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Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2012; Changes in Size and Square Footage of Inpatient Rehabilitation Units and Inpatient Psychiatric Units; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1349–P]

RIN 0938–AQ28

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2012; Changes in Size and Square Footage of Inpatient Rehabilitation Units and Inpatient Psychiatric Units

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement section 3004 of the Affordable Care Act, which establishes a new quality reporting program that provides for a 2 percent reduction in the annual increase factor beginning in 2014 for failure to report quality data to the Secretary of Health and Human Services. This proposed rule would also update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year 2012 (for discharges occurring on or after October 1, 2011 and on or before September 30, 2012) as required by the Social Security Act (the Act). The Act requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each FY the classification and weighting factors for the IRF prospective payment system (PPS) case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year. We are also proposing to consolidate, clarify, and revise existing policies regarding IRF hospitals and IRF units of hospitals to eliminate unnecessary confusion and enhance consistency. Furthermore, in accordance with the general principles of the President's January 18, 2011 Executive Order entitled "Improving Regulation and Regulatory Review," we are proposing to amend existing regulatory provisions regarding "new" facilities and changes in the bed size and square footage of IRFs and inpatient psychiatric facilities (IPFs) to improve clarity and remove obsolete material.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 21, 2011.

ADDRESSES: In commenting, please refer to file code CMS–1349–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1349–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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 to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1349–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 before the close of the comment period to either of the following addresses: a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the 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.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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.

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

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

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

FOR FURTHER INFORMATION CONTACT:
Gwendolyn Johnson, (410) 786–6954, for general information about the proposed rule.
Hillary Loeffler, (410) 786–0456, for information about the proposed payment rates.
Stella R. Mandl, (410) 786–2547, for information about the proposed quality reporting program.
Susanne Seagrave, (410) 786–0044, for information about the proposed payment policies.

SUPPLEMENTARY INFORMATION:

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.regulations.gov.* Follow the search instructions 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

To assist the reader, we are listing the acronyms used and their corresponding meaning in alphabetical order.

ADC Average Daily Census
AHA American Hospital Association
ASCA Administrative Simplification Compliance Act of 2002, Public Law 107–105
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
BEA Bureau of Economic Analysis
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106–554
BLS Bureau of Labor Statistics
CAH Critical Access Hospital
CAUTI Catheter-Associated Urinary Tract Infection
CDC Centers for Disease Control and Prevention
CBSA Core-Based Statistical Area
CCR Cost-to-Charge Ratio
CFR Code of Federal Regulations
CIPI Capital Input Price Index
CMG Case-Mix Group
CMS Centers for Medicare & Medicaid Services
CPI Consumer Price Index
DSH Disproportionate Share Hospital
ECI Employment Cost Index
EHR Electronic Health Record
FI Fiscal Intermediary
FR Federal Register
FTE Full-time Equivalent
FY Federal Fiscal Year
GDP Gross Domestic Product
GME Graduate Medical Education
HAI Healthcare Associated Infection
HHH Hubert H. Humphrey Building
HHS Department of Health Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996, Public Law 104–191
HOMER Home Office Medicare Records
IGI IHS Global Insight
IME Indirect Medical Education
I–O Input-Output
IPF Inpatient Psychiatric Facility
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
LTCH Long Term Care Hospital
LIP Low-Income Percentage
LOS Length of Stay
MA Medicare Advantage
MAC Medicare Administrative Contractor
MedPAR Medicare Provider Analysis and Review
MFP Multifactor Productivity
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 110–173
MSA Metropolitan Statistical Area
NAICS North American Industry Classification System
NHSN National Healthcare Safety Network
NQF National Quality Forum
OMB Office of Management and Budget
PLI Professional Liability Insurance
PPI Producer Price Indexes
PPS Prospective Payment System
QM Quality Measure
RFA Regulatory Flexibility Act of 1980, Public Law 96–354
RIA Regulatory Impact Analysis
RIC Rehabilitation Impairment Category
RO Regional Office
RP Rehabilitation and Psychiatric
RPL Rehabilitation, Psychiatric, and Long-Term Care Hospital
SCHIP State Children's Health Insurance Program
SSI Supplemental Security Income
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248

I. Background

A. Historical Overview of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

Section 4421 of the Balanced Budget Act of 1997 (Pub. L. 105–33, enacted on August 5, 1997) (BBA), as amended by section 125 of the Medicare, Medicaid, State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (Pub. L. 106–113, enacted on November 29, 1999) (BBRA) and by section 305 of the

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554, enacted on December 21, 2000) (BIPA) provides for the implementation of a per discharge prospective payment system (PPS) under 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 direct graduate medical education costs, costs of approved nursing and allied health education 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 original FY 2002 IRF PPS final rule (66 FR 41316) and 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 2010.

Under the IRF PPS from FY 2002 through FY 2005, as described in the FY 2002 IRF PPS final rule (66 FR 41316), 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 FY 2004 IRF PPS final rule (68 FR 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. Within the structure of the payment system, we then made adjustments to account for interrupted stays, transfers, short stays, and deaths. Finally, we applied the applicable adjustments to account for geographic variations in wages (wage index), the percentage of low-income patients, location in a rural area (if applicable), and outlier payments (if applicable) to the IRF's unadjusted Federal prospective payment rates.

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

Section 1886(j) of the Act confers broad statutory authority upon the Secretary to propose refinements to the IRF PPS. In the FY 2006 IRF PPS final rule (70 FR 47880) and in correcting amendments to the FY 2006 IRF PPS final rule (70 FR 57166) that we published on September 30, 2005, 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 included the adoption of the Office of Management and Budget's (OMB) Core-Based Statistical Area (CBSA) market definitions, modifications to the CMGs, tier comorbidities, and CMG relative weights, implementation of a new teaching status adjustment for IRFs, revision and rebasing of the market basket index used to update IRF payments, and updates to the rural, low-income percentage (LIP), and high-cost outlier adjustments. Beginning with the FY 2006 IRF PPS final rule (70 FR 47908 through 47917), the market basket index used to update IRF payments is a market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding inpatient psychiatric facilities (IPFs), and long-term care hospitals (LTCHs) (hereafter referred to as the rehabilitation, psychiatric, and long-term care (RPL) market basket). Any reference to the FY 2006 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments. For a detailed discussion of the final key policy changes for FY 2006, please refer to the FY 2006 IRF PPS final rule (70 FR 47880 and 70 FR 57166).

In the FY 2007 IRF PPS final rule (71 FR 48354), we further refined the IRF PPS case-mix classification system (the CMG relative weights) and the case-level adjustments, to ensure that IRF PPS payments would continue to reflect as accurately as possible the costs of care. For a detailed discussion of the FY 2007 policy revisions, please refer to the FY 2007 IRF PPS final rule (71 FR 48354).

In the FY 2008 IRF PPS final rule (72 FR 44284), we updated the Federal prospective payment rates and the outlier threshold, revised the IRF wage index policy, and clarified how we determine high-cost outlier payments for transfer cases. For more information on the policy changes implemented for FY 2008, please refer to the FY 2008 IRF PPS final rule (72 FR 44284), in which we published the final FY 2008 IRF Federal prospective payment rates.

After publication of the FY 2008 IRF PPS final rule (72 FR 44284), section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173, enacted on December 29, 2007) (MMSEA), amended section 1886(j)(3)(C) of the Act to apply a zero percent increase factor for FYs 2008 and 2009, effective for IRF discharges occurring on or after April 1, 2008. Section 1886(j)(3)(C) of the Act required the Secretary to develop an increase factor to update the IRF Federal prospective payment rates for each FY. Based on the legislative change to the increase factor, we revised the FY 2008 Federal prospective payment rates for IRF discharges occurring on or after April 1, 2008. Thus, the final FY 2008 IRF Federal prospective payment rates that were published in the FY 2008 IRF PPS final rule (72 FR 44284) were effective for discharges occurring on or after October 1, 2007 and on or before March 31, 2008; and the revised FY 2008 IRF Federal prospective payment rates were effective for discharges occurring on or after April 1, 2008 and on or before September 30, 2008. The

revised FY 2008 Federal prospective payment rates are available on the CMS Web site at *http://www.cms.gov/InpatientRehabFacPPS/07_DataFiles.asp#TopOfPage*.

In the FY 2009 IRF PPS final rule (73 FR 46370), we updated the CMG relative weights, the average length of stay values, and the outlier threshold; clarified IRF wage index policies regarding the treatment of "New England deemed" counties and multi-campus hospitals; and revised the regulation text in response to section 115 of the MMSEA to set the IRF compliance percentage at 60 percent ("the 60 percent rule") and continue the practice of including comorbidities in the calculation of compliance percentages. We also applied a zero percent market basket increase factor for FY 2009 in accordance with section 115 of the MMSEA. For more information on the policy changes implemented for FY 2009, please refer to the FY 2009 IRF PPS final rule (73 FR 46370), in which we published the final FY 2009 IRF Federal prospective payment rates.

In the FY 2010 IRF PPS final rule (74 FR 39762) and in correcting amendments to the FY 2010 IRF PPS final rule (74 FR 50712) that we published on October 1, 2009, we updated the Federal prospective payment rates, the CMG relative weights, the average length of stay values, the rural, LIP, and teaching status adjustment factors, and the outlier threshold; implemented new IRF coverage requirements for determining whether an IRF claim is reasonable and necessary; and revised the regulation text to require IRFs to submit patient assessments on Medicare Advantage (MA) (Medicare Part C) patients for use in the 60 percent rule calculations. Any reference to the FY 2010 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments. For more information on the policy changes implemented for FY 2010, please refer to the FY 2010 IRF PPS final rule (74 FR 39762 and 74 FR 50712), in which we published the final FY 2010 IRF Federal prospective payment rates.

After publication of the FY 2010 IRF PPS final rule (74 FR 39762), section 3401(d) of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010) as amended by section 10319 of the same Act and by section 1105 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010) (collectively, hereafter referred to as "The Affordable Care Act"), amended section 1886(j)(3)(C) of the Act and added section 1886(j)(3)(D) of the Act. Section 1886(j)(3)(C) of the Act requires the Secretary to estimate a multi-factor productivity adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010–2019.

Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(i) of the Act defined the adjustments that were to be applied to the market basket increase factors in FYs 2010 and 2011. Under these provisions, the Secretary was required to reduce the market basket increase factor in FY 2010 by a 0.25 percentage point adjustment. Notwithstanding this provision, in accordance with section 3401(p) of the Affordable Care Act, the adjusted FY 2010 rate was only to be applied to discharges occurring on or after April 1, 2010. Based on the self-implementing legislative changes to section 1886(j)(3) of the Act, we adjusted the FY 2010 Federal prospective payment rates as required, and applied these rates to IRF discharges occurring on or after April 1, 2010 and on or before September 30, 2010. Thus, the final FY 2010 IRF Federal prospective payment rates that were published in the FY 2010 IRF PPS final rule (74 FR 39762) were used for discharges occurring on or after October 1, 2009 and on or before March 31, 2010; and the adjusted FY 2010 IRF Federal prospective payment rates applied to discharges occurring on or after April 1, 2010 and on or before September 30, 2010. The adjusted FY 2010 Federal prospective payment rates are available on the CMS Web site at *http://www.cms.gov/InpatientRehabFacPPS/07_DataFiles.asp#TopOfPage*.

In addition, sections 1886(j)(3)(C) and (D) of the Act also affected the FY 2010 IRF outlier threshold amount because they required an adjustment to the FY 2010 RPL market basket increase factor, which changed the standard payment conversion factor for FY 2010. Specifically, the original FY 2010 IRF outlier threshold amount was determined based on the original estimated FY 2010 RPL market basket increase factor of 2.5 percent and the standard payment conversion factor of $13,661. However, as adjusted, the IRF prospective payments are based on the adjusted RPL market basket increase factor of 2.25 percent and the revised standard payment conversion factor of $13,627. To maintain estimated outlier payments for FY 2010 equal to the established standard of 3 percent of total estimated IRF PPS payments for FY 2010, we revised the IRF outlier threshold amount for FY 2010 for discharges occurring on or after April 1, 2010 and on or before September 30, 2010. The revised IRF outlier threshold amount for FY 2010 was $10,721.

Sections 1886(j)(3)(ii)(II) and 1886(j)(3)(D)(i) also required the Secretary to reduce the market basket increase factor in FY 2011 by a 0.25 percentage point adjustment. The FY 2011 IRF PPS notice (75 FR 42836) and the correcting amendments to the FY 2011 IRF PPS notice (75 FR 70013, November 16, 2010) described the required adjustments to the FY 2011 and FY 2010 IRF PPS Federal prospective payment rates and outlier threshold amount for IRF discharges occurring on or after April 1, 2010 and on or before September 30, 2011. It also updated the FY 2011 Federal prospective payment rates, the CMG relative weights, and the average length of stay values. Any reference to the FY 2011 IRF PPS notice in this proposed rule also includes the provisions effective in the correcting amendments. For more information on the FY 2010 and FY 2011 adjustments or the updates for FY 2011, please refer to the FY 2011 IRF PPS notice (75 FR 42836 and 75 FR 70013).

B. Provisions of the Affordable Care Act Affecting the IRF PPS in FY 2012 and Beyond

The Affordable Care Act included several provisions that affect IRF PPS in FYs 2012 and beyond. In addition to what was discussed above, section 3401(d) of the Affordable Care Act also added section 1886(j)(3)(C)(ii)(I) (providing for a "productivity" adjustment" for fiscal year 2012 and each subsequent fiscal year). The proposed productivity adjustment for FY 2012 is discussed in section V.A.6. of this proposed rule, and the 0.1 percentage point adjustment is discussed in section V.A of this proposed rule. Section 1886(j)(3)(C)(ii)(II) of the Act notes that the application of these adjustments to the market basket update may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year.

Section 3004(b) of the Affordable Care Act also addressed the IRF PPS program. It reassigned the previously-designated section 1886(j)(7) of the Act to section 1886(j)(8) and inserted a new section 1886(j)(7), which contains new requirements for the Secretary to establish a quality reporting program for IRFs. Under that program, data must be submitted in a form and manner, and at a time specified by the Secretary. Beginning in FY 2014, section 1886(j)(7)(A)(i) will require application

of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. Application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

Under section 1886(j)(7)(D)(i) and (ii) of the Act, the Secretary is generally required to select quality measures for the IRF quality reporting program from those that have been endorsed by the consensus-based entity which holds a performance measurement contract under section 1890(a) of the Act. This contract is currently held by the National Quality Forum (NQF). So long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization, section 1886(j)(7)(D)(ii) of the Act authorizes the Secretary to select non-endorsed measures for specified areas or medical topics when there are no feasible or practical endorsed measure(s). Under section 1886(j)(7)(D)(iii) of the Act, the Secretary is required to publish the measures that will be used in FY 2014 no later than October 1, 2012.

Section 1886(j)(7)(E) of the Act requires the Secretary to establish procedures for making the IRF PPS quality reporting data available to the public. In so doing, the Secretary must ensure that IRFs have the opportunity to review any such data prior to its release to the public. Future rulemaking will address these public reporting obligations.

The proposed quality reporting program for IRFs, in accordance with section 1886(j)(7) of the Act, is discussed in detail in section IX. of this proposed rule.

C. Operational Overview of the Current IRF PPS

As described in the FY 2002 IRF PPS 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, designated as the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI). In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each Medicare Part C (Medicare Advantage) patient, as described in the FY 2010 IRF PPS final rule. All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the GROUPER software. The GROUPER software uses specific IRF–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 5-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last 4 digits represent the distinct CMG number. Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available on the CMS Web site at *http://www.cms.gov/InpatientRehabFacPPS/06_Software.asp*.

Once a patient is discharged, the IRF submits a Medicare claim as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, enacted on August 21, 1996) (HIPAA), compliant electronic claim or, if the Administrative Simplification Compliance Act of 2002 (Pub. L. 107–105, enacted on December 27, 2002) (ASCA) permits, a paper claim (a UB–04 or a CMS–1450 as appropriate) using the five-digit CMG number and sends it to the appropriate Medicare fiscal intermediary (FI) or Medicare Administrative Contractor (MAC). Claims submitted to Medicare must comply with both ASCA and HIPAA.

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 situations in which there is no method available for the submission of claims in an electronic form or the entity submitting the claim is a small provider. In addition, the Secretary also has the authority to waive such denial "in such unusual cases as the Secretary finds appropriate." For more information, see the "Medicare Program; Electronic Submission of Medicare Claims" final rule (70 FR 71008, November 25, 2005). CMS instructions for the limited number of Medicare claims submitted on paper are available at *http://www.cms.gov/manuals/downloads/clm104c25.pdf*.

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 in 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 healthcare providers, to conduct covered electronic transactions according to the applicable transaction standards. (See the CMS program claim memoranda at *http://www.cms.gov/ElectronicBillingEDITrans/* and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600).

The Medicare FI or MAC 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).

II. Summary of Provisions of the Proposed Rule

In this proposed rule, we are proposing to update the IRF Federal prospective payment rates, to rebase and revise the RPL market basket, to implement refinements to the methodologies for calculating the LIP adjustment, and to establish a new quality reporting program for IRFs in accordance with section 1886(j)(7) of the Act. We are also proposing to revise existing regulations text for the purpose of updating and providing greater clarity. These proposals are as follows:

A. Proposed Updates to the IRF Federal Prospective Payment Rates for Federal Fiscal Year (FY) 2012

The proposed updates to the IRF Federal prospective payment rates for FY 2012 are as follows:

- Update the FY 2012 IRF PPS relative weights and average length of stay values using the most current and complete Medicare claims and cost report data in a budget neutral manner, as discussed in section III. of this proposed rule.

• Update the FY 2012 IRF facility-level adjustments (rural, LIP, and teaching status adjustments) in a budget neutral manner using the most current and complete Medicare claims and cost report data and by removing the weighting methodology previously used to analyze such data, and propose a temporary cap adjustment policy for the teaching status adjustment to reflect interns and residents displaced due to closure of IRFs or IRF residency training programs, as discussed in section IV. of this proposed rule.

• Update the FY 2012 IRF PPS payment rates by the proposed market basket increase factor, based upon the most current data available, with a 0.1 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act and a productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section V. of this proposed rule.

• Update the wage index and the labor-related share of the FY 2012 IRF PPS payment rates in a budget neutral manner, as discussed in section V. of this proposed rule.

• Calculate the IRF Standard Payment Conversion Factor for FY 2012, as discussed in section V. of this proposed rule.

• Update the outlier threshold amount for FY 2012, as discussed in section VI. of this proposed rule.

• Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2012, as discussed in section VI. of this proposed rule.

• Discuss the impact of the IPPS data matching process changes on the IRF PPS calculation of the Supplemental Security Income (SSI) ratios used to compute the IRF LIP adjustment factor, as discussed in section VII. of this proposed rule.

• Implement the IRF quality reporting program provisions of section 1886(j)(7) of the Act, as discussed in section IX. of this proposed rule.

B. Proposed Revisions to Existing Regulation Text

In this proposed rule, we are proposing to revise the existing requirements at § 412.25(b), § 412.25(b)(1), § 412.25(b)(2), § 412.25(b)(3), and § 412.25(e)(2)(ii)(A) that apply to all units that are excluded from the inpatient prospective payment system (IPPS), as described in section VIII. of this proposed rule. These proposed revisions would affect IRFs and inpatient psychiatric facilities (IPFs).

We are also proposing to relocate and revise the existing requirements at § 412.23(b), § 412.29, and § 412.30 that describe the requirements for facilities to qualify to receive payment under the IRF PPS, as described in section VIII. of this proposed rule.

Finally, we are proposing to re-designate the existing paragraph § 412.624(c)(4) as § 412.624(c)(5) and add a new paragraph § 412.624(c)(4) to implement the IRF quality reporting program.

III. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2012

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. Relative weights account for the variance in cost per discharge due to the variance in resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care, as well as provider efficiency.

In this proposed rule, we propose to update the CMG relative weights and average length of stay values for FY 2012. As required by statute, we always use the most recent available data to update the CMG relative weights and average lengths of stay. This ensures that the CMG relative weights and average length of stay values reflect as accurately as possible the current costs of care in IRFs. For FY 2012, we are proposing to use the FY 2010 IRF claims and FY 2009 IRF cost report data. These data are the most current and complete data available at this time. Currently, only a small portion of the FY 2010 IRF cost report data are available for analysis, but the majority of the FY 2010 IRF claims data are available for analysis.

In this proposed rule, we propose to use the same methodology that we used to update the CMG relative weights and average length of stay values in the FY 2009 IRF PPS final rule (73 FR 46370), which we also used to update the CMG relative weights and average length of stay values in the FY 2010 IRF PPS final rule (74 FR 39762) and the FY 2011 notice (75 FR 42836).

In calculating the CMG relative weights, we use a hospital-specific relative value method to estimate operating (routine and ancillary services) and capital costs of IRFs. The process used to calculate the CMG relative weights for this proposed rule is as follows:

Step 1. We estimate 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 CMG relative weights, using the hospital-specific relative value method.

Step 4. We normalize the FY 2012 CMG relative weights to the same average CMG relative weight from the CMG relative weights implemented in the FY 2011 IRF PPS notice (75 FR 42836).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we are proposing to update the CMG relative weights for FY 2012 in such a way that total estimated aggregate payments to IRFs for FY 2012 are the same with or without the changes (that is, in a budget neutral manner) by applying a budget neutrality factor to the standard payment amount. To calculate the appropriate proposed budget neutrality factor for use in updating the FY 2012 CMG relative weights, we propose to use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2012 (with no proposed changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2012 by applying the proposed changes to the CMG relative weights (as discussed above).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the proposed budget neutrality factor (0.9989) that would maintain the same total estimated aggregate payments in FY 2012 with and without the proposed changes to the CMG relative weights.

Step 4. Apply the proposed budget neutrality factor (0.9989) to the FY 2011 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V.C. of this proposed rule, we discuss the proposed use of the existing methodology to calculate the standard payment conversion factor for FY 2012.

Table 1, "Proposed Relative Weights and Average Length of Stay Values for Case-Mix Groups," presents the CMGs, the comorbidity tiers, the proposed corresponding relative weights, and the proposed average length of stay values for each CMG and tier for FY 2012. The average length of stay for each CMG is used to determine when an IRF

discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment. The proposed relative weights and average length of stay values shown in Table 1 are subject to change for the final rule if more recent data become available for use in these analyses.

TABLE 1: Proposed Relative Weights and Average Length of Stay Values for Case-Mix Groups

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0101	Stroke M>51.05	0.7654	0.7177	0.6447	0.6094	10	10	9	8
0102	Stroke M>44.45 and M<51.05 and C>18.5	0.9487	0.8896	0.7990	0.7553	12	13	10	10
0103	Stroke M>44.45 and M<51.05 and C<18.5	1.1340	1.0633	0.9551	0.9029	14	14	12	12
0104	Stroke M>38.85 and M<44.45	1.1790	1.1055	0.9930	0.9387	15	14	13	12
0105	Stroke M>34.25 and M<38.85	1.3705	1.2850	1.1543	1.0911	16	17	14	14
0106	Stroke M>30.05 and M<34.25	1.5762	1.4779	1.3275	1.2549	20	18	16	16
0107	Stroke M>26.15 and M<30.05	1.7841	1.6729	1.5026	1.4204	20	20	18	18
0108	Stroke M<26.15 and A>84.5	2.2109	2.0731	1.8621	1.7603	31	25	23	22
0109	Stroke M>22.35 and M<26.15 and A<84.5	2.0470	1.9193	1.7240	1.6297	24	23	20	20
0110	Stroke M<22.35 and A<84.5	2.6359	2.4715	2.2200	2.0986	33	29	26	25
0201	Traumatic brain injury M>53.35 and C>23.5	0.7564	0.6156	0.5707	0.5179	8	8	7	8
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5	1.0716	0.8722	0.8085	0.7337	12	12	10	10
0203	Traumatic brain injury M>44.25 and C<23.5	1.2095	0.9844	0.9125	0.8282	16	11	13	12
0204	Traumatic brain injury M>40.65 and M<44.25	1.2732	1.0362	0.9605	0.8717	16	12	12	12
0205	Traumatic brain injury M>28.75 and M<40.65	1.6075	1.3083	1.2128	1.1007	18	18	15	14
0206	Traumatic brain injury M>22.05 and M<28.75	2.0038	1.6308	1.5117	1.3720	23	19	19	18
0207	Traumatic brain injury M<22.05	2.7072	2.2034	2.0425	1.8537	35	27	25	22
0301	Non-traumatic brain injury M>41.05	1.0552	0.9514	0.8433	0.7724	12	12	11	10
0302	Non-traumatic brain injury M>35.05 and M<41.05	1.3362	1.2049	1.0679	0.9781	12	15	13	13
0303	Non-traumatic brain injury M>26.15 and M<35.05	1.5891	1.4329	1.2701	1.1632	21	17	15	14
0304	Non-traumatic brain injury M<26.15	2.1985	1.9823	1.7570	1.6093	29	23	20	19
0401	Traumatic spinal cord injury M>48.45	1.0503	0.8733	0.7923	0.6999	15	14	11	10
0402	Traumatic spinal cord injury M>30.35 and M<48.45	1.3721	1.1408	1.0351	0.9143	17	14	13	12
0403	Traumatic spinal cord injury M>16.05 and M<30.35	2.4551	2.0411	1.8520	1.6359	29	26	23	20
0404	Traumatic spinal cord injury M<16.05 and A>63.5	4.3686	3.6321	3.2955	2.9110	53	39	38	35
0405	Traumatic spinal cord injury M<16.05 and A<63.5	3.8362	3.1894	2.8938	2.5562	52	38	36	29
0501	Non-traumatic spinal cord injury M>51.35	0.6606	0.6293	0.5616	0.4974	10	10	7	7

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				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	0.9871	0.9403	0.8391	0.7432	13	13	11	10
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15	1.2549	1.1954	1.0668	0.9449	16	14	13	12
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25	1.5175	1.4455	1.2901	1.1426	18	16	16	14
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25	1.7660	1.6823	1.5013	1.3297	20	21	18	17
0506	Non-traumatic spinal cord injury M<23.75	2.4771	2.3597	2.1059	1.8651	33	28	24	23
0601	Neurological M>47.75	0.9418	0.7982	0.7277	0.6571	10	11	9	9
0602	Neurological M>37.35 and M<47.75	1.2488	1.0584	0.9649	0.8714	12	13	12	11
0603	Neurological M>25.85 and M<37.35	1.6123	1.3665	1.2458	1.1250	17	15	14	14
0604	Neurological M<25.85	2.1387	1.8126	1.6525	1.4923	23	21	19	18
0701	Fracture of lower extremity M>42.15	0.8008	0.7876	0.7576	0.6765	10	12	10	9
0702	Fracture of lower extremity M>34.15 and M<42.15	1.0476	1.0304	0.9912	0.8851	12	13	12	12
0703	Fracture of lower extremity M>28.15 and M<34.15	1.2605	1.2398	1.1926	1.0649	15	15	14	14
0704	Fracture of lower extremity M<28.15	1.6299	1.6031	1.5421	1.3770	18	19	18	17
0801	Replacement of lower extremity joint M>49.55	0.5585	0.5618	0.5618	0.4879	7	8	7	7
0802	Replacement of lower extremity joint M>37.05 and M<49.55	0.7514	0.7559	0.7559	0.6565	8	11	9	9

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5	1.0356	1.0417	1.0417	0.9048	11	14	13	12
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5	0.9151	0.9205	0.9205	0.7995	10	12	11	10
0805	Replacement of lower extremity joint M>22.05 and M<28.65	1.1274	1.1341	1.1341	0.9850	11	14	13	13
0806	Replacement of lower extremity joint M<22.05	1.3774	1.3856	1.3856	1.2034	13	18	16	15
0901	Other orthopedic M>44.75	0.8645	0.7442	0.6738	0.6105	10	10	9	8
0902	Other orthopedic M>34.35 and M<44.75	1.1584	0.9973	0.9029	0.8181	13	13	12	11
0903	Other orthopedic M>24.15 and M<34.35	1.4813	1.2752	1.1546	1.0461	16	16	14	13
0904	Other orthopedic M<24.15	1.9215	1.6542	1.4977	1.3569	21	20	18	17
1001	Amputation, lower extremity M>47.65	1.0282	0.9092	0.8110	0.7260	13	12	10	10
1002	Amputation, lower extremity M>36.25 and M<47.65	1.3476	1.1916	1.0630	0.9515	16	14	13	12
1003	Amputation, lower extremity M<36.25	1.9915	1.7611	1.5709	1.4063	21	21	18	17
1101	Amputation, non-lower extremity M>36.35	1.0359	1.0359	0.9879	0.9237	11	11	12	11
1102	Amputation, non-lower extremity M<36.35	1.5462	1.5462	1.4747	1.3787	14	18	16	16
1201	Osteoarthritis M>37.65	0.8086	0.8086	0.8068	0.7644	13	13	11	10
1202	Osteoarthritis M>30.75 and M<37.65	1.0576	1.0576	1.0553	0.9999	16	16	14	13

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
1203	Osteoarthritis M<30.75	1.2998	1.2998	1.2969	1.2288	13	19	15	15
1301	Rheumatoid, other arthritis M>36.35	0.8929	0.8929	0.8827	0.7872	11	10	11	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35	1.1777	1.1777	1.1643	1.0383	17	17	14	13
1303	Rheumatoid, other arthritis M<26.15	1.5197	1.5197	1.5025	1.3399	15	19	18	16
1401	Cardiac M>48.85	0.9414	0.7541	0.6671	0.6032	10	10	9	8
1402	Cardiac M>38.55 and M<48.85	1.2639	1.0125	0.8956	0.8098	13	12	11	10
1403	Cardiac M>31.15 and M<38.55	1.5236	1.2205	1.0796	0.9762	18	14	13	12
1404	Cardiac M<31.15	1.9752	1.5823	1.3996	1.2655	24	19	16	15
1501	Pulmonary M>49.25	0.9616	0.9031	0.7771	0.7334	10	11	8	9
1502	Pulmonary M>39.05 and M<49.25	1.2069	1.1334	0.9753	0.9205	13	13	11	11
1503	Pulmonary M>29.15 and M<39.05	1.4859	1.3954	1.2007	1.1333	16	16	13	13
1504	Pulmonary M<29.15	1.8826	1.7679	1.5212	1.4358	22	19	17	16
1601	Pain syndrome M>37.15	1.1157	0.8649	0.7697	0.7202	12	12	10	10
1602	Pain syndrome M>26.75 and M<37.15	1.4950	1.1589	1.0314	0.9650	19	13	13	13
1603	Pain syndrome M<26.75	1.9344	1.4996	1.3345	1.2486	22	18	16	15
1701	Major multiple trauma without brain or spinal cord injury M>39.25	1.0029	0.9213	0.8376	0.7323	10	11	11	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25	1.3284	1.2204	1.1094	0.9700	13	15	14	13
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05	1.5680	1.4405	1.3095	1.1449	15	16	15	15
1704	Major multiple trauma without brain or spinal cord injury M<25.55	2.0053	1.8423	1.6748	1.4642	26	22	20	18
1801	Major multiple trauma with brain or spinal cord injury M>40.85	1.1875	0.9426	0.9426	0.8659	14	14	12	11
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85	1.6397	1.3015	1.3015	1.1956	18	19	15	15
1803	Major multiple trauma with brain or spinal cord injury M<23.05	2.8012	2.2235	2.2235	2.0426	34	32	26	24
1901	Guillain Barre M>35.95	1.1421	0.9069	0.9069	0.8922	13	14	12	12
1902	Guillain Barre M>18.05 and M<35.95	2.1756	1.7276	1.7276	1.6996	22	22	21	21
1903	Guillain Barre M<18.05	3.6633	2.9089	2.9089	2.8618	48	29	35	33
2001	Miscellaneous M>49.15	0.8486	0.7527	0.6748	0.6064	9	10	9	8
2002	Miscellaneous M>38.75 and M<49.15	1.1378	1.0093	0.9048	0.8131	12	12	11	10
2003	Miscellaneous M>27.85 and M<38.75	1.4370	1.2747	1.1427	1.0269	15	15	13	13
2004	Miscellaneous M<27.85	1.9261	1.7085	1.5316	1.3764	24	20	18	16
2101	Burns M>0	3.0073	2.5965	2.0197	1.7146	34	23	19	18
5001	Short-stay cases, length of stay is 3 days or fewer				0.1476				3

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.5867				7
5102	Expired, orthopedic, length of stay is 14 days or more				1.4693				18
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.6951				8
5104	Expired, not orthopedic, length of stay is 16 days or more				1.8788				23

Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 2 shows how the application of the proposed revisions for FY 2012 would affect particular CMG relative weight values, which affect the overall distribution of payments within CMGs and tiers. Note that, because we propose to implement the CMG relative weight revisions in a budget neutral manner (as described above), total estimated aggregate payments to IRFs for FY 2012 would not be affected as a result of the CMG relative weight revisions. However, the proposed revisions would affect the distribution of payments within CMGs and tiers.

TABLE 2: Distributional Affects of the Proposed Changes to the CMG Relative Weights (FY 2011 Values Compared With FY 2012 Values)

Percentage Change	Number of Cases Affected	Percentage of Cases Affected
Increased by 15% or more	431	0.1%
Increased by between 5% and 15%	7,807	2.0%
Changed by less than 5%	376,683	96.9%
Decreased by between 5% and 15%	3,612	0.9%
Decreased by 15% or more	58	0.1%

As Table 2 shows, 97 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the proposed revisions for FY 2012. The largest increase in the proposed CMG relative weight values that affects a particularly large number of IRF discharges is a 1.7 percent increase in the CMG relative weight value for CMG A0704—Fracture of Lower Extremity with a motor score of less than 28.15—in the "no comorbidity" tier. In the FY 2010 data, 24,162 IRF discharges were classified into this CMG and tier. The largest decrease in a CMG relative weight value that affects a particularly large number of IRF discharges is a 0.7 percent decrease in the CMG relative weight for CMG A0110—Stroke, with a motor score of less than 22.35 and a patient age of less than 84.5 years in the "no comorbidity" tier. In the FY 2010 IRF claims data, this change affects 16,975 cases.

Given the changes in IRFs' case mix over time, we believe that it is important to update the CMG relative weights and average length of stay (LOS) values periodically to continue to reflect the trends in IRF patient populations. As we have more recent data that better reflect IRFs' case mix at this time, we propose the updates described in this section.

IV. Proposed Updates to the Facility-Level Adjustment Factors for FY 2012

A. Proposed Updates to the IRF Facility-Level Adjustment Factors

Section 1886(j)(3)(A)(v) of the Act confers broad authority upon the Secretary to adjust the per unit payment rate "by such * * * factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." For example, we adjust the Federal prospective payment amount associated with a CMG to account for facility-level characteristics such as an IRF's LIP, teaching status, and location in a rural area, if applicable, as described in § 412.624(e).

In the FY 2010 IRF PPS final rule (74 FR 39762), we updated the adjustment factors for calculating the rural, LIP, and teaching status adjustments based on the most recent three consecutive years worth of IRF claims data (at that time, FY 2006, FY 2007, and FY 2008) and the most recent available corresponding IRF cost report data. As discussed in the FY 2010 IRF PPS proposed rule (74 FR 21060 through 21061), we observed relatively large year-to-year fluctuations in the underlying data used to compute the adjustment factors, especially the teaching status adjustment factor. Therefore, we implemented a three-year moving average approach to updating the facility-level adjustment factors in the FY 2010 IRF PPS final rule (74 FR 39762) to provide greater stability and predictability of Medicare payments for IRFs.

Though the 3-year moving average approach that we implemented in FY 2010 improves the year-to-year stability and predictability of the facility-level adjustment factors, we have continued to estimate unusually large year-to-year fluctuations in the teaching status adjustment factor. To determine the underlying reasons for these large year-to-year fluctuations in the teaching status adjustment factor, we analyzed the data and reviewed the methodology that we were using to estimate all three of the facility-level adjustment factors (that is, the rural, the LIP, and the teaching status adjustment factors). We found that the unusually large year-to-year fluctuations in the teaching status adjustment factors were the result of a weighting methodology that we have been applying to the regression analysis used to estimate the facility-level adjustment factors since the implementation of the IRF PPS. This weighted regression methodology assigns greater weight to some facilities than to others and, in effect, exaggerates the differences among different types of IRF facilities. While this weighted regression methodology was appropriate when the IRF PPS was first being developed because we had limited data on which to base the initial facility-level adjustment factors, we believe that a more appropriate and conservative approach for the current IRF PPS is to assign equal weight to all facilities in the regression analysis that is used to estimate all of the IRF facility-level adjustment factors (that is, the rural, LIP, and teaching status adjustment factors). Thus, we propose to remove the weighting methodology from our analysis of the facility-level adjustment factors and update the IRF facility-level adjustment factors for FY 2012 using an unweighted regression analysis. The primary effect of the proposed change in methodology is to stabilize all three of the facility-level adjustment factors (that is, the rural, the LIP, and the teaching status adjustment factor) over time. However, the proposed change in the methodology also has a relatively large effect on our estimate of the LIP adjustment factor that we discuss in this section.

To update the facility-level adjustment factors for FY 2012, we propose using updated data (FY 2008, FY 2009, and 2010 IRF claims data and the corresponding year's cost report data or, if unavailable, the most recent available cost report data). To analyze the updated data, we propose to use a revised methodology from the methodology that we used to update the facility-level adjustment factors in the FY 2010 IRF PPS final rule (74 FR 39762). The revised methodology would remove a weighting factor from the regression analysis and, instead, assign equal weight to all facilities in the regression analysis. Based on analysis of the updated data using the proposed unweighted regression analysis and the 3-year moving average approach, we estimate that IRF PPS payments to IRFs in rural areas would be increased by 18.7 percent for FY 2012. In addition, to account for the percentage of low-income patients that an IRF treats, we estimate that IRF PPS payments for FY 2012 would be adjusted using an updated LIP adjustment formula of (1 + disproportionate share hospital (DSH) patient percentage) raised to the power of (0.1897), where the—

$$\text{DSH patient percentage for each IRF} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

Note that the proposed LIP adjustment factor of 0.1897 is substantially lower than the current LIP adjustment factor of 0.4613 due to the use of updated data and the proposed use of the unweighted regression methodology, which would give equal weight to all facilities in the regression. Finally, we estimate that IRF PPS payments to eligible IRFs that qualify for the teaching status adjustment will be adjusted by the following updated formula for FY 2012: (1 + full-time equivalent (FTE) interns and residents/average daily census) raised to the power of (0.4888). To calculate the proposed updates to the rural, LIP, and teaching status adjustment factors for FY 2012, we used the following steps:

[Steps 1 and 2 are performed independently for each of 3 years of IRF claims data: FY 2008, FY 2009, and FY 2010]

Step 1. Calculate the average cost per case for each IRF in the IRF claims data.

Step 2. Use logarithmic regression analysis on average cost per case to compute the coefficients for the rural, LIP, and teaching status adjustments. For FY 2012, we are proposing to update the logarithmic regression analysis so that we no longer apply weights to the analysis. The proposed unweighted regression analysis gives equal weight to all facilities in the regression analysis.

Step 3. Calculate a simple mean for each of the coefficients across the 3 years of data using logarithms for the LIP and teaching status adjustment coefficients (because they are continuous variables), but not for the rural adjustment coefficient (because the rural variable is either zero (if not rural) or 1 (if rural)). To compute the proposed

LIP and teaching status adjustment factors, we convert these factors back out of the logarithmic form.

The proposed adjustment factors are subject to change for the final rule if more recent data become available for use in these analyses.

B. Budget Neutrality Methodology for the Proposed Updates to the IRF Facility-Level Adjustment Factors

Consistent with the way that we implemented changes to the IRF facility-level adjustment factors (the rural, LIP, and teaching status adjustment factors) in the FY 2006 and FY 2010 IRF PPS final rules (70 FR 47880, 70 FR 57166, and 74 FR 39762), we propose to make changes to the rural, LIP, and teaching status adjustment factors for FY 2012 in such a way that total estimated aggregate payments to IRFs for FY 2012 would be the same with or without the proposed changes (that is, in a budget neutral manner) by applying budget neutrality factors for each of these three changes to the standard payment amount. To calculate the proposed budget neutrality factors used to update the rural, LIP, and teaching status adjustment factors, we propose to use the following steps:

Step 1. Using the most recent available data (currently FY 2010), calculate the estimated total amount of IRF PPS payments that would be made in FY 2012 (without applying the proposed changes to the rural, LIP, or teaching status adjustment factors).

Step 2. Calculate the estimated total amount of IRF PPS payments that would be made in FY 2012 if the proposed update to the rural adjustment factor were applied.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the proposed budget neutrality factor (0.9998) that would maintain the same total estimated aggregate payments in FY 2012 with and without the proposed change to the rural adjustment factor.

Step 4. Calculate the estimated total amount of IRF PPS payments that would be made in FY 2012 if the proposed update to the LIP adjustment factor were applied.

Step 5. Divide the amount calculated in step 1 by the amount calculated in step 4 to determine the proposed budget neutrality factor (1.0327) that would maintain the same total estimated aggregate payments in FY 2012 with and without the proposed change to the LIP adjustment factor.

Step 6. Calculate the estimated total amount of IRF PPS payments that would be made in FY 2012 if the proposed update to the teaching status adjustment factor were applied.

Step 7. Divide the amount calculated in step 1 by the amount calculated in step 6 to determine the proposed budget neutrality factor (1.0024) that would maintain the same total estimated aggregate payments in FY 2012 with and without the proposed change to the teaching status adjustment factor.

Step 8. Apply the proposed budget neutrality factors for the updates to the rural, LIP, and teaching status adjustment factors to the FY 2011 IRF PPS standard payment amount after the application of the proposed budget neutrality factors for the wage adjustment and the CMG relative weights.

The proposed budget neutrality factors for the proposed changes to the rural, LIP, and teaching status adjustment factors are subject to change for the final rule if more recent data become available for use in these analyses or if the proposed payment policies associated with the proposed budget neutrality factors change.

In section V.C. of this proposed rule, we discuss the proposed methodology for calculating the standard payment conversion factor for FY 2012.

C. Proposed Policy for Temporary Cap Adjustments To Reflect Interns and Residents Displaced Due to Closure of IRFs or IRF Residency Training Programs

1. Background

In the FY 2006 IRF PPS final rule (70 FR 47880 at 47928 through 47932), we implemented regulations at § 412.624(e)(4) to establish a facility-level adjustment for IRFs that are, or are part of, teaching hospitals. The teaching status adjustment accounts for the higher indirect operating costs experienced by hospitals that participate in graduate medical education (GME) programs. The payment adjustments are made based on the number of FTE interns and residents training in the IRF and the IRF's average daily census.

We established the IRF teaching status adjustment in a manner that limited the incentives for IRFs to add FTE interns and residents for the purpose of increasing their teaching status adjustment. We imposed a cap on the number of FTE interns and residents that may be counted for purposes of calculating the teaching status adjustment. The cap limits the number of FTE interns and residents that teaching IRFs may count for the purpose of calculating the IRF PPS teaching status adjustment, not the number of interns and residents teaching institutions can hire or train. We calculated the number of FTE interns and residents that trained in the IRF during a "base year" and used that FTE intern and resident number as the cap. An IRF's FTE intern and resident cap is ultimately determined based on the final settlement of the IRF's most recent cost reporting period ending on or before November 15, 2004. A complete discussion of how the IRF teaching status adjustment was calculated appears in the FY 2006 IRF PPS final rule (70 FR 47880, 47928 through 47932).

2. Proposed Temporary FTE Intern and Resident Cap Adjustment

Sometimes, interns and residents that are training in an IRF find themselves unable to complete their training in the IRF, either because the IRF closes or closes a residency training program (we refer to these interns and residents as "displaced"). Although we have not heard of any instances where IRFs did not accept displaced interns and residents because the additional interns and residents would put the facility over the facility's FTE intern and resident cap, we believe that it is important to maintain consistent policies with other Medicare PPS systems, to the extent feasible. The IPPS indirect medical education (IME) adjustment and the direct GME policies contain provisions that allow for temporary adjustments to the IME/GME caps for IPPS hospitals that train interns and residents that are displaced because a hospital closes or closes a medical residency training program. CMS has recently proposed to include a similar temporary cap adjustment policy for the inpatient psychiatric facility (IPF) PPS teaching status adjustment outlined in the rate year 2012 IPF PPS proposed rule (76 FR 4998 at 5018 through 5020). Consistent with the IPPS and the IPF PPS, in this proposed rule, we propose to permit a temporary increase in the FTE intern and resident cap when an IRF increases the number of FTE interns and residents it trains in order to accept displaced interns and residents because another IRF closes or closes a medical residency training program.

When an IRF temporarily takes on interns and residents that are displaced because another IRF closes or closes a residency training program, we believe that a temporary adjustment to the cap would be appropriate. In these situations, interns and residents may have partially completed a residency training program at the IRF that has closed or closed a training program and may be unable to complete their training

at another IRF that is already training interns and residents up to or in excess of its FTE intern and resident cap. We believe that it is appropriate to allow temporary adjustments to the FTE caps for an IRF that provides residency training to medical interns and residents who have partially completed a residency training program at an IRF that closes or at an IRF that discontinues training interns and residents in a residency training program(s). For this reason, we are proposing to adopt the following temporary intern and resident cap adjustment policies, similar to the temporary adjustments to the FTE cap used for acute care hospitals and the proposed temporary adjustments to the FTE caps for IPFs.

We are proposing that the cap adjustment would be temporary because it is intern and resident specific and would only apply to the displaced intern(s) or resident(s) until those intern(s) or resident(s) have completed their training in the program in which they were training at the time of the IRF closure or the closure of the program. We propose that, as under the IPPS policy for displaced interns and residents, the IRF PPS temporary cap adjustment would apply only to interns and residents that were still training at the IRF at the time the IRF closed or at the time the IRF ceased training interns and residents in the residency training program(s). Interns and residents who leave the IRF, for whatever reason, before the closure of the IRF or the closure of the residency training program would not be considered displaced interns and residents for purposes of the IRF temporary cap adjustment policy. We are proposing to adopt the same definition of "closure of a hospital residency training program" as it is currently defined at § 413.79(h)(1)(ii); that is, the hospital ceases to offer training for residents in a particular approved medical residency training program. Similarly, as under the IPPS policy, we are proposing that medical students who are accepted into a program at an IRF but the IRF or residency training program closes before the individual begins training at that IRF are also not considered displaced interns and residents for purposes of the IRF temporary cap adjustments. We note that although we are proposing to adopt a policy under the IRF PPS that is consistent with the policy applicable under the IPPS, the actual caps under the two payment systems are separate and distinct. This means, for example, if a program closes at an IPPS hospital that has an IRF unit, but the interns and residents from that closed program were not rotating into the IRF unit when the program closed, then there would be no temporary FTE cap adjustment under the IRF PPS, since the interns and residents were not displaced from the IRF. However, if an IPPS hospital that has an IRF unit closes a training program and interns and residents from that program were rotating into the IRF unit when the program closed, an IRF hospital or IRF unit may temporarily adjust their FTE intern and resident cap if they train the displaced interns and residents, but only for the portion of the training that has to be completed in the IRF setting and only if all of the requirements specified in section IV.C. of this proposed rule are met.

3. Proposed Temporary Adjustment to the FTE Cap To Reflect Interns and Residents Displaced Due to an IRF Closure

We are proposing to allow an IRF to receive a temporary adjustment to the FTE cap to reflect interns and residents added because of another IRF's closure. The temporary cap adjustment is intended to account for medical interns and residents who have partially completed a medical residency training program at the IRF that has closed and may be unable to complete their training at another IRF because that IRF is already training interns and residents up to or in excess of its cap. We are proposing this change because IRFs may be reluctant to accept additional interns and residents from a closed IRF without a temporary adjustment to their caps. For purposes of this policy, we are proposing to adopt the IPPS definition of "closure of a hospital" in § 413.79(h)(1)(i) to mean the IRF terminates its Medicare provider agreement as specified in § 489.52. Therefore, we are proposing to allow a temporary adjustment to an IRF's FTE cap to reflect interns and residents added because of an IRF's closure. The proposed policy would be effective for cost reporting periods beginning on or after October 1, 2011, when an IRF trains an intern or resident from an IRF that closed on or after October 1, 2011. We would allow an adjustment to an IRF's FTE cap if the IRF meets the following criteria:

(a) The IRF is training displaced interns and residents from an IRF that closed on or after October 1, 2011.

(b) The IRF that is training the displaced interns and residents from the closed IRF submits a request for a temporary adjustment to its FTE cap to its Medicare contractor no later than 60 days after the hospital first begins training the displaced interns and residents, and documents that the IRF is eligible for this temporary adjustment to its FTE cap by identifying the interns and residents who have come from the closed IRF and have caused the IRF to exceed its cap, (or the IRF may already be over its cap), and specifies the length of time that the adjustment is needed.

After the displaced interns and residents leave the IRF's training program or complete their residency program, the IRF's cap would revert to its original level. This means that the temporary adjustment to the FTE cap would be available to the IRF only for the period of time necessary for the displaced interns and residents to complete their training. Further, as under the IPPS policy, we are also proposing that the total amount of temporary cap adjustment that can be allotted to all receiving IRFs cannot exceed the cap amount of the IRF that closed.

We also note that section 5506 of the Affordable Care Act, "Preservation of Resident Cap Positions from Closed Hospitals," does not apply to IRFs that closed. Section 5506 of the Affordable Care Act only amends sections 1886(d) and (h) of the Act for direct GME and IPPS IME payments. Therefore, the IME FTE cap redistributions under section 5506 of the Affordable Care Act only apply to "subsection (d)" IPPS hospitals. Section 5506 of the Affordable Care Act has no applicability to the teaching status adjustments under the IRF PPS (or the IPF PPS, for that matter).

4. Proposed Temporary Adjustment to FTE Cap To Reflect Interns and Residents Displaced Due to a Residency Program Closure

We are proposing that if an IRF ceases training interns and residents in a residency training program(s) and agrees to temporarily reduce its FTE cap, another IRF may receive a temporary adjustment to its FTE cap to reflect the addition of the displaced interns and residents. For purposes of this policy on closed residency programs, we are proposing to adopt the IPPS definition of "closure of a hospital residency training program" as specified in § 413.79(h)(1)(ii) which means that the hospital ceases to offer training for interns and residents in a particular approved medical residency training program. The methodology for adjusting the caps for the "receiving IRF" and the "IRF that closed its program" is described below.

a. Receiving IRF

We are proposing that an IRF may receive a temporary adjustment to its FTE cap to reflect interns and residents added because of the closure of another

IRF's residency training program for cost reporting periods beginning on or after October 1, 2011 if—

- The IRF is training additional interns and residents from the residency training program of an IRF that closed its program on or after October 1, 2011; and
- No later than 60 days after the IRF begins to train the interns and residents, the IRF submits to its Medicare contractor a request for a temporary adjustment to its FTE cap, documents that the IRF is eligible for this temporary adjustment by identifying the interns and residents who have come from another IRF's closed program and have caused the IRF to exceed its cap (or the IRF may already be in excess of its cap), specifies the length of time the adjustment is needed, and, as explained in more detail below, submits to its Medicare contractor a copy of the FTE cap reduction statement by the IRF closing the residency training program.

In general, the proposed temporary adjustment criteria established for closed medical residency training programs at IRFs is similar to the criteria established for closed IRFs. We are proposing that more than 1 IRF may be eligible to apply for the temporary adjustment because interns and residents from one closed program may rotate to different IRFs, or they may complete their training at more than one IRF. Also, only to the extent to which an IRF would exceed its FTE cap by training displaced interns and residents would it be eligible for the temporary adjustment. Thus, for example, if the IRF has room below its cap to take 1 additional displaced FTE intern or resident but taking a second displaced FTE intern or resident would cause the IRF to exceed its FTE intern and resident cap, then the IRF would potentially qualify for a temporary cap adjustment for 1 FTE intern or resident, not 2.

b. IRF That Closed Its Program(s)

We are proposing that an IRF that agrees to train interns and residents who have been displaced by the closure of another IRF's residency training program may receive a temporary FTE cap adjustment only if the IRF that closed its program meets the following criteria—

- Temporarily reduces its FTE cap by the number of FTE interns and residents in each program year training and in the program at the time of the program's closure. The yearly reduction would be determined by deducting the number of those interns and residents who would have been training in the program up to the IRF's cap during the year of the closure, had the program not closed; and
- No later than 60 days after the interns and residents who were in the closed program begin training at another IRF, submits to its Medicare contractor a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the IRF training the displaced interns and residents to obtain a temporary adjustment to its cap; identifies the interns and residents who were training at the time of the program's closure; identifies the IRFs to which the interns and residents are transferring once the program closes; and specifies the reduction for the applicable program years.

In addition, we propose under this closed program policy that in order for the receiving IRF(s) to qualify for a temporary adjustment to their FTE cap, the IRFs that are closing their programs would need to reduce their FTE cap for the expected duration of time the displaced interns and residents would need to finish their training. We are proposing this because the IRF that closes the program still retains the FTE slots in its cap, even if the IRF chooses not to fill the slots with interns and residents. We believe that it is inappropriate to allow an increase to the receiving IRF's cap without an attendant decrease to the cap of the IRF with the closed program, because the IRF that ceased training the interns and residents could fill these slots with interns and residents from other programs even if the increase and related decrease is only temporary.

We are proposing that the cap reduction for the IRF with the closed program would be based on the number of FTE interns and residents in each program year that were in the program at the IRF at the time of the program's closure, and who begin training at another IRF.

In summary, we are proposing new IRF policies related to temporary adjustments to FTE caps to reflect interns and residents added due to closure of an IRF or closure of a residency training program. Finally, we are proposing that the IRFs that meet the proposed criteria would be eligible to receive temporary adjustments to their FTE caps for cost reporting periods beginning on or after October 1, 2011.

V. Proposed FY 2012 IRF PPS Federal Prospective Payment Rates

A. Proposed Market Basket Increase Factor, Productivity Adjustment, and Labor-Related Share for FY 2012

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. According to section 1886(j)(3)(A)(i) of the Act, the increase factor shall be used to update the IRF Federal prospective payment rates for each FY. Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act require the application of a 0.1 percentage point reduction to the market basket increase factor for FYs 2012 and 2013. In addition, section 1886(j)(3)(C)(ii)(I) of the Act requires the application of a productivity adjustment, as described below. Thus, in this proposed rule, we are proposing to update the IRF PPS payments for FY 2012 by a market basket increase factor based upon the most current data available, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act as described below and a 0.1 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act. Further, we are proposing to rebase the RPL market basket from a 2002-based market basket to a 2008-based market basket. We typically rebase the RPL market basket every 5 to 7 years to ensure that it continues to reflect the most accurate account of the cost of relevant goods and services.

Thus, in this proposed rule, we propose to start with a rebased RPL market basket (updated from a 2002 base year to a 2008 base year) and then apply a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act and a 0.1 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act. In section V.A.1 of this proposed rule, we describe the proposed methodology for rebasing the RPL market basket from a 2002 base year to a 2008 base year, and then in section V.A.2 of this proposed rule, we describe the proposed methodology for calculating the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. Finally, in section V.A.3 of this proposed rule, we describe the proposed calculation of the market basket increase factor to be used to adjust IRF PPS payments for FY 2012.

1. Proposed Rebasing of the RPL Market Basket for FY 2012

a. Background

The input price index (that is, the market basket) that was used to develop the IRF PPS was the Excluded Hospital with Capital market basket. This market basket was based on 1997 Medicare cost report data and included data for Medicare participating IRFs, IPFs, LTCHs, cancer hospitals, and children's hospitals. Although "market basket" technically describes the mix of goods and services used in providing hospital care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket. Accordingly, the term "market basket", as used in this document, refers to an input price index.

Beginning with the FY 2006 IRF PPS final rule (70 FR 47908), IRF PPS payments were updated using a FY 2002-based RPL market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding IPFs, and LTCHs.

We excluded cancer and children's hospitals from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented at § 413.40. Cancer and children's hospitals are not reimbursed through a PPS. Also, the FY 2002 cost structures for cancer and children's hospitals are noticeably different than the cost structures of freestanding IRFs, freestanding IPFs, and LTCHs. See the FY 2006 IRF PPS final rule (70 FR 47908) for a complete discussion of the FY 2002-based RPL market basket.

In the FY 2010 IRF proposed rule (74 FR 21062), we expressed our interest in exploring the possibility of creating a stand-alone IRF market basket that reflects the cost structures of only IRF providers. We noted that, of the available options, one is to combine the Medicare cost report data from freestanding IRF providers (presently incorporated into the FY 2002-based RPL market basket) with data from hospital-based IRF providers. We indicated that an examination of the Medicare cost report data comparing freestanding and hospital-based IRFs revealed considerable differences between the two with respect to cost levels and cost structures. At that time, we were unable to fully understand the differences between these two types of IRF providers. As a result, we believed that further research was required and we solicited public comment for additional information that might help us to better understand the reasons for the variations in costs and cost structures, as indicated by the cost report data, between freestanding and hospital-based IRFs (74 FR 21062).

We summarized the public comments we received and our responses in the FY 2010 IRF PPS final rule (74 FR 39762, 39776 through 39777). Despite receiving comments from the public on this issue, we remain unable to sufficiently understand the observed differences in costs and cost structures between hospital-based and freestanding IRFs, and therefore we do not believe it is appropriate at this time to incorporate data from hospital-based IRFs with those of freestanding IRFs to create a stand-alone IRF market basket.

Although we do not believe it would be appropriate to propose a stand-alone IRF market basket, we are currently exploring the viability of creating two separate market baskets from the current RPL, one of which would include freestanding IRFs and freestanding IPFs and would be used to update payments under both the IPF and IRF payment systems. The other would be a stand-alone LTCH market basket. Depending on the outcome of our research, we anticipate the possibility of proposing a rehabilitation and psychiatric (RP) market basket in the next update cycle. We welcome public comment on the possibility of using this type of market basket to update IRF payments in the future.

For this update cycle, we are proposing to rebase and revise the FY 2002-based RPL market basket by creating a proposed FY 2008-based RPL market basket. In the following discussion, we provide an overview of the market basket and describe the methodologies we propose to use for purposes of determining the operating and capital portions of the proposed FY 2008-based RPL market basket.

b. Overview of the Proposed FY 2008-Based RPL Market Basket

The proposed FY 2008-based RPL market basket is a fixed-weight, Laspeyres-type price index. A Laspeyres price index measures the change in price, over time, of the same mix of goods and services purchased in the base period. Any changes in the quantity or mix of goods and services (that is, intensity) purchased over time relative to a base period are not measured.

The index itself is constructed in three steps. First, a base period is selected (in this proposed rule, the base period is FY 2008) and total base period expenditures are estimated for a set of mutually exclusive and exhaustive spending categories with the proportion of total costs that each category represents being calculated. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price or wage variable, referred to as a price proxy. In nearly every instance, these price proxies are derived from publicly available statistical series that are published on a consistent schedule (preferably at least on a quarterly basis). Finally, the expenditure weight for each cost category is multiplied by the level of its respective price proxy. The sum of these products (that is, the expenditure weights multiplied by their price levels) for all cost categories yields the composite index level of the market basket in a given period. Repeating this step for other periods produces a series of market basket levels over time. Dividing an index level for a given period by an index level for an earlier period produces a rate of growth in the input price index over that timeframe.

As noted above, the market basket is described as a fixed-weight index because it represents the change in price over time of a constant mix (quantity and intensity) of goods and services needed to furnish hospital services. The effects on total expenditures resulting from changes in the mix of goods and services purchased subsequent to the base period are not measured. For example, a hospital hiring more nurses to accommodate the needs of patients would increase the volume of goods and services purchased by the hospital, but would not be factored into the price change measured by a fixed-weight hospital market basket. Only when the index is rebased would changes in the quantity and intensity be captured, with those changes being reflected in the cost weights. Therefore, we rebase the market basket periodically so the cost weights reflect recent changes in the mix of goods and services that hospitals purchase (hospital inputs) to furnish inpatient care between base periods.

c. Proposed Rebasing and Revising of the RPL Market Basket

We are inviting public comments on our proposed methodological changes to the RPL market basket. The terms "rebasing" and "revising," while often used interchangeably, actually denote different activities. "Rebasing" means moving the base year for the structure of costs of an input price index (for example, in this proposed rule, we are proposing to shift the base year cost structure for the RPL market basket from FY 2002 to FY 2008). "Revising" means

changing data sources, price proxies, or methods, used to derive the input price index. For FY 2012, we are proposing to rebase and revise the market basket used to update the IRF PPS.

(1) Development of Cost Categories and Weights

(a) Medicare Cost Reports

The proposed FY 2008-based RPL market basket consists of several major cost categories derived from the FY 2008 Medicare cost reports for freestanding IRFs, freestanding IPFs, and LTCHs including wages and salaries, pharmaceuticals, professional liability insurance (PLI), capital, and a residual. This residual reflects all remaining costs that are not captured in the four cost categories listed above. The FY 2008 cost reports include providers whose cost report begin date is on or between October 1, 2007, and September 30, 2008. We choose to use FY 2008 as the base year because we believe that the Medicare cost reports for this year represent the most recent, complete set of Medicare cost report data available for IRFs, IPFs, and LTCHs. However, there is an issue with obtaining data specifically for benefits and contract labor from this set of FY 2008 Medicare cost reports since IRFs, IPFs, and LTCHs were not required to complete the Medicare cost report worksheet from which these data were collected (Worksheet S–3, part II). As a result, only a small number of providers (less than 30 percent) reported data for these categories, and we do not expect these data to improve over time. Furthermore, since IRFs, IPFs, and LTCHs were not required to submit data for Worksheet S–3, part II in previous cost reporting years, we have always had this issue of incomplete Medicare cost report data for benefits and contract labor (including when we finalized the FY 2002-based RPL market basket). Due to the incomplete benefits and contract labor data for IRFs, IPFs, and LTCHs, we propose to develop these cost weights using FY 2008 Medicare cost report data for IPPS hospitals (similar to the method that was used for the FY 2002-based RPL market basket). Additional detail is provided later in this section.

Since our goal is to measure cost shares that are reflective of case mix and practice patterns associated with providing services to Medicare beneficiaries, we are proposing to limit our selection of Medicare cost reports to those from hospitals that have a Medicare average length of stay (LOS) that is within a comparable range of their total facility average LOS. We believe this provides a more accurate reflection of the structure of costs for Medicare covered days. We propose to use the cost reports of IRFs and LTCHs with Medicare average LOS within 15 percent (that is, 15 percent higher or lower) of the total facility average LOS for the hospital. This is the same edit applied to derive the FY 2002-based RPL market basket and generally includes those LTCHs and IRFs with Medicare LOS within approximately 5 days of the facility average LOS of the hospital.

We are proposing to use a less stringent measure of Medicare LOS for IPFs. For this provider-type, and in order to produce a robust sample size, we propose to use those facilities' Medicare cost reports whose average LOS is within 30 or 50 percent (depending on the total facility average LOS) of the total facility average LOS. This is the same edit applied to derive the FY 2002-based RPL market basket.

We applied these LOS edits to first obtain a set of cost reports for facilities that have a Medicare LOS within a comparable range of their total facility LOS. Using this set of Medicare cost reports, we then calculated cost weights for four cost categories and a residual as represented by all other costs directly from the FY 2008 Medicare cost reports for freestanding IRFs, freestanding IPFs, and LTCHs (see Table 3 for these four cost categories and their associated weights). These Medicare cost report cost weights were then supplemented with information obtained from other data sources (explained in more detail below) to derive the proposed FY 2008-based RPL market basket cost weights.

TABLE 3: Major Cost Categories and Their Respective Cost Weights as Calculated Directly from FY 2008 Medicare Cost Reports

Major Cost Categories	Proposed FY 2008-Based RPL Market Basket (Percent)
Wages and salaries	47.371
Professional Liability Insurance (Malpractice)	0.764
Pharmaceuticals	6.514
Capital	8.392
All other	36.959

(b) Other Data Sources

In addition to the IRF, IPF and LTCH Medicare cost reports for freestanding IRFs and freestanding IPFs, and LTCHs, the other data sources we used to develop the proposed FY 2008-based RPL market basket cost weights were the FY 2008 IPPS Medicare cost reports and the Benchmark Input-Output (I–O) Tables created by the Bureau of Economic Analysis (BEA), U.S. Department of Commerce. The FY 2008 Medicare cost reports include providers whose cost report begin date is on or between October 1, 2007 and September 30, 2008.

As noted above, the proposed FY 2008-based RPL cost weights for benefits and contract labor were derived using FY 2008-based IPPS Medicare cost reports. We used these Medicare cost reports to calculate cost weights for Wages and Salaries, Benefits, and Contract Labor for IPPS hospitals for FY 2008. For the proposed Benefits cost weight for the FY 2008-based RPL market basket, the ratio of the FY 2008 IPPS Benefits cost weight to the FY 2008 IPPS Wages and Salaries cost weight was applied to the RPL Wages and Salaries cost weight. Similarly, the ratio of the FY 2008 IPPS Contract Labor cost weight to the FY 2008 IPPS Wages and Salaries cost weight was applied to the RPL Wages and Salaries cost weight to derive a Contract Labor cost weight for the proposed FY 2008-based RPL market basket.

The All Other cost category is divided into other hospital expenditure category shares using the 2002 BEA Benchmark I–O data following the removal of the portions of the All Other cost category provided in Table 3 that are attributable to Benefits and Contract Labor. The BEA Benchmark I–O data are scheduled for publication every 5 years. The most recent data available are for 2002. BEA also produces Annual I–O estimates; however, the 2002 Benchmark I–O data represent a much more comprehensive and complete set of data that are derived from the 2002 Economic Census. The Annual I–O is simply an update of the Benchmark I–O tables. For the FY 2002-based RPL market basket, we used the 1997 Benchmark I–O data. We are proposing to use the 2002 Benchmark I–O data in the FY 2008-based RPL market basket. Instead of using the less detailed Annual I–O data, we inflated the 2002 Benchmark I–O data forward to 2008. The methodology we used to inflate the data forward involves applying the annual price changes from the respective price proxies to the appropriate cost categories. We repeat this practice for each year.

The "All Other" cost category expenditure shares are determined as being equal to each category's proportion to total "all other" based on the inflated 2002 Benchmark I–O data. For instance, if the cost for telephone services represented 10 percent of the sum of the "all other" Benchmark I–O hospital expenditures, then telephone services would represent 10 percent of the RPL market basket's All Other cost category.

(2) Final Cost Category Computation

As stated previously, for this rebasing we are proposing to use the Medicare cost reports for IRFs, IPFs, and LTCHs to derive four major cost categories. The proposed FY 2008-based RPL market basket includes two additional cost categories that were not broken out separately in the FY 2002-based RPL market basket: "Administrative and Business Support Services" and "Financial Services". The inclusion of these two additional cost categories, which are derived using the Benchmark I–O data, is consistent with the addition of these two cost categories to the FY 2006-based IPPS market basket (74 FR 43845). We are proposing to break out both categories so we can better match their respective expenses with more appropriate price proxies. A thorough discussion of our rationale for each of these cost categories is provided in the section V.A.1.c.(3) of this proposed rule. Also, the proposed FY 2008-based RPL market basket excludes 1 cost category: Photo Supplies. The 2002 Benchmark I–O weight for this category is considerably smaller than the 1997 Benchmark I–O weight, presently accounting for less than one-tenth of one percentage point of the RPL market basket. Therefore, we are proposing to include the photo supplies costs in the Chemical cost category weight with other similar chemical products.

We are not proposing to change our definition of the labor-related share. However, we are proposing to rename our aggregate cost categories from "labor-intensive" and "nonlabor-intensive" services to "labor-related" and "nonlabor-related" services. This is consistent with the FY 2006-based IPPS market basket (74 FR 43845). As discussed in more detail below and similar to the FY 2002-based RPL market basket, we classify a cost category as labor-related and include it in the labor-related share if the cost category is defined as being labor-intensive and its cost varies with the local labor market. In previous regulations, we grouped cost categories that met both of these criteria into labor-intensive services. We believe the proposed new labels more accurately reflect the concepts that they are intended to convey. We are not proposing to change our definition of the labor-related share because we continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

(3) Selection of Price Proxies

After computing the FY 2008 cost weights for the proposed rebased RPL market basket, it was necessary to select appropriate wage and price proxies to reflect the rate of price change for each expenditure category. With the exception of the proxy for PLI, all of the proxies for the operating portion of the proposed FY 2008-based RPL market basket are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

(a) Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in markets other than the retail market. PPIs are preferable price proxies for goods and services that hospitals purchase as inputs because these PPIs better reflect the actual price changes faced by hospitals. For example, we use a special PPI for prescription drugs, rather than the Consumer Price Index (CPI) for prescription drugs, because hospitals generally purchase drugs directly from a wholesaler. The PPIs that we use measure price changes at the final stage of production.

(b) Consumer Price Indexes—CPIs measure change in the prices of final goods and services bought by the typical consumer. Because they may not represent the price faced by a producer, we used CPIs only if an appropriate PPI was not available, or if the expenditures were more similar to those faced by retail consumers in general rather than by purchasers of goods at the wholesale level. For example, the CPI for food purchased away from home is used as a proxy for contracted food services.

(c) Employment Cost Indexes—Employment Cost Indexes (ECIs) measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. Appropriately, these indexes are not affected by shifts in employment mix.

We evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance. Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Timeliness implies that the proxy is published regularly, preferably at least once a quarter. Availability means that the proxy is publicly available. Finally, relevance means that the proxy is applicable and representative of the cost category weight to which it is applied. The proposed CPIs, PPIs, and ECIs selected meet these criteria.

Table 4 sets forth the proposed FY 2008-based RPL market basket including cost categories, and their respective weights and price proxies. For comparison purposes, the corresponding FY 2002-based RPL market basket cost weights are listed, as well. For example, Wages and Salaries are 49.447 percent of total costs in the proposed FY 2008-based RPL market basket compared to 52.895 percent for the FY 2002-based RPL market basket. Employee Benefits are 12.831 percent in the proposed FY 2008-based RPL market basket compared to 12.982 percent for the FY 2002-based RPL market basket. As a result, compensation costs (Wages and Salaries plus Employee Benefits) for the proposed FY 2008-based RPL market basket are 62.278 percent of total costs compared to 65.877 percent for the FY 2002-based RPL market basket.

Following Table 4 is a summary outlining the choice of the proxies we propose to use for the operating portion of the FY 2008-based RPL market basket. The price proxies proposed for the capital portion are described in more detail in the capital methodology section (see section V.A.1.c.(4) of this proposed rule).

We note that the proxies for the operating portion of the FY 2008-based RPL market basket are the same as those used for the FY 2006-based IPPS operating market basket. Because these proxies meet our criteria of reliability, timeliness, availability, and relevance, we believe they are the best measures of price changes for the cost categories. For further discussion on the FY 2006-based IPPS market basket, see the IPPS final rule published in the August 27, 2009 **Federal Register** (74 FR 43843).

TABLE 4: Proposed FY 2008-Based RPL Market Basket Cost Categories, Weights, and Price Proxies with FY 2002-Based RPL Market Basket Cost Weights Included for Comparison

Cost Categories	Proposed FY 2008-Based RPL Market Basket Cost Weights	FY 2002-Based RPL Market Basket Cost Weights	Proposed FY 2008-Based RPL Market Basket Price Proxies
1. Compensation	62.278	65.877	--
A. Wages and Salaries[1]	49.447	52.895	ECI for Wages and Salaries, Civilian Hospital Workers
B. Employee Benefits[1]	12.831	12.982	ECI for Benefits, Civilian Hospital Workers
2. Utilities	1.578	0.656	--
A. Electricity	1.125	0.351	PPI for Commercial Electric Power
B. Fuel, Oil, and Gasoline	0.371	0.108	PPI for Petroleum Refineries
C. Water and Sewage	0.082	0.197	CPI-U for Water and Sewerage Maintenance
3. Professional Liability Insurance	0.764	1.161	CMS Hospital Professional Liability Insurance Premium Index
4. All Other Products and Services	26.988	22.158	--
A. All Other Products	15.574	13.325	--
(1.) Pharmaceuticals	6.514	5.103	PPI for Pharmaceutical Preparations for Human Use(Prescriptions)
(2.) Food: Direct Purchases	2.959	0.873	PPI for Processed Foods and Feeds
(3.) Food: Contract Services	0.392	0.620	CPI-U for Food Away From Home
(4.) Chemicals[2]	1.100	1.100	Blend of Chemical PPIs
(5.) Medical Instruments	1.795	1.014	PPI for Medical, Surgical, and Personal Aid Devices
(6.) Photographic Supplies	--	0.096	--
(7.) Rubber and Plastics	1.131	1.052	PPI for Rubber and Plastic Products
(8.) Paper and Printing Products	1.021	1.000	PPI for Converted Paper and Paperboard Products
(9.) Apparel	0.210	0.207	PPI for Apparel
(10.) Machinery and Equipment	0.106	0.297	PPI for Machinery and Equipment
(11.) Miscellaneous Products	0.346	1.963	PPI for Finished Goods less Food and Energy
B. All Other Services	11.414	8.833	--
(1.) Labor-related Services	4.681	5.111	--
(a.) Professional Fees: Labor-related[3]	2.114	2.892	ECI for Compensation for Professional and Related Occupations
(b.) Administrative and Business Support Services[4]	0.422	n/a	ECI for Compensation for Office and Administrative Services
(c.) All Other: Labor-Related Services[5]	2.145	2.219	ECI for Compensation for Private Service Occupations
(2.) Nonlabor-Related Services	6.733	3.722	--
(a.) Professional Fees: Nonlabor-Related[3]	4.211	n/a	ECI for Compensation for Professional and Related Occupations
(b.) Financial Services [5]	0.853	n/a	ECI for Compensation for Financial Activities
(c.) Telephone Services	0.416	0.240	CPI-U for Telephone Services
(d.) Postage	0.630	0.682	CPI-U for Postage
(e.) All Other: Nonlabor-Related Services[6]	0.623	2.800	CPI-U for All Items less Food and Energy
5. Capital-Related Costs	8.392	10.149	--
A. Depreciation	5.519	6.187	--
(1.) Fixed Assets	3.286	4.250	BEA chained price index for nonresidential construction for hospitals and special care facilities—vintage weighted (26 years)

Cost Categories	Proposed FY 2008-Based RPL Market Basket Cost Weights	FY 2002-Based RPL Market Basket Cost Weights	Proposed FY 2008-Based RPL Market Basket Price Proxies
(2.) Movable Equipment	2.233	1.937	PPI for Machinery and Equipment—vintage weighted (11 years).
B. Interest Costs	1.954	2.775	--
(1.) Government/Nonprofit	0.653	2.081	Average yield on domestic municipal bonds (Bond Buyer 20 bonds)—vintage-weighted (26 years)
(2.) For Profit	1.301	0.694	Average yield on Moody's Aaa bonds—vintage-weighted (26 years)
C. Other Capital-Related Costs	0.919	1.187	CPI–U for Residential Rent
Total	100.000	100.000	--

Note: Detail may not add to total due to rounding.

[1]Contract Labor is distributed to Wages and Salaries and Employee Benefits based on the share of total compensation that each category represents.

[2]To proxy the Chemicals cost category, we used a blended PPI composed of the PPI for Industrial Gases, the PPI for Other Basic Inorganic Chemical Manufacturing, the PPI for Other Basic Organic Chemical Manufacturing, and the PPI for Soap and Cleaning Compound Manufacturing. For more detail about this proxy, see section V.A.1.c.(3).(c).(x) of this proposed rule.

[3]The Professional Fees: Labor-related and Professional Fees: Nonlabor-related cost categories were included in one cost category called Professional Fees in the FY 2002-based RPL market basket. For more detail about how these new categories were derived, we refer readers to sections V.A.1.c.(3).(c).(xviii) and V.A.1.c.(3).(c).(xxi) of this proposed rule.

[4]The Administrative and Business Support Services cost category was contained within All Other: Labor-intensive Services cost category in the FY 2002-based RPL market basket. The All Other: Labor-intensive Services cost category is renamed the All Other: Labor-related Services cost category for the FY 2008-based RPL market basket.

[5]The Financial Services cost category was contained within the All Other: Non-labor Intensive Services cost category in the FY 2002-based RPL market basket. The All Other: Non-labor Intensive Services cost category is renamed the All Other: Nonlabor-related Services cost category for the FY 2008-based RPL market basket.

(i) Wages and Salaries

We are proposing to use the ECI for Wages and Salaries for Hospital Workers (All Civilian) (BLS series code CIU1026220000000I) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(ii) Employee Benefits

We are proposing to use the ECI for Employee Benefits for Hospital Workers (All Civilian) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(iii) Electricity

We are proposing to use the PPI for Commercial Electric Power (BLS series code WPU0542). This same proxy was used in the FY 2002-based RPL market basket.

(iv) Fuel, Oil, and Gasoline

For the FY 2002-based RPL market basket, this category only included expenses classified under North American Industry Classification System (NAICS) 21 (Mining). We proxied this category using the PPI for Commercial Natural Gas (BLS series code WPU0552). For the proposed FY 2008-based market basket, we are proposing to add costs to this category that had previously been grouped in other categories. The added costs include petroleum-related expenses under NAICS 324110 (previously captured in the miscellaneous category), as well as petrochemical manufacturing classified under NAICS 325110 (previously captured in the chemicals category). These added costs represent 80 percent of the hospital industry's fuel, oil, and gasoline expenses (or 80 percent of this category). Because the majority of the industry's fuel, oil, and gasoline expenses originate from petroleum refineries (NAICS 324110), we are proposing to use the PPI for Petroleum Refineries (BLS series code PCU324110324110) as the proxy for this cost category.

(v) Water and Sewage

We are proposing to use the CPI for Water and Sewerage Maintenance (All Urban Consumers) (BLS series code CUUR0000SEHG01) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(vi) Professional Liability Insurance

We are proposing to proxy price changes in hospital PLI premiums using percentage changes as estimated by the CMS Hospital Professional Liability Index. To generate these estimates, we collect commercial insurance premiums for a fixed level of coverage while holding non-price factors constant (such as a change in the level of coverage). This method is also used to proxy PLI price changes in the Medicare Economic Index (75 FR 73268). This same proxy was used in the FY 2002-based RPL market basket.

(vii) Pharmaceuticals

We are proposing to use the PPI for Pharmaceuticals for Human Use, Prescription (BLS series code WPUSI07003) to measure the price growth of this cost category. We note that we are not making a change to the PPI that is used to proxy this cost category. There was a recent change to the BLS naming convention for this

series; however, this is the same proxy that was used in the FY 2002-based RPL market basket.

(viii) Food: Direct Purchases

We are proposing to use the PPI for Processed Foods and Feeds (BLS series code WPU02) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(ix) Food: Contract Services

We are proposing to use the CPI for Food Away From Home (All Urban Consumers) (BLS series code CUUR0000SEFV) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(x) Chemicals

We are proposing to use a blended PPI composed of the PPI for Industrial Gas Manufacturing (NAICS 325120) (BLS series code PCU325120325120P), the PPI for Other Basic Inorganic Chemical Manufacturing (NAICS 325180) (BLS series code PCU32518–32518–), the PPI for Other Basic Organic Chemical Manufacturing (NAICS 325190) (BLS series code PCU32519–32519–), and the PPI for Soap and Cleaning Compound Manufacturing (NAICS 325610) (BLS series code PCU32561–32561–). Using the 2002 Benchmark I–O data, we found that these NAICS industries accounted for approximately 90 percent of the hospital industry's chemical expenses.

Therefore, we are proposing to use this blended index because we believe its composition better reflects the composition of the purchasing patterns of hospitals than does the PPI for Industrial Chemicals (BLS series code WPU061), the proxy used in the FY 2002-based RPL market basket. Table 5 below shows the weights for each of the four PPIs used to create the blended PPI, which we determined using the 2002 Benchmark I–O data.

TABLE 5: Blended Chemical PPI Weights

Name	Weights (in percent)	NAICS
PPI for Industrial Gas Manufacturing	35%	325120
PPI for Other Basic Inorganic Chemical Manufacturing	25%	325180
PPI for Other Basic Organic Chemical Manufacturing	30%	325190
PPI for Soap and Cleaning Compound Manufacturing	10%	325610

(xi) Medical Instruments

We are proposing to use the PPI for Medical, Surgical, and Personal Aid Devices (BLS series code WPU156) to measure the price growth of this cost category. In the 1997 Benchmark I–O data, approximately half of the expenses classified in this category were for surgical and medical instruments. Therefore, we used the PPI for Surgical and Medical Instruments and Equipment (BLS series code WPU1562) to proxy this category in the FY 2002-based RPL market basket. The 2002 Benchmark I–O data show that surgical and medical instruments now represent only 33 percent of these expenses and that the largest expense category is surgical appliance and supplies manufacturing (corresponding to BLS series code WPU1563). Due to this reallocation of costs over time, we are proposing to change the price proxy for this cost category to the more aggregated PPI for Medical, Surgical, and Personal Aid Devices.

(xii) Photographic Supplies

We are proposing to eliminate the cost category specific to photographic supplies for the proposed FY 2008 based RPL market basket. These costs would now be included in the Chemicals cost category because the costs are presently reported as all other chemical products. Notably, although we would be eliminating the specific cost category, these costs would still be accounted for within the RPL market basket.

(xiii) Rubber and Plastics

We are proposing to use the PPI for Rubber and Plastic Products (BLS series code WPU07) to measure price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(xiv) Paper and Printing Products

We are proposing to use the PPI for Converted Paper and Paperboard Products (BLS series code WPU0915) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(xv) Apparel

We are proposing to use the PPI for Apparel (BLS series code WPU0381) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(xvi) Machinery and Equipment

We are proposing to use the PPI for Machinery and Equipment (BLS series code WPU11) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(xvii) Miscellaneous Products

We are proposing to use the PPI for Finished Goods Less Food and Energy (BLS series code WPUSOP3500) to measure the price growth of this cost category. Using this index would remove the double-counting of food and energy prices, which would already be captured elsewhere in the market basket. This same proxy was used in the FY 2002-based RPL market basket.

(xviii) Professional Fees: Labor-Related

We are proposing to use the ECI for Compensation for Professional and Related Occupations (Private Industry) (BLS series code CIS2020000120000I) to measure the price growth of this category. It includes occupations such as legal, accounting, and engineering services. This same proxy was used in the FY 2002-based RPL market basket.

(xix) Administrative and Business Support Services

We are proposing to use the ECI for Compensation for Office and Administrative Support Services (Private Industry) (BLS series code CIU2010000220000I) to measure the price growth of this category. Previously these costs were included in the All Other: Labor-intensive category (now renamed the All Other: Labor-related Services category), and were proxied by the ECI for Compensation for Service

Occupations. We believe that this compensation index better reflects the changing price of labor associated with the provision of administrative services and its incorporation represents a technical improvement to the market basket.

(xx) All Other: Labor-Related Services

We are proposing to use the ECI for Compensation for Service Occupations (Private Industry) (BLS series code CIU2010000300000I) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(xxi) Professional Fees: Nonlabor-Related

We are proposing to use the ECI for Compensation for Professional and Related Occupations (Private Industry) (BLS series code CIS2020000120000I) to measure the price growth of this category. This is the same price proxy that we are proposing to use for the Professional Fees: Labor-related cost category.

(xxii) Financial Services

We are proposing to use the ECI for Compensation for Financial Activities (Private Industry) (BLS series code CIU201520A000000I) to measure the price growth of this cost category. Previously these costs were included in the All Other: Nonlabor-intensive category (now renamed the All Other: Nonlabor-related Services category), and were proxied by the CPI for All Items. We believe that this compensation index better reflects the changing price of labor associated with the provision of financial services and its incorporation represents a technical improvement to the market basket.

(xxiii) Telephone Services

We are proposing to use the CPI for Telephone Services (BLS series code CUUR0000SEED) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(xxiv) Postage

We are proposing to use the CPI for Postage (BLS series code CUUR0000SEEC01) to measure the price growth of this cost category. This same proxy was used in the FY 2002-based RPL market basket.

(xxv) All Other: Nonlabor-Related Services

We are proposing to use the CPI for All Items Less Food and Energy (BLS series code CUUR0000SA0L1E) to measure the price growth of this cost category. Previously these costs were proxied by the CPI for All Items in the FY 2002-based RPL market basket. We believe that using the CPI for All Items Less Food and Energy would remove the double counting of changes in food and energy prices, as they are already captured elsewhere in the market basket. Consequently, we believe that the incorporation of this proxy would represent a technical improvement to the market basket.

(4) Proposed Methodology for Capital Portion of the RPL Market Basket

In the FY 2002-based RPL market basket, we did not have freestanding IRF, freestanding IPF, and LTCH 2002 Medicare cost report data for the capital cost weights, due to a change in the 2002 reporting requirements. Therefore, we used these hospitals' 2001 expenditure data for the capital cost categories of depreciation, interest, and other capital expenses, and inflated the data to a 2002 base year using relevant price proxies.

For the proposed FY 2008-based RPL market basket, we are proposing to calculate weights for the proposed RPL market basket capital costs using the same set of FY 2008 Medicare cost reports used to develop the operating share for IRFs, IPFs, and LTCHs. To calculate the proposed total capital cost weight, we first apply the same LOS edits as applied when calculating the operating cost weights as described above in section V.A.1.c.(1)(a) of this proposed rule. The resulting proposed capital weight for the FY 2008 base year is 8.392 percent.

Lease expenses are unique in that they are not broken out as a separate cost category in the RPL market basket, but rather are proportionally distributed amongst the cost categories of Depreciation, Interest, and Other, reflecting the assumption that the underlying cost structure of leases is similar to that of capital costs in general. As was done in the FY 2002-based RPL market basket, we first assumed 10 percent of lease expenses represents overhead and assigned those costs to the "Other Capital-Related Costs" category accordingly. The remaining lease expenses were distributed across the three cost categories based on the respective weights of depreciation, interest, and other capital not including lease expenses.

Depreciation contains two subcategories: (1) Building and Fixed Equipment; and (2) Movable Equipment. The apportionment between building and fixed equipment and movable equipment was determined using the FY 2008 Medicare cost reports for freestanding IRFs, freestanding IPFs, and LTCHs. This methodology was also used to compute the apportionment used in the FY 2002-based RPL market basket (70 FR 47912).

The total Interest expense cost category is split between government/nonprofit interest and for-profit interest. The FY 2002-based RPL market basket allocated 75 percent of the total Interest cost weight to government/nonprofit interest and proxied that category by the average yield on domestic municipal bonds. The remaining 25 percent of the Interest cost weight was allocated to for-profit interest and was proxied by the average yield on Moody's Aaa bonds (70 FR 47912). This was based on the FY 2002-based IPPS Capital input price index (CIPI) (70 FR 23406) due to insufficient Medicare cost report data for freestanding IRFs, freestanding IPFs, and LTCHs. For the proposed FY 2008-based RPL market basket, we are proposing to derive the split using the FY 2008 Medicare cost report data on interest expenses for government/nonprofit and for-profit freestanding IRFs, freestanding IPFs, and LTCHs. Based on these data, we calculated a proposed 33/67 split between government/nonprofit and for-profit interest. We believe it is important that this split reflects the latest relative cost structure of interest expenses for RPL providers. As stated above, we first apply the LOS edits (as described in section V.A.1.c.(1)(a) of this proposed rule) prior to calculating this split. Therefore, we are using cost reports that are reflective of case mix and practice patterns associated with providing services to Medicare beneficiaries. Using data specific to government/nonprofit and for-profit freestanding IRFs, freestanding IPFs, and LTCHs as well as the application of these LOS edits are the primary reasons for the difference in this split relative to the FY 2002-based RPL market basket.

Because capital is acquired and paid for over time, capital expenses in any given year are determined by both past and present purchases of physical and financial capital. The vintage-weighted capital portion of the FY 2008-based RPL market basket is intended to capture the long-term consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the proportion of capital purchases attributable to each year of the expected life of building and fixed equipment, movable equipment, and interest. We are proposing to use the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense.

Vintage weights are an integral part of the proposed FY 2008-based RPL market basket. Capital costs are inherently complicated and are determined by complex capital purchasing decisions, over time, based on such factors as interest rates and debt financing. In addition, capital is depreciated over time instead of being consumed in the same period it is purchased. The capital portion of the proposed FY 2008-based RPL market basket would reflect the annual price changes associated with capital costs, and would be a useful simplification of the actual capital investment process. By accounting for the vintage nature of capital, we are able to provide an accurate and stable annual measure of price changes. Annual nonvintage price changes for capital are unstable due to the volatility of interest rate changes and, therefore, do not reflect the actual annual price changes for Medicare capital-related costs. The capital component of the proposed FY 2008-based RPL market basket would reflect the underlying stability of the capital acquisition process and provides hospitals with the ability to plan for changes in capital payments.

To calculate the vintage weights for depreciation and interest expenses, we needed a time series of capital purchases for building and fixed equipment and movable equipment. We found no single source that provides an appropriate time series of capital purchases by hospitals for all of the above components of capital purchases. The early Medicare cost reports did not have sufficient capital data to meet this need. Data we obtained from the American Hospital Association (AHA) do not include annual capital purchases. However, AHA does provide a consistent database back to 1963. We used data from the AHA Panel Survey and the AHA Annual Survey to obtain a time series of total expenses for hospitals. We then used data from the AHA Panel Survey supplemented with the ratio of depreciation to total hospital expenses obtained from the Medicare cost reports to derive a trend of annual depreciation expenses for 1963 through 2008.

To estimate capital purchases using data on depreciation expenses, the expected life for each cost category (building and fixed equipment, movable equipment, and interest) is needed to calculate vintage weights. For the FY 2002-based RPL market basket, due to insufficient Medicare cost report data for freestanding IRFs, freestanding IPFs, and LTCHs, we used 2001 Medicare Cost Reports for IPPS hospitals to determine the expected life of building and fixed equipment and movable equipment (70 FR 47913). The FY 2002-based RPL market basket was based on an expected life of building and fixed equipment of 23 years. It used 11 years as the expected life for movable equipment. We believed that this data source reflected the latest relative cost structure of depreciation expenses for hospitals at the time and was analogous to freestanding IRFs, freestanding IPFs, and LTCHs.

The expected life of any piece of equipment can be determined by dividing the value of the asset (excluding fully depreciated assets) by its current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation were to continue at current year levels, assuming straight-line depreciation. Following a similar method to what was applied for the FY 2002-based RPL market basket, we are proposing to use the expected life of building and fixed equipment to be equal to 26 years, and the expected life of movable equipment to be 11 years. These expected lives are calculated using FY 2008 Medicare cost reports for IPPS hospitals since we are currently unable to obtain robust measures of the expected lives for building and fixed equipment and movable equipment using the Medicare cost reports from freestanding IRFs, freestanding IPFs, and LTCHs.

We also propose to use the building and fixed equipment and movable equipment weights derived from FY 2008 Medicare cost reports for freestanding IRFs, freestanding IPFs, and LTCHs to separate the depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation. Year-end asset costs for building and fixed equipment and movable equipment were determined by multiplying the annual depreciation amounts by the expected life calculations. We then calculated a time series, back to 1963, of annual capital purchases by subtracting the previous year asset costs from the current year asset costs. From this capital purchase time series, we were able to calculate the vintage weights for building and fixed equipment and for movable equipment. Each of these sets of vintage weights is explained in more detail below.

For the proposed building and fixed equipment vintage weights, we used the real annual capital purchase amounts for building and fixed equipment to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual purchase amount for building and fixed equipment was produced by deflating the nominal annual purchase amount by the building and fixed equipment price proxy, BEA's chained price index for nonresidential construction for hospitals and special care facilities. Because building and fixed equipment have an expected life of 26 years, the vintage weights for building and fixed equipment are deemed to represent the average purchase pattern of building and fixed equipment over 26-year periods. With real building and fixed equipment purchase estimates available from 2008 back to 1963, we averaged twenty 26-year periods to determine the average vintage weights for building and fixed equipment that are representative of average building and fixed equipment purchase patterns over time. Vintage weights for each 26-year period are calculated by dividing the real building and fixed capital purchase amount in any given year by the total amount of purchases in the 26-year period. This calculation is done for each year in the 26-year period, and for each of the twenty 26-year periods. We used the average of each year across the twenty 26-year periods to determine the average building and fixed equipment vintage weights for the FY 2008-based RPL market basket.

For the proposed movable equipment vintage weights, the real annual capital purchase amounts for movable equipment were used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment was calculated by deflating the nominal annual purchase amounts by the movable equipment price proxy, the PPI for Machinery and Equipment. This is the same proxy used for the FY 2002-based RPL market basket. Based on our determination that movable equipment has an expected life of 11 years, the vintage weights for movable equipment represent the average expenditure for movable equipment over an 11-year period. With real movable equipment purchase estimates available from 2008 back to 1963, thirty-five 11-year periods were averaged to determine the average vintage weights for movable equipment that are representative of average movable equipment purchase patterns over time. Vintage weights for each 11-year period are calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 11-year period. This calculation was done for each year in the 11-year period and for each of the thirty-five 11-year periods. We used the average of each year across the thirty-five 11-year periods to

determine the average movable equipment vintage weights for the FY 2008-based RPL market basket.

For the proposed interest vintage weights, the nominal annual capital purchase amounts for total equipment (building and fixed, and movable) were used to capture the value of the debt instrument. Because we have determined that hospital debt instruments have an expected life of 26 years, the vintage weights for interest are deemed to represent the average purchase pattern of total equipment over 26-year periods. With nominal total equipment purchase estimates available from 2008 back to 1963, twenty 26-year periods were averaged to determine the average vintage weights for interest that are representative of average capital purchase patterns over time. Vintage weights for each 26-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 26-year period. This calculation is done for each year in the 26-year period and for each of the twenty 26-year periods. We used the average of each year across the twenty 26-year periods to determine the average interest vintage weights for the FY 2008-based RPL market basket. The vintage weights for the capital portion of the FY 2002-based RPL market basket and the FY 2008-based RPL market basket are presented in Table 6.

TABLE 6: FY 2002 and FY 2008 Vintage Weights for Capital-Related Price Proxies

Year	Building and Fixed Equipment		Movable Equipment		Interest	
	FY 2002 23 years	FY 2008 26 years	FY 2002 11 years	FY 2008 11 years	FY 2002 23 years	FY 2008 26 years
1	0.021	0.021	0.065	0.071	0.010	0.010
2	0.022	0.023	0.071	0.075	0.012	0.012
3	0.025	0.025	0.077	0.080	0.014	0.014
4	0.027	0.027	0.082	0.083	0.016	0.016
5	0.029	0.028	0.086	0.085	0.019	0.018
6	0.031	0.030	0.091	0.089	0.023	0.020
7	0.033	0.031	0.095	0.092	0.026	0.021
8	0.035	0.033	0.100	0.098	0.029	0.024
9	0.038	0.035	0.106	0.103	0.033	0.026
10	0.040	0.037	0.112	0.109	0.036	0.029
11	0.042	0.039	0.117	0.116	0.039	0.033
12	0.045	0.041	--	--	0.043	0.035
13	0.047	0.042	--	--	0.048	0.038
14	0.049	0.043	--	--	0.053	0.041
15	0.051	0.044	--	--	0.056	0.043
16	0.053	0.045	--	--	0.059	0.046
17	0.056	0.046	--	--	0.062	0.049
18	0.057	0.047	--	--	0.064	0.052
19	0.058	0.047	--	--	0.066	0.053
20	0.060	0.045	--	--	0.070	0.053
21	0.060	0.045	--	--	0.071	0.055
22	0.061	0.045	--	--	0.074	0.056
23	0.061	0.046	--	--	0.076	0.060
24	--	0.046	--	--	--	0.063
25	--	0.045	--	--	--	0.064
26	--	0.046	--	--	--	0.068
Total	1.000	1.000	1.000	1.000	1.000	1.000

Note: Numbers may not add to total due to rounding.

After the capital cost category weights were computed, it was necessary to select appropriate price proxies to reflect the rate-of-increase for each expenditure category. We are proposing to use the same price proxies for the capital portion of the proposed FY 2008-based RPL market basket that were used in the FY 2002-based RPL market basket with the exception of the Boeckh Construction Index. We replaced the Boeckh Construction Index with BEA's chained price index for nonresidential construction for hospitals and special care facilities. The BEA index represents construction of facilities such as hospitals, nursing homes, hospices, and rehabilitation centers. Although these price indices move similarly over time, we believe that it is more technically appropriate to use an index that is more specific to the hospital industry. We believe these are the most appropriate proxies for hospital capital costs that meet our selection criteria of relevance, timeliness, availability, and reliability.

The price proxies (prior to any vintage weighting) for each of the capital cost categories are the same as those used for the FY 2006-based CIPI as described in the IPPS FY 2010 final rule (74 FR at 43857).

(5) Proposed FY 2012 Market Basket Increase Factor

For FY 2012 (that is, beginning October 1, 2011 and ending September 30, 2012), we are proposing to use an estimate of the proposed FY 2008-based RPL market basket increase factor based on the best available data. Consistent with historical practice, we estimate the RPL market basket update for the IRF PPS based on IHS Global Insight's forecast using the most recent available data. IHS Global Insight (IGI), Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets.

Based on IGI's 1st quarter 2011 forecast with historical data through the 4th quarter of 2010, the projected market basket increase factor for FY 2012 is 2.8 percent. Therefore, consistent with our historical practice of estimating market basket increases based on the best available data, we are proposing a market basket increase factor of 2.8 percent for FY 2012. Furthermore, because the proposed FY 2012 update is based on the most recent market basket estimate for the 12-month period (currently 2.8 percent), we are also proposing that if more recent data are subsequently available (for example, a more recent estimate of the market basket), we would use such data, if appropriate, to determine the FY 2012 update in the final rule.

Using the current FY 2002-based RPL market basket and IGI's 1st quarter 2011 forecast for the market basket components, the FY 2012 update would be 2.8 percent. Table 7 compares the proposed FY 2008-based RPL market basket and the FY 2002-based RPL market basket percent changes.

TABLE 7: FY 2002-Based and Proposed FY 2008-Based RPL Market Basket Percent Changes, FY 2006 through FY 2014

Fiscal Year (FY)	FY 2002-Based RPL Market Basket Index Percent Change	FY 2008-Based Proposed RPL Market Basket Index Percent Change
Historical data:		
FY 2006	3.9	3.7
FY 2007	3.4	3.4
FY 2008	3.8	3.7
FY 2009	2.5	2.7
FY 2010	2.3	2.2
Average 2006-2010	3.2	3.1
Forecast:		
FY 2011	2.6	2.7
FY 2012	2.8	2.8
FY 2013	2.9	2.9
FY 2014	3.0	3.0
Average 2011-2014	2.8	2.9

Note that these market basket percent changes do not include any further adjustments as may be statutorily required.

Source: IHS Global Insight, Inc. 1st quarter 2011 forecast.

For FY 2012, the proposed FY 2008-based RPL market basket update is the same as the FY 2002-based RPL market basket (2.8 percent). The lower total compensation weight in the proposed FY 2008-based RPL market basket (62.278 percent) relative to the FY 2002-based RPL market basket (65.877 percent), absent other factors, would have resulted in a slightly lower market basket update using the FY 2008-based RPL market basket. This impact, however, is partially offset by the larger weight associated with the Professional Fees category. In both market baskets, these expenditures are proxied by the ECI for Compensation for Professional and Related Services. The weight for Professional Fees in the FY 2002-based RPL market basket is 2.892 percent compared to 6.325 percent in the proposed FY 2008-based RPL market basket. The net effect is that the updates are the same for FY 2012 based on the current 2002-based RPL market basket and the proposed FY 2008-based RPL market basket.

2. Proposed Productivity Adjustment

According to Section 1886(j)(3)(C)(i) of the Act, the Secretary shall establish an increase factor "based on an appropriate percentage increase in a market basket of goods and services." As described in section V.A.1 of this proposed rule, we are proposing to estimate the IRF PPS increase factor for FY 2012 based on the proposed FY

2008-based RPL market basket. Section 1886(j)(3)(C)(ii) of the Act then requires that, after establishing the increase factor for a FY, "the Secretary shall reduce such increase factor for FY 2012 and each subsequent FY, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)" of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the "MFP adjustment"). The BLS is the agency that publishes the official measure of private nonfarm business MFP. Please see *http://www.bls.gov/mfp* to obtain the historical BLS-published MFP data.

The projection of MFP is currently produced by IGI, an economic forecasting firm. In order to generate a forecast of MFP, IGI replicated the MFP measure calculated by the BLS using a series of proxy variables derived from IGI's U.S. macroeconomic models. These models take into account a very broad range of factors that influence the total U.S. economy. IGI forecasts the underlying proxy components such as Gross Domestic Product (GDP), capital, and labor inputs required to estimate MFP and then combines those projections according to the BLS methodology. In Table 8, we identify each of the major MFP component series employed by the BLS to measure MFP. We also provide the corresponding concepts forecasted by IGI and determined to be the best available proxies for the BLS series.

TABLE 8: Multifactor Productivity Component Series Employed by the Bureau of Labor Statistics and IHS Global Insight

BLS series	IGI series
Real value-added output, constant 2005 dollars	Non-housing non-government non-farm real GDP, Billions of chained 2005 dollars – annual rate
Private non-farm business sector labor input; 2005=100.00	Hours of all persons in private nonfarm establishments, 2005=100.00, adjusted for labor composition effects.
Aggregate capital inputs; 2005=100.00	Real effective capital stock used for full employment GDP, Billions of chained 2005 dollars

IGI found that the historical growth rates of the BLS components used to calculate MFP and the IGI components identified are consistent across all series and therefore suitable proxies for calculating MFP. We have included below a more detailed description of the methodology used by IGI to construct a forecast of MFP, which is aligned closely with the methodology employed by the BLS. For more information regarding the BLS method for estimating productivity, see the BLS Web site at *http://www.bls.gov/mfp/mprtech.pdf*.

At the time of this proposed rule, the BLS has published a historical time series of private nonfarm business MFP for 1987 through 2009, with 2009 being a preliminary value. Using this historical MFP series and the IGI forecasted series, IGI has developed a forecast of MFP for 2010 through 2021, as described below.

To create a forecast of BLS' MFP index, the forecasted annual growth rates of the "non-housing, non-government, non-farm, real GDP", "hours of all persons in private nonfarm establishments adjusted for labor composition," and "real effective capital stock" series (ranging from 2010 to 2021) are used to "grow" the levels of the "real value-added output," "private non-farm business sector labor input," and "aggregate capital input" series published by the BLS. Projections of the "hours of all persons" measure are calculated using the difference between projections of the BLS index of output per hour and real GDP. This difference is then adjusted to account for changes in labor composition in the forecast interval.

Using these three key concepts, MFP is derived by subtracting the contribution of labor and capital inputs from output growth. However, in order to estimate MFP, we need to understand the relative contributions of labor and capital to total output growth. Therefore, two additional measures are needed to operationalize the estimation of the IGI MFP projection: Labor compensation and capital income. The sum of labor compensation and capital income represents total income. The BLS calculates labor compensation and capital income (in current dollar terms) to derive the nominal values of labor and capital inputs. IGI uses the "non-government total compensation" and "flow of capital services from the total private non-residential capital stock" series as proxies for the BLS' income measures. These two proxy measures for income are divided by total income to obtain the shares of labor compensation and capital income to total income. To estimate labor's contribution and capital's contribution to the growth in total output, the growth rates of the proxy variables for labor and capital inputs are multiplied by their respective shares of total income. These contributions of labor and capital to output growth are subtracted from total output growth to calculate the "change in the growth rates of multifactor productivity":

*MFP = Total output growth—((labor input growth * labor compensation share) + (capital input growth * capital income share))*

The change in the growth rates (also referred to as the compound growth rates) of the IGI MFP are multiplied by 100 in order to calculate the percent

change in growth rates (the percent change in growth rates are published by the BLS for its historical MFP measure). Finally, the growth rates of the IGI MFP are converted to index levels based to 2005 to be consistent with the BLS' methodology. For benchmarking purposes, the historical growth rates of IGI's proxy variables were used to estimate a historical measure of MFP, which was compared to the historical MFP estimate published by the BLS. The comparison revealed that the growth rates of the components were consistent across all series, and therefore validated the use of the proxy variables in generating the IGI MFP projections. The resulting MFP index was then interpolated to a quarterly frequency using the Bassie method for temporal disaggregation. The Bassie technique utilizes an indicator (pattern) series for its calculations. IGI uses the index of output per hour (published by the BLS) as an indicator when interpolating the MFP index.

3. Proposed Calculation of the IRF PPS Market Basket Increase Factor for FY 2012

To calculate the MFP-adjusted IRF PPS increase factor for FY 2012, in accordance with section 1886(j)(3)(C) of the Act, we propose to start with the FY 2008-based RPL market basket increase factor described above in section V.A.1. of this proposed rule and subtract from that the MFP percentage adjustment described in section V.A.2.of this proposed rule. Additionally, in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act, we propose to further reduce the MFP-adjusted IRF PPS increase factor by 0.1 percentage point for FY 2012.

Specifically, in calculating the MFP percentage adjustment, we propose that the end of the 10-year moving average of changes in the MFP should coincide with the end of the appropriate FY update period. Since the market basket update is reduced by the MFP adjustment to determine the annual update for the IRF PPS, we believe it is appropriate for the numbers associated with both components of the calculation (the market basket and the productivity adjustment) to line up so that changes in market conditions are aligned. Therefore, for the FY 2012 update, the MFP adjustment is calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2012. We propose to round the final annual adjustment to the one-tenth of 1 percentage point level up or down as applicable according to conventional rounding rules (that is, if the number we are rounding is followed by 5, 6, 7, 8, or 9, we will round the number up; if the number we are rounding is followed by 0, 1, 2, 3, or 4, we will round the number down).

Thus, in accordance with section 1886(j)(3)(C) of the Act, the proposed IRF PPS increase factor for FY 2012 is based on the 1st quarter 2011 forecast of the proposed FY 2008-based RPL market basket update, which is estimated to be 2.8 percent. This proposed increase factor is then reduced by the MFP adjustment (the 10-year moving average of MFP for the period ending FY 2012) of 1.2 percentage points, based on the proposed methodology described above and IHS Global Insight's 1st quarter 2011 forecast. The proposed increase factor for FY 2012 is then further reduced by 0.1 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act. The resulting proposed IRF PPS increase factor reduced by the productivity adjustment and the "other adjustment" for FY 2012 is equal to 1.5 percent, or 2.8 percent less 1.2 percentage points for the MFP less 0.1 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act. Consistent with historical practice, we propose to update the market basket increase factor estimate and the MFP adjustment in the final rule to reflect the most recent available data.

4. Proposed Calculation of the Labor-Related Share for FY 2012

Section 1886(j)(6) of the Act specifies that "[t]he Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels 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 such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment."

The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market. Given this, based on our definition of the labor-related share, we are proposing to include in the labor-related share the sum of the relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Business Support Services, All Other: Labor-related Services (previously referred to in the FY 2002-based RPL market basket as labor-intensive), and a portion of the Capital-Related cost weight.

Consistent with previous rebasings, the "All Other" Labor-related Services cost category is mostly comprised of building maintenance and security services (including, but not limited to, commercial and industrial machinery and equipment repair, nonresidential maintenance and repair, and investigation and security services). Because these services tend to be labor-intensive and are mostly performed at the hospital facility (and therefore, unlikely to be purchased in the national market), we believe that they meet our definition of labor-related services.

As stated in the FY 2006 IRF PPS final rule (70 FR 47880, 47915), the labor-related share was defined as the sum of the relative importance of Wages and Salaries, Fringe Benefits, Professional Fees, Labor-intensive Services, and a portion of the capital share from an appropriate market basket. Therefore, to determine the labor-related share for the IRF PPS for FY 2011, we used the FY 2002-based RPL market basket cost weights relative importance to determine the labor-related share for the IRF PPS.

For the proposed FY 2008-based RPL market basket rebasing, the proposed inclusion of the Administrative and Business Support Services cost category into the labor-related share remains consistent with the current labor-related share because this cost category was previously included in the Labor-intensive cost category. As previously stated, we are proposing to establish a separate Administrative and Business Support Service cost category so that we can use the ECI for Compensation for Office and Administrative Support Services to more precisely proxy these specific expenses.

For the FY 2002-based RPL market basket, we assumed that all nonmedical professional services (including accounting and auditing services,

engineering services, legal services, and management and consulting services) were purchased in the local labor market and, therefore, all of their associated fees varied with the local labor market. As a result, we previously included 100 percent of these costs in the labor-related share. In an effort to more accurately determine the share of professional fees that should be included in the labor-related share, we surveyed hospitals regarding the proportion of those fees that go to companies that are located beyond their own local labor market (the results are discussed below).

We continue to look for ways to refine our market basket approach to more accurately account for the proportion of costs influenced by the local labor market. To that end, we conducted a survey of hospitals to empirically determine the proportion of contracted professional services purchased by the industry that are attributable to local firms and the proportion that are purchased from national firms. We notified the public of our intent to conduct this survey on December 9, 2005 (70 FR 73250) and received no comments.

With approval from the OMB (Control Number 0938–1036), we contacted a sample of IPPS hospitals and received responses to our survey from 108 hospitals. We believe that these data serve as an appropriate proxy for the purchasing patterns of professional services for IRFs as they are also institutional providers of health care services. Using data on FTEs to allocate responding hospitals across strata (region of the country and urban/rural status), we calculated post-stratification weights. Based on these weighted results, we determined that hospitals purchase, on average, the following portions of contracted professional services outside of their local labor market:

- 34 percent of accounting and auditing services.
- 30 percent of engineering services.
- 33 percent of legal services.
- 42 percent of management consulting services.

We applied each of these percentages to its respective Benchmark I–O cost category underlying the professional fees cost category to determine the Professional Fees: Nonlabor-related costs. The Professional Fees: Labor-related costs were determined to be the difference between the total costs for each Benchmark I–O category and the Professional Fees: Nonlabor-related costs. This is the methodology that we used to separate the FY 2008-based RPL market basket professional fees category into Professional Fees: Labor-related and Professional Fees: Nonlabor-related cost categories. In addition to the professional services listed above, we also classified expenses under NAICS 55, Management of Companies and Enterprises, into the Professional Fees cost category as was done in previous rebasings. The NAICS 55 data are mostly comprised of corporate, subsidiary, and regional managing offices, or otherwise referred to as home offices. Formerly, all of the expenses within this category were considered to vary with, or be influenced by, the local labor market and were thus included in the labor-related share. Because many hospitals are not located in the same geographic area as their home office, we analyzed data from a variety of sources in order to determine what proportion of these costs should be appropriately included in the labor-related share.

Using data primarily from the Medicare cost reports and a CMS database of Home Office Medicare Records (HOMER) (a database that provides city and state information (addresses) for home offices), we were able to determine that 19 percent of the total number of freestanding IRFs, IPFs, and LTCHs that had home offices had those home offices located in their respective local labor markets—defined as being in the same Metropolitan Statistical Area (MSA).

The Medicare cost report requires hospitals to report their home office provider numbers. Using the HOMER database to determine the home office location for each home office provider number, we compared the location of the provider with the location of the hospital's home office. We then placed providers into one of the following three groups:

- Group 1—Provider and home office are located in different States.
- Group 2—Provider and home office are located in the same State and same city.
- Group 3—Provider and home office are located in the same State and different city.

We found that 63 percent of the providers with home offices were classified into Group 1 (that is, different State) and, thus, these providers were determined to not be located in the same local labor market as their home office. Although there were a very limited number of exceptions (that is, providers located in different States but the same MSA as their home office), the 63 percent estimate was unchanged.

We found that 9 percent of all providers with home offices were classified into Group 2 (that is, same State and same city and, therefore, the same MSA). Consequently, these providers were determined to be located in the same local labor market as their home offices.

We found that 27 percent of all providers with home offices were classified into Group 3 (that is, same State and different city). Using data from the Census Bureau to determine the specific MSA for both the provider and its home office, we found that 10 percent of all providers with home offices were identified as being in the same State, a different city, but the same MSA.

Pooling these results, we were able to determine that approximately 19 percent of providers with home offices had home offices located within their local labor market (that is, 9 percent of providers with home offices had their home offices in the same State and city (and, thus, the same MSA), and 10 percent of providers with home offices had their home offices in the same State, a different city, but the same MSA). We are proposing to apportion the NAICS 55 expense data by this percentage. Thus, we are proposing to classify 19 percent of these costs into the Professional Fees: Labor-related cost category and the remaining 81 percent into the Professional Fees: Nonlabor-related Services cost category.

Using this proposed method and the IHS Global Insight, Inc. forecast for the 1st quarter 2011 of the proposed FY 2008-based RPL market basket, the IRF labor-related share for FY 2012 is the sum of the FY 2012 relative importance of each labor-related cost category. Consistent with our proposal to update the labor-related share with the most recent available data, the labor-related share for this proposed rule reflects IHS Global Insight's 1st quarter 2011 forecast of the proposed FY 2008-based RPL market basket. Table 9 shows the proposed FY 2012 relative importance labor-related share using the proposed FY 2008-based RPL market basket and the FY 2002-based RPL market basket.

TABLE 9: Comparison of the FY 2011 Relative Importance Labor-Related Share based on the FY 2002-Based RPL Market Basket and the Proposed FY 2012 Relative Importance Labor-Related Share based on the Proposed FY 2008-Based RPL Market Basket

	FY 2011 Relative Importance Labor-Related Share	Proposed FY 2012 Relative Importance Labor-Related Share
Wages and Salaries	52.449	49.066
Employee Benefits	13.971	13.040
Professional Fees: Labor-Related	2.855	2.073
Administrative and Business Support Services	--	0.416
All Other: Labor-Related Services	2.109	2.094
Subtotal	71.384	66.689
Labor-Related Portion of Capital Costs (46%)	3.887	3.645
Total Labor-Related Share	**75.271**	**70.334**

Source: IHS Global Insight, Inc. 1st quarter 2011 forecast.

The proposed labor-related share for FY 2012 is the sum of the proposed FY 2012 relative importance of each labor-related cost category, and would reflect the different rates of price change for these cost categories between the base year (FY 2008) and FY 2012. The sum of the proposed relative importance for FY 2012 for operating costs (Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Business Support Services, and All Other: Labor-related Services) would be 66.689 percent, as shown in Table 9.

We are proposing that the portion of Capital that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage applied to the FY 2002-based RPL market basket. Since the relative importance for Capital-Related Costs would be 7.923 percent of the proposed FY 2008-based RPL market basket in FY 2012, we are proposing to take 46 percent of 7.923 percent to determine the proposed labor-related share of Capital for FY 2012. The result would be 3.645 percent, which we propose to add to 66.689 percent for the operating cost amount to determine the total proposed labor-related share for FY 2012. Thus, the labor-related share that we propose to use for IRF PPS in FY 2012 would be 70.334 percent. This proposed labor-related share is determined using the same methodology as employed in calculating all previous IRF labor-related shares. The wage index and the labor-related share are adjusted for budget neutrality.

B. Proposed Area Wage Adjustment

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion of rehabilitation facilities' costs attributable to wages and wage related costs (as estimated by the Secretary from time to time) 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 IRF PPS wage index on the basis of information available to the Secretary on the wages and wage-related costs to furnish rehabilitation services. Any adjustment or updates made under section 1886(j)(6) of the Act for a FY are made in a budget neutral manner.

In the FY 2009 IRF PPS final rule (73 FR 46378), we maintained 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 rationale outlined in the FY 2006 IRF PPS final rule (70 FR 47880, 47917 through 47926).

For FY 2012, we are maintaining the policies and methodologies described in the FY 2009 IRF PPS final rule (73 FR 46378) relating to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we are using the CBSA labor market area definitions and the FY 2011 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2011 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2006, and ending September 30, 2007 (that is, FY 2007 cost report data).

The labor market designations made by the OMB include some geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the IRF PPS wage index. We propose to continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data in which to base the calculation for the FY 2012 IRF PPS wage index.

Additionally, we propose to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage data used to determine the current IRF PPS wage index. The changes were nominal and did not represent substantive changes to the CBSA-based designations. Specifically, OMB added or deleted certain CBSA numbers and revised certain titles. The OMB bulletins are available at *http://www.whitehouse.gov/omb/bulletins/index.html*.

To calculate the wage-adjusted facility payment for the payment rates set forth in this proposed rule, we multiply the unadjusted Federal payment rate for IRFs by the proposed FY 2012 labor-related share based on the FY 2008-based RPL market basket (70.334 percent) to determine the labor-related portion of the standard payment amount. We then multiply the labor-related portion by the applicable IRF wage index from the tables in the addendum to this proposed rule. Table A is for urban areas and Table B is for rural areas.

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget neutral manner. We calculate a proposed budget neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45689), codified at § 412.624(e)(1), as described in the steps below. We use the listed steps to ensure that the proposed FY 2012 IRF standard payment conversion factor reflects the update to the wage indexes (based on the FY 2007 hospital cost report data) and the proposed labor-related share in a budget neutral manner:

Step 1. Determine the total amount of the estimated FY 2011 IRF PPS rates, using the FY 2011 standard payment conversion factor and the labor-related share and the wage indexes from FY 2011 (as published in the FY 2011 IRF PPS final rule (75 FR 42836)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the FY 2011 standard payment conversion factor and the proposed FY 2012 labor-related share and CBSA urban and rural wage indexes.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the proposed FY 2012 budget neutral wage adjustment factor of 0.9989.

Step 4. Apply the proposed FY 2012 budget neutral wage adjustment factor from step 3 to the FY 2011 IRF PPS standard payment conversion factor after the application of the adjusted market basket update to determine the proposed FY 2012 standard payment conversion factor.

We discuss the calculation of the proposed standard payment conversion factor for FY 2012 in section V.C. of this proposed rule.

C. Description of the Proposed IRF Standard Conversion Factor and Payment Rates for FY 2012

To calculate the proposed standard payment conversion factor for FY 2012, as illustrated in Table 10, we begin by applying the proposed adjusted market basket increase factor for FY 2012 that was adjusted in accordance with sections 1886(j)(3)(C) and (D) of the Act (1.5 percent, or 2.8 percent less a cumulative total adjustment of 1.3 percentage points, as described in section V.A.3. of this proposed rule), to the standard payment conversion factor for FY 2011 ($13,860). Applying the proposed 1.5 percent adjusted market basket increase factor for FY 2012 to the standard payment conversion factor for FY 2011 of $13,860 yields a standard payment amount of $14,068. Then, we apply the proposed budget neutrality factor for the FY 2012 wage index and labor-related share of 0.9989, which results in a standard payment amount of $14,052. Then we apply the proposed budget neutrality factor for the revised CMG relative weights of 0.9989, which results in a proposed standard payment amount of $14,037. Finally, we apply the proposed budget neutrality factors for the updates to the rural, LIP and IRF teaching status adjustments of 0.9998, 1.0327, and 1.0024, respectively, which results in a proposed standard payment amount of $14,528 for FY 2012.

TABLE 10: Calculations to Determine the Proposed FY 2012 Standard Payment Conversion Factor

Explanation for Adjustment	Calculations	
Standard Payment Conversion Factor for FY 2011		$13,860
Payment Update Factor for FY 2012 (1.5 percent), which reflects a 2.8 percent market basket increase, reduced by a 1.2 percentage point productivity adjustment, and reduced by 0.1 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act	x	1.015
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x	0.9989
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x	0.9989
Budget Neutrality Factor for the Update to the Rural Adjustment Factor	x	0.9998
Budget Neutrality Factor for the Update to the LIP Adjustment Factor	x	1.0327
Budget Neutrality Factor for the Update to the Teaching Status Adjustment Factor	x	1.0024
Proposed FY 2012 Standard Payment Conversion Factor	=	$14,528

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After the application of the CMG relative weights described in Section III of this proposed rule, to the proposed FY 2012 standard payment conversion factor ($14,528), the resulting proposed unadjusted IRF prospective payment rates for FY 2012 are shown in Table 11, "Proposed FY 2012 Payment Rates."

TABLE 11: Proposed FY 2012 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	$ 11,119.73	$ 10,426.75	$ 9,366.20	$ 8,853.36
0102	$ 13,782.71	$ 12,924.11	$ 11,607.87	$ 10,973.00
0103	$ 16,474.75	$ 15,447.62	$ 13,875.69	$ 13,117.33
0104	$ 17,128.51	$ 16,060.70	$ 14,426.30	$ 13,637.43
0105	$ 19,910.62	$ 18,668.48	$ 16,769.67	$ 15,851.50
0106	$ 22,899.03	$ 21,470.93	$ 19,285.92	$ 18,231.19
0107	$ 25,919.40	$ 24,303.89	$ 21,829.77	$ 20,635.57
0108	$ 32,119.96	$ 30,118.00	$ 27,052.59	$ 25,573.64
0109	$ 29,738.82	$ 27,883.59	$ 25,046.27	$ 23,676.28
0110	$ 38,294.36	$ 35,905.95	$ 32,252.16	$ 30,488.46
0201	$ 10,988.98	$ 8,943.44	$ 8,291.13	$ 7,524.05
0202	$ 15,568.20	$ 12,671.32	$ 11,745.89	$ 10,659.19
0203	$ 17,571.62	$ 14,301.36	$ 13,256.80	$ 12,032.09
0204	$ 18,497.05	$ 15,053.91	$ 13,954.14	$ 12,664.06
0205	$ 23,353.76	$ 19,006.98	$ 17,619.56	$ 15,990.97
0206	$ 29,111.21	$ 23,692.26	$ 21,961.98	$ 19,932.42
0207	$ 39,330.20	$ 32,011.00	$ 29,673.44	$ 26,930.55
0301	$ 15,329.95	$ 13,821.94	$ 12,251.46	$ 11,221.43
0302	$ 19,412.31	$ 17,504.79	$ 15,514.45	$ 14,209.84
0303	$ 23,086.44	$ 20,817.17	$ 18,452.01	$ 16,898.97
0304	$ 31,939.81	$ 28,798.85	$ 25,525.70	$ 23,379.91
0401	$ 15,258.76	$ 12,687.30	$ 11,510.53	$ 10,168.15
0402	$ 19,933.87	$ 16,573.54	$ 15,037.93	$ 13,282.95
0403	$ 35,667.69	$ 29,653.10	$ 26,905.86	$ 23,766.36
0404	$ 63,467.02	$ 52,767.15	$ 47,877.02	$ 42,291.01
0405	$ 55,732.31	$ 46,335.60	$ 42,041.13	$ 37,136.47
0501	$ 9,597.20	$ 9,142.47	$ 8,158.92	$ 7,226.23
0502	$ 14,340.59	$ 13,660.68	$ 12,190.44	$ 10,797.21
0503	$ 18,231.19	$ 17,366.77	$ 15,498.47	$ 13,727.51
0504	$ 22,046.24	$ 21,000.22	$ 18,742.57	$ 16,599.69
0505	$ 25,656.45	$ 24,440.45	$ 21,810.89	$ 19,317.88
0506	$ 35,987.31	$ 34,281.72	$ 30,594.52	$ 27,096.17
0601	$ 13,682.47	$ 11,596.25	$ 10,572.03	$ 9,546.35
0602	$ 18,142.57	$ 15,376.44	$ 14,018.07	$ 12,659.70
0603	$ 23,423.49	$ 19,852.51	$ 18,098.98	$ 16,344.00
0604	$ 31,071.03	$ 26,333.45	$ 24,007.52	$ 21,680.13
0701	$ 11,634.02	$ 11,442.25	$ 11,006.41	$ 9,828.19
0702	$ 15,219.53	$ 14,969.65	$ 14,400.15	$ 12,858.73
0703	$ 18,312.54	$ 18,011.81	$ 17,326.09	$ 15,470.87
0704	$ 23,679.19	$ 23,289.84	$ 22,403.63	$ 20,005.06
0801	$ 8,113.89	$ 8,161.83	$ 8,161.83	$ 7,088.21
0802	$ 10,916.34	$ 10,981.72	$ 10,981.72	$ 9,537.63
0803	$ 15,045.20	$ 15,133.82	$ 15,133.82	$ 13,144.93
0804	$ 13,294.57	$ 13,373.02	$ 13,373.02	$ 11,615.14
0805	$ 16,378.87	$ 16,476.20	$ 16,476.20	$ 14,310.08
0806	$ 20,010.87	$ 20,130.00	$ 20,130.00	$ 17,483.00

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0901	$ 12,559.46	$ 10,811.74	$ 9,788.97	$ 8,869.34
0902	$ 16,829.24	$ 14,488.77	$ 13,117.33	$ 11,885.36
0903	$ 21,520.33	$ 18,526.11	$ 16,774.03	$ 15,197.74
0904	$ 27,915.55	$ 24,032.22	$ 21,758.59	$ 19,713.04
1001	$ 14,937.69	$ 13,208.86	$ 11,782.21	$ 10,547.33
1002	$ 19,577.93	$ 17,311.56	$ 15,443.26	$ 13,823.39
1003	$ 28,932.51	$ 25,585.26	$ 22,822.04	$ 20,430.73
1101	$ 15,049.56	$ 15,049.56	$ 14,352.21	$ 13,419.51
1102	$ 22,463.19	$ 22,463.19	$ 21,424.44	$ 20,029.75
1201	$ 11,747.34	$ 11,747.34	$ 11,721.19	$ 11,105.20
1202	$ 15,364.81	$ 15,364.81	$ 15,331.40	$ 14,526.55
1203	$ 18,883.49	$ 18,883.49	$ 18,841.36	$ 17,852.01
1301	$ 12,972.05	$ 12,972.05	$ 12,823.87	$ 11,436.44
1302	$ 17,109.63	$ 17,109.63	$ 16,914.95	$ 15,084.42
1303	$ 22,078.20	$ 22,078.20	$ 21,828.32	$ 19,466.07
1401	$ 13,676.66	$ 10,955.56	$ 9,691.63	$ 8,763.29
1402	$ 18,361.94	$ 14,709.60	$ 13,011.28	$ 11,764.77
1403	$ 22,134.86	$ 17,731.42	$ 15,684.43	$ 14,182.23
1404	$ 28,695.71	$ 22,987.65	$ 20,333.39	$ 18,385.18
1501	$ 13,970.12	$ 13,120.24	$ 11,289.71	$ 10,654.84
1502	$ 17,533.84	$ 16,466.04	$ 14,169.16	$ 13,373.02
1503	$ 21,587.16	$ 20,272.37	$ 17,443.77	$ 16,464.58
1504	$ 27,350.41	$ 25,684.05	$ 22,099.99	$ 20,859.30
1601	$ 16,208.89	$ 12,565.27	$ 11,182.20	$ 10,463.07
1602	$ 21,719.36	$ 16,836.50	$ 14,984.18	$ 14,019.52
1603	$ 28,102.96	$ 21,786.19	$ 19,387.62	$ 18,139.66
1701	$ 14,570.13	$ 13,384.65	$ 12,168.65	$ 10,638.85
1702	$ 19,299.00	$ 17,729.97	$ 16,117.36	$ 14,092.16
1703	$ 22,779.90	$ 20,927.58	$ 19,024.42	$ 16,633.11
1704	$ 29,133.00	$ 26,764.93	$ 24,331.49	$ 21,271.90
1801	$ 17,252.00	$ 13,694.09	$ 13,694.09	$ 12,579.80
1802	$ 23,821.56	$ 18,908.19	$ 18,908.19	$ 17,369.68
1803	$ 40,695.83	$ 32,303.01	$ 32,303.01	$ 29,674.89
1901	$ 16,592.43	$ 13,175.44	$ 13,175.44	$ 12,961.88
1902	$ 31,607.12	$ 25,098.57	$ 25,098.57	$ 24,691.79
1903	$ 53,220.42	$ 42,260.50	$ 42,260.50	$ 41,576.23
2001	$ 12,328.46	$ 10,935.23	$ 9,803.49	$ 8,809.78
2002	$ 16,529.96	$ 14,663.11	$ 13,144.93	$ 11,812.72
2003	$ 20,876.74	$ 18,518.84	$ 16,601.15	$ 14,918.80
2004	$ 27,982.38	$ 24,821.09	$ 22,251.08	$ 19,996.34
2101	$ 43,690.05	$ 37,721.95	$ 29,342.20	$ 24,909.71
5001	$ -	$ -	$ -	$ 2,144.33
5101	$ -	$ -	$ -	$ 8,523.58
5102	$ -	$ -	$ -	$ 21,345.99
5103	$ -	$ -	$ -	$ 10,098.41
5104	$ -	$ -	$ -	$ 27,295.21

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

Table 12 illustrates the methodology for adjusting the proposed Federal prospective payments (as described in sections V.A. through V.C. of this proposed rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified into CMG 0110 (without comorbidities). The proposed unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) appears in Table 11.

Example: 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 rural non-teaching hospital has a DSH percentage of 5 percent (which would result in a LIP adjustment of 1.0093), a wage index of 0.8391, and a rural adjustment of 18.7 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0269 percent), a wage index of 0.8896, and a teaching status adjustment of 0.0610.

To calculate each IRF's labor and non-labor portion of the proposed Federal prospective payment, we begin by taking the proposed unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) from Table 11. Then, we multiply the proposed labor-related share for FY 2012 (70.334 percent) described in section V.A.4 of this proposed rule by the proposed unadjusted Federal prospective payment rate. To determine the non-labor portion of the proposed Federal prospective payment rate, we subtract the labor portion of the proposed Federal payment from the proposed unadjusted Federal prospective payment.

To compute the proposed wage-adjusted Federal prospective payment, we multiply the labor portion of the proposed Federal payment by the appropriate wage index found in the addendum in Tables A and B. The resulting figure is the wage-adjusted labor amount. Next, we compute the proposed wage-adjusted Federal payment by adding the wage-adjusted labor amount to the non-labor portion.

Adjusting the proposed wage-adjusted Federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted Federal prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.0610, 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 rates. Table 12 illustrates the components of the adjusted payment calculation.

TABLE 12: Example of Computing the Proposed IRF FY 2012 Federal Prospective Payment

Steps		Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)	
1	Unadjusted Federal Prospective Payment		$ 30,488.46		$ 30,488.46
2	Labor Share	X	0.70334	X	0.70334
3	Labor Portion of Federal Payment	=	$21,443.75	=	$21,443.75
4	CBSA Based Wage Index (shown in the Addendum , Tables 1 and 2)	X	0.8391	X	0.8896
5	Wage-Adjusted Amount	=	$17,993.45	=	$19,076.36
6	Nonlabor Amount	+	$9,004.71	+	$9,004.71
7	Wage-Adjusted Federal Payment	=	$27,038.16	=	$28,121.07
8	Rural Adjustment	X	1.187	X	1.000
9	Wage- and Rural- Adjusted Federal Payment	=	$32,094.30	=	$28,121.07
10	LIP Adjustment	X	1.0093	X	1.0269
11	FY 2012 Wage-, Rural- and LIP- Adjusted Federal Prospective Payment Rate	=	$32,392.77	=	$28,877.53
12	FY 2012 Wage- and Rural-Adjusted Federal Prospective Payment		$32,094.30		$28,121.07
13	Teaching Status Adjustment	X	0.0000	X	0.0610
14	Teaching Status Adjustment Amount	=	$0.00	=	$1,715.39
15	FY2012 Wage-, Rural-, and LIP-Adjusted Federal Prospective Payment Rate	+	$32,392.77	+	$28,877.53
16	Total FY 2012 Adjusted Federal Prospective Payment	=	$32,392.77	=	$30,592.91

Thus, the proposed adjusted payment for Facility A would be $32,392.77 and the proposed adjusted payment for Facility B would be $30,592.91.

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

A. Proposed Update to the Outlier Threshold Amount for FY 2012

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 CCR 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 FY 2002 IRF PPS final rule (66 FR 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. For the 2002 IRF PPS final rule, we analyzed various outlier policies using 3, 4, and 5 percent of the total estimated payments, and we concluded that an outlier policy set at 3 percent of total estimated payments would optimize the extent to which we could reduce the financial risk to IRFs of caring for high-cost patients, while

still providing for adequate payments for all other (non-high cost outlier) cases.

Subsequently, we updated the IRF outlier threshold amount in the FYs 2006 through 2010 IRF PPS final rules and the FY 2011 notice (70 FR 47880, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, and 75 FR 42836, respectively) to maintain estimated outlier payments at 3 percent of total estimated payments. We also stated in the FY 2009 final rule (73 FR 46370 at 46385) that we would continue to analyze the estimated outlier payments for subsequent years and adjust the outlier threshold amount as appropriate to maintain the 3 percent target.

To update the IRF outlier threshold amount for FY 2012, we propose to use FY 2010 claims data and the same methodology that we used to set the initial outlier threshold amount in the FY 2002 IRF PPS final rule (66 FR 41316 and 41362 through 41363), which is also the same methodology that we used to update the outlier threshold amounts for FYs 2006 through 2011. Based on an analysis of this updated data, we estimate that IRF outlier payments as a percentage of total estimated payments are approximately 2.7 percent in FY 2011. Based on the updated analysis, we propose to update the outlier threshold amount to $11,822 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2012.

The proposed outlier threshold amount of $11,822 for FY 2012 is subject to change in the final rule if more recent data become available for analysis or if any changes are made to any of the other proposed payment policies set forth in this proposed rule.

B. Proposed Update to the IRF Cost-to-Charge Ratio Ceilings

In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR 45674, 45692 through 45694), we apply a ceiling to IRFs' CCRs. Using the methodology described in that final rule, we propose to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2012, based on analysis of the most recent data that is available. We 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 the national CCR ceiling for FY 2012, as discussed below.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2012, we estimate a proposed national average CCR of 0.669 for rural IRFs, which we calculate by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, we estimate a national average CCR of 0.520 for urban IRFs, which we calculate by taking an average of the CCRs for all urban IRFs using their most recently submitted cost report data. We apply weights to both of these averages using the IRFs' estimated costs, meaning that the CCRs of IRFs with higher costs factor more heavily into the averages than the CCRs of IRFs with lower costs. For this proposed rule, we have used the most recent available cost report data (FY 2009). This includes all IRFs whose cost reporting periods begin on or after October 1, 2008, and before October 1, 2009. If, for any IRF, the FY 2009 cost report was missing or had an "as submitted" status, we used data from a previous fiscal year's (that is, FY 2004 through FY 2008) settled cost report for that IRF. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care.

In addition, in accordance with past practice, we propose to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, the national CCR ceiling is set at 1.55 for FY 2012. This means that, if an individual IRF's CCR exceeds this ceiling of 1.55 for FY 2012, we would replace the IRF's CCR with the appropriate national average CCR (either rural or urban, depending on the geographic location of the IRF). We estimate the national CCR ceiling by:

Step 1. Taking the national average CCR (weighted by each IRF's total costs, as discussed above) of all IRFs for which we have sufficient cost report data (both rural and urban IRFs combined).

Step 2. Estimating the standard deviation of the national average CCR computed in step 1.

Step 3. Multiplying the standard deviation of the national average CCR computed in step 2 by a factor of 3 to compute a statistically significant reliable ceiling.

Step 4. Adding the result from step 3 to the national average CCR of all IRFs for which we have sufficient cost report data, from step 1.

We note that the proposed national average rural and urban CCRs and our estimate of the national CCR ceiling in this section are subject to change in the final rule if more recent data become available for use in these analyses.

VII. Impact of the IPPS Data Matching Process Changes on the IRF PPS Calculation of the Low-Income Percentage Adjustment Factor

Section 1886(j)(3)(A)(v) of the Act confers broad authority upon the Secretary to adjust the per unit payment rate "by such * * * factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities." For example, we adjust the Federal prospective payment amount associated with a CMG to account for facility-level characteristics such as an IRF's LIP, teaching status, and location in a rural area, if applicable, as described in § 412.624(e).

In the FY 2002 IRF PPS final rule (66 FR 41359 through 41361) that implemented the IRF PPS, we established the IRF LIP adjustment. In that final rule, we said that we would calculate the LIP adjustment by using the same disproportionate share hospital (DSH) patient percentage used in the acute IPPS DSH adjustment.

The DSH patient percentage is equal to the sum of the "Supplemental Security Income (SSI) fraction" and the "Medicaid Fraction." We compute the SSI fraction (also known as the "SSI ratio" or the "Medicare fraction") by dividing the number of the facility's inpatient days that are furnished to patients who were entitled to both Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan) and SSI benefits by the facility's total number of patient days furnished to patients entitled to benefits under Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan). To determine the number of inpatient days for individuals entitled to both Medicare Part A and SSI, as required for calculation of the numerator of the SSI fraction, CMS matches the Medicare records and SSI eligibility records for each IRF's patients during the FY. The data underlying the match process are drawn from: (a) The Medicare Provider Analysis and Review (MedPAR) data file; and (b) SSI eligibility data provided by the Social Security Administration (SSA). CMS recently revised this data match. See the FY 2011 IPPS final rule (75 FR 50041, 50276).

As previously stated, it is our policy to calculate the LIP adjustment using the same DSH patient percentage used in the acute IPPS DSH adjustment. In keeping with this long-standing policy, we will use the same matching process

as IPPS for calculating the SSI fractions for FYs 2011 and beyond. This process is described in the FY 2011 IPPS final rule, and will be used to calculate IRFs' SSI fractions for FY 2011. The FY 2011 IPPS final rule (75 FR 50277 through 50286) gives information on this revised data matching process.

VIII. Proposed Updates to the Policies in 42 CFR Part 412

Prior to the implementation of the IRF PPS on January 1, 2002, IRFs were paid based on the costs that they reported on their Medicare cost reports, subject to some limits. To simplify the cost reporting process, both for providers and for CMS and the Medicare contractors that monitored the cost reports, regulations were put into place that carefully defined, for example, when and how providers could be considered "new" and when and how they could expand their bed size and square footage. Under the IRF PPS, however, Medicare pays IRFs according to Federal prospective payment rates that are no longer tied to an individual IRF's Medicare cost reports. This new payment methodology has made some of the requirements regarding new IRFs and IRF expansions obsolete.

In addition, prior to 2002, the regulations distinguished between freestanding rehabilitation hospitals and rehabilitation units of acute care hospitals, with separate regulatory sections for the two types of facilities even though many of the same requirements applied to both. Under the IRF PPS, the distinctions between freestanding IRFs and IRF units are no longer relevant because both types of facilities are paid the same and are subject to the same rules and requirements. The current separation of the regulatory sections results in unnecessary repetition and confusion about which regulations apply to which types of facilities.

In addition, we added new IRF coverage requirements to § 412.622(a)(3), (4), and (5) in the FY 2010 IRF PPS final rule (74 FR 39762 at 39811 through 39812) for IRF discharges occurring on or after January 1, 2010. Several of the IRF conditions of payment in the existing § 412.23(b) and § 412.29, including the requirements for preadmission screenings to be conducted on all prospective patients, the requirements for IRF patients to receive close medical supervision, the requirements for plans of care to be developed for all IRF patients, and the requirements for patients to receive an interdisciplinary approach to care in the IRF, mirror some of the IRF coverage requirements in § 412.622(a)(3), (4), and (5).

Finally, in recent years, we have observed an increase in the number and complexity of acquisitions and mergers occurring in this industry. In some cases, the current Medicare rules and requirements for IRFs do not adequately address the number and complexity of acquisitions and mergers because they simply did not occur when the regulations were written. In other cases, regulations were written to address issues that do not exist today.

For all of these reasons, in this proposed rule we propose to consolidate, clarify, and revise the regulations for inpatient rehabilitation facilities at § 412.23(b), § 412.25(b), § 412.29, and § 412.30 to update and simplify the policies, to eliminate unnecessary repetition and confusion, and to enhance the consistency with the IRF coverage requirements in § 412.622(a)(3), (4), and (5). Since the proposed modifications would eliminate regulations that may no longer be strictly necessary under the IRF PPS, they would enable IRFs to more easily adjust to beneficiary changes in demand for IRF services, which would improve beneficiary access to these services. The proposed modifications would also reduce costs for providers and for the government by reducing the amount of time and expenditures devoted to adhering to (for providers) and enforcing (for the government) regulations that may no longer be strictly necessary. Since we have no way of determining how many IRFs might take advantage of the added flexibility these regulations afford to expand or change their operations, we are not able to quantify the savings. However, for example, each time an IRF unit submits a request to add beds to its facility under the current regulations, the Medicare contractor must determine whether or not the added IRF beds will be considered "new." To be considered "new," the beds must be added at the start of a cost reporting period, and the hospital must have "obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds it seeks to add to the unit." We believe that the first requirement (that beds can only be added at the start of a cost reporting period) is difficult, and potentially costly, for IRFs that are expanding through new construction because the exact timing of the end of a construction project is often difficult to predict. Construction delays can hamper an IRF's ability to have the construction completed exactly at the start of a cost reporting period, which can lead to significant revenue loss for the facility if the IRF is unable to add beds until the next cost reporting period. We believe that it is no longer necessary to require IRF beds to be added at the start of a cost reporting period. Further, the current regulations require Medicare contractors to expend unnecessary resources determining whether the IRF has met the second criteria, which requires the hospital to have "obtained approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds it seeks to add to the unit." The proposed modifications to the regulations are designed to simplify the regulations in order to minimize the amount of effort that Medicare contractors would need to spend enforcing them. Finally, the proposed modifications would enhance the consistency between the IRF coverage and payment requirements.

We note that § 412.25(b) applies to both IRFs and inpatient psychiatric facilities (IPFs), so the proposed revisions to § 412.25(b) would also affect IPFs in similar ways.

A. Proposed Consolidation of the Requirements for Rehabilitation Hospitals and Rehabilitation Units

Under the IRF PPS, rehabilitation hospitals and rehabilitation units of acute care hospitals (and critical access hospitals (CAHs)) are paid the same and, with very few exceptions, are subject to the same Medicare rules and requirements. For this reason, we believe that it is no longer necessary to have separate sections in 42 CFR part 412 that define the requirements for rehabilitation hospitals and rehabilitation units of acute care hospitals (and CAHs). This leads to excessive repetition and potential confusion about which rules apply to which types of facilities.

Thus, we propose to revise and consolidate the regulations for rehabilitation facilities that are currently in § 412.23(b) (for rehabilitation hospitals), § 412.29 (for rehabilitation units), and § 412.30 (for rehabilitation units) into a revised § 412.29 that would contain the requirements for all IRFs, whether they be freestanding rehabilitation hospitals or rehabilitation units of acute care hospitals (or CAHs). We believe that this would simplify the regulations by consolidating the majority of the requirements for IRFs into just one sub-section of part 412.

Although we are proposing slight modifications to the regulations in § 412.25(b), as discussed in section

VII.C. of this proposed rule, we are not proposing to move the IRF regulations in § 412.25 to § 412.29 in this proposed rule. The regulations in § 412.25, such as the requirement to have beds that are physically separate from the rest of the hospital, the requirement that the unit be serviced by the same Medicare contractor as the rest of the hospital, and the requirement that the unit be treated as a separate cost center for cost finding and apportionment purposes, by their nature apply uniquely to units that are part of another hospital. Since these requirements are not applicable to freestanding IRFs, we do not believe that it would be appropriate to include them with the rest of the IRF regulations in § 412.29 that are intended to apply to both freestanding IRF hospitals and to IRF units of hospitals. Further, we are not proposing modifications to § 412.25, other than the proposed changes to § 412.25(b) as discussed in section VII.C. of this proposed rule, because the regulations in § 412.25(a) through (g) (excluding (b)) remain relevant and important for defining IRF units of hospitals for payment purposes.

However, we propose to replace the text that is currently located at § 412.23(b) with text that simply refers the reader to the requirements in § 412.29, and move the rest of § 412.23(b) and all of § 412.30 to § 412.29. We propose to leave text in § 412.23(b) that refers IRFs to the requirements they must meet in § 412.29 only so that we do not disturb the ordering of the rest of § 412.23 that contain the Medicare regulations for inpatient psychiatric facilities, children's hospitals, and long-term care hospitals. Specifically, we propose to move all of the text in § 412.23(b) to § 412.29 except for a new paragraph that refers to the requirements in § 412.29, which would read as follows: "(b) Rehabilitation hospitals. A rehabilitation hospital must meet the requirements specified in § 412.29 to be excluded from the prospective payment systems specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(3) and in subpart P of this part."

B. Proposed Revisions to the Regulations at Proposed § 412.29

As described in section VIII.A. of this proposed rule, we propose to replace the text that is currently located at § 412.23(b) with text that simply refers the reader to the requirements in § 412.29, and move the rest of § 412.23(b) and all of § 412.30 to § 412.29. To eliminate any unnecessary repetition, and to update and clarify the regulations, we are also proposing revisions to the language from all three of the current sections, § 412.23(b), § 412.29, and § 412.30. As stated in current § 412.30, a rehabilitation unit can only be considered "new" if the hospital has never had a rehabilitation unit before. We have encountered circumstances in which a hospital closed a rehabilitation unit over 20 years ago and is now seeking to re-open the rehabilitation unit, and we believe that it would be reasonable to consider the rehabilitation unit to be "new." Thus, we are proposing to revise the requirements for an IRF to be considered "new" to indicate that an IRF can be considered "new" if it has not been paid under the IRF PPS in 42 CFR part 412, subpart P for at least 5 calendar years. These proposed requirements would now apply equally to both rehabilitation hospitals and rehabilitation units of acute care hospitals (or CAHs), and would be located in proposed § 412.29(c)(1). We believe that 5 calendar years would allow a sufficient amount of time between an IRF closing and an IRF reopening to prevent IRFs from closing and reopening annually to avoid meeting certain requirements, while allowing IRFs more flexibility to meet changing demand for IRF services.

In addition, we propose to clarify and simplify the rules regarding change of ownership (including mergers) or leasing, as defined in § 489.18. Changes of ownership or leasing, as defined in § 489.18, and mergers in which the new owner(s) accept assignment of the previous owner's provider agreements are transfers of the provider agreement. Therefore, we propose that IRFs in these situations would retain their excluded status and would continue to be paid under the IRF PPS before and after the change, as long as the IRF continues to meet all of the requirements specified in § 412.29. However, we propose to clarify that a change of ownership (including merger) or leasing in which the new owner(s) do not accept assignment of the previous owner's provider agreement would be considered a voluntary termination of the provider agreement, and the new owner(s) would need to reapply to the Medicare program as an initial applicant to operate a new IRF. In the case of changes of ownership (including mergers) or leasing, we propose that the new owner(s) would not be required to wait for 5 calendar years to reapply to operate a new IRF, but would be required to complete the initial hospital or critical access hospital certification process to participate in Medicare as a new IRF.

Further, we also propose to revise the regulations regarding new IRF beds. The regulations currently in § 412.30(d), which require an IRF to obtain "approval, under State licensure and Medicare certification, for an increase in its hospital bed capacity that is greater than 50 percent of the number of beds it seeks to add to the unit," have become less and less relevant under a prospective payment system in which payments are no longer based on IRFs' reported costs. Thus, we propose to eliminate these requirements and, instead, propose in § 412.29(c)(2) that IRF beds would be considered "new" if they meet all applicable State Certificate of Need and State licensure laws and if they get written approval from the appropriate CMS regional office (RO), as described below. We propose that new IRF beds can be added one time at any point during a cost reporting period (instead of at the start of a cost reporting period), but we propose to require that a full 12-month cost reporting period elapse before an IRF that has had beds delicensed or decertified can add new beds. The reason for this proposed requirement is to prevent IRFs from decreasing and increasing bed size every year to avoid having to meet certain requirements. We propose to require the IRF to obtain written approval from the appropriate CMS RO for the addition of the new beds in order to allow the CMS RO to verify that a full 12-month cost reporting period has elapsed before an IRF that has had beds delicensed or decertified can add new beds.

C. Proposed Revisions to the Requirements for Changes in Bed Size and Square Footage

Prior to the IRF PPS and the IPF PPS, excluded units (IRFs and IPFs) were paid based on their costs, as reported on their Medicare cost reports, subject to certain facility-specific cost limits. These cost-based payments were determined separately for operating and capital costs. Thus, under cost-based payments, the facilities' capital costs were determined, in part, by their bed size and square footage. Changes in the bed size and square footage would complicate the facilities' capital cost allocation. Thus, the Medicare regulations at § 412.25 limited the situations under which an IRF or IPF could change its bed size and square footage.

Under the IRF PPS and IPF PPS, however, a facility's bed size and square footage is not relevant for determining the individual facility's Medicare payment. Thus, we believe it is appropriate to modify some of the restrictions on a facility's ability to

change its bed size and square footage. We are therefore proposing in this proposed rule to relax the restrictions on a facility's ability to increase its bed size and square footage. Under the proposed requirements in § 412.25, an IRF or IPF could change (either increase or decrease) its bed size or square footage one time at any point in a given cost reporting period as long as it notifies the CMS RO within 30 days of the proposed change and maintains the required documentation. We note that any IRF beds that are added to an existing IRF during the IRF's cost reporting period would only be considered new through the end of that cost reporting period. Further, the new IRF beds would be included in the IRF's compliance review calculations under the 60 percent rule specified in § 412.29(b) beginning on the date that they are first added to the IRF.

D. Proposed Revisions To Enhance Consistency Between the IRF Coverage and Payment Requirements

In the FY 2010 IRF PPS final rule (74 FR 39762 at 39788 through 39798), CMS implemented new IRF coverage requirements in § 412.622(a)(3),(4), and (5). These new IRF coverage requirements replaced coverage requirements that were 25 years old and no longer reflected current medical practice. In updating these coverage requirements, we added further specificity to some of the terms that had been discussed in the old coverage requirements. For example, we more clearly defined in the new IRF coverage requirements what we mean by an IRF preadmission screening, care planning, and close medical supervision. In the proposed revisions to § 412.23(b) and § 412.29, we propose to enhance the consistency between the IRF coverage and payment requirements by incorporating some of the added specificity from the coverage requirements into the same requirements for payment. Specifically, we propose to clarify that, as in the IRF coverage requirements, IRF preadmission screenings must be reviewed and approved by a rehabilitation physician prior to each prospective patient's admission to an IRF. As we said in the FY 2010 IRF PPS final rule (74 FR 39791), we believe that it is important to require that a rehabilitation physician document the reasoning behind the decision to admit a patient to an IRF, to enable medical reviewers to understand the rationale for the decision.

Further, we propose to clarify, as we did in the coverage requirements at § 412.622(a)(3)(iv), that close medical supervision in an IRF means that the patient receives at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. As we stated in the FY 2010 IRF PPS final rule (74 FR 39796), we believe that at least 3 face-to-face rehabilitation physician visits per week are necessary to coordinate the patient's medical needs with his or her functional rehabilitation needs while in the facility.

Finally, we propose to clarify that we believe that discharge planning, in addition to assessment of the patient's goals and progress toward those goals, is an integral part of the interdisciplinary team approach to care that is provided in IRFs.

The specific proposed changes to the regulations at part 412 are shown in the "Regulation Text" of this proposed rule of this proposed rule. We encourage stakeholder comment on these proposed changes.

IX. Quality Reporting for Inpatient Rehabilitation Hospitals

A. Background and Statutory Authority

CMS seeks to promote higher quality and more efficient health care for Medicare beneficiaries. Our efforts are, in part, effectuated by quality reporting programs coupled with the public reporting of data collected under those programs. The quality reporting programs exist for various settings such as hospital inpatient services (the Hospital Inpatient Quality Reporting (Hospital IQR) Program), hospital outpatient services (the Hospital Outpatient Quality Data Reporting Program (HOP QDRP)), and for physicians and other eligible professionals the Physician Quality Reporting System (formerly called the Physician Quality Reporting Initiative, or PQRI). We have also implemented quality reporting programs for home health agencies and skilled nursing facilities that are based on conditions of participation, and an end-stage renal disease quality incentive program (ESRD QIP) that links payment to performance.

Section 3004(b) of the Affordable Care Act added section 1886(j)(7) to the Act, which requires the Secretary to implement a quality reporting program for Inpatient Rehabilitation Facilities (IRFs), including freestanding IRF hospitals and IRF units within hospitals. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Act requires the Secretary to reduce the increase factor with respect to a fiscal year by 2 percentage points for any IRFs that do not submit data to the Secretary in accordance with requirements established by the Secretary for that fiscal year. Section 1886(j)(7)(A)(ii) of the Act notes that this reduction may result in the increase factor being less than 0.0 for a fiscal year, and in payment rates under this subsection for a fiscal year being less than the payment rates for the preceding fiscal year. Any reduction based on failure to comply with the reporting requirements is, in accordance with section 1886(j)(7)(B) of the Act, limited to the particular fiscal year involved. The reductions are not to be cumulative and will not be taken into account in computing the payment amount under subsection (j) for a subsequent fiscal year.

Section 1886(j)(7)(C) of the Act requires that each IRF submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form and manner, and at a time, specified by the Secretary. The Secretary is generally required to specify measures that have been endorsed by the entity with a contract under section 1890(a) of the Act. This contract is currently held by the National Quality Forum (NQF). The NQF is a voluntary consensus standard-setting organization with a diverse representation of consumer, purchaser, provider, academic, clinical, and other health care stakeholder organizations. The NQF was established to standardize health care quality measurement and reporting through its consensus development process. We have generally adopted NQF-endorsed measures in our reporting programs. However, section 1886(j)(7)(D)(ii)of the Act provides that "in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization identified by the Secretary." Under section 1886(j)(7)(D)(iii) of the Act, the Secretary must publish the selected measures that will be applicable with respect to FY 2014 no later than October 1, 2012.

Section 1886(j)(7)(E) of the Act requires the Secretary to establish procedures for making data submitted

under the IRF quality reporting program available to the public. The Secretary must ensure that an IRF is given the opportunity to review the data that is to be made public prior to the data being made public. The Secretary must report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the CMS Web site.

B. Quality Measures for IRF Quality Reporting Program for FY 2014

1. General

We propose to adopt 2 quality measures for FY 2014. These quality measures are: (1) Urinary Catheter-Associated Urinary Tract Infections (CAUTI), and (2) Pressure Ulcers that are New or Have Worsened. We also discuss below a third measure that we are currently developing and intend to propose to adopt for FY 2014 in future rulemaking. That measure will be the 30-day Comprehensive All-Cause Risk-Standardized Readmission Measure.

2. Considerations in the Selection of the Proposed Quality Measures

In implementing the IRF Quality Reporting Program, we seek to collect data on measures that will provide information on the full spectrum of the quality of care being furnished by IRFs while imposing as little burden as possible on IRFs. We seek to collect data on valid, reliable, and relevant quality measures and to make that data available to the public in accordance with applicable law.

We also seek to align new Affordable Care Act reporting requirements for IRFs with HHS high priority conditions and topics, as reflected in the National Quality Strategy released by the Secretary (*http://www.healthcare.gov/center/reports/quality03212011a.html#es*) and to ultimately provide a comprehensive assessment of the quality of healthcare delivered. We note that adopting a comprehensive set of measures may take multiple years because of the time, effort and resources required by IRFs and CMS to develop and implement the data collection and reporting infrastructure needed to support an expanded quality reporting program. Current areas of high priority for HHS include patient safety, healthcare associated infections, and reduction of avoidable readmissions. These priorities are consistent with the aim of providing safe, sound care for all patients receiving services in any healthcare setting including IRFs.

In our consideration and selection of a comprehensive set of quality measures, we have several objectives. First, the measures should align with CMS' three-part aim for better care for individuals, better health for populations, and lower cost through improvement. Second, the measures should relate to specific priorities in the care setting for which they are adopted. For IRFs, these include improving patient safety (such as avoiding healthcare associated infections (HAI)), reducing adverse events, and encouraging better coordination of care and person-and-family-centered care. Third, the measures should address improved quality for the primary role of IRFs, which is to address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.

Other considerations in proposing quality measures include alignment with other Medicare quality reporting programs and other private sector initiatives; suggestions and input received from multiple stakeholders and national subject matter experts; seeking measures that have a low probability of causing unintended adverse consequences; and considering measures that are feasible, that is, measures that can be technically implemented within the capacity of the CMS infrastructure for data collection, analyses, and calculation of reporting and performance rates as applicable.

3. FY 2014 Measure #1: Healthcare Associated Infection Measure (HAI): Urinary Catheter-Associated Urinary Tract Infections (CAUTI)

The first measure we propose for IRFs for purposes of calculating the FY 2014 Increase Factor is an application of the NQF-endorsed measure developed by the Centers for Disease Control (CDC) for hospitals entitled (NQF# 0138) "Urinary Catheter-Associated Urinary Tract Infection [CAUTI] for Intensive Care Unit Patients" to the IRF setting. This measure was developed by the CDC to measure the percentage of patients with urinary catheter associated urinary tract infections in the ICU context. At the time of this proposed rule, the measure we are applying (NQF# 0138) is undergoing measure maintenance review by NQF which may result in a change in how the CDC calculates the aggregated data from using a standard rate for CAUTI, to the use of a standardized infection ratio (SIR) of healthcare associated urinary catheter-associated urinary tract infections. We propose to adopt the current measure in this rulemaking cycle. However, we intend to propose the adoption of any modifications to this measure that may result from the NQF review process in future rulemaking. We recognize that the NQF has endorsed this measure for the hospital setting, but believe that this measure is highly relevant to IRFs in that urinary catheters are commonly used in the IRF setting. Section 1886(j)(7)(D)(ii) provides that "in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization identified by the Secretary." We reviewed the NQF's consensus endorsed measures, and were unable to identify any NQF-endorsed measures for urinary catheter-associated urinary tract infections for the IRF setting. We are unaware of any other measures of urinary tract infections that have been approved by voluntary consensus standards bodies.

Having given due consideration to other measures that have been endorsed or adopted by a consensus entity, we propose to adopt an application of the NQF-endorsed CAUTI measure under the Secretary's authority to select non-NQF endorsed measures where NQF-endorsed measures do not exist for a specified area or medical topic. While we are proposing to adopt the measure under the exception authority provided in section 1886(j)(7)(D)(ii), we note that we intend to ask NQF to formally extend its endorsement of the existing CAUTI measure to the IRF setting.

Urinary tract infections (UTIs) are a common cause of morbidity and mortality. The urinary tract is the most common site of healthcare-associated infection, accounting for more than 30 percent of infections reported by acute care hospitals.[1] Healthcare-associated UTIs are commonly attributed to catheterization of the urinary tract.

CAUTI can lead to complications as cystitis, pyelonephritis, gram-negative bacteremia, prostatitis, epididymitis, and orchitis in males and, less commonly, endocarditis, vertebral osteomyelitis, septic arthritis, endophthalmitis, and meningitis in all patients. Complications associated with CAUTI include discomfort to the patient, prolonged hospital stay, and increased cost and mortality. Each year, more than 13,000 deaths are associated

[1] Klevens RM, Edward JR, *et al.* Estimating health care-associated infections and deaths in U.S. hospitals, 2002. Public Health Reports 2007;122:160–166.

with UTIs.[1] Prevention of CAUTIs is discussed in the CDC/HICPAC document, *Guideline for Prevention of Catheter-associated Urinary Tract Infections*.[2] The NQF endorsed CAUTI measure we are proposing is currently collected by the CDC's National Healthcare Safety Network (NHSN), a secure Internet-based health surveillance system, and we note that the CDC is also collecting data on this measure from IRFs. NHSN is currently used, in part, as one means by which certain State-mandated reporting and surveillance data are collected.

The HHS National Action Plan to Prevent HAI (*http://www.hhs.gov/ash/initiatives/hai/actionplan/index.html*) identified catheter-associated urinary tract infections as the leading type of HAI that is largely preventable. The technical expert panel (TEP) convened by the CMS measure-developer-contractor on February 4, 2011 (*https://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/*) also identified CAUTI as a high priority quality issue for IRFs.

4. FY 2014 Measure #2: Percent of Patients With Pressure Ulcers That are New or Worsened

The second measure we propose for IRFs for purposes of calculating the FY 2014 increase factor is an application of a CMS developed NQF-endorsed measure for short-stay nursing home patients; (NQF# NH–012–10) "Percent of Residents with Pressure Ulcers that Are New or Worsened." This is the percentage of patients who have one or more stage 2–4 pressure ulcers that are new or worsened, when assessed at the time of discharge as compared with the patient's condition when it was assessed at admission. We recognize NQF endorsement of this measure is limited to short-stay nursing home patients, but believe that this measure is highly relevant and a high priority quality issue in the care of IRF patients. Currently, there are no other NQF-endorsed pressure ulcer measures that are applicable to IRFs and we were unable to identify other measures for pressure ulcers that have been endorsed or adopted for the IRF context by a consensus organization. We are also unaware of any other measures of pressure ulcers that have been approved by voluntary consensus standards bodies. For these reasons, we propose to adopt an application of this NQF-endorsed measure under the Secretary's authority to select non-NQF endorsed measures where measures do not exist for a specified area or medical topic. We also intend to ask NQF to extend its endorsement of the existing short-stay nursing home pressure ulcer measure to the IRF setting.

Pressure ulcers are high-volume and high-cost adverse events across the spectrum of health care settings from acute hospitals to home health. Patients in the IRF setting may have medically complex conditions and severe functional limitations, and are therefore at high risk for the development, or worsening, of pressure ulcers. Pressure ulcers are serious medical conditions and an important measure of quality. Pressure ulcers can lead to serious, life-threatening infections, which substantially increase the total cost of care. As reported in the August 22, 2007, Inpatient Hospital PPS Final Rule for FY 2008 (72 FR 47205) in 2006 there were 322,946 reported cases of Medicare patients with a pressure ulcer as a secondary diagnosis in acute care hospitals.

5. Potential FY 2014 measure #3: 30-day Comprehensive All-Cause Risk-Standardized Readmission Measure

Avoidable hospital readmissions are a high priority for HHS and CMS. We are currently developing setting-specific risk adjusted 30-day all-condition all-cause risk-standardized readmission measures for hospitals, IRFs, long term care hospitals and nursing homes. The main features of the measure methodology will be consistent with that of the NQF-endorsed CMS hospital risk-adjusted 30-day readmission measures for the Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia and Percutaneous Coronary Intervention (PCI). We plan to cover the maximum number of patient conditions possible in the all-condition measures. We will consult literature and national experts and conduct analyses on the types and comorbidities of the patients of each setting in order to establish appropriate risk-adjustment of the measures as well as the meaning/definition of readmission and the appropriate time-window for readmission for each care setting. To expand beyond the condition-specific measures to an all-condition readmission measure for each setting, we will conduct analyses to determine whether it is statistically and clinically sound to derive the all-condition measures from one single risk adjustment model, or if it would be better to form a composite of multiple models for multiple conditions. We plan to use hierarchical logistic regression modeling to take into account the effects of the clustering of patients and the sample size in the IRF setting. This measure is expected to be completed in late 2011, at which time it will be submitted to the entity with a contract under section 1890(a) of the Act for endorsement.

We invite public comments on the proposed quality measures for FY 2014: (1) Urinary Catheter-Associated Urinary Tract Infections (CAUTI); (2) Pressure Ulcers that are New or Have Worsened. We also invite public comment on our intent to propose a 30-day Comprehensive All-Cause Risk-Standardized Readmission Measure.

C. Data Submission Requirements

1. Proposed Method of Data Submission for HAI Measure (CAUTI)

We propose to require that IRFs submit data on the Urinary Catheter-Associated Urinary Tract Infection (CAUTI) measure through the Centers for Disease Control (CDC)/National Healthcare Safety Network (NHSN). As we noted above, the NHSN is a secure, Internet-based surveillance system maintained by the CDC that can be utilized by all types of healthcare facilities in the United States, including acute care hospitals, long term acute care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long term care facilities. The NHSN enables healthcare facilities to collect and use data about HAIs, including information on clinical practices known to prevent HAIs, information on the incidence or prevalence of multidrug-resistant organisms within their organizations, and information on other adverse events. Some States use the NHSN as a means of collecting state law mandated HAI reporting. NHSN collects data via a Web-based tool hosted by the CDC (*http://www.cdc.gov/*). This reporting service is provided free of charge to healthcare facilities. Additionally, the ability of the CDC to receive NHSN measures data from electronic health records (EHR) may be possible in the near future. Currently, more than 20 States require hospitals to report HAIs using NHSN, and the CDC supports more 4,000 hospitals that are using the NHSN.

We propose for IRFs to submit the data elements needed to calculate the Urinary Catheter-Associated Urinary Tract Infection measure using the NHSN's standard data submission requirements which requires submission of data on HAI events on all patients. Collecting data on all patients will provide CMS with the most robust,

[2] Wong ES. Guideline for prevention of catheter-associated urinary tract infections. Infect Control 1981; 2:126–30.

accurate reflection of the quality of care delivered to Medicare beneficiaries as compared with non-Medicare patients. Therefore, to measure the quality of care that is delivered to Medicare beneficiaries in the IRF setting, we are proposing to collect quality data related to HAI events on all patients regardless of payor.

CDC/NHSN requirements may include adherence to training requirements, use of CDC measure specifications, data element definitions, data submission requirements and instructions, data reporting timeframes, as well as NHSN participation forms and indications to CDC allowing CMS to access data for this measure for the IRF quality reporting program purposes. Detailed requirements for NHSN participation, measure specifications, and data collection can be found at *http://www.cdc.gov/nhsn/*. We propose to require IRFs to use the specifications and data collection tools for the proposed Urinary Catheter-Associated Urinary Tract Infections as required by CDC as of the time that the data is submitted.

For purposes of calculating the FY 2014 increase factor we propose to collect data on CAUTI events that occur from October 1, 2012 through December 31, 2012, the final fiscal quarter of FY 2013. We propose that all subsequent IRF quality reporting cycles would be based on a full calendar year (CY) cycle (that is January 1 through December 31 of the applicable year). For example, the FY 2015 payment determinations will be made based on CY 2013 data submitted to CDC. We welcome comments on the proposed reporting cycle for IRFs.

Should this proposed measure be finalized, further details regarding data submission and reporting requirements for this measure will be posted on the CMS Web site *http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/* by no later than January 31, 2012.

IRFs are also encouraged to visit the CDC Web site *http://www.cdc.gov/nhsn/* in order to review the NHSN enrollment and reporting requirements.

2. Proposed Method of Data Submission for the Percent of Patients With New or Worsened Pressure Ulcer Measure

We seek to implement the IRF Quality Reporting Program in a manner that imposes as little burden as possible. IRFs already are required to submit certain data for purposes of determining payment via the current Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI). The IRF–PAI also includes currently optional "quality indicators" (QI). To support the standardized collection and calculation of quality measures specifically focused on IRF services, we propose to modify the current IRF–PAI by replacing the current optional pressure ulcer items in the QI section of the IRF–PAI with mandatory pressure ulcer data elements for the proposed measure.

We propose for IRFs to submit the data needed to calculate the measure "Percent of Patients with New or Worsened Pressure Ulcers" on all Medicare patients. Therefore, to measure the quality of care that is delivered to Medicare beneficiaries in the IRF setting, we are proposing to collect quality data related to new or worsening pressure ulcers on all Medicare patients.

We propose to use the IRF–PAI to collect pressure ulcer data elements that would be similar to those collected through the Minimum Data Set 3.0 (MDS 3.0), which is a reporting instrument that is used in nursing homes. A draft of the proposed IRF–PAI revisions with the new pressure ulcer elements is available on the CMS Web site at *http://www.cms.gov/InpatientRehabFacPPS/04_IRFPAI.asp#TopOfPage*. The current MDS 3.0 pressure ulcer items evolved as an outgrowth of CMS' work to develop a standardized patient assessment instrument, now referred to as CARE (Continuity Assessment Record & Evaluation).

The CARE assessment instrument was developed and tested in the post-acute care payment reform demonstration (PAC–PRD) which included IRFs as required by section 5008 of the 2005 Deficit Reduction Act (DRA) (Pub. L. 109–171, enacted February 8, 2006) (more information may be found at *http://www.pacdemo.rti.org*). We note that the MDS data elements were supported by the National Pressure Ulcer Advisory Panel (NPUAP). We believe that modifying the current IRF–PAI pressure ulcer items to be consistent with the standardized data elements now used in the MDS 3.0, will drive uniformity across settings that will lead to better quality of care in IRFs and ultimately, across the continuum of care settings. If this proposal is finalized, additional details regarding the use of modified IRF–PAI data elements to calculate this measure will be published on the CMS Web site at *http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/* by no later than January 31, 2012. We invite comments on these proposals for the submission of data on the proposed quality measure for pressure ulcers.

3. Potential Method of Data Submission for the 30-day Comprehensive All-Cause Risk-Standardized Readmission Measure

In the FY 2013 rule cycle we anticipate being able to propose using claims data otherwise submitted by the IRF as the data to calculate this measure. As such, we anticipate not needing additional reporting to fulfill the data needs if this measure is proposed and adopted. We generally anticipate calculating the measure based on 3 years of claims data in order to provide a sufficient number of discharges to calculate this measure.

D. Public Reporting

Under section 1886(j)(7)(E) of the Act, the Secretary is required to establish procedures for making data submitted by IRFs under the IRF quality reporting program available to the public. In accordance with this provision, we propose to establish procedures to make the data available to the public. We do not intend to make individual patient data public. We believe that existing laws governing access to agency records will adequately address requests for such data. We will adopt procedures that will ensure that an IRF has the opportunity to review the data to be made public prior to the data being made public. Additionally, as required under section 1886(j)(7)(E) of the Act, we will report quality measures that relate to services furnished in IRFs on CMS Web site.

E. Quality Measures for Future Consideration for Determination of Increase Factors for Future Fiscal Year Payments

As indicated previously in this section, we ultimately seek to adopt a comprehensive set of quality measures to be available for widespread use for informed decision making and quality improvement. While we are beginning with a limited set of measures in the IRF context, we expect to expand the measure set through rulemaking which will allow us, for example, to assess an IRF patient's functional status and whether he/she has achieved his or her rehabilitation goals and potential. As noted above, IRFs are currently required to submit certain data for purposes of determining payment via the IRF–PAI. The IRF–PAI currently includes optional QIs, and, if finalized, it would include mandatory data elements for use in the calculation of the pressure ulcer measure. Only a small number of IRFs are currently submitting data on the optional QI data elements.

We intend to propose a more robust set of measures for the IRF quality reporting program in the FY 2013 rulemaking cycle for the determination of the FY 2015 payment increase factor. We are considering the measures listed in Table 13 which include, but are not limited to, measure topics reported by providers of skilled nursing facility (SNF) services for short stay nursing home patients. We invite public comment on which quality measures would be considered most feasible and useful for IRFs to report for purposes of the FY 2015 payment update.

The quality data on short stay nursing home patients, which generates the short stay nursing home measures, are generated from the MDS 3.0 data collection vehicle. We are currently analyzing the quality data collected by nursing homes through the 3.0 version of the MDS which was implemented nationally in nursing homes in October 2010. Nursing homes are reporting data for long stay residents as well as short stay residents. We will be analyzing the performance of these nursing home measures through the end of 2011 and expect to have findings on their performance in the nursing home setting by early 2012. Next steps would include analyzing whether any of these measures would be appropriate for application in the IRF setting. We would invite public comment on the application of some or all of the short stay nursing home measures listed below. We are seeking NQF endorsement of these measures by August 2011. These measures may also be found at the NQF Web site *http://www.qualityforum.org/*. CMS' short stay nursing home measures undergoing NQF endorsement include NH–010–10 percent of residents who self-report moderate to severe pain; NH–014–10 percent of residents assessed and appropriately given the seasonal influenza vaccine; NH–016–10 percent of residents assessed and appropriately given the seasonal pneumococcal vaccine and NH–009–10 percentage of residents on a scheduled pain medication regimen on admission who self-report a decrease in pain intensity or frequency.

If any of the short stay nursing home measures are appropriate for application to the IRF setting we would intend to propose some or all of those measures in the FY 2013 rulemaking cycle. Any added measures proposed through the FY 2013 rulemaking cycle would apply to the payment determination for FY 2015. We expect that any measures proposed through the FY 2013 rulemaking cycle would require changes to the IRF–PAI as a data collection vehicle and changes to the supporting information technology (IT) infrastructure. We expect that it would take providers, vendors, and CMS approximately one year to make the necessary changes to their IT systems to support the collection and reporting of new or modified IRF–PAI data elements. We would expect providers, vendors, and CMS to complete any needed changes to their IT systems by August 2013. We would intend to propose IRFs submit any additional or revised IRF–PAI data elements starting October 1, 2013 through December 31, 2013 for the FY 2015 payment update. Alternatively, we are considering and invite public comment on the possibility of basing future quality measures on data sources or assessment instruments other than the IRF–PAI. As stated earlier, we developed and tested the CARE assessment instrument for the post-acute demonstration under section 5008 of the DRA. We intend to submit a report to Congress by the end of 2011 with findings from the three year Post Acute Care-Payment Reform Demonstration (PAC–PRD) and its use of the CARE patient assessment instrument as a data collection vehicle. More details on the PAC–PRD which concluded in late 2010 are available at *http://www.pacdemo.rti.org*. We believe that the data elements that were collected using this CARE standardized assessment instrument could be used across all post-acute care sites to measure functional status and other factors during treatment and at discharge which are key indicators of quality in IRFs and in nursing homes treating short stay patients requiring rehabilitative services. We believe the instrument could be beneficial in supporting the submission of data on quality measures by IRFs and other care settings by ensuring standardized data collection. We invite comments on the use of a standardized assessment instrument such as the CARE assessment instrument in IRFs to collect data that would generate additional quality measures for the IRF quality reporting program in the future.

We also invite public comment on the measures and measures topics in Table 13, as well as potential methods for collecting quality data on the percent of patients whose individually stated goals were met and the percent of patients for whom care delivered was consistent with patient stated care preferences. During the NQF endorsement process for nursing home quality measures mentioned above, the NQF steering committee pointed to the need for CMS to consider pairing pain measures with a measure or measures that reflect patients' preferences for how their care, treatment and symptoms are managed by healthcare providers. These items, and other items in Table 13, are under consideration for future years. We also invite other suggestions regarding our implementation of the IRF quality measures program.

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TABLE 13: Possible Future Measures and Topics for the IRF Quality Reporting Program

Overarching Goal: Safety and Healthcare Acquired Conditions: Avoidable Adverse Events and Serious Reportable Events*	
	• Unplanned acute care hospitalizations • Falls with Major Injury* ** • Falls with major injury per 1000 days. • Incidence of venous thromboembolism (VTE), potentially preventable. * • Poly-pharmacy related injury • Medication errors* • Stage III and IV Pressure Ulcers**
Overarching Goal: Safety and Prevention	
	• VTE Prophylaxis • Patient Immunization for Influenza • Patient Immunization for Pneumonia • Staff immunization
Overarching Goal: Safety and Healthcare Acquired Conditions – HAIs	
	• Surgical site infections • Multidrug resistant organism infection
Overarching Goal: Better, Person Centered-Care: Care Coordination/Care Outcome	
	• Functional Change: Change in Motor Score • Change in Cognitive Function: Change in Cognitive Score • Communication • Percent of patients whose individually stated goals were met • Care Transitions Measure-3 (CTM-3) • Discharge Outcome/Discharge disposition: - Home - Assisted Living - Nursing Home - LTCH - Hospital - Hospice • Patient Preferences for care, treatment and management of symptoms by healthcare providers
Overarching Goal: Better, Person Centered-Care: Symptom Management	
	• Percent of patients on a scheduled pain management regime on admission who report a decrease in pain intensity or frequency • Percent of patients with pain assessment conducted and documented prior to therapy. • Percent of patients who self-report moderate to severe pain. • Percent of patients with dyspnea improved within one day of assessment.
Overarching Goal: Better, Person Centered-Care: Experience of Care	
	• Patient Survey, e.g., Hospital Consumer Assessment of Healthcare Providers & Systems • Percent of patients for whom care delivered was consistent with patient stated care preferences.

*Consistent with NQF Serious Reportable Events
**Consistent with HAC Prevalence Measure

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F. Proposed New Regulation Text for the IRF Quality Reporting Program

To implement the new IRF quality reporting program, we propose to re-designate the existing paragraph § 412.624(c)(4) as § 412.624(c)(5) and add a new paragraph § 412.624(c)(4). The specific proposed changes to the regulations at part 412 are shown in the "Regulation Text" of this proposed rule of this proposed rule. We encourage stakeholder comment on these proposed changes.

X. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This proposed rule does not impose any new information collection requirements as outlined in the regulation text. However, this proposed rule does make reference to associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

As stated in Section IX.B. of the preamble of this proposed rule, for purposes of calculating the FY 2014 IRF PPS increase factor, we propose that IRFs submit data on 2 quality measures. These quality measures are: (1) Catheter Associated Urinary Tract Infections; and (2) Pressure Ulcers that are New or Have Worsened. The aforementioned measures will be collected via the following respective means.

Catheter Associated Urinary Tract Infections (CAUTI)

Regarding the collection of data on the first quality measure, Catheter Associated Urinary Tract Infections, we propose to require as the form and manner of submission for the measure, CAUTI rate per 1000 urinary catheter days, to be through the Centers for Disease Control (CDC)/National Health Safety Network (NHSN). Data collection by the NHSN occurs via a Web-based tool hosted by the CDC. This reporting service is provided free of charge to healthcare facilities. In fact, some IRFs are already using the NHSN to collect and submit this data. With this proposed rule, CMS seeks to impose an information collection requirement for the CAUTI measure. It should be noted that information collection activities associated with the CDC/NHSN are currently approved under OMB control number 0920–0666. Detailed requirements for NHSN participation, measure specifications, and data collection can be found at *http://www.cdc.gov/nhsn/*. IRFs must use the current specifications and data collection tools for Catheter Associated Urinary Tract Infections.

CMS does not currently require IRFs to report data to NHSN; however, according to the CDC, there are 26 IRFs that already submit data to NHSN either voluntarily or per state mandate. In order to report data to NHSN, the CDC requires the facility to enroll into the NHSN and take specified training. As per the NHSN Web site, we estimate that it will take 240 minutes (4 hours) to register and complete the necessary training provided by the CDC. The estimated annual burden associated with this requirement is 268,800 minutes/4,480 hours (240 minutes × 1,120 IRFs) at an estimated cost of $186,323. This cost is estimated using the average hourly wage of a Registered Nurse which is reported by the U.S. Bureau of Statistics to be $41.59. Once each facility has been properly registered into NHSN and trained, they will need to submit two types of forms in order for CDC to calculate the CAUTI rate per 1,000 urinary catheter days. The first form, the Urinary Tract Infection (UTI) form, is submitted by facilities for each patient with a CAUTI. We estimate that it will take 15 minutes per form per IRF. This time estimate consists of 5 minutes of nursing time needed to collect the clinical data and 10 minutes of clerical time necessary to enter the data into NHSN. We further anticipate that there will be approximately 2.25 forms submitted per IRF per month. Based on this estimate, we expect for each IRF to expend 33.75 minutes (0.5625 hours) per month and 405 minutes (6.75 hours) per year reporting to NHSN. The estimated annual burden to all IRFs in the U.S. for reporting to NHSN is 7,735.5 hours. The estimated cost per IRF is $186.14 per year. Similarly, the estimated total yearly cost across all IRFs is $213,322. These costs are estimated using an hourly wage for a Registered Nurse of $41.59 and a Medical Billing Clerk/Data Entry person of $20.57 as stated by the U.S. Bureau of Labor Statistics. The second form, the denominator form, is used to count daily the number of patients with an indwelling catheter device. These daily counts are summed and only the total for each month is submitted to NHSN. While CDC estimates that the denominator form takes 5 hours per month to complete, we estimate that it will take 2.5 hours per form per IRF per month, as the number of patients with an indwelling catheter is the only part of this form that IRFs will be required to complete. We anticipate that there will be one form submitted per IRF per month. Based on this estimate, we expect for each IRF to expend 150 minutes (2.5 hours) per month and 1,800 minutes (30 hours) per year reporting to NHSN. The estimated annual burden to all IRFs in the U.S. for reporting to NHSN is 34,380 hours. The estimated cost per IRF is $1,247.70 per year. Similarly, the estimated total yearly cost across all IRFs is $1,429,864. These costs are estimated using an hourly wage for a Registered Nurse of $41.59.

Pressure Ulcers That Are New or Have Worsened

As stated in Section IX.C.2 of this preamble, to support the standardized collection and calculation of quality measures specifically focused on IRF services, we propose to modify the current Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI) by replacing and harmonizing the pressure ulcer items with data elements similar to those collected through the Minimum Data Set 3.0 (MDS 3.0) used in nursing homes. Additionally, the MDS 3.0 pressure ulcer items have been harmonized with the Continuity Assessment Record and Evaluation (CARE) data set, which was developed for and broadly tested in the post-acute demonstration as required by section 5008 of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171, enacted on February 8, 2006). We believe modifying the IRF–PAI pressure ulcer items to be consistent with the standardized data elements now used in the MDS 3.0, and supported by the National Pressure Ulcer Advisory Panel (NPUAP), would provide better informed decision making and quality improvement in IRFs and ultimately, across the continuum of care settings.

Since all IRFs are already required to complete and transmit IRF–PAIs on all Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) patients in order to receive payment from Medicare, and the number of IRFs submitting claims to Medicare has remained stable over the past several years, we do not estimate that there are any IRFs that would need to conduct additional training or set-up for completing and transmitting the IRF–PAI. Thus, we do not estimate any additional burden on IRFs for these

activities. In addition, we do not estimate any additional burden for IRFs to complete the IRF–PAI with the mandatory quality measures as the IRF–PAI currently contains a voluntary "Quality Indicators" section. If finalized, the voluntary data items will be replaced with the proposed pressure ulcer question set. When the original burden estimates were completed for the IRF–PAI, we estimated that the "Quality Indicators" section of the IRF–PAI would take about 10 minutes to complete, and we assumed that all IRFs would complete the Quality Indicators items, even though completion of this section was voluntary. Thus, removing the Quality Indicators items from the IRF–PAI would decrease the total estimated burden of completing each IRF–PAI by about 10 minutes. However, we estimate that it will take about 10 minutes to complete the new pressure ulcer item that we are proposing to require IRFs to complete as part of the new IRF quality reporting program. Since the time to complete the items that we are proposing to remove from the IRF–PAI is the same as the time to complete the new items we are proposing to add, we estimate no net change in the amount of time associated with completing each IRF–PAI and no net change in burden.

We will be submitting a revision to the IRF–PAI information collection request currently approved under OMB control number 0938–0842 for OMB review and approval.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget; Attention: CMS Desk Officer, CMS–1349–P; Fax: (202) 395–6974; or E-mail: *OIRA_submission@omb.eop.gov*.

XI. Response to Public 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 data 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.

XII. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 30, 1993, Regulatory Planning and Review), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (September 19, 1980, Pub. L. 96–354) (RFA), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct 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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an "economically" significant rule, under section 3(f)(1) of Executive Order 12866. Accordingly, the rule has been reviewed by the Office of Management and Budget.

2. Statement of Need

This proposed rule updates the IRF prospective payment rates for FY 2012 as required under section 1886(j)(3)(C) of the Act. It responds to Section 1886(j)(5) of the Act, which 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 IRF PPS's case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

This rule also proposes some policy changes within the statutory discretion afforded to the Secretary under section 1886(j) of the Act. We believe that the proposed policy changes would better align IRF PPS policies with those of other Medicare payment systems and would clarify the current IRF payment regulations. Further, many of the proposed policy changes are designed to promote greater flexibility in the IRF PPS policies.

This proposed rule also implements section 3401(d) of the Affordable Care Act, which amended section 1886(j)(3)(C) of the Act and added section 1886(j)(3)(D) of the Act. Section 1886(j)(3)(C) of the Act requires the Secretary to estimate a multi-factor productivity adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010–2019.

Finally, this proposed rule discusses the IRF quality measures that we are proposing to adopt for the first year of implementation of a new IRF quality reporting program, as required by section 3004(b) of the Affordable Care Act.

3. Overall Impacts

We estimate that the total impact of these proposed changes for estimated FY 2012 payments compared to estimated FY 2011 payments would be an increase of approximately $120 million (this reflects a $100 million increase from the update to the payment rates and a $20 million increase due to the proposed update to the outlier threshold amount to increase estimated outlier payments from approximately 2.7 percent in FY 2011 to 3 percent in FY 2012).

4. Detailed Economic Analysis

i. Basis and Methodology of Estimates

This proposed rule sets forth updates of the IRF PPS rates contained in the FY 2011 notice and proposes updates to the CMG relative weights and average length of stay values, the facility-level adjustments, the wage index, and the outlier threshold for high-cost cases. This proposed rule also implements a 0.1 percentage point reduction to the proposed FY 2012 rebased RPL market basket increase factor (updated from a 2002 base year to a 2008 base year) in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act and a 1.2 percent productivity adjustment to the proposed FY 2012 rebased RPL market basket increase factor as required by section 1886(j)(3)(C)(ii)(I) of the Act.

We estimate that the FY 2012 impact would be a net increase of $120 million in payments to IRF providers (this reflects a $100 million estimated increase from the proposed update to the payment rates and a $20 million estimated increase due to the proposed update to the outlier threshold amount to increase the estimated outlier payments from approximately 2.7 percent in FY 2011 to 3.0 percent in FY 2012). The impact analysis in Table 14 of this proposed rule represents the projected effects of the proposed policy

changes in the IRF PPS for FY 2012 compared with estimated IRF PPS payments in FY 2011 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 because of other changes in the forecasted impact time period. Some examples could be legislative changes made by the Congress to the Medicare program that would impact program funding, or changes specifically related to IRFs. Although some of these changes may not necessarily 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 rates for FY 2012, we are proposing a number of standard annual revisions and clarifications mentioned elsewhere in this proposed rule (for example, the proposed update to the wage index and market basket increase factor used to adjust the Federal rates). We estimate that these proposed revisions would increase payments to IRFs by approximately $100 million (all due to the update to the market basket increase factor, since the update to the wage index is done in a budget neutral manner—as required by statute—and therefore neither increases nor decreases aggregate payments to IRFs).

The aggregate change in estimated payments associated with this proposed rule is estimated to be an increase in payments to IRFs of $120 million for FY 2012. The market basket increase of $100 million and the $20 million increase due to the proposed update to the outlier threshold amount to increase estimated outlier payments from approximately 2.7 percent in FY 2011 to 3.0 percent in FY 2012 would result in a net change in estimated payments from FY 2011 to FY 2012 of $120 million.

The effects of the proposed changes that impact IRF PPS payment rates are shown in Table 14. The following proposed changes that affect the IRF PPS payment rates are discussed separately below:

- The effects of the proposed update to the outlier threshold amount, from approximately 2.7 to 3.0 percent of total estimated payments for FY 2012, consistent with section 1886(j)(4) of the Act.
- The effects of the 2.8 percent annual market basket update for FY 2012 (using the proposed rebased RPL market basket) to IRF PPS payment rates, as required by section 1886(j)(3)(A)(i) and section 1886(j)(3)(C) of the Act, including a 0.1 percentage point reduction for FY 2012 in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act and a 1.2 percent productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.
- 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 proposed budget-neutral changes to the CMG relative weights and average length of stay values, under the authority of section 1886(j)(2)(C)(i) of the Act.
- The effects of the proposed budget-neutral changes to the facility-level adjustment factors, as permitted under section 1886(j)(3)(A)(v) of the Act.
- The effect of the data matching process to compute the DSH patient percentage used in the IPPS DSH adjustment that is also used by IRF PPS to compute the low-income percentage adjustment factor.
- The effect of the proposed IRF quality reporting program, Beginning in FY 2013.
- The total proposed change in estimated payments based on the FY 2012 proposed policies relative to estimated FY 2011 payments without the proposed policies.

ii. Description of Table 14

The table below categorizes IRFs by geographic location, including urban or rural location, and location with respect to CMS's nine census divisions (as defined on the cost report) 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, 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 1,146 IRFs included in the analysis.

The next 12 rows of Table 14 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 all rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 952 IRFs located in urban areas included in our analysis. Among these, there are 749 IRF units of hospitals located in urban areas and 203 freestanding IRF hospitals located in urban areas. There are 194 IRFs located in rural areas included in our analysis. Among these, there are 174 IRF units of hospitals located in rural areas and 20 freestanding IRF hospitals located in rural areas. There are 376 for-profit IRFs. Among these, there are 314 IRFs in urban areas and 62 IRFs in rural areas. There are 710 non-profit IRFs. Among these, there are 589 urban IRFs and 121 rural IRFs. There are 60 government-owned IRFs. Among these, there are 49 urban IRFs and 11 rural IRFs.

The remaining three parts of Table 14 show IRFs grouped by their geographic location within a region and 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 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 impacts of each proposed change to the facility categories listed above are shown in the columns of Table 14. 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 in our FY 2010 analysis file.

Column (3) shows the number of cases in each category in our FY 2010 analysis file.

Column (4) shows the estimated effect of the proposed adjustment to the outlier threshold amount so that estimated outlier payments increase

from approximately 2.7 percent in FY 2011 to 3.0 percent of total estimated payments for FY 2012.

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

Column (6) shows the estimated effect of the update to the IRF labor-related share and wage index, in a budget neutral manner.

Column (7) shows the estimated effect of the update to the CMG relative weights and average length of stay values, in a budget neutral manner.

Column (8) shows the estimated effects of the updates to the facility-level adjustment factors (rural, LIP, and teaching status), in a budget neutral manner.

Column (9) compares our estimates of the payments per discharge, incorporating all of the proposed changes reflected in this proposed rule for FY 2012, to our estimates of payments per discharge in FY 2011 (without these proposed changes).

The average estimated increase for all IRFs is approximately 1.8 percent. This estimated increase includes the effects of the 1.5 percent market basket update, which is derived from a 2.8 percent rebased market basket update that is reduced by 0.1 percentage point for FY 2012 in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act and by a 1.2 percentage point productivity adjustment as required by section 1886 (j)(3)(C)(ii)(I) of the Act. It also includes the 0.3 percent overall estimated increase (the difference between 2.7 percent in FY 2011 and 3.0 percent in FY 2012) in estimated IRF outlier payments from the proposed update to the outlier threshold amount. Because we are making the remainder of the proposed 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.

TABLE 14: Proposed IRF Impact Table for FY 2012

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2012 Adjusted Market Basket Increase Factor[1]	FY2012 CBSA wage index and labor-share	CMG	Facility Adjustments	Total Percent Change
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Total	1,146	393,611	0.3%	1.5%	0.0%	0.0%	0.0%	1.8%
Urban unit	749	198,550	0.4	1.5	-0.2	0.0	-0.3	1.4
Rural unit	174	27,842	0.3	1.5	0.7	0.1	0.6	3.3
Urban hospital	203	160,607	0.1	1.5	0.0	0.0	0.3	1.8
Rural hospital	20	6,612	0.1	1.5	1.6	0.0	0.7	3.9
Urban For-Profit	314	149,735	0.1	1.5	0.1	-0.1	0.2	1.9
Rural For-Profit	62	12,663	0.2	1.5	1.1	0.1	0.4	3.3
Urban Non-Profit	589	196,463	0.3	1.5	-0.3	0.0	-0.2	1.4
Rural Non-Profit	121	19,985	0.3	1.5	0.7	0.1	0.8	3.5
Urban Government	49	12,959	0.5	1.5	0.2	0.0	-0.8	1.3
Rural Government	11	1,806	0.5	1.5	1.3	0.2	0.2	3.6
Urban	952	359,157	0.3	1.5	-0.1	0.0	-0.1	1.6
Rural	194	34,454	0.3	1.5	0.9	0.1	0.7	3.4
Urban by region								
Urban New England	32	16,350	0.2	1.5	-1.1	0.0	-0.1	0.5
Urban Middle Atlantic	142	66,074	0.2	1.5	-0.7	0.0	-0.4	0.6
Urban South Atlantic	130	62,319	0.2	1.5	0.0	0.0	-0.1	1.7
Urban East North Central	188	56,771	0.3	1.5	0.0	0.0	0.2	2.1
Urban East South Central	49	26,281	0.1	1.5	0.4	-0.1	0.6	2.5
Urban West North Central	73	18,001	0.4	1.5	0.0	0.0	-0.1	1.8
Urban West South Central	168	65,894	0.2	1.5	0.5	0.0	0.6	2.8
Urban Mountain	70	23,787	0.3	1.5	0.2	-0.1	0.2	2.0
Urban Pacific	100	23,680	0.4	1.5	-0.2	0.0	-1.7	0.0
Rural by region								
Rural New England	6	1,350	0.6	1.6	0.8	0.1	1.1	4.1
Rural Middle Atlantic	16	3,207	0.1	1.5	1.8	0.1	1.9	5.4
Rural South Atlantic	24	5,958	0.2	1.5	0.8	0.1	0.9	3.4
Rural East North Central	33	5,749	0.3	1.5	0.1	0.1	1.4	3.4
Rural East South Central	23	3,983	0.2	1.5	1.3	0.0	-0.4	2.6
Rural West North Central	31	3,926	0.5	1.5	-0.2	0.1	1.1	3.0
Rural West South Central	50	9,228	0.3	1.5	1.6	0.1	-0.2	3.3
Rural Mountain	7	666	0.4	1.5	0.3	0.1	1.2	3.5
Rural Pacific	4	387	1.1	1.5	-0.3	0.0	0.6	2.9
Teaching status								
Non-teaching	1,029	341,958	0.2	1.5	0.1	0.0	0.5	2.3
Resident to ADC less than 10%	70	36,669	0.3	1.5	-0.4	0.0	-1.9	-0.5
Resident to ADC 10%-19%	32	12,272	0.4	1.5	-0.3	0.0	-3.4	-1.9
Resident to ADC greater than 19%	15	2,712	0.5	1.5	-0.6	0.0	-5.3	-3.9

[1]This column reflects the impact of the rebased RPL market basket increase factor for FY 2012 of 1.5 percent, including a 0.1 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act and a 1.2 percent productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

iii. Impact of the Proposed Update to the Outlier Threshold Amount

In the FY 2011 IRF PPS notice (75 FR 42836), we used FY 2009 patient-level claims data (the best, most complete data available at that time) to set the outlier threshold amount for FY 2011 so that estimated outlier payments would equal 3 percent of total estimated payments for FY 2011. For this proposed rule, we are proposing to update our analysis using more current FY 2010 data. Using the updated FY 2010 data, we now estimate that IRF outlier payments, as a percentage of total estimated payments for FY 2011, decreased from 3 percent using the FY 2009 data to approximately 2.7 percent using the updated FY 2010 data. As a result, we are proposing to adjust the outlier threshold amount for FY 2012 to $11,822, reflecting total estimated outlier payments equal to 3 percent of total estimated payments in FY 2012.

The impact of the proposed update to the outlier threshold amount (as shown in column 4 of Table 14) is to increase estimated overall payments to IRFs by 0.3 percent. We do not estimate that any group of IRFs would experience a decrease in payments from this proposed update. We estimate the largest increase in payments to be a 1.1 percent increase in estimated payments to rural IRFs in the Pacific region.

iv. Impact of the Proposed Market Basket Update to the IRF PPS Payment Rates

The proposed adjusted market basket update to the IRF PPS payment rates is presented in column 5 of Table 14. The proposed FY 2008-based RPL market basket update is the same as the FY 2002-based RPL market basket (2.8 percent). In the aggregate the proposed update would result in a net 1.5 percent increase in overall estimated payments to IRFs. This net increase reflects the estimated rebased RPL market basket increase factor for FY 2012 of 2.8 percent, reduced by 0.1 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act and a 1.2 percent productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

v. Impact of the Proposed CBSA Wage Index and Labor-Related Share

In column 6 of Table 14, we present the effects of the proposed budget neutral update of the wage index and labor-related share. The changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related share portion of payments, so the changes in the two have a combined effect on payments to providers. As discussed in section V.A.4 of this proposed rule, the labor-related share decreased from 75.271 percent in FY 2011 to 70.334 percent in FY 2012.

In the aggregate, since these updates to the wage index and the labor-related share are applied in a budget-neutral manner as required under section 1886(j)(6) of the Act, we do not estimate that these updates will affect overall estimated payments to IRFs. However, we estimate that these proposed changes would have small distributional effects. For example, we estimate a 0.9 percent increase in payments to rural IRFs, with the largest increase in payments of 1.8 percent for rural IRFs in the Mid-Atlantic region. We estimate the largest decrease in payments from the proposed update to the CBSA wage index and labor-related share to be a 1.1 percent decrease for urban IRFs in the New England region.

vi. Impact of the Proposed Update to the CMG Relative Weights and Average Length of Stay Values

In column 7 of Table 14, we present the effects of the proposed budget neutral update of the CMG relative weights and average length of stay values. In the aggregate we do not estimate that these proposed updates will affect overall estimated payments to IRFs. However, we estimate that these proposed updates will have small distributional effects, with the largest increase in payments as a result of these updates being a 0.2 percent increase to rural government IRFs. The largest estimated decrease in payments as a result of these proposed updates is a 0.1 percent decrease to urban for-profit IRFs and urban IRFs in the Mountain region and East South Central region.

vii. Impact of the Proposed Update to the Rural, LIP, and Teaching Status Adjustment Factors

In column 8 of Table 14, we present the effects of the proposed budget neutral update to the rural, LIP, and teaching status adjustment factors. In the aggregate, we do not estimate that these proposed changes would affect overall estimated payments to IRFs. However, we estimate that these proposed changes would have small distributional effects. We estimate the largest increase in payments to be a 1.9 percent increase for IRFs in the rural Mid-Atlantic region. We estimate the largest decrease in payments to be a 5.3 percent decrease for teaching IRFs with resident to ADC ratios of greater than 19 percent.

viii. Impact of the IPPS Data Matching Process Changes on the IRF PPS Calculation of the Low-Income Percentage Adjustment Factor

In section VII of this proposed rule, we note the recent revision of the data matching process that is used to calculate the disproportionate share hospital (DSH) patient percentage used in the acute IPPS DSH adjustment. As we have stated previously, it is our policy in calculating the LIP adjustment factor to use the same disproportionate share hospital (DSH) patient percentage used in the acute IPPS DSH adjustment. This would include the data matching process. We are not able to provide a detailed analysis of the impact of the revised data matching process. That is, it is not possible to determine whether IRF LIP adjustment payments will generally increase or decrease, because IRFs' SSI fractions will vary depending on various factors, including the use of a more updated MedPAR claims data file, use of a more updated SSI eligibility data file, and the other features of the revised data matching process. See the FY 2011 IPPS final rule (75 FR 50663 through 50664) for more information on the revised data matching process.

ix. Impact of the Proposed IRF Quality Reporting Program Beginning in FY 2013

As discussed in section IX.B. of this proposed rule, we propose to begin collecting data on 2 quality measures from October 1, 2012 through December 31, 2012 (FY 2013). These quality measures are: (1) Catheter Associated Urinary Tract Infections; and (2) Pressure Ulcers that are New or Have Worsened. As discussed in section X. of this proposed rule, we estimate that IRFs would incur costs associated with the collection of these data, which we detail below.

Catheter Associated Urinary Tract Infections

As stated in section IX.C.1. of this proposed rule, we propose to collect data on the first quality measure, Catheter Associated Urinary Tract Infections, through the Centers for Disease Control (CDC)/National Health Safety Network (NHSN). CMS does not currently require IRFs to report data to NHSN. However, some IRFs submit data to NHSN either voluntarily or per state mandate. According to the CDC, 26 IRFs already report data to NHSN. We estimate that 1,120 IRFs (1146 minus the 26 IRFs that are already reporting data to NHSN) would incur costs for registering and completing the

necessary training provided by the CDC in FY 2012 in preparation for submitting the data beginning on October 1, 2012 (FY 2013). We estimate that registering and completing the necessary training of the required personnel at each IRF would take 4 hours at a cost of $41.59 per hour, at an estimated cost per IRF of $166.36 per IRF and a total estimated cost across all IRFs of $186,323.

Once IRFs begin submitting data to the NHSN on Catheter Associated Urinary Tract Infections by October 1, 2012 (FY 2013), they will need to submit two types of forms in order for CDC to calculate the CAUTI rate per 1000 urinary catheter days. We estimate that the first form, the Urinary Tract Infection (UTI) form, will take 15 minutes per reporting episode per IRF and that there will be approximately 2.25 NHSN submissions per IRF per month. Based on this estimate, we expect for each IRF to expend 33.75 minutes (0.5625) hours per month and 405 minutes (6.75) hours per year reporting to NHSN. The estimated annual burden to all IRFs in the U.S. for reporting to NHSN is 7,735.5 hours. The estimated yearly cost per IRF is $186.14 and the estimated total yearly cost across all IRFs is $213,322. While CDC estimates that the second form, the denominator form used to count daily the number of patients with an indwelling catheter device, will take 5 hours per month to complete, we estimate that it will take 2.5 hours per form per IRF per month as the number of patients with an indwelling catheter is the only part of this form that IRFs will be required to complete. We anticipate that there will be one form submitted per IRF per month and each IRF will expend 150 minutes (2.5 hours) per month and 1,800 minutes (30 hours) per year reporting to NHSN. The estimated annual burden to all IRFs in the U.S. for reporting to NHSN is 34,380 hours. The estimated cost per IRF is $1,247.70 per year and the estimated total yearly cost across all IRFs is $1,429,864. These costs are estimated using an hourly wage for a Registered Nurse of $41.59 and a Medical Billing Clerk/Data Entry person of $20.57.

Pressure Ulcers That Are New or Have Worsened

As stated in Section IX.C.2 of this proposed rule, we propose to modify the current IRF–PAI by removing the items currently in the "Quality Indicators" section and replacing them with pressure ulcer items similar to elements from the Minimum Data Set 3.0 (MDS 3.0) nursing home instrument. Since all IRFs are already required to complete and transmit IRF–PAIs on all Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) patients in order to receive payment from Medicare, and since the number of IRFs submitting claims to Medicare has remained stable over the past several years, we do not estimate that there are any IRFs that would need to conduct additional training or set-up for completing and transmitting the IRF–PAI. Thus, we do not estimate any additional cost to IRFs in FY 2012 for these activities. In addition, since IRFs are already transmitting the IRF–PAI form to CMS, we do not estimate any additional transmission costs associated with the proposed IRF quality reporting program. Further, we do not estimate any additional burden for IRFs to complete an IRF–PAI with mandatory quality measures as the IRF–PAI currently contains a voluntary "Quality Indicators" section, which will be replaced with the proposed pressure ulcer question set. When the original burden estimates were completed for the IRF–PAI, we estimated that the "Quality Indicators" section of the IRF–PAI would take about 10 minutes to complete, and we assumed that all IRFs would complete the Quality Indicators items, even though completion of this section was voluntary. Thus, removing the Quality Indicators items from the IRF–PAI would decrease the total estimated burden of completing each IRF–PAI by about 10 minutes. However, we estimate that it will take about 10 minutes to complete the new pressure ulcer item that we are proposing to require IRFs to complete as part of the new IRF quality reporting program. Since the time to complete the items that we are proposing to remove from the IRF–PAI is the same as the time to complete the new items we are proposing to add, we estimate no net change in the amount of time or the costs associated with completing each IRF–PAI.

5. Alternatives Considered

Although we have determined that this proposed rule will not have a significant economic impact on a substantial number of small entities, we have voluntarily prepared a discussion on the alternatives considered to the IRF PPS.

Section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by 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. Thus, we did not consider alternatives to updating payments using the estimated RPL market basket increase factor for FY 2012. In this proposed rule, we are proposing to rebase the RPL market basket for FY 2012, as we typically do every 5 to 7 years, from a 2002 base year to a 2008 base year. We considered not proposing this rebasing of the RPL market basket for FY 2012; however, periodically rebasing the RPL market basket ensures that it continues to reflect the most accurate account of the cost of relevant goods and services. For FY 2012, the proposed update on the FY 2008-based RPL market basket is the same as the FY 2002-based RPL market basket (2.8 percent). In accordance with the recently amended section 1886(j)(3)(C) of the Act, we are proposing to update IRF Federal prospective payments in this proposed rule by 1.5 percent (which equals the 2.8 percent estimated rebased RPL market basket increase factor for FY 2012 reduced by 0.1 percentage point, as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act and reduced by a 1.2 percent productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act).

We considered maintaining the existing CMG relative weights and average length of stay values for FY 2012. However, in light of recently available data and our desire to ensure that the CMG relative weights and average length of stay values are as reflective as possible of recent changes in IRF utilization and case mix, we believe that it is appropriate to update the CMG relative weights and average length of stay values at this time to ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs.

We also considered maintaining the existing rural, LIP, and teaching status adjustment factors for FY 2012. However, as a result of recent changes in IRF utilization that have occurred because of changes in the IRF compliance percentage and the consequences of recent IRF medical necessity reviews, we believe that it is important to update these adjustment factors at this time to ensure that payments to IRFs reflect as accurately as possible the current costs of care in IRFs. In estimating the proposed updates to the rural, LIP, and teaching status adjustment factors, we implemented a 3-year moving average approach to updating the facility-level adjustment factors in the FY 2010 IRF PPS final rule (74 FR 39762) to provide greater stability and predictability of Medicare payments for IRFs.

We considered maintaining the existing outlier threshold amount for FY 2012. However, the proposed update to the outlier threshold amount would have a positive impact on IRF providers

and, therefore, on small entities (as shown in Table 14, column 4). If we were to maintain the FY 2011 outlier threshold amount, less outlier cases would qualify for the additional outlier payments in FY 2012. Analysis of updated FY 2010 data indicates that estimated outlier payments would not equal 3 percent of estimated total payments for FY 2012 unless we proposed to update the outlier threshold amount. Thus, we believe that this update is appropriate for FY 2012.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 15 below, we have prepared an accounting statement showing the classification of the transfers 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 1,146 IRFs in our database.

TABLE 15.--Accounting Statement: Classification of Estimated Transfers, from the 2011 IRF PPS Fiscal Year to the 2012 IRF PPS Fiscal Year

Category	Transfers
Annualized Monetized Transfers	$120 million
From Whom to Whom?	Federal Government to IRF Medicare Providers

7. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2012 are projected to increase by 1.8 percent, compared with those in FY 2011, as reflected in column 9 of Table 14. IRF payments are estimated to increase 1.6 percent in urban areas and 3.4 percent in rural areas, per discharge, compared with FY 2011. Payments to rehabilitation units in urban areas are estimated to increase 1.4 percent per discharge. Payments to rehabilitation freestanding hospitals in urban areas are estimated to increase 1.8 percent per discharge. Payments to rehabilitation units in rural areas are estimated to increase 3.3 percent per discharge, while payments to freestanding rehabilitation hospitals in rural areas are estimated to increase 3.9 percent per discharge.

Overall, the largest payment increase is estimated at 5.4 percent for rural IRFs in the Mid-Atlantic region. The only payment decreases we estimate are a 0.5 percent decrease, a 1.9 percent decrease, and a 3.9 percent decrease for teaching IRFs with resident to ADC ratios less than 10 percent, 10 to 19 percent, and greater than 19 percent, respectively.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IRFs and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $34.5 million in any one year. (For details, see the Small Business Administration's Web site at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2465b064ba6965cc1fbd2eae60854b11&rgn=div8&view=text&node=13:1.0.1.1.16.1.266.9&idno=13*) (refer to subsector 622). Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs or the proportion of IRFs' revenue that is derived from Medicare payments. Therefore, we assume that all IRFs (an estimated 1,146 IRFs that are in our analysis file by virtue of having submitted at least one IRF claim to Medicare in FY 2010 that we are able to match to an IRF–PAI, of which approximately 60 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. The Department of Health and Human Services generally uses a revenue or cost impact of 3 to 5 percent as a significance threshold under the RFA. There is no negative estimated impact as a result of this proposed rule that is within the significance threshold of 3 to 5 percent. As shown in Table 14, we estimate that the net revenue impact, of this proposed rule, on all IRFs is to increase estimated payments by about 1.8 percent, with an estimated increase in payments of 3 percent or higher for some categories of IRFs (such as rural IRFs in the New England, Mid-Atlantic, South Atlantic, East North Central, West North Central, West South Central, and Mountain) and an estimated decrease in payments of 3 percent or more for 15 teaching IRFs with resident to ADC ratios greater than 19 percent. Therefore, the majority of IRFs will experience a net positive increase in payments. As a result, the Secretary has determined that this proposed rule would not have a significant impact on a substantial number of small entities. We present, in the Alternatives Considered section (XII.A.5) above, an analysis of the alternatives we considered for this proposed IRF PPS rule. 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. We solicit comment on the RFA analysis.

In addition, section 1102(b) of the Act requires us to prepare a RIA 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 MSA and has fewer than 100 beds. Based on the data of the 174 rural units and 20 rural hospitals in our database of 1,146 IRFs, we estimate that small rural IRF hospitals would receive between 2.6 percent and 5.4 percent higher net payments in FY 2012 due to the provisions in this proposed rule, with no rural IRF hospitals estimated to receive negative net payments. Thus, the Secretary has determined that the rates and policies set forth in this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation. In 2011, that threshold level is approximately $136 million. This proposed rule will not impose spending costs on State, local, or tribal governments, in the aggregate, or by the private sector, of $136 million.

XIII. Federalism Analysis

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. This proposed rule would have no substantial direct effect on State and local governments, preempt State law, or otherwise have Federalism implications.

List of Subjects in 42 CFR 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: Sections 1102, 1862, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395y, and 1395hh).

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

2. Section 412.23 is amended by revising paragraph (b) to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(b) *Rehabilitation hospitals.* A rehabilitation hospital or unit must meet the requirements specified in § 412.29 of this subpart to be excluded from the prospective payment systems specified in § 412.1(a)(1) of this subpart and to be paid under the prospective payment system specified in § 412.1(a)(3) of this subpart and in subpart P of this part.

* * * * *

3. Section 412.25 is amended by revising paragraphs (b) and (e)(2)(ii)(A) to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(b) *Changes in the size of excluded units.* Except in the special cases noted at the end of this paragraph, changes in the number of beds or square footage considered to be part of an excluded unit under this section are allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and the CMS RO in writing of the planned change at least 30 days before the date of the change. The hospital must maintain the information needed to accurately determine costs that are attributable to the excluded unit. A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the rest of that cost reporting period. Changes in bed size or square footage may be made at any time if these changes are made necessary by relocation of a unit to permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

* * * * *

(e) * * *

(2) * * *

(ii) * * *

(A) For a rehabilitation unit, the requirements under § 412.29 of this subpart; or

* * * * *

4. Section 412.29 is revised to read as follows:

§ 412.29 Classification criteria for payment Under the Inpatient Rehabilitation Facility Prospective Payment System.

To be excluded from the prospective payment systems described in § 412.1(a)(1) of this subpart and to be paid under the prospective payment system specified in § 412.1(a)(3) of this subpart, an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:

(a) Have (or be part of a hospital that has) a provider agreement under part 489 of this chapter to participate as a hospital.

(b) Except in the case of a "new" IRF or "new" IRF beds, as defined in paragraph (c) of this section, an IRF must show that, during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor), it served an inpatient population that meets the following criteria:

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

(i) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2) of this section;

(ii) The patient has a comorbidity that falls in one of the conditions specified in paragraph (b)(2) of this section; and

(iii) The comorbidity has caused significant decline in functional ability in the individual that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and that cannot be appropriately performed in another care setting covered under this title.

(2) List of conditions.

(i) Stroke.

(ii) Spinal cord injury.

(iii) Congenital deformity.

(iv) Amputation.

(v) Major multiple trauma.

(vi) Fracture of femur (hip fracture).

(vii) Brain injury.

(viii) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(ix) Burns.

(x) Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to

improve with more intensive rehabilitation.

(xi) Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(xii) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

(xiii) Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:

(A) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

(B) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

(C) The patient is age 85 or older at the time of admission to the IRF.

(c) In the case of new IRFs (as defined in paragraph (c)(1) of this section) or new IRF beds (as defined in paragraph (c)(2)of this section), the IRF must provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b) of this section. This written certification will apply until the end of the IRF's first full 12-month cost reporting period or, in the case of new IRF beds, until the end of the cost reporting period during which the new beds are added to the IRF.

(1) *New IRFs.* An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS in subpart P of this part for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.

(2) *New IRF beds.* Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any point during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified. New IRF beds are included in the compliance review calculations under paragraph (b) of this section from the time that they are added to the IRF.

(3) *Change of Ownership or Leasing.* An IRF hospital or IRF unit that undergoes a change of ownership or leasing, as defined in § 489.18 of this chapter, retains its excluded status and will continue to be paid under the prospective payment system specified in § 412.1(a)(3) of this subpart before and after the change of ownership or leasing if the new owner(s) of the IRF accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the IRF prospective payment system. If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to participate in the Medicare program. If the IRF does not continue to meet all of the requirements for payment under the IRF prospective payment system, then the IRF loses its excluded status and is paid according to the prospective payment systems described in § 412.1(a)(1).

(4) *Mergers.* If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the prospective payment system specified in § 412.1(a)(3) of this subpart before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF prospective payment system. If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may reapply to the Medicare program to operate a new IRF.

(d) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program. Each prospective patient's preadmission screening must be reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.

(e) Ensure that the patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

(f) Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

(g) Have a director of rehabilitation who—

(1) Provides services to the IRF hospital and its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;

(2) Is a doctor of medicine or osteopathy;

(3) Is licensed under State law to practice medicine or surgery; and

(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services.

(h) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.

(i) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans, and that team conferences are held at least once per week to determine the appropriateness of treatment.

(j) *Retroactive adjustments.* If a new IRF (or new beds that are added to an existing IRF) are excluded from the prospective payment systems specified in § 412.1(a)(1) of this subpart and paid under the prospective payment system specified in § 412.1(a)(3) of this subpart for a cost reporting period under paragraph (c) of this section, but the inpatient population actually treated during that period does not meet the requirements of paragraph (b) of this section, we adjust payments to the IRF retroactively in accordance with the provisions in § 412.130 of this subpart.

§ 412.30 [Removed and Reserved]

5. Section 412.30 is removed and reserved.

Subpart P—Prospective payment for inpatient rehabilitation hospitals and rehabilitation units

6. Section 412.624 is amended by:

A. Re-designating paragraph (c)(4) as (c)(5).

B. Adding a new paragraph (c)(4).

The addition reads as follows:

§ 412.624 Methodology for calculating the Federal prospective payment rates.

* * * * *

(c) * * *

(4) Applicable increase factor for fiscal year 2014 and for subsequent fiscal years. Subject to the provisions of paragraphs (c)(4)(i) and (c)(4)(ii) of this section, the applicable increase factor for fiscal year 2014 and for subsequent years for updating the standard payment conversion factor is the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(i) In the case of an IRF that is paid under the prospective payment system specified in § 412.1(a)(3) of this part that does not submit quality data to CMS, in the form and manner specified by CMS, the applicable increase factor specified in paragraph (a)(3) of this section is reduced by 2 percentage points.

(ii) Any reduction of the increase factor will apply only to the fiscal year involved and will not be taken into account in computing the applicable increase factor for a subsequent fiscal year.

* * * * *

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

Dated: March 18, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: April 18, 2011.

Kathleen Sebelius,

Secretary.

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

Addendum

In this addendum, we provide the wage index tables referred to throughout the preamble to this proposed rule. The tables presented below are as follows:

Table A.—Proposed Inpatient Rehabilitation Facility Wage Index for Urban Areas for Discharges Occurring from October 1, 2011 through September 30, 2012.

Table B—Proposed Inpatient Rehabilitation Facility Wage Index for Rural Areas for Discharges Occurring from October 1, 2011 through September 30, 2012.

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TABLE A: PROPOSED INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2012

	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8003
10380	Aguadilla-Isabela-San Sebastián, PR 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	0.3471
10420	Akron, OH Portage County, OH Summit County, OH	0.8843
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9036
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8653
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9456
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.7995
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9194
11020	Altoona, PA Blair County, PA	0.8620
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8644
11180	Ames, IA Story County, IA	0.9970
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.1964
11300	Anderson, IN Madison County, IN	0.9192
11340	Anderson, SC Anderson County, SC	0.8691
11460	Ann Arbor, MI Washtenaw County, MI	1.0124
11500	Anniston-Oxford, AL Calhoun County, AL	0.7918
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9361
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9001
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9659

	Urban Area (Constituent Counties)	Wage Index
12060	Atlanta-Sandy Springs-Marietta, GA 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 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	0.9549
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1129
12220	Auburn-Opelika, AL Lee County, AL	0.7190
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9538
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9514
12540	Bakersfield, CA Kern County, CA	1.1707
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0255
12620	Bangor, ME Penobscot County, ME	0.9777
12700	Barnstable Town, MA Barnstable County, MA	1.2823
12940	Baton Rouge, LA 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	0.8583
12980	Battle Creek, MI Calhoun County, MI	0.9656
13020	Bay City, MI Bay County, MI	0.9221
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8488
13380	Bellingham, WA Whatcom County, WA	1.1390
13460	Bend, OR Deschutes County, OR	1.1372

	Urban Area (Constituent Counties)	Wage Index
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0525
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8674
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8719
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.8611
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7348
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8314
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8989
14060	Bloomington-Normal, IL McLean County, IL	0.9439
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9273
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2178
14500	Boulder, CO Boulder County, CO	1.0065
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8666
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0667
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2547
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9173
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9209
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9530
15500	Burlington, NC Alamance County, NC	0.8863
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9947
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1250
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0386
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8749
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9195
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.8983
16180	Carson City, NV Carson City, NV	1.0465
16220	Casper, WY Natrona County, WY	0.9655

	Urban Area (Constituent Counties)	Wage Index
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8844
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0235
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.7895
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9354
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9420
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9342
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8829
16940	Cheyenne, WY Laramie County, WY	0.9392
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0593
17020	Chico, CA Butte County, CA	1.1533
17140	Cincinnati-Middletown, OH-KY-IN 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 Hamilton County, OH Warren County, OH	0.9699
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.7888
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.7731
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9050
17660	Coeur d'Alene, ID Kootenai County, ID	0.9364

	Urban Area (Constituent Counties)	Wage Index
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9588
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9481
17860	Columbia, MO Boone County, MO Howard County, MO	0.8282
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8733
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9027
18020	Columbus, IN Bartholomew County, IN	0.9434
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	1.0141
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8585
18700	Corvallis, OR Benton County, OR	1.0455
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa County, FL	0.8842

	Urban Area (Constituent Counties)	Wage Index
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8186
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	0.9860
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8622
19180	Danville, IL Vermilion County, IL	0.9693
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8168
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8400
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9140
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7621
19500	Decatur, IL Macon County, IL	0.7916
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8736

	Urban Area (Constituent Counties)	Wage Index
19740	Denver-Aurora-Broomfield, CO 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	1.0718
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9621
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9699
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7435
20100	Dover, DE Kent County, DE	0.9921
20220	Dubuque, IA Dubuque County, IA	0.8774
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0565
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9664
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9639
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1006
20940	El Centro, CA Imperial County, CA	0.9258
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8449
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9465
21300	Elmira, NY Chemung County, NY	0.8445
21340	El Paso, TX El Paso County, TX	0.8475
21500	Erie, PA Erie County, PA	0.8360
21660	Eugene-Springfield, OR Lane County, OR	1.1384
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8433
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1080
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3883
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8064
22140	Farmington, NM San Juan County, NM	0.9339
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9323

	Urban Area (Constituent Counties)	Wage Index
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8616
22380	Flagstaff, AZ Coconino County, AZ	1.2443
22420	Flint, MI Genesee County, MI	1.1496
22500	Florence, SC Darlington County, SC Florence County, SC	0.8252
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8144
22540	Fond du Lac, WI Fond du Lac County, WI	0.9223
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9892
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0160
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7599
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9362
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9474
23420	Fresno, CA Fresno County, CA	1.1422
23460	Gadsden, AL Etowah County, AL	0.7180
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9160
23580	Gainesville, GA Hall County, GA	0.9223
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9084
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8507
24140	Goldsboro, NC Wayne County, NC	0.9067
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7717
24300	Grand Junction, CO Mesa County, CO	0.9850
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9169
24500	Great Falls, MT Cascade County, MT	0.8289
24540	Greeley, CO Weld County, CO	0.9496
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9586
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.8882
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9370

	Urban Area (Constituent Counties)	Wage Index
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9644
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3686
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8877
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9254
25260	Hanford-Corcoran, CA Kings County, CA	1.1205
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9296
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9158
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.0927
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7714
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8693
25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.8958
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8632
26180	Honolulu, HI Honolulu County, HI	1.1807
26300	Hot Springs, AR Garland County, AR	0.9151
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7852
26420	Houston-Sugar Land-Baytown, TX 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	0.9824
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.8953
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9191
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9663
26900	Indianapolis-Carmel, IN 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	0.9672
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9657

	Urban Area (Constituent Counties)	Wage Index
27060	Ithaca, NY Tompkins County, NY	0.9842
27100	Jackson, MI Jackson County, MI	0.9155
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8042
27180	Jackson, TN Chester County, TN Madison County, TN	0.8404
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.8884
27340	Jacksonville, NC Onslow County, NC	0.7807
27500	Janesville, WI Rock County, WI	0.9415
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8434
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.8105
27780	Johnstown, PA Cambria County, PA	0.8090
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7757
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8214
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0292
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0619
28140	Kansas City, MO-KS 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	0.9652
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9976
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8798
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7588
28740	Kingston, NY Ulster County, NY	0.9075
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7842
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9130
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9803

	Urban Area (Constituent Counties)	Wage Index
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9289
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8489
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8196
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0781
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0235
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8447
29540	Lancaster, PA Lancaster County, PA	0.9344
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0298
29700	Laredo, TX Webb County, TX	0.7914
29740	Las Cruces, NM Dona Ana County, NM	0.9296
29820	Las Vegas-Paradise, NV Clark County, NV	1.2099
29940	Lawrence, KS Douglas County, KS	0.8533
30020	Lawton, OK Comanche County, OK	0.8285
30140	Lebanon, PA Lebanon County, PA	0.7807
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9358
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.8903

	Urban Area (Constituent Counties)	Wage Index
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.8817
30620	Lima, OH Allen County, OH	0.9271
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9617
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8546
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8794
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8563
31020	Longview, WA Cowlitz County, WA	1.0296
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2130
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.8896

	Urban Area (Constituent Counties)	Wage Index
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8847
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8694
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9202
31460	Madera-Chowchilla, CA Madera County, CA	0.7986
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1294
31700	Manchester-Nashua, NH Hillsborough County, NH	0.9869
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.7847
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9083
31900	Mansfield, OH Richland County, OH	0.8918
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3640
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.8837
32780	Medford, OR Jackson County, OR	1.0061

	Urban Area (Constituent Counties)	Wage Index
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9268
32900	Merced, CA Merced County, CA	1.2359
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0128
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9470
33260	Midland, TX Midland County, TX	0.9711
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0183
33460	Minneapolis-St. Paul-Bloomington, MN-WI 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	1.1143
33540	Missoula, MT Missoula County, MT	0.8921
33660	Mobile, AL Mobile County, AL	0.7960
33700	Modesto, CA Stanislaus County, CA	1.2104

	Urban Area (Constituent Counties)	Wage Index
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7993
33780	Monroe, MI Monroe County, MI	0.8684
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8442
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8137
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7041
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0363
34620	Muncie, IN Delaware County, IN	0.8206
34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.9809
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8738
34900	Napa, CA Napa County, CA	1.4604
34940	Naples-Marco Island, FL Collier County, FL	0.9698
34980	Nashville-Davidson—Murfreesboro-Franklin, TN 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	0.9457
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2315
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1460
35300	New Haven-Milford, CT New Haven County, CT	1.1515
35380	New Orleans-Metairie-Kenner, LA 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	0.9070

	Urban Area (Constituent Counties)	Wage Index
35644	New York-White Plains-Wayne, NY-NJ 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	1.2955
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8872
35840	North Port-Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	0.9481
35980	Norwich-New London, CT New London County, CT	1.1215
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6354
36100	Ocala, FL Marion County, FL	0.8468
36140	Ocean City, NJ Cape May County, NJ	1.0879
36220	Odessa, TX Ector County, TX	0.9436
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9267
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.8877
36500	Olympia, WA Thurston County, WA	1.1269

	Urban Area (Constituent Counties)	Wage Index
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	0.9583
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9163
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9566
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8370
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2377
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9211
37380	Palm Coast, FL Flagler County, FL	0.8405
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.7954
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7455
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8299
37764	Peabody, MA Essex County, MA	1.0979
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8254

	Urban Area (Constituent Counties)	Wage Index
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9149
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0803
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0642
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8012
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8605
38340	Pittsfield, MA Berkshire County, MA	1.0371
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9507
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4326
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9899
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1476
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.0723
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1354
39140	Prescott, AZ Yavapai County, AZ	1.2234
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.0714
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9321
39380	Pueblo, CO Pueblo County, CO	0.8721
39460	Punta Gorda, FL Charlotte County, FL	0.8759
39540	Racine, WI Racine County, WI	1.0580
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9811
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0442
39740	Reading, PA Berks County, PA	0.8904
39820	Redding, CA Shasta County, CA	1.4134

	Urban Area (Constituent Counties)	Wage Index
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0419
40060	Richmond, VA 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 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	0.9661
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1570
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8827
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.0942
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8595

	Urban Area (Constituent Counties)	Wage Index
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0033
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0026
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9034
40660	Rome, GA Floyd County, GA	0.8635
40900	Sacramento-Arden-Arcade-Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4053
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8728
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1042
41100	St. George, UT Washington County, UT	0.9133
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0302

	Urban Area (Constituent Counties)	Wage Index
41180	St. Louis, MO-IL 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 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	0.9090
41420	Salem, OR Marion County, OR Polk County, OR	1.1133
41500	Salinas, CA Monterey County, CA	1.5686
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9005
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9266
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8303
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.8998
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1979
41780	Sandusky, OH Erie County, OH	0.8686
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5733
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4560
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6703
41980	San Juan-Caguas-Guaynabo, PR 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 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	

	Urban Area (Constituent Counties)	Wage Index
	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	0.4296
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.2915
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2162
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.1909
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6740
42140	Santa Fe, NM Santa Fe County, NM	1.0847
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6143
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.8907
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8238
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1556
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9097
43100	Sheboygan, WI Sheboygan County, WI	0.9233
43300	Sherman-Denison, TX Grayson County, TX	0.8279

	Urban Area (Constituent Counties)	Wage Index
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8536
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9091
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9299
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9948
43900	Spartanburg, SC Spartanburg County, SC	0.9383
44060	Spokane, WA Spokane County, WA	1.0571
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9130
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0251
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8371
44220	Springfield, OH Clark County, OH	0.9234
44300	State College, PA Centre County, PA	0.8779
44600	Steubenville-Weirton, OH-WV Jefferson County, OH Brooke County, WV Hancock County, WV	0.7315

	Urban Area (Constituent Counties)	Wage Index
44700	Stockton, CA San Joaquin County, CA	1.2644
44940	Sumter, SC Sumter County, SC	0.7860
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9905
45104	Tacoma, WA Pierce County, WA	1.1343
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8806
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9054
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9205
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.7748
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9432
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8952
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0150
46060	Tucson, AZ Pima County, AZ	0.9480
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8793
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8843
46340	Tyler, TX Smith County, TX	0.8065
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8471
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.7941
46700	Vallejo-Fairfield, CA Solano County, CA	1.4931
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8219
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0534

	Urban Area (Constituent Counties)	Wage Index
47260	Virginia Beach-Norfolk-Newport News, VA-NC 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	0.8961
47300	Visalia-Porterville, CA Tulare County, CA	1.0738
47380	Waco, TX McLennan County, TX	0.8403
47580	Warner Robins, GA Houston County, GA	0.8028
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9648

	Urban Area (Constituent Counties)	Wage Index
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV 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 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	1.0723
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8462
48140	Wausau, WI Marathon County, WI	0.9563
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	0.9615
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9934
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6675
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8898
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9566

	Urban Area (Constituent Counties)	Wage Index
48700	Williamsport, PA Lycoming County, PA	0.7256
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0580
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9202
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0002
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8939
49340	Worcester, MA Worcester County, MA	1.1012
49420	Yakima, WA Yakima County, WA	1.0067
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3536
49620	York-Hanover, PA York County, PA	0.9983
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8625
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1043
49740	Yuma, AZ Yuma County, AZ	0.9283

[1] At this time, there are no hospitals located in this urban area on which to base a wage index.

TABLE B: PROPOSED INPATIENT REHABILITATION FACILITY WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2012

State Code	Nonurban Area	Wage Index
1	Alabama	0.7380
2	Alaska	1.2626
3	Arizona	0.9095
4	Arkansas	0.7222
5	California	1.2056
6	Colorado	0.9933
7	Connecticut	1.1128
8	Delaware	0.9757
10	Florida	0.8409
11	Georgia	0.7566
12	Hawaii	1.1189
13	Idaho	0.7556
14	Illinois	0.8343
15	Indiana	0.8391
16	Iowa	0.8545
17	Kansas	0.7981
18	Kentucky	0.7830
19	Louisiana	0.7712
20	Maine	0.8588
21	Maryland	0.9175
22	Massachusetts[1]	1.1769
23	Michigan	0.8555
24	Minnesota	0.9038
25	Mississippi	0.7620
26	Missouri	0.7655
27	Montana	0.8517
28	Nebraska	0.8911
29	Nevada	0.9350
30	New Hampshire	1.0207
31	New Jersey[1]	-----
32	New Mexico	0.8911
33	New York	0.8185
34	North Carolina	0.8359

State Code	Nonurban Area	Wage Index
35	North Dakota	0.6831
36	Ohio	0.8561
37	Oklahoma	0.7860
38	Oregon	1.0029
39	Pennsylvania	0.8480
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	-----
42	South Carolina	0.8413
43	South Dakota	0.8536
44	Tennessee	0.7886
45	Texas	0.7806
46	Utah	0.8649
47	Vermont	0.9591
48	Virgin Islands	0.7993
49	Virginia	0.7841
50	Washington	1.0184
51	West Virginia	0.7474
52	Wisconsin	0.9186
53	Wyoming	0.9528
65	Guam	0.9611

[1] All counties within the State are classified as urban, with the exception of Massachusetts and Puerto Rico. Massachusetts and Puerto Rico have areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for FY 2011. The rural Massachusetts wage index is calculated as the average of all contiguous CBSAs. The Puerto Rico wage index is the same as FY 2010.

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