

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 August 1, 2002 IRF PPS notice was only to provide an update to the IRF payment rates for discharges during FY 2003. This final rule provides updated IRF PPS rates for discharges that occur during FY 2004 as well as makes policy changes in the IRF PPS system.

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 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 final 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.

#### *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 this final rule, we are using 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 VII. of this final rule. By updating the IRF PPS rates to FY 2004, we estimate that the overall cost to the Medicare program for IRF services in FY 2004 will increase by \$187.3 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 updated IRF market basket of 3.2 percent. Because the combined distributional effects and the cost to the Medicare program are greater than \$100 million, this final rule is considered a major rule as defined above.

#### *C. 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 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 at 65 FR 69432 that set forth size standards for health care industries.) 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.

The provisions of this final rule represent a 3.2 percent increase to the Federal PPS rates. We do not expect an incremental increase of 3.2 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 final 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 final 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 final rule will not have a significant impact on the operations of small rural hospitals. As indicated above, the provisions of this final rule represent a 3.2 percent increase to the Federal PPS rates. In addition, we do not expect an incremental increase of 3.2 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 final rule will not have a significant impact on the operations of small rural hospitals.

#### *D. 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 final rule will not have a substantial effect on the governments mentioned nor will it affect private sector costs.

#### *E. Executive Order 13132*

We examined this final 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.

#### *F. 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 final rule will not have a significant impact on small entities or the operations of small rural hospitals.