

C and is paid under the prospective payment systems specified in § 412.1(a)(1). We proposed to specify that either CMS or the Medicare fiscal intermediary may take such action, as appropriate.

Comment: We did not receive any comments concerning this proposed change.

Response: We are therefore adopting the proposed change to § 412.604(a)(2) to indicate that CMS or the Medicare fiscal intermediary may take actions if the IRF does not meet the conditions specified in the section.

C. Classification Criteria for IRFs Subject to the IRF PPS

Section 412.604(b) states that, subject to the special payment provisions of § 412.22(c), an IRF must meet the general criteria set forth in § 412.22 and the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in § 412.23(b), § 412.25, and § 412.29 for exclusion from the IPPS specified in § 412.1(a)(1). These general criteria are located under 42 CFR part 412, subpart B of the regulations. In the August 7, 2001 final rule implementing the IRF PPS, we did not make any changes to the exclusion criteria and requirements to be classified as an IRF under subpart B of part 412. Since the implementation of the IRF PPS, a number of questions have been raised on the application of some of these requirements and the necessity of other criteria.

Below, we discuss each requirement as it relates to the classification of an IRF, the proposed changes, if any, included in the May 16, 2003 proposed rule, the public comments received, and the provisions of this final rule.

1. Relationship to IPPS

Section 1886 to the Act established a PPS for acute care inpatient hospital services for cost reporting periods beginning on or after October 1, 1983. Under section 1886(d)(1)(B) of the Act, several types of hospitals and units of hospitals are excluded from the IPPS. Sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act specify that rehabilitation hospitals and units (as defined by the Secretary) are excluded from the IPPS. The Secretary has defined rehabilitation hospitals and units in regulations at 42 CFR part 412 subpart B.

Extensive discussion and public comments on developing the criteria under which a hospital or unit of a hospital can be excluded from the IPPS as an IRF began with the September 1, 1983 publication of the interim final rule with comment period in the

Federal Register (48 FR 39752). (That interim final rule discussed the provisions necessary to implement section 1886 of the Act.) On January 3, 1984, we published in the **Federal Register** a final rule (49 FR 234) that responded to public comments on the provisions of the September 1, 1983 interim final rule and established the initial set of criteria that must be met by a hospital or unit of a hospital seeking exclusion from the IPPS as an IRF. Since the publication of these earlier rules, the criteria to be an IRF have been revised and codified at 42 CFR part 412, subpart B of the existing Medicare regulations.

2. IRF Hospital Services Furnished to HMOs or CMP Enrollees

Section 412.20(b) of the existing regulations state that covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet the conditions of § 412.604 are paid under the IRF PPS described in subpart P of 42 CFR part 412.

In the May 16, 2003 proposed rule, we proposed to redesignate existing § 412.20(b) as § 412.20(b)(1) and add § 412.20(b)(2) to ensure that inpatient hospital services will not be paid under the IRF PPS if the services are paid by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not to have CMS make payments to an IRF for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees under 42 CFR Part 417. This provision is similar to the provision at § 412.20(d)(3) that prohibits payments under the IPPS for similar HMO or CMP services.

Comment: We did not receive any comments concerning this proposed change.

Response: Therefore, we are adopting the proposed redesignation of existing § 412.20(b) as § 412.20(b)(1) and add § 412.20(b)(2) to ensure that inpatient hospital services will not be paid under the IRF PPS if the services are paid by a HMO or CMP that elects not to have CMS make payments to an IRF for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees under 42 CFR part 417.

3. Bed-Number Criteria for Freestanding Satellite IRFs

Section 412.22(h) describes the requirements to be a satellite facility of a hospital that is excluded from the IPPS. The following describes our proposed changes in the May 16, 2003 proposed rule to eliminate the provision that limits the bed size of a satellite IRF.

In the July 30, 1999 **Federal Register** (64 FR 41540), we revised § 412.22(h) to require that in order to be excluded from the acute care hospital inpatient PPS, a satellite of a hospital: (1) Effective for cost reporting periods beginning on or after October 1, 2002, is not under the control of the governing body or chief executive officer of the hospital in which it is located, and furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located; (2) must maintain admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available; (3) cannot commingle beds with beds of the hospital in which it is located; (4) must be serviced by the same FI as the hospital of which it is a part; (5) must be treated as a separate cost center of the hospital of which it is a part; (6) for cost reporting and apportionment purposes, must use an accounting system that properly allocates costs and maintains adequate data to support the basis of allocation; and (7) must report costs in the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part. In addition, the satellite facility must independently comply with the qualifying criteria for exclusion from the IPPS. Lastly, the total number of State-licensed and Medicare-certified beds (including those of the satellite facility) for a hospital (other than a children's hospital) that was excluded from the IPPS for the most recent cost reporting period beginning before October 1, 1997, may not exceed the hospital's number of beds on the last day of that cost reporting period.

In § 412.22(h)(1), we define a satellite as "a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital." Satellite arrangements exist when an existing hospital that is excluded from the IPPS and that is either a freestanding hospital or a hospital-within-a-hospital under § 412.22(e) shares space in a building or on a campus occupied by another hospital in order to establish an additional location for the excluded hospital. The July 30, 1999 IPPS final rule (64 FR 41532–41534) includes a detailed discussion of our policies regarding Medicare payments for satellite facilities of hospitals excluded from the IPPS.