the distribution of power and responsibilities between the Federal government and Indian tribes, as specified in Executive Order 13175. This action will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999), because it merely authorizes State requirements as part of the State RCRA hazardous waste program without altering the relationship or the distribution of power and responsibilities established by RCRA. This action also is not subject to Executive Order 13045 (62 FR 19885, April 23, 1997), because it is not economically significant and it does not make decisions based on environmental health or safety risks. This rule is not subject to Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply Distribution or Use'' (66 FR 28344, May 22, 2001) because it is not a significant regulatory action under Executive Order 12866. This action does not include environmental justice issues that require consideration under Executive Order 12898 (59 FR 7629, February 16, 1994).

Under RCRA 3006(b), EPA grants a State's application for authorization as long as the State meets the criteria required by RCRA. It would thus be inconsistent with applicable law for EPA, when it reviews a State authorization application, to require the use of any particular voluntary consensus standard in place of another standard that otherwise satisfies the requirements of RCRA. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272) do not apply. As required by section 3 of Executive Order 12988 (61 FR 4729, February 7, 1996), in issuing this rule, EPA has taken the necessary steps to eliminate drafting errors and ambiguity, minimize potential litigation, and provide a clear legal standard for affected conduct. EPA has complied with Executive Order 12630 (53 FR 8859, March 15, 1988) by examining the takings implications of the rule in accordance with the ''Attorney General's Supplemental Guidelines for the Evaluation of Risk and Avoidance of Unanticipated Takings' issued under the executive order. This final rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

List of Subjects in 40 CFR Part 271

Environmental protection, Administrative practice and procedure, Confidential business information, Hazardous waste, Hazardous waste transportation, Indian lands, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements.

Authority: This action is issued under the authority of Sections 2002(a), 3006 and 7004(b) of the Solid Waste Disposal Act as amended 42 U.S.C. 6912(a), 6926, 6974(b).

Dated: June 20, 2002.

L. John Iani,

Regional Administrator, Region 10.

[FR Doc. 02–16465 Filed 6–28–02; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 413

[CMS–1069–F2]

RIN –0938–AL40

Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities; Correcting Amendment

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule; correcting amendment.

SUMMARY: In the August 7, 2001 issue of the **Federal Register** (66 FR 41316), we published a final rule establishing a prospective payment system (PPS) for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or rehabilitation unit of a hospital. The effective date was January 1, 2002. This correcting amendment corrects a limited number of technical and typographical errors identified in the August 7, 2001 final rule. It also corrects an example related to the Inpatient Rehabilitation Facility Patient Assessment Instrument contained within the final rule.

EFFECTIVE DATE: This correcting amendment is effective July 31, 2002.

FOR FURTHER INFORMATION CONTACT: Robert Kuhl, (410) 786–4597.

SUPPLEMENTARY INFORMATION:

Need for Corrections

In our August 7, 2001 final rule (66 FR 41316), referred to as the final rule throughout this correcting amendment, we provided an extensive discussion of the inpatient rehabilitation facility (IRF) patient assessment instrument and its implementation that employed various examples to illustrate essential points of the patient assessment process. A number of those examples contain technical errors. In addition, we are making technical corrections to the regulations text where the regulations text inadvertently fails to reflect the policies set forth in the preamble of the final rule.

Summary of Technical Corrections to the Preamble to the August 7, 2001 Final Rule

In section IV of the final rule, we describe the process of using the IRF patient assessment instrument to collect patient data that are the basis of payments made under the IRF prospective payment system. Beginning on page 41330 of the final rule, we describe the schedule for completing, encoding (computerizing), and transmitting data contained in the IRF patient assessment instrument. The rules associated with the assessment schedule are codified at §§ 412.610 and 412.614.

Interruption of the Stay During the Admission Assessment

After the patient is admitted, the IRF has a time period to observe the patient's functional status/clinical condition that is then recorded on the patient assessment instrument. This time period is referred to in the final rule as the admission assessment time period. Section 412.610(b) states that ''The first day that the Medicare Part A fee-for-service inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the patient assessment schedule.'' Section 412.610(c)(1)(i) specifies the general rule that the admission assessment time period is a span of time that covers calendar days 1 through 3 of the patient's current Medicare Part A fee-for-service hospitalization. The patient's IRF admission day is the first day of the admission assessment time period. For example, Chart 1 on page 41330 illustrates the assessment schedule for an inpatient stay in an IRF; the admission assessment time period is the first 3 days of the patient's IRF hospitalization, with day 3 being the admission assessment reference date, day 4 being the admission assessment completion date, and day 10 being the encoded by date. Chart 2 on page 41331 illustrates the application of the general rule for a patient who is admitted on July 3, 2002. The admission assessment

time period would be July 3, 4, and 5, the admission assessment reference date July 5, the admission assessment completion date July 6, and the admission assessment encoded by date July 12, 2002.

The preamble also explains the admission assessment time period, admission assessment reference date, the admission assessment completion date, and the admission assessment encoded by date for the case in which the beneficiary has an interrupted stay during the admission assessment time period. As defined in § 412.602, an interrupted stay means a stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within three consecutive calendar days. The duration of the interruption of the stay of three consecutive calendar days begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the third day. However, the August 7, 2001, final rule contains some technical errors in illustrating the assessment process for a patient who has an interruption in a stay which occurs during the admission assessment time period.

On page 41331 of the preamble of the final rule, we describe the process of shifting the dates associated with the admission assessment schedule when an inpatient rehabilitation stay has been interrupted. In the example on page 41331, the patient's stay begins with an admission to the IRF on July 3, 2002. However, the stay is interrupted on July 4, 2002, and the patient returns to the IRF before midnight of July 6, 2002. The example on page 41331 incorrectly states that, due to this interruption in the hospital stay, the admission assessment time period would be shifted to July 6, 7, and 8. The example is incorrect because the three calendar days to observe the patient during the admission assessment time period must include July 3, because July 3 is the day of admission to the IRF. As stated previously, the day of admission to the IRF is the first day of the admission assessment time period. Because July 3 is day 1 of the admission assessment time period, then July 6, the date when the patient returns to the IRF after the interruption in the stay, is day 2 of the admission assessment time period. Accordingly, July 7 is day 3 of the admission assessment time period.

The admission assessment reference date, completion date, and encoded by date are based upon the admission assessment time period. Because the final rule example regarding the shifting of the admission assessment time period is incorrect, it follows that the admission assessment reference date of July 8, the admission assessment completion date of July 9, and the encoded by date of July 15, 2002 included in the example are also incorrect. The correct admission assessment time period, as a result of an interruption in the stay as described in the final rule example, is July 3, 6, and 7, with July 7 being the assessment reference date, July 8 the completion date, and July 14, 2002, the encoded by date.

If, for example, the patient was admitted to the IRF on July 3, but the stay is interrupted on July 5, 2002, and the patient returns to the IRF before midnight of July 7, 2002, the admission assessment time period dates would be July 3, 4, and 7. In this case, the admission assessment reference date would be July 7, the completion date would be July 8, and the encoded by date would be July 14, 2002.

Discharge Assessment

Section 412.610, ''Assessment schedule,'' specifies the general rules for the admission assessment and the discharge assessment. As stated previously, the admission assessment time period is a span of time that covers calendar days 1 through 3 of the patient's current Medicare Part A fee-for-service hospitalization. The first day of the patient's IRF stay is counted as day 1 of the patient assessment schedule, with day 3 of the hospitalization being the admission assessment reference date. Section 412.610 specifies the general rule that the discharge assessment reference date is the day the first of the following two events occurs: (1) The patient is discharged from the IRF; or (2) the patient stops being furnished Medicare Part A fee-for-service IRF services. The discharge assessment time period includes the discharge assessment reference date and the two calendar days prior to the discharge assessment reference date.

Applying the admission assessment general rule means that a patient admitted on October 1, 2002, and discharged on October 4, 2002, would have an admission assessment time period of October 1, 2, and 3 (the first three days of the current Medicare Part A IRF hospitalization), with October 3 being the admission assessment reference date. Applying the discharge assessment general rule means that October 4, 2002 (the day the patient is discharged from the IRF) is the discharge assessment reference date, with October 2 and 3 (the two calendar days prior to the discharge assessment reference date) being part of the discharge assessment time period.

In this situation, the admission assessment time period and the discharge assessment time period both include October 2 and 3. However, on page 41327, we incorrectly stated that ''In addition, for the discharge assessment, in no case will the discharge assessment time period include a calendar day(s) prior to the admission assessment reference calendar date or the admission assessment reference calendar date itself.'' That statement is incorrect because there will be situations, such as when a patient's IRF stay is only 4 days in length, when it would be impossible to apply the admission assessment and discharge assessment general rules and not include the admission assessment reference date itself, or another day of the admission assessment time period, as part of the discharge assessment time period. Consequently, a patient who has a very short IRF stay may have a discharge assessment time period that includes (that is, overlaps) a calendar day(s) prior to the admission assessment reference calendar date or the admission assessment reference calendar date itself.

In order to correct for this overly broad statement, previously quoted from page 41327, that makes application of both the admission assessment and discharge assessment general rules impossible when a short stay causes the time periods for the admission and discharge assessments to overlap, we are adding, after the word ''itself'', the phrase, '', unless a patient's IRF length of stay causes these assessment periods to overlap.''

Transmission of Assessment Data

Under § 412.610, patient data are collected on the same IRF patient assessment instrument two times. The first time is during the admission assessment time period, and the second time is during the discharge assessment time period. Under § 412.614(c), we require that both the admission and discharge assessment data be transmitted together only one time after the patient is discharged. Because the discharge date is the sole basis for determining when the transmission of the data must occur, an event, such as an interruption of a stay, that occurs before the actual day of discharge will not affect any of the discharge assessment schedule dates, including the date to transmit the data. However, on page 41331 of the preamble and in § 412.618(c) on page 41390, we incorrectly stated that if an interruption

of a stay occurred for (that is, during) the admission assessment time period, the patient assessment instrument transmitted by date would be shifted forward. We are correcting the statement on page 41331 by removing the phrase ''and patient assessment instrument transmitted by date'', because an interruption of the stay, which occurs before the discharge date, has no effect on the ''transmitted by date.'' A corresponding correction to the regulations text at § 412.618(c) will be addressed in the next section of this correcting amendment.

Definition of a Discharge

As stated on page 41331 and § 412.602 of the final rule, a discharge of a Medicare patient occurs when—(1) the patient is formally released; (2) the patient stops receiving Medicare-covered Part A inpatient rehabilitation services; or (3) the patient dies in the inpatient rehabilitation facility. However, in defining a discharge, we inadvertently failed to account for situations where a patient stops receiving Medicare-covered Part A inpatient rehabilitation services, but meets the condition, under § 424.13(b), for continued hospitalization. Specifically, under § 424.13(b), a physician may certify or recertify the need for continued hospitalization if the physician finds that the patient could receive proper treatment in a skilled nursing facility (SNF) but no bed is available in a participating SNF. To account for situations where a patient meets the requirement at § 424.13(b) in our definition of a discharge, on page 41331, we are correcting the condition ''(2) the day on which the patient ceases to receive Medicare-covered Part A inpatient rehabilitation services'' by adding ''unless the patient qualifies for continued hospitalization under § 424.13(b) of the regulations.'' A corresponding correction to the regulations text at § 412.602 will be addressed in the next section of this correcting amendment.

Example of Computing a Facility's Federal Prospective Payment

The example on page 41367 of the preamble reflects an incorrect amount ($20,033.81) for the Federal Prospective Payment amounts associated with CMG 0111 (without comorbidities). Inserting the correct amount from Table 2 of the final rule ($19,071.89), the corrected adjusted payment for Facility A will be $24,133.91 and the corrected adjusted payment for Facility B will be $24,990.08. In addition, the line after the subtotal is incorrectly labeled as ''DSH adjustment'' and should be labeled ''LIP adjustment'' to indicate an adjustment for low-income patients as referred to throughout the final rule.

We also found and corrected other typographical errors.

Correction of Errors in the Preamble of the August 7, 2001 Final Rule

1. On page 41327, third column; third full paragraph, in line 17 from the bottom of the page, after the word ''itself'' add the following text: '', unless a patient's IRF length of stay causes these assessment periods to overlap.''

2. On page 41331, in the first column, in the next to last line add the word ''and'' before the word ''patient''.

3. On page 41331 in the first column, in the last line, and continuing in the second column, first and second lines, remove the following text, ''and patient assessment instrument transmitted by date''.

4. On page 41331, in the second column, line 19, the date ''July 6'' is corrected to read ''July 3''.

5. On page 41331, second column, line 20, the date ''July 7'' is corrected to read ''July 6'' and the date ''July 8'' is corrected to read ''July 7''.

6. On page 41331, second column, line 27, the date ''July 8'' is corrected to read ''July 7''.

7. On page 41331, second column, lines 29 to 30, the date ''July 9'' is corrected to read ''July 8''.

8. On page 41331, second column, lines 32 to 33, the date ''July 15, 2002'' is corrected to read ''July 14, 2002''.

9. On page 41331, third column, line 7, after the phrase ''(2) the day on which the patient ceases to receive Medicare-covered Part A inpatient rehabilitation services'', add the phrase, ''unless the patient qualifies for continued hospitalization under § 424.13(b) of the regulations''.

10. On page 41350, third column, line two, remove the number ''191''.

11. On page 41367, replace the label ''DSH Adjustment'' with ''LIP Adjustment'' and replace the values in the table labeled ''Examples of Computing a Facility's Federal Prospective Payment'' with the following:

	Facility A	Facility B
Federal Prospective Payment	$19,971.89	$19,971.89
Labor Share	× .72395	× .72395
Labor Portion of Federal Payment	$14,458.65	$14,458.65
Wage Index	× 0.987	× 1.234
Wage Adjusted Amount	$14,270.69	$17,841.97
Non-Labor Amount	+ 5,513.24	+ 5,513.24
Wage Adjusted Federal Payment	$19,783.93	$23,355.21
Rural Adjustment	× 1.1914	× 1.0000
Subtotal	$23,570.57	$23,355.21
LIP Adjustment	× 1.0239	× 1.070
Total Adjusted Federal Prospective Payment	$24,133.91	$24,990.08

12. On page 41367, first column, second paragraph from the bottom, the dollar amount of ''$24,208.73'' is corrected to read ''$24,133.91'' and the dollar amount of ''$25,067.56'' is corrected to read ''$24,990.08''.

Summary of Technical Corrections to the Regulations Text of the August 7, 2001 Final Rule

Definition of a Discharge

As stated in the previous section of this correcting amendment, we inadvertently failed to account for a patient that stops receiving Medicare-covered Part A inpatient rehabilitation services, but meets the condition, under § 424.13(b), for continued hospitalization in defining a discharge in § 412.602 of the final rule.

Specifically, under § 424.13(b), a physician may certify or recertify the need for continued hospitalization if the physician finds that the patient could receive proper treatment in a skilled nursing facility (SNF) but no bed is available in a participating SNF. To account for a patient who meets the requirement at § 424.13(b), we are correcting the second definition of a discharge on page 41388 under § 412.602 to read as follows: ''The patient stops receiving Medicare-covered Part A inpatient rehabilitation services, unless the patient qualifies for continued hospitalization under § 424.13(b) of this chapter''. This correction does not affect the criteria, under § 412.610(c)(2)(ii), to determine the discharge assessment reference date.

Criteria To Be Classified as an IRF

Our clearly stated intention in the preambles of both the November 3, 2000 proposed rule (65 FR 66304) and the final rule, was not to change the existing general criteria to be excluded from the acute care hospital prospective payment system (§ 412.22), or the specific criteria to be classified as an excluded rehabilitation hospital or rehabilitation unit (§§ 412.23, 412.25, 412.29, and 412.30) under subpart B of part 412 of the regulation. In § 412.604(b) on page 41388, we inadvertently failed to include reference to the general exclusion criteria under § 412.22 as a condition to be paid under the IRF PPS. In this document, we are correcting § 412.604(b) to state that subject to the special payment provisions of § 412.22(c), an inpatient rehabilitation facility must meet the general criteria of § 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 inpatient hospital prospective payment systems specified in § 412.1(a)(1).

Assessment Process for Interrupted Stays

We are making several technical corrections to § 412.618(c), on pages 41390 to 41391, which describes the ''Revised assessment schedule'' when an interruption of a stay occurs. The corrections we are making to § 412.618(c) conform the policies regarding the assessment process for interrupted stays to those stated in the corrected preamble to the regulation text.

Section 412.618(c)(1) of the final rule states that, ''If the interruption in the stay occurs before the admission assessment, the assessment reference date, completion dates, encoding dates, and data transmission dates for the admission and discharge assessments are advanced by the same number of calendar days as the length of the patient's interruption in the stay.'' The phrase ''occurs before the admission assessment'' is incorrect because an interruption of a stay affects the admission assessment schedule only if the interruption occurs during, not before, the admission assessment time period. Specifically, an interruption of a stay that occurs ''during the admission assessment time period'' results in a shifting of the relevant assessment schedule dates. We are correcting the phrase ''occurs before the admission assessment'' to read ''occurs during the admission assessment time period'' to accurately reflect when an interruption in a stay affects the assessment schedule as indicated in our policy described in the corrected preamble. In addition, the phrase ''data transmission dates'' in § 412.618(c)(1) of the final rule is incorrect because, as discussed earlier in this correcting amendment, an interruption of a stay does not affect the date of transmitting the assessment data. Specifically, the date to transmit admission and discharge assessment data together is based solely on the day that the patient is discharged. Thus, an interruption of a stay will not impact the data transmission date. We are correcting § 412.618(c)(1) to remove the reference to the ''data transmission dates'' and, thus, conform the regulations text to the corrected preamble.

Section 412.618(c)(2) of the final rule states that, ''If the interruption of the stay occurs after the admission assessment and before the discharge assessment, the completion date, encoding date, and data transmission date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.'' Under § 412.610(c)(1), the admission assessment schedule can only be established after the admission assessment time period is known. If an interruption of a stay occurs after the admission assessment time period (and before the discharge assessment), the admission assessment schedule, which has already been established, cannot be revised, contrary to what was incorrectly indicated in § 412.618(c)(2) of the final rule. Since the situation specified in § 412.618(c)(2) would never result in a revised assessment schedule, we are correcting § 412.618 by eliminating § 412.618(c)(2).

In summary, to conform the regulations text to the policy in the corrected preamble, § 412.618(c)(2) is removed, and the regulations text in formerly designated paragraph (c)(1) becomes paragraph (c), ''Revised assessment schedule.'' The corrected text of § 412.618(c) reads, ''If the interruption in the stay occurs during the admission assessment time period, the assessment reference date, completion date, and encoding date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.''

Special Payment Provision for Interrupted Stays

On page 41356 of the preamble of the final rule, we responded to a request to clarify how services during an interrupted stay would be paid if a beneficiary is discharged from the IRF to an acute care hospital. In our response to this comment, we stated that, under § 412.624(g), there would be no separate diagnostic related group (DRG) payment to the acute care hospital when the beneficiary is ''discharged and returns to the same IRF on the same day''. However, § 412.624(g)(1) incorrectly states that this provision applies to a patient with an ''interruption of one day or less''. Therefore, in order to conform the regulations text to the policy as stated in the preamble, we are correcting § 412.624(g)(1) to apply to a patient who is discharged and returns to the same IRF on the same day. Additionally, in our response to this comment, we correctly stated the policy in the preamble that if a beneficiary receives inpatient acute care hospital services, the acute care hospital can receive a DRG payment if the beneficiary is ''discharged from the IRF and does not return to that IRF by the end of that same day''. However, § 412.624(g)(2) in the final rule incorrectly states that this provision applies to a patient with an ''interruption of more than one day''. To conform the regulation text to the correction to § 412.624(g)(1) above and to the policy as stated in the preamble, we are correcting § 412.624(g)(2) to apply to a patient who is discharged and does not return to the same IRF on the same day.

Waiver of Proposed Rulemaking

We ordinarily publish a correcting amendment of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a correcting amendment such as this can take effect. We can waive this procedure, however, if we find good cause that a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of

finding and its reasons in the correcting amendment issued.

We find for good cause that it is unnecessary to undertake notice and public comment procedures because this correcting amendment does not make any substantive policy changes. This document makes technical corrections and conforming changes to the August 7, 2001 final rule. Therefore, for good cause, we waive notice and public comment procedures under 5 U.S.C. 553(b)(B).

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

Accordingly, 42 CFR chapter IV is corrected by making the following correcting amendments:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 412.602 [Amended]

2. In § 412.602, make the following corrections:

a. In the introductory text of the definition of ''Discharge,'' correct the phrase ''a inpatient'' to read ''an inpatient''.

b. In the definition of ''Discharge'', paragraph (2) is revised to read as follows:

§ 412.602 Definitions.

* * * * *

Discharge. * * *

(2) The patient stops receiving Medicare-covered Part A inpatient rehabilitation services, unless the patient qualifies for continued hospitalization under § 424.13(b) of this chapter; or

* * * * *

§ 412.604 [Amended]

3. In § 412.604, make the following corrections:

a. In paragraph (b), add the phrase ''general criteria set forth in § 412.22 and the'' before the word ''criteria''.

b. In paragraph (e)(1)(i), remove the closed parentheses after the word ''basis''.

c. In paragraph (e)(1)(iii), remove the ''s'' from ''practitioners''.

§ 412.610 [Amended]

4. In § 412.610, in paragraph (c)(2)(ii)(A), remove the abbreviation ''IRF'', and in its place, add the phrase ''inpatient rehabilitation facility''.

§ 412.618 [Amended]

5. In § 412.618, revise paragraph (c) to read as follows:

§ 412.618 Assessment process for interrupted stays.

* * * * *

(c) If the interruption in the stay occurs during the admission assessment time period, the assessment reference date, completion date, and encoding date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

§ 412.624 [Amended]

6. In § 412.624, make the following corrections:

a. In paragraph (a)(1), remove the phrase ''under this subchapter'' and in its place, add the phrase ''of this subchapter''.

b. In paragraph (c)(4), remove the phrase ''is the product'' and in its place, add the phrase ''are the product''.

c. In paragraph (e)(4), in the first sentence, remove the ''s'' from the word ''exceeds''.

d. Revise paragraph (g)(1) and the introductory text of paragraph (g)(2) to read as set forth below:

§ 412.624 Methodology for calculating the Federal prospective payment rates.

* * * * *

(g) * * *

(1) *Patient is discharged and returns on the same day.* Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will be the adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in § 412.618(a)(1). Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will only be made to the inpatient rehabilitation facility.

(2) *Patient is discharged and does not return by the end of the same day.* Payment for a patient who is discharged and does not return on the same day but does return to the same inpatient rehabilitation facility by or on midnight of the third day, defined as an interrupted stay under § 412.602, will be—

* * * * *

§ 412.626 [Amended]

7. In § 412.626, make the following corrections:

(a) In paragraph (b)(1), remove the acronym ''IRF'' and in its place, add the phrase ''inpatient rehabilitation facility''.

(b) In paragraph (b)(2), in the last sentence, remove the word, ''or'', and in its place, add the phrase, ''timely or is otherwise''.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

§ 413.1 [Amended]

2. In § 413.1, in paragraph (d)(2)(iv), after the word ''is'', add the word ''made''.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: June 26, 2002.

Ann Agnew,

Executive Secretary to the Department.

[FR Doc. 02–16476 Filed 6–28–02; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 64

[Docket No. FEMA–7787]

Suspension of Community Eligibility

AGENCY: Federal Emergency Management Agency, FEMA.

ACTION: Final rule.

SUMMARY: This rule identifies communities, where the sale of flood insurance has been authorized under the National Flood Insurance Program (NFIP), that are suspended on the effective dates listed within this rule because of noncompliance with the floodplain management requirements of the program. If the Federal Emergency Management Agency (FEMA) receives documentation that the community has adopted the required floodplain