DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 413

[CMS–1069–F]

RIN 0938–AJ55

Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities

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

ACTION: Final rule.

SUMMARY: This final rule establishes a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital. It implements section 1886(j) of the Social Security Act (the Act), as added by section 4421 of the Balanced Budget Act of 1997 and as amended by section 125 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Section 1886(j) of the Act authorizes the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units of hospitals. This section also authorizes the Secretary to require rehabilitation hospitals and rehabilitation units to submit data as the Secretary deems necessary to establish and administer the prospective payment system. The prospective payment system described in this final rule replaces the reasonable cost-based payment system under which rehabilitation hospitals and rehabilitation units of hospitals are paid under Medicare.

DATES: *Effective Date:* These regulations are effective on January 1, 2002.

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

FOR FURTHER INFORMATION CONTACT:
Robert Kuhl, (410) 786–4597 (General information, the case-mix classification system, and transition payments).
Pete Diaz, (410) 786–1235 (Requirements for completing the patient assessment instrument, and other assessment instrument issues).
Nora Hoban, (410) 786–0675 (Payment system, calculation of the payment rates, update factors, relative weights/case-mix index, wage index, transfer policies, and payment adjustments).

SUPPLEMENTARY INFORMATION:

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Alphabetical List of Acronyms Appearing in the Final Rule

ADL Activities of Daily Living
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106–554

changes to the existing § 412.30 as the commenters suggested.

3. Provisions of the Final Rule

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

• Requirements for IRFs. The IRF prospective payment system will apply to inpatient rehabilitation services furnished by Medicare participating entities that are classified as rehabilitation hospitals or rehabilitation units under §§ 412.23(b), 412.25, and 412.29. In addition, we are adopting as final the proposed technical changes to §§ 412.22, 412.23, 412.25, and 412.29 to reflect the application of the classification criteria to IRFs under the IRF prospective payment system.

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

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

—Veterans Administration hospitals.

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

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

• Other Technical Changes. In addition to the technical changes to §§ 412.22, 412.23, 412.25, and 412.29 cited above, we are adopting as final the proposed technical changes to §§ 412.1, 412.20, 412.116, 412.130, 413.1, 413.40, and 413.64 to reflect payment for inpatient rehabilitation services furnished by IRFs under the IRF prospective payment system, effective January 1, 2002.

B. Completion of Patient Assessment Instrument

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

C. Limitation on Charges to Beneficiaries

Proposed § 412.604(d) specified that an IRF may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the IRF prospective payment system. Proposed § 412.604(d) further specified that an IRF receiving a prospective payment for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of the regulations.

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

D. Furnishing of Inpatient Hospital Services Directly or Under Arrangement

Proposed § 412.604(e) specified that an IRF must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements. The IRF prospective payments are payment in full for all inpatient hospital services, as defined in § 409.10. We proposed that we would not pay any provider or supplier other than the IRF for services furnished to a Medicare beneficiary who is an inpatient of the IRF, except for physicians' services reimbursable under § 405.550(b) and services of an anesthetist employed by a physician reimbursable under § 415.102(a) of the regulations.

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

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

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

E. Reporting and Recordkeeping Requirements

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

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

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

A. Overview of Research for the Proposed Rule

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

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

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 (66⅔ percent of the facility specific payment and 33⅓ 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 (33⅓ percent of the facility specific payment and 66⅔ 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 33⅓ percent of the facility-specific payment and 66⅔ percent of the adjusted Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, payment will be based entirely on the Federal prospective payment.

2. Payments Based on the Election To Apply the Full Prospective Payment for Cost Reporting Periods Beginning During FY 2002

Under § 412.626(b) of the final regulations, we are specifying that a provider may elect not to be paid under the transition period described in section VI.H.I. above. Payment to IRFs making this election will be based on 100 percent of the adjusted Federal prospective payment in effect for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

An IRF must request this election no later than 30 days before the start of its first cost reporting period for which payment is based on the IRF prospective payment system. The IRF must make its request in writing to its Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the start of the cost reporting period, regardless of any postmarks or anticipated delivery dates. Requests received (whether mailed or delivered by other means) later than the 30th day before the cost reporting period will not be approved. If the 30th day before the start of the cost reporting period falls on a day on which the postal service or other delivery sources are not open for business, the IRF is responsible to ensure that enough time is allowed for the delivery of the request before the deadline. If an IRF's request is not received timely or is otherwise not approved, payment will be based on the transition period methodology.

3. Payments Based on the Full Prospective Payment for Cost Reporting Periods Beginning During FY 2003 and After

Under § 412.626(a)(l)(ii) of the final regulations, we are specifying that payment made to IRFs with cost reporting periods beginning on or after October 1, 2002 (FY 2003 and after) will consist of 100 percent of the adjusted Federal prospective payment. We described the basis of payments made for fiscal years after FY 2002 in § 412.624 of the final regulations.

I. Method of Payment

We will base a beneficiary's classification into a CMG on data obtained during the initial patient assessment. The CMG will determine the Federal prospective payment that the IRF receives for the Medicare-covered Part-A services furnished during the Medicare beneficiary's episode of care. However, under § 412.632(a) of these final regulations, the payment arises from the submission

of a discharge bill. This will allow us to pay for comorbidities diagnosed during the stay, classify cases appropriately to one of the five special CMGs (for cases in which the patient expires or has a very short length of stay), adjust the payment to reflect an early transfer, and determine if the case qualifies for an outlier payment. Accordingly, the IRF will record the CMG and other information on the beneficiary's discharge bill, and will submit the bill to its Medicare fiscal intermediary for processing. The payment made represents payment in full, under § 412.622(b) of these final regulations, for inpatient operating and capital-related costs, but not for the costs of an approved medical education program, bad debts, blood clotting factors provided to patients with hemophilia, or other costs not paid for under the IRF prospective payment system.

Under the existing payment system, (1) an IRF may be paid using the periodic interim payment (PIP) method described in § 413.64(h) of the existing regulations; (2) rehabilitation units are paid under the PIP method if the hospital of which they are a part is paid under existing § 412.116(b); (3) IRFs may be eligible to receive accelerated payments as described in existing § 413.64(g); or (4) rehabilitation units are eligible for accelerated payments under existing § 412.116(f). The statute does not preclude the continuation of PIP. We presently see no reason to discontinue our existing policy of allowing the PIP and accelerated payment methods under the prospective payment system for qualified IRFs, although we may choose to evaluate its continuing need in the future. Therefore, we will permit the continued availability of PIP and accelerated payments for services of IRFs paid under the prospective payment system at paragraphs (b) and (e) of § 412.632 of the final regulations.

For those services paid under the PIP method, the amount reflects the estimated prospective payments for the year rather than estimated cost reimbursement. An IRF receiving prospective payments, whether or not it received a PIP prior to receiving prospective payments, may receive a PIP if it meets the requirements in § 412.632 and receives approval by its intermediary. Similarly, if an intermediary determines that an IRF that received a PIP prior to receiving prospective payments is no longer entitled to receive a PIP, it will remove the IRF from the PIP method. As provided in § 412.632, intermediary approval of a PIP is conditioned upon the intermediary's best judgment as to whether making payment under the PIP method would not entail undue risk of resulting in an overpayment to the provider.

Excluded from the PIP amount are outlier payments that are paid in final upon the submission of a discharge bill. In addition, Part A costs that are not paid for under the IRF prospective payment system, including Medicare bad debts and costs of an approved educational program, will be subject to the interim payment provisions of the existing regulations at § 413.64.

Under the prospective payment system, if an IRF is not paid under the PIP method, it may qualify to receive an accelerated payment. Under § 412.632, the IRF must be experiencing financial difficulties due to a delay by the intermediary in making payment to the IRF, or there is a temporary delay in the IRF's preparation and submittal of bills to the intermediary beyond its normal billing cycle because of an exceptional situation. The IRF must make a request for an accelerated payment, which is subject to approval by the intermediary and by us. The amount of an accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services. Recoupment of an accelerated payment occurs as bills are processed or through direct payment by the IRF.

J. Update to the Adjusted Facility Federal Prospective Payment

Under section 1886(j)(3)(C) of the Act and under § 412.624(c)(3)(ii) of the final regulations, future updates, for FY 2003 and subsequent fiscal years, to the adjusted facility Federal prospective payments (budget neutral conversion factor) will include the use of an increase factor based on an appropriate percentage increase in a market basket of goods and services comprising services for which the IRF prospective payment system makes payment. This increase factor may be the market basket percentage increase described in section 1886(b)(3)(B)(iii) of the Act. We include in Appendix D of this final rule a description of the IRF market basket that we used in developing an increase factor under section 1886(j)(3)(C) of the Act.

K. Publication of the Federal Prospective Payment Rates

In accordance with section 1886(j)(5) of the Act, we will publish in the **Federal Register**, on or before August 1 prior to the beginning of each fiscal year, the classifications and weighting factors for the IRF case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year (§ 412.628 of these final regulations).

L. Limitation on Administrative or Judicial Review

In accordance with sections 1886(j)(7)(A), (B), and (C) of the Act, we are specifying under § 412.630 of these final regulations that administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

VII. Provisions of the Final Regulations

After careful consideration of the public comments received on the November 3, 2000 proposed rule, we are adopting as final, with the modifications discussed throughout this preamble and summarized below, the proposed regulations set forth in 42 CFR Part 412, Subpart P, to implement the prospective payment system for IRFs, and the proposed technical and conforming changes to §§ 412.1, 412.20, 412.22, 412.23, 412.25, 412.29, 412.116, 412.130, 413.1, 413.40, and 413.64. The table of contents for Subpart P is as follows:

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

- 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.

and discharge assessments are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

(2) If the interruption in the stay occurs after the admission assessment and before the discharge assessment, the completion date, encoding date, and data transmission date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

§ 412.620 Patient classification system.

(a) *Classification methodology.*

(1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from admission assessments under § 412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(4) Data from the discharge assessment under § 412.610(c)(2) are used to determine the weighting factors under paragraph (b)(4) of this section.

(b) *Weighting factors.*

(1) *General.* An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) *Short-stay outliers.* We will determine a weighting factor or factors for patients that are discharged and not transferred (as defined in § 412.602) within a number of days from admission as specified by us.

(3) *Patients who expire.* We will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by us.

(4) *Comorbidities.* We will determine a weighting factor or factors to account for the presence of a comorbidity, as defined in § 412.602, that is relevant to resource use in the classification system.

(c) *Revision of case-mix group classifications and weighting factors.* We may periodically adjust the case-mix groups and weighting factors to reflect changes in—

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of resources.

§ 412.622 Basis of payment.

(a) *Method of payment.*

(1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in § 412.624 and, if applicable, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in § 412.626.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§ 413.85 and 413.86 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following:

(i) Bad debts of Medicare beneficiaries, as provided in § 413.80 of this chapter; and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

§ 412.624 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities, we use—

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, to estimate payments for inpatient operating and capital-related costs made under part 413 under this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient rehabilitation services; and

(4) Patient assessment data described in § 412.606 and other data that account for the relative resource utilization of different patient types.

(b) *Determining the average costs per discharge for fiscal year 2001.* We determine the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data specified under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2001 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2001.

(c) *Determining the Federal prospective payment rates.* (1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the budget neutral conversion factor. The budget neutral conversion factor is a standardized payment amount based on average costs from a base year which reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments, and other adjustments.

(2) *Update the cost per discharge.* We apply the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, we estimate the payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the budget neutral conversion factor.* The budget neutral conversion factor is computed as follows:

(i) *For fiscal year 2002.* Based on the updated costs per discharge and estimated payments for fiscal year 2002 determined in paragraph (c)(2) of this section, we compute a budget neutral conversion factor for fiscal year 2002, as specified by us, that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The budget neutral conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(4) *Determining the Federal prospective payment rate for each case-mix group.* The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in § 412.620(b) and the budget neutral conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the budget neutral conversion factor.* The budget neutral