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Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1540–P]

RIN 0938–AO16

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2007

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2007 (for discharges occurring on or after October 1, 2006 and on or before September 30, 2007) as required under section 1886(j)(3)(C) of the Social Security Act (the Act). Section 1886(j)(5) of the Act requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the inpatient rehabilitation facility prospective payment system's case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

We are proposing to revise existing policies regarding the prospective payment system within the authority granted under section 1886(j) of the Act. In addition, we are proposing to revise the current regulation text at 42 CFR 412.23(b)(2)(i) and (b)(2)(ii) to reflect the changes enacted under section 5005 of the Deficit Reduction Act of 2005.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 7, 2006.

ADDRESSES: In commenting, please refer to file code CMS–1540–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1540–P, P.O. Box 8012, Baltimore, MD 21244–8012.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1540–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the Hubert H. Humphrey (HHH) Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the Centers for Medicare & Medicaid Services (CMS) drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Pete Diaz, (410) 786–1235, for information regarding the 75 percent rule.

Susanne Seagrave, (410) 786–0044, for information regarding the new payment policy proposals.

Zinnia Ng, (410) 786–4587, for information regarding the wage index and prospective payment rate calculation.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1540–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Acronyms

Because of the many terms to which we refer by acronym in this proposed rule, we are listing the acronyms used and their corresponding terms in alphabetical order below.

ADC Average Daily Census
SCA Adminstrative Simplification Compliance Act of 2002, Pub. L. 107–105
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CBSA Core-Based Statistical Area
CCR Cost-to-Charge Ratio
CFR Code of Federal Regulations
CMG Case-Mix Group
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DRG Diagnosis-Related Group
DSH Disproportionate Share Hospital
ECI Employment Cost Indexes
FI Fiscal Intermediary
FR Federal Register
FY Federal Fiscal Year
GDP Gross Domestic Product
HHH Hubert H. Humphrey Building
HIPAA Health Insurance Portability and Accountability Act, Pub. L. 104–191
HIT Health Information Technology
IFMC Iowa Foundation for Medical Care
IPPS Inpatient Prospective Payment System
IRF Inpatient Rehabilitation Facility
IRF–PAI Inpatient Rehabilitation Facility-Patient Assessment Instrument
IRF PPS Inpatient Rehabilitation Facility Prospective Payment System
IRVEN Inpatient Rehabilitation Validation and Entry
LIP Low-Income Percentage
MEDPAR Medicare Provider Analysis and Review
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MSA Metropolitan Statistical Area
NAICS North American Industrial Classification System
OMB Office of Management and Budget
PAC Post Acute Care
PAI Patient Assessment Instrument
PPS Prospective Payment System
RAND RAND Corporation
RFA Regulatory Flexibility Act, Pub. L. 96–354
RIA Regulation Impact Analysis
RIC Rehabilitation Impairment Category
RPL Rehabilitation, Psychiatric, and Long-Term Care Hospital Market Basket
SCHIP State Children's Health Insurance Program
SIC Standard Industrial Code
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248

I. Background

[If you choose to comment on issues in this section, please include the caption ''Background'' at the beginning of your comments.]

A. Historical Overview of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) for Fiscal Years (FYs) 2002 Through 2005

Section 4421 of the Balanced Budget Act of 1997 (BBA, Pub. L. 105–33), as amended by section 125 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (BBRA, Pub. L. 106–113), and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, Pub. L. 106–554), provides for the implementation of a per discharge prospective payment system (PPS), through section 1886(j) of the Social Security Act (the Act), for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (hereinafter referred to as IRFs).

Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of approved educational activities, bad debts, and other services or items outside the scope of the IRF PPS. Although a complete discussion of the IRF PPS provisions appears in the August 7, 2001 final rule (66 FR 41316) as revised in the FY 2006 IRF PPS final rule (70 FR 47880), we are providing below a general description of the IRF PPS for fiscal years (FYs) 2002 through 2005.

Under the IRF PPS from FY 2002 through FY 2005, as described in the August 7, 2001 final rule, the Federal prospective payment rates were computed across 100 distinct case-mix groups (CMGs). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed five special CMGs to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors accounted for the relative difference in resource use across all CMGs. Within each CMG, we created tiers based on the estimated effects that certain comorbidities would have on resource use.

We established the Federal PPS rates using a standardized payment conversion factor (formerly referred to as the budget neutral conversion factor). For a detailed discussion of the budget neutral conversion factor, please refer to our August 1, 2003 final rule (68 FR 45674, 45684 through 45685). In the FY 2006 IRF PPS final rule (70 FR 47880), we discussed in detail the methodology for determining the standard payment conversion factor.

We applied the relative weighting factors to the standard payment conversion factor to compute the unadjusted Federal prospective payment rates. Under the IRF PPS from FYs 2002 through 2005, we then applied adjustments for geographic variations in wages (wage index), the percentage of low-income patients, and location in a rural area (if applicable) to the IRF's unadjusted Federal prospective payment rates. In addition, we made adjustments to account for short-stay transfer cases, interrupted stays, and high cost outliers.

For cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, we determined the final prospective payment amounts using the transition methodology prescribed in section 1886(j)(1) of the Act. Under this provision, IRFs transitioning into the PPS were paid a blend of the Federal IRF PPS rate and the payment that the IRF would have received had the IRF PPS not been implemented. This provision also

allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the Federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs now consist of 100 percent of the Federal IRF PPS rate.

We established a CMS Web site as a primary information resource for the IRF PPS. The Web site URL is *http://www.cms.hhs.gov/InpatientRehabFacPPS/* and may be accessed to download or view publications, software, data specifications, educational materials, and other information pertinent to the IRF PPS.

B. Revisions Made by the IRF PPS Final Rule for FY 2006

Section 1886(j) of the Act confers broad statutory authority to propose refinements to the IRF PPS. The refinements described in this section were finalized in the FY 2006 IRF PPS final rule (70 FR 47880). The provisions of the FY 2006 IRF PPS final rule became effective for discharges beginning on or after October 1, 2005. We published correcting amendments to the FY 2006 IRF PPS final rule in the **Federal Register** on September 30, 2005 (70 FR 57166). Any reference to the FY 2006 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments.

In the FY 2006 final rule (70 FR 47880 and 70 FR 57166), we finalized a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. These refinements were based on analyses by the RAND Corporation (RAND), a non-partisan economic and social policy research group, using calendar year 2002 and FY 2003 data. These were the first significant refinements to the IRF PPS since its implementation. In conducting the analysis, RAND used claims and clinical data for services furnished after the implementation of the IRF PPS. These newer data sets were more complete, and reflected improved coding of comorbidities and patient severity by IRFs. The researchers were able to use new data sources for imputing missing values and more advanced statistical approaches to complete their analyses. The RAND reports supporting the refinements made to the IRF PPS are available on the CMS Web site at: *http://www.cms.hhs.gov/InpatientRehabFacPPS/09_Research.asp.*

The final key policy changes, effective for discharges occurring on or after October 1, 2005, are discussed in detail in the FY 2006 IRF PPS final rule (70 FR 47880 and 70 FR 57166). The following is a brief summary of the key policy changes:

The FY 2006 IRF PPS final rule (70 FR 47880, 47917 through 47928) included the adoption of the Office of Management and Budget's (OMB's) Core-Based Statistical Area (CBSA) market area definitions in a budget neutral manner. This geographic adjustment was made using the most recent final wage data available (that is, pre-reclassification and pre-floor hospital wage index based on FY 2001 hospital wage data). In addition, we implemented a budget-neutral three-year hold harmless policy for rural IRFs in FY 2005 that became urban in FY 2006, as described in the FY 2006 IRF PPS final rule (70 FR 47880, 47923 through 47925).

The FY 2006 final rule (70 FR 47880, 47904) also implemented a payment adjustment to account for changes in coding that did not reflect real changes in case mix. In that final rule, we reduced the standard payment amount by 1.9 percent to account for such changes in coding following implementation of the IRF PPS. Our contractors conducted a series of analyses to identify real case mix change over time and the effect of this change on aggregate IRF PPS payments. The contractors identified the impact of changing case mix on the IRF PPS payment ranges. From calendar year 1999 through calendar year 2002, the real change in IRFs' case mix ranged from negative 2.4 percent to positive 1.5 percent. They attributed the remaining change in IRF payments (between 1.9 percent and 5.8 percent) to coding changes. For FY 2006, we implemented a reduction in the standard payment amount based on the lowest of these estimates. At the time, we stated that we would continue to analyze the data and would make additional coding adjustments, as needed.

In addition, in the FY 2006 final rule (70 FR 47880, 47886 through 47904), we made modifications to the CMGs, tier comorbidities, and relative weights in a budget-neutral manner. The final rule included a number of adjustments to the IRF classification system that are designed to improve the system's ability to predict IRF costs. The data indicated that moving or eliminating some comorbidity codes from the tiers, redefining the CMGs, and other minor changes to the system would improve the ability of the classification system to ensure that Medicare payments to IRFs continue to be aligned with the costs of care. These refinements resulted in 87 CMGs using Rehabilitation Impairment Categories (RICs), functional status (motor and cognitive scores), and age (in some cases, cognitive status and age may not be factors in defining CMGs). The five special CMGs remained the same as they had been before FY 2006 and continue to account for very short stays and for patients who expire in the IRF.

In addition, the FY 2006 IRF PPS final rule (70 FR 47928 through 47932) implemented a new teaching status adjustment for IRFs, similar to the one adopted for inpatient psychiatric facilities. We implemented the teaching status adjustment in a budget neutral manner.

The FY 2006 IRF PPS final rule (70 FR 47880, 47908 through 47917) also revised and rebased the market basket. We finalized the use of a new market basket reflecting the operating and capital cost structures for rehabilitation, psychiatric, and long term care (RPL) hospitals to update IRF payment rates. The RPL market basket excludes data from cancer hospitals, children's hospitals, and religious non-medical institutions. In addition, we rebased the market basket to account for 2002-based cost structures for RPL hospitals. Further, we calculated the labor-related share using the RPL market basket. The FY 2006 IRF market basket increase factor was 3.6 percent and the RPL labor-related share was 75.865 percent.

In the FY 2006 final rule (70 FR 47880, 47932 through 47933), we updated the rural adjustment (from 19.14 percent to 21.3 percent), the low-income percentage (LIP) adjustment (from an exponent of 0.484 to an exponent of 0.6229), and the outlier threshold amount (from $11,211 to $5,129, as further revised in the FY 2006 IRF PPS correction notice (70 FR 57166, 57168)). We implemented the changes to the rural and the LIP adjustments in a budget neutral manner.

The final FY 2006 standard payment conversion factor, accounting for the refinements, was $12,762 (as discussed in the FY 2006 IRF PPS correction notice (70 FR 57166, 57168)).

C. Requirements for Updating the IRF PPS Rates

On August 7, 2001, we published a final rule entitled ''Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities'' in the **Federal Register** (66 FR 41316) that established a PPS for IRFs as authorized under section 1886(j) of the Act and codified at subpart P of part 412 of the Medicare regulations. In the August 7,

2001 final rule, we set forth the per discharge Federal prospective payment rates for FY 2002, which provided payment for inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IRF PPS. The provisions of the August 7, 2001 final rule were effective for cost reporting periods beginning on or after January 1, 2002. On July 1, 2002, we published a correcting amendment to the August 7, 2001 final rule in the **Federal Register** (67 FR 44073). Any references to the August 7, 2001 final rule in this proposed rule include the provisions effective in the correcting amendment.

Section 1886(j)(5) of the Act and § 412.628 of the regulations require the Secretary to publish in the **Federal Register**, on or before the August 1 that precedes the start of each new FY, the classifications and weighting factors for the IRF CMGs and a description of the methodology and data used in computing the prospective payment rates for the upcoming FY. On August 1, 2002, we published a notice in the **Federal Register** (67 FR at 49928) to update the IRF Federal prospective payment rates from FY 2002 to FY 2003 using the methodology as described in § 412.624. As stated in the August 1, 2002 notice, we used the same classifications and weighting factors for the IRF CMGs that were set forth in the August 7, 2001 final rule to update the IRF Federal prospective payment rates from FY 2002 to FY 2003. We continued to update the prospective payment rates in accordance with the methodology set forth in the August 7, 2001 final rule for each succeeding FY up to and including FY 2005. For FY 2006, however, we published a final rule that revised several IRF PPS policies (70 FR 47880), as summarized in sections I.B and I.C of this proposed rule. The provisions of the FY 2006 IRF PPS final rule became effective for discharges occurring on or after October 1, 2005. We published correcting amendments to the FY 2006 IRF PPS final rule in the **Federal Register** (70 FR 57166). Any reference to the FY 2006 IRF PPS final rule in this proposed rule includes the provisions effective in the correcting amendments.

In this proposed rule for FY 2007, we are proposing to update the IRF Federal prospective payment rates. In addition, we will update the cost-to-charge ratios from FY 2006 to FY 2007 and the outlier threshold. We are also proposing a one-time, 2.9 percent reduction to the FY 2007 standard payment amount to account for changes in coding practices that do not reflect real changes in case mix. (See section III.A of this proposed rule for further discussion of the proposed reduction of the standard payment amount to account for coding changes.)

We are also proposing changes to the tier comorbidities and the relative weights to ensure that IRF PPS payments reflect, as closely as possible, the costs of caring for patients in IRFs. (See section II for a detailed discussion of these proposed changes.) The proposed FY 2007 Federal prospective payment rates would be effective for discharges occurring on or after October 1, 2006 and on or before September 30, 2007.

In addition, we are proposing to revise the regulation text in § 412.23(b)(2)(i) and § 412.23(b)(2)(ii) to reflect the statutory changes in section 5005 of the Deficit Reduction Act of 2005 (DRA, Pub. L. 109–171). The proposed regulation text change would prolong the overall duration of the phased transition to the full 75 percent threshold established in current regulation text in § 412.23(b)(2)(i) and § 412.23(b)(2)(ii), by extending the transition's current 60 percent phase for an additional 12 months.

D. Operational Overview of the Current IRF PPS

As described in the August 7, 2001 final rule, upon the admission and discharge of a Medicare Part A fee-for-service patient, the IRF is required to complete the appropriate sections of a patient assessment instrument, the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI). All required data must be electronically encoded into the IRF-PAI software product. Generally, the software product includes patient grouping programming called the GROUPER software. The GROUPER software uses specific Patient Assessment Instrument (PAI) data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The GROUPER software produces a five-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last four digits represent the distinct CMG number. (Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available at the CMS Web site at *http://www.cms.hhs.gov/InpatientRehabFacPPS/06_Software.asp)*

Once a patient is discharged, the IRF completes the Medicare claim (UB–92 or its equivalent) using the five-digit CMG number and sends it to the appropriate Medicare fiscal intermediary (FI). Claims submitted to Medicare must comply with both the Administrative Simplification Compliance Act (ASCA, Pub. L. 107–105), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Pub. L. 104–191). Section 3 of the ASCA amends section 1862(a) of the Act by adding paragraph (22) which requires the Medicare program, subject to section 1862(h) of the Act, to deny payment under Part A or Part B for any expenses for items or services ''for which a claim is submitted other than in an electronic form specified by the Secretary.'' Section 1862(h) of the Act, in turn, provides that the Secretary shall waive such denial in two types of cases and may also waive such denial ''in such unusual cases as the Secretary finds appropriate.'' See also the interim final rule on Electronic Submission of Medicare Claims (68 FR 48805, August 15, 2003). Section 3 of the ASCA operates in the context of the administrative simplification provisions of HIPAA, which include, among others, the requirements for transaction standards and code sets codified as 45 CFR parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered providers, to conduct covered electronic transactions according to the applicable transaction standards. (See the program claim memoranda issued and published by CMS at: *http://www.cms.hhs.gov/ElectronicBillingEDITrans/* and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600. Instructions for the limited number of claims submitted to Medicare on paper are located in section 3604 of Part 3 of the Medicare Intermediary Manual.)

The Medicare FI processes the claim through its software system. This software system includes pricing programming called the PRICER software. The PRICER software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the new teaching status adjustment that became effective

as of FY 2006, as discussed in the FY 2006 IRF PPS final rule (70 FR 47880).

E. Brief Summary of Proposed Revisions to the IRF PPS for FY 2007

In this proposed rule, we are proposing to make the following revisions and updates:

- Revise the IRF GROUPER software and the relative weight and average length of stay tables based on re-analysis of the data by CMS and our contractor, the RAND Corporation, as discussed in section II of this proposed rule.
- Reduce the standard payment amount by 2.9 percent to account for coding changes, as discussed in section III.A of this proposed rule.
- Update the FY 2007 IRF PPS payment rates by the proposed market basket, as discussed in section III.B of this proposed rule.
- Update the FY 2007 IRF PPS payment rates by the proposed labor related share, the wage indexes, and the second year of the hold harmless policy in a budget neutral manner, as discussed in sections III.C through G of this proposed rule.
- Update the outlier threshold for FY 2007 to $5,609, as discussed in section IV.A of this proposed rule.
- Update the urban and rural national cost-to-charge ratio ceilings for purposes of determining outlier payments under the IRF PPS and propose clarifications to the methodology described in the regulation text, as discussed in section IV.B of this proposed rule.
- Revise the regulation text at § 412.23(b)(2)(i) and § 412.23(b)(2)(ii) to reflect section 5005 of the DRA, which maintains the compliance percentage requirement transition at its current 60 percent phase for an additional 12 months, as discussed in section VI of this proposed rule.

II. Refinements to the Patient Classification System

[If you choose to comment on issues in this section, please include the caption ''Refinements to the Patient Classification System'' at the beginning of your comments.]

A. Proposed Changes to the Existing List of Tier Comorbidities

As discussed in the FY 2006 IRF PPS final rule (70 FR 47880, 47888 through 47892), we finalized several changes to the comorbidity tiers associated with the CMGs for FY 2006.

A comorbidity is a specific patient condition that is secondary to the patient's principal diagnosis or impairment. We use the patient's principal diagnosis or impairment to classify the patient into a rehabilitation impairment category (RIC), and then we use the patient's secondary diagnoses (or comorbidities) to determine whether to classify the patient into a higher-paying tier. A patient could have one or more comorbidities present during the inpatient rehabilitation stay. Our analysis for the August 7, 2001 final rule (66 FR 41316) found that the presence of certain comorbidities could have a major effect on the cost of furnishing inpatient rehabilitation care. We also found that the effect of comorbidities varied across RICs, significantly increasing the costs of patients in some RICs, while having no effect in others. Therefore, in determining whether the presence of a certain comorbidity should trigger placement in a higher-paying tier, we considered whether the comorbidity was an inherent part of the diagnosis that assigned the patient to the RIC. If it was an inherent part of the diagnosis, we excluded it from the RIC.

The changes for FY 2006 included removing several tier comorbidity codes that RAND's analysis found were no longer positively related to treatment costs, moving the comorbidity code for patients needing dialysis to tier 1, and moving certain comorbidity codes among tiers based on their marginal cost, as determined by RAND's regression analysis. In accordance with the final rule, we implemented these changes by updating the IRF PPS GROUPER software for discharges occurring on or after October 1, 2005.

In the FY 2006 IRF PPS final rule (70 FR 47880, 47892), we explained that the purpose of these changes was to place comorbidity codes in tiers based on RAND's analysis of how much the associated comorbidity would increase the costs of care in the IRF. (RAND's detailed analysis and methodology can be found in their report ''Preliminary Analyses for Refinement of the Tier Comorbidities in the Inpatient Rehabilitation Facility Prospective Payment System,'' which is available on their Web site at *http://www.rand.org/pubs/technicalreports/TR201/*).

After publishing the FY 2006 IRF PPS final rule, we continued to monitor the IRF classification system. As a result of our review and an analysis of recently updated data from RAND, we are proposing to implement some additional refinements (described below) to the comorbidity tiers for FY 2007 to ensure that IRF PPS payments continue to reflect as accurately as possible the costs of care in IRFs.

Section 1886(j)(2)(C)(i) of the Act requires the Secretary from time to time to adjust the classifications and weighting factors for the IRF case-mix classification system as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under the IRF PPS, and other factors which may affect the relative use of resources.

Accordingly, as described below, we propose to revise the tier comorbidity list in the IRF GROUPER for FY 2007 to ensure that the list appropriately reflects current ICD–9–CM national coding guidelines (as discussed below) and to ensure that the comorbidity codes are in the most appropriate tiers, based on RAND's analysis of the amount the associated comorbidities add to treatment costs. We are proposing the following five types of changes to the list of tier comorbidities in the IRF PPS GROUPER for FY 2007:

- Adding four comorbidity codes, as shown in Table 1.
- Deleting five comorbidity codes, as shown in Table 2.
- Continuing to update the tier comorbidities in the IRF GROUPER, as appropriate, to reflect ICD–9–CM national coding guidelines, as discussed below.
- Moving nine comorbidity codes from tier 2 to tier 3, as shown in Table 3.
- Deleting all category codes from the IRF GROUPER, as shown in Table 4.

We note that the proposed revisions to the IRF GROUPER described in this section are subject to change for the final rule based on the results of updated analysis.

The proposed changes listed below in Tables 1 and 2 are related to the monitoring and updating of the comorbidity tiers that CMS has been doing on an annual basis since we first implemented the IRF PPS, as described in detail below. We will continue to provide ongoing monitoring of additions, deletions, and changes to the ICD–9 coding structure, in order to ensure that the list of tier comorbidities in the IRF GROUPER is as consistent as possible with current national coding guidelines (as discussed below).

Each year since 1986, the National Center for Health Statistics (NCHS) and CMS have issued new diagnosis and procedure codes for the International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM). The ICD–9–CM Coordination and Maintenance Committee, sponsored jointly by NCHS and CMS, is responsible for determining these new code assignments each year. The new ICD–9 codes generally become effective on October 1 of each year, and replace previously assigned ''code equivalents.'' However, the ICD–9–CM Coordination and Maintenance Committee recently

indicated that it may begin updating the ICD–9 codes twice a year. A mid-year revision of the code assignments has not occurred yet, but we will monitor any such revisions that may occur and update the IRF coding instructions, as appropriate.

In order to ensure that the list of tier comorbidities accurately reflects changes to the ICD–9–CM codes, we propose to continue to update the list of ICD–9 codes in the IRF GROUPER software, as appropriate. For example, to the extent that the ICD–9–CM Coordination and Maintenance Committee changes an ICD–9 code for a comorbid condition on our tier comorbidity list into one or more codes that provide additional detail, we are proposing (as a general rule) to update the IRF GROUPER software to reflect the new codes. However, we recognize that there may be situations in which the addition of one or more of these new codes to the list of tier comorbidities may not be appropriate. For example, a situation could occur in which an ICD–9 code for a particular condition is divided into two more detailed codes, one of which represents a condition that generally increases the costs of care in an IRF and one of which does not. In such a case, we may propose through notice and comment procedures to delete the code that does not reflect increased costs of care in an IRF from the list of tier comorbidities in the IRF GROUPER software.

We propose to continue to indicate changes to the GROUPER software that reflect national coding guidelines by posting a complete ICD–9 table, including new, discontinued, and modified codes, on the IRF PPS Web site. We also propose to continue to report the complete list of ICD–9 codes associated with the tiers in the IRF GROUPER documentation, which is also posted on the IRF PPS Web site.

In addition, we propose that the finalized list of tier comorbidities for FY 2007 that we are proposing to post on the IRF PPS website and in the IRF GROUPER documentation (also posted on the IRF PPS website) as of October 1, 2006 would generally reflect Appendix C of the August 7, 2001 final rule (66 FR 41316, 41414 through 41427) as modified by the tier comorbidity changes adopted in the FY 2006 IRF PPS final rule (70 FR 47880) and any tier comorbidity changes as adopted in the FY 2007 IRF PPS final rule, as well as changes adopted due to ICD–9 national coding guideline updates. This version would constitute the baseline for any future updates to the tier comorbidities. Moreover, we note that, if we decide that a substantive change to the comorbid conditions on the list of tier comorbidities in the IRF GROUPER is appropriate, we will propose the change through notice and comment procedures.

Accordingly, in Table 1, we propose to add comorbidity codes 466.11, 466.19, 282.68, and 567.29 to the GROUPER for FY 2007 to be consistent with the national ICD–9–CM coding guidelines, as discussed above. In Table 1, on the basis of RAND's analysis, we also indicate the proposed tier assignment for each ICD–9 comorbidity code and any applicable RIC exclusions.

TABLE 1.—ICD–9 CODES WE PROPOSE TO ADD TO THE IRF PPS GROUPER

ICD–9–CM	ICD–9–CM label	Tier	RIC exclusion
466.11	ACU BRONCHOLITIS D/T RSV	3	15
466.19	ACU BRNCHLTS D/T OTH ORG	3	15
282.68	OTH SICKLE-CELL DISEASE W/O CRISIS	3	None
567.29	OTH SUPPURATIVE PERITONITIS	3	None

In Table 2, we list all of the comorbidity codes that we propose to delete from the IRF GROUPER for FY 2007. The clinical conditions that these codes represent were not part of the initial list of tier comorbidities in Appendix C of the August 7, 2001 final rule (66 FR 41316, 41414 through 41427), but we inadvertently added these codes to the IRF GROUPER in our annual GROUPER updating process. Thus, we are proposing to delete these codes from the tier comorbidities for FY 2007.

TABLE 2.—PROPOSED ICD–9 CODES TO BE DELETED FROM THE IRF PPS GROUPER

ICD–9–CM	ICD–9–CM label	Tier
453.40	VEN EMBOL THRMBS UNSPEC DP VSLS LWR EXTREM	3
453.41	VEN EMBOL THRMBS DP VSLS PROX LWR EXTREM	3
453.42	VEN EMBOL THRMBS DP VSLS DIST LWR EXTREM	3
799.01	ASPHYXIA	3
799.02	HYPOXEMIA	3

Finally, in Table 3, we list the ICD–9 codes that we propose to move to a different tier to reflect the amount that the associated comorbidities increase the costs of care in the IRF. In the FY 2006 IRF GROUPER, we placed all of these codes in tier 2 based on the most up-to-date list of tier comorbidities we had at the time CMS published the FY 2006 IRF PPS final rule. We have recently reanalyzed the data and found that these codes should be in tier 3, based on the amount that RAND's updated analysis shows that the associated comorbidities increase the costs of treatment in IRFs. Thus, we propose to move the ICD–9 codes listed in Table 3 from tier 2 to tier 3, so that IRF PPS payments will continue to reflect as closely as possible the costs of care.

TABLE 3.—PROPOSED ICD–9 CODES TO BE MOVED FROM TIER 2 TO TIER 3 IN THE IRF PPS GROUPER

ICD–9–CM	ICD–9–CM label	Tier	RIC exclusion
112.4	CANDIDIASIS OF LUNG	3	15
112.5	DISSEMINATED CANDIDIASIS	3	None
112.81	CANDIDAL ENDOCARDITIS	3	14
112.83	CANDIDAL MENINGITIS	3	03,05
112.84	CANDIDAL ESOPHAGITIS	3	None
785.4	GANGRENE	3	10,11
995.90	SIRS NOS	3	None
995.91	SIRS INF W/O ORG DYS	3	None
995.92	SIRS INF W ORG DYS	3	None
995.93	SIRS NON-INF W/O ORG DYS	3	None
995.94	SIRS NON-INF W ORG DYS	3	None

In our ongoing fiscal oversight of the IRF PPS, we will continue closely monitoring providers' use of the ICD–9 codes that increase IRF payments. To the extent that we find any inappropriate coding of particular ICD–9 codes that increase payments, we may reconsider the appropriateness of their inclusion on the list of tier comorbidities in the future.

Finally, in order to clarify the ICD–9 comorbidity codes we use to increase payments to IRFs, we propose to remove the category codes listed in Appendix C of the August 7, 2001 final rule (66 FR 41316, 41414 through 41427). We use the term ''category code'' to refer to a three-digit ICD–9 code for which one or more four- or five-digit ICD–9 codes exist to describe the same condition.

Appendix C of the August 7, 2001 final rule lists both ICD–9–CM codes and category codes to identify the comorbidity tiers. The category codes in that Appendix C are identified with an asterisk (*).

ICD–9–CM diagnosis codes are composed of codes with three, four, or five digits. Occasionally, three digit codes are complete ICD–9–CM codes (examples include 037 (TETANUS) and 042 (HUMAN IMMUNODEFICIENCY VIRUS (HIV) DISEASE)), and thus should be used to code comorbidities on the IRF–PAI form. However, codes with three digits are generally included in the ICD–9–CM coding system as the heading of a category of codes that are further subdivided using a fourth and/or fifth digit to provide greater detail. In most cases, it is inappropriate for providers to use a category code to indicate a comorbidity on the IRF–PAI form because the national ICD–9–CM coding guidelines require use of the more detailed codes. The national ICD–9–CM coding guidelines (published in the introduction to all releases of the ICD–9–CM codes themselves), were adopted, along with the ICD–9–CM codes themselves, as the standard medical data code set in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

To avoid any confusion regarding the fact that category codes should not be used to indicate comorbidities on the IRF–PAI form, we propose to remove the category codes from the tier comorbidities in the IRF GROUPER. This is consistent with the ICD–9–CM national coding guidelines. Table 4 contains the list of category codes we are proposing to delete from the list of tier comorbidities in the IRF GROUPER.

We note that three of the codes listed in Table 4, 998.3 (POSTOP WOUND DISRUPTION), 567.2 (SUPPURAT PERITONITIS NEC), and 567.8 (PERITONITIS NEC), were listed in Appendix C of the August 7, 2001 final rule (70 FR 41316, 41414 through 41427) without asterisks because they were not category codes at the time, but we are proposing to delete them from the IRF GROUPER now because they became category codes in 2002 and 2005. In 2002, the ICD–9–CM Coordination and Maintenance Committee created ICD–9 codes 998.31 and 998.32 as more specific codes for the condition that was coded using 998.3 before 2002. Similarly, in 2005, the committee created ICD–9 codes 567.21, 567.22, 567.23, and 567.29 as more specific codes for the condition that was coded using 567.2 before 2005, and codes 567.81, 567.82, and 567.89 as more specific codes for the condition that was coded using 567.8 before 2005. Once the committee introduced these more specific codes, 998.3, 567.2, and 567.8 became category codes. For this reason, we are proposing to delete them from the IRF GROUPER along with the other category codes. ICD–9 codes 998.31, 998.32, 567.21, 567.22, 567.23, 567.29, 567.81, 567.82, and 567.89 will be included in the IRF GROUPER, but we will monitor these codes carefully to ensure that they are being used properly.

TABLE 4.—CATEGORY CODES WE PROPOSE TO DELETE FROM THE IRF GROUPER

Category code	Category code label
011.	PULMONARY TUBERCULOSIS.
011.0	TB OF LUNG, INFILTRATIVE.
011.1	TB OF LUNG, NODULAR.
011.2	TB OF LUNG W CAVITATION.
011.3	TUBERCULOSIS OF BRONCHUS.
011.4	TB FIBROSIS OF LUNG.
011.5	TB BRONCHIECTASIS.
011.6	TUBERCULOUS PNEUMONIA.
011.7	TUBERCULOUS PNEUMOTHORAX.
011.8	PULMONARY TB NEC.
011.9	PULMONARY TB NOS.
012.	OTHER RESPIRATORY TB.
012.0	TUBERCULOUS PLEURISY.
012.1	TB THORACIC LYMPH NODES.

TABLE 4.—CATEGORY CODES WE PROPOSE TO DELETE FROM THE IRF GROUPER—Continued

Category code	Category code label
012.2	ISOLATED TRACH/BRONCH TB.
012.3	TUBERCULOUS LARYNGITIS.
012.8	RESPIRATORY TB NEC.
013.	CNS TUBERCULOSIS.
013.0	TUBERCULOUS MENINGITIS.
013.1	TUBERCULOMA OF MENINGES.
013.2	TUBERCULOMA OF BRAIN.
013.3	TB ABSCESS OF BRAIN.
013.4	TUBERCULOMA SPINAL CORD.
013.5	TB ABSCESS SPINAL CORD.
013.6	TB ENCEPHALITIS/MYELITIS.
013.8	CNS TUBERCULOSIS NEC.
013.9	CNS TUBERCULOSIS NOS.
014.	INTESTINAL TB.
014.0	TUBERCULOUS PERITONITIS.
014.8	INTESTINAL TB NEC.
015.	TB OF BONE AND JOINT.
015.0	TB OF VERTEBRAL COLUMN.
015.1	TB OF HIP.
015.2	TB OF KNEE.
015.5	TB OF LIMB BONES.
015.6	TB OF MASTOID.
015.7	TB OF BONE NEC.
015.8	TB OF JOINT NEC.
015.9	TB OF BONE & JOINT NOS.
016.	GENITOURINARY TB.
016.0	TB OF KIDNEY.
016.1	TB OF BLADDER.
016.2	TB OF URETER.
016.3	TB OF URINARY ORGAN NEC.
016.4	TB OF EPIDIDYMIS.
016.5	TB MALE GENITAL ORG NEC.
016.6	TB OF OVARY AND TUBE.
016.7	TB FEMALE GENIT ORG NEC.
016.9	GENITOURINARY TB NOS.
017.	TUBERCULOSIS NEC.
017.0	TB SKIN & SUBCUTANEOUS.
017.1	ERYTHEMA NODOSUM IN TB.
017.2	TB OF PERIPH LYMPH NODE.
017.3	TB OF EYE.
017.4	TB OF EAR.
017.5	TB OF THYROID GLAND.
017.6	TB OF ADRENAL GLAND.
017.7	TB OF SPLEEN.
017.8	TB OF ESOPHAGUS.
017.9	TB OF ORGAN NEC.
018.	MILIARY TUBERCULOSIS.
018.0	ACUTE MILIARY TB.
018.8	MILIARY TB NEC.
018.9	MILIARY TUBERCULOSIS NOS.
038.1	STAPHYLOCOCC SEPTICEMIA.
038.4	GRAM-NEG SEPTICEMIA NEC.
115.	HISTOPLASMOSIS.
115.0	HISTOPLASMA CAPSULATUM.
115.1	HISTOPLASMA DUBOISII.
115.9	HISTOPLASMOSIS UNSPEC.
415.1	PULMON EMBOLISM/INFARCT.
441.0	DISSECTING ANEURYSM.
453.	OTH VENOUS THROMBOSIS.
466.1	ACUTE BRONCHIOLITIS.
482.8	BACTERIAL PNEUMONIA NEC.
567.2	SUPPURAT PERITONITIS NEC.
567.8	PERITONITIS NEC.
682.	OTHER CELLULITIS/ABSCESS.
998.3	POSTOP WOUND DISRUPTION.
998.5	POSTOPERATIVE INFECTION.

As explained in detail below, we propose to apply all of these proposed changes to the tier comorbidities and the proposed changes to the CMG relative weights (described below) in a budget neutral manner. In the next section, we discuss our methodology for calculating the appropriate proposed budget neutrality factor.

B. Proposed Changes to the CMG Relative Weights

1. Development of CMG Relative Weights

Section 1886(j)(2)(B) of the Act requires that we assign an appropriate relative weight to each CMG. Relative weights account for the variance in cost per discharge and resource utilization among the payment groups and are a primary element of a case-mix adjusted PPS. Use of the most accurate CMG relative weights possible helps ensure that beneficiaries have access to care and receive the same appropriate services as other Medicare beneficiaries in the same CMG. In addition, prospective payments based on relative weights encourage provider efficiency and, therefore, help ensure a fair distribution of Medicare payments. Accordingly, as specified in § 412.620(b)(1), we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1.

2. Overview of the Methodology for Calculating the CMG Relative Weights

As indicated in the original IRF PPS final rule (66 FR 41316) and the FY 2006 IRF PPS final rule (70 FR 47880, 47887 through 47888), in calculating the relative weights, we use a hospital-specific relative value method to estimate operating (routine and ancillary services) and capital costs of IRFs. For FY 2007, we have used this same methodology to recalculate the relative weights to reflect the changes in comorbidity coding discussed in the next section of this proposed rule. The process used to calculate the relative weights for this proposed rule is shown below.

Step 1. We calculate the CMG relative weights by estimating the effects that comorbidities have on costs.

Step 2. We adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step.

Step 3. We use the adjusted costs from the second step to calculate ''relative adjusted weights'' in each CMG using the hospital-specific relative value method.

Step 4. We calculate the CMG relative weights by modifying the ''relative adjusted weight'' with the effects of the existence of the comorbidity tiers and normalizing the weights to 1.

3. Proposed Changes to the CMG Relative Weights and Average Lengths of Stay

Relative weights that account for the variance in cost per discharge and resource utilization among payment groups are a primary element of a case-mix adjusted PPS. The accuracy of the relative weights helps to ensure that payments reflect as closely as possible the relative costs of IRF patients and, therefore, that beneficiaries have access to care and receive appropriate services.

We are proposing to update the relative weights for FY 2007 based on a revised analysis of the data used to construct the relative weights for FY 2006. As part of CMS's ongoing monitoring of the IRF PPS, we recently reviewed the analysis for the FY 2006 final rule and discovered certain minor discrepancies. These discrepancies included ICD–9 codes in the 428.xx series that were not appropriately excluded from RIC 14, ICD–9 codes for tracheostomy that were incorrectly excluded from RIC 15, and two ICD–9 comorbidity codes—428.0 (CONGESTIVE HEART FAILURE UNSPECIFIED) and V43.3 (HEART VALVE REPLACED BY OTHER MEANS)—that were incorrectly included in the analysis. Thus, we are proposing to revise the CMG relative weights for FY 2007 because the data file used in RAND's analysis was recently revised to correct these minor discrepancies so the file would comport with the policies outlined in the FY 2006 IRF PPS final rule and this proposed rule. This led to changes in the CMG relative weights.

Based on RAND's reanalysis of the FY 2003 data using the corrected list of tier comorbidities and the same methodology we used to construct the CMG relative weights in the FY 2002 and FY 2006 IRF PPS final rules (66 FR 41316, 41351, and 70 FR 47880, 47887 through 47888), but using the correct tier comorbidities, we propose to update the CMG relative weights for FY 2007 to ensure that they continue to reflect as accurately as possible the costs of treatment for various types of patients in IRFs. Table 5 below contains the proposed new CMG relative weights and average lengths of stay for FY 2007. The proposed relative weights and average lengths of stay shown in Table 5 are subject to change for the final rule based on updated analysis and data.

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Table 5: Proposed FY 2007 IRF PPS Relative Weights and Average Lengths of Stay for Case-Mix Groups

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Proposed Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0101	Stroke M>51.05	0.7707	0.7303	0.6572	0.6347	8	11	9	9
0102	Stroke M>44.45 and M<51.05 and C>18.5	0.9493	0.8995	0.8095	0.7818	11	15	11	10
0103	Stroke M>44.45 and M<51.05 and C<18.5	1.1192	1.0605	0.9544	0.9218	14	13	12	12
0104	Stroke M>38.85 and M<44.45	1.1885	1.1260	1.0134	0.9787	13	14	13	13
0105	Stroke M>34.25 and M<38.85	1.4261	1.3512	1.2161	1.1745	16	17	16	15
0106	Stroke M>30.05 and M<34.25	1.6594	1.5722	1.4150	1.3666	18	20	18	18
0107	Stroke M>26.15 and M<30.05	1.9150	1.8145	1.6330	1.5771	21	23	21	20
0108	Stroke M<26.15 and A>84.5	2.2160	2.0997	1.8897	1.8250	28	29	25	24
0109	Stroke M>22.35 and M<26.15 and A<84.5	2.1998	2.0843	1.8758	1.8116	23	26	24	23
0110	Stroke M<22.35 and A<84.5	2.6287	2.4907	2.2416	2.1649	30	33	28	27
0201	Traumatic brain injury M>53.35 and C>23.5	0.8143	0.6806	0.6080	0.5647	10	9	9	8
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5	1.0460	0.8743	0.7810	0.7254	12	10	11	9
0203	Traumatic brain injury M>44.25 and C<23.5	1.2503	1.0450	0.9335	0.8671	15	15	12	12
0204	Traumatic brain injury M>40.65 and M<44.25	1.3390	1.1192	0.9998	0.9287	15	16	13	13

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Proposed Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0205	Traumatic brain injury M>28.75 and M<40.65	1.6412	1.3718	1.2254	1.1382	17	18	16	15
0206	Traumatic brain injury M>22.05 and M<28.75	2.1445	1.7924	1.6011	1.4873	23	22	21	20
0207	Traumatic brain injury M<22.05	2.7664	2.3122	2.0655	1.9185	35	29	26	25
0301	Non-traumatic brain injury M>41.05	1.1394	0.9533	0.8552	0.7772	12	12	11	10
0302	Non-traumatic brain injury M>35.05 and M<41.05	1.4875	1.2446	1.1164	1.0147	14	16	14	13
0303	Non-traumatic brain injury M>26.15 and M<35.05	1.7701	1.4810	1.3285	1.2074	20	19	17	16
0304	Non-traumatic brain injury M<26.15	2.4395	2.0410	1.8309	1.6640	32	25	23	21
0401	Traumatic spinal cord injury M>48.45	0.9587	0.8456	0.7722	0.6858	12	12	11	10
0402	Traumatic spinal cord injury M>30.35 and M<48.45	1.3256	1.1691	1.0676	0.9482	18	16	14	13
0403	Traumatic spinal cord injury M>16.05 and M<30.35	2.3069	2.0347	1.8580	1.6502	22	24	24	22
0404	Traumatic spinal cord injury M<16.05 and A>63.5	4.1542	3.6639	3.3458	2.9717	51	46	41	37
0405	Traumatic spinal cord injury M<16.05 and A<63.5	3.1371	2.7668	2.5266	2.2441	33	37	33	28
0501	Non-traumatic spinal cord injury M>51.35	0.7648	0.6455	0.5687	0.5071	9	8	8	7

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Proposed Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0502	Non-traumatic spinal cord injury M>40.15 and M<51.35	1.0262	0.8661	0.7630	0.6804	13	12	11	9
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15	1.3596	1.1476	1.0109	0.9014	15	15	13	12
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25	1.6984	1.4335	1.2628	1.1260	21	19	16	15
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25	2.0171	1.7025	1.4997	1.3373	23	22	19	18
0506	Non-traumatic spinal cord injury M<23.75	2.7402	2.3128	2.0374	1.8167	29	28	26	23
0601	Neurological M>47.75	0.8991	0.7330	0.7019	0.6522	11	10	9	9
0602	Neurological M>37.35 and M<47.75	1.1968	0.9757	0.9342	0.8682	13	13	13	12
0603	Neurological M>25.85 and M<37.35	1.5326	1.2495	1.1965	1.1118	17	17	15	15
0604	Neurological M<25.85	1.9592	1.5973	1.5295	1.4213	22	20	21	19
0701	Fracture of lower extremity M>42.15	0.9028	0.7717	0.7338	0.6617	12	11	10	9
0702	Fracture of lower extremity M>34.15 and M<42.15	1.1736	1.0033	0.9539	0.8602	13	14	13	12
0703	Fracture of lower extremity M>28.15 and M<34.15	1.4629	1.2506	1.1890	1.0722	16	17	16	14
0704	Fracture of lower extremity M<28.15	1.7969	1.5361	1.4605	1.3170	20	20	19	18

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Proposed Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0801	Replacement of lower extremity joint M>49.55	0.6537	0.5504	0.5131	0.4607	7	7	7	6
0802	Replacement of lower extremity joint M>37.05 and M<49.55	0.8542	0.7193	0.6704	0.6020	10	10	9	8
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5	1.2707	1.0700	0.9974	0.8956	15	15	13	12
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5	1.1040	0.9296	0.8665	0.7781	13	12	12	10
0805	Replacement of lower extremity joint M>22.05 and M<28.65	1.3927	1.1727	1.0931	0.9816	17	16	14	13
0806	Replacement of lower extremity joint M<22.05	1.6723	1.4082	1.3126	1.1787	18	19	17	15
0901	Other orthopedic M>44.75	0.8425	0.7641	0.6868	0.6120	10	11	10	9
0902	Other orthopedic M>34.35 and M<44.75	1.1088	1.0057	0.9039	0.8056	13	13	12	11
0903	Other orthopedic M>24.15 and M<34.35	1.4638	1.3277	1.1934	1.0635	18	19	16	15
0904	Other orthopedic M<24.15	1.8341	1.6636	1.4952	1.3325	25	23	21	19
1001	Amputation, lower extremity M>47.65	0.9625	0.8879	0.7957	0.7361	11	11	11	10

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Proposed Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
1002	Amputation, lower extremity M>36.25 and M<47.65	1.2709	1.1724	1.0507	0.9719	14	15	14	13
1003	Amputation, lower extremity M<36.25	1.7876	1.6491	1.4779	1.3671	19	22	19	18
1101	Amputation, non-lower extremity M>36.35	1.2554	1.0482	0.9225	0.8496	14	15	12	11
1102	Amputation, non-lower extremity M<36.35	1.8824	1.5717	1.3832	1.2739	19	19	18	17
1201	Osteoarthritis M>37.65	1.0177	0.8785	0.8182	0.7405	11	12	11	10
1202	Osteoarthritis M>30.75 and M<37.65	1.3168	1.1367	1.0586	0.9581	15	16	14	13
1203	Osteoarthritis M<30.75	1.6241	1.4020	1.3057	1.1817	21	19	17	16
1301	Rheumatoid, other arthritis M>36.35	1.0354	0.9636	0.8511	0.7429	12	13	11	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35	1.4321	1.3327	1.1772	1.0275	15	18	15	14
1303	Rheumatoid, other arthritis M<26.15	1.8250	1.6984	1.5002	1.3094	22	21	20	18
1401	Cardiac M>48.85	0.8160	0.7351	0.6534	0.5861	10	9	9	8
1402	Cardiac M>38.55 and M<48.85	1.1038	0.9944	0.8839	0.7928	12	13	12	11
1403	Cardiac M>31.15 and M<38.55	1.3705	1.2347	1.0975	0.9844	16	16	14	13
1404	Cardiac M<31.15	1.7370	1.5649	1.3910	1.2477	21	20	18	16
1501	Pulmonary M>49.25	0.9986	0.8870	0.7793	0.7399	11	13	10	10

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Proposed Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
1502	Pulmonary M>39.05 and M<49.25	1.2661	1.1246	0.9880	0.9381	13	15	12	12
1503	Pulmonary M>29.15 and M<39.05	1.5457	1.3730	1.2062	1.1453	16	16	15	15
1504	Pulmonary M<29.15	2.0216	1.7957	1.5775	1.4979	26	21	20	18
1601	Pain syndrome M>37.15	1.0070	0.8550	0.7774	0.6957	12	11	10	10
1602	Pain syndrome M>26.75 and M<37.15	1.3826	1.1739	1.0673	0.9552	15	17	14	13
1603	Pain syndrome M<26.75	1.7025	1.4455	1.3143	1.1762	19	19	18	16
1701	Major multiple trauma without brain or spinal cord injury M>39.25	0.9818	0.9641	0.8479	0.7368	12	12	11	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25	1.2921	1.2688	1.1158	0.9696	14	16	15	13
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05	1.5356	1.5080	1.3262	1.1524	17	20	18	16
1704	Major multiple trauma without brain or spinal cord injury M<25.55	1.9246	1.8899	1.6620	1.4443	26	26	22	19
1801	Major multiple trauma with brain or spinal cord injury M>40.85	1.1920	0.9866	0.8243	0.7342	15	13	13	10

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Proposed Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85	1.9058	1.5774	1.3179	1.1738	19	21	18	16
1803	Major multiple trauma with brain or spinal cord injury M<23.05	3.4302	2.8391	2.3721	2.1127	43	33	30	27
1901	Guillian Barre M>35.95	1.2399	1.0986	1.0965	0.9350	14	13	14	12
1902	Guillian Barre M>18.05 and M<35.95	2.3194	2.0552	2.0512	1.7491	27	25	25	23
1903	Guillian Barre M<18.05	3.3464	2.9651	2.9593	2.5235	37	39	31	33
2001	Miscellaneous M>49.15	0.8734	0.7381	0.6735	0.6084	10	10	9	8
2002	Miscellaneous M>38.75 and M<49.15	1.1447	0.9674	0.8827	0.7975	12	13	12	11
2003	Miscellaneous M>27.85 and M<38.75	1.4777	1.2488	1.1395	1.0294	16	16	15	14
2004	Miscellaneous M<27.85	1.9716	1.6662	1.5204	1.3735	25	22	20	18
2101	Burns M>0	2.1842	2.1842	1.6606	1.4587	27	24	20	17
5001	Short-stay cases, length of stay is 3 days or fewer				0.2201				2
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.6351				8
5102	Expired, orthopedic, length of stay is 14 days or more				1.5985				22

CMG	CMG Description (M=motor, C=cognitive, A=age)	Proposed Relative Weights				Proposed Average Length of Stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.7203				8
5104	Expired, not orthopedic, length of stay is 16 days or more				1.8784				24

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We propose to make these revisions to the tier comorbidities and the CMG relative weights in a budget neutral manner, consistent with the budget neutral manner in which we implemented changes to the IRF classification system for FY 2006 as described in the FY 2006 IRF PPS final rule (70 FR 47880, 47900). The purpose of these proposed changes to the IRF classification system is to ensure that the existing resources in the IRF PPS are distributed as accurately as possible among IRFs according to the relative costliness of the types of patients they treat.

To ensure that total estimated aggregate payments to IRFs do not change, we propose to apply a factor to the proposed standard payment amount to ensure that estimated aggregate payments due to the proposed changes to the tier comorbidities and the relative weights for FY 2007 are not greater or less than those estimated payments that would have been made in FY 2007 without the proposed changes. To calculate an appropriate proposed budget neutrality factor to apply to the standard payment amount, we propose to use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2007 (with no proposed changes to the tier comorbidities and the CMG relative weights).

Step 2. Apply the proposed changes to the tier comorbidities and the CMG relative weights (as discussed above) to calculate the estimated total amount of IRF PPS payments for FY 2007.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the proposed factor (1.0079) that would maintain the same total estimated aggregate payments in FY 2007 with and without the proposed changes to the tier comorbidities and the CMG relative weights.

Step 4. Apply the proposed budget neutrality factor (1.0079) to the FY 2006 IRF PPS standard payment amount after the application of the market basket update, the budget-neutral wage adjustment factor, and the proposed 2.9 percent reduction to account for coding changes that do not reflect real changes in case mix.

In section III.D and section III.E of this proposed rule, we discuss the methodology and the factor we would apply to the proposed standard payment amount for FY 2007. The proposed budget neutrality factor for the proposed revisions to the tier comorbidities and the CMG relative weights is subject to change for the final rule based on updated analysis and data.

III. Proposed FY 2007 Federal Prospective Payment Rates

[If you choose to comment on issues in this section, please include the caption ''Proposed FY 2007 Federal Prospective Payment Rates'' at the beginning of your comments.]

A. Proposed Reduction of the Standard Payment Amount To Account for Coding Changes

Section 1886(j)(2)(C)(ii) of the Act requires the Secretary to adjust the per payment unit payment rate for IRF services to eliminate the effect of coding or classification changes that do not reflect real changes in case mix, to the extent that such changes affect aggregate payments under the classification system. As described in detail in the FY 2006 IRF PPS final rule (70 FR 47880), in accordance with this section of the Act, we applied a one-time adjustment of 1.9 percent to the standard payment amount for FY 2006 to account for changes in provider coding practices that, according to research conducted by the RAND Corporation under contract with us, increased Medicare payments to IRFs between 1999 and 2002. In that final rule, we stated that the 1.9 percent reduction amount was ''the lowest possible amount of change attributable to coding change,'' as determined by RAND's analysis. Further, in that same final rule (70 FR 47880, 47906), we stated that we would continue to review the need for any further reduction in the standard payment amount in subsequent years as part of our overall monitoring and evaluation of the IRF PPS.

Since publication of the FY 2006 final rule, we have continued our fiscal oversight of the IRF PPS, and have conducted detailed analyses of IRF payment and utilization practices. We believe the results of these analyses (described in detail below) indicate that a large portion of the increase in Medicare payments under the IRF PPS can be attributed to changes in provider coding practices that do not reflect real changes in case mix. Upon review of these data, and in accordance with section 1886(j)(2)(C)(ii) of the Act, we propose to apply a one-time adjustment consisting of a 2.9 percent reduction to the proposed standard payment amount for FY 2007. This proposed adjustment would be in addition to the 1.9 percent adjustment implemented for FY 2006. Our rationale for these changes is described below. The resulting total adjustment of 4.8 percent (1.9 + 2.9 = 4.8) would still fall well within the range of estimates for reducing the standard payment amount as indicated by RAND's analysis. (RAND's analysis is detailed in the report entitled ''Preliminary Analyses of Changes in Coding and Case Mix Under the Inpatient Rehabilitation Facility Prospective Payment System,'' which

can be found on RAND's Web site at *http://www.rand.org/pubs/technical_reports/TR213/*.)

As we discussed in detail in the FY 2006 IRF PPS final rule (70 FR 47880), we had asked RAND to support us in developing potential refinements for the FY 2006 IRF PPS proposed rule (70 FR 30188). As part of this research, we asked RAND to examine changes in case mix and coding since the inception of the IRF PPS. We considered real changes in case mix to be those in which RAND found evidence that IRF patients required more resources in IRFs because they had more costly impairments, lower functional status, or more comorbidities in 2002 than in 1999. Conversely, we considered observed case mix changes to be due to changes in coding practices if RAND found that IRF patients had the same impairments, functional status, and comorbidities in 2002 as they did in 1999, but were coded differently resulting in higher payment. Based on these distinctions, we asked RAND to quantify the amount of change that was due to real case mix change and the amount that was due to coding. The purpose of this analysis was to ensure that changes in Medicare payments would accurately reflect the actual change in IRFs' patient case mix (that is, the true cost of treating patients), rather than changes in coding practices.

To examine the interaction between case mix and coding changes, RAND compared 2002 data from the first year of IRF PPS implementation with the 1999 (pre-PPS) data used to construct the IRF PPS. RAND's regression analysis of CY 2002 data showed that payments to IRFs were about 3.4 percent (or $140 million) higher than expected during 2002 due to changes in the classification of patients in IRFs that did not reflect real changes in case mix. As described below and in detail in the FY 2006 IRF PPS final rule (70 FR 47880, 47904 through 47906), RAND estimated that between 1.9 and 5.8 percent of the increase in payments to IRFs was attributable to coding.

As part of this study, RAND performed two sets of analyses on the 1999 (pre-PPS) and 2002 (post-PPS) data to derive this range of estimates. RAND based its first analysis on examination of IRF patients' acute care hospital records. Using this analysis, RAND found little evidence that the patients admitted to IRFs in 2002 had higher resource needs (that is, more impairments, lower functioning, or more comorbidities) than the patients admitted in 1999. In fact, most of the changes in case mix that RAND documented from the acute care hospital records implied that IRF patients should have been *less* costly to treat in 2002 than in 1999. For example, when it compared the results of the 2002 data with the 1999 data, RAND found a 16 percent decrease in the proportion of patients treated in IRFs following acute hospitalizations for stroke. Stroke patients tend to be relatively more costly than other types of patients for IRFs, because their care tends to be relatively more intensive. A decrease in the proportion of stroke patients relative to other types of patients, therefore, would likely contribute to a decrease in the overall expected costliness of IRF patients. (CMS is concerned about this finding because stroke patients represent a cohort of patients who have been demonstrated to benefit substantially from inpatient rehabilitation care. We will continue to monitor access to IRF care for stroke patients closely and will consider proposing appropriate refinements to the IRF PPS in the future to support access for this important population. We solicit comments on this issue.)

RAND also found a 22 percent increase in the proportion of cases treated in IRFs following a lower extremity joint replacement. Lower extremity joint replacement patients tend to be relatively less costly for IRFs than other types of patients, because their care needs tend to be relatively less intensive. For this reason, the increase in the proportion of these patients treated in IRFs would suggest a decrease in the overall expected costliness of IRF patients. Because this analysis of IRF patients' acute care hospital records suggested that IRF patients in 2002 should have been less costly to treat than IRF patients in 1999, RAND estimated that coding changes likely led to as much as a 5.8 percent increase in IRF payments between 1999 and 2002.

However, RAND recognized a limitation in relying solely on acute care hospital records, in that they do not reflect changes in a patient's condition that may occur after discharge from the hospital. For example, patients could develop impairments, functional problems, or comorbidities after leaving the acute care hospital that would make them more costly once they are in the IRF. Thus, RAND acknowledged that the 5.8 percent estimate was likely an ''upper bound,'' or a high-end estimate, of the amount of case mix change that was attributable to coding.

For this reason, RAND performed a second analysis based on specific examples of coding in the IRF setting that we know have changed over time, such as direct indications of improvements in impairment coding, changes in coding instructions for bladder and bowel functioning, and dramatic increases in coding of certain conditions that affect patients' placement into tiers (resulting in higher payments). Since this analysis focused solely on the IRFs' classification of the patients, it automatically accounted for any changes in the patients' condition at the start of or during the IRF stay. However, this approach was limited in that it generally assumed that IRFs' coding practices did not change in response to implementation of the IRF PPS, other than for the specific, previously known examples listed above. That is, this analysis did not look beyond the specific, known examples to account for other, broader changes in IRFs' coding practices that may have occurred. For this reason, RAND acknowledged that the second analysis, based on the specific, known examples listed above, was likely a ''lower bound,'' or low-end estimate, of the amount of case mix change that was attributable to coding.

For FY 2006, we proposed and implemented a 1.9 percent adjustment to the standard payment amount. At the time, we adjusted the standard payment amount by the lowest amount attributable to coding change because we wanted to provide some flexibility to account for the possibility that all or some of the observed changes may have been attributable to factors other than coding changes or could be temporary changes associated with the transition to a new payment system.

Since publication of the FY 2006 final rule, however, CMS and MedPAC have conducted several analyses that indicate that coding changes had a larger impact on payment than we initially believed. First, recent MedPAC analyses found that, since the introduction of the IRF PPS, increases in IRF payments far outstripped increases in IRFs' costs. In fact, in its March 2006 report, MedPAC reported that IRF profit margins increased from 1.5 percent in 2001, the year before the introduction of the IRF PPS, to 11.1 percent in 2002, 17.7 percent in 2003, and 16.3 in 2004. MedPAC also found that cost increases lagged far behind payment increases, with IRFs' costs increasing only 2.4 percent and 3.6 percent in 2003 and 2004, respectively. The relatively low cost increases for these years suggest that patient severity could not have been increasing substantially over this time period. Thus, the rapid increases in IRF payments over this time period are likely attributable to coding increases

that do not reflect real changes in case mix.

Based on our more recent analyses of IRF PPS payments, it is evident that changes in IRFs' coding practices associated with implementation of the IRF PPS (not related to real changes in case mix) likely had a greater effect on Medicare payments than we initially anticipated.

These findings have led us to reevaluate the amount of case mix change attributable to coding, within the 1.9 to 5.8 percent range RAND estimated. Based on our updated payment analyses (described below), we now believe that the impact of coding on Medicare payments to IRFs is significantly higher than 1.9 percent, the lowest possible figure within RAND's range of estimates, and that it would be more appropriate at this time to propose a total coding adjustment to the proposed standard payment amount closer to the upper end of RAND's range of estimates.

Further, as part of our ongoing analysis of provider coding practices, we analyzed IRF–PAI data from 2002 and 2005 to examine trends in the distribution of patients in each of the four payment tiers, and found that the proportion of patients shifted each year from the lowest to the higher-paying tiers.

To illustrate, to determine the IRF PPS payment for a particular patient, we first classify the patient into a major group, called a RIC, based on the patient's primary reason for receiving inpatient rehabilitation (for example, a stroke). Next, we assign the patient to a CMG based on the patient's ability to perform specific activities of daily living, and, for certain CMGs, based on the patient's cognitive ability and age, as well.

We also take into account special circumstances in determining the appropriate CMG, such as whether the case is a very short stay or whether the patient expires in the facility. Finally, we classify the patient into one of four tiers, based on the presence of any relevant comorbidities. One of the tiers contains patients with no relevant comorbidities. The other three tiers contain patients with increasingly costly comorbidities. For this reason, an IRF will receive higher payments for patients in one of the three more-costly tiers than for patients in the ''no comorbidity'' tier.

As shown in Table 6, the proportion of IRF patients in the lowest-paying tier, the tier for patients with ''no comorbidities,'' decreased by 6 percentage points between 2002 and 2005. Conversely, the proportion of patients in each of the three higher-paying tiers increased each year. However, MedPAC's analysis of IRFs' reported costs (described above) suggests that patient severity was not increasing substantially over this time period. Thus, we believe this lends further support to the conclusion that a substantial portion of the unexpected increase in IRF payments since the establishment of the IRF PPS is due to changes in provider coding practices.

TABLE 6.—PERCENT OF IRF PATIENTS IN EACH TIER, 2002–2005

Tier	Percent			
	2002	2003	2004	2005
''No comorbidity'' tier	74.42	72.01	70.81	68.41
Tier 3	14.74	15.54	16.00	18.39
Tier 2	9.04	9.95	10.44	10.16
Tier 1	1.80	2.50	2.75	3.03

Note: Tier 1 is the highest-paying tier, followed by tier 2 and then tier 3. The ''no comorbidity'' tier does not mean that the patient does not have any comorbidities, but that patients do not have any of the designated comorbidities that would elevate them to a higher-paying tier.

Based on a review of the evidence above, we further analyzed providers' responses to the tier comorbidity changes that we finalized in the FY 2006 IRF PPS final rule (70 FR 47880). These changes became effective for discharges occurring on or after October 1, 2005, and, as described below, affect Medicare payments to IRFs.

In the FY 2006 IRF PPS final rule (70 FR 47880), we finalized a number of changes to the comorbidity codes that we use to assign patients to one of the three higher-paying tiers, including adding or deleting certain comorbidity codes, and moving certain others among the tiers based on RAND's analysis of the marginal cost of these comorbidities. After we implemented these changes to the tier comorbidity codes for FY 2006, we found that facilities responded quickly to the coding changes. For example, in updating the GROUPER software, we inadvertently added one comorbidity code (278.02, overweight) to one of the higher-payment tiers, even though RAND's analysis did not indicate that this code belonged in a higher-paying tier. We had not adopted this particular code for addition to the tier in the FY 2006 IRF PPS final rule, and its addition to the IRF GROUPER software was simply a clerical error that we are in the process of correcting. However, the presence of this comorbidity code on the IRF patient assessment instrument (IRF–PAI) triggered an increased IRF per discharge payment in FY 2006. The increase in payment ranged from $171 to $4,587 per discharge, depending on the patient's CMG classification.

Once we discovered the inadvertent presence of code 278.02 in the higher-paying tier, we analyzed IRF–PAI data for the first quarter of FY 2006, the first period during which use of this code increased payment. We also reviewed IRF–PAI data to identify the way this particular code had been used before October 2005; that is, before it triggered increased payment. From January 2002 through October 2005, code 278.02 appeared as a coded comorbidity on only 8 IRF–PAI forms out of approximately 1.8 million total IRF–PAI forms submitted. For the first quarter of FY 2006, however, the same code, 278.02, appeared as a coded comorbidity on 2,315 IRF–PAI forms out of approximately 113,000 total forms submitted in that quarter. The dramatic increase in the use of this ICD–9 code in such a short period of time leads us to believe that its increased use most likely reflects changes in the payment structure rather than in patient severity levels and suggests that providers respond more rapidly to coding changes than we initially believed.

Based on these analyses and MedPAC's findings that costs were not increasing substantially in 2003 and 2004 (suggesting that patient acuity could not have been increasing substantially), we are now convinced that an additional coding adjustment for FY 2007 is needed to adjust for more of the impact of coding changes not related to real changes in case mix on IRF PPS payments. Therefore, for FY 2007, we

propose to reduce the IRF standard payment amount by 2.9 percent, which would result in a total adjustment (when combined with the 1.9 percent adjustment for FY 2006) of 4.8 percent (1.9 + 2.9 = 4.8). In this way, we can adjust the IRF PPS to reflect more fully the impact of coding changes on payments. Because 4.8 percent is well within the range of RAND's estimates of the effects of coding changes on IRF PPS payments, we continue to believe that we are still providing flexibility to account for the possibility that some of the observed changes may be attributable to factors other than coding changes. We note that in the course of our analysis, we also considered the possibility of making a somewhat lower adjustment of 2.3 percent, which would fall at approximately the middle of RAND's range of estimates. However, in view of the industry's extremely rapid adoption of coding changes, we believe that a 2.9 percent reduction would likely account more accurately for the actual degree of these changes. We are continuing to analyze the data and, therefore, the specific amount of payment adjustment is subject to change for the final rule based on the results of the ongoing analysis. We specifically invite comments on the figure that would represent the most appropriate adjustment to account for changes in coding practices.

We propose to use the same methodology that we used in the FY 2006 IRF PPS final rule (70 FR 47880, 47908) to reduce the standard payment amount to adjust for coding changes that affect payment. To reduce the standard payment amount by an additional 2.9 percent for FY 2007, we first update the FY 2006 standard payment conversion factor by the estimated market basket update of 3.4 percent ($12,762 × 1.034 = $13,196). Next, we propose to multiply this standard payment amount by 0.971 (obtained by subtracting 0.029 from 1.000), which reduces the standard payment amount by 2.9 percent ($13,196 × 0.971 = $12,813).

In section III.D of this proposed rule, we further propose to adjust the resulting amount of $12,813 by the proposed budget neutrality factors for the wage index, the second year of the hold harmless policy, and the proposed revisions to the CMG relative weights and tier comorbidities, producing the proposed FY 2007 standard payment conversion factor. In section III.D of this proposed rule, we provide a step-by-step calculation that results in the proposed FY 2007 standard payment conversion factor. The proposed FY 2007 standard payment conversion factor is subject to change in the final rule based on updated analysis and data.

B. Proposed FY 2007 IRF Market Basket Increase Factor and Labor-Related Share

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services, which is referred to as a market basket index. Accordingly, in updating the FY 2007 payment rates set forth in this proposed rule, we apply an appropriate increase factor to the FY 2006 IRF PPS payment rates that is based on the rehabilitation, psychiatric, and long-term care hospital (RPL) market basket. In constructing the RPL market basket, we used the methodology set forth in the FY 2006 IRF PPS final rule (70 FR 47880, 47908 through 47915).

As discussed in that final rule, the RPL market basket primarily uses the Bureau of Labor Statistics' (BLS) data as price proxies, which are grouped in one of the three BLS categories: Producer Price Indexes (PPI), Consumer Price Indexes (CPI), and Employment Cost Indexes (ECI). We evaluated and selected these particular price proxies using the criteria of reliability, timeliness, availability, and relevance, and believe they continue to be the best measures of price changes for the cost categories.

Beginning April 2006 with the publication of March 2006 data, the BLS' ECI will use a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Codes (SIC), which will no longer exist. We have consistently used the ECI as the data source for our wages and salaries and other price proxies in the RPL market basket and are not making any changes to the usage at this time. However, we are soliciting comments on our continued use of the BLS ECI data in light of the BLS change in system usage to the NAICS-based ECI. The estimated FY 2007 IRF market basket increase factor and labor-related share in this proposed rule will be updated for the final rule based on the most recent data available from the BLS.

We will use the same methodology described in the FY 2006 IRF PPS final rule to compute the FY 2007 IRF market basket increase factor and labor-related share. For this proposed rule, the FY 2007 IRF market basket increase factor is 3.4 percent. This is based on Global Insight, Inc. for the first quarter of 2006 (2006q1) forecast with historical data through the fourth quarter of 2005 (2005q4). We propose to update the market basket with more recent data for the final rule to the extent it is available.

In addition, we have used the methodology described in the FY 2006 IRF PPS final rule to update the labor-related share for FY 2007. In FY 2004 and FY 2005, we updated the 1992 market basket data to 1997 based on the methodology described in the August 1, 2003 final rule (68 FR 45688 through 45689). As discussed in the FY 2006 IRF PPS final rule (70 FR 47880, 47915 through 47917), we rebased and revised the market basket for FY 2006, using the 2002-based cost structures for IRFs, IPFs, and LTCHs to determine the FY 2006 labor-related share. For FY 2007, we will use the same methodology discussed in the FY 2006 IRF PPS final rule (70 FR 47880, 47908 through 47917) to determine the FY 2007 IRF labor-related share. As shown in Table 7, the total FY 2007 RPL labor-related share is 75.720 percent in this proposed rule. We propose to update the labor-related share with more recent data for the final rule to the extent it is available.

TABLE 7.—PROPOSED FY 2007 IRF LABOR-RELATED SHARE RELATIVE IMPORTANCE

Cost category	Proposed FY 2007 IRF labor-related relative importance
Wages and salaries	52.534
Employee Benefits	14.082
Professional fees	2.890
All other labor intensive services	2.156
Subtotal	71.662
Labor-related share of capital costs	4.058
Total	75.720

Source: Global Insight, Inc. 1stQtr 2006, @USMACRO/CONTROL0306 @CISSIM/CNTL08R3.SIM.

C. Area Wage Adjustment

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs attributable to wages and wage-related costs by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. The Secretary is required to update the wage index on the basis of information available to the Secretary on the wages and wage-related costs to furnish rehabilitation services. Any

adjustments or updates made under section 1886(j)(6) of the Act for a FY are made in a budget neutral manner.

In the FY 2006 IRF PPS final rule (70 FR 47880, 47917), we established an IRF wage index based on FY 2001 acute care hospital wage data to adjust the FY 2006 IRF payment rates. We also adopted the CBSA-based labor market area definitions set forth by the OMB (70 FR 47880, 47917 through 47921). We applied a one-year blended wage index for FY 2006 to mitigate the impact of the wage index change from the Metropolitan Statistical Area (MSA) to the CBSA-based labor market area definitions. In addition to the blended wage index, we also adopted a three-year budget neutral hold harmless policy beginning FY 2006 for IRFs that met the definition in § 412.602 as rural in FY 2005 and became urban in FY 2006 under the CBSA-based designation.

For FY 2007, we propose to maintain the methodology described in the FY 2006 IRF PPS final rule to determine the wage index, labor market area definitions, and hold harmless policy consistent with the rational outlined in that final rule (70 FR 47880, 47917 through 47933). However for FY 2007, the proposed wage index will be based solely on the previously adopted CBSA-based labor market area definitions and its wage index (rather than on a blended wage index) because the FY 2006 blended wage index will expire for discharges on or after October 1, 2006 (70 FR 47880, 47921 through 47926). We propose to continue to use the most recent final pre-reclassified and pre-floor hospital wage data available (FY 2002 hospital wage data) based on the CBSA labor market area definitions consistent with the rational outlined in the FY 2006 IRF PPS final rule.

Furthermore, we propose to continue to use the methodology described in that FY 2006 final rule in the event there is no hospital wage data available for urban or rural areas consistent with the rational outlined in the final rule (70 FR 47880, 47927). In addition, FY 2007 is the second year of the three-year phase out of the budget neutral hold harmless policy described in the FY 2006 IRF PPS final rule. For FY 2007, the hold harmless adjustment will be up to 6.38 percent for IRFs that meet the criteria described in the FY 2006 final rule (70 FR 47880, 47923 through 47926).

As we described in the FY 2006 final rule, certain titles to the CBSAs were changed based on OMB Bulletin No. 05–02 (November 2004). The title changes listed below are nomenclatures that do not result in substantive changes to the CBSA-based designations. The proposed wage index tables in the addendum reflect the following title changes:

- CBSA 36740: Orlando-Kissimmee, FL
- CBSA 37620: Parkersburg-Marietta-Vienna, WV-OH
- CBSA 42060: Santa Barbara-Santa Maria, CA
- CBSA 13644: Bethesda-Gaithersburg-Fredrick, MD
- CBSA 32580: McAllen-Edinburg-Mission, TX
- CBSA 26420: Houston-Sugar Land-Baytown, TX
- CBSA 35644: New York-White Plains-Wayne, NY-NJ

To calculate the wage-adjusted facility payment for the payment rates set forth in this proposed rule, we multiply the unadjusted Federal prospective payment by the proposed FY 2007 RPL labor-related share (75.720 percent) to determine the labor-related portion of the Federal prospective payments. We then multiply this labor-related portion by the applicable proposed IRF wage index shown in Table 1 for urban areas and Table 2 for rural areas in the Addendum.

In addition, because any adjustment or update to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget neutral manner, we have calculated a budget neutral wage adjustment factor as established in the August 1, 2003 final rule and codified at § 412.624(e)(1), and described in the steps below. We propose to use the following steps to ensure that the FY 2007 IRF standard payment conversion factor reflects the update to the proposed wage indexes (based on the FY 2002 pre-reclassified and pre-floor hospital wage data) and the proposed labor-related share in a budget neutral manner:

Step 1. Determine the total amount of the estimated FY 2006 IRF PPS rates, using the FY 2006 standard payment conversion factor and the labor-related share and the wage indexes from FY 2006 (as published in the FY 2006 IRF PPS final rule).

Step 2. Calculate the total amount of estimated IRF PPS payments, using the FY 2006 standard payment conversion factor and the proposed FY 2007 labor-related share and proposed full CBSA urban and rural wage indexes.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2, which equals the FY 2007 budget neutral wage adjustment factor of 1.0017.

Step 4. Apply the FY 2007 budget neutral wage adjustment factor from step 3 to the FY 2006 IRF PPS standard payment conversion factor after the application of the estimated market basket update to determine the FY 2007 standard payment conversion factor.

D. Description of the Proposed Methodology Used To Implement the Changes in a Budget Neutral Manner

To ensure that total estimated aggregate payments to IRFs would not change with the proposed budget neutral changes described in this proposed rule, we are proposing to apply a factor to the standard payment amount for the proposed changes to ensure that estimated aggregate payments in FY 2007 would not be greater or less than those that would have been made in the year without the proposed changes. Using the methodology described below, we propose to apply the budget neutrality factors to the standard payment amount for the proposed changes to ensure that estimated aggregate payments in FY 2007 would be the same with or without the proposed changes. We are proposing to apply the two budget neutrality factors using the following steps:

Step 1. Determine the proposed FY 2007 IRF PPS standard payment amount using the FY 2006 standard payment conversion factor ($12,762) increased by the estimated market basket (3.4 percent) and reduced by the proposed 2.9 percent adjustment to account for coding changes that do not reflect real changes in case mix, as discussed in section III.A of this proposed rule.

Step 2. Multiply the wage index budget neutrality factor by the proposed standard payment amount computed in step 1 to account for the proposed wage index and labor-related share (1.0017), as discussed in section III.C of this proposed rule.

Step 3. Calculate the estimated total amount of IRF PPS payments for FY 2007 (with no change to the tier comorbidities and the CMG relative weights, and without the hold harmless policy for FY 2007).

Step 4. Apply the FY 2007 hold harmless policy to IRFs that meet the criteria as described in § 412.624(e)(7) to calculate the estimated total amount of IRF PPS payment for FY 2007.

Step 5. Divide the amount calculated in step 3 by the amount calculated in step 4 to determine the factor (1.0012) that keeps total estimated payments in FY 2007 the same with and without the change to the hold harmless policy.

Step 6. Apply the factor computed in step 5 to the proposed standard payment amount in step 2, and calculate estimated total IRF PPS payments for FY 2007.

Step 7. Apply the proposed new tier comorbidities and CMG relative weights

(as discussed in section II of this proposed rule) to calculate the estimated total amount of IRF PPS payments for FY 2007.

Step 8. Divide the amount calculated in step 6 by the amount calculated in step 7 to determine the proposed factor (1.0079) that maintains the same total estimated aggregated payments in FY 2007 with and without the proposed revisions to the tier comorbidities and CMG relative weights.

Each of these proposed budget neutrality factors increases the proposed standard payment amount. The proposed budget neutrality factor for the second year of the hold harmless policy would increase the proposed standard payment amount from $12,835 to $12,850. The proposed budget neutrality factor for the proposed revisions to the tier comorbidities and CMG relative weights would increase the standard payment amount from $12,850 to $12,952. As indicated previously, the proposed standard payment conversion factor would need to be increased in order to ensure that total estimated payments for FY 2007 with the proposed changes equal total estimated payments for FY 2007 without the proposed changes. This is because the continuation of the hold harmless policy and the proposed revisions to the tier comorbidities and CMG relative weights would result in a slight decrease, on average, to total estimated aggregate payments to IRFs if we were not to propose to implement the policies in a budget neutral manner. To maintain the same total estimated aggregate payments to all IRFs with and without the policies, we are proposing to redistribute payments among IRFs. Thus, some redistribution of payment would occur among facilities, while total estimated aggregate payments would not change. To determine how these proposed changes are estimated to affect payments among different types of facilities, please see Table 11 in this proposed rule.

E. Proposed Budget Neutrality Factor Methodology for Fiscal Year 2007

In the FY 2006 final rule (70 FR 47880, 47937 through 47398), we revised the IRF regulation by adding § 412.624(d)(4) to allow the Secretary the authority to apply a factor when revisions are made to the tier comorbidities and the CMGs, the rural adjustment, the LIP adjustment, the teaching status adjustment, the hold harmless adjustment, or other budget-neutral policies. To clarify, we are not proposing to revise for FY 2007 the rural adjustment of 21.3 percent, the LIP exponential factor of 0.6229, and the teaching status adjustment exponential factor of 0.9012, as described in the FY 2006 IRF PPS final rule. Since we are not proposing changes to these policies, we do not need to calculate budget neutrality factors for these policies because they are assumed in the FY 2006 standard payment conversion factor.

Although we are not calculating budget neutrality factors for the rural adjustment, the LIP adjustment, and the teaching status adjustment, we are continuing the budget neutral hold harmless policy (the second year of a three-year phase out of the rural adjustment) implemented in FY 2006 as well as proposing to revise the list of tier comorbidities and the CMG relative weights for FY 2007. Consistent with the hold harmless policy in the FY 2006 IRF PPS final rule, we are implementing the policy in a budget neutral manner for FY 2007. We are also proposing to implement the revisions to the tier comorbidities and the CMG relative weights in a budget neutral manner for FY 2007.

Consistent with § 412.624(d)(4), we apply a factor to the proposed standard payment amount in order to make the proposed changes described in this proposed rule in a budget neutral manner for FY 2007. We begin by using the methodology described in sections III.A and B of this proposed rule. We will use the FY 2006 standard payment conversion factor ($12,762) and apply the market basket (3.4 percent), which equals $13,196. Then, we propose to apply a one-time reduction to the standard payment amount of 2.9 percent as discussed in section III.A of this proposed rule, which equals $12,813. We will then apply the budget neutral wage adjustment (as described above in section III.C of this proposed rule) of 1.0017 to $12,813, which will result in a standard payment amount of $12,835.

The factors we propose to apply are 1.0079 for the tier comorbidity and CMG relative weight changes and 1.0012 for the second year of the hold harmless policy. We propose to combine these factors, by multiplying the two factors to establish one proposed budget neutrality factor for the two changes ($1.0012 \times 1.0079 = 1.0091$). We propose to apply this overall budget neutrality factor to $12,835 (the proposed standard payment amount that includes the 3.4 percent market basket, the proposed 2.9 percent reduction, and the budget neutrality factor for the wage index and labor related share), which would result in a proposed standard payment conversion factor of $12,952 for FY 2007.

The proposed FY 2007 standard payment conversion factor would be applied to each of the proposed CMG relative weights shown in Table 5, ''Proposed FY 2007 IRF PPS Relative Weights and Average Lengths of Stay for Case-Mix Groups,'' to compute the unadjusted IRF prospective payment rates for FY 2007 shown in Table 8. To clarify further, the proposed budget neutrality factors described above would only be applied for FY 2007. However, if necessary, we will apply budget neutrality factors in applicable years hereafter to the extent that further adjustments are made to the IRF PPS consistent with § 412.624(d)(4). Otherwise, the general methodology to determine the Federal prospective payment rate is described in § 412.624(c)(3)(ii).

F. Description of the Proposed IRF Standard Payment Conversion Factor and Proposed Payment Rates for FY 2007

To calculate the proposed standard payment conversion factor for FY 2007 and as illustrated in Table 8 below, we begin by applying the estimated market basket increase factor (3.4 percent) to the standard payment conversion factor for FY 2006 ($12,762), which equals $13,196. Then, we propose to apply a one-time 2.9 percent reduction to the standard payment amount to adjust for coding changes that have increased payments to IRFs since implementation of the IRF PPS, as discussed in section III.A of this proposed rule. This would result in a proposed standard payment amount of $12,813. We then apply the proposed budget neutrality factor for the wage index and labor related share of 1.0017, which would result in a proposed standard payment amount of $12,835. Then, we propose to apply a combined budget neutrality factor for the hold harmless provision and the revisions to the tier comorbidities and the CMG relative weights of 1.0091 ($1.0012 \times 1.0079 = 1.0091$), which would result in a proposed FY 2007 standard payment conversion factor of $12,952.

TABLE 8.—CALCULATIONS TO DETERMINE THE PROPOSED FY 2007 STANDARD PAYMENT CONVERSION FACTOR

Explanation for adjustment	Calculations
FY 2006 Standard Payment Conversion Factor	$12,762
Proposed FY 2007 Market Basket Increase Factor	× 1.034
Subtotal	=$13,196
Proposed One-Time 2.9% Reduction for Coding Changes	× 0.971
Subtotal	=$12,813
Proposed Budget Neutrality Factor for the Wage Index and Labor-Related Share	× 1.0017
Subtotal	=$12,835
Proposed Budget Neutrality Factor for the Hold Harmless Provision and Revisions to the Tier Comorbidities and the CMG Relative Weights	× 1.0091
Proposed FY 2007 Standard Payment Conversion Factor	=$12,952

Finally, we would apply the proposed relative weights for each CMG and tier, shown in section II.B of this proposed rule, Table 5 ''Proposed FY 2007 IRF PPS Relative Weights and Average Lengths of Stay for Case-Mix Groups,'' to the proposed FY 2007 standard payment conversion factor.

After the application of the proposed relative weights, the resulting proposed unadjusted IRF prospective payment rates for FY 2007 are shown below in Table 9, ''Proposed FY 2007 Payment Rates Based on the Proposed Revisions.''

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Table 9: Proposed FY 2007 Payment Rates Based On The Proposed Revisions

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	$9,982.24	$9,458.20	$8,512.31	$8,220.89
0102	$12,295.59	$11,650.06	$10,485.03	$10,126.00
0103	$14,496.40	$13,735.21	$12,361.65	$11,938.51
0104	$15,392.80	$14,584.47	$13,126.07	$12,676.64
0105	$18,470.98	$17,501.13	$15,751.06	$15,211.74
0106	$21,492.16	$20,363.65	$18,327.34	$17,699.81
0107	$24,803.34	$23,501.02	$21,150.88	$20,426.73
0108	$28,701.63	$27,194.67	$24,475.14	$23,637.14
0109	$28,491.29	$26,995.34	$24,295.75	$23,463.97
0110	$34,047.31	$32,259.55	$29,033.59	$28,039.53
0201	$10,546.81	$8,815.26	$7,874.56	$7,314.51
0202	$13,548.05	$11,323.93	$10,115.38	$9,395.90
0203	$16,193.89	$13,535.36	$12,090.95	$11,230.94
0204	$17,343.25	$14,495.88	$12,949.02	$12,027.87
0205	$21,256.56	$17,766.91	$15,870.86	$14,741.97
0206	$27,775.18	$23,215.29	$20,737.84	$19,262.86
0207	$35,829.77	$29,947.61	$26,751.71	$24,848.80
0301	$14,757.77	$12,347.40	$11,076.16	$10,066.55
0302	$19,266.23	$16,119.54	$14,460.00	$13,142.01
0303	$22,925.95	$19,181.39	$17,206.60	$15,638.24
0304	$31,596.02	$26,435.42	$23,713.82	$21,552.39
0401	$12,417.34	$10,951.82	$10,001.15	$8,882.74
0402	$17,168.78	$15,142.44	$13,827.94	$12,281.60
0403	$29,879.23	$26,352.92	$24,065.20	$21,373.91
0404	$53,804.81	$47,454.83	$43,335.19	$38,488.94
0405	$40,631.07	$35,835.85	$32,724.91	$29,065.19
0501	$9,906.21	$8,361.03	$7,365.41	$6,567.70

Table 9: Proposed FY 2007 Payment Rates Based On The Proposed Revisions

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0502	$13,291.21	$11,217.99	$9,882.12	$8,812.02
0503	$17,610.06	$14,863.20	$13,093.31	$11,675.32
0504	$21,997.55	$18,566.30	$16,355.40	$14,584.21
0505	$26,125.35	$22,050.26	$19,424.50	$17,320.97
0506	$35,491.07	$29,955.13	$26,388.02	$23,530.42
0601	$11,644.88	$9,493.69	$9,090.62	$8,447.68
0602	$15,500.31	$12,636.88	$12,100.28	$11,244.54
0603	$19,850.62	$16,183.65	$15,496.42	$14,400.55
0604	$25,375.69	$20,687.97	$19,809.44	$18,408.55
0701	$11,692.55	$9,995.58	$9,503.53	$8,569.95
0702	$15,200.34	$12,994.22	$12,354.65	$11,141.05
0703	$18,947.87	$16,197.90	$15,400.45	$13,887.65
0704	$23,272.93	$19,895.18	$18,915.88	$17,057.65
0801	$8,466.46	$7,129.17	$6,645.28	$5,967.25
0802	$11,063.34	$9,315.73	$8,683.41	$7,797.36
0803	$16,458.24	$13,858.51	$12,917.81	$11,599.81
0804	$14,299.27	$12,040.44	$11,223.17	$10,078.08
0805	$18,038.51	$15,189.20	$14,158.09	$12,713.55
0806	$21,660.02	$18,238.49	$17,000.54	$15,265.87
0901	$10,911.41	$9,896.88	$8,895.17	$7,927.14
0902	$14,361.44	$13,026.21	$11,707.70	$10,433.61
0903	$18,959.66	$17,196.89	$15,456.27	$13,774.32
0904	$23,755.65	$21,546.95	$19,366.09	$17,258.54
1001	$12,465.78	$11,500.21	$10,306.29	$9,533.32
1002	$16,460.05	$15,185.18	$13,608.67	$12,588.05
1003	$23,152.74	$21,359.53	$19,141.89	$17,706.29
1101	$16,260.07	$13,576.03	$11,947.83	$11,003.37
1102	$24,381.23	$20,356.66	$17,915.21	$16,499.03
1201	$13,181.12	$11,378.33	$10,596.81	$9,590.70
1202	$17,055.19	$14,722.67	$13,711.38	$12,409.44
1203	$21,035.47	$18,158.44	$16,911.30	$15,305.51
1301	$13,410.63	$12,480.29	$11,023.58	$9,621.91
1302	$18,547.91	$17,261.26	$15,246.45	$13,307.79
1303	$23,637.66	$21,997.94	$19,430.33	$16,959.61

Table 9: Proposed FY 2007 Payment Rates Based On The Proposed Revisions

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1401	$10,568.31	$9,521.27	$8,462.97	$7,590.91
1402	$14,296.16	$12,879.73	$11,448.14	$10,268.60
1403	$17,750.46	$15,991.70	$14,214.30	$12,749.69
1404	$22,497.75	$20,268.58	$18,015.84	$16,159.56
1501	$12,933.87	$11,488.68	$10,092.98	$9,583.31
1502	$16,398.27	$14,565.82	$12,796.32	$12,150.14
1503	$20,020.17	$17,783.10	$15,622.70	$14,833.80
1504	$26,183.12	$23,257.39	$20,432.04	$19,400.28
1601	$13,042.40	$11,073.44	$10,068.50	$9,010.58
1602	$17,907.05	$15,203.83	$13,823.93	$12,371.36
1603	$22,050.13	$18,721.47	$17,022.30	$15,233.62
1701	$12,716.53	$12,487.28	$10,981.74	$9,542.77
1702	$16,735.28	$16,433.63	$14,452.36	$12,558.65
1703	$19,889.61	$19,531.10	$17,176.42	$14,925.76
1704	$24,927.16	$24,477.86	$21,526.61	$18,706.06
1801	$15,438.91	$12,778.70	$10,676.46	$9,508.97
1802	$24,683.40	$20,430.36	$17,069.31	$15,202.80
1803	$44,427.43	$36,772.41	$30,722.79	$27,363.30
1901	$16,058.93	$14,229.46	$14,201.61	$12,110.25
1902	$30,041.39	$26,619.08	$26,566.88	$22,654.60
1903	$43,341.93	$38,404.49	$38,329.11	$32,684.63
2001	$11,311.63	$9,559.61	$8,722.78	$7,880.39
2002	$14,826.28	$12,529.89	$11,433.12	$10,328.83
2003	$19,138.65	$16,174.20	$14,758.54	$13,333.05
2004	$25,536.03	$21,580.75	$19,691.83	$17,789.96
2101	$28,290.02	$28,290.02	$21,508.09	$18,893.60
5001	$0.00	$0.00	$0.00	$2,850.48
5101	$0.00	$0.00	$0.00	$8,225.94
5102	$0.00	$0.00	$0.00	$20,704.03
5103	$0.00	$0.00	$0.00	$9,329.46
5104	$0.00	$0.00	$0.00	$24,329.43

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G. Example of the Methodology for Adjusting the Proposed Federal Prospective Payment Rates

In the FY 2006 final rule, we presented an example similar to the one in Table 10 below to illustrate the methodology we used to adjust the Federal prospective payments based on the refinements described in that final rule. Table 10 illustrates the proposed methodology for adjusting the Federal prospective payments (as described in sections III.D through F of this proposed rule). We have relabeled each step in Table 10 to illustrate more clearly how the case-level and facility-level adjustments are applied to the unadjusted Federal prospective payments in the IRF PPS. Thus, the content in Table 10 is modified from that of Table 11 in the FY 2006 final rule (70 FR 57166, 57169), in order to illustrate the step-by-step computations to determine the hypothetical examples. The examples below are based on two hypothetical Medicare beneficiaries, both classified into CMG 0110 (without comorbidities). The unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) can be found in Table 9 above.

One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a non-teaching hospital, has a disproportionate share hospital (DSH) percentage of 5 percent (which results in a LIP adjustment of 1.0309), a wage index of 0.8624, and an applicable rural adjustment of 21.3 percent. Facility B, a teaching hospital, has a DSH percentage of 15 percent (which results in a LIP adjustment of 1.0910), a wage index of 0.9251, and an applicable teaching status adjustment of 0.109.

To calculate each IRF's labor and non-labor portion of the Federal prospective payment, we begin by taking the unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) from Table 9 above. Then, we multiply the estimated labor-related share (75.720) described in section III.B by the unadjusted Federal prospective payment rate. To determine the non-labor portion of the Federal prospective payment rate, we subtract the labor portion of the Federal payment from the unadjusted Federal prospective payment.

To compute the wage-adjusted Federal prospective payment, we multiply the result of the labor portion of the Federal payment by the appropriate wage index found in the Addendum in Tables 1 and 2, which will result in the wage-adjusted amount. Next, we compute the wage-adjusted Federal payment by adding the wage-adjusted amount to the non-labor portion.

To adjust the Federal prospective payment by the facility-level adjustments, there are several steps. First, we take the wage-adjusted Federal prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Then, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.109, in this example) by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted Federal prospective payment rate. Table 10 illustrates the components of the proposed adjusted payment calculation.

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Table 10: Example of Computing an IRF's Proposed FY 2007 Federal Prospective Payment

Steps		Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)	
1	Unadjusted Federal Prospective Payment (from Table 9 above)		$28,039.53		$28,039.53
2	Labor Share	X	0.75720	X	0.75720
3	Labor Portion of Federal Payment	=	$21,231.53	=	$21,231.53
4	CBSA Based Wage Index (shown in the Addendum, Tables 1 and 2)	X	0.8624	X	0.9251
5	Wage-Adjusted Amount	=	$18,310.07	=	$19,641.29
6	Nonlabor Amount (Step 1 - Step 3)	+	$6,808.00	+	$6,808.00
7	Wage-Adjusted Federal Payment	=	$25,118.07	=	$26,449.29
8	Rural Adjustment	X	1.213	X	1.000
9	Wage- and Rural-Adjusted Federal Payment	=	$30,468.22	=	$26,449.29
10	LIP Adjustment	X	1.0309	X	1.0910
11	FY2007 Wage-, Rural- and LIP- Adjusted Federal Prospective Payment Rate	=	$31,409.69	=	$28,856.17
12	Wage- and Rural-Adjusted Federal Payment (from Step 9 above)		$30,468.22		$26,449.29
13	Teaching Status Adjustment	X	0.000	X	0.109
14	Teaching Status Adjustment Amount	=	$0.00	=	$2,882.97
15	FY2007 Wage-, Rural-, and LIP-Adjusted Federal Prospective Payment Rate (from Step 11 above)	+	$31,409.69	+	$28,856.17
16	Total FY 2007 Adjusted Federal Prospective Payment (Step 14 + Step 15)	=	$31,409.69	=	$31,739.15

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Thus, the proposed adjusted payment for Facility A would be $31,409.69 and the proposed adjusted payment for Facility B would be $31,739.15.

IV. Proposed Update to Payments for High-Cost Outliers Under the IRF PPS

[If you choose to comment on issues in this section, please include the caption ''High-Cost Outliers Under the IRF PPS' at the beginning of your comments.]

A. Proposed Update to the Outlier Threshold Amount for FY 2007

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of a case by multiplying the IRF's overall cost-to-charge ratio by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, we make

an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

In the August 7, 2001 final rule (66 FR 41316, 41362 through 41363), we discussed our rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments. FY 2006 was the first year for which we had sufficient post-PPS data (FY 2003) to adjust the outlier threshold amount. Therefore, in the FY 2006 IRF PPS final rule, as corrected by the September 30, 2005 correction notice (70 FR 47880 and 70 FR 57166), we updated the outlier threshold amount for FY 2006 to $5,129 based on RAND's analysis of FY 2003 data. We also stated that we would continue to analyze the estimated outlier payments for subsequent years and adjust as appropriate in order to maintain estimated outlier payments at 3 percent of total estimated payments.

For this proposed rule, we performed an updated analysis of FY 2004 claims and IRF–PAI data using the same methodology described in the FY 2006 IRF PPS final rule (70 FR 47880, 47934 through 47936). Based on this updated analysis, and consistent with the broad statutory authority conferred upon the Secretary in sections 1886(j)(4)(A)(i) and 1886(j)(4)(A)(ii) of the Act, we propose to update the outlier threshold amount to $5,609 to set estimated outlier payments equal to 3 percent of total estimated aggregate IRF payments for FY 2007.

We propose to increase the outlier threshold amount for FY 2007 because we estimate that IRF costs for FY 2007 would be 3.4 percent (the estimated market basket increase) higher than FY 2006 costs, but we estimate that IRF PPS (non-outlier) payments for FY 2007 would be about 0.5 percent higher than FY 2006 payments (3.4 percent minus the proposed 2.9 percent coding adjustment described in section III.A of this proposed rule). Since estimated IRF costs would increase by more than proposed IRF PPS payments under the proposed policies for FY 2007, more cases would qualify for outlier payments and estimated outlier payments would exceed 3 percent of total estimated payments if we did not propose to adjust the outlier threshold amount.

The appropriate outlier threshold amount for FY 2007 depends on the other proposed policies, especially the 2.9 percent coding adjustment, described in this proposed rule. Therefore, the proposed outlier threshold amount for FY 2007 is subject to change in the final rule depending on the other policies contained in the final rule and updated analysis and data.

B. Update to the IRF Cost-to-Charge Ratio Ceilings and Proposed Clarification to the Regulation Text for FY 2007

In accordance with the methodology stated in the August 1, 2003 final rule (68 FR 45692 through 45694), as clarified below, we apply a ceiling to IRFs' cost-to-charge ratios (CCRs). We propose a clarification to the current regulation text in § 412.624(e)(5) to emphasize that we calculate a single overall cost-to-charge ratio (CCR) for IRFs because IRF PPS payments are based on a prospective payment per discharge for both inpatient operating and capital-related costs. Specifically, we calculate an IRF's CCR using its total Medicare-allowable costs (that is, the sum of its allowable operating and capital inpatient routine and ancillary costs) divided by its total Medicare charges (that is, the sum of its operating and capital inpatient routine and ancillary charges). Accordingly, we are proposing to revise the current regulation text in § 412.624(e)(5) to clarify that we apply adjustments to IRFs' CCRs using the methodology described in § 412.84(i) and § 412.84(m), except that we use a single overall (combined operating and capital) cost-to-charge ratio for IRFs. We note that we are not proposing any changes to the substantive policies of how we calculate CCRs and national average CCRs, or of how we conduct reconciliation of outlier payments. Our proposal merely seeks to emphasize that the IRF PPS uses a single overall CCR instead of separate CCRs for operating and capital costs.

Using the methodology described in the August 1, 2003 final rule, as clarified above, we propose to update the national urban and rural CCRs for IRFs. Under the proposed revision (clarification) to § 412.624(e)(5), we would apply the national urban and rural CCRs in the following situations:

- New IRFs that have not yet submitted their first Medicare cost report.
- IRFs whose overall CCR is in excess of 3 standard deviations above the corresponding national geometric mean, which we propose to set at 1.57 (based on the current estimate) for FY 2007.
- Other IRFs for whom accurate data with which to calculate an overall CCR are not available.

Specifically, for FY 2007, we estimate a proposed national CCR of 0.613 for rural IRFs and 0.488 for urban IRFs. For new facilities, we use these national ratios until the data become available for us to compute the facility's actual CCR using the first tentative settled or final settled cost report data, which we then use for the subsequent cost reporting period. We note that the proposed national average rural and urban CCRs and our estimate of 3 standard deviations above the corresponding national geometric mean in this section are subject to change in the final rule based on updated analysis and data.

V. Other Issues

[If you choose to comment on issues in this section, please include the caption ''Other Issues'' at the beginning of your comments.]

Both Medicare's payment structures and the actual delivery of post acute care have evolved significantly over the past decade. Before the BBA, IRFs and other post-acute settings such as skilled nursing facilities (SNFs) were paid on the basis of cost. Since that time, we have implemented various legislative mandates that established prospective payment systems (PPSs) in these settings. The PPS methodologies used in these settings rely on patient-level clinical information to provide accurate pricing, support the provision of high quality services, and create incentives to deliver care more efficiently.

Medicare is exploring refinements to the existing provider-oriented ''silos'' to create a more seamless system for payment and delivery of post-acute care (PAC) under Medicare. This new model will be characterized by more consistent payments for the same type of care across different sites of service, quality-driven pay-for-performance incentives, and collection of uniform clinical assessment information to support quality and discharge planning functions.

Section 5008 of the DRA provides a pathway to achieve the goals of the new model by providing for a demonstration on uniform assessment and data collection across different sites of service. We are in the early stages of developing a standard, comprehensive assessment instrument to be completed at hospital discharge and ultimately integrated with PAC assessments. The demonstration will enable us to test the usefulness of this instrument, and analyze cost and outcomes across different PAC sites. The lessons learned from this demonstration will inform efforts to improve the post-acute payment systems. The instrument is intended to cover the population admitted to all PAC settings (SNFs, IRFs, and long-term care hospitals) as well as residential-based PAC (home health agencies, outpatient programs).

We have evaluated existing assessment instruments used by managed care and other insurers. These instruments will form the basis of our efforts to create a hospital discharge assessment tool that may be used in the following ways: To facilitate post-hospital placement decision making; to enhance the safety and quality of care during patient transfers through transmission of core information to a receiving provider; and to provide baseline information for longitudinal follow-up of health and function.

At this time, we do not offer specific proposals related to the preceding discussion. However, we believe that it is useful to encourage discussion of a broad range of ideas in order to assess the relative advantages and disadvantages of the various policies affecting PAC sites. Accordingly, in this proposed rule, we invite comments on these and other approaches.

In the April 25, 2006 Inpatient Prospective Payment Systems proposed rule (71 FR 23996), we discussed in detail the Health Care Information Transparency Initiative and our efforts to promote effective use of health information technology (HIT) as a means to help improve health care quality and improve efficiency. Specifically, with regard to the transparency initiative, we discussed several potential options for making pricing and quality information available to the public (71 FR 24120 through 24121). We solicited comments on ways the Department can encourage transparency in health care quality and pricing whether through its leadership on voluntary initiatives or through regulatory requirements. We also sense sought comments on the Department's statutory authority to impose such requirements. In addition, we discussed the potential for HIT to facilitate improvements in the quality and efficiency of health care services (71 FR 24100 through 24101). We solicited comments on our statutory authority to encourage the adoption and use of HIT. The 2007 Budget states that ''the Administration supports the adoption of health information technology (IT) as a normal cost of doing business to ensure patients receive high quality care.'' We also sought comments on the appropriate role of HIT in potential value-based purchasing program, beyond the intrinsic incentives of a PPS to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care. In addition, we sought comments on promotion of the use of effective HIT through Medicare conditions of participation.

We intend to consider both the health care information transparency initiative and the use of health information technology as we refine and update all Medicare payment systems. Therefore, we seek comments on these initiatives as applied to IRF PPS in this proposed rule, and we may address these initiatives in the final IRF rule. We note that we are in the process of seeking input on these initiatives in various proposed Medicare payment rules being issued this year.

VI. Proposed Revisions to the Classification Criteria Percentage for IRFs

[If you choose to comment on issues in this section, please include in the caption ''Revisions to the Classification Criteria Percentage for IRFs'' at the beginning of your comments.]

The regulations implementing the IRF PPS provisions are presently in 42 CFR part 412, subpart P. In order to be paid under the IRF PPS, a hospital or unit of a hospital, must meet the requirements for classification as an IRF contained in subpart B of part 412, and must meet the specific conditions for payment under the IRF PPS at § 412.604 in order to be excluded from the inpatient hospital prospective payment system specified in § 412.1(a)(1).

As discussed in previous **Federal Register** publications (68 FR 26786 (May 16, 2003), 68 FR 53266 (September 9, 2003), 69 FR 25752 (May 7, 2004), and 70 FR 36640 (June 24, 2005)), § 412 23(b)(2) specifies one criterion, commonly known as the ''75 percent rule,'' which Medicare uses for classifying a hospital or unit of a hospital as an IRF. This criterion sets a minimum percentage of a facility's total inpatient population that must meet one of 13 medical conditions listed in the regulation in order for the facility to be classified as an IRF. This minimum percentage is known as the ''compliance threshold.'' In the May 7, 2004 final rule (69 FR 25752), we revised § 412.23(b)(2) to provide that the compliance threshold would gradually transition to the full 75 percent level over several cost reporting periods, as follows:

- For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, a compliance threshold of 50 percent.
- For cost reporting periods beginning on or after July 1, 2005, and before July 1, 2006, a compliance threshold of 60 percent.
- For cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007, a compliance threshold of 65 percent.
- For cost reporting periods beginning on or after July 1, 2007, a compliance threshold of 75 percent.

Section 5005 of the DRA recently revised the compliance thresholds that must be met for certain cost reporting periods. Therefore, we will make conforming revision to the latter phases of the compliance threshold transition currently specified in § 412.23(b)(2), as follows:

- For cost reporting periods beginning on or after July 1, 2005 and before July 1, 2007, the compliance threshold will be 60 percent.
- For cost reporting periods beginning on or after July 1, 2007, and before July 1, 2008, the compliance threshold will be 65 percent.
- For cost reporting periods beginning on or after July 1, 2008, the compliance threshold will be 75 percent.

Currently, in accordance with § 412.23(b)(2)(i), a case with a principal diagnosis that does not match one of the 13 medical conditions listed in § 412.23(b)(2)(iii) nonetheless can be considered as meeting one of those medical conditions if all of the following criteria are met:

(1) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions listed in § 412.23(b)(2)(iii);

(2) The patient also has a comorbidity that falls within one of the conditions listed in § 412.23(b)(2)(iii); and

(3) The comorbidity has caused significant functional ability decline in the individual to such an extent that, even in the absence of the admitting condition, the individual would still require intensive rehabilitation treatment that is unique to IRFs paid under subpart P and cannot be appropriately performed in another setting.

Thus, under § 412.23(b)(2)(i), as long as the compliance percentage is still transitioning to the full 75 percent level, patients with a comorbidity that meets the conditions described above are counted toward meeting the facility's compliance percentage. However, under § 412.23(b)(2)(ii), once the compliance percentage has completed the transition to the full 75 percent level, such patients will no longer be counted toward meeting the facility's compliance percentage. Under current regulations, the compliance percentage's transition to the full 75 percent level would be complete as of an IRF's first cost reporting period that begins on or after July 1, 2007. Under the revised transition timeframes that we are now proposing in order to implement the DRA provision, a facility will not have to meet the full 75 percent compliance threshold until its first cost reporting period beginning on or after July 1,

2008. Consequently, we are also proposing that a comorbidity that meets the criteria as specified in § 412.23(b)(2)(i) may continue to be used to determine the compliance threshold for cost reporting periods that begin before July 1, 2008, but not for those beginning on or after July 1, 2008.

VII. Provisions of the Proposed Rule

[If you choose to comment on issues in this section, please include the caption ''Provisions of the Proposed Regulations'' at the beginning of your comments.]

We are proposing to make revisions to the regulation text in order to implement the proposed policy changes for IRFs for FY 2007 and subsequent fiscal years. Specifically, we are proposing to make conforming changes in 42 CFR part 412. These proposed revisions and others are discussed in detail below.

A. Section 412.23 Excluded Hospitals: Classifications.

As discussed in section VI of this proposed rule, we would revise the regulation text in paragraphs (b)(2)(i) and (b)(2)(ii) to reflect the applicable percentages specified in this section as amended by the DRA. To summarize, for cost reporting periods—

(1) Beginning on or after July 1, 2005 and before July 1, 2007, the hospital has served an inpatient population of whom at least 60 percent;

(2) Beginning on or after July 1, 2007 and before July 1, 2008, the hospital has served an inpatient population of whom at least 65 percent; and

(3) Beginning on or after July 1, 2008, the hospital has served an inpatient population of whom at least 75 percent require intensive rehabilitative services for treatment of one or more of the conditions specified at paragraph (b)(2)(iii) of this section.

Since we are revising the transition timeframes in order to implement the DRA provision, a facility will not have to meet the full 75 percent compliance threshold until its first cost reporting period beginning on or after July 1, 2008. Consequently, a comorbidity that meets the criteria as specified in § 412.23(b)(2)(i) may continue to be used to determine the compliance threshold for cost reporting periods that begin before July 1, 2008. However, for cost reporting periods beginning on or after July 1, 2008, a comorbidity specified in § 412.23(b)(2)(i) will not be use to determine the compliance at the 75 percent threshold.

B. Section 412.624 Methodology for Calculating the Federal Prospective Payment Rates.

In this section, we are proposing to revise the current regulation text in paragraph (e)(5) to clarify that the cost-to-charge ratio for IRFs is a single overall (combined operating and capital) cost-to-charge ratio. We emphasize that we use the methodology described in § 412.84(i) and § 412.84(m) except that the IRF PPS uses a single overall (combined operating and capital) cost-to-charge ratio and national averages are used instead of statewide averages.

C. Additional Proposed Changes

- Revise the IRF GROUPER software and the relative weight and average lengths of stay tables based on the re-analysis RAND has done with the corrected tier list, as discussed in section II of this proposed rule.
- Reduce the standard payment amount by an additional 2.9 percent to account more fully for coding changes, as discussed in detail in section III.A of this proposed rule.
- Update payment rates for rehabilitation facilities using the RPL market basket, RPL labor-related share, and CBSA urban and rural wage indexes, as discussed in section III.B through section III.C of this proposed rule.
- Update the outlier threshold for FY 2007 to $5,609, as discussed in section IV.A of this proposed rule.
- Update the upper threshold (ceiling) and the national average urban and rural cost-to-charge ratios for determining high-cost outlier payments, as discussed in detail in section IV.B of this proposed rule.

VIII. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

IX. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

X. Regulatory Impact Analysis

[If you choose to comment on issues in this section, please include the caption ''Regulatory Impact Analysis'' at the beginning of your comments.]

A. Overall Impact

We have examined the impacts of this proposed 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.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) 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). This proposed rule is a major rule, as defined in Title 5, United States Code, section 804(2), because we estimate the impact to the Medicare program, and the annual effects to the overall economy, would be more than $100 million. We estimate that the total impact of these proposed changes for estimated FY 2007 payments compared to estimated FY 2006 payments would be an increase of approximately $40 million (this reflects a $230 million increase from the update to the payment rates and a $10 million increase due to updating the outlier threshold amount to increase estimated outlier payments from 2.9 percent in FY 2006 to 3.0 percent in FY 2007, offset by a $200 million estimated decrease from the proposed reduction to the standard payment amount to account for changes in coding that do not reflect real changes in case mix).

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 IRFs and most other providers and suppliers are considered small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. (For details, see the Small Business Administration's final rule that set forth size standards for health care

industries, at 65 FR 69432, November 17, 2000.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs. Therefore, we assume that all IRFs (an approximate total of 1,200 IRFs, of which approximately 60 percent are nonprofit facilities) are considered small entities. The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. Because the net effect of this proposed rule on almost all facilities would only be about 1 percent or less of revenues, and would be positive, we have concluded that this proposed rule would not have a significant effect on a substantial number of small entities. 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.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule 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. 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 and has fewer than 100 beds. As discussed in detail below, the rates and policies set forth in this proposed rule would not have an adverse impact on rural hospitals based on the data of the 181 rural units and 20 rural hospitals in our database of 1,202 IRFs for which data were available.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This proposed rule would not mandate any requirements for State, local, or tribal governments, nor would it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this proposed rule would not have a substantial effect on State and local governments.

B. Anticipated Effects of the Proposed Rule

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

1. Basis and Methodology of Estimates

This proposed rule sets forth updates of the IRF PPS rates contained in the FY 2006 final rule and proposes a 2.9 percent decrease to the standard payment amount to account for the increase in estimated aggregate payments due to changes in coding. In addition, we propose updates to the comorbidity tiers and the CMG relative weights, and to the outlier threshold amount.

Based on the above, we estimate the FY 2007 impact would be a net increase of $40 million in payments to IRF providers (this reflects a $230 million estimated increase from the update to the payment rates and a $10 million estimated increase due to updating the outlier threshold amount to increase estimated outlier payments from 2.9 percent in FY 2006 to 3.0 percent in FY 2007, offset by a $200 million estimated decrease from the proposed reduction to the standard payment amount to account for the increase in estimated aggregate payments due to changes in coding). The impact analysis in Table 11 of this proposed rule represents the projected effects of the proposed policy changes in the IRF PPS for FY 2007 compared with estimated IRF PPS payments in FY 2006 without the proposed policy changes. We estimate the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these proposed changes, and we do not make adjustments for future changes in such variables as number of 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 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 the BBA, the BBRA, the BIPA, the MMA, the DRA, or 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.

In updating the proposed rates for FY 2007, we made a number of standard annual revisions and clarifications mentioned elsewhere in this proposed rule (for example, the update to the wage and market basket indexes used to adjust the Federal rates). These revisions would increase payments to IRFs by approximately $230 million.

The aggregate change in payments associated with this proposed rule is estimated to be an increase in payments to IRFs of $40 million for FY 2007. The market basket increase of $230 million and the $10 million increase due to updating the outlier threshold amount to increase estimated outlier payments from 2.9 percent in FY 2006 to 3.0 percent in FY 2007, combined with the estimated decrease of $200 million due to the proposed reduction to the standard payment amount to account for coding changes (not related to real changes in case mix), results in a net change in estimated payments from FY 2006 to FY 2007 of $40 million.

The impacts are shown in Table 11. The following proposed changes are discussed separately below:

- The effects of applying the budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the expiration of the one-year budget-neutral transition policy for adopting the new CBSA-based geographic area definitions announced by OMB in June 2003.
- The effects of the proposed update to the outlier threshold amount to increase total estimated outlier payments from 2.9 to 3 percent of total estimated payments for FY 2007, consistent with section 1886(j)(4) of the Act.
- The effects of the annual market basket update (using the RPL market basket) to IRF PPS payment rates, as required by sections 1886(j)(3)(A)(i) and 1886(j)(3)(C) of the Act.
- The effects of the proposed decrease to the standard payment amount to account for the increase in estimated aggregate payments due to changes in coding, as required under section 1886(j)(2)(C)(ii) of the Act.
- The effects of the second year of the 3-year budget-neutral hold-harmless policy for IRFs that were rural under § 412.602 during FY 2005, but are urban under § 412.602 during FY 2006 and FY 2007 and lose the rural adjustment, resulting in a loss of estimated IRF PPS payments if not for the hold harmless policy.

- The effect of the proposed budget-neutral revisions to the comorbidity tiers and the CMG relative weights, under the authority of section 1886(j)(2)(C)(i) of the Act.
- The total change in estimated payments based on the proposed FY 2007 policies relative to estimated FY 2006 payments without the proposed policies for FY 2007.

2. Description of Table 11

The table below categorizes IRFs by geographic location, including urban or rural location and location with respect to CMS' nine regions of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities by ownership (otherwise called for-profit, non-profit, and government), and by teaching status. The top row of the table shows the overall impact on the 1,202 IRFs included in the analysis.

The next 12 rows of Table 11 contain IRFs categorized according to their geographic location, designation as either a freestanding hospital or a unit of a hospital, and by type of ownership: all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 1,001 IRFs located in urban areas included in our analysis. Among these, there are 807 IRF units of hospitals located in urban areas and 194 freestanding IRF hospitals located in urban areas. There are 201 IRFs located in rural areas included in our analysis. Among these, there are 181 IRF units of hospitals located in rural areas and 20 freestanding IRF hospitals located in rural areas. There are 311 for-profit IRFs. Among these, there are 260 IRFs in urban areas and 51 IRFs in rural areas. There are 743 non-profit IRFs. Among these, there are 630 urban IRFs and 113 rural IRFs. There are 148 government-owned IRFs. Among these, there are 111 urban IRFs and 37 rural IRFs.

The remaining three parts of Table 11 show IRFs grouped by their geographic location within a region, and the last part groups IRFs by teaching status. First, IRFs located in urban areas are categorized with respect to their location within a particular one of the nine CMS geographic regions. Second, IRFs located in rural areas are categorized with respect to their location within a particular one of the nine CMS geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. Finally, IRFs are grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent.

The estimated impact of each proposed change to the facility categories listed above is shown in the columns of Table 11. The description of each column is as follows:

Column (1) shows the facility classification categories described above.

Column (2) shows the number of IRFs in each category.

Column (3) shows the number of cases in each category.

Column (4) shows the estimated effect of adjusting the outlier threshold amount so that estimated outlier payments increases from 2.9 percent in FY 2006 to 3 percent of total estimated payments for FY 2007.

Column (5) shows the estimated effect of the market basket update to the IRF PPS payment rates.

Column (6) shows the estimated effect of the update to the IRF labor-related share, wage index, and hold harmless policy.

Column (7) shows the estimated effects of the proposed budget-neutral revisions to the comorbidity tiers and the CMG relative weights.

Column (8) shows the estimated effects of the proposed decrease in the standard payment amount to account for the increase in aggregate payments due to changes in coding that do not reflect real changes in case mix, as discussed in section III.A of this proposed rule. Section 1886(j)(2)(C)(ii) of the Act requires us to adjust the per discharge PPS payment rate to eliminate the effect of coding or classification changes that do not reflect real changes in case mix if we determine that such changes result in a change in aggregate payments under the classification system.

Column (9) compares our estimates of the payments per discharge, incorporating all proposed changes reflected in this proposed rule for FY 2007, to our estimates of payments per discharge in FY 2006 (without these proposed changes). The average estimated increase for all IRFs is approximately 0.6 percent. This estimated increase includes the effects of the 3.4 percent market basket update. It also includes the 0.1 percent overall estimated increase to IRF payments from the proposed update to the outlier threshold amount, and the estimated impact of the proposed one-time 2.9 percent reduction to the standard payment amount to account for changes in coding that increased payments to IRFs. Because we propose to make the remainder of the changes outlined in this proposed rule in a budget-neutral manner, they would not affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they would affect the estimated distribution of payments among providers.

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Table 11: Projected Impact on the IRF PPS for FY 2007

Facility Classification (1)	No. of IRFs (2)	No. of cases (3)	Proposed Outlier (4)	Prop. Market Basket (5)	Prop. FY07 Wage Index, Labor-share, and Hold Harmless (6)	Prop. Comorbid. Tier and relative weight Revisions (7)	Prop. 2.9% reduct (8)	Est. Total % Change (9)
Total	1,202	487,281	0.1%	3.4%	0.0%	0.0%	-2.9%	0.6%
Urban unit	807	272,017	0.2%	3.4%	-0.1%	0.0%	-2.9%	0.5%
Rural unit	181	38,880	0.1%	3.4%	-0.1%	0.1%	-2.9%	0.6%
Urban hospital	194	168,880	0.1%	3.4%	0.2%	0.0%	-2.9%	0.7%
Rural hospital	20	7,504	0.1%	3.4%	0.2%	0.0%	-2.9%	0.7%
Urban For-Profit	260	149,260	0.1%	3.4%	0.1%	0.1%	-2.9%	0.7%
Rural For-Profit	51	11,885	0.1%	3.4%	-0.5%	0.1%	-2.9%	0.0%
Urban Non-Profit	630	258,037	0.1%	3.4%	0.0%	-0.1%	-2.9%	0.5%
Rural Non-Profit	113	26,950	0.1%	3.4%	0.2%	0.1%	-2.9%	0.8%
Urban Government	111	33,600	0.2%	3.4%	0.1%	-0.1%	-2.9%	0.6%
Rural Government	37	7,549	0.2%	3.4%	0.1%	0.2%	-2.9%	0.8%
Urban	1,001	440,897	0.1%	3.4%	0.0%	0.0%	-2.9%	0.6%
Rural	201	46,384	0.1%	3.4%	0.0%	0.1%	-2.9%	0.6%
Urban by region								
New England	36	21,739	0.1%	3.4%	-0.2%	0.0%	-2.9%	0.4%
Middle Atlantic	159	80,502	0.1%	3.4%	0.6%	0.1%	-2.9%	1.2%
South Atlantic	127	78,495	0.1%	3.4%	-0.4%	0.1%	-2.9%	0.3%
East North Central	192	70,435	0.1%	3.4%	-0.3%	-0.3%	-2.9%	-0.1%
East South Central	50	29,203	0.1%	3.4%	0.2%	0.0%	-2.9%	0.7%
West North Central	70	23,874	0.2%	3.4%	-0.6%	-0.1%	-2.9%	-0.2%
West South Central	183	81,394	0.1%	3.4%	0.0%	0.1%	-2.9%	0.6%
Mountain	74	27,231	0.1%	3.4%	0.0%	0.1%	-2.9%	0.7%
Pacific	110	28,024	0.2%	3.4%	0.9%	-0.2%	-2.9%	1.3%
Rural by region								
New England	4	1,010	0.2%	3.4%	2.1%	-0.1%	-2.9%	2.7%
Middle Atlantic	19	6,074	0.1%	3.4%	0.4%	0.2%	-2.9%	1.2%
South Atlantic	25	6,692	0.1%	3.4%	-0.8%	0.2%	-2.9%	-0.1%
East North Central	29	6,255	0.1%	3.4%	0.4%	0.0%	-2.9%	0.9%
East South Central	22	5,629	0.1%	3.4%	0.3%	0.1%	-2.9%	0.9%

Facility Classification (1)	No. of IRFs (2)	No. of cases (3)	Proposed Outlier (4)	Prop. Market Basket (5)	Prop. FY07 Wage Index, Labor-share, and Hold Harmless (6)	Prop. Comorbid. Tier and relative weight Revisions (7)	Prop. 2.9% reduct (8)	Est. Total % Change (9)
West North Central	34	6,471	0.2%	3.4%	0.0%	0.0%	-2.9%	0.6%
West South Central	55	12,650	0.2%	3.4%	-0.3%	0.1%	-2.9%	0.3%
Mountain	9	1,041	0.3%	3.4%	-1.9%	0.1%	-2.9%	-1.2%
Pacific	4	562	0.2%	3.4%	2.8%	0.0%	-2.9%	3.5%
Teaching Status								
Non-teaching	1,090	433,028	0.1%	3.4%	0.0%	0.1%	-2.9%	0.6%
Resident to ADC less than 10%	61	35,227	0.1%	3.4%	0.3%	-0.3%	-2.9%	0.5%
Resident to ADC 10%-19%	32	15,011	0.1%	3.4%	-0.3%	-0.4%	-2.9%	-0.1%
Resident to ADC greater than 19%	19	4,015	0.1%	3.4%	-0.1%	-0.1%	-2.9%	0.3%

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3. Impact of the Proposed Update to the Outlier Threshold Amount (Column 4, Table 11)

In the FY 2006 IRF PPS final rule (70 FR 30188), we used FY 2003 patient-level claims data (the best, most complete data available at that time) to set the outlier threshold amount for FY 2006 so that estimated outlier payments would equal 3 percent of total estimated payments for FY 2006. For this proposed rule, we have updated our analysis using FY 2004 data. Between FYs 2003 and 2004, we observed that IRFs' cost-to-charge ratios continued to fall, a trend that has occurred each year since we first implemented the IRF PPS. We are still investigating the reasons for this. However, this decrease in cost-to-charge ratios affected our estimate of outlier payments as a percentage of total estimated payments for FY 2006, which declined from 3 percent using the FY 2003 data to 2.9 percent using the updated FY 2004 data. Thus, we are proposing to adjust the outlier threshold amount for FY 2007 to $5,609 in order to set total estimated outlier payments equal to 3 percent of total estimated payments in FY 2007 (see section IV.A of this proposed rule for a detailed discussion of the factors that influence how we arrive at the proposed outlier threshold amount). The estimated change in total payments between FY 2006 and FY 2007, therefore, includes a 0.1 percent overall estimated increase in payments because the outlier portion of total payments is estimated to increase from 2.9 percent to 3 percent.

The impact of this proposed update (as shown in column 4 of Table 11) is to increase estimated overall payments to IRFs by 0.1 percent. We estimate the largest increase in payments to be a 0.3 percent increase in payments to rural IRFs in the Mountain region. We do not estimate that any group of IRFs would experience a decrease in payments from this proposed update.

4. Impact of the Market Basket Update to the IRF PPS Payment Rates (Column 5, Table 11)

In column 5 of Table 11, we present the estimated effects of the market basket update to the IRF PPS payment rates. In the aggregate, and across all hospital groups, the update would result in a 3.4 percent increase in overall payments to IRFs.

5. Impact of the Full CBSA Wage Index, Labor-Related Share, and the Hold Harmless Policy for FY 2007 (Column 6, Table 11)

In column 6 of Table 11, we present the effects of the budget neutral wage index, labor-related share, and the hold harmless policy. In FY 2006, we provided a 1-year blended wage index and a 3-year phase out of the rural adjustment for IRFs that changed designation due to the change from MSAs to CBSAs (referenced as the hold harmless policy). We applied the blended wage index to all IRFs and the hold harmless policy to those IRFs that qualify, as described in § 412.624(e)(7), in order to mitigate the impact of the change from the MSA-based labor area definitions to the CBSA-based labor area definitions for IRFs.

As discussed in this proposed rule, the blended wage index expires in FY 2007 and will not be applied for discharges on or after October 1, 2006. Since we are in the second year of the hold harmless policy, we are not proposing a change to this policy and will continue to apply it as described in the FY 2006 final rule in a budget neutral manner.

As discussed in this proposed rule, we are proposing to update the wage index based on the CBSA-based labor market area definitions in a budget neutral manner. We will also apply the second year of the hold harmless policy in a budget neutral manner. Thus, in the aggregate, the estimated impact of the wage index and the labor-related share is zero percent.

In the aggregate for all urban and all rural IRFs, we do not estimate that these changes would affect overall estimated payments to IRFs. However, we estimate these changes to have small distributional effects. We estimate the largest increase in payments to be a 2.8 percent increase for rural IRFs in the Pacific region and the largest decrease in payments to be a 1.9 percent decrease among rural IRFs in the Mountain region.

6. Impact of the Proposed Changes to the Comorbidity Tiers and the CMG Relative Weights (Column 7, Table 11)

In column 7 of Table 11, we present the effects of the proposed changes to the comorbidity tiers and the CMG relative weights. Since we are proposing to implement these changes in a budget neutral manner, we estimate that they would have no overall effect on payments to IRFs. Similarly, we estimate no overall effect of these proposed changes on payments to urban IRFs. However, we estimate a 0.1 percent increase in payments to rural IRFs. We estimate the largest increase in payments to be a 0.2 percent increase among rural government-owned IRFs and rural IRFs located in the Middle Atlantic and South Atlantic regions. We estimate the largest decrease to be a 0.4 percent decrease among teaching IRFs with intern and resident to average daily census ratios in the 10 percent to 19 percent category.

7. Impact of the Proposed 2.9 Percent Decrease to the Standard Payment Amount to Account for Coding Changes (Column 8, Table 11)

In column 8 of Table 11, we present the effects of the proposed decrease in the standard payment amount to account for the increase in estimated aggregate payments due to changes in coding that do not reflect real changes in case mix.

In the aggregate, and across all hospital groups, we estimate that the proposed policy would result in a 2.9 percent decrease in overall payments to IRFs. Thus, we estimate that the proposed 2.9 percent reduction in the standard payment amount would result in a cost savings to the Medicare program of approximately $200 million.

C. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 12 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the proposed changes presented in this proposed rule based on the data for 1,202 IRFs in our database. All estimated expenditures are classified as transfers to Medicare providers (that is, IRFs).

TABLE 12.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2006 IRF PPS RATE YEAR TO THE 2007 IRF PPS RATE YEAR

[In Millions]

Category	Transfers
Annualized Monetized Transfers.	$40 million.
From Whom To Whom.	Federal Government to IRF Medicare Providers.

D. Alternatives Considered

Because we have determined that this proposed rule would have a significant economic impact on IRFs, we will discuss the alternative changes to the IRF PPS that we considered.

We considered a proposed reduction to the standard payment amount by an amount of up to 3.9 percent (5.8 percent minus the 1.9 percent adjustment to the standard payment amount for FY 2006), because one of RAND's methodologies for determining the amount of real change in case mix and the amount of coding change that occurred between 1999 and 2002 suggested that coding change could possibly have been responsible for up to 5.8 percent of the observed increase in IRFs' case mix. This suggests that we could potentially have proposed a reduction greater than 2.9 percent and as high as 3.9 percent. We also considered the possibility of making a somewhat lower adjustment of 2.3 percent, which would fall at approximately the middle of RAND's range of estimates. However, for the reasons discussed in section III.A of this proposed rule, we have instead decided to propose a 2.9 percent reduction to the standard payment amount. Further, in light of recent changes to the IRF PPS that affect IRF utilization trends, including the revised phase-in schedule of the IRF 75 percent rule compliance percentage, we believe it is appropriate to take an incremental approach to adjusting for coding changes. In this way, we maintain the flexibility to assess the impact of these changes and propose additional changes, if appropriate, in the future.

We considered not proposing to update the comorbidity tiers and the CMG relative weights for FY 2007. However, as described in section II of this proposed rule, re-analysis of the data indicates that some minor technical revisions are appropriate to align the distribution of payments as closely as possible with the costs of IRF care.

We also considered not proposing an update to the outlier threshold amount for FY 2007. However, analysis of updated FY 2004 data indicates that estimated outlier payments would not equal 3 percent of estimated total payment for FY 2007 unless we were to update the outlier threshold amount.

E. Conclusion (Column 9, Table 11)

Overall, estimated payments per discharge for IRFs in FY 2007 are projected to increase by 0.6 percent, compared with those in FY 2006, as reflected in column 9 of Table 11. We estimate that IRFs in urban and rural areas would both experience a 0.6 percent increase in estimated payments per discharge compared with FY 2006. We estimate that rehabilitation units in urban areas would experience a 0.5 percent increase in estimated payments per discharge, while freestanding rehabilitation hospitals in urban areas would experience a 0.7 percent increase in estimated payments per discharge. We estimate that rehabilitation units in rural areas would experience a 0.6 percent increase in estimated payments per discharge, while freestanding rehabilitation hospitals in rural areas would experience a 0.7 percent increase in estimated payments per discharge.

Overall, we estimate that the largest payment increase would be 3.5 percent among rural IRFs in the Pacific region. We estimate that the largest overall decrease in estimated payments would be a 1.2 percent decrease for rural IRFs in the Mountain region.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 412

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

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

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).

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

2. Section 412.23 is amended by—

A. Revising paragraph (b)(2)(i) introductory text.

B. Revising paragraph (b)(2)(ii).

The revisions read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(b) * * *

(2) * * *

(i) For cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005, the hospital has served an inpatient population of whom at least 50 percent, and for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2007, the hospital has served an inpatient population of whom at least 60 percent, and for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the hospital has served an inpatient population of whom at least 65 percent required intensive rehabilitative services for treatment of one or more of the conditions specified at paragraph (b)(2)(iii) of this section. A patient with a comorbidity, as defined at § 412.602, may be included in the inpatient population that counts toward the required applicable percentage if—

* * * * *

(ii) For cost reporting periods beginning on or after July 1, 2008, the hospital has served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the conditions specified in paragraph (b)(2)(iii) of this section. A patient with a comorbidity as described in paragraph (b)(2)(i) of this section is not included in the inpatient population that counts toward the required 75 percent.

* * * * *

3. In § 412.624, paragraph (e)(5) is revised to read as follows:

§ 412.624 Methodology for calculating the Federal prospective payment rates.

* * * * *

(e) * * *

(5) *Adjustment for high-cost outliers.* CMS provides for an additional payment to an inpatient rehabilitation facility if its estimated costs for a patient exceed a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients, for rural location, and for teaching programs) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at § 412.84(i), except that CMS calculates a single overall combined operating and capital cost-to-charge ratio (instead of a separate operating cost-to-charge ratio and a separate capital cost-to-charge ratio) and national averages will be used instead of statewide averages. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at § 412.84(m), except that CMS calculates a single overall combined operating and capital cost-to-charge ratio (instead of a separate operating cost-to-charge ratio and a separate capital cost-to-charge ratio).

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplemental Medical Insurance Program.)

Dated: March 30, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: May 8, 2006.

Michael O. Leavitt,

Secretary.

The following addendum will not appear in the Code of Federal Regulations.

Addendum

This addendum contains the tables referred to throughout the preamble of this proposed rule. The tables presented below are as follows:

Table 1.—Proposed Inpatient Rehabilitation Facility Urban Area Wage Index for Discharges Occurring from October 1, 2006 through September 30, 2007

Table 2.—Proposed Inpatient Rehabilitation Facility Rural Area Wage Index for Discharges Occurring from October 1, 2006 through September 30, 2007

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007

CBSA code	Urban area (constituent counties)	Full wage index
10180	Abilene, TX	0.7896
	Callahan County, TX.	
	Jones County, TX.	
	Taylor County, TX.	
10380	Aguadilla-Isabela-San Sebastián, PR	0.4738
	Aguada Municipio, PR.	
	Aguadilla Municipio, PR.	
	Añasco Municipio, PR.	
	Isabela Municipio, PR.	
	Lares Municipio, PR.	
	Moca Municipio, PR.	
	Rincón Municipio, PR.	
	San Sebastián Municipio, PR.	
10420	Akron, OH	0.8982
	Portage County, OH.	
	Summit County, OH.	
10500	Albany, GA	0.8628
	Baker County, GA.	
	Dougherty County, GA.	
	Lee County, GA.	
	Terrell County, GA.	
	Worth County, GA.	
10580	Albany-Schenectady-Troy, NY	0.8589
	Albany County, NY.	
	Rensselaer County, NY.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Saratoga County, NY.	
	Schenectady County, NY.	
	Schoharie County, NY.	
10740	Albuquerque, NM	0.9684
	Bernalillo County, NM.	
	Sandoval County, NM.	
	Torrance County, NM.	
	Valencia County, NM.	
10780	Alexandria, LA	0.8033
	Grant Parish, LA.	
	Rapides Parish, LA.	
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9818
	Warren County, NJ.	
	Carbon County, PA.	
	Lehigh County, PA.	
	Northampton County, PA.	
11020	Altoona, PA	0.8944
	Blair County, PA.	
11100	Amarillo, TX	0.9156
	Armstrong County, TX.	
	Carson County, TX.	
	Potter County, TX.	
	Randall County, TX.	
11180	Ames, IA	0.9536
	Story County, IA.	
11260	Anchorage, AK	1.1895
	Anchorage Municipality, AK.	
	Matanuska-Susitna Borough, AK.	
11300	Anderson, IN	0.8586
	Madison County, IN.	
11340	Anderson, SC	0.8997
	Anderson County, SC.	
11460	Ann Arbor, MI	1.0859
	Washtenaw County, MI.	
11500	Anniston-Oxford, AL	0.7682
	Calhoun County, AL.	
11540	Appleton, WI	0.9288
	Calumet County, WI.	
	Outagamie County, WI.	
11700	Asheville, NC	0.9285
	Buncombe County, NC.	
	Haywood County, NC.	
	Henderson County, NC.	
	Madison County, NC.	
12020	Athens-Clarke County, GA	0.9855
	Clarke County, GA.	
	Madison County, GA.	
	Oconee County, GA.	
	Oglethorpe County, GA.	
12060	Atlanta-Sandy Springs-Marietta, GA	0.9793
	Barrow County, GA.	
	Bartow County, GA.	
	Butts County, GA.	
	Carroll County, GA.	
	Cherokee County, GA.	
	Clayton County, GA.	
	Cobb County, GA.	
	Coweta County, GA.	
	Dawson County, GA.	
	DeKalb County, GA.	
	Douglas County, GA.	
	Fayette County, GA.	
	Forsyth County, GA.	
	Fulton County, GA.	
	Gwinnett County, GA.	
	Haralson County, GA.	
	Heard County, GA.	
	Henry County, GA.	
	Jasper County, GA.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Lamar County, GA.	
	Meriwether County, GA.	
	Newton County, GA.	
	Paulding County, GA.	
	Pickens County, GA.	
	Pike County, GA.	
	Rockdale County, GA.	
	Spalding County, GA.	
	Walton County, GA.	
12100	Atlantic City, NJ	1.1615
	Atlantic County, NJ.	
12220	Auburn-Opelika, AL	0.8100
	Lee County, AL.	
12260	Augusta-Richmond County, GA-SC	0.9748
	Burke County, GA.	
	Columbia County, GA.	
	McDuffie County, GA.	
	Richmond County, GA.	
	Aiken County, SC.	
	Edgefield County, SC.	
12420	Austin-Round Rock, TX	0.9437
	Bastrop County, TX.	
	Caldwell County, TX.	
	Hays County, TX.	
	Travis County, TX.	
	Williamson County, TX.	
12540	Bakersfield, CA	1.0470
	Kern County, CA.	
12580	Baltimore-Towson, MD	0.9897
	Anne Arundel County, MD.	
	Baltimore County, MD.	
	Carroll County, MD.	
	Harford County, MD.	
	Howard County, MD.	
	Queen Anne's County, MD.	
	Baltimore City, MD.	
12620	Bangor, ME	0.9993
	Penobscot County, ME.	
12700	Barnstable Town, MA	1.2600
	Barnstable County, MA.	
12940	Baton Rouge, LA	0.8593
	Ascension Parish, LA.	
	East Baton Rouge Parish, LA.	
	East Feliciana Parish, LA.	
	Iberville Parish, LA.	
	Livingston Parish, LA.	
	Pointe Coupee Parish, LA.	
	St. Helena Parish, LA.	
	West Baton Rouge Parish, LA.	
	West Feliciana Parish, LA.	
12980	Battle Creek, MI	0.9508
	Calhoun County, MI.	
13020	Bay City, MI	0.9343
	Bay County, MI.	
13140	Beaumont-Port Arthur, TX	0.8412
	Hardin County, TX.	
	Jefferson County, TX.	
	Orange County, TX.	
13380	Bellingham, WA	1.1731
	Whatcom County, WA.	
13460	Bend, OR	1.0786
	Deschutes County, OR.	
13644	Bethesda-Gaithersburg-Frederick, MD	1.1483
	Frederick County, MD.	
	Montgomery County, MD.	
13740	Billings, MT	0.8834
	Carbon County, MT.	
	Yellowstone County, MT.	
13780	Binghamton, NY	0.8562

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Broome County, NY.	
	Tioga County, NY.	
13820	Birmingham-Hoover, AL	0.8959
	Bibb County, AL.	
	Blount County, AL.	
	Chilton County, AL.	
	Jefferson County, AL.	
	St. Clair County, AL.	
	Shelby County, AL.	
	Walker County, AL.	
13900	Bismarck, ND	0.7574
	Burleigh County, ND.	
	Morton County, ND.	
13980	Blacksburg-Christiansburg-Radford, VA	0.7954
	Giles County, VA.	
	Montgomery County, VA.	
	Pulaski County, VA.	
	Radford City, VA.	
14020	Bloomington, IN	0.8447
	Greene County, IN.	
	Monroe County, IN.	
	Owen County, IN.	
14060	Bloomington-Normal, IL	0.9075
	McLean County, IL.	
14260	Boise City-Nampa, ID	0.9052
	Ada County, ID.	
	Boise County, ID.	
	Canyon County, ID.	
	Gem County, ID.	
	Owyhee County, ID.	
14484	Boston-Quincy, MA	1.1558
	Norfolk County, MA.	
	Plymouth County, MA.	
	Suffolk County, MA.	
14500	Boulder, CO	0.9734
	Boulder County, CO.	
14540	Bowling Green, KY	0.8211
	Edmonson County, KY.	
	Warren County, KY.	
14740	Bremerton-Silverdale, WA	1.0675
	Kitsap County, WA.	
14860	Bridgeport-Stamford-Norwalk, CT	1.2592
	Fairfield County, CT.	
15180	Brownsville-Harlingen, TX	0.9804
	Cameron County, TX.	
15260	Brunswick, GA	0.9311
	Brantley County, GA.	
	Glynn County, GA.	
	McIntosh County, GA.	
15380	Buffalo-Niagara Falls, NY	0.9511
	Erie County, NY.	
	Niagara County, NY.	
15500	Burlington, NC	0.8905
	Alamance County, NC.	
15540	Burlington-South Burlington, VT	0.9410
	Chittenden County, VT.	
	Franklin County, VT.	
	Grand Isle County, VT.	
15764	Cambridge-Newton-Framingham, MA	1.1172
	Middlesex County, MA.	
15804	Camden, NJ	1.0517
	Burlington County, NJ.	
	Camden County, NJ.	
	Gloucester County, NJ.	
15940	Canton-Massillon, OH	0.8935
	Carroll County, OH.	
	Stark County, OH.	
15980	Cape Coral-Fort Myers, FL	0.9356
	Lee County, FL.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
16180	Carson City, NV	1.0234
	Carson City, NV.	
16220	Casper, WY	0.9026
	Natrona County, WY.	
16300	Cedar Rapids, IA	0.8825
	Benton County, IA.	
	Jones County, IA.	
	Linn County, IA.	
16580	Champaign-Urbana, IL	0.9594
	Champaign County, IL.	
	Ford County, IL.	
	Piatt County, IL.	
16620	Charleston, WV	0.8445
	Boone County, WV.	
	Clay County, WV.	
	Kanawha County, WV.	
	Lincoln County, WV.	
	Putnam County, WV.	
16700	Charleston-North Charleston, SC	0.9245
	Berkeley County, SC.	
	Charleston County, SC.	
	Dorchester County, SC.	
16740	Charlotte-Gastonia-Concord, NC-SC	0.9750
	Anson County, NC.	
	Cabarrus County, NC.	
	Gaston County, NC.	
	Mecklenburg County, NC.	
	Union County, NC.	
	York County, SC.	
16820	Charlottesville, VA	1.0187
	Albemarle County, VA.	
	Fluvanna County, VA.	
	Greene County, VA.	
	Nelson County, VA.	
	Charlottesville City, VA.	
16860	Chattanooga, TN-GA	0.9088
	Catoosa County, GA.	
	Dade County, GA.	
	Walker County, GA.	
	Hamilton County, TN.	
	Marion County, TN.	
	Sequatchie County, TN.	
16940	Cheyenne, WY	0.8775
	Laramie County, WY.	
16974	Chicago-Naperville-Joliet, IL	1.0790
	Cook County, IL.	
	DeKalb County, IL.	
	DuPage County, IL.	
	Grundy County, IL.	
	Kane County, IL.	
	Kendall County, IL.	
	McHenry County, IL.	
	Will County, IL.	
17020	Chico, CA	1.0511
	Butte County, CA.	
17140	Cincinnati-Middletown, OH-KY-IN	0.9615
	Dearborn County, IN.	
	Franklin County, IN.	
	Ohio County, IN.	
	Boone County, KY.	
	Bracken County, KY.	
	Campbell County, KY.	
	Gallatin County, KY.	
	Grant County, KY.	
	Kenton County, KY.	
	Pendleton County, KY.	
	Brown County, OH.	
	Butler County, OH.	
	Clermont County, OH.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Hamilton County, OH.	
	Warren County, OH.	
17300	Clarksville, TN-KY	0.8284
	Christian County, KY.	
	Trigg County, KY.	
	Montgomery County, TN.	
	Stewart County, TN.	
17420	Cleveland, TN	0.8139
	Bradley County, TN.	
	Polk County, TN.	
17460	Cleveland-Elyria-Mentor, OH	0.9213
	Cuyahoga County, OH.	
	Geauga County, OH.	
	Lake County, OH.	
	Lorain County, OH.	
	Medina County, OH.	
17660	Coeur d'Alene, ID	0.9647
	Kootenai County, ID.	
17780	College Station-Bryan, TX	0.8900
	Brazos County, TX.	
	Burleson County, TX.	
	Robertson County, TX.	
17820	Colorado Springs, CO	0.9468
	El Paso County, CO.	
	Teller County, CO.	
17860	Columbia, MO	0.8345
	Boone County, MO.	
	Howard County, MO.	
17900	Columbia, SC	0.9057
	Calhoun County, SC.	
	Fairfield County, SC.	
	Kershaw County, SC.	
	Lexington County, SC.	
	Richland County, SC.	
	Saluda County, SC.	
17980	Columbus, GA-AL	0.8560
	Russell County, AL.	
	Chattahoochee County, GA.	
	Harris County, GA.	
	Marion County, GA.	
	Muscogee County, GA.	
18020	Columbus, IN	0.9588
	Bartholomew County, IN.	
18140	Columbus, OH	0.9860
	Delaware County, OH.	
	Fairfield County, OH.	
	Franklin County, OH.	
	Licking County, OH.	
	Madison County, OH.	
	Morrow County, OH.	
	Pickaway County, OH.	
	Union County, OH.	
18580	Corpus Christi, TX	0.8550
	Aransas County, TX.	
	Nueces County, TX.	
	San Patricio County, TX.	
18700	Corvallis, OR	1.0729
	Benton County, OR.	
19060	Cumberland, MD-WV	0.9317
	Allegany County, MD.	
	Mineral County, WV.	
19124	Dallas-Plano-Irving, TX	1.0228
	Collin County, TX.	
	Dallas County, TX.	
	Delta County, TX.	
	Denton County, TX.	
	Ellis County, TX.	
	Hunt County, TX.	
	Kaufman County, TX.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Rockwall County, TX.	
19140	Dalton, GA	0.9079
	Murray County, GA.	
	Whitfield County, GA.	
19180	Danville, IL	0.9028
	Vermilion County, IL.	
19260	Danville, VA	0.8489
	Pittsylvania County, VA.	
	Danville City, VA.	
19340	Davenport-Moline-Rock Island, IA-IL	0.8724
	Henry County, IL.	
	Mercer County, IL.	
	Rock Island County, IL.	
	Scott County, IA.	
19380	Dayton, OH	0.9064
	Greene County, OH.	
	Miami County, OH.	
	Montgomery County, OH.	
	Preble County, OH.	
19460	Decatur, AL	0.8469
	Lawrence County, AL.	
	Morgan County, AL.	
19500	Decatur, IL	0.8067
	Macon County, IL.	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9299
	Volusia County, FL.	
19740	Denver-Aurora, CO	1.0723
	Adams County, CO.	
	Arapahoe County, CO.	
	Broomfield County, CO.	
	Clear Creek County, CO.	
	Denver County, CO.	
	Douglas County, CO.	
	Elbert County, CO.	
	Gilpin County, CO.	
	Jefferson County, CO.	
	Park County, CO.	
19780	Des Moines, IA	0.9669
	Dallas County, IA.	
	Guthrie County, IA.	
	Madison County, IA.	
	Polk County, IA.	
	Warren County, IA.	
19804	Detroit-Livonia-Dearborn, MI	1.0424
	Wayne County, MI.	
20020	Dothan, AL	0.7721
	Geneva County, AL.	
	Henry County, AL.	
	Houston County, AL.	
20100	Dover, DE	0.9776
	Kent County, DE.	
20220	Dubuque, IA	0.9024
	Dubuque County, IA.	
20260	Duluth, MN-WI	1.0213
	Carlton County, MN.	
	St. Louis County, MN.	
	Douglas County, WI.	
20500	Durham, NC	1.0244
	Chatham County, NC.	
	Durham County, NC.	
	Orange County, NC.	
	Person County, NC.	
20740	Eau Claire, WI	0.9201
	Chippewa County, WI.	
	Eau Claire County, WI.	
20764	Edison, NJ	1.1249
	Middlesex County, NJ.	
	Monmouth County, NJ.	
	Ocean County, NJ.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Somerset County, NJ.	
20940	El Centro, CA	0.8906
	Imperial County, CA.	
21060	Elizabethtown, KY	0.8802
	Hardin County, KY.	
	Larue County, KY.	
21140	Elkhart-Goshen, IN	0.9627
	Elkhart County, IN.	
21300	Elmira, NY	0.8250
	Chemung County, NY.	
21340	El Paso, TX	0.8977
	El Paso County, TX.	
21500	Erie, PA	0.8737
	Erie County, PA.	
21604	Essex County, MA	1.0538
	Essex County, MA.	
21660	Eugene-Springfield, OR	1.0818
	Lane County, OR.	
21780	Evansville, IN-KY	0.8713
	Gibson County, IN.	
	Posey County, IN.	
	Vanderburgh County, IN.	
	Warrick County, IN.	
	Henderson County, KY.	
	Webster County, KY.	
21820	Fairbanks, AK	1.1408
	Fairbanks North Star Borough, AK.	
21940	Fajardo, PR	0.4153
	Ceiba Municipio, PR.	
	Fajardo Municipio, PR.	
	Luquillo Municipio, PR.	
22020	Fargo, ND-MN	0.8486
	Cass County, ND.	
	Clay County, MN.	
22140	Farmington, NM	0.8509
	San Juan County, NM.	
22180	Fayetteville, NC	0.9416
	Cumberland County, NC.	
	Hoke County, NC.	
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8661
	Benton County, AR.	
	Madison County, AR.	
	Washington County, AR.	
	McDonald County, MO.	
22380	Flagstaff, AZ	1.2092
	Coconino County, AZ.	
22420	Flint, MI	1.0655
	Genesee County, MI.	
	22500 Florence, SC	0.8947
	Darlington County, SC.	
	Florence County, SC.	
22520	Florence-Muscle Shoals, AL	0.8272
	Colbert County, AL.	
	Lauderdale County, AL.	
22540	Fond du Lac, WI	0.9640
	Fond du Lac County, WI.	
22660	Fort Collins-Loveland, CO	1.0122
	Larimer County, CO.	
22744	Fort Lauderdale-Pompano Beach-Deerfield	1.0432
	Beach, FL.	
	Broward County, FL.	
22900	Fort Smith, AR-OK	0.8230
	Crawford County, AR.	
	Franklin County, AR.	
	Sebastian County, AR.	
	Le Flore County, OK.	
	Sequoyah County, OK.	
23020	Fort Walton Beach-Crestview-Destin, FL	0.8872
	Okaloosa County, FL.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
23060	Fort Wayne, IN	0.9793
	Allen County, IN.	
	Wells County, IN.	
	Whitley County, IN.	
23104	Fort Worth-Arlington, TX	0.9486
	Johnson County, TX.	
	Parker County, TX.	
	Tarrant County, TX.	
	Wise County, TX.	
23420	Fresno, CA	1.0538
	Fresno County, CA.	
23460	Gadsden, AL	0.7938
	Etowah County, AL.	
23540	Gainesville, FL	0.9388
	Alachua County, FL.	
	Gilchrist County, FL.	
23580	Gainesville, GA	0.8874
	Hall County, GA.	
23844	Gary, IN	0.9395
	Jasper County, IN.	
	Lake County, IN.	
	Newton County, IN.	
	Porter County, IN.	
24020	Glens Falls, NY	0.8559
	Warren County, NY.	
	Washington County, NY.	
24140	Goldsboro, NC	0.8775
	Wayne County, NC.	
24220	Grand Forks, ND-MN	0.7901
	Polk County, MN.	
	Grand Forks County, ND.	
24300	Grand Junction, CO	0.9550
	Mesa County, CO.	
24340	Grand Rapids-Wyoming, MI	0.9390
	Barry County, MI.	
	Ionia County, MI.	
	Kent County, MI.	
	Newaygo County, MI.	
24500	Great Falls, MT	0.9052
	Cascade County, MT.	
24540	Greeley, CO	0.9570
	Weld County, CO.	
24580	Green Bay, WI	0.9483
	Brown County, WI.	
	Kewaunee County, WI.	
	Oconto County, WI.	
24660	Greensboro-High Point, NC	0.9104
	Guilford County, NC.	
	Randolph County, NC.	
	Rockingham County, NC.	
24780	Greenville, NC	0.9425
	Greene County, NC.	
	Pitt County, NC.	
24860	Greenville, SC	1.0027
	Greenville County, SC.	
	Laurens County, SC.	
	Pickens County, SC.	
25020	Guayama, PR	0.3181
	Arroyo Municipio, PR.	
	Guayama Municipio, PR.	
	Patillas Municipio, PR.	
25060	Gulfport-Biloxi, MS	0.8929
	Hancock County, MS.	
	Harrison County, MS.	
	Stone County, MS.	
25180	Hagerstown-Martinsburg, MD-WV	0.9489
	Washington County, MD.	
	Berkeley County, WV.	
	Morgan County, WV.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
25260	Hanford-Corcoran, CA	1.0036
	Kings County, CA.	
25420	Harrisburg-Carlisle, PA	0.9313
	Cumberland County, PA.	
	Dauphin County, PA.	
	Perry County, PA.	
25500	Harrisonburg, VA	0.9088
	Rockingham County, VA.	
	Harrisonburg City, VA.	
25540	Hartford-West Hartford-East Hartford, CT	1.1073
	Hartford County, CT.	
	Litchfield County, CT.	
	Middlesex County, CT.	
	Tolland County, CT.	
25620	Hattiesburg, MS	0.7601
	Forrest County, MS.	
	Lamar County, MS.	
	Perry County, MS.	
25860	Hickory-Lenoir-Morganton, NC	0.8921
	Alexander County, NC.	
	Burke County, NC.	
	Caldwell County, NC.	
	Catawba County, NC.	
25980	Hinesville-Fort Stewart, GA	[1] 0.7662
	Liberty County, GA.	
	Long County, GA.	
26100	Holland-Grand Haven, MI	0.9055
	Ottawa County, MI.	
26180	Honolulu, HI	1.1214
	Honolulu County, HI.	
26300	Hot Springs, AR	0.9005
	Garland County, AR.	
26380	Houma-Bayou Cane-Thibodaux, LA	0.7894
	Lafourche Parish, LA.	
	Terrebonne Parish, LA.	
26420	Houston-Sugar Land-Baytown, TX	0.9996
	Austin County, TX.	
	Brazoria County, TX.	
	Chambers County, TX.	
	Fort Bend County, TX.	
	Galveston County, TX.	
	Harris County, TX.	
	Liberty County, TX.	
	Montgomery County, TX.	
	San Jacinto County, TX.	
	Waller County, TX.	
26580	Huntington-Ashland, WV-KY-OH	0.9477
	Boyd County, KY.	
	Greenup County, KY.	
	Lawrence County, OH.	
	Cabell County, WV.	
	Wayne County, WV.	
26620	Huntsville, AL	0.9146
	Limestone County, AL.	
	Madison County, AL.	
26820	Idaho Falls, ID	0.9420
	Bonneville County, ID.	
	Jefferson County, ID.	
26900	Indianapolis, IN	0.9920
	Boone County, IN.	
	Brown County, IN.	
	Hamilton County, IN.	
	Hancock County, IN.	
	Hendricks County, IN.	
	Johnson County, IN.	
	Marion County, IN.	
	Morgan County, IN.	
	Putnam County, IN.	
	Shelby County, IN.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
26980	Iowa City, IA	0.9747
	Johnson County, IA.	
	Washington County, IA.	
27060	Ithaca, NY	0.9793
	Tompkins County, NY.	
27100	Jackson, MI	0.9304
	Jackson County, MI.	
27140	Jackson, MS	0.8311
	Copiah County, MS.	
	Hinds County, MS.	
	Madison County, MS.	
	Rankin County, MS.	
	Simpson County, MS.	
27180	Jackson, TN	0.8964
	Chester County, TN.	
	Madison County, TN.	
27260	Jacksonville, FL	0.9290
	Baker County, FL.	
	Clay County, FL.	
	Duval County, FL.	
	Nassau County, FL.	
	St. Johns County, FL.	
27340	Jacksonville, NC	0.8236
	Onslow County, NC.	
27500	Janesville, WI	0.9538
	Rock County, WI.	
27620	Jefferson City, MO	0.8387
	Callaway County, MO.	
	Cole County, MO.	
	Moniteau County, MO.	
	Osage County, MO.	
27740	Johnson City, TN	0.7937
	Carter County, TN.	
	Unicoi County, TN.	
	Washington County, TN.	
27780	Johnstown, PA	0.8354
	Cambria County, PA.	
27860	Jonesboro, AR	0.7911
	Craighead County, AR.	
	Poinsett County, AR.	
27900	Joplin, MO	0.8582
	Jasper County, MO.	
	Newton County, MO.	
28020	Kalamazoo-Portage, MI	1.0381
	Kalamazoo County, MI.	
	Van Buren County, MI.	
28100	Kankakee-Bradley, IL	1.0721
	Kankakee County, IL.	
28140	Kansas City, MO-KS	0.9476
	Franklin County, KS.	
	Johnson County, KS.	
	Leavenworth County, KS.	
	Linn County, KS.	
	Miami County, KS.	
	Wyandotte County, KS.	
	Bates County, MO.	
	Caldwell County, MO.	
	Cass County, MO.	
	Clay County, MO.	
	Clinton County, MO.	
	Jackson County, MO.	
	Lafayette County, MO.	
	Platte County, MO.	
	Ray County, MO.	
28420	Kennewick-Richland-Pasco, WA	1.0619
	Benton County, WA.	
	Franklin County, WA.	
28660	Killeen-Temple-Fort Hood, TX	0.8526
	Bell County, TX.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Coryell County, TX.	
	Lampasas County, TX.	
28700	Kingsport-Bristol-Bristol, TN-VA	0.8054
	Hawkins County, TN.	
	Sullivan County, TN.	
	Bristol City, VA.	
	Scott County, VA.	
	Washington County, VA.	
28740	Kingston, NY	0.9255
	Ulster County, NY.	
	28940 Knoxville, TN	0.8441
	Anderson County, TN.	
	Blount County, TN.	
	Knox County, TN.	
	Loudon County, TN.	
	Union County, TN.	
29020	Kokomo, IN	0.9508
	Howard County, IN.	
	Tipton County, IN.	
29100	La Crosse, WI-MN	0.9564
	Houston County, MN.	
	La Crosse County, WI.	
29140	Lafayette, IN	0.8736
	Benton County, IN.	
	Carroll County, IN.	
	Tippecanoe County, IN.	
29180	Lafayette, LA	0.8428
	Lafayette Parish, LA.	
	St. Martin Parish, LA.	
29340	Lake Charles, LA	0.7833
	Calcasieu Parish, LA.	
	Cameron Parish, LA.	
29404	Lake County-Kenosha County, IL-WI	1.0429
	Lake County, IL.	
	Kenosha County, WI.	
29460	Lakeland, FL	0.8912
	Polk County, FL.	
29540	Lancaster, PA	0.9694
	Lancaster County, PA.	
29620	Lansing-East Lansing, MI	0.9794
	Clinton County, MI.	
	Eaton County, MI.	
	Ingham County, MI.	
29700	Laredo, TX	0.8068
	Webb County, TX.	
	29740 Las Cruces, NM	0.8467
	Dona Ana County, NM.	
29820	Las Vegas-Paradise, NV	1.1437
	Clark County, NV.	
29940	Lawrence, KS	0.8537
	Douglas County, KS.	
30020	Lawton, OK	0.7872
	Comanche County, OK.	
30140	Lebanon, PA	0.8459
	Lebanon County, PA.	
30300	Lewiston, ID-WA	0.9886
	Nez Perce County, ID.	
	Asotin County, WA.	
30340	Lewiston-Auburn, ME	0.9331
	Androscoggin County, ME.	
30460	Lexington-Fayette, KY	0.9075
	Bourbon County, KY.	
	Clark County, KY.	
	Fayette County, KY.	
	Jessamine County, KY.	
	Scott County, KY.	
	Woodford County, KY.	
30620	Lima, OH	0.9225
	Allen County, OH.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
30700	Lincoln, NE	1.0214
	Lancaster County, NE.	
	Seward County, NE.	
30780	Little Rock-North Little Rock, AR	0.8747
	Faulkner County, AR.	
	Grant County, AR.	
	Lonoke County, AR.	
	Perry County, AR.	
	Pulaski County, AR.	
	Saline County, AR.	
30860	Logan, UT-ID	0.9164
	Franklin County, ID.	
	Cache County, UT.	
30980	Longview, TX	0.8730
	Gregg County, TX.	
	Rusk County, TX.	
	Upshur County, TX.	
31020	Longview, WA	0.9579
	Cowlitz County, WA.	
31084	Los Angeles-Long Beach-Glendale, CA	1.1783
	Los Angeles County, CA.	
31140	Louisville, KY-IN	0.9251
	Clark County, IN.	
	Floyd County, IN.	
	Harrison County, IN.	
	Washington County, IN.	
	Bullitt County, KY.	
	Henry County, KY.	
	Jefferson County, KY.	
	Meade County, KY.	
	Nelson County, KY.	
	Oldham County, KY.	
	Shelby County, KY.	
	Spencer County, KY.	
	Trimble County, KY.	
31180	Lubbock, TX	0.8783
	Crosby County, TX.	
	Lubbock County, TX.	
31340	Lynchburg, VA	0.8691
	Amherst County, VA.	
	Appomattox County, VA.	
	Bedford County, VA.	
	Campbell County, VA.	
	Bedford City, VA.	
	Lynchburg City, VA.	
31420	Macon, GA	0.9443
	Bibb County, GA.	
	Crawford County, GA.	
	Jones County, GA.	
	Monroe County, GA.	
	Twiggs County, GA.	
31460	Madera, CA	0.8713
	Madera County, CA.	
31540	Madison, WI	1.0659
	Columbia County, WI.	
	Dane County, WI.	
	Iowa County, WI.	
31700	Manchester-Nashua, NH	1.0354
	Hillsborough County, NH.	
	Merrimack County, NH.	
31900	Mansfield, OH	0.9891
	Richland County, OH.	
32420	Mayagüez, PR	0.4020
	Hormigueros Municipio, PR.	
	Mayagŭ≤ez Municipio, PR.	
32580	McAllen-Edinburg-Mission, TX	0.8934
	Hidalgo County, TX.	
32780	Medford, OR	1.0225
	Jackson County, OR.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
32820	Memphis, TN-MS-AR	0.9397
	Crittenden County, AR.	
	DeSoto County, MS.	
	Marshall County, MS.	
	Tate County, MS.	
	Tunica County, MS.	
	Fayette County, TN.	
	Shelby County, TN.	
	Tipton County, TN.	
32900	Merced, CA	1.1109
	Merced County, CA.	
33124	Miami-Miami Beach-Kendall, FL	0.9750
	Miami-Dade County, FL.	
33140	Michigan City-La Porte, IN	0.9399
	LaPorte County, IN.	
33260	Midland, TX	0.9514
	Midland County, TX.	
33340	Milwaukee-Waukesha-West Allis, WI	1.0146
	Milwaukee County, WI.	
	Ozaukee County, WI.	
	Washington County, WI.	
	Waukesha County, WI.	
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.1075
	Anoka County, MN.	
	Carver County, MN.	
	Chisago County, MN.	
	Dakota County, MN.	
	Hennepin County, MN.	
	Isanti County, MN.	
	Ramsey County, MN.	
	Scott County, MN.	
	Sherburne County, MN.	
	Washington County, MN.	
	Wright County, MN.	
	Pierce County, WI.	
	St. Croix County, WI.	
33540	Missoula, MT	0.9473
	Missoula County, MT.	
33660	Mobile, AL	0.7891
	Mobile County, AL.	
33700	Modesto, CA	1.1885
	Stanislaus County, CA.	
33740	Monroe, LA	0.8031
	Ouachita Parish, LA.	
	Union Parish, LA.	
33780	Monroe, MI	0.9468
	Monroe County, MI.	
33860	Montgomery, AL	0.8618
	Autauga County, AL.	
	Elmore County, AL.	
	Lowndes County, AL.	
	Montgomery County, AL.	
34060	Morgantown, WV	0.8420
	Monongalia County, WV.	
	Preston County, WV.	
34100	Morristown, TN	0.7961
	Grainger County, TN.	
	Hamblen County, TN.	
	Jefferson County, TN.	
34580	Mount Vernon-Anacortes, WA	1.0454
	Skagit County, WA.	
34620	Muncie, IN	0.8930
	Delaware County, IN.	
34740	Muskegon-Norton Shores, MI	0.9664
	Muskegon County, MI.	
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.8934
	Horry County, SC.	
34900	Napa, CA	1.2643
	Napa County, CA.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
34940	Naples-Marco Island, FL	1.0139
	Collier County, FL.	
34980	Nashville-Davidson—Murfreesboro, TN	0.9790
	Cannon County, TN.	
	Cheatham County, TN.	
	Davidson County, TN.	
	Dickson County, TN.	
	Hickman County, TN.	
	Macon County, TN.	
	Robertson County, TN.	
	Rutherford County, TN.	
	Smith County, TN.	
	Sumner County, TN.	
	Trousdale County, TN.	
	Williamson County, TN.	
	Wilson County, TN.	
35004	Nassau-Suffolk, NY	1.2719
	Nassau County, NY.	
	Suffolk County, NY.	
35084	Newark-Union, NJ-PA	1.1883
	Essex County, NJ.	
	Hunterdon County, NJ.	
	Morris County, NJ.	
	Sussex County, NJ.	
	Union County, NJ.	
	Pike County, PA.	
35300	New Haven-Milford, CT	1.1887
	New Haven County, CT.	
35380	New Orleans-Metairie-Kenner, LA	0.8995
	Jefferson Parish, LA.	
	Orleans Parish, LA.	
	Plaquemines Parish, LA.	
	St. Bernard Parish, LA.	
	St. Charles Parish, LA.	
	St. John the Baptist Parish, LA.	
	St. Tammany Parish, LA.	
35644	New York-White Plains-Wayne, NY-NJ	1.3188
	Bergen County, NJ.	
	Hudson County, NJ.	
	Passaic County, NJ.	
	Bronx County, NY.	
	Kings County, NY.	
	New York County, NY.	
	Putnam County, NY.	
	Queens County, NY.	
	Richmond County, NY.	
	Rockland County, NY.	
	Westchester County, NY.	
35660	Niles-Benton Harbor, MI	0.8879
	Berrien County, MI.	
35980	Norwich-New London, CT	1.1345
	New London County, CT.	
36084	Oakland-Fremont-Hayward, CA	1.5346
	Alameda County, CA.	
	Contra Costa County, CA.	
36100	Ocala, FL	0.8925
	Marion County, FL.	
36140	Ocean City, NJ	1.1011
	Cape May County, NJ.	
36220	Odessa, TX	0.9884
	Ector County, TX.	
36260	Ogden-Clearfield, UT	0.9029
	Davis County, UT.	
	Morgan County, UT.	
	Weber County, UT.	
36420	Oklahoma City, OK	0.9031
	Canadian County, OK.	
	Cleveland County, OK.	
	Grady County, OK.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Lincoln County, OK.	
	Logan County, OK.	
	McClain County, OK.	
	Oklahoma County, OK.	
36500	Olympia, WA	1.0927
	Thurston County, WA.	
36540	Omaha-Council Bluffs, NE-IA	0.9560
	Harrison County, IA.	
	Mills County, IA.	
	Pottawattamie County, IA.	
	Cass County, NE.	
	Douglas County, NE.	
	Sarpy County, NE.	
	Saunders County, NE.	
	Washington County, NE.	
36740	Orlando-Kissimmee, FL	0.9464
	Lake County, FL.	
	Orange County, FL.	
	Osceola County, FL.	
	Seminole County, FL.	
36780	Oshkosh-Neenah, WI	0.9183
	Winnebago County, WI.	
36980	Owensboro, KY	0.8780
	Daviess County, KY.	
	Hancock County, KY.	
	McLean County, KY.	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1622
	Ventura County, CA.	
37340	Palm Bay-Melbourne-Titusville, FL	0.9839
	Brevard County, FL.	
37460	Panama City-Lynn Haven, FL	0.8005
	Bay County, FL.	
37620	Parkersburg-Marietta-Vienna, WV-OH	0.8270
	Washington County, OH.	
	Pleasants County, WV.	
	Wirt County, WV.	
	Wood County, WV.	
37700	Pascagoula, MS	0.8156
	George County, MS.	
	Jackson County, MS.	
37860	Pensacola-Ferry Pass-Brent, FL	0.8096
	Escambia County, FL.	
	Santa Rosa County, FL.	
37900	Peoria, IL	0.8870
	Marshall County, IL.	
	Peoria County, IL.	
	Stark County, IL.	
	Tazewell County, IL.	
	Woodford County, IL.	
37964	Philadelphia, PA	1.1038
	Bucks County, PA.	
	Chester County, PA.	
	Delaware County, PA.	
	Montgomery County, PA.	
	Philadelphia County, PA.	
38060	Phoenix-Mesa-Scottsdale, AZ	1.0127
	Maricopa County, AZ.	
	Pinal County, AZ.	
38220	Pine Bluff, AR	0.8680
	Cleveland County, AR.	
	Jefferson County, AR.	
	Lincoln County, AR.	
38300	Pittsburgh, PA	0.8845
	Allegheny County, PA.	
	Armstrong County, PA.	
	Beaver County, PA.	
	Butler County, PA.	
	Fayette County, PA.	
	Washington County, PA.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Westmoreland County, PA.	
38340	Pittsfield, MA	1.0181
	Berkshire County, MA.	
38540	Pocatello, ID	0.9351
	Bannock County, ID.	
	Power County, ID.	
38660	Ponce, PR	0.4939
	Juana Díaz Municipio, PR.	
	Ponce Municipio, PR.	
	Villalba Municipio, PR.	
38860	Portland-South Portland-Biddeford, ME	1.0382
	Cumberland County, ME.	
	Sagadahoc County, ME.	
	York County, ME.	
38900	Portland-Vancouver-Beaverton, OR-WA	1.1266
	Clackamas County, OR.	
	Columbia County, OR.	
	Multnomah County, OR.	
	Washington County, OR.	
	Yamhill County, OR.	
	Clark County, WA.	
	Skamania County, WA.	
38940	Port St. Lucie-Fort Pierce, FL	1.0123
	Martin County, FL.	
	St. Lucie County, FL.	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0891
	Dutchess County, NY.	
	Orange County, NY.	
39140	Prescott, AZ	0.9869
	Yavapai County, AZ.	
39300	Providence-New Bedford-Fall River, RI-MA	1.0966
	Bristol County, MA.	
	Bristol County, RI.	
	Kent County, RI.	
	Newport County, RI.	
	Providence County, RI.	
	Washington County, RI.	
39340	Provo-Orem, UT	0.9500
	Juab County, UT.	
	Utah County, UT.	
39380	Pueblo, CO	0.8623
	Pueblo County, CO.	
39460	Punta Gorda, FL	0.9255
	Charlotte County, FL.	
39540	Racine, WI	0.8997
	Racine County, WI.	
39580	Raleigh-Cary, NC	0.9691
	Franklin County, NC.	
	Johnston County, NC.	
	Wake County, NC.	
39660	Rapid City, SD	0.8987
	Meade County, SD.	
	Pennington County, SD.	
39740	Reading, PA	0.9686
	Berks County, PA.	
39820	Redding, CA	1.2203
	Shasta County, CA.	
39900	Reno-Sparks, NV	1.0982
	Storey County, NV.	
	Washoe County, NV.	
40060	Richmond, VA	0.9328
	Amelia County, VA.	
	Caroline County, VA.	
	Charles City County, VA.	
	Chesterfield County, VA.	
	Cumberland County, VA.	
	Dinwiddie County, VA.	
	Goochland County, VA.	
	Hanover County, VA.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Henrico County, VA.	
	King and Queen County, VA.	
	King William County, VA.	
	Louisa County, VA.	
	New Kent County, VA.	
	Powhatan County, VA.	
	Prince George County, VA.	
	Sussex County, VA.	
	Colonial Heights City, VA.	
	Hopewell City, VA.	
	Petersburg City, VA.	
	Richmond City, VA.	
40140	Riverside-San Bernardino-Ontario, CA	1.1027
	Riverside County, CA.	
	San Bernardino County, CA.	
40220	Roanoke, VA	0.8374
	Botetourt County, VA.	
	Craig County, VA.	
	Franklin County, VA.	
	Roanoke County, VA.	
	Roanoke City, VA.	
	Salem City, VA.	
40340	Rochester, MN	1.1131
	Dodge County, MN.	
	Olmsted County, MN.	
	Wabasha County, MN.	
40380	Rochester, NY	0.9121
	Livingston County, NY.	
	Monroe County, NY.	
	Ontario County, NY.	
	Orleans County, NY.	
	Wayne County, NY.	
40420	Rockford, IL	0.9984
	Boone County, IL.	
	Winnebago County, IL.	
40484	Rockingham County-Strafford County, NH	1.0374
	Rockingham County, NH.	
	Strafford County, NH.	
40580	Rocky Mount, NC	0.8915
	Edgecombe County, NC.	
	Nash County, NC.	
40660	Rome, GA	0.9414
	Floyd County, GA.	
40900	Sacramento—Arden-Arcade—Roseville, CA	1.2969
	El Dorado County, CA.	
	Placer County, CA.	
	Sacramento County, CA.	
	Yolo County, CA.	
40980	Saginaw-Saginaw Township North, MI	0.9088
	Saginaw County, MI.	
41060	St. Cloud, MN	0.9965
	Benton County, MN.	
	Stearns County, MN.	
41100	St. George, UT	0.9392
	Washington County, UT.	
41140	St. Joseph, MO-KS	0.9519
	Doniphan County, KS.	
	Andrew County, MO.	
	Buchanan County, MO.	
	DeKalb County, MO.	
41180	St. Louis, MO-IL	0.8954
	Bond County, IL.	
	Calhoun County, IL.	
	Clinton County, IL.	
	Jersey County, IL.	
	Macoupin County, IL.	
	Madison County, IL.	
	Monroe County, IL.	
	St. Clair County, IL.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Crawford County, MO.	
	Franklin County, MO.	
	Jefferson County, MO.	
	Lincoln County, MO.	
	St. Charles County, MO.	
	St. Louis County, MO.	
	Warren County, MO.	
	Washington County, MO.	
	St. Louis City, MO.	
41420	Salem, OR	1.0442
	Marion County, OR.	
	Polk County, OR.	
41500	Salinas, CA	1.4128
	Monterey County, CA.	
41540	Salisbury, MD	0.9064
	Somerset County, MD.	
	Wicomico County, MD.	
41620	Salt Lake City, UT	0.9421
	Salt Lake County, UT.	
	Summit County, UT.	
	Tooele County, UT.	
41660	San Angelo, TX	0.8271
	Irion County, TX.	
	Tom Green County, TX.	
41700	San Antonio, TX	0.8980
	Atascosa County, TX.	
	Bandera County, TX.	
	Bexar County, TX.	
	Comal County, TX.	
	Guadalupe County, TX.	
	Kendall County, TX.	
	Medina County, TX.	
	Wilson County, TX.	
41740	San Diego-Carlsbad-San Marcos, CA	1.1413
	San Diego County, CA.	
41780	Sandusky, OH	0.9019
	Erie County, OH.	
41884	San Francisco-San Mateo-Redwood City, CA	1.4994
	Marin County, CA.	
	San Francisco County, CA.	
	San Mateo County, CA.	
41900	San Germán-Cabo Rojo, PR	0.4650
	Cabo Rojo Municipio, PR.	
	Lajas Municipio, PR.	
	Sabana Grande Municipio, PR.	
	San Germán Municipio, PR.	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.5099
	San Benito County, CA.	
	Santa Clara County, CA.	
41980	San Juan-Caguas-Guaynabo, PR	0.4621
	Aguas Buenas Municipio, PR.	
	Aibonito Municipio, PR.	
	Arecibo Municipio, PR.	
	Barceloneta Municipio, PR.	
	Barranquitas Municipio, PR.	
	Bayamón Municipio, PR.	
	Caguas Municipio, PR.	
	Camuy Municipio, PR.	
	Canóvanas Municipio, PR.	
	Carolina Municipio, PR.	
	Cataño Municipio, PR.	
	Cayey Municipio, PR.	
	Ciales Municipio, PR.	
	Cidra Municipio, PR.	
	Comerío Municipio, PR.	
	Corozal Municipio, PR.	
	Dorado Municipio, PR.	
	Florida Municipio, PR.	
	Guaynabo Municipio, PR.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Gurabo Municipio, PR.	
	Hatillo Municipio, PR.	
	Humacao Municipio, PR.	
	Juncos Municipio, PR.	
	Las Piedras Municipio, PR.	
	Loíza Municipio, PR.	
	Manatí Municipio, PR.	
	Maunabo Municipio, PR.	
	Morovis Municipio, PR.	
	Naguabo Municipio, PR.	
	Naranjito Municipio, PR.	
	Orocovis Municipio, PR.	
	Quebradillas Municipio, PR.	
	Río Grande Municipio, PR.	
	San Juan Municipio, PR.	
	San Lorenzo Municipio, PR.	
	Toa Alta Municipio, PR.	
	Toa Baja Municipio, PR.	
	Trujillo Alto Municipio, PR.	
	Vega Alta Municipio, PR.	
	Vega Baja Municipio, PR.	
	Yabucoa Municipio, PR.	
42020	San Luis Obispo-Paso Robles, CA	1.1349
	San Luis Obispo County, CA.	
42044	Santa Ana-Anaheim-Irvine, CA	1.1559
	Orange County, CA.	
42060	Santa Barbara-Santa Maria, CA	1.1694
	Santa Barbara County, CA.	
42100	Santa Cruz-Watsonville, CA	1.5166
	Santa Cruz County, CA.	
42140	Santa Fe, NM	1.0920
	Santa Fe County, NM.	
42220	Santa Rosa-Petaluma, CA	1.3493
	Sonoma County, CA.	
42260	Sarasota-Bradenton-Venice, FL	0.9639
	Manatee County, FL.	
	Sarasota County, FL.	
42340	Savannah, GA	0.9461
	Bryan County, GA.	
	Chatham County, GA.	
	Effingham County, GA.	
42540	Scranton—Wilkes-Barre, PA	0.8540
	Lackawanna County, PA.	
	Luzerne County, PA.	
	Wyoming County, PA.	
42644	Seattle-Bellevue-Everett, WA	1.1577
	King County, WA.	
	Snohomish County, WA.	
43100	Sheboygan, WI	0.8911
	Sheboygan County, WI.	
43300	Sherman-Denison, TX	0.9507
	Grayson County, TX.	
43340	Shreveport-Bossier City, LA	0.8760
	Bossier Parish, LA.	
	Caddo Parish, LA.	
	De Soto Parish, LA.	
43580	Sioux City, IA-NE-SD	0.9381
	Woodbury County, IA.	
	Dakota County, NE.	
	Dixon County, NE.	
	Union County, SD.	
43620	Sioux Falls, SD	0.9635
	Lincoln County, SD.	
	McCook County, SD.	
	Minnehaha County, SD.	
	Turner County, SD.	
43780	South Bend-Mishawaka, IN-MI	0.9788
	St. Joseph County, IN.	
	Cass County, MI.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
43900	Spartanburg, SC	0.9172
	Spartanburg County, SC.	
44060	Spokane, WA	1.0905
	Spokane County, WA.	
44100	Springfield, IL	0.8792
	Menard County, IL.	
	Sangamon County, IL.	
44140	Springfield, MA	1.0248
	Franklin County, MA.	
	Hampden County, MA.	
	Hampshire County, MA.	
44180	Springfield, MO	0.8237
	Christian County, MO.	
	Dallas County, MO.	
	Greene County, MO.	
	Polk County, MO.	
	Webster County, MO.	
44220	Springfield, OH	0.8396
	Clark County, OH.	
44300	State College, PA	0.8356
	Centre County, PA.	
44700	Stockton, CA	1.1307
	San Joaquin County, CA.	
44940	Sumter, SC	0.8377
	Sumter County, SC.	
45060	Syracuse, NY	0.9574
	Madison County, NY.	
	Onondaga County, NY.	
	Oswego County, NY.	
45104	Tacoma, WA	1.0742
	Pierce County, WA.	
45220	Tallahassee, FL	0.8688
	Gadsden County, FL.	
	Jefferson County, FL.	
	Leon County, FL.	
	Wakulla County, FL.	
45300	Tampa-St. Petersburg-Clearwater, FL	0.9233
	Hernando County, FL.	
	Hillsborough County, FL.	
	Pasco County, FL.	
	Pinellas County, FL.	
45460	Terre Haute, IN	0.8304
	Clay County, IN.	
	Sullivan County, IN.	
	Vermillion County, IN.	
	Vigo County, IN.	
45500	Texarkana, TX-Texarkana, AR	0.8283
	Miller County, AR.	
	Bowie County, TX.	
45780	Toledo, OH	0.9574
	Fulton County, OH.	
	Lucas County, OH.	
	Ottawa County, OH.	
	Wood County, OH.	
45820	Topeka, KS	0.8920
	Jackson County, KS.	
	Jefferson County, KS.	
	Osage County, KS.	
	Shawnee County, KS.	
	Wabaunsee County, KS.	
45940	Trenton-Ewing, NJ	1.0834
	Mercer County, NJ.	
46060	Tucson, AZ	0.9007
	Pima County, AZ.	
46140	Tulsa, OK	0.8543
	Creek County, OK.	
	Okmulgee County, OK.	
	Osage County, OK.	
	Pawnee County, OK.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Rogers County, OK.	
	Tulsa County, OK.	
	Wagoner County, OK.	
46220	Tuscaloosa, AL	0.8645
	Greene County, AL.	
	Hale County, AL.	
	Tuscaloosa County, AL.	
46340	Tyler, TX	0.9168
	Smith County, TX.	
46540	Utica-Rome, NY	0.8358
	Herkimer County, NY.	
	Oneida County, NY.	
46660	Valdosta, GA	0.8866
	Brooks County, GA.	
	Echols County, GA.	
	Lanier County, GA.	
	Lowndes County, GA.	
46700	Vallejo-Fairfield, CA	1.4936
	Solano County, CA.	
46940	Vero Beach, FL	0.9434
	Indian River County, FL.	
47020	Victoria, TX	0.8160
	Calhoun County, TX.	
	Goliad County, TX.	
	Victoria County, TX.	
47220	Vineland-Millville-Bridgeton, NJ	0.9827
	Cumberland County, NJ.	
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.8799
	Currituck County, NC.	
	Gloucester County, VA.	
	Isle of Wight County, VA.	
	James City County, VA.	
	Mathews County, VA.	
	Surry County, VA.	
	York County, VA.	
	Chesapeake City, VA.	
	Hampton City, VA.	
	Newport News City, VA.	
	Norfolk City, VA.	
	Poquoson City, VA.	
	Portsmouth City, VA.	
	Suffolk City, VA.	
	Virginia Beach City, VA.	
	Williamsburg City, VA.	
47300	Visalia-Porterville, CA	1.0123
	Tulare County, CA.	
47380	Waco, TX	0.8518
	McLennan County, TX.	
47580	Warner Robins, GA	0.8645
	Houston County, GA.	
47644	Warren-Farmington Hills-Troy, MI	0.9871
	Lapeer County, MI.	
	Livingston County, MI.	
	Macomb County, MI.	
	Oakland County, MI.	
	St. Clair County, MI.	
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.0926
	District of Columbia, DC.	
	Calvert County, MD.	
	Charles County, MD.	
	Prince George's County, MD.	
	Arlington County, VA.	
	Clarke County, VA.	
	Fairfax County, VA.	
	Fauquier County, VA.	
	Loudoun County, VA.	
	Prince William County, VA.	
	Spotsylvania County, VA.	
	Stafford County, VA.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Warren County, VA.	
	Alexandria City, VA.	
	Fairfax City, VA.	
	Falls Church City, VA.	
	Fredericksburg City, VA.	
	Manassas City, VA.	
	Manassas Park City, VA.	
	Jefferson County, WV.	
47940	Waterloo-Cedar Falls, IA	0.8557
	Black Hawk County, IA.	
	Bremer County, IA.	
	Grundy County, IA.	
48140	Wausau, WI	0.9590
	Marathon County, WI.	
48260	Weirton-Steubenville, WV-OH	0.7819
	Jefferson County, OH.	
	Brooke County, WV.	
	Hancock County, WV.	
48300	Wenatchee, WA	1.0070
	Chelan County, WA.	
	Douglas County, WA.	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	1.0067
	Palm Beach County, FL.	
48540	Wheeling, WV-OH	0.7161
	Belmont County, OH.	
	Marshall County, WV.	
	Ohio County, WV.	
48620	Wichita, KS	0.9153
	Butler County, KS.	
	Harvey County, KS.	
	Sedgwick County, KS.	
	Sumner County, KS.	
48660	Wichita Falls, TX	0.8285
	Archer County, TX.	
	Clay County, TX.	
	Wichita County, TX.	
48700	Williamsport, PA	0.8364
	Lycoming County, PA.	
48864	Wilmington, DE-MD-NJ	1.0471
	New Castle County, DE.	
	Cecil County, MD.	
	Salem County, NJ.	
48900	Wilmington, NC	0.9582
	Brunswick County, NC.	
	New Hanover County, NC.	
	Pender County, NC.	
49020	Winchester, VA-WV	1.0214
	Frederick County, VA.	
	Winchester City, VA.	
	Hampshire County, WV.	
49180	Winston-Salem, NC	0.8944
	Davie County, NC.	
	Forsyth County, NC.	
	Stokes County, NC.	
	Yadkin County, NC.	
49340	Worcester, MA	1.1028
	Worcester County, MA.	
49420	Yakima, WA	1.0155
	Yakima County, WA.	
49500	Yauco, PR	0.4408
	Guánica Municipio, PR.	
	Guayanilla Municipio, PR.	
	Peñuelas Municipio, PR.	
	Yauco Municipio, PR.	
49620	York-Hanover, PA	0.9347
	York County, PA.	
49660	Youngstown-Warren-Boardman, OH-PA	0.8603
	Mahoning County, OH.	
	Trumbull County, OH.	

TABLE 1.—PROPOSED INPATIENT REHABILITATION FACILITY URBAN AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Urban area (constituent counties)	Full wage index
	Mercer County, PA.	
49700	Yuba City, CA	1.0921
	Sutter County, CA.	
	Yuba County, CA.	
49740	Yuma, AZ	0.9126
	Yuma County, AZ.	

[1] At this time, there are no hospitals located in this CBSA-based urban area on which to base a wage index. Therefore, the wage index value is based on the methodology described in the August 15, 2005 final rule (70 FR 47880). The wage index value for this area is the average wage index for all urban areas within the state.

TABLE 2.—PROPOSED INPATIENT REHABILITATION FACILITY RURAL AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007

CBSA code	Nonurban area	Full wage Index
01	Alabama	0.7446
02	Alaska	1.1977
03	Arizona	0.8768
04	Arkansas	0.7466
05	California	1.1054
06	Colorado	0.9380
07	Connecticut	1.1730
08	Delaware	0.9579
10	Florida	0.8568
11	Georgia	0.7662
12	Hawaii	1.0551
13	Idaho	0.8037
14	Illinois	0.8271
15	Indiana	0.8624
16	Iowa	0.8509
17	Kansas	0.8035
18	Kentucky	0.7766
19	Louisiana	0.7411
20	Maine	0.8843
21	Maryland	0.9353
22	Massachusetts [2]	1.0216
23	Michigan	0.8895
24	Minnesota	0.9132
25	Mississippi	0.7674
26	Missouri	0.7900
27	Montana	0.8762
28	Nebraska	0.8657
29	Nevada	0.9065
30	New Hampshire	1.0817
31	New Jersey [1]	.....
32	New Mexico	0.8635

TABLE 2.—PROPOSED INPATIENT REHABILITATION FACILITY RURAL AREA WAGE INDEX FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2006 THROUGH SEPTEMBER 30, 2007—Continued

CBSA code	Nonurban area	Full wage Index
33	New York	0.8154
34	North Carolina	0.8540
35	North Dakota	0.7261
36	Ohio	0.8826
37	Oklahoma	0.7581
38	Oregon	0.9826
39	Pennsylvania	0.8291
40	Puerto Rico [2]	0.4047
41	Rhode Island [1]	.....
42	South Carolina	0.8638
43	South Dakota	0.8560
44	Tennessee	0.7895
45	Texas	0.8003
46	Utah	0.8118
47	Vermont	0.9830
48	Virgin Islands	0.7615
49	Virginia	0.8013
50	Washington	1.0510
51	West Virginia	0.7717
52	Wisconsin	0.9509
53	Wyoming	0.9257
65	Guam	0.9611

[1] All counties within the State are classified as urban.

[2] Massachusetts and Puerto Rico have areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for FY 2007. As discussed in the FY 2006 IRF PPS Final Rule (70 FR 47880), we use the previous year's wage index value.

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