

are considered small entities, either by nonprofit status or by having receipts of \$6 million to \$29 million in any 1 year. (For details, see the Small Business Administration's regulation that set forth size standards for health care industries at 65 FR 69432.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs. Therefore, we assume that all IRFs are considered small entities for the purpose of the analysis that follows. 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.

This proposed rule proposes a 3.3 percent increase to the Federal PPS rates. We do not expect an incremental increase of 3.3 percent to the Medicare Federal rates to have a significant effect on the overall revenues of IRFs. Most IRFs are units of hospitals that provide many different types of services (for example, acute care, outpatient services) and the rehabilitation component of their business is relatively minor in comparison. In addition, IRFs provide services to (and generate revenues from) patients other than Medicare beneficiaries. Accordingly, we certify that this proposed rule will not have a significant impact on small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed 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 603 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 (MSA) and has fewer than 100 beds.

This proposed rule will not have a significant impact on the operations of small rural hospitals. As indicated above, this proposed rule proposes a 3.3 percent increase to the Federal PPS rates. In addition, we do not expect an incremental increase of 3.3 percent to the Federal rates to have a significant effect on overall revenues or operations since most rural hospitals provide many different types of services (for example, acute care, outpatient services) and the rehabilitation component of their business is relatively minor in comparison. Accordingly, we certify that this proposed rule will not have a significant impact on the operations of small rural hospitals.

3. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates 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 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of at least \$110 million. This proposed rule will not have a substantial effect on the governments mentioned nor will it affect private sector costs.

4. Executive Order 13132

We examined this proposed rule in accordance with Executive Order 13132 and determined that it will not have a substantial impact on the rights, roles, or responsibilities of State, local, or tribal governments.

5. Overall Impact

For the reasons stated above, we have not prepared an analysis under the RFA and section 1102(b) of the Act because we have determined that this proposed rule will not have a significant impact on small entities or the operations of small rural hospitals.

B. Anticipated Effects of the Proposed Rule

We discuss below the impacts of this proposed rule on the Federal budget and on IRFs.

1. Budgetary Impact

Section 1886(j)(3)(C) of the Act requires annual updates to the IRF PPS payment rates. Section 1886 (j)(6) of the Act requires the Secretary to adjust or update the labor-related share and the wage indices or the labor-related share and the wage indices the applicable to IRFs not later than October 1, 2001 and at least every 36 months thereafter. We project that updating the IRF PPS for discharges occurring on or after October 1, 2003 and before October 1, 2004 will cost the Medicare program \$204.2 million. The proposed update to the IRF labor-related share and wage indices if finalized will be made in a budget neutral manner. Thus, updating the IRF labor-related share and the wage indices to FY 2004 would 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.

2. Impact on Providers

For the impact analyses shown in the August 7, 2001 IRF PPS final rule, we simulated payments for 1,024 facilities. To construct the impact analyses set forth in this proposed rule, we use the latest available data. These data include the same facilities that were used in constructing the impact analyses

displayed in the August 7, 2001 IRF PPS final rule (66 FR 41364–41365, and 41372). We do not have enough post-IRF PPS data to develop the overall budgetary impact and the impact on providers. Further, we will need a sufficient amount of these data to be able to rely on them as the basis for the impact analysis. Because IRFs began to be paid under the IRF PPS based on their cost report start date that occurred on or after January 1, 2002, sufficient Medicare claims data will not be available for those facilities whose cost report start date occurs later in the calendar year. We do not have enough post-IRF PPS data to develop the overall budgetary impact and the impact on providers. Further, we will need a sufficient amount of these data to be able to rely on them as the basis for the impact analysis. Because IRFs began to be paid under the IRF PPS based on their cost report start date that occurred on or after January 1, 2002, sufficient Medicare claims data will not be available for those facilities whose cost report start date occurs later in the calendar year. The estimated monetary changes among the various classifications of IRFs for discharges occurring on or after October 1, 2003 and before October 1, 2004 is reflected in Chart 8 "Projected Impact of Proposed FY 2004 Update" of this proposed rule.

3. Calculation of the Estimated FY 2003 IRF Prospective Payments

To estimate payments under the IRF PPS for FY 2003, we multiplied each facility's case-mix index by the facility's number of Medicare discharges, the FY 2003 standardized payment amount, the applicable FY 2003 labor-related share and wage indices, a low-income patient adjustment, and a rural adjustment (if applicable). The adjustments include the following:

The wage adjustment, calculated as follows: $(.27605 + (.72395 \times \text{FY 2003 Wage Index}))$.

The disproportionate share adjustment, calculated as follows: $(1 + \text{Disproportionate Share Percentage})$ raised to the power of .4838).

The rural adjustment, if applicable, calculated by multiplying payments by 1.1914.

4. Calculation of the Proposed Estimated FY 2004 IRF Prospective Payments

To calculate proposed FY 2004 payments, we use the payment rates described in this proposed rule that reflect the proposed 3.3 percent market basket increase factor using the proposed FY 2004 labor-related share