaluate an outlier policy at the hospital level, we compared payment-to-cost ratios over each outlier percentage option. Because outliers in the data sample appeared to be widely distributed across all types of hospitals, we found that the amount of the outlier payment has little effect on the payment-to-cost ratio for any specific group at the hospital level.

In summary, the results of financial risk, accuracy at the case level, and accuracy at the hospital level suggest that there should be a limit on the outlier percentage that is less than the statutory limit and that balances the need to compensate accurately for high-cost care while still maximizing remaining resources to improve the payment accuracy of nonoutlier cases. The 3-percent outlier policy set forth in the proposed rule reflected a careful analysis of the previously discussed issues and research that

supported this policy. Therefore, under §412.624(e)(4) of this final rule, we are adopting the outlier policy that we had proposed. Accordingly, we are establishing an outlier policy to adjust payments under §412.624(d)(1) of this final rule. This outlier policy reflects 3 percent of estimated aggregate payments under the IRF prospective payment system.

Comment: Some commenters requested clarification of how new facilities will be able to qualify for outlier payments, since these facilities will not have the historical cost reports needed to compute the estimated cost that determines if the case is an outlier.

Response: We will calculate national average cost-to-charge ratios for urban and rural areas. We will apply these cost-to-charge ratios to new facilities based on the facility's urban or rural status.

Comment: Some commenters requested clarification of whether we will pay more or less for outlier cases retrospectively based on actual cost-to-charge ratios once they exist.

Response: We will not make any retrospective adjustments for outlier payments.

Comment: A few commenters suggested that we adjust payments in the initial 5 years of the IRF prospective payment system in order to provide a financial cushion for hospitals that experience significant losses.

Response: We developed the adjustments described in this final rule based on an analysis of empirical data, as well as consideration of numerous comments. The impacts of the IRF prospective payment system among the various classes of providers are shown in section VIII. of this final rule. In general, the new payment to current payment ratios in Table II of section VIII. of this preamble illustrate that most groups of providers will benefit under the IRF prospective payment system. Further, based on these impacts, there is no strong indication that any particular group of providers will experience significant losses under the IRF prospective payment system. Therefore, we are not adopting the suggestion to provide an additional adjustment for those facilities that may be paid less than their costs under the IRF prospective payment system.

Comment: Some commenters requested clarification regarding the order in which the case-level and facility-level payment provisions apply to a case.

Response: First, we will discuss the order in which the case-level adjustments (excluding outlier payments) may apply to a case. Then we will describe the order in which the facility-level adjustments apply. Lastly, we will discuss the possible application of outlier payments.

The first case-level adjustment that needs to be considered for possible application is whether or not the case meets the definition of an interrupted stay. If the case meets the definition of an interrupted stay, then one CMG payment will be made based on the assessments from the initial stay. Also, if the case meets the definition of an interrupted stay, the total number of days the beneficiary was in the IRF, both prior to and after the interruption, is counted in order to determine if the case meets the definition of a transfer case or the short-stay CMG.

The next case-level adjustment considered for application is the transfer policy. To do this, the length of stay is considered, as well as the discharge destination. Specifically, if the length of stay of the case is less than the average length of stay for the given CMG and the patient is transferred to another IRF, long-term care hospital, inpatient hospital, or nursing home that accepts Medicare or Medicaid, then the case will be

considered to be a transfer. If the case is not a transfer, then we determine whether or not the case falls under the short-stay CMG where the length of stay is 3 days or less, irrespective of whether the beneficiary expired. If the beneficiary's length of stay is more than 3 days and he or she expires, one of the four CMGs for expired cases will be applicable, depending on the length of stay and whether the beneficiary is classified to an orthopedic RIC or not. If none of the above case-level adjustments are applicable to a given case, then the case is classified to the appropriate CMG.

After the appropriate case-level adjustments and the CMG is assigned, facility-level adjustments will be applied. First, the wage adjustment is applied by taking the labor-related share of the payment, multiplying by the appropriate wage index, and adding the results to the nonlabor-related portion of the payment. Then the adjustment for low-income patients is determined and multiplied by the wage adjusted payment. Also, if the IRF is a rural facility, the payment will be further multiplied by 1.1914. After all the adjustments described above, both case-level and facility-level, are applied to a case, a

determination can be made as to whether or not an outlier payment is warranted.

E. Calculation of the Budget Neutral Conversion Factor

1. Overview of Development of the Budget Neutral Conversion Factor

Prior to BIPA, section 1886(j)(3)(B) of the Act specified that, for prospective payment units during FYs 2001 and 2002, the amount of total payments, including any payment adjustments under sections 1886(j)(4) and (6) of the Act, must be projected to equal 98 percent of the amount of payments that would have been made during these fiscal years for operating and capital-related costs of rehabilitation facilities had section 1886(j) of the Act not been enacted. We proposed to incorporate this provision in proposed §412.624(d).

Under proposed §412.624(c)(1) and (c)(3), we proposed to calculate the budget neutral conversion factor using the following steps:

Step 1--Update the latest cost report data to the midpoint of the fiscal year 2001.

Step 2--Estimate total payments under the current payment system.

Step 3--Calculate the average weighted payment per discharge amount under the current payment system.

Step 4--Estimate new payments under the proposed payment system without a budget neutral adjustment.

Step 5--Determine the budget neutral conversion factor.

These same steps are used in developing the payment rates set forth in this final rule.

However, in this final rule, we update the latest cost report data to the midpoint of the FY 2002 because the IRF prospective payment system will be implemented on or after January 1, 2002 and before October 1, 2002.

2. Steps for Developing the Budget Neutral Conversion Factor

? Data Sources

In the November 3, 2000 proposed rule, the data sources that we proposed under §412.624(a)(1) to construct the budget neutral conversion factor included the cost report data from FYs 1995, 1996, and 1997, a list obtained from the fiscal intermediaries of facility-specific target amounts applicable for providers that applied to rebase their target amount in FY 1998, and calendar year 1996 and 1997 Medicare claims with corresponding UDSmr or COS (FIM)

data. We used data from 508 facilities to calculate the budget neutral conversion factor. These facilities represented those providers for which we had cost report data available from FYs 1995, 1996, and 1997. We used the 3 years of cost report data to trend the data to the midpoint of the year 2001 based on the facilities' historical relationship of costs and target amounts.

In the proposed rule, we indicated that we were unable to calculate payment under the current payment system for some IRFs because cost report data were unavailable. We stated that we would attempt to obtain the most recent payment amounts for these IRFs through their Medicare fiscal intermediaries and we would consider using these data to construct the payment rates for the final rule. We also indicated that we would examine the extent to which certain IRFs (such as new facilities) are not included in the construction of the budget neutral conversion factor, and would consider the appropriateness of an adjustment to reflect total estimated payments for IRFs more accurately.

In addition, because we did not have FIM data for all rehabilitation facilities, we indicated that for the final rule we would further analyze the extent to which the data used to construct the budget neutral conversion factor

accurately reflect the relationship between case-mix and cost. We stated that we were considering the use of weighted averages to account more fully for those types of facilities that might be underrepresented with the given data.

Comment: Some commenters suggested that the sample of IRFs used to develop the budget neutral conversion factor was not representative of all IRFs in terms of size, location, and case-mix. They added that a nonrepresentative sample would skew the development of a budget neutral conversion factor.

Response: To address these concerns, for the final rule we used more IRFs in the construction of the budget neutral conversion factor. To do this, we modified the update methodology to include newer IRFs for which we were unable to obtain cost report data for FYs 1996, 1997, and 1998. We explain the modifications to the update methods below.

For IRFs that did not have cost report data for FYs 1996, 1997, and 1998, we updated their cost report data by applying the excluded hospital operating market basket update. For instance, if an IRF was new in FY 1997, we applied the excluded hospital operating market basket to

update its cost report data to FY 1999. If the IRF was new in FY 1998, we used the excluded hospital operating market basket update to update its cost report data for FY 1999 and FY 2000. For IRFs that were not considered “new,” we used cost report data from FYs 1996, 1997, and 1998 to trend the data to the midpoint of the year 2001 based on the IRF's historical relationship of costs and target amounts. The FY 1996 cost report data were used to determine the update to be used for FY 1999; the FY 1997 cost report data were used to determine the update to be used for FY 2000; and the FY 1998 cost report data were used to determine the update for FY 2001.

In the proposed rule, we discussed the methodology for developing the budget neutral conversion factor in which we used data from only those IRFs that we had matching bill and FIM data and historical cost report data. In the proposed rule, we stated our intent to further analyze the extent to which the data used to construct the budget neutral conversion factor accurately reflects the relationship between case-mix and cost. Through this further analysis, we are able to include more IRFs into the data used to construct the budget neutral conversion factor. Including more IRFs with characteristics, as well

as more cases in addition to the data for which we have Medicare bills matched with FIM data, allows for the development of prospective payments that will better reflect the IRF population.

The CMI for an IRF is computed as the average of the CMG relative weights for all rehabilitation cases for that particular facility. The CMI reflects resource use and can be regarded as a measure of the average relative cost of each IRF's cases. Because case payment under the IRF will be a function of the budget neutral conversion factor as well as case-level and facility-level adjustments, the conversion factor can be influenced by each facility's historical CMI.

In an attempt to include IRFs, as well as cases, with missing FIM data in the calculation of the budget neutral conversion factor, we developed a technique to estimate CMI data for these facilities. By utilizing the relationship between case-level and facility-level characteristics and their predictive power of an IRF's CMI, we can include more IRFs in the calculation of the budget neutral conversion factor, which should better reflect the characteristics of all types of facilities. We are able to estimate the CMI because we can obtain pertinent information regarding the

characteristics of all IRFs, such as the facility's TEFRA payment, the facility's adjustment factor(s), (the wage adjustment, the LIP adjustment, and, if applicable, the rural adjustment) and other facility characteristics (for example, freestanding/unit status). We also use pertinent information regarding the characteristics of a case (even those cases for which we do not have matched FIM data) such as surgical procedures performed during the preceding acute care stay, the principal diagnosis of the acute care stay, and all the diagnoses for the rehabilitation stay, the length of stay, and the type of facility the beneficiary may be transferred to after the rehabilitation stay. Using these facility and case characteristics, we estimated the CMI. We then combined these CMI estimates with the CMIs derived from those cases for which we had matching bill and FIM data and we calculated the budget neutral conversion factor using the methodology described in the proposed rule and in this final rule.

By using these estimated CMIs, the data used to construct the budget neutral conversion factor better represents IRFS. The overall effect of using more data in the construction of the budget neutral conversion factor is an increase of 1.0 percent. The majority of this increase

occurs because IRFs are less likely to report FIM data for very short stay cases.

In summary, in this final rule, we specify under §412.624(a)(1) the data sources used to construct the budget neutral conversion factor (the basis for the prospective payment). For this final rule, the latest available data include the cost report data from FYs 1996, 1997, and 1998 and calendar year 1998 and 1999 Medicare claims with corresponding FIM data. We used data from 1,024 facilities to calculate the budget neutral conversion factor.

The steps below describe the methodology we used to calculate the budget neutral conversion factor for the payment rates set forth in this final rule.

Step 1--Update the latest operating and capital cost report data to the midpoint of fiscal year 2002.

Section 1886(j)(3)(A)(i) of the Act and §412.624(b) of these final regulations specify that the per-payment-unit amount is to be updated to the midpoint of the fiscal year 2001, using the weighted average of the applicable percentage increases provided under section 1886(b)(3)(B)(ii) of the Act. The statute allows us more discretion in determining an appropriate methodology to

update from the year 2000 to 2001. For this final rule, under §412.624(c)(2), we update from the midpoint of the year 2001 to the midpoint of the year 2002 using the same methodology provided under section 1886(b)(3)(B)(ii) of the Act. For this final rule, as in the proposed rule, we determine the appropriate update factor for each facility by using one of the following four methodologies:

? For facilities with costs that equal or exceed their target amounts by 10 percent or more for the most recent cost reporting period for which information is available, the update factor is the market basket percentage increase.

? For facilities that exceed their target by less than 10 percent, the update factor is equal to the market basket minus .25 percentage points for each percentage point by which operating costs are less than 10 percent over the target (but in no case less than 0).

? For facilities that are at or below their target but exceed two-thirds of the target amount, the update factor is the market basket minus 2.5 percentage points (but in no case less than 0).

? For facilities that do not exceed two-thirds of their target amount, the update factor is 0 percent.

Step 2--Estimate total payments under the current payment system.

Operating payments are calculated using the following methodology:

Step 2a--We determine the facility-specific target amount, subject to the applicable cap on the target amounts for rehabilitation facilities. There are two national caps for rehabilitation facilities. We used the cap amounts for excluded rehabilitation hospitals and units published in the August 1, 2000 **Federal Register** (65 FR 47096). For facilities certified before October 1, 1997, the applicable cap for FY 2001 is $15,164 for the labor-related share, adjusted by the appropriate geographic wage index and added to $6,029 for the nonlabor-related share. For facilities certified on or after October 1, 1997, the cap applicable for FY 2001 is $13,002 for the labor-related share, adjusted by the appropriate geographic wage index and added to $5,169 for the nonlabor-related share (65 FR 47098). We then inflate these amounts to the midpoint of the year 2002 by applying the excluded hospital operating market basket.

Step 2b--We calculate the lower of the results of Step 2a.

? The facility-specific target amount (including application of the cap) times the Medicare discharges (the ceiling); or

? The facility average operating cost per case times Medicare discharges. We determine payment for operating costs by using one of the following methods:

(1) For facilities whose operating costs are lower than or equal to the ceiling, payment is the lower of either the operating costs plus 15 percent of the difference between the operating costs and the ceiling, or the operating costs plus 2 percent of the ceiling.

(2) For facilities whose operating costs are more than 110 percent of the ceiling, payment is the lower of either the ceiling multiplied by 1.10 or half of the difference between 110 percent of the ceiling and the operating costs.

(3) For facilities whose operating costs are greater than the ceiling but less than 110 percent of the ceiling, payment is the ceiling.

Step 2c--After operating payments are computed, we determine capital payments. As we previously stated in step 1, capital cost report data are updated to the midpoint of FY 2002. Section 4412 of the BBA amended

section 1886(g) of the Act by reducing capital payments that would otherwise be made for rehabilitation facilities. Payments for capital-related costs are made on a reasonable cost basis. The BBA mandated the reduction of capital payments by 15 percent. Therefore, we reduce capital payments for IRFs multiplying the costs by .85.

Step 2d--The next step in determining total payments under the current payment system is to add operating and capital payments. Section 1886(j)(1)(A) of the Act specifies that the IRF prospective payment system will include both operating and capital-related costs. Once we determine appropriate payments for operating costs (including bonus and penalty payments as appropriate), and after making reductions for capital payments, we add the operating costs and the reduced capital-related costs together.

Step 2e--The BIPA provides for the Secretary to adjust the rates so that the amount of total payments to IRFs are projected to equal payments that would have been paid in the absence of this new payment methodology. Payments made for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002 are based on both the facility-specific payment and the Federal

prospective payment that we implement with this final rule. Therefore, in accordance with §412.624(d)(2) in this final rule, we adjust the Federal prospective payment rates for FY 2002 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been made to IRFs had the IRF prospective payment system not been implemented. However, under the amendments made by section 305(b) of BIPA, in calculating the budget neutrality adjustment, we do not take into account payment adjustments resulting from elections by hospitals under section 1886(j)(1)(F) of the Act (as added by section 305(b)(1)(C) of BIPA) to not be paid under the transition period methodology described in section VI.H. of this final rule. In addition, we adjust total estimated payments to reflect the estimated proportion of additional outlier payments under §412.624(d)(1), and for coding and classification changes under §412.624(d)(3). These payments are the numerator of the equation used to calculate the budget neutral adjustment.

Step 3--Calculate the average weighted payment per discharge amount under the excluded hospital payment system.

Once we calculate total payments under the excluded hospital payment system, we can then calculate an average per discharge payment amount weighted by the number of Medicare discharges under the current payment system. We do this by first determining the average payment per discharge amount under the excluded hospital payment system for each facility. We use cost report data to calculate each facility’s average payment per discharge by dividing the number of discharges into the total payments. The next step is to determine the weighted average per discharge payment amount. To calculate this amount, we multiply the number of discharges from the Medicare bills by each facility’s average payment per discharge amount. We then sum the amounts for all facilities and divide by the total number of discharges from the Medicare bills to derive an average payment per discharge amount that is weighted by the number of Medicare discharges.

Step 4--Estimate payments under the IRF prospective payment system without a budget neutral adjustment.

We then simulate payments under the IRF prospective payment system without a budget neutral adjustment. To do this, we multiply the following: each facility's CMI, the number of discharges from the Medicare bills, the

appropriate wage index, the rural adjustment (if applicable), an appropriate LIP adjustment, and the weighted average per discharge payment amount computed in Step 3. We then add together the total payments for each facility. This total is the denominator in the calculation of the budget neutral adjustment.

Step 5--Determine the budget neutral conversion factor.

The denominator of the budget neutral adjustment equation is the total estimated payments for the prospective payment system without a budget neutral adjustment (the total amount calculated in Step 4). We calculate the budget neutral adjustment by dividing total reduced payments under the excluded hospital payment system (the total amount calculated in Step 2) by estimated payments for the prospective payment system implemented with this final rule. We then multiply the resulting budget neutral adjustment by the average weighted per discharge payment amount under the excluded hospital payment system to derive the budget neutral conversion factor.

Comment: A few commenters suggested that the proposed budget neutral conversion factor was too low.

Response: As explained in the proposed rule, the conversion factor is the payment amount adjusted for budget neutrality and standardized to account for a number of facility-level and case-level adjustments. Because the adjustments in this final rule reflect modifications from the proposed rule (specifically the LIP adjustment), the budget neutral conversion factor is higher compared to the proposed budget neutral conversion factor. We further adjust the budget neutral conversion factor to include a behavioral offset in order to calculate the final budget neutral conversion factor.

As previously stated, to calculate the budget neutral conversion factor, we had to estimate what would have been paid under the excluded hospital payment system. However, due to the incentives for premature discharge inherent in the new IRF prospective payment system, we expect that differences in the utilization of these services might result. In the case of the IRF prospective payment system implemented with this final rule, discharges to other settings of care may take place earlier than under the excluded hospital payment system due to payments based on average costs. This would result in lower payments under that payment system for this care, which must be taken into

account when computing budget neutral payment rates. Accounting for this effect through an adjustment is commonly known as a behavioral offset.

For this final rule, the budget neutral conversion factor with a behavioral offset is $11,838.00. This represents a 1.16 percent reduction in the calculation of the budget neutral conversion factor otherwise calculated under the methodology described in this section VI.E. of this final rule. In determining this adjustment, we actuarially assumed that the IRFs would regain 15 percent of potential losses and augment payment increases by 5 percent through transfers occurring at or beyond the mean length of stay associated with CMG or home health care at any point. We applied this actuarial assumption, which was based on consideration of our historical experience with new payment systems, to the estimated "losses" and "gains" among the IRFs.

Comment: Some commenters were concerned about the inclusion of the reduction to the budget neutral conversion factor (the behavioral offset) and suggested that the reduction be removed in the final calculation of the IRF prospective payments. For example, the commenters advanced various reasons for eliminating the offset, including the

perception that the reduction penalizes efficient providers and the concern that the offset further reduces facility revenues to offset the costs of implementing the MDS-PAC.

Response: We apply the behavioral offset as a reduction to the budget neutral conversion factor before applying all case-level and facility-level adjustments to determine a final payment amount. For this final rule, the behavioral offset is very low, at 1.16 percent and represents an integral part of the budget neutrality system. The justification for including an offset relates to the inherent incentives of a discharged-based prospective payment system. Because the prospective payment system bases payment rates on average costs for clinically similar cases, it will be more profitable for facilities to discharge patients earlier than under the excluded hospital cost-based payment system. We have identified the length of stay of a case as an important variable in predicting the costs of the case. Reductions in length of stay will reduce costs for the facilities while Medicare, in the absence of a behavioral offset, would continue to pay based on lengths of stay and rehabilitation services provided prior to the IRF prospective payment system. Our application of this

adjustment is consistent with Section 1886(j)(3)(B) of the Act. This provision requires the Secretary, in establishing budget neutral rates, to consider the effects of the new payment system on utilization and other factors reflected in the composition of Medicare payments. Although one of the primary purposes of a prospective payment system is to provide incentives to be efficient, historic reductions in length of stay after a prospective payment system is implemented indicate the need to reduce the budget neutral conversion factor further. The purpose of the budget neutrality provision is to pay the same amount under the prospective payment system as would have been paid under the excluded hospital cost-based payment system for a given set of services, but not to pay that same amount for fewer services furnished as a result of the inherent incentives of the new prospective payment system. Thus, our methodology must account for the change in practice patterns due to new incentives in order to maintain a budget neutral payment system.

Efficient providers are adept at modifying and adjusting practice patterns to maximize revenues while still maintaining optimum quality of care for the patient. We take this behavior into account in the behavioral

offset. Thus, the purpose of the offset is not just to account for the behavior of inefficient providers but also to account for the behavior of other providers who, due to the new incentives, provide more efficient care. Since providing more efficient care would have lowered reimbursement under the old payment system, the offset does not just account for inefficient behavior, but also accounts for what the costs will be under the new payment system as compared to the old one. For these reasons, we believe that such a minimal behavioral offset will not adversely affect efficient providers.

Prior to BIPA, section 1886(j)(3)(B) of the Act specified that, for prospective payment units during FYs 2001 and 2002, the amount of total payments, including any payment adjustments under sections 1886(j)(4) and 1886(j)(6) of the Act, must be projected to equal 98 percent of the amount of payments that would have been made during these fiscal years for operating and capital-related costs of rehabilitation facilities had section 1886(j) of the Act not been enacted. Section 305(a) of BIPA amended section 1886(j)(3)(B) of the Act to delete the 2-percent reduction of the budget neutrality provision for FY 2002. This statutory change results in higher payment rates for

IRFs; these additional monies can be used by IRFs to better assist them with the costs associated with completing patient assessment instruments.

As we previously discussed, we believe including a behavioral offset is appropriate to ensure a budget neutral payment system for the IRF prospective payment system. We derived the low behavioral offset of the IRF prospective payment system through careful consideration of many factors, including the estimated impacts among the facilities and the analysis of the incentives inherent in the new payment system, as well as the recognition that, as more prospective payment systems evolve, there is a reduction in the extent to which providers can modify their behavior to influence payment.

In summary, in this final rule, we are maintaining the methodology used to calculate the behavioral offset as specified in the proposed rule.

F. Development of the Federal Prospective Payment

Once we calculate the relative weights for each CMG and the budget neutral conversion factor, we can determine the Federal prospective payments. In accordance with §412.624(c)(4) of these final regulations, we calculate these CMG payments by multiplying the budget neutral

conversion factor by each of the CMG relative weights. The equation is as follows:

Federal Prospective Payment = CMG Relative Weight*Budget Neutral Conversion Factor

Table 2 in the Addendum to this final rule displays the CMGs, the comorbidity tiers, and the corresponding Federal prospective payments.

G. Examples of Computing the Adjusted Facility Prospective Payments

We will adjust the Federal prospective payments, described above, to account for geographic wage variation, low-income patients and, if applicable, facilities located in rural areas.

To illustrate the methodology that we will use for adjusting the Federal prospective payments, we provide the following example. One beneficiary is in rehabilitation facility A and another beneficiary is in rehabilitation facility B. Rehabilitation facility A's DSH is 5 percent, with a LIP adjustment of 1.0239 and a wage index of 0.987, and the facility is located in a rural area. Rehabilitation facility B's DSH is 15 percent, with a LIP adjustment of 1.0700 and a wage index of 1.234, and the facility is located in an urban area. Both Medicare

beneficiaries are classified to CMG 0111 (without comorbidities). This CMG represents a stroke with motor scores in the 27 to 33 range and the patient is between 82 and 88 years old. To calculate the facility's total adjusted Federal prospective payment, we compute the wage adjusted Federal prospective payment and multiply the result by: the appropriate disproportionate share adjustment and the rural adjustment (if applicable). The following table illustrates the components of the adjusted payment calculation.

Examples of Computing a Facility's

Federal Prospective Payment

	FACILITY A	FACILITY B
Federal Prospective Payment	$20,033.81	$20,033.81
Labor Share	x .72395	x .72395
Labor Portion of Federal Payment	= $14,503.48	= $14,503.48
Wage Index	x 0.987	x 1.234
Wage Adjusted Amount	= $14,314.93	$17,897.29
Non-Labor Amount	+ $5,530.33	+ $5,530.33
Wage Adjusted Federal Payment	19,845.26	$23,427.62
Rural Adjustment	x 1.1914	x 1.0000
Subtotal	23,643.65	= $23,427.62
DSH Adjustment	x 1.0239	x 1.070

Total Adjusted Federal Prospective Payment	**$24,208.73**	**$25,067.56**

Thus, the adjusted payment for facility A will be $24,208.73 and the adjusted payment for facility B will be $25,067.56.

H. Computing Total Payments Under the IRF Prospective Payment System

Under the BBA, section 1886(j)(1) of the Act describes how to compute a facility's payment during a transition period. Under the transition period, the prospective payment amount consists of a portion of the amount the facility would have been paid if the prospective payment system had not been implemented (facility-specific payment) and a portion of the adjusted facility Federal prospective payment. The transition period specifically covers cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003. During the first transition period, for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001 (FY 2001), payment would consist of 66 2/3 percent of the amount of the facility-specific payment and 33 1/3 percent of the IRF adjusted facility Federal prospective payment. During the second transition period, for cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002 (FY 2002), payment would consist of

33 1/3 percent of the amount of the facility-specific payment and 66 2/3 percent of the IRF adjusted facility Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002 (FY 2003), payment would be 100 percent of the adjusted facility Federal prospective payment.

Section 305(b)(1)(C) of the BIPA added section 1886(j)(1)(F) to the Act, which allows an IRF to elect to be paid 100 percent of the adjusted facility Federal prospective payment for each cost reporting period to which the blended payment methodology would otherwise apply. This provision of the BIPA is effective as though it were included in the enactment of the BBA.

1. Payments Based on the Transition Period for Cost Reporting Periods Beginning During FY 2002

In the proposed rule, we described how the application of the transition period percentages would be affected by the delay in implementation of the IRF prospective payment system. Specifically, as proposed, a facility with a cost reporting period beginning on or after October 1, 2000 and before April 1, 2001 (the planned implementation date as stated in the proposed rule) would not be paid under the IRF prospective payment system for that cost reporting

period. For a facility with a cost reporting period beginning on or after April 1, 2001 and before October 1, 2001, the prospective payment during that period would be comprised of the blended rate for FY 2001 as specified by the statute (66 2/3 percent of the facility specific payment and 33 1/3 percent of the adjusted facility Federal prospective payment). For a facility with a cost reporting period beginning on or after October 1, 2001 and before October 1, 2002 (FY 2002), the prospective payment during that period would be comprised of the blended rate for FY 2002 as specified by the statute (33 1/3 percent of the facility specific payment and 66 2/3 percent of the adjusted facility Federal prospective payment). For cost reporting periods beginning on or after October 1, 2002, the prospective payment would be 100 percent of the adjusted facility Federal prospective payment.

Comment: Many commenters suggested that it would be unfair for the transition period to apply to two cost reporting periods for some facilities while other facilities have the transition period apply to only one cost reporting period. In addition, some commenters believed that the law intended for all facilities to be afforded a 2-year transition period.

Response: We recognize that the statute contemplated a 2-year transition period, but the statute (at section 1886(j)(1)(B) of the Act) also provides that the IRF prospective payment system must be fully implemented for cost reporting periods beginning on or after October 1, 2002. In other words, the statute provides that, for cost reporting periods beginning on or after October 1, 2002, payment will no longer be based on a blend of the Federal prospective payment and the facility-specific payment. As stated earlier, the earliest feasible date for implementation of the IRF prospective payment system is for cost reporting periods beginning on or after January 1, 2002, and we are adhering to the statutory payment formula applicable beginning January 1, 2002.

We recognize that the delayed implementation of the IRF prospective payment system means that hospitals will be paid under the blend methodology for a period of less than 2 years (under section 1886(d)(1)(F) of the Act, as added by section 305 of Public Law 106-554, hospitals may elect to not be paid under the blend methodology at all). But we believe that a shortened transition period caused by a delay in implementation of the IRF prospective payment system is not inequitable. One purpose of the transition

period is to give hospitals time to adjust before a prospective payment system is fully implemented. Hospitals have been on notice since the enactment of Public Law 105-33 that the IRF prospective payment system would be fully implemented for cost reporting period beginning on or after October 1, 2002. We did not shorten the timetable for full implementation of the prospective payment system payment rates, and hospitals have had ample time to prepare. Also, we note that, presumably, hospitals that would be "disadvantaged" by a shortened transition period (hospitals whose facility-specific rate is higher than the Federal prospective payment rate) have been "advantaged" by the delay in implementation.

Accordingly, we are adhering to the statutory payment formula applicable for cost reporting periods beginning on January 1, 2002. In §412.626(a)(1)(i) of this final rule, we are specifying that payment to an IRF for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002 consists of 33 1/3 percent of the facility-specific payment and 66 2/3 percent of the adjusted Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, payment will be based entirely on the Federal prospective payment.

2. Payments Based on the Election to Apply the Full Prospective Payment for Cost Reporting Periods Beginning During FY 2002

Under §412.626(b) of the final regulations, we are specifying that a provider may elect not to be paid under the transition period described in section VI.H.I. above. Payment to IRFs making this election will be based on 100 percent of the adjusted Federal prospective payment in effect for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

An IRF must request this election no later than 30 days before the start of its first cost reporting period for which payment is based on the IRF prospective payment system. The IRF must make its request in writing to its Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the start of the cost reporting period, regardless of any postmarks or anticipated delivery dates. Requests received (whether mailed or delivered by other means) later than the 30th day before the cost reporting period will not be approved. If the 30th day before the start of the cost reporting period falls on a day on which the postal service or other delivery sources are not open for business, the

IRF is responsible to ensure that enough time is allowed for the delivery of the request before the deadline. If an IRF's request is not received timely or is otherwise not approved, payment will be based on the transition period methodology.

3. Payments Based on the Full Prospective Payment for Cost Reporting Periods Beginning During FY 2003 and After

Under §412.626(a)(l)(ii) of the final regulations, we are specifying that payment made to IRFs with cost reporting periods beginning on or after October 1, 2002 (FY 2003 and after) will consist of 100 percent of the adjusted Federal prospective payment. We described the basis of payments made for fiscal years after FY 2002 in §412.624 of the final regulations.

I. Method of Payment

We will base a beneficiary's classification into a CMG on data obtained during the initial patient assessment. The CMG will determine the Federal prospective payment that the IRF receives for the Medicare-covered Part-A services furnished during the Medicare beneficiary’s episode of care. However, under §412.632(a) of these final regulations, the payment arises from the submission of a discharge bill. This will allow us to pay for comorbidities diagnosed during the stay, classify cases appropriately to one of the five special CMGs (for cases in which the patient expires or has a very short length of stay), adjust the payment to reflect an early transfer, and determine if the case qualifies for an outlier payment.

Accordingly, the IRF will record the CMG and other information on the beneficiary's discharge bill, and will submit the bill to its Medicare fiscal intermediary for processing. The payment made represents payment in full, under §412.622(b) of these final regulations, for inpatient operating and capital-related costs, but not for the costs of an approved medical education program, bad debts, blood clotting factors provided to patients with hemophilia, or other costs not paid for under the IRF prospective payment system.

Under the existing payment system, (1) an IRF may be paid using the periodic interim payment (PIP) method described in §413.64(h) of the existing regulations; (2) rehabilitation units are paid under the PIP method if the hospital of which they are a part is paid under existing §412.116(b); (3) IRFs may be eligible to receive accelerated payments as described in existing §413.64(g); or (4) rehabilitation units are eligible for accelerated payments under existing §412.116(f). The statute does not preclude the continuation of PIP. We presently see no reason to discontinue our existing policy of allowing the PIP and accelerated payment methods under the prospective payment system for qualified IRFs, although we may choose

to evaluate its continuing need in the future. Therefore, we will permit the continued availability of PIP and accelerated payments for services of IRFs paid under the prospective payment system at paragraphs (b) and (e) of §412.632 of the final regulations.

For those services paid under the PIP method, the amount reflects the estimated prospective payments for the year rather than estimated cost reimbursement. An IRF receiving prospective payments, whether or not it received a PIP prior to receiving prospective payments, may receive a PIP if it meets the requirements in §412.632 and receives approval by its intermediary. Similarly, if an intermediary determines that an IRF that received a PIP prior to receiving prospective payments is no longer entitled to receive a PIP, it will remove the IRF from the PIP method. As provided in §412.632, intermediary approval of a PIP is conditioned upon the intermediary's best judgment as to whether making payment under the PIP method would not entail undue risk of resulting in an overpayment to the provider.

Excluded from the PIP amount are outlier payments that are paid in final upon the submission of a discharge bill. In addition, Part A costs that are not paid for under the

IRF prospective payment system, including Medicare bad debts and costs of an approved educational program, will be subject to the interim payment provisions of the existing regulations at §413.64.

Under the prospective payment system, if an IRF is not paid under the PIP method, it may qualify to receive an accelerated payment. Under §412.632, the IRF must be experiencing financial difficulties due to a delay by the intermediary in making payment to the IRF, or there is a temporary delay in the IRF's preparation and submittal of bills to the intermediary beyond its normal billing cycle because of an exceptional situation. The IRF must make a request for an accelerated payment, which is subject to approval by the intermediary and by us. The amount of an accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services. Recoupment of an accelerated payment occurs as bills are processed or through direct payment by the IRF.

J. Update to the Adjusted Facility Federal Prospective Payment

Under section 1886(j)(3)(C) of the Act and under §412.624(c)(3)(ii) of the final regulations, future updates, for FY 2003 and subsequent fiscal years, to the

adjusted facility Federal prospective payments (budget neutral conversion factor) will include the use of an increase factor based on an appropriate percentage increase in a market basket of goods and services comprising services for which the IRF prospective payment system makes payment. This increase factor may be the market basket percentage increase described in section 1886(b)(3)(B)(iii) of the Act. We include in Appendix D of this final rule a description of the IRF market basket that we used in developing an increase factor under section 1886(j)(3)(C) of the Act.

K. Publication of the Federal Prospective Payment Rates

In accordance with section 1886(j)(5) of the Act, we will publish in the **Federal Register,** on or before August 1 prior to the beginning of each fiscal year, the classifications and weighting factors for the IRF case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year (§412.628 of these final regulations).

L. Limitation on Administrative or Judicial Review

In accordance with sections 1886(j)(7)(A), (B), and (C) of the Act, we are specifying under §412.630 of these final regulations that administrative or judicial review

under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

VII. Provisions of the Final Regulations

After careful consideration of the public comments received on the November 3, 2000 proposed rule, we are adopting as final, with the modifications discussed throughout this preamble and summarized below, the proposed regulations set forth in 42 CFR Part 412, Subpart P, to implement the prospective payment system for IRFs, and the proposed technical and conforming changes to §§412.1, 412.20, 412.22, 412.23, 412.25, 412.29, 412.116, 412.130, 413.1, 413.40, and 413.64. The table of contents for Subpart P is as follows:

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

Sec.

412.600 Basis and scope of subpart.

412.602 Definitions.

412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

412.606 Patient assessment.

412.608 Patients' rights regarding the collection of patient assessment data.

412.610 Assessment schedule.

412.612 Coordination of the collection of patient assessment data.

412.614 Transmission of patient assessment data.

412.616 Release of information collected using the patient assessment instrument.

412.618 Assessment process for interrupted stays.

412.620 Patient classification system.

412.622 Basis of payment.

412.624 Methodology for calculating the Federal prospective payment rates.

412.626 Transition period.

412.628 Publication of the Federal prospective payment rates.

412.630 Limitation on review.

412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

? Throughout Subpart P and in §§412.1, 412.20, 412.116, 412.130, 413.1, and 413.40, we are changing the date and any related references for implementation of the IRF prospective payment system from "April 1, 2001" to "January 1, 2002". Effective for cost reporting periods beginning on or after January 1, 2002, IRFs must meet the

conditions specified in the Subpart P for payment of all covered inpatient hospital services furnished to beneficiaries under the IRF prospective payment system.

? Throughout Subpart P, we are changing all references to the MDS-PAC to either the CMS inpatient rehabilitation facility patient assessment instrument or deleting reference to the MDS-PAC, as appropriate, including deletion of the definition in §412.602. We are adding a new definition of "patient assessment instrument" to conform to the replacement of the MDS-PAC.

? Use of Authorized Clinician in Patient Assessments (§§412.602--Definitions; 412.606--Patient assessment; 412.608--Patients' rights regarding the collection of patient assessment data; and 412.612--Coordination of the collection of patient assessment data). As explained in section IV.A.3. of this final rule, we are deleting the definition of "authorized clinician" in proposed §412.602. In addition, we are revising proposed §§412.606(c) and 412.612 to specify that any IRF clinician may perform the patient assessment and any clinician who is employed or contracted by the IRF and who is trained on how to conduct a patient assessment using our inpatient rehabilitation facility patient assessment instrument may complete items

on the assessment instrument. We are deleting the provisions under proposed §§412.606(c)(4) and 412.612(b) and (c) that an authorized clinician must sign the patient assessment instrument attesting to its completion and accuracy. We are revising proposed §412.606(c)(3) to clarify one of the other sources, in addition to direct patient observation, from which patient data may be obtained for the assessment process when appropriate and to the extent feasible. We are deleting the "friends" source and adding instead "someone personally knowledgeable about the patient's clinical condition or capabilities".

We are revising proposed §412.612(d) (§412.612(b) in this final rule) to specify that a person who knowingly and willfully completes or causes another person to complete a false patient assessment is subject to a civil money penalty. We are making conforming changes to proposed §412.608 to indicate that an IRF clinician must inform inpatients of their patient rights relating to the collection of patient assessment data.

? Patient Assessment Schedule and Data Transmission (§§412.602--Definitions; 412.610--Assessment schedule; 412.614--Transmission of patient assessment data; and 412.624--Methodology for calculating the Federal

prospective payment rates). We are revising proposed §§412.610(c) to specify that the patient assessment instrument is to be completed only twice, at the time of the patient's admission and at discharge. We are revising the definition of "discharge" in §412.602 to add a provision that a Medicare patient in an IRF is also considered discharged when the patient stops receiving Medicare-covered Part A inpatient rehabilitation services.

In addition, we are specifying the time period the admission assessment must cover; the assessment reference date for the admission and discharge assessments; and the dates by which the admission and discharge assessments must be completed. As conforming changes, we are revising the definition of "assessment reference date" in proposed §412.602; we are deleting the contents of proposed §412.610(d), which described the late assessment reference dates and related penalties for late completion of the patient assessment, which are no longer applicable; and we are deleting from proposed §412.610(e) the provisions on assessment completion dates, which are now specified in §412.610(c).

We are revising proposed §412.610(e) (paragraph (d) in this final rule) to specify that admission and discharge

assessments must be encoded by the 7th calendar day from the applicable assessment completion dates. (As conforming changes, proposed §§412.610(f) and (g) are now §§412.610(e) and (f), respectively.)

We are revising proposed §412.614(c) to specify data transmission dates to us that are adjusted to reflect changes in the completion dates for admission and discharge assessments and for encoding data under §§412.610(c) and (d).

We are revising proposed §412.614(d)(2) to specify the date by which transmission of the assessment data is considered late (late transmission means more than 10 days after the 7th calendar day in the period beginning with the last permitted patient assessment encoding date) and to modify the penalties associated with late transmission of the patient assessment data. We also are revising proposed §412.624(e)(5) to specify the adjustment to the prospective payment to the IRF for late transmission of patient assessment data to reflect the provisions in §412.614(d)(2).

These changes from the proposed rule are discussed in detail in sections IV.B. and IV.D. of this preamble.

? Interrupted Stays (§§412.602--Definitions; 412.618--Assessment process for interrupted stays; and 412.624--Methodology for calculating the prospective payment rates). We are revising the proposed definition of "interrupted stay" in proposed §412.602 to clarify that an interruption in a stay in an IRF is 3 consecutive calendar days that begins with the day of discharge and ends at midnight of the third day.

We are revising proposed §§412.618(a)(1) and (a)(3) (paragraphs (a)(1) and (a)(2) in this final rule) to specify that the initial case-mix classification from the admission assessment remains in effect during the interrupted stay(s); and to specify that a discharge assessment must be completed when the patient stay (that includes one or more interrupted stays) is completed. We are deleting proposed §412.618(a)(2), which referenced the proposed multiple patient assessments that we are not adopting in this final rule; and deleting proposed §412.618(c), which discussed the transmission of data from the interrupted stay tracking form.

In addition, we are revising proposed §412.618(d)(1) through (d)(4) (paragraphs (c)(1) and (c)(2) in this final rule) to specify the adjustment to dates to be used if an

interrupted stay occurs before the patient admission assessment is completed or after the admission assessment is completed but before the discharge assessment is completed.

We are adding new §412.624(g) to codify in this regulation text the policy on the adjustment to the IRF prospective payment for interrupted stays.

These changes from the proposed rule are discussed in detail in sections IV.D. and VI.C.3. of this preamble.

? Patient Classification (§412.620--Patient classification system). We are revising proposed §412.620(a)(3) to specify that we will use the data from the admission assessment to classify the patient into the appropriate case-mix group as opposed to proposed data from the Day 4 assessment (the assessment schedule has been revised to specify only two assessments as discussed earlier).

We are adding a definition of "comorbidity" in §412.602 and adding new paragraphs (a)(4) and (b)(4) under §412.620 to specify that we will determine a weighting factor(s) to account for the presence of a comorbidity that is relevant to resource use in the classification system in determining payment rates under the IRF prospective payment

system, and that we will use data from the discharge assessment to determine this weighting factor. These changes are discussed in detail in section VI.A. of the preamble in relation to our use in this final rule of a 3-tiered approach to determining adjustments in payment rates for CMGs based on differences in costs among relevant comorbidities.

? Payment Rates (§412.624--Methodology for calculating the prospective payment rates). We are revising the budget neutrality provision of proposed §412.624(d)(2) to reflect the deletion of the 2-percent reduction as specified in section 305(a) of BIPA.

We are revising proposed §412.624(e) to specify that the prospective payment rate for each IRF discharge will be based on whether the IRF's cost reporting period begins on or after January 1, 2002 and before October 1, 2002 or begins after October 1, 2002.

We are revising proposed §§412.624(f)(2)(ii) and (f)(2)(iii) (paragraph (f)(2)(v) in this final rule) and adding new §§412.624(f)(2)(iii) and (f)(2)(iv) to specify the adjustment to the prospective payment to the IRF for patients who are transferred to another site of care.

These changes from the proposed rule are discussed in detail in sections VI.B., VI.D., and VI.E. of this preamble.

? Transition Period (§§412.622--Basis of payment and 412.626--Transition period). We are revising proposed §§412.622(a)(2) and 412.626(a)(1) and adding new §412.626(b) to reflect the provisions under section 305(b) of BIPA that provide that, during the transition period, facilities may elect to be paid the full prospective payment rather than the payment determined under the transition period methodology.

These changes from the proposed rule are discussed in detail in section VI.H. of this preamble.

Technical Changes

? Noncovered Items and Services (§412.604--Conditions for payment under the prospective payment system for inpatient rehabilitation facilities). We are revising proposed §412.604(d) to specify that in addition to the applicable deductible and coinsurance amounts, a facility may charge Medicare beneficiaries and other individuals on their behalf only for items and services as provided under existing regulations at §489.20(a).

We are revising proposed §412.604(e)(1) to conform it to the provisions of existing §412.50 which lists the types of services that are not included as inpatient hospital services.

We also are adding to §412.604(e)(1) a citation to the provisions of §412.622(b) to clarify that payments for certain services are not included in the full prospective payment to IRFs for inpatient rehabilitation services (that is, payment for approved educational activities, bad debts, and blood clotting factors).

These changes from the proposed rule are discussed in detail in section II.B. of this preamble.

VIII. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this final rule as required by Executive Order 12866, the Unfunded Mandate Reform Act of 1995 (Public Law 104-4), the Regulatory Flexibility Act (RFA) (Public Law 96-354), and Executive Order 13132 (Federalism).

1. Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory

approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

We estimate that the impact of this final rule that implements section 1886(j) of the Act will result in a total cost to the Medicare program. Section 305(a) of BIPA eliminated the 2-percent reduction to the budget neutral adjustment. Under the amendments made by section 305(a) of BIPA, then, we set payment amounts under the prospective payment system for FY 2002 so that payments under the IRF prospective payment system for FY 2002 are projected to equal "100 percent . . . of the amount of payments that would have been made under this title . . . for operating and capital costs of rehabilitation facilities had this subsection not been enacted," but under the amendments made by section 305(b) of BIPA, in calculating the budget neutrality adjustment, we do not take into account payment adjustments resulting from elections by hospitals under section 1886(j)(1)(F) of the Act (as added by section 305(b)(1)(C) of BIPA) to not be paid under the transition

period methodology described in section VI.H. of this final rule. Because elections under section 1886(j)(1)(F) of the Act are not taken into account in calculating the budget adjustment requirement, the implementation of the prospective payment system results in a cost.

Payment to facilities that elect not to be paid under the transition period methodology will be based on 100 percent of the adjusted facility Federal prospective payment in effect for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002. Providers that will be paid more under the IRF prospective payment system than they would have been paid had the system not been in effect will likely elect to be paid based on 100 percent of the Federal prospective payment rate. We estimate that, of the 1024 IRFs used to simulate the impacts among the various classes of IRFs, approximately 48 percent or 496 of these IRFs will elect not to be paid under the transition period methodology. For cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, we estimate that the IRF prospective payment system will cost $60 million, and for FY 2003, the costs will be $10 million. Because cost reporting periods can begin in one fiscal year and end in

the next fiscal year, the FY 2002 estimated costs of $60 million are associated with the portion of IRF cost reporting periods between January 1, 2002 and September 30, 2002. The FY 2003 estimated costs of $10 million are associated with the portion of IRF cost reporting periods between October 1, 2002, and September 30, 2003.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze the economic impact of our regulations on small entities. If we determine that the regulation will impose a significant burden on a substantial number of small entities, we must examine options for reducing the burden. For purposes of the RFA, businesses include small businesses, nonprofit organizations, and governmental agencies. Most hospitals are considered small entities, either by nonprofit status or by having receipt of less than $25 million per year. Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary rehabilitation hospitals. Therefore, the analysis that follows is based on all rehabilitation facilities doing business with Medicare. Medicare fiscal intermediaries and carriers are not considered to be small entities.

Individuals and States are not included in the definition of a small entity.

3. Unfunded Mandate

Section 202 of the Unfunded Mandate Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of at least $110 million. This final rule will not have an effect on the governments mentioned nor will it affect private sector costs.

4. Executive Order 13132

We examined this final rule in accordance with Executive Order 13132 and determined that it will not have any negative impact on the rights, roles, or responsibilities of State, local, or tribal governments.

5. Impact on Rural Hospitals

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that will have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a

small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

6. Overall Impact

For the reasons stated above, we have prepared an analysis under the RFA and section 1102(b) of the Act because we have determined that this final rule will 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. As discussed earlier in this preamble, we are adjusting payments for IRFs located in rural areas. Therefore, the impacts shown below reflect the adjustments that are designed to minimize or eliminate the negative impact that the IRF prospective payment system would otherwise have on rural facilities.

This final rule sets forth the factors used to determine prospective payments under the Medicare program for IRFs. While section 1886(j) of the Act specifies the basic methodology of constructing a case-mix adjusted prospective payment system, the statute does allow us some discretion in designing the key elements of the system, and we did consider alternatives for these elements. The

elements include the patient assessment instrument, the patient classification methodology based on functional-related groups, and adjustments to the prospective payments. We have included a detailed discussion of these elements and the alternatives that we considered in sections IV., V., and VI., respectively, of the preamble of this final rule.

B. Anticipated Effects of the Final Rule

We discuss below the impacts of this final rule on the budget and on IRFs.

1. Budgetary Impact

Section 1886(j)(3)(B) of the Act, as amended by section 305(a) of BIPA, requires us to set the payment rates contained in this final rule at levels such that total payments under the IRF prospective payment system are projected to equal the amount that would have been paid for operating and capital-related costs of rehabilitation facilities if this prospective payment system had not been implemented, but under the amendments made by section 305(b) of BIPA, in calculating budget neutrality, we do not take into account elections by facilities to receive the full Federal prospective payment rather than the payment determined under the transition period methodology. We

project that implementing the IRF prospective payment system (as amended by section 305(b) of BIPA) for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002 will cost the Medicare program $70 million over 2 years, as follows:

$60 million for FY 2002

$10 million for FY 2003

2. Impact on Providers

In order to understand the impact of the new IRF prospective payment system on different categories of facilities, it is necessary to compare estimated payments under the current payment system (current payments) to estimated payments under the prospective payment system as set forth in this final rule (new prospective payments). To estimate the impact among the various classes of IRFs, it is imperative that the estimates of current payments and new prospective payments contain similar inputs. More specifically, we simulate new prospective payments only for those IRFs for which we are able to calculate current payment, and vice versa.

As previously stated in section VI.D. of this preamble, we have both case-mix and cost data for 714 rehabilitation facilities. We used data from these facilities to analyze the appropriateness of various adjustments to the Federal unadjusted payment rates. However, for the impact analyses shown in the following tables, we simulate payments for 1024 facilities. As we previously stated in section VI. of this final rule, we estimate the case-mix index for those IRFs and cases for which we do not have FIM data to match corresponding Medicare bills. Therefore, in this final rule, we are able to include more facilities in the impact analysis among the various classes of IRFs. Table I below reflect the estimated "losses/gains" among the various classifications of IRFs for cost reporting periods that begin on or after January 1, 2002 and before October 1, 2002. Table II below reflects the estimated "losses/gains" among the various classifications of IRFs for cost reporting periods that begin on or after October 1, 2002 and before October 1, 2003.

3. Calculation of Current Payments

To calculate current payments, we trend cost report data forward from the midpoint of the cost reporting period

to the midpoint of FY 2002, using the methodology set forth in section VI.E.2. of this preamble. To estimate current payments, we calculate operating payments for each rehabilitation facility in accordance with section 1886(b) of the Act. Further, we compute capital payments by reducing reasonable costs by 15 percent, consistent with section 1886(g)(4) of the Act, as added by section 4412 of the BBA. To determine each facility's average per discharge payment amount under the current payment system, we add operating and capital-related payments together, and then divide the total payment by the number of Medicare discharges from the cost reports. We compute total payments for each facility by multiplying the number of discharges from the Medicare bills by the average per discharge payment amount.

4. Calculation of New Prospective Payments

To estimate payments under the IRF prospective payment system as set forth in this final rule, we multiply each facility’s case-mix index by the facility’s number of Medicare discharges, the budget neutral conversion factor, the applicable wage index, a low income patient adjustment, and a rural adjustment (if applicable). We include a

detailed description of the following specific adjustments in section VI.D. of the preamble of this final rule.

- The wage adjustment, calculated as follows: (.27605 (.72395 x Wage Index)).
- The disproportionate share adjustment, calculated as follows:

(1 + Disproportionate Share Percentage) raised to the power of .4838).

- The rural adjustment, if applicable, calculated by multiplying payments by 1.1914.

After calculating the new Federal rate payments for each facility, we blend together the appropriate percentages of the current payments and the new Federal rate payments to determine the appropriate amount for the first year of implementation of the IRF prospective payment system. Specifically, for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002 we combine 33 1/3 percent of the current payment amount with 66 2/3 percent of the new Federal rate payment amount as shown in Table I below. However, for those providers that will receive higher payments under the IRF prospective payment system than they would have if the system had not been in effect, we simulate their payments in Table I as though they chose not to be paid under the transition payment methodology. (We estimate that 48 percent of the

IRFs will elect not to be paid under the transition payment methodology.) For cost reporting periods beginning in FY 2003, we show the impact of the fully phased-in IRF prospective payment amount. All payment simulations reflect data trended to the midpoint of FY 2002. These data were not trended out to the midpoint of FY 2003.

Tables I and II below illustrate the aggregate impact of the new payment system among various classifications of facilities. The first column, Facility Classifications, identifies the type of facility. The second column identifies the number of cases. The third column lists the number of facilities of each classification type, and the fourth column is the ratio of new prospective payments to current payments. The impact reflects the adjustments that we are making, including the specific geographic wage adjustment, the adjustment for rural facilities (if applicable), and a low-income patient adjustment for all facilities.

Table I.—Projected Impact Reflecting 2/3 of New Prospective Payments Plus 1/3 of Current Payments and Option to Decline the Blended Payment Method

Facility Classifications	Number of Cases	Number of Facilities	New Payment to Current Payment Ratio
All Facilities	347,809	1,024	1.03
Geographic Location			
Large Urban	163,970	489	1.04
Other Urban	152,647	392	1.01
Rural	31,192	143	1.03
Region			
New England	15,868	36	1.00
Middle Atlantic	66,466	143	1.05
South Atlantic	59,172	132	1.06
East North Central	60,223	200	1.02
East South Central	27,024	51	1.05
West North Central	21,907	92	1.03

Facility Classifications	Number of Cases	Number of Facilities	New Payment to Current Payment Ratio
West South Central	59,663	186	0.97
Mountain	15,697	65	1.04
Pacific	21,789	119	1.04
Urban by Region			
Urban- New England	15,039	32	1.01
Urban-Middle Atlantic	64,042	133	1.04
Urban-South Atlantic	52,980	112	1.06
Urban-East North Central	55,071	171	1.02
Urban-East South Central	23,434	41	1.07
Urban-West North Central	18,087	70	1.03
Urban-West South Central	52,346	154	0.96
Urban-Mountain	14,655	56	1.04
Urban-Pacific	20,963	112	1.04
Rural by Region			
Rural-New England	829	4	0.95
Rural-Middle Atlantic	2,424	10	1.16

Facility Classifications	Number of Cases	Number of Facilities	New Payment to Current Payment Ratio
Rural-South Atlantic	6,192	20	1.09
Rural-East NorthCentral	5,152	29	1.01
Rural-East SouthCentral	3,590	10	0.98
Rural-West NorthCentral	3,820	22	1.04
Rural-West SouthCentral	7,317	32	1.01
Rural-Mountain	1,042	9	1.05
Rural-Pacific	826	7	1.00
Type and Size of Facility			
Unit of acute hospital	233,433	856	1.04
Average Daily Census < 10	39,123	289	1.00
Average Daily Census 10-25	122,904	436	1.05
Average Daily Census >25	71,406	131	1.06
Freestanding hospital	114,376	168	0.99
Average Daily Census < 25	8,437	36	0.92
Average Daily Census 25-50	41,626	71	0.98
Average Daily Census > 50	64,313	61	1.01

Facility Classifications	Number of Cases	Number of Facilities	New Payment to Current Payment Ratio
Disproportionate Share			
Disproportionate Share < 10%	121,046	329	1.05
Disproportionate Share 10%-19%	101,405	261	1.02
Disproportionate Share 20%-29%	24,216	70	1.01
Disproportionate Share >= 30%	14,851	72	1.05
Disproportionate Share Missing	86,291	292	1.01
Teaching Status			
Non-Teaching	285,112	872	1.03
Resident to Average Daily Census < 10%	41,944	86	1.02
Resident to Average Daily Census 10%-19%	15,741	38	1.00
Resident to Average Daily Census >19%	5,012	28	1.02
Alaska/Hawaii	991	4	0.99

Table II.—Projected Impact

Reflecting the Fully Phased-In Prospective Payments

Facility Classifications	Number of Cases	Number of Facilities	New Payment to Current Payment Ratio
All Facilities	347,809	1,024	1.00
Geographic Location			
Large Urban	163,970	489	1.01
Other Urban	152,647	392	0.99
Rural	31,192	143	1.00
Region			
New England	15,868	36	0.98
Middle Atlantic	66,466	143	1.02
South Atlantic	59,172	132	1.04
East North Central	60,223	200	0.99
East South Central	27,024	51	1.03
West North Central	21,907	92	1.01
West South Central	59,663	186	0.93
Mountain	15,697	65	1.01
Pacific	21,789	119	1.02

Facility Classifications	Number of Cases	Number of Facilities	New Payment to Current Payment Ratio
Urban by Region			
Urban- New England	15,039	32	0.99
Urban-Middle Atlantic	64,042	133	1.02
Urban-South Atlantic	52,980	112	1.03
Urban-East North Central	55,071	171	0.99
Urban-East South Central	23,434	41	1.05
Urban-West North Central	18,087	70	1.01
Urban-West South Central	52,346	154	0.92
Urban-Mountain	14,655	56	1.01
Urban-Pacific	20,963	112	1.02
Rural by Region			
Rural-New England	829	4	0.91
Rural-Middle Atlantic	2,424	10	1.14
Rural-South Atlantic	6,192	20	1.07
Rural-East NorthCentral	5,152	29	0.98
Rural-East SouthCentral	3,590	10	0.94
Rural-West NorthCentral	3,820	22	1.02

Facility Classifications	Number of Cases	Number of Facilities	New Payment to Current Payment Ratio
Rural-West SouthCentral	7,317	32	0.97
Rural-Mountain	1,042	9	1.04
Rural-Pacific	826	7	0.97
Type and Size of Facility			
Unit of acute hospital	233,433	856	1.02
Average Daily Census < 10	39,123	289	0.96
Average Daily Census 10-25	122,904	436	1.03
Average Daily Census >25	71,406	131	1.04
Freestanding hospital	114,376	168	0.96
Average Daily Census < 25	8,437	36	0.86
Average Daily Census 25-50	41,626	71	0.95
Average Daily Census > 50	64,313	61	0.99
Disproportionate Share			
Disproportionate Share < 10%	121,046	329	1.02
Disproportionate Share 10%-19%	101,405	261	0.99
Disproportionate Share 20%-29%	24,216	70	0.98
Disproportionate Share >= 30%	14,851	72	1.03

Facility Classifications	Number of Cases	Number of Facilities	New Payment to Current Payment Ratio
Disproportionate Share Missing	86,291	292	0.98
Teaching Status			
Non-Teaching	285,112	872	1.00
Resident to Average Daily Census < 10%	41,944	86	1.00
Resident to Average Daily Census 10%-19%	15,741	38	0.97
Resident to Average Daily Census >19%	5,012	28	0.98
Alaska/Hawaii	991	4	0.97

5. Costs Associated With the Patient Assessment Instrument

In this final rule, it is specified that an IRF must assess its Medicare Part A fee-for-service patients using the CMS IRF patient assessment instrument. Costs associated with the collection of the patient assessment data using the CMS IRF patient assessment instrument, and the associated reporting of data, are related to both personnel and equipment. These two classes of costs include the costs associated with using the CMS IRF patient assessment instrument to assess patients (data collection costs), the IRF's costs to start the patient assessment process using our patient assessment instrument, and the IRF's ongoing costs after the patient assessment process has been initiated. We note that many of the components of the costs associated with initiation of the patient assessment process specified in this final rule and the IRF's ongoing costs are the same.

a. Patient Assessment Instrument Data Collection Costs

As stated in section IV. of this preamble, in this final rule we are using a modified version of the UDSmr patient assessment instrument that is frequently referred to as the FIM, as the CMS IRF patient assessment instrument. We are permitting any clinician who is employed or contracted by

the IRF, and is trained on how to complete a patient assessment using our patient assessment instrument, to complete the data items on our patient assessment instrument (§412.606(c)).

For this final rule, we calculated the cost to collect the patient assessment data using the CMS IRF patient assessment instrument by using the wage data and assumptions below. Although we are only specifying wage data for nine different types of clinicians, this should not be interpreted as meaning that these nine types are the only types of clinicians permitted to complete our patient assessment instrument.

(Note: The 2000-2001 version of the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, is still our most current source of salary data available.)

? The hourly wage data for the nine specific types of clinicians, according to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, are as follows (presented in ascending order):

(1) The median earnings of social work assistants, which is included in the human service workers and assistants category, in 1998 were $21,360. That is equivalent to a

median hourly wage of $10.27. ($21,360/52 weeks = $410.77/week. $410.77/40 hours = $10.27).

(2) The median earnings of licensed practical nurses (licensed vocational nurses) in 1998 were $26,940. That is equivalent to a median hourly wage of $12.95. ($26,940/52 weeks = $518.07/week. $518.07/40 hours = $12.95).

(3) The median earnings of recreational therapists in 1998 were $27,760. That is equivalent to a median hourly wage of $13.35. ($27,760/52 weeks = $533.84/week. $533.84/40 hours = $13.35).

(4) The median earnings of social workers in 1998 were $30,590. That is equivalent to a median hourly wage of $14.71. ($30,590/52 weeks = $588.27/week. $588.27/40 hours = $14.7067).

(5) The median earnings of dietitians and nutritionists in 1998 were $35,020. That is equivalent to a median hourly wage of $16.84. ($35,020/52 weeks = $673.46/week.$673.46/40 hours = $16.8365).

(6) The median earnings of registered nurses in 1998 were $40,690. That is equivalent to a median hourly wage of $19.56. ($40,690/52 weeks = $782.50/week. $782.50/40 hours = $19.5625).

(7) The median earnings of speech-language pathologists and audiologists in 1998 were $43,080. That is equivalent to a median hourly wage of $20.71. ($43,080/52 weeks = $828.46/week. $828.46/40 hours = $20.7115).

(8) The median earnings of occupational therapists in 1998 were $48,230. That is equivalent to a median hourly wage of $23.19. ($48,230/52 weeks = $927.50/week. $927.50/40 hours = $23.1875).

(9) The median earnings of physical therapists in 1998 were $56,600. That is equivalent to a median hourly wage of $27.21. ($56,600/52 weeks = $1088.46/week.$1088.46/40 hours = $27.2115).

? IRF staff familiar with the MDS-PAC that was the product of our pilot and field testing required a median of 85 minutes to complete an admission intake assessment.

? IRF staff familiar with the MDS-PAC that was the product of our pilot and field testing required a median of 48 minutes to complete an update assessment.

? Our data indicate that in 1999 there were 390,048 IRF admissions and 1,165 IRFs, an average of 334.8 admissions per IRF. (For the calculations in the tables that follow, 334.8 admissions was rounded to 335 admissions.)

We stated in the proposed rule that data from a non-HCFA associated source indicated that it could take a maximum of 45 minutes to complete an admission assessment using the FIM. However, according to information obtained from UDSmr, it takes an estimated combined time of 25 minutes to collect both the admission and discharge patient assessment data using the UDSmr patient assessment instrument. We believe that the UDSmr estimated combined time of 25 minutes to collect both the admission and discharge data is the more accurate span of time estimate to use. Although in 2000 both the other non-HCFA source and UDSmr performed surveys to obtain instrument completion data, there is more precise data from the UDSmr survey results. Specifically, for the surveys that both performed: (1) the other non-HCFA associated source did not state its sample size or the numerical size of the universe from which the sample was obtained, while UDSmr had a sample size of 303 facilities out of a universe of 600 to 700 IRFs; (2) the other non-HCFA associated source only gave ranges of the span of times it took experienced or inexperienced personnel to complete the UDSmr instrument, while UDSmr provided the mean and median spans of times it took experienced and inexperienced personnel to complete the UDSmr instrument.

In addition, we believe that UDSmr, instead of the other non-HCFA source, is more knowledgeable of the span of time it takes to complete its own instrument. We estimate that it will take a combined time of 45 minutes to collect both the admission and discharge patient assessment data using our patient assessment instrument.

We believe that IRFs that currently use the UDSmr patient assessment instrument to collect admission and discharge data, which we believe is 85 percent of the 1,165 IRFs (990 IRFs), are completing the entire UDSmr patient assessment instrument when collecting the admission and discharge data. Therefore, for IRFs currently using the UDSmr patient assessment instrument, we believe that the estimated additional time to collect both the admission and discharge patient assessment data using our patient assessment instrument is 20 minutes.

For IRFs that are not currently using the UDSmr patient assessment instrument, or a similar instrument, which we believe is 15 percent of the 1,165 IRFs (175 IRFs), we estimate an additional assessment time burden of 45 minutes.

The 1998 median hourly wages from the U.S. Dept. of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook,

2000-2001 Edition, specified above have been updated, using our Occupational Compensation Index from the excluded hospital market basket. The update factor is 1.159. Using the updated 1998 median hourly wages, we show in Table III below the range of the costs of the estimated additional patient assessment time burden by clinician discipline. In addition, we show in Table III the range of the costs of the minimum and maximum additional time burden by clinician discipline using the 1999 data of 390,048 IRF admissions and 1,165 IRFs (an average of approximately 335 admissions per IRF).

Table III.--Range of the Incremental Costs to Collect Both the Admission and Discharge Patient Assessment Data Using the CMS IRF Patient Assessment Instrument

(Column 1) Updated Hourly Wages For Each Clinician Discipline	(Column 2) Range of Incremental Time of 20 Minutes -- Incremental Cost Per Clinician Discipline Column 1 Times 0.333333	(Column 3) Range of Incremental Cost Per Clinical Discipline Per IRF-- Column 2 Times 335 Admissions	(Column 4) Range of Incremental Time of 45 Minutes -- Incremental Cost Per Clinician Discipline Column 1 Times 0.75	(Column 5) Range of Incremental Cost Per Clinician Discipline Per IRF Column 4 Times 335 Admissions
$11.90	$3.97	$1,328.83	$8.93	$2,989.88
$15.01	$5.00	$1,676.11	$11.26	$3,771.26
$15.47	$5.16	$1,727.48	$11.60	$3,886.84
$17.05	$5.68	$1,903.91	$12.79	$4,283.81
$19.52	$6.51	$2,179.73	$14.64	$4,904.40
$22.67	$7.56	$2,531.48	$17.00	$5,695.84
$24.00	$8.00	$2,680.00	$18.00	$6,030.00
$26.88	$8.96	$3,001.60	$20.16	$6,753.60
$31.54	$10.51	$3,521.96	$23.66	$7,924.43

Table IV below compares the average estimated time to complete the inpatient rehabilitation facility patient assessment instrument as specified in this final rule to the average estimated time to complete the MDS-PAC in the proposed rule, assuming that the expanded list of

clinicians could complete the proposed MDS-PAC. We are only comparing the costs to perform the combined admission and discharge assessment using the CMS IRF patient assessment instrument in this final rule to the cost to perform the admission MDS-PAC assessment because the best time span data we have is how long it takes to do the admission MDS-PAC assessment. The admission MDS-PAC assessment took 85 minutes to perform, that is, to collect the data,(85 minutes divided by 60 minutes is 1.412 (rounded)). Table IV is based on the assumption that all 1,165 IRFs would collect the assessment data.

Table IV.--Comparison of the Costs

of Performing the Patient Assessment Using the CMS IRF Patient Assessment Instrument to Costs Using the Proposed MDS-PAC

	Costs to Perform the Combined Admission and Discharge Assessments Using the CMS IRF Patient Assessment Instrument			Costs to Perform Only the Admission Assessment Using the MDS-PAC		
(Column 1) Updated Hourly Wages For Each Clinical Clinical Discipline	**(Column 2)** Range of Maximum Incremental Time of 45 Minutes Per Clinical Discipline (Column 1 Times 0.75 Hour)	**(Column 3)** Range of Maximum Incremental Cost Per Clinical Discipline Per IRF (Column 2 Times 335 Admissions)	**(Column 4)** National Costs- (Column 3 Times 1,165 IRFs)	**(Column 5)** Range of Maximum Incremental Time of 85 Minutes Per Clinical Discipline (Column 1 Times 1.412)	**(Column 6)** Range of Maximum Incremental Cost Per Clinical Discipline Per IRF (Column 5 Times 335 Admissions)	**(Column 7)** National Costs (Column 6 Times 1,165 IRFs)
$11.90	$ 8.93	$2,990	$3,483,204	$16.80	$ 5,629	$ 6,557,713
$15.01	$11.26	$3,771	$4,393,521	$21.19	$ 7,100	$ 8,271,535
$15.47	$11.60	$3,887	$4,528,166	$21.84	$ 7,318	$ 8,525,027
$17.05	$12.79	$4,284	$4,990,642	$24.07	$ 8,065	$ 9,395,715
$19.52	$14.64	$4,904	$5,713,626	$27.56	$ 9,233	$10,756,853
$22.67	$17.00	$5,696	$6,635,651	$32.01	$10,723	$12,492,718
$24.00	$18.00	$6,030	$7,024,950	$33.89	$11,352	$13,225,639

$26.88	$20.16	$6,754	$7,867,944	$37.95	$12,715	$14,812,716
$31.54	$23.66	$7,924	$9,231,955	$44.53	$14,919	$17,380,694

b. Start-Up Costs

The costs that an IRF will incur to start the patient assessment process using our assessment instrument consist of material costs and personnel costs. Our data indicate that in 1999 there were 1,165 IRFs.

(1) Start-up Hardware Costs

We believe that all IRFs have the hardware computer capability (that is, hard drive, printer, RAM memory, modem) and the related software (that is, Internet Browser software) to be able to handle the computerization, data transmission, and GROUPER software requirements associated with our patient assessment instrument. Our belief is based on indications that (a) approximately 99 percent of all hospital inpatient claims currently are submitted electronically; (b) approximately 100 percent of IRFs submit their cost reports electronically; and (c) approximately 85 percent of IRFs that use the FIM subscribe to the full UDSmr FIM system and submit their data to UDSmr electronically.

Because we will supply to the IRFs free of charge the software that performs the electronic functions associated with our patient assessment instrument, the IRFs will incur no software costs to purchase that software. Although we

will supply the software version of our patient assessment instrument, which includes the GROUPER software and the data transmission software, IRFs may incur costs, which we are not able to estimate, associated with making changes to their information management systems to incorporate our patient assessment process software.

IRFs have the option of purchasing data collection software that can be used to support other clinical or operational needs (for example, care planning, quality assurance, or billing), or other regulatory requirements for reporting patient information. However, the software associated with our patient assessment instrument will be available to IRFs at no charge through our IRF prospective payment system website. That website is: **www.hcfa.gov/medicare/irfpps.htm**. Our patient assessment instrument software will allow users to computerize their assessment data and transmit the data in a standard format specified by us to the CMS patient data system. Therefore, IRFs that plan to use our patient assessment instrument software will need Internet access and a dial-up Internet Service Provider account in order to be able to download and install our software into their computer system. We

believe that all IRFs currently have the capability to access the Internet.

(2) Start-Up Training Costs

IRF staff will require training in performing assessments with the CMS IRF patient assessment instrument, encoding assessment data, preparing the assessment data for electronic submission, and actually transmitting the data. We believe that the initial training of IRF clinical and data entry personnel will require about 129.5 hours of staff time.

We expect that the IRF will send one discipline-specific lead clinician to a training session of 16 hours sponsored by us, and then have that individual train the other IRF clinicians. We estimate that, on average, nine nonlead clinicians per IRF will require 12 hours of training. These nonlead clinicians will be trained at their respective IRF. As stated in section IV. of this preamble, in this final rule we are permitting any clinician who is employed or contracted by the IRF and who is trained on how to perform a patient assessment using the CMS IRF patient assessment instrument to complete the data items on the CMS IRF patient assessment instrument.

We also estimate that one data entry staff person will require approximately 5.5 hours of training. The estimated hourly wage cost of the data entry staff person from the

proposed rule is $12.50. Using the update factor for hourly wages of the 1.159 cited earlier, we estimate that the updated hourly wage for the data entry staff person is $14.49 (rounded). Using this updated hourly wage rate, we estimate that the 5.5 hours of training will cost approximately $79.70 (5.5 hours x $14.49) per IRF, for an estimated cost of $92,844 nationally ($79.70 x 1,165 IRFs).

(3) Start-Up Data Entry and Data Transmission Costs

We do not know the time span it takes to enter the UDSmr data into the UDSmr patient assessment software, or the time span it takes to perform a data entry audit on those data. Our patient assessment data will be collected for the admission and discharge assessments. The estimated wage cost of the data entry staff person is $14.49 per hour. We estimate 6 minutes for data entry and data review per assessment, for approximately 335 assessments per IRF, which equals 2,010 minutes (34 hours) per IRF per year. We estimate the associated data entry cost per IRF per year to be $493 (34 hours x $14.49), and the national costs to be $573,949 ($493 x 1,165 IRFs).

We estimate that an IRF will perform a 15-minute monthly data entry audit for quality assurance purposes, equaling 3 hours per IRF per year (15 minutes per month x

12 months). We estimate the cost per IRF per year to be $43 (3 hours x $14.49), and the national costs to be $50,643 ($43 x 1,165 IRFs).

We believe that the combination of checking all the data prior to transmission of the data, and actual transmission of the data, will take an IRF 1 hour per month. Although we believe that approximately 85 percent of the IRFs already transmit data to UDSmr, we do not know if these 85 percent of IRFs will stop transmitting data to UDSmr after they start transmitting data to us. Therefore, we are estimating for all 1,165 IRFs the same additional burden of 1 hour per month for the combination of checking all the data prior to transmission of the data and the actual transmission of the data. We estimate the cost per IFR per year to be $174 (rounded) (12 months x $14.49/hour), and the national costs to be $202,570 ($174 x 1,165 IRFs).

IRFs will have flexibility in choosing the data entry software used to computerize the patient assessment data, but the software must, at a minimum, perform the same functions as our patient assessment software. In addition, when IRFs are performing data entry functions themselves, or contracting for the performance of these functions, the

IRFs must ensure that the performance of data entry complies with our requirement for safeguarding the confidentiality of clinical records.

IRFs must collect and transmit the patient assessment data to the CMS patient data system in accordance with the assessment schedule and transmission requirements specified in section IV. of this final rule. The data may be entered into the computerized version of the CMS IRF patient assessment instrument by an IRF staff member, using a paper version that has been completed by a clinical staff member who has been trained to perform a patient assessment using our patient assessment instrument according to this final rule, or by a data entry operator under contract to the IRF to key in data. The patient assessment data will be transmitted to the CMS patient data system. This system is similar to the systems that HHAs use to report OASIS data and that SNFs use to report MDS 2.0 data. IRFs will transmit the patient assessment data using the toll-free MDCN line.

(4) Start-Up Systems Maintenance and Supplies Costs

There are costs associated with normal maintenance related to computer equipment. Typically, this maintenance is provided through warranty agreements with the original

equipment manufacturer, system retailer, or a firm that provides computer support. These maintenance costs are estimated to average no more than $100 per year per IRF. Although we believe that approximately 85 percent of the IRFs already have systems maintenance costs associated with transmitting data to UDSmr, we do not know if these 85 percent of IRFs will stop transmitting data to UDSmr after they start transmitting data to us. Therefore, we estimate for all 1,165 IRFs the same additional systems maintenance costs of $100 per IRF per year, for an estimated $116,500 national yearly cost ($100 x 1,165 IRFs).

Supplies necessary for collection and transmission of data, including forms, diskettes, computer paper, and toner, will vary according to the size of the IRF, the number of patients served, and the number of assessments conducted. Although we believe that approximately 85 percent of the IRFs already have supplies costs associated with transmitting data to UDSmr, we do not know if these 85 percent of IRFs will stop transmitting data to UDSmr after they start transmitting data to us. Therefore, we estimate for all 1,165 IRFs the same additional supplies costs of

$200 per IRF per year, for an estimated national yearly cost of $233,000 ($200 x 1,165 IRFs).

Tables V-A, V-B, V-C, and V-D below illustrate our estimates of the different categories of start-up costs that we have discussed above. In addition, in the proposed rule we proposed to only allow four types of clinicians to collect patient assessment data. Table V illustrates the effect of allowing more types of clinicians to collect patient assessment data on IRF start-up costs. Also, instead of averaging the hourly wages of the nonlead clinicians, as we did in the proposed rule, in order to better specify costs in Table V-A, we are illustrating a range of the nonlead clinicians' hourly wages and, thus, presenting a range of the training start-up costs for these nonlead clinicians. Due to the changes in illustrating and estimating the start-up costs, particularly the range of costs for training the nonlead clinicians, we estimate the total start-up costs to be approximately $2,988,580 to $5,825,775, which equal approximately $2,565 to $5,001 per IRF.

Table V-A.--IRF Start-Up Costs Associated With the CMS IRF Patient Assessment Instrument: Training Costs Per IRF[1]

(Column 1) Type of Cost	(Column 2) Hours Per IRF	(Column 3) Hourly Wages Per Staff Member	(Column 4) Number of Staff	(Column 5) Range of the Costs per IRF (Column 2 Times Column 3 Times Column 4)	(Column 6) Range of National Costs
Training on data collection for lead clinician for the admission and discharge assessments	16	$11.90	1	$190	Column 5 Low and High Times 1,165 $221,816 to $587,906
	16	$15.01	1	$240	
	16	$15.47	1	$248	
	16	$17.05	1	$273	
	16	$19.52	1	$312	
	16	$22.67	1	$363	
	16	$24.00	1	$384	
	16	$26.88	1	$430	
	16	$31.54	1	$505	

Training on data collection for other IRF clinicians for the admission and discharge assessments	12 12 12 12 12 12 12 12 12	$11.90 $15.01 $15.47 $17.05 $19.52 $22.67 $24.00 $26.88 $31.54	9 9 9 9 9 9 9 9 9	$1,285 $1,621 $1,671 $1,841 $2,108 $2,448 $2,592 $2,903 $3,406	Column 5 Low and High Times 1,165 $1,497,258 to $3,968,363
Data Entry (encoding and Transmission) training	5.5	$14.49	1	$79.70	Column 5 Times 1,165 $92,844
Total					$1,811,919 to $4,649,113

[1] **Excludes the incremental clinician labor costs associated with collecting the patient assessment data.**

Table V-B.--IRF Start-Up Costs Associated with the CMS IRF Patient Assessment Instrument: Data Entry and Data Transmission Costs Per IRF

(Column 1) **Type of Cost**	**(Column 2)** **Hours Per IRF Per Year**	**(Column 3)** **Hourly Wage**	**(Column 4)** **Cost Per IRF (Column 2 Times Column 3)**	**(Column. 5)** **Number of IRFs**	**(Column 6)** **National Costs (Column 4 Times Column 5)**
Data Entry	34	$14.49	$493	1,165	$573,949
Data Entry Audits	3	$14.49	$ 43	1,165	$50,643

Data Transmissions	12	$14.49	$174	1,165	$202,570
Total					$827,162

Table V-C.--IRF Start-Up Costs Associated with the CMS IRF Patient Assessment Instrument: System Maintenance and Supplies Costs

(Column 1) Type of Cost	(Column 2) Cost Per IRF Per Year	(Column 3) Number of IRFs	(Column 4) National Costs (Column 2 Times Column 3)
Systems Maintenance	$100	1,165	$116,500
Supplies	$200	1,165	$233,000
Total			$349,500

Table V-D.--IRF Start-Up Costs Associated with the CMS IRF Patient Assessment Instrument: Total Range of Start-up Costs

Range of Start-up Training-Low to High (From Table V-A)	$1,811,919 $4,649,113
Start-up Data Entry and Data Transmission Costs (From Table V-B)	$827,162
Start-up Systems Maintenance and Supplies Costs (From Table V-C)	$349,500

Grand Total Range of Start-up Costs Per IRF	$2,988,580 to $5,825,775
Low Start-Up Cost per IRF ($2,988,580 Divided By 1,165 IRFs)	$2,565.31
High Start-Up Costs per IRF ($5,825,775 Divided By 1,165 IRFs)	$5,000.67
High Start-Up Costs Per Admission ($4,971.69 Divided By 335 Admissions)	$14.93

c. Ongoing Costs

We want to differentiate between the one-time start-up costs the IRF will incur and costs we believe the IRFs will incur on a regular, yearly basis. Therefore, using the same cost concepts discussed above for the startup costs, we illustrate in Tables VI-A, VI-B, VI-C, and VI-D below the different categories of costs an IRF will incur on an ongoing basis.

Table VI-A.--IRF Ongoing Costs Associated With the CMS IRF Patient Assessment Instrument: Ongoing Training Costs Per IRF[1]

(Column 1) Type of Cost	(Column 2) Hours Per IRF	(Column 3) Hourly Wages	(Column 4) Number of Staff	(Column 5) Range of Costs Per IRF (Column 2 Times Column 3 Times Column 4)	(Column 6) Range of National Costs

Clinician training on data collection for lead clinician	12 12 12 12 12 12 12 12 12	$11.90 $15.01 $15.47 $17.05 $19.52 $22.67 $24.00 $26.88 $31.54	1 1 1 1 1 1 1 1 1	$143 $180 $186 $205 $234 $272 $288 $323 $378	Column 5 Low and High Times 1,165 $166,362 to $440,929
Clinician training on data collection for non-lead clinicians	2 2 2 2 2 2 2 2 2	$11.90 $15.01 $15.47 $17.05 $19.52 $22.67 $24.00 $26.88 $31.54	9 9 9 9 9 9 9 9 9	$214 $270 $278 $307 $351 $408 $432 $484 $568	$249,543 to $661,394
Data Entry (encoding and Transmission) training	5	$14.49	1	$72.45	Column 5 Times 1,165 $84,404
Total					$500,309 to $1,186,727

[1] **Excludes the incremental clinician labor costs associated with collecting the patient assessment data.**

Table VI-B.--IRF Ongoing Costs Associated with the CMS IRF Patient Assessment Instrument: Data Entry and Data Transmission Costs Per IRF

(Column 1) Type of Cost	(Column 2) Hours Per IRF Per Year	(Column 3) Hourly Wage	(Column 4) Cost Per IRF (Column 2 Times Column 3)	(Column 5) Number of IRFs	(Column 6) National Costs (Column 4 Times Column 5)
Data Entry	34	$14.49	$493	1,165	$573,949
Data Entry Audits	3	$14.49	$ 43	1,165	$ 50,643
Data Transmissions	12	$14.49	$174	1,165	$202,570
Total					$827,162

Table VI-C.--IRF Ongoing Costs Associated with the CMS IRF Patient Assessment Instrument: System Maintenance and Supplies Costs

(Column 1) Type of Cost	(Column 2) Cost Per IRF Per Year	(Column 3) Number of IRFs	(Column 4) National Costs (Column 2 Times Column 3)
Systems Maintenance	$100	1,165	$116,500
Supplies	$200	1,165	$233,000

Total	$349,500

Table VI-D.--IRF Ongoing Costs Associated with the CMS IRF Patient Assessment Instrument: Total Range of Ongoing Costs

Range of Ongoing Training-Low to High (From Table VI-A)	$500,309 to $1,186,727
Ongoing Data Entry and Data Transmission Costs (From Table VI-B)	$827,162
Ongoing Systems Maintenance and Supplies Costs (From Table VI-C)	$349,500
Grand Total Range of Ongoing Costs Per IRF	$1,676,971 to $2,363,389

d. Clinical Labor Data Collection Costs

As stated more fully in section VIII.B.5.a. of this final rule, we estimate that it will take a combined time of 45 minutes to collect both the admission and discharge patient assessment data using our patient assessment instrument. In addition, we stated more fully that it currently takes 25 minutes for 85 percent of 1,165 IRFs (990 IRFs) to complete the admission and discharge UDSmr patient assessment instrument, and that we believe that 15 percent of the IRFs (175 IRFs) are not currently using the UDSmr patient assessment instrument or a similar instrument.

Table VII below illustrates the costs of the data collection burden for all IRFs.

Table VII.--Clinician Incremental Labor Data Collection Costs for All IRFs

(Column 1) Incremental Data Collection Time	(Column 2) Hours Per IRF Per Year (Column 1 times 335 Admissions Divided by 60 Minutes)	(Column 3) Hourly Wages Per Clinician (From Table III)	(Column 4) Range of the Costs Per IRF (Column 2 Times Column 3)	(Column 5) Number of IRFs	(Column 6) Range of National Costs (Column 4 Times Column 5)
20	111.67	$11.90 $15.01 $15.47 $17.05 $19.52 $22.67 $24.00 $26.88 $31.54	$1,328.83 $1,676.12 $1,727.48 $1,903.92 $2,179.73 $2,531.48 $2,680.00 $3,001.60 $3,521.97	990.25	$1,315,877 to $3,487,627
45	251.25	$11.90 $15.01 $15.47 $17.05 $19.52 $22.67 $24.00 $26.88 $31.54	$2,989.88 $7,924.43	174.75	$522,481 to $1,384,793

Total for All IRFs	$1,838,358 to $3,487,656

e. Conclusion

As discussed above, IRFs will incur costs associated with the patient assessment process. In section IV. of this preamble, we specified each item of the CMS IRF patient assessment instrument that must be collected on either the admission or discharge assessment. In order to complete our analysis, we summarize in Table VIII below, by category of data, the data items of the CMS IRF patient assessment instrument. Table VIII illustrates the possible maximum number of items collected on the admission and discharge assessment. The term "possible maximum" means that an item may allow for recording up to 10 separate pieces of information. For example, the item that collects data on a patient's comorbid conditions allows the clinician to record up to 10 separate comorbid conditions. However, due to the patient's clinical status, the patient may only have 5 comorbid conditions, so only 5 comorbid conditions will be recorded. The combined total of all possible maximum admission and discharge items is 83 + 72, which equals 155. Therefore, as is illustrated in Table VIII, 53.5 percent (83 divided by 155) of the items may be collected during

the admission assessment, and 46.5 percent (72 divided by 155) of the items may be collected during the discharge assessment.

Table VIII.--Number of Admission and Discharge Items by Item Category

Item Category	Admission Items	Discharge Items
Identification Information	17	0
Admission Information	8	0
Payer Information	2	0
Medical Information	13	11
Medical Needs	4	2
Function Modifiers	10	10
FIM Instrument	18	18
Discharge Information	0	19
Quality Indicators	11	12
Total	83	72

Table IX below reflects an analysis of the per case costs for the approximately 85 percent of IRFs that we believe currently use the UDSmr patient assessment instrument to collect admission and discharge data. In Table IX, the time to complete each patient assessment instrument item is

weighted equally at 1.000, which means that each data item takes the same span of time to collect. The percentages in Table IX, column 2, are based on the data in Table VIII above. The maximum costs shown in Table IX will decrease after the first year of implementation because the greatest costs are in the first year.

Table IX.--Maximum Patient Assessment

Costs Per Case for 85 Percent of the IRFs

(Column 1) **Assessment Type**	**(Column 2)** **Percent of Patient Assessment Instrument Items Completed (See Table VIII)**	**(Column 3)** **Maximum Incremental Clinician (Physical Therapist) Cost Per IRF (From Table III)**	**(Column 4)** **Total Incremental Maximum Cost Per IRF (Column 2 Times Column 3)**	**(Column 5)** **Average Maximum Incremental Cost Per Case (Column 4 Divided by 335 Average Admissions per IRF)**
Admission	0.535	$3,521.96	$1,884.25	$ 5.62
Discharge	0.465	$3,521.96	$1,637.71	$ 4.89
Total Average Maximum Costs Per Case				$10.51

The estimated maximum start-up cost per IRF is approximately $5,001. We estimate a start-up cost per case

of $14.93 ($5,001 by 335 average admissions per IRF). Therefore, when we add the $10.51 average maximum incremental cost per case from column 5 of Table IX above to the $14.93 start-up costs per case, we arrive at an estimated total average maximum first year cost per case of $25.44 for 85 percent of the IRFs.

Table X below reflects an analysis of the per case costs for the approximately 15 percent of IRFs that we believe do not currently use the UDSmr patient assessment instrument or a similar patient assessment instrument to collect admission and discharge data.

Table X.--Maximum Patient Assessment Costs Per Case For 15 Percent of the IRFs

(Column 1) Assessment Type	(Column 2) Percent of Patient Assessment Instrument Items Completed (See Table VIII)	Column 3) Maximum Incremental Clinician (Physical Therapist) Cost Per IRF (From Table III)	(Column 4) Total Incremental Maximum Cost Per IRF (Column 2 Times Column 3)	(Column 5) Average Maximum Incremental Cost Per Case (Column 4 Divided by 335 Average Admissions per IRF)

Admission	0.535	$7,924.43	$4,239.57	$12.66
Discharge	0.465	$7,924.43	$3,684.86	$11.00
Total Average Maximum Cost Per Case				$23.66

As stated above, we estimate the maximum start-up cost per IRF is approximately $5,001. We estimate a start-up cost per case of $14.93 ($5,001 divided by 335 average admissions per IRF). Therefore, when we add the $23.66 average maximum incremental cost per case from column 5 of Table X above to the $14.93 start-up costs per case, we arrive at a total average maximum first year cost per case of $38.59 for 15 percent of the IRFs.

Table XI below illustrates the maximum national incremental start-up costs when 85 percent of IRFs have an average maximum cost of $25.44 per case, and 15 percent of IRFs have an average maximum cost of $38.59 per case.

Table XI.--Total Maximum Patient

Assessment Start-Up Costs For All IRFs

(Column 1) **Cost Per Case** **Per IRF**	**(Column 2)** **Average** **Admissions** **Per** **IRF**	**(Column 3)** **Number of IRFs**	**(Column 4)** **Average Maximum** **National Costs** **(Column 1 Times** **Column 2 Times** **Column 3)**
$25.44 (for 85 Percent of IRFs)	335	990.25	$8,437,176
$38.59 (for 15 Percent of IRFs)	335	174.75	$2,262,339
Total Maximum Start-up Costs			$10,699,515

We believe that the estimated costs of administering our patient assessment instrument are justified when considered within the context of the statutory requirement and the methodology needed to implement the IRF prospective payment system, the probability that our patient assessment process will lead to increased quality of care for IRF patients, as well as the potential uses of the automated data by the IRFs themselves, States, fiscal intermediaries, and us. Our cost estimates may actually overstate anticipated costs, because they do not take into account cost savings that IRFs may achieve by improving their management

information systems, as well as potential improvements in the quality of patients' clinical care resulting from improved care planning under the patient assessment process.

C. Alternatives Considered

In the proposed rule, we proposed to use the MDS-PAC as the patient assessment instrument. However, as more fully explained in section IV. of this preamble, we have decided to use a modified version of the UDSmr patient assessment instrument as the CMS IRF patient assessment instrument. We agree with the vast majority of the commenters who stated that a patient assessment instrument and patient assessment schedule patterned after the UDSmr patient assessment instrument and assessment schedule will achieve our goals of paying IRFs appropriately and monitoring the quality of the care the IRFs furnish. Our payment system was in part determined by using both UDSmr and COS patient admission and discharge assessment data. Therefore, we believe that using a modified version of the UDSmr patient assessment instrument that retains the basic UDSmr items used by RAND in its data analysis to determine the CMGs and payment rates (our payment system) is appropriate. (Note: COS has ceased its IRF patient assessment data business

operations, so we are patterning our assessment system after the UDSmr system.)

D. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

IX. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 30-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 PRA 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.

In the November 3, 2000 proposed rule, we solicited public comment for 60 days on each of these issues for the sections that contain information collection requirements.

Section 412.23 Excluded hospitals: Classifications

- Section 412.23(b)(2) requires that, except in the case of a newly participating hospital seeking classification as a rehabilitation hospital for its first 12-month cost reporting period, the entity show that during its most recent 12-month cost reporting period it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more specified conditions.

- Section 412.23(b)(8) requires that a hospital seeking classification as a rehabilitation hospital for the first 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of §412.23(b)(2), instead of showing that it has treated this population during its most recent 12-month cost reporting period.

The information collection requirements of these two paragraphs of this section are currently approved under OMB approval number 0938-0358 (Psychiatric Unit Criteria Work

Sheet, Rehabilitation Hospital Criteria Work Sheet, Rehabilitation Unit Criteria Work Sheet) through November 30, 2003. Any changes to these two paragraphs and the work sheets will be submitted to OMB for approval.

Sections 412.116(a)(3) Method of payment and 412.632(b) Method of payment under inpatient rehabilitation facility prospective payment system: Periodic interim payments

Under §412.116(a)(3), for cost reporting periods beginning on or after January 1, 2002, payment to a rehabilitation hospital or rehabilitation unit for inpatient hospital services under the prospective payment system will be made as described in §412.632. Section 412.632(b) provides that a rehabilitation hospital or unit under the prospective payment system may receive periodic interim payments for Part A services subject to the provisions of §413.64(h). Section 413.64(h)(3) specifies that the request for periodic interim payments must be made to the fiscal intermediary.

The burden associated with this provision is the time it takes a hospital to prepare and submit its request for periodic interim payments. We estimate that 34 IRFs will request periodic interim payments under the prospective

payment system and that it will take each 1 hour to prepare and make the request.

Sections 412.604(c) Completion of patient assessment instrument, 412.606(a) Patient assessment, 412.606(c) Comprehensive assessments, and 412.610(c) Assessment schedule

- Section 412.604(c) requires an IRF to complete the CMS IRF patient assessment instrument for each Medicare fee-for-service patient who is admitted to or discharged (or who stopped receiving Medicare Part A inpatient rehabilitation services) from the IRF on or after January 1, 2002. Section 412.606(c) requires that an IRF clinician perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare fee-for-service patient using the CMS IRF patient assessment instrument as part of his or her assessment. The assessment must include direct patient observation and communication with the patient, and, when appropriate and to the extent feasible, patient data from the patient's physician(s), family, someone personally knowledgeable about the patient's clinical condition or capabilities, the patient's clinical record, and other sources. Section 412.610(c) provides for an assessment upon admission, an assessment upon discharge, and, if the patient is not discharged but stops receiving Medicare

Part A covered inpatient rehabilitation services, an assessment at the time he or she stops receiving these services.

For the proposed rule, we used 1997 data that showed that there were approximately 359,000 admissions to 1,123 IRFs, averaging 320 admissions annually. For the final rule, we are using more recent 1999 data that showed that there were approximately 390,000 admissions to 1,165 IRFs, averaging 335 admissions annually. We estimate that it will take 45 minutes to complete both the admission and discharge assessments. The costs associated with the IRF patient assessment instrument are discussed in detail in section VIII.B.5. of this preamble. The IRF patient assessment instrument has been submitted to OMB for approval and was published in the **Federal Register** on July 13, 2001 (66 FR 36795), in which the information collection is referred to as "Request to Use Inpatient Rehabilitation Assessment Instrument and Data Set for PPS for Inpatient Rehabilitation Facilities."

We are furnishing an estimate that assumes that no facility is currently completing all items of the FIM instrument. With that in mind, we estimate a national

burden of 292,500 hours (390,000 admissions x 45 minutes/60 minutes).

We also are including training in our burden estimates: 16 hours to train the lead clinician and 12 hours to train the other clinicians (an average of 9 hours). This totals 144,460 hours nationally for a one-time burden. In addition, we estimate an ongoing burden for training of 14 hours per IRF per year (16,310 hours nationally).

- Section 412.606(a) requires that, at the time each Medicare patient is admitted, the facility must have physician orders for the patient's care during the time the patient is hospitalized.

This requirement is subject to the PRA. However, we believe that the burden associated with it is exempt as defined in 5 CFR 1320.3(b)(2), because the time, effort, and financial resources necessary to comply with the requirement are incurred by persons in the normal course of their activities.

Section 412.608 Patients' rights regarding the collection of patient assessment data

Under §412.608(a), before performing an assessment of a Medicare inpatient using the IRF patient assessment

instrument, an IRF clinician must inform the Medicare inpatient of the following patient rights:

(1) The right to be informed of the purpose of the collection of the patient assessment data;

(2) The right to have the patient assessment information collected kept confidential and secure;

(3) The right to be informed that the patient assessment information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(4) The right to refuse to answer patient assessment questions; and

(5) The right to see, review, and request changes on his or her patient assessment.

Under §412.608(b), the IRF must ensure that a clinician documents in the patient's clinical record that the patient was informed of these patient rights. The patient rights in §412.608(a) are in addition to the patient rights specified under the conditions of participation for hospitals in §482.13.

The burden of disclosure to IRF patients and documenting that disclosure is in addition to the burden in §482.13 on hospitals furnishing a patient rights statement.

The hospitals will easily be able to give both statements to patients upon admission, along with other required notifications. The burden for the general patient rights statement has not yet been approved but is under development. We estimate that it takes each hospital 5 minutes to disclose the general hospital statement to each patient on admission. The disclosure of the IRF patient rights statement will increase that time by an estimated 2 minutes. Since this disclosure will occur for each admission and there are, on average, an estimated 335 admissions annually per IRF, we are estimating that this disclosure will occur, on average, 335 times annually per IRF.

Section 412.610(f) Patient assessment instrument record retention

Section 412.610(f) requires an IRF to maintain all patient assessment data sets completed within the previous 5 years either in a paper format in the patient's clinical record or in an electronic computer file format that the IRF can easily obtain.

We estimate that, for IRFs that choose to file a paper copy, it will take the IRF 5 minutes to print out, or copy, each assessment and file it in the patient’s record. On

average, we estimate that each IRF will need to obtain a copy of and file 670 assessments per year, for a burden of 56 hours. We cannot estimate how many facilities will choose to file paper copies. However, we are assuming that most facilities will choose to retain the assessments in an electronic format, which would not add to the paperwork burden.

Section 412.614 Transmission of patient assessment

Section 412.614(a) requires each IRF to encode and transmit data using the computer program(s) available from us; or using a computer program(s) that conforms to our standard electronic record layout, data specifications, and data dictionary, includes the required patient assessment data set, and meets our other specifications. Section 412.614(b) requires each IRF to electronically transmit complete, accurate, and encoded data to our patient data system using electronic communications software that provides a direct telephone connection from the IRF to our system.

The patient assessment data may be entered into the computerized system by an IRF staff member from a paper document completed by an IRF clinician or by a data entry operator under contract to the IRF to key in data. Also, IRFs will have to allow time for data validation, preparation of data for transmission, and correction of returned records that failed checks by the inpatient rehabilitation facility patient assessment system.

We estimate that an average IRF with 335 admissions per year will require 3 minutes for data review and entry per assessment for up-front review and another 3 minutes

for data entry review, for a total of 6 minutes. The burden of entering and reviewing the data is contained in that 6 minutes. We estimate the yearly burden will be 34 hours per facility.

In addition, we estimate that an IRF will perform a 15-minute monthly data entry audit for quality assurance purposes. We estimate the yearly burden will be 3 hours per facility.

Other Data Transmission Functions

We estimate that it will take about one additional hour of staff time to perform data transmission-related tasks each month. With 1,165 facilities, we estimate the national burden will be 13,980 hours.

We estimate that it will require a one-time burden of 5.5 hours per hospital to train the personnel to be able to complete data transmission tasks. With 1,165 facilities, we estimate the national burden will be 6,408 hours.

Section 412.616 Release of information collected using the patient assessment instrument

Under §412.616(b), an IRF may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes

specified in the contract and to the extent the facility itself is permitted to do so.

The burden associated with this information collection requirement is the time required to include the necessary information in the contract. While this requirement is subject to the PRA, we believe the burden associated with it is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement will be incurred by persons in the normal course of their activities.

Section 412.618(b) Assessment process for interrupted stay: Recording and encoding the data

Section 412.618(b) requires that if a patient has an interrupted stay, the IRF must record the interrupted stay data on the patient assessment instrument.

We currently have no data on the incidence of interrupted stays. We estimate, however, that it will take no more than 5 minutes to record the interrupted stay data.

Section 412.626(b) Transition period: Election not to be paid under the transition period methodology

Under §412.626(b), an IRF may elect a payment that is based entirely on the adjusted Federal prospective payment for cost reporting periods beginning on or after

January 1, 2002, and before October 1, 2002 without regard to the transition period percentages. Section 412.626(b)(2) specifies that the request to make the election must be made in writing to the Medicare fiscal intermediary for the facility.

We estimate that 580 IRFs will make a request under this section and that it will take each IRF 1 hour to complete the request.

Public Comments Received and Departmental Responses

Comment: Many commenters stated that the length and complexity of the MDS-PAC patient assessment instrument in the proposed rule create an unreasonable burden for performing patient assessments and result in excessive IRF patient assessment costs.

Response: As indicated in section IV. of this final rule, we are changing the patient assessment instrument from the MDS-PAC to the CMS IRF patient assessment instrument that is similar to the UDSmr patient assessment instrument, FIM. Because the patient assessment instrument we are adopting in this final rule is based upon the FIM, we have estimated the burden hours based upon the actual estimate contained in the special study completed by RAND. In the study entitled "Assessment Instruments for PPS," two

tests of administration times were performed (that is, institutional teams and calibration teams). The institutional and calibration teams were not familiar with the MDS-PAC and, therefore, they were trained to complete it. The institutional teams were familiar with the FIM and had previously completed the instrument. The calibration teams were not familiar with the FIM instrument and, therefore, they were trained to complete it. The study found that the average time to complete the admission FIM (the instrument we will be using for the purposes of payment) was 25 minutes for the institutional team. For the calibration team, the FIM burden was 148 minutes for a small number of cases. The estimated burden hours for the MDS-PAC were 145 minutes for the institutional team and 221 minutes for the calibration team.

We have expanded the UDSmr patient assessment instrument to include a minimal number of questions related to quality of care. For the purposes of estimating the burden, we are maintaining the burden estimates for the assessment stated in the proposed rule. In that proposed rule, we estimated that there was a range of 30 to 45 minutes to complete the UDSmr patient assessment instrument. For the purpose of the estimate in this final

rule, we are using the maximum number of 45 minutes to calculate the burden required to complete the admission and discharge assessments associated with our IRF patient assessment instrument. In addition, because the majority of IRFs currently use the UDSmr patient assessment instrument, we have used the experience from the institutional teams in our time burden estimates.

The burden estimate for this final rule represents a considerable reduction in the burden that we had estimated using the MDS-PAC in the proposed rule.

Submission to OMB

We have submitted a copy of this final rule to OMB for its review of the information collection requirements in §§412.23, 412.116, 412.604 through 412.610, 412.614 through 412.618, and 412.626. These requirements are not effective until they have been approved by OMB. As stated earlier, the information collection requirements under §412.23 are already approved by OMB through November 30, 2003 (OMB approval number 0938-0358).

X. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes

a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. The notice of proposed rulemaking can be waived, however, if an agency finds good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest, and it incorporates a statement of the finding and its reasons in the rule issued.

On November 3, 2000, we published a proposed rule addressing proposed policies for establishment of the Medicare prospective payment system for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit of a hospital (65 FR 66304). On December 21, 2000, Public Law 106-554 was enacted. Section 305 of Public Law 106-554 amends section 1886(j) of the Act, and this final rule incorporates the amendments made by section 305 of Public Law 106-554. We find good cause to waive notice and comment procedures with respect to the provisions of this final rule implementing the amendments made to section 305 of Public Law 106-554 because the amendments do not require an exercise of discretion and therefore publishing a notice of proposed rulemaking with respect to the amendments is unnecessary.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Chapter IV is amended as set forth below:

PART 412--PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as follows:

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A--General Provisions

2. Section §412.1 is revised to read as follows:

§**412.1 Scope of part.**

(a) Purpose. (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare

beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (organ acquisition costs incurred by hospitals with approved organ transplantation centers, the costs of qualified nonphysician anesthetist's services, as described in §412.113(c), and direct costs of approved nursing and allied health educational programs) is made on a reasonable cost basis. Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with §413.86 of this chapter. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may

keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(2) This part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meets the conditions of §412.604.

(b) Summary of content. (1) This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems specified in paragraph (a)(1) of this section and sets forth the general basis of these systems.

(2) Subpart B sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems specified in paragraph (a)(1) of this section, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification.

(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems specified in paragraph (a)(1) of this section.

(4) Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined under the prospective payment system specified in paragraph (a)(1) of this section.

(5) Subpart E describes the transition ratesetting methods that are used to determine transition payment rates for inpatient operating costs during the first 4 years of the prospective payment system specified in paragraph (a)(1) of this section.

(6) Subpart F sets forth the methodology for determining payments for outlier cases under the prospective payment system specified in paragraph (a)(1) of this section.

(7) Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(8) Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective

payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(9) Subpart K describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs is implemented for hospitals located in Puerto Rico.

(10) Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation under the prospective payment systems specified in paragraph (a)(1) of this section.

(11) Subpart M describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient capital-related costs is implemented effective with reporting periods beginning on or after October 1, 1991.

(12) Subpart P describes the prospective payment system specified in paragraph (a)(2) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation

units effective with cost reporting periods beginning on or after January 1, 2002.

Subpart B--Hospital Services Subject to and Excluded from the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

3. Section 412.20 is amended by:

A. Revising paragraph (a).

B. Redesignating paragraph (b) as paragraph (c).

C. Adding a new paragraph (b).

D. Revising the introductory text of the redesignated paragraph (c).

§412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b) and (c) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid under the prospective payment systems specified in §412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after January 1, 2002, covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet

the conditions of §412.604 are paid under the prospective payment system described in subpart P of this part.

(c) Inpatient hospital services will not be paid under the prospective payment systems specified in §412.1(a)(1) under any of the following circumstances:

* * * * *

4. Section 412.22 is amended by:

A. Revising paragraphs (a) and (b).

B. Revising the introductory text of paragraph (e).

C. Revising introductory text of paragraph (h)(2).

§**412.22 Excluded hospitals and hospital units: General rules.**

(a) Criteria. Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified in §412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in §412.23.

(b) Cost reimbursement. Except for those hospitals specified in paragraph (c) of this section and §412.20(b), all excluded hospitals (and excluded hospital units, as described in §§412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of

hospital cost increases described in §413.40 of this subchapter.

* * * * *

(e) Hospitals within hospitals. Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in §412.1(a)(1):

* * * * *

(h) Satellite facilities. * * *

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the prospective payment systems specified in §412.1(a)(1) for any period:

* * * * *

5. Section 412.23 is amended by:

A. Revising the introductory text of the section.

B. Revising the introductory text of paragraph (b).

C. Revising paragraphs (b)(2) introductory text, (b)(8), and (b)(9).

§412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in §412.1(a)(1):

* * * * *

(b) Rehabilitation hospitals. A rehabilitation hospital must meet the following requirements to be excluded from the prospective payment systems specified in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(2) and in Subpart P of this part:

* * * * *

(2) Except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative

services for treatment of one or more of the following conditions:

* * * * *

(8) A hospital that seeks classification under this paragraph as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated that population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital’s regular 12-month cost reporting period.

(9) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems specified in §412.1(a)(1) or is paid under the prospective payment system specified in §412.1(a)(2) for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population it actually treated during that period does not meet the

requirements of paragraph (b)(2) of this section, we adjust payments to the hospital retroactively in accordance with the provisions in §412.130.

* * * * *

6. In §412.25, paragraph (a) introductory text and paragraph (e)(2) introductory text are revised to read as follows:

§**412.25 Excluded hospital units: Common requirements.**

(a) Basis for exclusion. In order to be excluded from the prospective payment systems specified in §412.1(a)(1), a psychiatric or rehabilitation unit must meet the following requirements.

* * * * *

(e) Satellite facilities. * * *

(2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital unit that establishes a satellite facility must meet the following requirements in order to be excluded from the prospective payment systems specified in §412.1(a)(1) for any period:

* * * * *

7. In §412.29, the introductory text is revised to read as follows:

§412.29 Excluded rehabilitation units: Additional requirements.

In order to be excluded from the prospective payment systems described in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(2), a rehabilitation unit must meet the following requirements:

* * * * *

Subpart H--Payments to Hospitals Under the Prospective Payment Systems

8. In §412.116, paragraph (a) is revised to read as follows:

§412.116 Method of payment.

(a) General rule. (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before January 1, 2002) are made as described in §§413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after January 1, 2002, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the conditions of §412.604 are made as described in §412.632.

* * * * *

9. In §412.130, paragraphs (a)(1), (a)(2), and (b) are revised to read as follows:

§**412.130 Retroactive adjustments for incorrectly excluded hospitals and units.**

(a) Hospitals for which adjustment is made. * * *

(1) A hospital that was excluded from the prospective payment systems specified in §412.1(a)(1) or paid under the prospective payment system specified in §412.1(a)(2), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under §412.23(b)(8) of this part regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of §412.23(b)(2).

(2) A hospital that has a unit excluded from the prospective payment systems specified in §412.1(a)(1) or paid under the prospective payment system specified in §412.1(a)(2), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under §412.30(a) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of §412.23(b)(2).

* * * * *

(b) Adjustment of payment. (1) For cost reporting periods beginning before January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1).

(2) For cost reporting periods beginning on or after January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1).

Subparts N and O—-[Reserved]

10. Subparts N and O are added and reserved.

11. A new subpart P, consisting of §§412.600, 412.602, 412.604, 412.606, 412.608, 412.610, 412.612, 412.614, 412.616, 412.618, 412.620, 412.622, 412.624, 412.626, 412.628, 412.630, and 412.632, is added to read as follows:

Subpart P—-Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

Sec.

412.600 Basis and scope of subpart.

412.602 Definitions.

412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

412.606 Patient assessments.

412.608 Patients' rights regarding the collection of patient assessment data.

412.610 Assessment schedule.

412.612 Coordination of the collection of patient assessment data.

412.614 Transmission of patient assessment data.

412.616 Release of information collected using the patient assessment instrument.
412.618 Assessment process for interrupted stays.
412.620 Patient classification system.
412.622 Basis of payment.
412.624 Methodology for calculating the Federal prospective payment rates.
412.626 Transition period.
412.628 Publication of the Federal prospective payment rates.
412.630 Limitation on review.
412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

Subpart P--Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

§412.600 Basis and scope of subpart.

(a) Basis. This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as "inpatient rehabilitation facilities").

(b) Scope. This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2002, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined rates and applied on a per discharge basis.

§412.602 Definitions.

As used in this subpart—

Assessment reference date means the specific calendar day in the patient assessment process that sets the designated endpoint of the common patient observation period, with most patient assessment items usually referring back in time from this endpoint.

CMS stands for the Centers for Medicare & Medicaid Services.

Comorbidity means a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay.

Discharge. A Medicare patient in a inpatient rehabilitation facility is considered discharged when--

(1) The patient is formally released;

(2) The patient stops receiving Medicare-covered Part A inpatient rehabilitation services; or

(3) The patient dies in the inpatient rehabilitation facility.

Encode means entering data items into the fields of the computerized patient assessment software program.

Functional-related groups refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

Interrupted stay means a stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of the stay of 3 consecutive calendar days begins with the day of discharge from the inpatient

rehabilitation facility and ends on midnight of the third day.

Outlier payment means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

Patient assessment instrument refers to a document that contains clinical, demographic, and other information on a patient.

Rural area means an area as defined in §412.62(f)(1)(iii).

Transfer means the release of a Medicare inpatient from an inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term, acute-care prospective payment hospital, a long-term care hospital as described in §412.23(e), or a nursing home that qualifies to receive Medicare or Medicaid payments.

Urban area means an area as defined in §412.62(f)(1)(ii).

§412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

(a) General requirements. (1) Effective for cost reporting periods beginning on or after January 1, 2002, an inpatient rehabilitation facility must meet the conditions

of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(2) If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare Part A fee-for-service beneficiaries, we may, as appropriate--

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient rehabilitation facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient rehabilitation facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment systems specified in §412.1(a)(1).

(b) Inpatient rehabilitation facilities subject to the prospective payment system. Subject to the special payment provisions of §412.22(c), an inpatient rehabilitation facility must meet the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in §§412.23(b), 412.25, and 412.29 for

exclusion from the inpatient hospital prospective payment systems specified in §412.1(a)(1).

(c) Completion of patient assessment instrument. For each Medicare Part A fee-for-service patient admitted to or discharged from an IRF on or after January 1, 2002, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with §412.606.

(d) Limitation on charges to beneficiaries--(1) Prohibited charges. Except as provided in paragraph (d)(2) of this section, an inpatient rehabilitation facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) Permitted charges. An inpatient rehabilitation facility receiving payment under this subpart for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§409.82, 409.83, and 409.87 of this subchapter and for items or services as specified under §489.20(a) of this chapter.

(e) Furnishing of inpatient hospital services directly or under arrangement. (1) Subject to the provisions of §412.622(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in §409.10 of this subchapter. Inpatient hospital services do not include the following:

(i) Physicians' services that meet the requirements of §415.102(a) of this subchapter for payment on a fee schedule basis).

(ii) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(iii) Nurse practitioners and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(v) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(vi) Services of an anesthetist, as defined in §410.69 of this chapter.

(2) Medicare does not pay any provider or supplier other than the inpatient rehabilitation facility for

services furnished to a Medicare beneficiary who is an inpatient of the inpatient rehabilitation facility, except for services described in paragraphs (e)(1)(i) through (e)(1)(vi) of this section.

(3) The inpatient rehabilitation facility must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements (as defined in §409.3 of this subchapter).

(f) Reporting and recordkeeping requirements. All inpatient rehabilitation facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§413.20 and 413.24 of this subchapter.

§412.606 Patient assessments.

(a) Admission orders. At the time that each Medicare Part A fee-for-service patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized.

(b) Patient assessment instrument. An inpatient rehabilitation facility must use the CMS inpatient rehabilitation facility patient assessment instrument to assess Medicare Part A fee-for-service inpatients who--

(1) Are admitted on or after January 1, 2002; or

(2) Were admitted before January 1, 2002, and are still inpatients as of January 1, 2002.

(c) Comprehensive assessments. (1) A clinician of the inpatient rehabilitation facility must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare Part A fee-for-service inpatient using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of this section as part of his or her patient assessment in accordance with the schedule described in §412.610.

(2) A clinician employed or contracted by an inpatient rehabilitation facility who is trained on how to perform a patient assessment using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of the section must record appropriate and applicable data accurately and completely for each item on the patient assessment instrument.

(3) The assessment process must include--

(i) Direct patient observation and communication with the patient; and

(ii) When appropriate and to the extent feasible, patient data from the patient's physician(s), family,

someone personally knowledgeable about the patient's clinical condition or capabilities, the patient's clinical record, and other sources.

§412.608 Patients' rights regarding the collection of patient assessment data.

(a) Before performing an assessment using the patient assessment instrument, a clinician of the IRF must inform the Medicare Part A fee-for-service inpatient of the following patient rights:

(1) The right to be informed of the purpose of the collection of the patient assessment data;

(2) The right to have the patient assessment information collected be kept confidential and secure;

(3) The right to be informed that the patient assessment information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(4) The right to refuse to answer patient assessment questions; and

(5) The right to see, review, and request changes on his or her patient assessment.

(b) The inpatient rehabilitation facility must ensure that a clinician documents in the Medicare Part A fee-for-

service inpatient's clinical record that the patient was informed of the patient rights specified in paragraph (a) of this section.

(c) The patient rights specified in paragraph (a) of this section are in addition to the patient rights specified under the conditions of participation for hospitals in §482.13 of this chapter.

§412.610 Assessment schedule.

(a) General. For each Medicare Part A fee-for-service inpatient, an inpatient rehabilitation facility must complete a patient assessment instrument as specified in §412.606 that covers a time period that is in accordance with the assessment schedule specified in paragraph (c) of this section.

(b) Starting the assessment schedule day count. The first day that the Medicare Part A fee-for-service inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the patient assessment schedule.

(c) Assessment schedules and reference dates. The inpatient rehabilitation facility must complete a patient assessment instrument upon the Medicare Part A fee-for-

service patient's admission and discharge as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) Admission assessment.

(i) General rule. The admission assessment--

(A) Time period is a span of time that covers calendar days 1 through 3 of the patient's current Medicare Part A fee-for-service hospitalization;

(B) Has an admission assessment reference date that is the third calendar day of the span of time specified in paragraph (c)(1)(i)(A) of this section; and

(C) Must be completed on the calendar day that follows the admission assessment reference day.

(ii) Exception to the general rule. We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different admission assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(2) Discharge assessment.

(i) General rule. The discharge assessment--

(A) Time period is a span of time that covers 3 calendar days, and is the discharge assessment reference date itself specified in paragraph (c)(2)(ii) of this

section and the 2 calendar days prior to the discharge assessment reference date; and

(B) Must be completed on the 5th calendar day that follows the discharge assessment reference date specified in paragraph (c)(2)(ii) of this section with the discharge assessment reference date itself being counted as the first day of the 5 calendar day time span.

(ii) Discharge assessment reference date. The discharge assessment reference date is the actual day that the first of either of the following two events occurs:

(A) The patient is discharged from the IRF; or

(B) The patient stops being furnished Medicare Part A fee-for-service inpatient rehabilitation services.

(iii) Exception to the general rule. We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different discharge assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(d) Encoding dates. The admission and discharge patient assessments must be encoded by the 7th calendar day from the completion dates specified in paragraph (c) of this section.

(e) Accuracy of the patient assessment data. The encoded patient assessment data must accurately reflect the patient's clinical status at the time of the patient assessment.

(f) Patient assessment instrument record retention. An inpatient rehabilitation facility must maintain all patient assessment data sets completed on Medicare Part A fee-for-service patients within the previous 5 years either in a paper format in the patient's clinical record or in an electronic computer file format that the inpatient rehabilitation facility can easily obtain.

§412.612 Coordination of the collection of patient assessment data.

(a) Responsibilities of the clinician. A clinician of an inpatient rehabilitation facility who has participated in performing the patient assessment must have responsibility for--

(1) The accuracy and thoroughness of the specific data recorded by that clinician on the patient's assessment instrument; and

(2) The accuracy of the assessment reference date inserted on the patient assessment instrument completed under §412.610(c).

(b) Penalty for falsification.

(1) Under Medicare, an individual who knowingly and willfully--

(i) Completes a material and false statement in a patient assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to complete a material and false statement in a patient assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

§412.614 Transmission of patient assessment data.

(a) Data format. The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service inpatient––

(1) Using the computerized version of the patient assessment instrument available from us; or

(2) Using a computer program(s) that conforms to our standard electronic record layout, data specifications, and data dictionary, includes the required patient assessment instrument data set, and meets our other specifications.

(b) How to transmit data. The inpatient rehabilitation facility must--

(1) Electronically transmit complete, accurate, and encoded data from the patient assessment instrument for each Medicare Part A fee-for-service inpatient to our patient data system in accordance with the data format specified in paragraph (a) of this section; and

(2) Transmit data using electronic communications software that provides a direct telephone connection from the inpatient rehabilitation facility to the our patient data system.

(c) Transmission dates. The inpatient rehabilitation facility must transmit both the admission patient assessment and the discharge patient assessments at the same time to the our patient data system by the 7th calendar day in the period beginning with the applicable patient assessment instrument encoding date specified in §412.610(d).

(d) Late transmission penalty. (1) We assess a penalty when an inpatient rehabilitation facility does not transmit the required data from the patient assessment instrument to the our patient data system in accordance

with the transmission timeframe in paragraph (c) of this section.

(2) If the actual patient assessment data transmission date is later than 10 calendar days from the transmission date specified in paragraph (c) of this section, the patient assessment data is considered late and the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

§412.616 Release of information collected using the patient assessment instrument.

(a) General. An inpatient rehabilitation facility may release information from the patient assessment instrument only as specified in §482.24(b)(3) of this chapter.

(b) Release to the inpatient rehabilitation facility's agent. An inpatient rehabilitation facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and only to the extent the facility itself is permitted to do so under paragraph (a) of this section.

§412.618 Assessment process for interrupted stays.

For purposes of the patient assessment process, if a Medicare Part A fee-for-service patient has an interrupted stay, as defined under §412.602, the following applies:

(a) Assessment requirements. (1) The initial case-mix group classification from the admission assessment remains in effect (that is, no new admission assessment is performed).

(2) When the patient has completed his or her entire rehabilitation episode stay, a discharge assessment must be performed.

(b) Recording and encoding of data. The clinician must record the interruption of the stay on the patient assessment instrument.

(c) Revised assessment schedule. (1) If the interruption in the stay occurs before the admission assessment, the assessment reference date, completion dates, encoding dates, and data transmission dates for the admission and discharge assessments are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

(2) If the interruption in the stay occurs after the admission assessment and before the discharge assessment,

the completion date, encoding date, and data transmission date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

§412.620 Patient classification system.

(a) Classification methodology.

(1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from admission assessments under §412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(4) Data from the discharge assessment under §412.610(c)(2) are used to determine the weighting factors under paragraph (b)(4) of this section.

(b) Weighting factors.

(1) General. An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) Short-stay outliers. We will determine a weighting factor or factors for patients that are discharged and not transferred (as defined in §412.602) within a number of days from admission as specified by us.

(3) Patients who expire. We will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by us.

(4) Comorbidities. We will determine a weighting factor or factors to account for the presence of a comorbidity, as defined in §412.602, that is relevant to resource use in the classification system.

(c) Revision of case-mix group classifications and weighting factors. We may periodically adjust the case-mix groups and weighting factors to reflect changes in--

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of resources.

§412.622 Basis of payment.

(a) Method of payment.

(1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in §412.624 and, if applicable, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in §412.626.

(b) Payment in full. (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§413.85 and 413.86 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following:

(i) Bad debts of Medicare beneficiaries, as provided in §413.80 of this chapter; and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

§412.624 Methodology for calculating the Federal prospective payment rates.

(a) Data used. To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities, we use--

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, to estimate payments for inpatient operating and capital-related costs made under part 413 under this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient rehabilitation services; and

(4) Patient assessment data described in §412.606 and other data that account for the relative resource utilization of different patient types.

(b) Determining the average costs per discharge for fiscal year 2001. We determine the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data specified under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2001 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2001.

(c) Determining the Federal prospective payment rates. (1) General. The Federal prospective payment rates will be established using a standard payment amount referred to as the budget neutral conversion factor. The budget neutral conversion factor is a standardized payment amount based on average costs from a base year which reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments, and other adjustments.

(2) Update the cost per discharge. We apply the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, we estimate the payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) Computation of the budget neutral conversion factor. The budget neutral conversion factor is computed as follows:

(i) For fiscal year 2002. Based on the updated costs per discharge and estimated payments for fiscal year 2002 determined in paragraph (c)(2) of this section, we compute a budget neutral conversion factor for fiscal year 2002, as specified by us, that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) For fiscal years after 2002. The budget neutral conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of

this section, including adjustments described in paragraph (d) of this section as appropriate.

(4) Determining the Federal prospective payment rate for each case-mix group. The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in §412.620(b) and the budget neutral conversion factor described in paragraph (c)(3) of this section.

(d) Adjustments to the budget neutral conversion factor. The budget neutral conversion factor described in paragraph (c)(3) of this section will be adjusted for the following:

(1) Outlier payments. We determine a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(4) of this section.

(2) Budget neutrality. We adjust the Federal prospective payment rates for fiscal year 2002 so that aggregate payments under the prospective payment system, excluding any additional payments associated with elections not to be paid under the transition period methodology under §412.626(b), are estimated to equal the amount that would have been made to inpatient rehabilitation facilities

under part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.

(3) Coding and classification changes. We adjust the budget neutral conversion factor for a given year if we determine that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that such revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(e) Calculation of the adjusted Federal prospective payment. For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate that is in effect for its cost reporting period that begins in a Federal fiscal year specified under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) Adjustment for area wage levels. The labor portion of a facility's Federal prospective payment is

adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in §412.602.

(2) Adjustments for low-income patients. We adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us.

(3) Adjustments for rural areas. We adjust the Federal prospective payment by a factor, as specified by us for facilities located in rural areas, as defined in §412.602.

(4) Adjustment for high-cost outliers. We provide for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients and for rural locations) as specified by us. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount.

(5) Adjustments related to the patient assessment instrument. An adjustment to a facility's Federal prospective payment amount for a given discharge will be made, as specified under §412.614(d), if the transmission of data from a patient assessment instrument is late.

(f) Special payment provision for patients that are transferred.

(1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who--

(i) Is transferred from the inpatient rehabilitation facility to another site of care, as defined in §412.602; and

(ii) Stays in the facility for a number of days that is less than the average length of stay for nontransfer cases in the case-mix group to which the patient is classified.

(2) We calculate the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for nontransfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the per day payment amount.

(iii) By multiplying the payment per day under paragraph (f)(2)(i) by 0.5 to equal an additional one half day payment for the first day of the stay before the discharge.

(iv) By adding the per day payment amount under paragraph (f)(2)(ii) and the additional one-half day payment under paragraph (f)(2)(iii) to equal the unadjusted payment amount.

(v) By applying the adjustments described in paragraphs (e)(1), (e)(2), and (e)(3) of this section to the unadjusted payment amount determined in paragraph (f)(2)(iv) of this section to equal the adjusted transfer payment amount.

(g) Special payment provision for interrupted stays. When a patient in an inpatient rehabilitation facility has one or more interruptions in the stay, as defined in §412.602 and as indicated on the patient assessment instrument in accordance with §412.618(b), we will make payments in the following manner:

(1) Interruption of one day or less. Payment for a patient stay with an interruption of one day or less will be the adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in §412.618(a)(1). Payment for an interruption of one day or less will only be made to the inpatient rehabilitation facility.

(2) Interruption of more than one day. Payment for a patient stay with an interruption of more than one day but less than 3 consecutive days, as defined in §412.602, will be--

(i) The adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in §412.618(a)(1) made to the inpatient rehabilitation facility; and

(ii) If the reason for the interrupted patient stay is to receive inpatient acute care hospital services, an amount based on the prospective payment systems described in §412.1(a)(1) made to the acute care hospital.

§412.626 Transition period.

(a) Duration of transition period and proportion of the blended transition rate. (1) Except for a facility that makes an election under paragraph (b) of this section,

for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, an inpatient rehabilitation facility receives a payment comprised of a blend of the adjusted Federal prospective payment, as determined under §412.624(e) or §412.624(f) and a facility-specific payment as determined under paragraph (a)(2) of this section.

(i) For cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, payment is based on 33 1/3 percent of the facility-specific payment and 66 2/3 percent of the adjusted FY 2002 Federal prospective payment.

(ii) For cost reporting periods beginning on or after October 1, 2002, payment is based entirely on the adjusted Federal prospective payment.

(2) Calculation of the facility-specific payment. The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital-related costs in accordance with part 413 of this chapter.

(b) Election not to be paid under the transition period methodology. An inpatient rehabilitation facility may elect a payment that is based entirely on the adjusted Federal prospective payment for cost reporting periods beginning before fiscal year 2003 without regard to the transition period percentages specified in paragraph (a)(1)(i) of this section.

(1) General requirement. An inpatient rehabilitation facility will be required to request the election under this paragraph (b) within 30 days of its first cost reporting period for which payment is based on the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

(2) Notification requirement to make election. The request by the inpatient rehabilitation facility to make the election under this paragraph (b) must be made in writing to the Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins

will not be approved. If the 30th day before the cost reporting period begins falls on a day that the postal service or other delivery sources are not open for business, the inpatient rehabilitation facility is responsible for allowing sufficient time for the delivery of the request before the deadline. If an inpatient rehabilitation facility's request is not received or not approved, payment will be based on the transition period rate specified in paragraph (a)(1)(i) of this section.

§412.628 Publication of the Federal prospective payment rates.

We publish information pertaining to the inpatient rehabilitation facility prospective payment system effective for each fiscal year in the **Federal Register**. This information includes the unadjusted Federal payment rates, the patient classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

§412.630 Limitation on review.

Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard

to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

§412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

(a) General rule. Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient rehabilitation facility receives payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) Periodic interim payments.

(1) Criteria for receiving periodic interim payments.

(i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of §413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in §413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in §412.116.

(iv) As provided in §413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary’s best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) Frequency of payment. For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if

an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) Termination of PIP. (i) Request by the inpatient rehabilitation facility. Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) Removal by the intermediary. An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of §413.64(h) of this chapter.

(c) Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system. For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each

payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) Outlier payments. Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) Accelerated payments. (1) General rule. Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility’s

preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) Approval of payment. An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and us.

(3) Amount of payment. The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) Recovery of payment. Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

B. Part 413 is amended as set forth below:

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

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

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A -- Introduction and General Rules

2. Section 413.1 is amended by:

A. Revising paragraph (d)(2)(ii).

B. Adding paragraphs (d)(2)(iv) and (d)(2)(v).

§**413.1 Introduction.**

* * * * *

(d) * * *

(2) * * *

(ii) Payment to children's, psychiatric, and long-term hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals), that are excluded from the prospective payment systems under subpart B of part 412 of this subchapter, and hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of §413.40.

* * * * *

(iv) For cost reporting periods beginning before January 1, 2002, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals), that are excluded under subpart B of part 412 of this subchapter from the prospective payment systems is on a reasonable cost basis, subject to the provisions of §413.40.

(v) For cost reporting periods beginning on or after January 1, 2002, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals) that meet the conditions of §412.604 of this chapter is based on prospectively determined rates under subpart P of part 412 of this subchapter.

* * * * *

Subpart C-- Limits on Cost Reimbursement

3. Section 413.40 is amended by:

A. Republishing the introductory text of paragraph (a)(2)(i).

B. Adding a new paragraph (a)(2)(i)(C).

C. Revising paragraph (a)(2)(ii).

D. Adding a new paragraph (a)(2)(iii).

§413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) Introduction. * * *

(2) Applicability. (i) This section is not applicable to--

* * * * *

(C) Rehabilitation hospitals and rehabilitation units that are paid under the prospective payment system for

inpatient hospital services in accordance with section 1886(j) of the Act and subpart P of part 412 of this subchapter for cost reporting periods beginning on or after January 1, 2002.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to--

(A) Hospitals excluded from the prospective payment systems described in §412.1(a)(1) of this subchapter; and

(B) Psychiatric and rehabilitation units excluded from the prospective payment systems, as described in §412.1(a)(1) of this chapter and in accordance with §§412.25 through 412.30 of this chapter, except as limited by paragraph (a)(2)(iii) of this section with respect to rehabilitation hospitals and rehabilitation units specified in §§412.23(b), 412.27, and 412.29 of this subchapter.

(iii) For cost reporting periods beginning on or after October 1, 1983 and before January 1, 2002, this section applies to rehabilitation hospitals and rehabilitation units that are excluded from the prospective payment systems described in §412.1(a)(1) of this subchapter.

* * * * *

Subpart E-- Payments to Providers

4. In §413.64, paragraph (h)(2)(i) is revised to read as follows:

§413.64 Payment to providers: Specific rules.

* * * * *

(h) Periodic interim payment method of reimbursement--

* * *

(2) * * *

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, described in §412.1(a)(1) of this chapter, under subpart B of part 412 of this chapter or are paid under the prospective payment system described in subpart P of part 412 of this chapter.

* * * * *

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

Dated: _____

_____

Thomas A. Scully,
Administrator,
Centers for Medicare & Medicaid Services

Dated: _____

_____

Tommy G. Thompson,
Secretary.

BILLING CODE 4120-01

Editorial Note: The following Addendum and Appendix A through Appendix D to the preamble will not appear in the Code of Federal Regulations.

Addendum--Tables

This section contains tables referred to throughout the preamble to this final rule. The tables presented below are as follows:

Table 1 – Relative Weights for Case-Mix Groups (CMGs)

Table 2 – Federal Prospective Payments for Case-Mix Groups

Table 3A – Wage Index for Urban Areas

Table 3B – Wage Index for Rural Areas

Table 1.--Relative Weights for Case-Mix Groups (CMGs)

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0101	Stroke M=69-84 and C=23-35	0.4778	0.4279	0.4078	0.3859	10	9	6	8
0102	Stroke M=59-68 and C=23-35	0.6506	0.5827	0.5553	0.5255	11	12	10	10
0103	Stroke M=59-84 and C=5-22	0.8296	0.7430	0.7080	0.6700	14	12	12	12
0104	Stroke M=53-58	0.9007	0.8067	0.7687	0.7275	17	13	12	13
0105	Stroke M=47-52	1.1339	1.0155	0.9677	0.9158	16	17	15	15
0106	Stroke M=42-46	1.3951	1.2494	1.1905	1.1267	18	18	18	18
0107	Stroke M=39-41	1.6159	1.4472	1.3790	1.3050	17	20	21	21
0108	Stroke M=34-38 and A>=83	1.7477	1.5653	1.4915	1.4115	25	27	22	23
0109	Stroke M=34-38 and A<=82	1.8901	1.6928	1.6130	1.5265	24	24	22	24
0110	Stroke M=12-33 and A>=89	2.0275	1.8159	1.7303	1.6375	29	25	27	26
0111	Stroke M=27-33 and A=82-88	2.0889	1.8709	1.7827	1.6871	29	26	24	27
0112	Stroke M=12-26 and A=82-88	2.4782	2.2195	2.1149	2.0015	40	33	30	31
0113	Stroke M=27-33 and A<=81	2.2375	2.0040	1.9095	1.8071	30	27	27	28
0114	Stroke M=12-26 and A<=81	2.7302	2.4452	2.3300	2.2050	37	34	32	33
0201	Traumatic brain injury M=52-84 and C=24-35	0.7689	0.7276	0.6724	0.6170	13	14	14	11
0202	Traumatic brain injury M=40-51 and C=24-35	1.1181	1.0581	0.9778	0.8973	18	16	17	16
0203	Traumatic brain injury M=40-84 and C=5-23	1.3077	1.2375	1.1436	1.0495	19	20	19	18
0204	Traumatic brain injury M=30-39	1.6534	1.5646	1.4459	1.3269	24	23	22	22
0205	Traumatic brain injury M=12-29	2.5100	2.3752	2.1949	2.0143	44	36	35	31
0301	Non-traumatic brain injury M=51-84	0.9655	0.8239	0.7895	0.7195	14	14	12	13
0302	Non-traumatic brain injury M=41-50	1.3678	1.1672	1.1184	1.0194	19	17	17	16

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0303	Non-traumatic brain injury M=25-40	1.8752	1.6002	1.5334	1.3976	23	23	22	22
0304	Non-traumatic brain injury M=12-24	2.7911	2.3817	2.2824	2.0801	44	32	34	31
0401	Traumatic spinal cord injury M=50-84	0.9282	0.8716	0.8222	0.6908	15	15	16	14
0402	Traumatic spinal cord injury M=36-49	1.4211	1.3344	1.2588	1.0576	21	18	22	19
0403	Traumatic spinal cord injury M=19-35	2.3485	2.2052	2.0802	1.7478	32	32	31	30
0404	Traumatic spinal cord injury M=12-18	3.5227	3.3078	3.1203	2.6216	46	43	62	40
0501	Non-traumatic spinal cord injury M=51-84 and C=30-35	0.7590	0.6975	0.6230	0.5363	12	13	10	10
0502	Non-traumatic spinal cord injury M=51-84 and C=5-29	0.9458	0.8691	0.7763	0.6683	15	17	10	12
0503	Non-traumatic spinal cord injury M=41-50	1.1613	1.0672	0.9533	0.8206	17	17	15	14
0504	Non-traumatic spinal cord injury M=34-40	1.6759	1.5400	1.3757	1.1842	23	21	21	19
0505	Non-traumatic spinal cord injury M=12-33	2.5314	2.3261	2.0778	1.7887	31	31	29	28
0601	Neurological M=56-84	0.8794	0.6750	0.6609	0.5949	14	13	12	12
0602	Neurological M=47-55	1.1979	0.9195	0.9003	0.8105	15	15	14	15
0603	Neurological M=36-46	1.5368	1.1796	1.1550	1.0397	21	18	18	18
0604	Neurological M=12-35	2.0045	1.5386	1.5065	1.3561	31	24	25	23
0701	Fracture of lower extremity M=52-84	0.7015	0.7006	0.6710	0.5960	13	13	12	11
0702	Fracture of lower extremity M=46-51	0.9264	0.9251	0.8861	0.7870	15	15	16	14
0703	Fracture of lower extremity M=42-45	1.0977	1.0962	1.0500	0.9326	18	17	17	16
0704	Fracture of lower extremity M=38-41	1.2488	1.2471	1.1945	1.0609	14	20	19	18
0705	Fracture of lower extremity M=12-37	1.4760	1.4740	1.4119	1.2540	20	22	22	21
0801	Replacement of lower extremity joint M=58-84	0.4909	0.4696	0.4518	0.3890	9	9	8	8

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0802	Replacement of lower extremity joint M=55-57	0.5667	0.5421	0.5216	0.4490	10	10	9	9
0803	Replacement of lower extremity joint M=47-54	0.6956	0.6654	0.6402	0.5511	9	11	11	10
0804	Replacement of lower extremity joint M=12-46 and C=32-35	0.9284	0.8881	0.8545	0.7356	15	14	14	12
0805	Replacement of lower extremity joint M=40-46 and C=5-31	1.0027	0.9593	0.9229	0.7945	16	16	14	14
0806	Replacement of lower extremity joint M=12-39 and C=5-31	1.3681	1.3088	1.2592	1.0840	21	20	19	18
0901	Other orthopedic M=54-84	0.6988	0.6390	0.6025	0.5213	12	11	11	11
0902	Other orthopedic M=47-53	0.9496	0.8684	0.8187	0.7084	15	15	14	13
0903	Other orthopedic M=38-46	1.1987	1.0961	1.0334	0.8942	18	18	17	16
0904	Other orthopedic M=12-37	1.6272	1.4880	1.4029	1.2138	23	23	23	21
1001	Amputation, lower extremity M=61-84	0.7821	0.7821	0.7153	0.6523	13	13	12	13
1002	Amputation, lower extremity M=52-60	0.9998	0.9998	0.9144	0.8339	15	15	14	15
1003	Amputation, lower extremity M=46-51	1.2229	1.2229	1.1185	1.0200	18	17	17	18
1004	Amputation, lower extremity M=39-45	1.4264	1.4264	1.3046	1.1897	20	20	19	19
1005	Amputation, lower extremity M=12-38	1.7588	1.7588	1.6086	1.4670	21	25	23	23
1101	Amputation, non-lower extremity M=52-84	1.2621	0.7683	0.7149	0.6631	18	11	13	12
1102	Amputation, non-lower extremity M=38-51	1.9534	1.1892	1.1064	1.0263	25	18	17	18

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1103	Amputation, non-lower extremity M=12-37	2.6543	1.6159	1.5034	1.3945	33	23	22	25
1201	Osteoarthritis M=55-84 and C=34-35	0.7219	0.5429	0.5103	0.4596	13	10	11	9
1202	Osteoarthritis M=55-84 and C=5-33	0.9284	0.6983	0.6563	0.5911	16	11	13	13
1203	Osteoarthritis M=48-54	1.0771	0.8101	0.7614	0.6858	18	15	14	13
1204	Osteoarthritis M=39-47	1.3950	1.0492	0.9861	0.8882	22	19	16	17
1205	Osteoarthritis M=12-38	1.7874	1.3443	1.2634	1.1380	27	21	21	20
1301	Rheumatoid, other arthritis M=54-84	0.7719	0.6522	0.6434	0.5566	13	14	13	11
1302	Rheumatoid, other arthritis M=47-53	0.9882	0.8349	0.8237	0.7126	16	14	14	14
1303	Rheumatoid, other arthritis M=36-46	1.3132	1.1095	1.0945	0.9469	20	18	16	17
1304	Rheumatoid, other arthritis M=12-35	1.8662	1.5768	1.5555	1.3457	25	25	29	22
1401	Cardiac M=56-84	0.7190	0.6433	0.5722	0.5156	15	12	11	11
1402	Cardiac M=48-55	0.9902	0.8858	0.7880	0.7101	13	15	13	13
1403	Cardiac M=38-47	1.2975	1.1608	1.0325	0.9305	21	19	16	16
1404	Cardiac M=12-37	1.8013	1.6115	1.4335	1.2918	30	24	21	20
1501	Pulmonary M=61-84	0.8032	0.7633	0.6926	0.6615	15	13	13	13
1502	Pulmonary M=48-60	1.0268	0.9758	0.8855	0.8457	17	17	14	15
1503	Pulmonary M=36-47	1.3242	1.2584	1.1419	1.0906	21	20	18	18
1504	Pulmonary M=12-35	2.0598	1.9575	1.7763	1.6965	30	28	30	26
1601	Pain syndrome M=45-84	0.8707	0.8327	0.7886	0.6603	15	14	13	13
1602	Pain syndrome M=12-44	1.3320	1.2739	1.2066	1.0103	21	20	20	18
1701	Major multiple trauma without brain or spinal cord injury M=46-84	0.9996	0.9022	0.8138	0.7205	16	14	11	13

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1702	Major multiple trauma without brain or spinal cord injury M=33-45	1.4755	1.3317	1.2011	1.0634	21	21	20	18
1703	Major multiple trauma without brain or spinal cord injury M=12-32	2.1370	1.9288	1.7396	1.5402	33	28	27	24
1801	Major multiple trauma with brain or spinal cord injury M=45-84 and C=33-35	0.7445	0.7445	0.6862	0.6282	12	12	12	10
1802	Major multiple trauma with brain or spinal cord injury M=45-84 and C=5-32	1.0674	1.0674	0.9838	0.9007	16	16	16	16
1803	Major multiple trauma with brain or spinal cord injury M=26-44	1.6350	1.6350	1.5069	1.3797	22	25	20	22
1804	Major multiple trauma with brain or spinal cord injury M=12-25	2.9140	2.9140	2.6858	2.4589	41	29	40	40
1901	Guillian Barre M=47-84	1.1585	1.0002	0.9781	0.8876	15	15	16	15
1902	Guillian Barre M=31-46	2.1542	1.8598	1.8188	1.6505	27	27	27	24
1903	Guillian Barre M=12-30	3.1339	2.7056	2.6459	2.4011	41	35	30	40
2001	Miscellaneous M=54-84	0.8371	0.7195	0.6705	0.6029	12	13	11	12
2002	Miscellaneous M=45-53	1.1056	0.9502	0.8855	0.7962	15	15	14	14
2003	Miscellaneous M=33-44	1.4639	1.2581	1.1725	1.0543	20	18	18	18
2004	Miscellaneous M=12-32 and A>=82	1.7472	1.5017	1.3994	1.2583	30	22	21	22
2005	Miscellaneous M=12-32 and A<=81	2.0799	1.7876	1.6659	1.4979	33	25	24	24
2101	Burns M=46-84	1.0357	0.9425	0.8387	0.8387	18	18	15	16
2102	Burns M=12-45	2.2508	2.0482	1.8226	1.8226	31	26	26	29

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative Weights				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
5001	Short-stay cases, length of stay is 3 days or fewer	.	.	.	0.1651	.	.	.	3
5101	Expired, orthopedic, length of stay is 13 days or fewer	.	.	.	0.4279	.	.	.	8
5102	Expired, orthopedic, length of stay is 14 days or more	.	.	.	1.2390	.	.	.	23
5103	Expired, not orthopedic, length of stay is 15 days or fewer	.	.	.	0.5436	.	.	.	9
5104	Expired, not orthopedic, length of stay is 16 days or more	.	.	.	1.7100	.	.	.	28

TABLE 2.--Federal Prospective Payments for Case-Mix Groups (CMGs)

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidities
0101	$ 5,656.20	$ 5,065.48	$ 4,827.54	$ 4,568.28
0102	7,701.80	6,898.00	6,573.64	6,220.87
0103	9,820.80	8,795.63	8,381.30	7,931.46
0104	10,662.49	9,549.71	9,099.87	8,612.15
0105	13,423.11	12,021.49	11,455.63	10,841.24
0106	16,515.19	14,790.40	14,093.14	13,337.87
0107	19,129.02	17,131.95	16,324.60	15,448.59
0108	20,689.27	18,530.02	17,656.38	16,709.34
0109	22,375.00	20,039.37	19,094.69	18,070.71
0110	24,001.55	21,496.62	20,483.29	19,384.73
0111	24,728.40	22,147.71	21,103.60	19,971.89
0112	29,336.93	26,274.44	25,036.19	23,693.76
0113	26,487.53	23,723.35	22,604.66	21,392.45
0114	32,320.11	28,946.28	27,582.54	26,102.79
0201	9,102.24	8,613.33	7,959.87	7,304.05
0202	13,236.07	12,525.79	11,575.20	10,622.24
0203	15,480.55	14,649.53	13,537.94	12,423.98
0204	19,572.95	18,521.73	17,116.56	15,707.84
0205	29,713.38	28,117.62	25,983.23	23,845.28
0301	11,429.59	9,753.33	9,346.10	8,517.44
0302	16,192.02	13,817.31	13,239.62	12,067.66
0303	22,198.62	18,943.17	18,152.39	16,544.79
0304	33,041.04	28,194.56	27,019.05	24,624.22
0401	10,988.03	10,318.00	9,733.20	8,177.69
0402	16,822.98	15,796.63	14,901.67	12,519.87
0403	27,801.54	26,105.16	24,625.41	20,690.46
0404	41,701.72	39,157.74	36,938.11	31,034.50
0501	8,985.04	8,257.01	7,375.07	6,348.72
0502	11,196.38	10,288.41	9,189.84	7,911.34
0503	13,747.47	12,633.51	11,285.17	9,714.26
0504	19,839.30	18,230.52	16,285.54	14,018.56
0505	29,966.71	27,536.37	24,597.00	21,174.63
0601	10,410.34	7,990.65	7,823.73	7,042.43
0602	14,180.74	10,885.04	10,657.75	9,594.70
0603	18,192.64	13,964.10	13,672.89	12,307.97

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidities
0604	23,729.27	18,213.95	17,833.95	16,053.51
0701	8,304.36	8,293.70	7,943.30	7,055.45
0702	10,966.72	10,951.33	10,489.65	9,316.51
0703	12,994.57	12,976.82	12,429.90	11,040.12
0704	14,783.29	14,763.17	14,140.49	12,558.93
0705	17,472.89	17,449.21	16,714.07	14,844.85
0801	5,811.27	5,559.12	5,348.41	4,604.98
0802	6,708.59	6,417.38	6,174.70	5,315.26
0803	8,234.51	7,877.01	7,578.69	6,523.92
0804	10,990.40	10,513.33	10,115.57	8,708.03
0805	11,869.96	11,356.19	10,925.29	9,405.29
0806	16,195.57	15,493.57	14,906.41	12,832.39
0901	8,272.39	7,564.48	7,132.40	6,171.15
0902	11,241.36	10,280.12	9,691.77	8,386.04
0903	14,190.21	12,975.63	12,233.39	10,585.54
0904	19,262.79	17,614.94	16,607.53	14,368.96
1001	9,258.50	9,258.50	8,467.72	7,721.93
1002	11,835.63	11,835.63	10,824.67	9,871.71
1003	14,476.69	14,476.69	13,240.80	12,074.76
1004	16,885.72	16,885.72	15,443.85	14,083.67
1005	20,820.67	20,820.67	19,042.61	17,366.35
1101	14,940.74	9,095.14	8,462.99	7,849.78
1102	23,124.35	14,077.75	13,097.56	12,149.34
1103	31,421.60	19,129.02	17,797.25	16,508.09
1201	8,545.85	6,426.85	6,040.93	5,440.74
1202	10,990.40	8,266.48	7,769.28	6,997.44
1203	12,750.71	9,589.96	9,013.45	8,118.50
1204	16,514.01	12,420.43	11,673.45	10,514.51
1205	21,159.24	15,913.82	14,956.13	13,471.64
1301	9,137.75	7,720.74	7,616.57	6,589.03
1302	11,698.31	9,883.55	9,750.96	8,435.76
1303	15,545.66	13,134.26	12,956.69	11,209.40
1304	22,092.08	18,666.16	18,414.01	15,930.40
1401	8,511.52	7,615.39	6,773.70	6,103.67
1402	11,721.99	10,486.10	9,328.34	8,406.16
1403	15,359.81	13,741.55	12,222.74	11,015.26
1404	21,323.79	19,076.94	16,969.77	15,292.33
1501	9,508.28	9,035.95	8,199.00	7,830.84
1502	12,155.26	11,551.52	10,482.55	10,011.40

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidities
1503	15,675.88	14,896.94	13,517.81	12,910.52
1504	24,383.91	23,172.89	21,027.84	20,083.17
1601	10,307.35	9,857.50	9,335.45	7,816.63
1602	15,768.22	15,080.43	14,283.73	11,959.93
1701	11,833.26	10,680.24	9,633.76	8,529.28
1702	17,466.97	15,764.66	14,218.62	12,588.53
1703	25,297.81	22,833.13	20,593.38	18,232.89
1801	8,813.39	8,813.39	8,123.24	7,436.63
1802	12,635.88	12,635.88	11,646.22	10,662.49
1803	19,355.13	19,355.13	17,838.68	16,332.89
1804	34,495.93	34,495.93	31,794.50	29,108.46
1901	13,714.32	11,840.37	11,578.75	10,507.41
1902	25,501.42	22,016.31	21,530.95	19,538.62
1903	37,099.11	32,028.89	31,322.16	28,424.22
2001	9,909.59	8,517.44	7,937.38	7,137.13
2002	13,088.09	11,248.47	10,482.55	9,425.42
2003	17,329.65	14,893.39	13,880.06	12,480.80
2004	20,683.35	17,777.12	16,566.10	14,895.76
2005	24,621.86	21,161.61	19,720.92	17,732.14
2101	12,260.62	11,157.32	9,928.53	9,928.53
2102	26,644.97	24,246.59	21,575.94	21,575.94
5001				1,954.45
5101				5,065.48
5102				14,667.28
5103				6,435.14
5104				20,242.98

Table 3A.--Wage Index for Urban Areas

MSA	Urban Area (Constituent Counties or County Equivalents)	Wage Index
0040	Abilene, TX Taylor, TX	0.8240
0060	Aguadilla, PR Aguada, PR Aguadilla, PR Moca, PR	0.4391
0080	Akron, OH Portage, OH Summit, OH	0.9541
0120	Albany, GA Dougherty, GA Lee, GA	0.9893
0160	Albany-Schenectady-Troy, NY Albany, NY Montgomery, NY Rensselaer, NY Saratoga, NY Schenectady, NY Schoharie, NY	0.8480
0200	Albuquerque, NM Bernalillo, NM Sandoval, NM Valencia, NM	0.9146
0220	Alexandria, LA Rapides, LA	0.8121
0240	Allentown-Bethlehem-Easton, PA Carbon, PA Lehigh, PA Northampton, PA	0.9839
0280	Altoona, PA Blair, PA	0.9317
0320	Amarillo, TX Potter, TX Randall, TX	0.8673
0380	Anchorage, AK Anchorage, AK	1.2775
0440	Ann Arbor, MI Lenawee, MI Livingston, MI Washtenaw, MI	1.1093

0450	Anniston,AL Calhoun, AL	0.8284
0460	Appleton-Oshkosh-Neenah, WI Calumet, WI Outagamie, WI Winnebago, WI	0.9052
0470	Arecibo, PR Arecibo, PR Camuy, PR Hatillo, PR	0.4525
0480	Asheville, NC Buncombe, NC Madison, NC	0.9479
0500	Athens, GA Clarke, GA Madison, GA Oconee, GA	0.9739
0520	Atlanta, GA Barrow, GA Bartow, GA Carroll, GA Cherokee, GA Clayton, GA Cobb, GA Coweta, GA De Kalb, GA Douglas, GA Fayette, GA Forsyth, GA Fulton, GA Gwinnett, GA Henry, GA Newton, GA Paulding, GA Pickens, GA Rockdale, GA Spalding, GA Walton, GA	1.0097
0560	Atlantic City-Cape May, NJ Atlantic City, NJ Cape May, NJ	1.1167
0580	Auburn-Opelika, AL Lee, AL	0.8079

0600	Augusta-Aiken, GA-SC Columbia, GA McDuffie, GA Richmond, GA Aiken, SC Edgefield, SC	0.9127
0640	Austin-San Marcos, TX Bastrop, TX Caldwell, TX Hays, TX Travis, TX Williamson, TX	0.9540
0680	Bakersfield, CA Kern, CA	0.9684
0720	Baltimore, MD Anne Arundel, MD Baltimore, MD Baltimore City, MD Carroll, MD Harford, MD Howard, MD Queen Annes, MD	0.9223
0733	Bangor, ME Penobscot, ME	0.9550
0743	Barnstable-Yarmouth, MA Barnstable, MA	1.3801
0760	Baton Rouge, LA Ascension, LA East Baton Rouge Livingston, LA West Baton Rouge, LA	0.8796
0840	Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	0.8734
0860	Bellingham, WA Whatcom, WA	1.1439
0870	Benton Harbor, MI Berrien, MI	0.8671
0875	Bergen-Passaic, NJ Bergen, NJ Passaic, NJ	1.1818
0880	Billings, MT Yellowstone, MT	0.9604

0920	Biloxi-Gulfport-Pascagoula, MS Hancock, MS Harrison, MS Jackson, MS	0.8236
0960	Binghamton, NY Broome, NY Tioga, NY	0.8600
1000	Birmingham, AL Blount, AL Jefferson, AL St. Clair, AL Shelby, AL	0.8360
1010	Bismarck, ND Burleigh, ND Morton, ND	0.7625
1020	Bloomington, IN Monroe, IN	0.8733
1040	Bloomington-Normal, IL McLean, IL	0.9095
1080	Boise City, ID Ada, ID Canyon, ID	0.9006
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH Bristol, MA Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA Worcester, MA Hillsborough, NH Merrimack, NH Rockingham, NH Strafford, NH	1.1086
1125	Boulder-Longmont, CO Boulder, CO	0.9731
1145	Brazoria, TX Brazoria, TX	0.8658
1150	Bremerton, WA Kitsap, WA	1.0975
1240	Brownsville-Harlingen-San Benito, TX Cameron, TX	0.8714
1260	Bryan-College Station, TX Brazos, TX	0.8237

1280	Buffalo-Niagara Falls, NY Erie, NY Niagara, NY	0.9455
1303	Burlington, VT Chittenden, VT Franklin, VT Grand Isle, VT	1.0840
1310	Caguas, PR Caguas, PR Cayey, PR Cidra, PR Gurabo, PR San Lorenzo, PR	0.4548
1320	Canton-Massillon, OH Carroll, OH Stark, OH	0.8480
1350	Casper, WY Natrona, WY	0.8724
1360	Cedar Rapids, IA Linn, IA	0.8716
1400	Champaign-Urbana, IL Champaign, IL	0.9189
1440	Charleston-North Charleston, SC Berkeley, SC Charleston, SC Dorchester, SC	0.9029
1480	Charleston, WV Kanawha, WV Putnam, WV	0.9235
1520	Charlotte-Gastonia-Rock Hill, NC-SC Cabarrus, NC Gaston, NC Lincoln, NC Mecklenburg, NC Rowan, NC Stanly, NC Union, NC York, SC	0.9321
1540	Charlottesville, VA Albemarle, VA Charlottesville City, VA Fluvanna, VA Greene, VA	1.0581

1560	Chattanooga, TN-GA Catoosa, GA Dade, GA Walker, GA Hamilton, TN Marion, TN	0.9790
1580	Cheyenne, WY Laramie, WY	0.8308
1600	Chicago, IL Cook, IL De Kalb, IL Du Page, IL Grundy, IL Kane, IL Kendall, IL Lake, IL McHenry, IL Will, IL	1.1092
1620	Chico-Paradise, CA Butte, CA	0.9918
1640	Cincinnati, OH-KY-IN Dearborn, IN Ohio, IN Boone, KY Campbell, KY Gallatin, KY Grant, KY Kenton, KY Pendleton, KY Brown, OH Clermont, OH Hamilton, OH Warren, OH	0.9349
1660	Clarksville-Hopkinsville, TN-KY Christian, KY Montgomery, TN	0.8173
1680	Cleveland-Lorain-Elyria, OH Ashtabula, OH Geauga, OH Cuyahoga, OH Lake, OH Lorain, OH Medina, OH	0.9528
1720	Colorado Springs, CO El Paso, CO	0.9698

1740	Columbia MO Boone, MO	0.8920
1760	Columbia, SC Lexington, SC Richland, SC	0.9557
1800	Columbus, GA-AL Russell,AL Chattanoochee, GA Harris, GA Muscogee, GA	0.8531
1840	Columbus, OH Delaware, OH Fairfield, OH Franklin, OH Licking, OH Madison, OH Pickaway, OH	0.9573
1880	Corpus Christi, TX Nueces, TX San Patricio, TX	0.8746
1890	Corvallis, OR Benton, OR	1.1326
1900	Cumberland, MD-WV Allegany MD Mineral WV	0.8369
1920	Dallas, TX Collin, TX Dallas, TX Denton, TX Ellis, TX Henderson, TX Hunt, TX Kaufman, TX Rockwall, TX	0.9792
1950	Danville, VA Danville City, VA Pittsylvania, VA	0.8589
1960	Davenport-Moline-Rock Island, IA-IL Scott, IA Henry, IL Rock Island, IL	0.8897

2000	Dayton-Springfield, OH Clark, OH Greene, OH Miami, OH Montgomery, OH	0.9384
2020	Daytona Beach, FL Flagler, FL Volusia, FL	0.9165
2030	Decatur, AL Lawrence, AL Morgan, AL	0.8534
2040	Decatur, IL Macon, IL	0.8095
2080	Denver, CO Adams, CO Arapahoe, CO Denver, CO Douglas, CO Jefferson, CO	1.0120
2120	Des Moines, IA Dallas, IA Polk, IA Warren, IA	0.9073
2160	Detroit, MI Lapeer, MI Macomb, MI Monroe, MI Oakland, MI St. Clair, MI Wayne, MI	1.0364
2180	Dothan, AL Dale, AL Houston, AL	0.7943
2190	Dover, DE Kent, DE	1.0078
2200	Dubuque, IA Dubuque, IA	0.8746
2240	Duluth-Superior, MN-WI St. Louis, MN Douglas, WI	1.0032
2281	Dutchess County, NY Dutchess, NY	1.0187
2290	Eau Claire, WI Chippewa, WI Eau Claire, WI	0.8761

2320	El Paso, TX El Paso, TX	0.9332
2330	Elkhart-Goshen, IN Elkhart, IN	0.9145
2335	Elmira, NY Chemung, NY	0.8546
2340	Enid, OK Garfield, OK	0.8610
2360	Erie, PA Erie, PA	0.8892
2400	Eugene-Springfield, OR Lane, OR	1.0960
2440	Evansville-Henderson, IN-KY Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	0.8137
2520	Fargo-Moorhead, ND-MN Clay, MN Cass, ND	0.8750
2560	Fayetteville, NC Cumberland, NC	0.8655
2580	Fayetteville-Springdale-Rogers, AR Benton, AR Washington, AR	0.7910
2620	Flagstaff, AZ-UT Coconino, AZ Kane, UT	1.0681
2640	Flint, MI Genesee, MI	1.1153
2650	Florence, AL Colbert, AL Lauderdale, AL	0.7616
2655	Florence, SC Florence, SC	0.8737
2670	Fort Collins-Loveland, CO Larimer, CO	1.0620
2680	Ft. Lauderdale, FL Broward, FL	1.0118
2700	Fort Myers-Cape Coral, FL Lee, FL	0.9247
2710	Fort Pierce-Port St. Lucie, FL Martin, FL St. Lucie, FL	0.9538

2720	Fort Smith, AR-OK Crawford, AR Sebastian, AR Sequoyah, OK	0.8052
2750	Fort Walton Beach, FL Okaloosa, FL	0.9607
2760	Fort Wayne, IN Adams, IN Allen, IN De Kalb, IN Huntington, IN Wells, IN Whitley, IN	0.8647
2800	Fort Worth-Arlington, TX Hood, TX Johnson, TX Parker, TX Tarrant, TX	0.9392
2840	Fresno, CA Fresno, CA Madera, CA	1.0057
2880	Gadsden, AL Etowah, AL	0.8423
2900	Gainesville, FL Alachua, FL	0.9741
2920	Galveston-Texas City, TX Galveston, TX	0.9796
2960	Gary, IN Lake, IN Porter, IN	0.9451
2975	Glens Falls, NY Warren, NY Washington, NY	0.8361
2980	Goldsboro, NC Wayne, NC	0.8423
2985	Grand Forks, ND-MN Polk, MN Grand Forks, ND	0.8774
2995	Grand Junction, CO Mesa, CO	0.8947
3000	Grand Rapids-Muskegon-Holland, MI Allegan, MI Kent, MI Muskegon, MI Ottawa, MI	1.0070

3040	Great Falls, MT Cascade, MT	0.9065
3060	Greeley, CO Weld, CO	0.9664
3080	Green Bay, WI Brown, WI	0.9207
3120	Greensboro-Winston-Salem-High Point, NC Alamance, NC Davidson, NC Davie, NC Forsyth, NC Guilford, NC Randolph, NC Stokes, NC Yadkin, NC	0.9068
3150	Greenville, NC Pitt, NC	0.9402
3160	Greenville-Spartanburg-Anderson, SC Anderson, SC Cherokee, SC Greenville, SC Pickens, SC Spartanburg, SC	0.8894
3180	Hagerstown, MD Washington, MD	0.9409
3200	Hamilton-Middletown, OH Butler, OH	0.9061
3240	Harrisburg-Lebanon-Carlisle, PA Cumberland, PA Dauphin, PA Lebanon, PA Perry, PA	0.9338
3283	Hartford, CT Hartford, CT Litchfield, CT Middlesex, CT Tolland, CT	1.1236
3285	Hattiesburg, MS Forrest, MS Lamar, MS	0.7490
3290	Hickory-Morganton-Lenoir, NC Alexander, NC Burke, NC Caldwell, NC Catawba, NC	0.9008

3320	Honolulu, HI Honolulu, HI	1.1865
3350	Houma, LA Lafourche, LA Terrebonne, LA	0.8100
3360	Houston, TX Chambers, TX Fort Bend, TX Harris, TX Liberty, TX Montgomery, TX Waller, TX	0.9663
3400	Huntington-Ashland, WV-KY-OH Boyd, KY Carter, KY Greenup, KY Lawrence, OH Cabell, WV Wayne, WV	0.9876
3440	Huntsville, AL Limestone, AL Madison, AL	0.8932
3480	Indianapolis, IN Boone, IN Hamilton, IN Hancock, IN Hendricks, IN Johnson, IN Madison, IN Marion, IN Morgan, IN Shelby, IN	0.9747
3500	Iowa City, IA Johnson, IA	0.9537
3520	Jackson, MI Jackson, MI	0.9134
3560	Jackson, MS Hinds, MS Madison, MS Rankin, MS	0.8749
3580	Jackson, TN Chester, TN Madison, TN	0.8796

3600	Jacksonville, FL Clay, FL Duval, FL Nassau, FL St. Johns, FL	0.9186
3605	Jacksonville, NC Onslow, NC	0.7777
3610	Jamestown, NY Chautaqua, NY	0.7818
3620	Janesville-Beloit, WI Rock, WI	0.9587
3640	Jersey City, NJ Hudson, NJ	1.1440
3660	Johnson City-Kingsport-Bristol, TN-VA Carter, TN Hawkins, TN Sullivan, TN Unicoi, TN Washington, TN Bristol City, VA Scott, VA Washington, VA	0.8272
3680	Johnstown, PA Cambria, PA Somerset, PA	0.8767
3700	Jonesboro, AR Craighead, AR	0.7831
3710	Joplin, MO Jasper, MO Newton, MO	0.8148
3720	Kalamazoo-Battlecreek, MI Calhoun, MI Kalamazoo, MI Van Buren, MI	1.0440
3740	Kankakee, IL Kankakee, IL	0.9902

3760	Kansas City, KS-MO Johnson, KS Leavenworth, KS Miami, KS Wyandotte, KS Cass, MO Clay, MO Clinton, MO Jackson, MO Lafayette, MO Platte, MO Ray, MO	0.9458
3800	Kenosha, WI Kenosha, WI	0.9611
3810	Killeen-Temple, TX Bell, TX Coryell, TX	1.0164
3840	Knoxville, TN Anderson, TN Blount, TN Knox, TN Loudon, TN Sevier, TN Union, TN	0.8221
3850	Kokomo, IN Howard, IN Tipton, IN	0.9518
3870	La Crosse, WI-MN Houston, MN La Crosse, WI	0.9197
3880	Lafayette, LA Acadia, LA Lafayette, LA St. Landry, LA St. Martin, LA	0.8390
3920	Lafayette, IN Clinton, IN Tippecanoe, IN	0.8834
3960	Lake Charles, LA Calcasieu, LA	0.7399
3980	Lakeland-Winter Haven, FL Polk, FL	0.9239
4000	Lancaster, PA Lancaster, PA	0.9247

4040	Lansing-East Lansing, MI Clinton, MI Eaton, MI Ingham, MI	0.9880
4080	Laredo, TX Webb, TX	0.8168
4100	Las Cruces, NM Dona Ana, NM	0.8639
4120	Las Vegas, NV-AZ Mohave, AZ Clark, NV Nye, NV	1.0796
4150	Lawrence, KS Douglas, KS	0.8190
4200	Lawton, OK Comanche, OK	0.8996
4243	Lewiston-Auburn, ME Androscoggin, ME	0.9003
4280	Lexington, KY Bourbon, KY Clark, KY Fayette, KY Jessamine, KY Madison, KY Scott, KY Woodford, KY	0.8774
4320	Lima, OH Allen, OH Auglaize, OH	0.9320
4360	Lincoln, NE Lancaster, NE	0.9619
4400	Little Rock-North Little, AR Faulkner, AR Lonoke, AR Pulaski, AR Saline, AR	0.8908
4420	Longview-Marshall, TX Gregg, TX Harrison, TX Upshur, TX	0.8922
4480	Los Angeles-Long Beach, CA Los Angeles, CA	1.1984

4520	Louisville, KY-IN Clark, IN Floyd, IN Harrison, IN Scott, IN Bullitt, KY Jefferson, KY Oldham, KY	0.9261
4600	Lubbock, TX Lubbock, TX	0.8848
4640	Lynchburg, VA Amherst, VA Bedford City, VA Bedford, VA Campbell, VA Lynchburg City, VA	0.8851
4680	Macon, GA Bibb, GA Houston, GA Jones, GA Peach, GA Twiggs, GA	0.8848
4720	Madison, WI Dane, WI	1.0316
4800	Mansfield, OH Crawford, OH Richland, OH	0.8690
4840	Mayaguez, PR Anasco, PR Cabo Rojo, PR Hormigueros, PR Mayaguez, PR Sabana Grande, PR San German, PR	0.4577
4880	McAllen-Edinburg-Mission, TX Hidalgo, TX	0.8566
4890	Medford-Ashland, OR Jackson, OR	1.0344
4900	Melbourne-Titusville-Palm Bay, FL Brevard, FL	0.9688

4920	Memphis, TN-AR-MS Crittenden, AR De Soto, MS Fayette, TN Shelby, TN Tipton, TN	0.8688
4940	Merced, CA Merced, CA	0.9559
5000	Miami, FL Dade, FL	1.0110
5015	Middlesex-Somerset-Hunterdon, NJ Hunterdon, NJ Middlesex, NJ Somerset, NJ	1.0987
5080	Milwaukee-Waukesha, WI Milwaukee, WI Ozaukee, WI Washington, WI Waukesha, WI	0.9664
5120	Minneapolis-St. Paul, MN-WI Anoka, MN Carver, MN Chisago, MN Dakota, MN Hennepin, MN Isanti, MN Ramsey, MN Scott, MN Sherburne, MN Washington, MN Wright, MN Pierce, WI St. Croix, WI	1.0971
5140	Missoula, MT Missoula, MT	0.9274
5160	Mobile, AL Baldwin, AL Mobile, AL	0.8006
5170	Modesto, CA Stanislaus, CA	1.0401
5190	Monmouth-Ocean, NJ Monmouth, NJ Ocean, NJ	1.1293
5200	Monroe, LA Ouachita, LA	0.8316

5240	Montgomery, AL Autauga, AL Elmore, AL Montgomery, AL	0.7642
5280	Muncie, IN Delaware, IN	1.0683
5330	Myrtle Beach, SC Horry, SC	0.8440
5345	Naples, FL Collier, FL	0.9661
5360	Nashville, TN Cheatham, TN Davidson, TN Dickson, TN Robertson, TN Rutherford, TN Sumner, TN Williamson, TN Wilson, TN	0.9327
5380	Nassau-Suffolk, NY Nassau, NY Suffolk, NY	1.3784
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT Fairfield, CT New Haven, CT	1.2192
5523	New London-Norwich, CT New London, CT	1.2061
5560	New Orleans, LA Jefferson, LA Orleans, LA Plaquemines, LA St. Bernard, LA St. Charles, LA St. James, LA St. John The Baptist, LA St. Tammany, LA	0.9235

5600	New York, NY Bronx, NY Kings, NY New York, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY	1.4483
5640	Newark, NJ Essex, NJ Morris, NJ Sussex, NJ Union, NJ Warren, NJ	1.1828
5660	Newburgh, NY-PA Orange, NY Pike, PA	1.0847
5720	Norfolk-Virginia Beach-Newport News, VA-NC Currituck, NC Chesapeake City, VA Gloucester, VA Hampton City, VA Isle of Wight, VA James City, VA Mathews, VA Newport News City, VA Norfolk City, VA Poquoson City,VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA York, VA	0.8374
5775	Oakland, CA Alameda, CA Contra Costa, CA	1.5029
5790	Ocala, FL Marion, FL	0.9243
5800	Odessa-Midland, TX Ector, TX Midland, TX	0.9206

5880	Oklahoma City, OK Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK	0.8774
5910	Olympia, WA Thurston, WA	1.0689
5920	Omaha, NE-IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE	0.9470
5945	Orange County, CA Orange, CA	1.1453
5960	Orlando, FL Lake, FL Orange, FL Osceola, FL Seminole, FL	0.9550
5990	Owensboro, KY Daviess, KY	0.8159
6015	Panama City, FL Bay, FL	0.9010
6020	Parkersburg-Marietta, WV-OH Washington, OH Wood, WV	0.8258
6080	Pensacola, FL Escambia, FL Santa Rosa, FL	0.8176
6120	Peoria-Pekin, IL Peoria, IL Tazewell, IL Woodford, IL	0.8494

6160	Philadelphia, PA-NJ Burlington, NJ Camden, NJ Gloucester, NJ Salem, NJ Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA	1.0753
6200	Phoenix-Mesa, AZ Maricopa, AZ Pinal, AZ	0.9628
6240	Pine Bluff, AR Jefferson, AR	0.7771
6280	Pittsburgh, PA Allegheny, PA Beaver, PA Butler, PA Fayette, PA Washington, PA Westmoreland, PA	0.9570
6323	Pittsfield, MA Berkshire, MA	1.0130
6340	Pocatello, ID Bannock, ID	0.9076
6360	Ponce, PR Guayanilla, PR Juana Diaz, PR Penuelas, PR Ponce, PR Villalba, PR Yauco, PR	0.4993
6403	Portland, ME Cumberland, ME Sagadahoc, ME York, ME	0.9687
6440	Portland-Vancouver, OR-WA Clackamas, OR Columbia, OR Multnomah, OR Washington, OR Yamhill, OR Clark, WA	1.0913

6483	Providence-Warwick-Pawtucket, RI Bristol, RI Kent, RI Newport, RI Providence, RI Washington, RI	1.0771
6520	Provo-Orem, UT Utah, UT	1.0014
6560	Pueblo, CO Pueblo, CO	0.8783
6580	Punta Gorda, FL Charlotte, FL	0.9602
6600	Racine, WI Racine, WI	0.9231
6640	Raleigh-Durham-Chapel Hill, NC Chatham, NC Durham, NC Franklin, NC Johnston, NC Orange, NC Wake, NC	0.9583
6660	Rapid City, SD Pennington, SD	0.8779
6680	Reading, PA Berks, PA	0.9105
6690	Redding, CA Shasta, CA	1.1641
6720	Reno, NV Washoe, NV	1.0550
6740	Richland-Kennewick-Pasco, WA Benton, WA Franklin, WA	1.1460

6760	Richmond-Petersburg, VA Charles City County, VA Chesterfield, VA Colonial Heights City, VA Dinwiddie, VA Goochland, VA Hanover, VA Henrico, VA Hopewell City, VA New Kent, VA Petersburg City, VA Powhatan, VA Prince George, VA Richmond City, VA	0.9618
6780	Riverside-San Bernardino, CA Riverside, CA San Bernardino, CA	1.1229
6800	Roanoke, VA Botetourt, VA Roanoke, VA Roanoke City, VA Salem City, VA	0.8663
6820	Rochester, MN Olmsted, MN	1.1334
6840	Rochester, NY Genesee, NY Livingston, NY Monroe, NY Ontario, NY Orleans, NY Wayne, NY	0.8991
6880	Rockford, IL Boone, IL Ogle, IL Winnebago, IL	0.8819
6895	Rocky Mount, NC Edgecombe, NC Nash, NC	0.8849
6920	Sacramento, CA El Dorado, CA Placer, CA Sacramento, CA	1.1932

6960	Saginaw-Bay City-Midland, MI Bay, MI Midland, MI Saginaw, MI	0.9557
6980	St. Cloud, MN Benton, MN Stearns, MN	0.9994
7000	St. Joseph, MO Andrews, MO Buchanan, MO	0.9071
7040	St. Louis, MO-IL Clinton, IL Jersey, IL Madison, IL Monroe, IL St. Clair, IL Franklin, MO Jefferson, MO Lincoln, MO St. Charles, MO St. Louis, MO St. Louis City, MO Warren, MO Sullivan City, MO	0.8947
7080	Salem, OR Marion, OR Polk, OR	1.0189
7120	Salinas, CA Monterey, CA	1.4518
7160	Salt Lake City-Ogden, UT Davis, UT Salt Lake, UT Weber, UT	0.9782
7200	San Angelo, TX Tom Green, TX	0.8083
7240	San Antonio, TX Bexar, TX Comal, TX Guadalupe, TX Wilson, TX	0.8540
7320	San Diego, CA San Diego, CA	1.1784

7360	San Francisco, CA Marin, CA San Francisco, CA San Mateo, CA	1.4250
7400	San Jose, CA Santa Clara, CA	1.3759
7440	San Juan-Bayamon, PR Aguas Buenas, PR Barceloneta, PR Bayamon, PR Canovanas, PR Carolina, PR Catano, PR Ceiba, PR Comerio, PR Corozal, PR Dorado, PR Fajardo, PR Florida, PR Guaynabo, PR Humacao, PR Juncos, PR Los Piedras, PR Loiza, PR Luguillo, PR Manati, PR Morovis, PR Naguabo, PR Naranjito, PR Rio Grande, PR San Juan, PR Toa Alta, PR Toa Baja, PR Trujillo Alto, PR Vega Alta, PR Vega Baja, PR Yabucoa, PR	0.4651
7460	San Luis Obispo-Atascadero-Paso Robles, CA San Luis Obispo, CA	1.0673
7480	Santa Barbara-Santa Maria-Lompoc, CA Santa Barbara, CA	1.0580
7485	Santa Cruz-Watsonville, CA Santa Cruz, CA	1.4040

7490	Santa Fe, NM Los Alamos, NM Santa Fe, NM	1.0538
7500	Santa Rosa, CA Sonoma, CA	1.2649
7510	Sarasota-Bradenton, FL Manatee, FL Sarasota, FL	0.9809
7520	Savannah, GA Bryan, GA Chatham, GA Effingham, GA	0.9601
7560	Scranton--Wilkes-Barre--Hazleton, PA Columbia, PA Lackawanna, PA Luzerne, PA Wyoming, PA	0.8401
7600	Seattle-Bellevue-Everett, WA Island, WA King, WA Snohomish, WA	1.0985
7610	Sharon, PA Mercer, PA	0.7900
7620	Sheboygan, WI Sheboygan, WI	0.8379
7640	Sherman-Denison, TX Grayson, TX	0.8694
7680	Shreveport-Bossier City, LA Bossier, LA Caddo, LA Webster, LA	0.8705
7720	Sioux City, IA-NE Woodbury, IA Dakota, NE	0.8471
7760	Sioux Falls, SD Lincoln, SD Minnehaha, SD	0.8790
7800	South Bend, IN St. Joseph, IN	0.9848
7840	Spokane, WA Spokane, WA	1.0496
7880	Springfield, IL Menard, IL Sangamon, IL	0.8656

7920	Springfield, MO Christian, MO Greene, MO Webster, MO	0.8484
8003	Springfield, MA Hampden, MA Hampshire, MA	1.0485
8050	State College, PA Centre, PA	0.9022
8080	Steubenville-Weirton, OH-WV Jefferson, OH Brooke, WV Hancock, WV	0.8548
8120	Stockton-Lodi, CA San Joaquin, CA	1.0606
8140	Sumter, SC Sumter, SC	0.8271
8160	Syracuse, NY Cayuga, NY Madison, NY Onondaga, NY Oswego, NY	0.9378
8200	Tacoma, WA Pierce, WA	1.1553
8240	Tallahassee, FL Gadsden, FL Leon, FL	0.8482
8280	Tampa-St. Petersburg-Clearwater, FL Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL	0.8960
8320	Terre Haute, IN Clay, IN Vermillion, IN Vigo, IN	0.8268
8360	Texarkana, AR-Texarkana, TX Miller, AR Bowie, TX	0.8341
8400	Toledo, OH Fulton, OH Lucas, OH Wood, OH	0.9742
8440	Topeka, KS Shawnee, KS	0.9051

8480	Trenton, NJ Mercer, NJ	1.0113
8520	Tucson, AZ Pima, AZ	0.8785
8560	Tulsa, OK Creek, OK Osage, OK Rogers, OK Tulsa, OK Wagoner, OK	0.8480
8600	Tuscaloosa, AL Tuscaloosa, AL	0.8064
8640	Tyler, TX Smith, TX	0.9340
8680	Utica-Rome, NY Herkimer, NY Oneida, NY	0.8547
8720	Vallejo-Fairfield-Napa, CA Napa, CA Solano, CA	1.2849
8735	Ventura, CA Ventura, CA	1.1040
8750	Victoria, TX Victoria, TX	0.8154
8760	Vineland-Millville-Bridgeton, NJ Cumberland, NJ	1.0501
8780	Visalia-Tulare-Porterville, CA Tulare, CA	0.9551
8800	Waco, TX McLennan, TX	0.8253

8840	Washington, DC-MD-VA-WV District of Columbia, DC Calvert, MD Charles, MD Frederick, MD Montgomery, MD Prince Georges, MD Alexandria City, VA Arlington, VA Clarke, VA Culpepper, VA Fairfax, VA Fairfax City, VA Falls Church City, VA Fauquier, VA Fredericksburg City, VA King George, VA Loudoun, VA Manassas City, VA Manassas Park City, VA Prince William, VA Spotsylvania, VA Stafford, VA Warren, VA Berkeley, WV Jefferson, WV	1.0711
8920	Waterloo-Cedar Falls, IA Black Hawk, IA	0.8404
8940	Wausau, WI Marathon, WI	0.9418
8960	West Palm Beach-Boca Raton, FL Palm Beach, FL	0.9699
9000	Wheeling, OH-WV Belmont, OH Marshall, WV Ohio, WV	0.7665
9040	Wichita, KS Butler, KS Harvey, KS Sedgwick, KS	0.9502
9080	Wichita Falls, TX Archer, TX Wichita, TX	0.7647
9140	Williamsport, PA Lycoming, PA	0.8332

9160	Wilmington-Newark, DE-MD New Castle, DE Cecil, MD	1.0826
9200	Wilmington, NC New Hanover, NC Brunswick, NC	0.9394
9260	Yakima, WA Yakima, WA	0.9876
9270	Yolo, CA Yolo, CA	1.0199
9280	York, PA York, PA	0.9196
9320	Youngstown-Warren, OH Columbiana, OH Mahoning, OH Trumbull, OH	0.9477
9340	Yuba City, CA Sutter, CA Yuba, CA	1.0706
9360	Yuma, AZ Yuma, AZ	0.9529

Table 3B.--Wage Index for Rural Areas

Nonurban Area	Wage Index
Alabama	0.7483
Alaska	1.2380
Arizona	0.8309
Arkansas	0.7444
California	0.9857
Colorado	0.8967
Connecticut	1.1715
Delaware	0.9058
Florida	0.8918
Georgia	0.8326
Guam	.....
Hawaii	1.1053
Idaho	0.8650
Illinois	0.8152
Indiana	0.8602
Iowa	0.8000
Kansas	0.7574
Kentucky	0.7921
Louisiana	0.7655
Maine	0.8736
Maryland	0.8651
Massachusetts	1.1205
Michigan	0.8969
Minnesota	0.8864
Mississippi	0.7481
Missouri	0.7693
Montana	0.8679

Nebraska	0.8055
Nevada	0.9228
New Hampshire	0.9741
New Jersey 1/	.....
New Mexico	0.8495
New York	0.8472
North Carolina	0.8437
North Dakota	0.7676
Ohio	0.8663
Oklahoma	0.7484
Oregon	1.0124
Pennsylvania	0.8535
Puerto Rico	0.4264
Rhode Island 1/	.....
South Carolina	0.8369
South Dakota	0.7550
Tennessee	0.7836
Texas	0.7490
Utah	0.9029
Vermont	0.9266
Virginia	0.8181
Virgin Islands	.....
Washington	1.0422
West Virginia	0.8206
Wisconsin	0.8865
Wyoming	0.8805

1/ All counties within the State are classified urban.

APPENDIX A--Technical Discussion of Cases and Providers Used in RAND Analysis

This Appendix explains the methodology used to create the data files used to develop the final IRF prospective payment system. A general description of the process to create this data file is contained in section III.B. of this final rule. RAND has performed the following analysis to match FIM data (that is, collectively, patient assessment data from the Uniform Data System for medical rehabilitation (UDSmr) (1996 through 1999); the Caredata Data System (COS) for medical rehabilitation (1996 and 1997); and the HealthSouth Corporation (HS) (1998 and 1999)) and our Medicare data files.

Table A shows that, for 1996 through 1999, the MedPAR files had over 12 million records per year. We are interested in a subset of these records: cases paid by Medicare as rehabilitation stays that were excluded from the acute care hospital prospective payment system.

Table A.--Number of MedPAR Cases and Facilities

Calendar Year	Number of Cases	Number of Facilities
1996	12,231,275	6,339
1997	12,263,463	6,257
1998	12,266,445	6,235
1999	12,073,949	6,223

Table B shows total 1996 through 1999 rehabilitation stays by type of provider (freestanding rehabilitation facility versus excluded unit of an acute care hospital). This was the "sampling" frame. In order to describe the IRF prospective payment system case-mix, RAND attached information from FIM instruments to each record in this frame, thereby obtaining "complete" records. To the extent that RAND was unable to add information to some records, it was important to know both how to and whether to weight the complete records so they would be representative of the 1996 through 1999 rehabilitation stays in the "sampling" frames.

Table B.--Number of Rehabilitation MedPAR Cases and Facilities

Calendar Year	Type	Number of Cases	Number of Facilities	Total Number of Cases	Total Number of Facilities
1996	Excluded Unit	229,193	877	344,126	1,081
	Freestanding	114,933	204		
1997	Excluded Unit	240,491	911	359,032	1,123
	Freestanding	118,541	212		
1998	Excluded Unit	248,015	941	370,352	1,155
	Freestanding	122,337	214		
1999	Excluded Unit	260,745	961	390,048	1,165
	Freestanding	129,303	204		

Note: Freestanding facilities have characters 3-6 of the Medicare provider number in the range 3025-3099. Patients receiving rehabilitation care in excluded units of acute care hospitals have a "provider code" of T in their MedPAR records.

Table C shows the number of facilities and the number of FIM records for calendar years 1996 through 1999. Our sources for 1996 and 1997 were UDSmr and COS. For 1998 and 1999, we used UDSmr data and data from Caredata's principal client, HealthSouth Corporation. (Caredata ceased to exist prior to our getting its 1998 and 1999 data.) Our tables combine data from the different sources to preserve confidentiality.

Table C.--Number of FIM Records and Facilities, By Year

Calendar Year	Sources	Number of Records	Number of Facilities*
1996	UDSmr/COS	269,547	692
1997	UDSmr/COS	326,265	759
1998	UDSmr/HS	343,004	751
1999	UDSmr/HS	381,453	766

*For the discussion that follows, consider facilities as distinct entities within a FIM source. We adjust our counts later for possible overlap and double counting.

Matching MedPAR and FIM Facilities

The first step in the matching process is to link MedPAR facilities to FIM facilities. For each of these combinations, RAND counted the number of exact matches of MedPAR and FIM records based on admission date, discharge date, and zip code. Table D summarizes the results of this stage of the linking process. The number of facilities represented in our FIM data sets is slightly more than half of all IRFs.

Table D.--Numbers of FIM Facilities Linked to MedPAR Facilities

Calendar Year	Sources	MedPAR Unique[a]	MedPAR Multiple[b]	MedPAR Nonmatch[c]	Total
1996	UDSmr/COS	568	18	106	692
1997	UDSmr/COS	625	33	101	759
1998	UDSmr/HS	730	19	2	751
1999	UDSmr/HS	729	35	2	766

[a]FIM IRFs that appear to have a single MedPAR provider.
[b]FIM IRFs that appear to have more than one MedPAR provider.
[c]FIM IRFs that did not link to our Medicare files. The large drop between 1997 and 1998 is because SNF and long-term care hospital data were excluded from our 1998/1999 request.

The FIM data do not contain the Medicare beneficiary identifier and, therefore, it was necessary to use a probabilistic matching algorithm based on characteristics of the beneficiary and the hospitalization. The matching was accomplished in a series of four steps:

(1) Identify match variables;

(2) Recode certain FIM variables to be consistent with MedPAR, create additional records for UDSmr interrupted stays, and eliminate duplicate cases;

(3) Run a match algorithm to link FIM and MedPAR records; and

(4) Choose a single MedPAR case if it matches multiple UDSmr or COS cases.

Step 1: Identify Match Variables

A further search for matches only within the provider number and facility identifier pairings was performed. An attempt was made to match all MedPAR records to a FIM record for all facilities.

For MedPAR, in addition to facility identity, six variables were used to link the records: admission date, discharge date, zip code, age at admission, sex, and race. For FIM, the same information in a slightly recoded form was available (for example, birth date). An indicator of whether Medicare was the primary payer was used to determine how to set certain parameters for the matching algorithm.

Step 2: Create/Delete FIM Records

COS and HS coded interrupted stays in a manner similar to Medicare: one record per rehabilitation discharge episode. Therefore, these records did not require any additional processing. However, UDSmr codes multiple stays via a series of "transfer/return" dates on a single UDSmr record. To facilitate matching UDSmr and MedPAR records, multiple records for interrupted stays were created with admission and discharge dates corresponding to the beginning and ending of each stay. The additional records

were then given the same chance of matching MedPAR records as any noninterrupted stay.

For UDSmr, COS, and HS files, there were some duplicate cases that had to be eliminated.

Table E shows the number of records present at the various stages of processing. The last column shows the number of cases that would be matched to MedPAR.

Table E.--Number of FIM Records At Various Stages of Processing

Calendar Year	Source	Number of Records		
		Original	After Expansion	After Duplicate Elimination
1996	UDSmr/COS	269,547	276,554	275,378
1997	UDSmr/COS	326,265	334,794	333,370
1998	UDSmr/HS	343,004	352,602	352,469
1999	UDSmr/HS	381,453	391,820	391,627

Step 3: Match Discharges from MedPAR and FIM Facilities

A match algorithm similar to the one used in Carter, Relles, et al. (1997) was run assuming that links are imperfect--any variable can be in error. A scoring function was developed, based on Bayes' Theorem, which gives the odds of a match based on how consistent variables tend to be for true matching and nonmatching cases.

The scoring function selects pairs with the greatest likelihood of being correct matches. A cutoff under which scores below are considered "nonmatches" and scores above are considered "matches" is chosen empirically. We sorted the pairings by score, and examined candidate matches as a function of this score. We wanted a conservative criterion--agreement between two "matched" records not likely to be resulting from chance. We noticed that cases in the 3.2 range and above appeared to be the same: race and sex agreeing, mild disagreement between usually at most one of the other match variables (admission date, discharge date, age, and zip code). We also looked at additional variables not employed in the matching process. For cases above the 3.2 threshold, a FIM variable tended to indicate that Medicare was the "primary payer," and the Medicare provider code tended to be "T" in acute care hospitals; both were less likely below 3.2. Thus, we chose 3.2 as our cutoff.

Step 4: Choose a Single MedPAR Case for Multiple FIM Matches

While the matching was unique within a facility/provider pair, some MedPAR providers were paired with different facilities, as shown in Table F. Also, some

UDSmr and COS/HS facilities were the same: 6 overlaps in 1996, 7 in 1997, 26 in 1998, and 1 in 1999.

Table F.--MedPAR Facilities Paired with Multiple Facilities

Calendar Year	Sources	Number of Facilities
1996	UDSmr	5
	COS	5
1997	UDSmr	8
	COS	10
1998	UDSmr	10
	HS	0
1999	UDSmr	18
	HS	0

Each nonunique pairing had the potential of creating multiple matches to a single MedPAR record. We eliminated these matches in two steps. First, working within each UDSmr, COS, and HS file, we eliminated MedPAR duplicate links, keeping the match with the highest score. Then we checked for duplicate links between UDSmr and the corresponding COS/HS files within the same year, again keeping the match with the highest score. Table G provides results for cutoff score 3.2, as discussed in Step 3.

Table G.--Number of Linked Records After Duplicates Elimination

Calendar Year	Sources	Number of Records		
		Total Records	Duplicates Eliminated[1]	Overlap Eliminated[2]
1996	UDSmr/COS	191,173	190,480	188,889
1997	UDSmr/COS	227,696	226,411	222,682
1998	UDSmr/HS	252,662	247,296	246,450
1999	UDSmr/HS	281,230	273,772	273,548

[1]Multiple pairings can link the same MedPAR record to more than one FIM case. This step eliminates those multiple links, keeping the link with the highest match score.
[2]The same MedPAR provider might show up in both UDSmr and COS, again allowing the same MedPAR record to match more than one FIM case.

Quality of the Match

There are two aspects to evaluating the quality of the match. The first is whether we actually matched all of the cases. To evaluate this, we computed match rates for each of our populations: FIM and MedPAR, by year. The second aspect is the representativeness of the match for the entire population. To evaluate this, we compared patient and facility characteristics to both linked and full population, and considered whether some form of weighting would make those populations look sufficiently the same.

Match Rates

Table H suggests overall match rates in these FIM facilities for the eligible population in the IRF prospective payment system to be almost 90 percent. This

was slightly higher than expected--the Carter, Relles, et al. (1997) match rates were about 86 percent.

Table H.--MedPAR Match Rates, Providers with a Full Year of Data

Calendar Year	Sources	MedPAR Cases	Matched Cases	Percent Matched
1996	UDSmr/COS	162,659	142,410	87.6
1997	UDSmr/COS	212,581	190,069	89.4
1998	UDSmr/HS	234,623	208,769	89.0
1999	UDSmr/HS	263,785	237,568	90.1

Note: Tabulations are for patients eligible for IRF prospective payment system.

The FIM files contain many cases not paid by Medicare, but the files provide an indication of whether Medicare is the primary payer. Accordingly, restricting our attention to Medicare cases, we obtain the percentages shown in Table I.

Table I.--FIM Match Rates for Medicare as the Primary Payer

Calendar Year	Source	FIM Cases	Matched Cases	Percent Matched
1996	UDSmr/COS	188,892	180,783	95.7
1997	UDSmr/COS	223,351	213,053	95.4
1998	UDSmr/HS	246,727	235,261	95.4
1999	UDSmr/HS	273,303	261,969	95.9

Note: FIM cases matching any Medicare case.

These match rates are also slightly higher than reported in Carter and Relles (1997), where a 93.7 percent rate was achieved for 1994 UDSmr data. We consider these

match rates to be acceptable, within the limitations of information available.

Representativeness of Linked MedPAR

For analytical purposes, lack of representativeness is most important for characteristics that are related to outcomes we are trying to model. For example, if costs for treating a patient in freestanding facilities differed from costs in excluded units of acute care hospitals, we would consider re-weighting the sample of linked cases to adjust our total cost estimates.

Tables J through N present an analysis of the characteristics of the facilities and cases in the matched sample described in the previous tables. The data in Tables J through N are the latest data available for the purposes of constructing a data file used to develop the IRF prospective payment system in this final rule.

Representativeness of Linked MedPAR Hospital Characteristics

This section addresses the extent to which the facilities present in the FIM file are representative of the set of all facilities that provide inpatient rehabilitation care to Medicare beneficiaries, and the extent to which FIM patients are representative of all

Medicare eligible patients under the IRF prospective payment system. This analysis reflects the effects of the partial-year sample available for some FIM facilities as well as the sampling of MedPAR facilities. The MedPAR records contain data from over 1,000 IRFs in each year. Table J divides these facilities into freestanding rehabilitation facilities (freestanding rehabilitation) and excluded rehabilitation units of acute-care hospitals (excluded units). It presents the number of facilities in the linked MedPAR sample, along with the total MedPAR counts of rehabilitation patients at these facilities.

Table J.--Comparison of Number of FIM and MedPAR Rehabilitation Facilities, by Type

Year	Type of Facility	Number of Facilities			Number of Rehabilitation Patients		
		FIM[a]	Total MedPAR[b]	Percent FIM	FIM[a]	Total MedPAR[b]	Percent FIM
1996	Freestanding Rehabilitation	130	204	64	86,301	114,933	75
	Excluded Unit	435	877	50	130,623	229,193	57
	Total	565	1,081	42	216,924	344,126	63
1997	Freestanding Rehabilitation	142	212	67	94,327	118,541	80
	Excluded Unit	489	911	54	150,787	240,491	63
	Total	631	1,123	56	245,114	359,032	68
1998	Freestanding Rehabilitation	171	214	80	111,503	122,337	91
	Excluded Unit	515	941	55	157,483	248,015	63
	Total	686	1,155	59	268,986	370,352	73
1999	Freestanding Rehabilitation	170	204	83	120,284	129,303	93
	Excluded Unit	554	961	58	171,886	260,745	66
	Total	724	1,165	62	292,170	390,048	75

[a]Hospitals with at least one linked MedPAR/ FIM rehabilitation record.
[b]Total (matched and unmatched) rehabilitation cases.

As shown in Table J, for 1999, FIM facilities represented 62 percent of the facilities, but served almost 75 percent of all MedPAR IRF cases. Based on data found in the table, in 1999, FIM freestanding facilities had an average of 708 patients, 442 more than other-MedPAR freestanding facilities; and FIM excluded units had an average of 310 patients, 92 more than other-MedPAR excluded units.

Table K shows the distribution of FIM IRFs by size. This shows both that freestanding facilities are larger than excluded units and that FIM IRFs tend to be larger than other MedPAR facilities within type of facility.

Table K.--Comparison of Sizes of FIM and MedPAR Facilities, by Type of Facility

Number of MedPAR Patients	1996				1997			
	Freestanding		Excluded Unit		Freestanding		Excluded Unit	
	FIM	Other MedPAR	FIM	Other MedPAR	FIM	Other MedPAR	FIM	Other MedPAR
1-100	2	23	30	97	4	24	33	105
101-200	14	9	139	140	14	7	143	126
201-300	14	2	105	102	11	5	123	103
301-400	14	10	59	48	17	9	65	40
401-500	8	8	38	27	12	7	52	29
501-1000	56	16	58	26	59	15	67	18
1001-2000	20	6	6	2	24	3	6	1
2001-3000	1	0	0	0	0	0	0	0
3001-4000	1	0	0	0	1	0	0	0
Total	**130**	**74**	**435**	**442**	**142**	**70**	**489**	**422**
	1998				1999			
1-100	6	19	50	115	3	13	57	100
101-200	14	9	136	125	10	9	148	115
201-300	11	5	130	82	12	5	130	85
301-400	18	2	78	52	15	1	79	63
401-500	17	2	51	28	20	1	66	26
501-1000	80	3	60	24	76	2	62	17
1001-2000	24	3	10	0	33	3	12	1
2001-3000	0	0	0	0	0	0	0	0
3001-4000	1	0	0	0	1	0	0	0
Total	**171**	**43**	**515**	**426**	**170**	**34**	**554**	**407**

Table L shows the percentage of cases in FIM facilities in each State.

Table L.--Number and Percentage of MedPAR Rehabilitation Cases For FIM Sample Hospitals, by State

STATE	MedPAR Rehabilitation Cases				Percent of Cases in FIM Hospital Sample			
	1996	1997	1998	1999	1996	1997	1998	1999
AL	7,839	8,654	8,855	8,667	91	96	79	81
AK	247	302	280	301	55	51	56	55
AR	6,581	6,973	8,349	9,626	43	48	63	65
AZ	3,672	4,084	4,436	5,244	62	57	63	67
CA	15,294	15,559	15,579	16,936	53	51	56	58
CO	4,757	4,263	4,035	3,946	27	65	33	69
CT	2,217	2,290	1,901	1,989	69	88	90	89
DC	1,097	996	1,076	1,167	12	10	8	20
DE	1,399	1,361	1,375	1,628	76	72	70	66
FL	23,021	23,630	24,058	24,741	74	79	91	90
GA	9,615	10,716	10,874	11,062	64	65	66	68
HI	1,087	1,016	831	696	100	100	100	100
IA	1,264	1,404	1,324	1,579	100	100	98	100
ID	1,829	1,807	1,782	1,903	97	98	97	97
IL	14,953	14,894	14,720	16,111	54	62	60	62
IN	8,943	8,884	9,301	9,683	60	60	83	86
KS	3,224	3,333	3,647	4,074	27	24	64	72
KY	5,198	5,201	5,653	6,489	74	79	86	80
LA	9,206	10,061	10,292	11,079	36	50	68	67
MA	8,765	8,631	8,973	9,582	52	67	77	78
MD	867	715	767	782	77	80	80	86
ME	1,255	1,460	1,629	1,873	10	72	79	80
MI	16,523	17,255	18,157	18,797	82	82	80	81
MN	2,048	2,112	2,508	2,594	54	74	49	49
MO	9,788	10,513	10,677	11,009	34	42	58	62
MS	1,968	2,021	2,050	2,442	86	86	85	83
MT	878	766	652	681	100	100	100	100
NC	7,123	8,771	9,588	9,912	89	88	97	98
ND	1,821	1,636	1,627	1,697	86	83	73	71
NE	1,195	1,107	1,143	1,083	92	91	89	88
NH	2,310	2,505	2,435	2,375	57	58	77	75
NJ	11,234	11,083	11,172	11,988	89	96	93	99
NM	1,283	1,277	1,355	1,537	28	35	40	45
NV	2,230	2,303	2,855	3,471	0	0	52	51
NY	21,431	22,875	25,755	26,271	37	51	58	72
OH	11,837	13,888	13,683	13,938	76	73	75	71
OK	6,356	6,949	7,757	8,716	51	59	58	54
OR	1,179	1,184	1,198	1,173	70	61	74	75
PA	36,989	35,700	34,201	35,552	63	69	71	73
RI	2,247	2,307	1,771	1,460	61	66	100	100
SC	4,536	4,878	5,691	6,182	83	86	83	82
SD	2,096	2,101	2,031	2,071	80	81	79	78
TN	10,731	11,917	12,317	12,744	71	71	72	76

STATE	MedPAR Rehabilitation Cases				Percent of Cases in FIM Hospital Sample			
	1996	1997	1998	1999	1996	1997	1998	1999
TX	33,619	36,616	38,871	40,387	58	62	70	72
UT	858	984	1,044	1,673	43	62	57	65
VA	6,738	7,235	7,544	7,671	73	78	70	73
VT	603	567	582	691	74	73	68	75
WA	3,753	3,608	3,598	3,918	99	99	99	91
WI	6,591	6,690	6,468	6,643	87	93	89	89
WV	3,497	3,574	3,467	3,899	100	99	99	100
WY	334	376	418	315	31	75	23	49
Total	344,126	359,032	370,352	390,048	63	68	73	75

Representativeness of Patient and Stay Characteristics

Table M compares demographic characteristics of all Medicare rehabilitation patients with the matched FIM sample. Of all the characteristics examined, the FIM sample of discharges appears very similar.

Table M.--Patient Characteristics for MedPAR Rehabilitation Inpatients, by FIM Status

PATIENT CHARACTERISTIC	FIM	OTHER MedPAR	TOTAL MedPAR	FIM	OTHER MedPAR	TOTAL MedPAR
	1996			**1997**		
Sample Size	171,626	172,500	344,126	206,032	153,000	359,032
Average Age	75.4	75.6	75.5	75.4	75.6	75.5
Age 0-50	2.6%	2.8%	2.7%	2.8%	3.0%	2.8%
Age 51-60	3.1%	3.1%	3.1%	3.2%	3.2%	3.2%
Age 61-70	20.1%	19.3%	19.7%	19.5%	18.9%	19.2%
Age 71-80	44.2%	42.8%	43.5%	43.9%	42.8%	43.4%
Age 81-90	26.9%	28.1%	27.5%	27.4%	28.2%	27.7%
Age 91+	3.2%	3.9%	3.5%	3.2%	4.0%	3.6%
Male	37.9%	37.3%	37.6%	38.0%	37.6%	37.8%
White	86.7%	85.8%	86.3%	86.6%	85.3%	86.1%
Black	9.8%	10.6%	10.2%	10.1%	10.9%	10.4%
In-hospital death	0.2%	0.6%	0.4%	0.3%	0.7%	0.4%
	1998			**1999**		
Sample Size	232,691	137,661	370,352	257,024	133,024	390,048
Average Age	75.5	75.7	75.6	75.8	76.0	75.9
Age 0-50	2.8%	2.9%	2.8%	2.8%	2.8%	2.8%
Age 51-60	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%
Age 61-70	18.9%	18.4%	18.7%	18.1%	17.8%	18.0%
Age 71-80	43.6%	42.1%	43.0%	42.8%	41.5%	42.3%
Age 81-90	27.8%	28.8%	28.2%	28.9%	29.9%	29.2%
Age 91+	3.6%	4.2%	3.8%	3.9%	4.5%	4.1%
Male	37.9%	37.3%	37.7%	37.6%	37.2%	37.4%
White	86.5%	84.8%	85.9%	86.6%	84.8%	86.0%
Black	10.1%	10.8%	10.4%	9.8%	10.8%	10.2%
In-hospital death	0.3%	0.6%	0.4%	0.3%	0.7%	0.4%

Table N compares resources used for linked FIM stays with those for other Medicare rehabilitation patients. Average length of stay for FIM cases is the same as for non-FIM patients in 1996 and 1997, but is higher for FIM patients in 1998 and 1999. For cases in freestanding hospitals, FIM stays consume fewer resources in the first half of the data period, but not in the second half.

During this time, the FIM database grew from 75 percent to 93 percent of all freestanding cases.

Table N.--Comparison of Resource Use for Medicare Rehabilitation Inpatients, by FIM Status

		All Hospitals			Freestanding Hospitals		
Year	Hospitalization Characteristic	FIM	OTHER MedPAR	TOTAL MedPAR	FIM	OTHER MedPAR	TOTAL MedPAR
1996	Sample size	171,626	172,500	344,126	65,349	49,584	114,933
	Length of Stay (days)	16.2	16.2	16.2	18.0	18.9	18.4
	Daily therapy charges	$360	$351	$355	$360	$387	$371
	Total therapy charges	$5,960	$5,829	$5,894	$6,652	$7,605	$7,063
	Total charges	$18,013	$18,790	$18,403	$19,443	$21,214	$20,207
1997	Sample size	206,032	153,000	359,032	82,393	36,148	118,541
	Length of Stay (days)	15.7	15.7	15.7	17.8	19.2	18.2
	Daily therapy charges	$379	$368	$374	$384	$406	$391
	Total therapy charges	$6,064	$5,924	$6,004	$7,002	$8,064	$7,325
	Total charges	$18,348	$19,287	$18,748	$20,202	$22,541	$20,915
1998	Sample size	232,691	137,661	370,352	96,262	26,075	122,337
	Length of Stay (days)	15.8	14.6	15.3	18.2	17.1	18.0
	Daily therapy charges	$396	$383	$391	$398	$414	$402
	Total therapy charges	$6,361	$5,676	$6,106	$7,458	$7,285	$7,421
	Total charges	$19,230	$19,090	$19,178	$21,129	$21,558	$21,220
1999	Sample size	257,024	133,024	390,048	108,290	21,013	129,303
	Length of Stay (days)	15.4	14.0	14.9	17.8	16.1	17.5
	Daily therapy charges	$425	$409	$419	$428	$436	$430
	Total therapy charges	$6,621	$5,843	$6,355	$7,789	$7,231	$7,698
	Total charges	$20,000	$19,359	$19,781	$21,821	$21,449	$21,761

Note: FIM case totals count matched cases; hence, they differ from the total in Table J, which counts matched and unmatched cases.