

“Privacy Act Statement—Health Care Records” and the simplified plain language description of the Privacy Act Statement—Health Care Records, which is a form entitled “Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities;” the inpatient rehabilitation facility must document in the Medicare inpatient’s clinical record that the Medicare inpatient has been given the documents specified in the section.

The burden associated with this section is the time it will take to document that the patient has been given the requisite forms. We estimate that it will take no more than a minute per patient. There will be an estimated 390,000 admissions per year, for a total of 6,500 hours per year.

Section 412.614 Transmission of Patient Assessment Data

1. The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service inpatient.

These information collection requirements associated with the IRF PPS are currently approved by OMB through July 31, 2005 under OMB number 0938–0842.

2. Under paragraph (e), *Exemption to being assessed a penalty for transmitting the IRF-PAI data late*, CMS may waive the penalty specified in paragraph (d) of this section. To assist CMS in determining if a waiver is appropriate the inpatient rehabilitation facility must fully document the circumstances surrounding the occurrence.

Given that it is estimated that fewer than 10 instances will occur on an annual basis to necessitate a waiver, this requirement is not subject to the PRA as stipulated under 5 CFR 1320.3(c).

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in § 412.604, § 412.608 and § 412.614. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies to CMS within 60 days of this publication date directly to the following: Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Office of Regulations Development and Issuances, Reports Clearance Officer, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Attn: Julie Brown, CMS–1474–P; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive

Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

Comments submitted to OMB may also be emailed to the following address: e-mail: baguilar@omb.eop.gov; or faxed to OMB at (202) 395–6974.

IX. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

X. Regulatory Impact Analysis

A. Introduction

The August 7, 2001 IRS PPS final rule (66 FR 41316) established the IRF PPS for the payment of inpatient hospital services furnished by a rehabilitation hospital or rehabilitation unit of a hospital with cost reporting periods beginning on or after January 1, 2002. We incorporated a number of elements into the IRF PPS, such as case-level adjustments, a wage adjustment, an adjustment for the percentage of low-income patients, a rural adjustment, and outlier payments. The August 1, 2002 IRF PPS notice (67 FR 49928) set forth updates of the IRF PPS rates contained in the August 7, 2001 IRF PPS final rule. The purpose of the updates set forth in the August 1, 2002 IRF PPS notice was to provide an update to the IRF payment rates for discharges during FY 2003. This proposed rule proposes updated IRF PPS rates for discharges that occur during FY 2004.

In constructing these impacts, we do not attempt to predict behavioral responses, and we do not make adjustments for future changes in such variables as discharges or case-mix. We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors due to other changes in the forecasted impact time period. Some examples of such possible events are newly legislated general Medicare program funding changes by the Congress, or changes specifically related to IRFs. In addition, changes to the Medicare program may continue to be made as a result of the BBA, the BBRA, the BIPA, or new statutory provisions. Although these changes may not be specific to the IRF PPS, the nature of the Medicare program

is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

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).

In this proposed rule, we are proposing to use an updated FY 2004 IRF market basket index and an updated FY 2004 IRF labor-related share and wage indices to update the IRF PPS rates to FY 2004, as described in section VI of this proposed rule. By updating the IRF PPS rates to FY 2004, as proposed in this proposed rule, we estimate that the overall cost to the Medicare program for IRF services in FY 2004 will increase by \$204.2 million over FY 2003 levels. The updates to the IRF labor-related share and wage indices are made in a budget neutral manner. Thus, updating the IRF labor-related share and the wage indices to FY 2004 have no overall effect on estimated costs to the Medicare program. Therefore, this estimated cost to the Medicare program is due to the application of the proposed updated IRF market basket of 3.3 percent. Because the cost to the Medicare program is greater than \$100 million, this proposed rule is considered a major rule as defined above.

2. Regulatory Flexibility Act (RFA) and Impact on Small Hospitals

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, small entities include small businesses, nonprofit organizations, and governmental agencies. Most hospitals