

susceptible to the same payment vulnerabilities as the IPPS and, therefore, merit revision. As proposed for acute care hospitals under the IPPS at proposed § 412.84(i) and (m) in the March 5, 2003, proposed rule (68 FR 10429) and as we proposed for LTCHs above for high-cost outlier payments at § 412.525(a)(4)(ii), we proposed under § 412.529 that short-stay outlier payments would be subject to the proposed provisions in the regulations at § 412.84(i) and (m). Therefore, consistent with the proposed changes to the high-cost outlier policy discussed in section VI.C.3. of the March 7, 2003, proposed rule, we proposed, by cross-referencing § 412.84(i), that fiscal intermediaries would use either the most recent settled cost report or the most recent tentatively settled cost report, whichever is later, in estimating a LTCH's cost-to-charge ratio. We also proposed, by cross-referencing § 412.84(i), that the applicable statewide average cost-to-charge ratio would only be applied when a LTCH's cost-to-charge ratio exceeds the ceiling. Finally, we proposed, by cross-referencing § 412.84(m), that any reconciliation of payments for short-stay outliers would be made upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. We further noted that as was the case with the proposed changes to the outlier policy for acute care hospitals under the IPPS, we were still assessing the procedural changes that would be necessary to implement this change.

We received numerous comments on the proposed changes to the outlier policy as it relates to short-stay outliers. We have summarized and responded to these comments in the previous section related to outlier payments under the LTCH PPS. Therefore, as discussed above, under § 412.529, short-stay outlier payments are subject to the provisions of §§ 412.84(i)(1), (3), and (4) and § 412.84(m) for discharges occurring on or after August 8, 2003, and subject to the provisions of § 412.84(i)(2) for discharges occurring on or after October 1, 2003.

### VIII. 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 Paperwork Reduction Act of 1995 (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 March 5, 2003, proposed rule, we solicited comment on the recordkeeping requirements referenced in the proposed amendments to § 412.84. Under the proposed amendments to § 412.84(h), a hospital may request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. The burden imposed by this section is the time it takes to write the request. We estimated that 120 hospitals would make this request per year and that it would take each one 8 hours for a total annual burden of 960 hours.

We did not receive any comments on this information collection requirement and are making no revisions to it. We will submit this information collection requirement to the Office of Management and Budget for review and approval in accordance with the Paperwork Reduction Act. The requirement will not go into effect until we receive OMB approval.

If you comment on this information collection and recordkeeping requirement, please mail, e-mail or fax copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Attn: Julie Brown, CMS-1243-F, Room C5-16-03, 7500 Security Boulevard, Baltimore, MD 21244-1850;

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, [baguilar@omb.eop.gov](mailto:baguilar@omb.eop.gov). Fax: (202) 395-6974.

### IX. Impact Analysis

#### A. Introduction

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993,

Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 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.

#### B. 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 any 1 year).

We have determined that this final rule is a major rule as defined in 5 U.S.C. 804(2). We estimate the total impact of the policies implemented in this final rule will be to reduce outlier payments for the remainder of FY 2003 by \$150 million. Therefore, we have prepared the quantitative analysis under this impact analysis section at IX.G. of this preamble.

#### C. Regulatory Flexibility Analysis

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either based on their nonprofit status or by having revenues of \$6 million to \$29 million in any 1 year. For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. As stated above, we have prepared the quantitative analysis under this impact analysis section at IX.G. of this preamble.

#### D. Effects on Rural Hospitals

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any final rule that may 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. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical