

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 $A = \text{cost per discharge} / \exp(a \cdot x)$. 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 w_k 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 significantly 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:

$(1 + \text{DSH})$ raised to the power of .4838

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

Total Medicare Days

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:

$$\text{Federal Prospective Payment} = \text{CMG Relative Weight} * \text{Budget Neutral Conversion Factor}$$

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 <u>.72395</u>	x <u>.72395</u>
Labor Portion of Federal Payment	= \$14,503.48	= \$14,503.48
Wage Index	x <u>0.987</u>	x <u>1.234</u>
Wage Adjusted Amount	= \$14,314.93	\$17,897.29
Non-Labor Amount	+ <u>\$5,530.33</u>	+ <u>\$5,530.33</u>
Wage Adjusted Federal Payment	19,845.26	\$23,427.62
Rural Adjustment	x <u>1.1914</u>	x <u>1.0000</u>
Subtotal	23,643.65	= \$23,427.62
DSH Adjustment	x <u>1.0239</u>	x <u>1.070</u>
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 $66 \frac{2}{3}$ percent of the amount of the facility-specific payment and $33 \frac{1}{3}$ 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)(1)(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
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
Rural-South Atlantic	6,192	20	1.09
Rural-East NorthCentral	5,152	29	1.01
Rural-East SouthCentral	3,590	10	0.98

Facility Classifications	Number of Cases	Number of Facilities	New Payment to Current Payment Ratio
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
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
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
Rural-West SouthCentral	7,317	32	0.97
Rural-Mountain	1,042	9	1.04

Facility Classifications	Number of Cases	Number of Facilities	New Payment to Current Payment Ratio
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
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 = $\$410.77/\text{week}$. $\$410.77/40$ 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 = $\$518.07/\text{week}$. $\$518.07/40$ 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 = $\$533.84/\text{week}$. $\$533.84/40$ 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 = $\$588.27/\text{week}$. $\$588.27/40$ 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 = $\$673.46/\text{week}$. $\$673.46/40$ 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. ($\$40,690/52 \text{ weeks} = \$782.50/\text{week}$. $\$782.50/40 \text{ 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. ($\$43,080/52 \text{ weeks} = \$828.46/\text{week}$. $\$828.46/40 \text{ 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. ($\$48,230/52 \text{ weeks} = \$927.50/\text{week}$. $\$927.50/40 \text{ 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. ($\$56,600/52 \text{ weeks} = \$1088.46/\text{week}$. $\$1088.46/40 \text{ 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)	(Column 2)	(Column 3)	(Column 4)	(Column 5)
Updated Hourly Wages For Each Clinician Discipline	Range of Incremental Time of 20 Minutes-- Incremental Cost Per Clinician Discipline Column 1 Times 0.333333	Range of Incremental Cost Per Clinical Discipline Per IRF-- Column 2 Times 335 Admissions	Range of Incremental Time of 45 Minutes-- Incremental Cost Per Clinician Discipline Column 1 Times 0.75	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 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 ($\$100 \times 1,165$ 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 ($\$200 \times 1,165$ 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 IRF¹**

(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	
Training on data collection for other IRF clinicians for the admission and discharge assessments	12	\$11.90	9	\$1,285	Column 5 Low and High Times 1,165 \$1,497,258 to \$3,968,363
	12	\$15.01	9	\$1,621	
	12	\$15.47	9	\$1,671	
	12	\$17.05	9	\$1,841	
	12	\$19.52	9	\$2,108	
	12	\$22.67	9	\$2,448	
	12	\$24.00	9	\$2,592	
12	\$26.88	9	\$2,903		
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
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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 IRF¹**

(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	\$11.90	1	\$143	Column 5 Low and High Times 1,165 \$166,362 to \$440,929
	12	\$15.01	1	\$180	
	12	\$15.47	1	\$186	
	12	\$17.05	1	\$205	
	12	\$19.52	1	\$234	
	12	\$22.67	1	\$272	
	12	\$24.00	1	\$288	
	12	\$26.88	1	\$323	
Clinician training on data collection for non-lead clinicians	2	\$11.90	9	\$214	\$249,543 to \$661,394
	2	\$15.01	9	\$270	
	2	\$15.47	9	\$278	
	2	\$17.05	9	\$307	
	2	\$19.52	9	\$351	
	2	\$22.67	9	\$408	
	2	\$24.00	9	\$432	
	2	\$26.88	9	\$484	
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)	(Column 2)	(Column 3)	(Column 4)	(Column 5)
Assessment Type	Percent of Patient Assessment Instrument Items Completed (See Table VIII)	Maximum Incremental Clinician (Physical Therapist) Cost Per IRF (From Table III)	Total Incremental Maximum Cost Per IRF (Column 2 Times Column 3)	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 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)	(Column 2)	(Column 3)	(Column 4)
Cost Per Case Per IRF	Average Admissions Per IRF	Number of IRFs	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.