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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; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1349–F]

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: Final rule.

SUMMARY: This final rule will 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 final rule will also update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2012 (for discharges occurring on or after October 1, 2011 and on or before September 30, 2012) as required under section 1886(j)(3)(C) of the Social Security Act (the Act). Section 1886(j)(5) of the Act requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each 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 consolidating, clarifying, and revising 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 amending 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: *Effective Date:* This final rule becomes effective on October 1, 2011.

FOR FURTHER INFORMATION CONTACT:

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Susanne Seagrave, (410) 786–0044, for information about the payment policies.

Judith C. Tobin, (410) 786–6892, for information about the quality reporting program.

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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
CBSA Core-Based Statistical Area
CDC Centers for Disease Control and Prevention
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 and 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 5 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 Web site 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 final 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 final 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) of the Act 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 final 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 the 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) of the Act (providing for a ''productivity adjustment'' for fiscal year 2012 and each subsequent fiscal year). The productivity adjustment for FY 2012 is discussed in section VI.A.6 of this final rule, and the 0.1 percentage point reduction is discussed in section VI.A of this final 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 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) of the Act, 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) of the Act will require application of a 2 percentage point reduction to 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 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. Also, the Secretary must ensure that IRFs have the opportunity to review any data prior to its release to the public. Future rulemaking will address these public reporting obligations.

The quality reporting program for IRFs, in accordance with section 1886(j)(7) of the Act, is discussed in detail in section X. of this final 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. For further discussion of these requirements, please see the FY 2011 IRF PPS Notice (75 FR 42836 at 42838).

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 the FY 2012 IRF PPS proposed rule (76 FR 24214), we proposed 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 also proposed 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 the FY 2012 IRF PPS proposed rule (76 FR 24214, 24219 through 24220).
- 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 the 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 the FY 2012 IRF PPS proposed rule (76 FR 24214, 24226).
- 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 the FY 2012 IRF PPS proposed rule (76 FR 24214, 24228 through 24241).
- 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 the FY 2012 IRF PPS proposed rule (76 FR 24214, 24241 through 24244).
- Calculate the IRF Standard Payment Conversion Factor for FY 2012, as discussed in section V. of the FY 2012 IRF PPS proposed rule (76 FR 24214, 24244 through 24245).
- Update the outlier threshold amount for FY 2012, as discussed in section VI. of the FY 2012 IRF PPS proposed rule (76 FR 24214, 24248 through 24249).
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2012, as discussed in section VI. of the FY 2012 IRF PPS proposed rule 76 (FR 24214, 24249).
- Discuss the impact of the Inpatient Prospective Payment System (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 the FY 2012 IRF PPS proposed rule (76 FR 24214, 24249 through 24250).
- Implement the IRF quality reporting program provisions of section 1886(j)(7) of the Act, as discussed in section IX. of the FY 2012 IRF PPS proposed rule (76 FR 24214, 24252 through 24257).

B. Proposed Revisions to Existing Regulation Text

We proposed to revise the existing requirements at § 412.25(b), § 412.25(b)(1), § 412.25(b)(2), and § 412.25(b)(3) that apply to all units that are excluded from the IPPS, as described in section VIII. of the FY 2012 IRF PPS proposed rule (76 FR 24214, 24250 through 24252). To amend the regulatory reference to conform with the other proposed changes, we also proposed to revise the existing requirements at § 412.25(e)(2)(ii)(A). With the exception of § 412.25(e)(2)(ii)(A), the proposed revisions would affect both IRFs and IPFs.

We also proposed 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 the FY 2012 IRF PPS proposed rule (76 FR 24214, 24252).

Finally, we proposed 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. Analysis and Responses to Public Comments

We received approximately 46 timely responses, many of which contained multiple comments on the FY 2012 IRF PPS proposed rule (76 FR 24214) from the public. We received comments from various trade associations, inpatient rehabilitation facilities, individual physicians, therapists, clinicians, health care industry organizations, and health care consulting firms. The following sections, arranged by subject area, include a summary of the public comments that we received, and our responses.

IV. 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 the FY 2012 proposed rule (76 FR 24214, 24219 through 24225), we proposed 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 proposed 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.

We proposed to use the same methodology that we have used to update the CMG relative weights and average length of stay values in the FY 2009 IRF PPS final rule (73 FR 46370), 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 we use to calculate the CMG relative weights 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 proposed to update the CMG relative weights for FY 2012 in 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 budget neutrality factor for use in updating the FY 2012 CMG relative weights, we use the following steps:

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

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2012 by applying the 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 budget neutrality factor (0.9988) that would maintain the same total estimated aggregate payments in FY 2012 with and without the changes to the CMG relative weights.

Step 4. Apply the budget neutrality factor (0.9988) to the FY 2011 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

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

Note that the budget neutrality factor that we used to update the CMG relative weights for FY 2012 changed from 0.9989 in the proposed rule to 0.9988 in this final rule due to the use of updated FY 2010 IRF claims data in this final rule.

We received 2 comments on the proposed updates to the CMG relative weights and average length of stay values, which are summarized below.

Comment: One commenter expressed confusion about whether CMS might have used an ''older'' methodology to calculate the CMG relative weights in the FY 2011 IRF PPS Notice (75 FR 42836) that differed from the methodology that CMS used to calculate the CMG relative weights in the FY 2009 IRF PPS final rule (73 FR 46370), the FY 2010 IRF PPS final rule (74 FR 39762), or the FY 2012 IRF PPS proposed rule (76 FR 24214).

Response: We used the same methodology to update the CMG relative weights in the FY 2002 IRF PPS final rule (66 FR 41316), the FY 2006 IRF PPS final rule (70 FR 47880), and the FY 2007 IRF PPS final rule (71 FR 48354). We did not update the CMG relative weights in the FY 2008 IRF PPS final rule (72 FR 44284). In the FY 2009 IRF PPS final rule (73 FR 46370), we implemented one change to the methodology which involved the use of more detailed cost-to-charge ratio (CCR) data from the cost reports of IRF subprovider units of primary acute care hospitals, instead of CCR data from the associated primary acute care hospitals, to calculate IRFs' average costs per case. We have used this same revised methodology from FY 2009 to update the CMG relative weights in the FY 2010 IRF PPS final rule (74 FR 39762), the FY 2011 notice (75 FR 42836), and the FY 2012 IRF PPS proposed rule (76 FR 24214). We continue to use the same methodology that was revised in FY 2009 for updating the CMG relative weights in this final rule.

Comment: Two commenters requested that CMS provide more information about the methodology that we use to calculate the average length of stay values. One commenter noted that it would be useful for CMS to provide information on the standard deviations for the average length of stay values, and another commenter suggested that we reiterate the purpose of the average length of stay values.

Response: To calculate the average length of stay values for the proposed and final rules each year, we use the following steps:

Step 1. Sum the lengths of stay for all of the cases in each CMG and tier using the most current IRF claims data (for this final rule, we used FY 2010 IRF claims data).

Step 2. Divide the number in step 1 by the number of cases in each CMG and tier in the most current IRF claims data (for this final rule, we used FY 2010 IRF claims data) to obtain an average.

Step 3. Use the average length of stay value calculated in step 2 to identify all of the cases in each CMG and tier that would meet the criteria for payment under the IRF short-stay transfer policy, and remove those cases from the analysis.

Step 4. Repeat steps 1 through 3 until no additional cases are identified in step 3 (that is, until all of the cases left in step 3 are ''full CMG'' cases that would not meet the short-stay transfer policy criteria).

As we have stated in previous rules, 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 average length of stay values should not be used to limit a patient's length of stay in an IRF.

At the request of several of the commenters, we have placed the standard deviations for the proposed average length of stay values from the FY 2012 IRF PPS proposed rule (76 FR 24214) with the other proposed rule data files on the IRF PPS Web site at *http://www.cms.gov/InpatientRehabFacPPS/07_DataFiles.asp#TopOfPage.* We will continue to provide this information as part of our standard rulemaking files that we post to the Web site in conjunction with the IRF PPS rules.

Final Decision: After carefully considering all of the comments that we received on the proposed updates to the CMG relative weights and average length of stay values, we are implementing the FY 2012 updates to the CMG relative weights and average length of stay values presented in Table 1 (which are different from the relative weights and average length of stay values that we had proposed because these final values are based on analysis of updated FY 2010 IRF claims data).

TABLE 1—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			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0101	Stroke M > 51.05	0.7676	0.7182	0.6451	0.6102	10	10	9	8
0102	Stroke M > 44.45 and M < 51.05 and C > 18.5	0.9527	0.8913	0.8007	0.7573	12	13	10	10
0103	Stroke M > 44.45 and M< 51.05 and C < 18.5	1.1377	1.0644	0.9562	0.9043	14	14	12	12
0104	Stroke M > 38.85 and M < 44.45	1.1819	1.1058	0.9934	0.9395	15	14	13	12
0105	Stroke M > 34.25 and M < 38.85	1.3733	1.2849	1.1542	1.0916	16	17	14	14
0106	Stroke M > 30.05 and M < 34.25	1.5815	1.4796	1.3291	1.2571	20	18	16	16
0107	Stroke M > 26.15 and M < 30.05	1.7906	1.6753	1.5049	1.4233	20	20	18	18
0108	Stroke M < 26.15 and A > 84.5	2.2178	2.0749	1.8639	1.7629	31	25	23	22
0109	Stroke M > 22.35 and M < 26.15 and A < 84.5	2.0508	1.9188	1.7236	1.6302	24	23	20	20
0110	Stroke M < 22.35 and A < 84.5	2.6434	2.4731	2.2216	2.1012	33	29	26	25
0201	Traumatic brain injury M > 53.35 and C > 23.5	0.7470	0.6132	0.5680	0.5158	8	8	7	8
0202	Traumatic brain injury M > 44.25 and M < 53.35 and C > 23.5	1.0613	0.8712	0.8070	0.7327	12	12	10	10
0203	Traumatic brain injury M > 44.25 and C < 23.5	1.2080	0.9917	0.9185	0.8341	16	11	13	12
0204	Traumatic brain injury M > 40.65 and M < 44.25	1.2655	1.0388	0.9622	0.8737	16	12	12	12
0205	Traumatic brain injury M > 28.75 and M < 40.65	1.5982	1.3120	1.2152	1.1035	17	18	15	14
0206	Traumatic brain injury M > 22.05 and M < 28.75	1.9895	1.6332	1.5128	1.3736	23	19	19	18
0207	Traumatic brain injury M < 22.05	2.6903	2.2085	2.0456	1.8574	35	27	25	22
0301	Non-traumatic brain injury M > 41.05	1.0576	0.9514	0.8441	0.7730	12	12	11	10
0302	Non-traumatic brain injury M > 35.05 and M < 41.05	1.3393	1.2048	1.0689	0.9789	12	15	13	13
0303	Non-traumatic brain injury M > 26.15 and M < 35.05	1.5924	1.4325	1.2709	1.1640	21	17	15	14
0304	Non-traumatic brain injury M < 26.15	2.2048	1.9834	1.7596	1.6116	29	23	20	19
0401	Traumatic spinal cord injury M > 48.45	1.0588	0.8815	0.8019	0.7036	14	14	11	10
0402	Traumatic spinal cord injury M > 30.35 and M < 48.45	1.3802	1.1491	1.0453	0.9171	17	14	13	12
0403	Traumatic spinal cord injury M > 16.05 and M < 30.35	2.4659	2.0529	1.8675	1.6386	29	26	23	20
0404	Traumatic spinal cord injury M < 16.05 and A > 63.5	4.3797	3.6461	3.3169	2.9102	52	39	38	35
0405	Traumatic spinal cord injury M < 16.05 and A < 63.5	3.8686	3.2206	2.9298	2.5706	52	39	36	29
0501	Non-traumatic spinal cord injury M > 51.35	0.6559	0.6297	0.5616	0.4977	10	10	7	7
0502	Non-traumatic spinal cord injury M > 40.15 and M < 51.35	0.9815	0.9423	0.8404	0.7448	13	13	11	10
0503	Non-traumatic spinal cord injury M > 31.25 and M < 40.15	1.2460	1.1962	1.0668	0.9455	16	14	13	12
0504	Non-traumatic spinal cord injury M > 29.25 and M < 31.25	1.5023	1.4423	1.2863	1.1400	18	16	16	14
0505	Non-traumatic spinal cord injury M > 23.75 and M < 29.25	1.7558	1.6856	1.5033	1.3324	20	21	18	17
0506	Non-traumatic spinal cord injury M < 23.75	2.4607	2.3624	2.1069	1.8673	34	28	24	23
0601	Neurological M > 47.75	0.9457	0.7992	0.7289	0.6589	10	11	9	9
0602	Neurological M > 37.35 and M < 47.75	1.2516	1.0577	0.9648	0.8721	12	13	12	11
0603	Neurological M > 25.85 and M < 37.35	1.6164	1.3660	1.2460	1.1263	17	16	14	14
0604	Neurological M < 25.85	2.1432	1.8112	1.6521	1.4934	24	21	19	18
0701	Fracture of lower extremity M > 42.15	0.8001	0.7877	0.7586	0.6772	10	12	10	9

TABLE 1—RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS—Continued

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0702	Fracture of lower extremity M > 34.15 and M < 42.15	1.0470	1.0307	0.9927	0.8861	12	13	12	12
0703	Fracture of lower extremity M > 28.15 and M < 34.15	1.2599	1.2402	1.1945	1.0662	15	15	14	14
0704	Fracture of lower extremity M < 28.15	1.6283	1.6029	1.5439	1.3780	18	19	18	17
0801	Replacement of lower extremity joint M > 49.55	0.5745	0.5745	0.5354	0.4888	7	8	7	7
0802	Replacement of lower extremity joint M > 37.05 and M < 49.55	0.7725	0.7725	0.7199	0.6573	8	11	9	9
0803	Replacement of lower extremity joint M > 28.65 and M < 37.05 and A > 83.5	1.0651	1.0651	0.9926	0.9062	11	14	13	12
0804	Replacement of lower extremity joint M > 28.65 and M < 37.05 and A < 83.5	0.9407	0.9407	0.8767	0.8004	10	12	11	10
0805	Replacement of lower extremity joint M > 22.05 and M < 28.65	1.1584	1.1584	1.0795	0.9856	11	14	13	13
0806	Replacement of lower extremity joint M < 22.05	1.4144	1.4144	1.3181	1.2034	13	18	16	15
0901	Other orthopedic M > 44.75	0.8467	0.7460	0.6751	0.6116	10	10	9	8
0902	Other orthopedic M > 34.35 and M < 44.75	1.1324	0.9978	0.9029	0.8180	12	13	12	11
0903	Other orthopedic M > 24.15 and M < 34.35	1.4503	1.2779	1.1564	1.0477	16	16	14	13
0904	Other orthopedic M < 24.15	1.8791	1.6557	1.4983	1.3575	21	20	18	17
1001	Amputation, lower extremity M > 47.65	1.0335	0.9087	0.8119	0.7256	13	12	10	10
1002	Amputation, lower extremity M > 36.25 and M < 47.65	1.3571	1.1931	1.0660	0.9528	16	14	13	12
1003	Amputation, lower extremity M < 36.25	2.0050	1.7628	1.5750	1.4077	21	21	18	17
1101	Amputation, non-lower extremity M > 36.35	1.0359	1.0359	0.9826	0.9222	11	11	12	11
1102	Amputation, non-lower extremity M < 36.35	1.5586	1.5586	1.4783	1.3875	14	18	16	16
1201	Osteoarthritis M > 37.65	0.8102	0.8102	0.8104	0.7660	13	13	11	10
1202	Osteoarthritis M > 30.75 and M < 37.65	1.0564	1.0564	1.0566	0.9987	16	16	14	13
1203	Osteoarthritis M < 30.75	1.3031	1.3031	1.3033	1.2319	13	19	15	15
1301	Rheumatoid, other arthritis M > 36.35	0.8937	0.9714	0.9714	0.7882	11	10	11	10
1302	Rheumatoid, other arthritis M > 26.15 and M < 36.35	1.1769	1.2792	1.2792	1.0379	17	17	14	13
1303	Rheumatoid, other arthritis M < 26.15	1.5211	1.6533	1.6533	1.3415	15	19	18	16
1401	Cardiac M > 48.85	0.9411	0.7535	0.6663	0.6026	10	10	9	8
1402	Cardiac M > 38.55 and M < 48.85	1.2638	1.0118	0.8947	0.8092	13	12	11	10
1403	Cardiac M > 31.15 and M < 38.55	1.5263	1.2220	1.0806	0.9773	18	14	13	12
1404	Cardiac M < 31.15	1.9770	1.5828	1.3997	1.2659	24	19	16	15
1501	Pulmonary M > 49.25	0.9610	0.8973	0.7734	0.7311	10	11	8	9
1502	Pulmonary M > 39.05 and M < 49.25	1.2094	1.1293	0.9734	0.9201	13	13	11	11
1503	Pulmonary M > 29.15 and M < 39.05	1.4914	1.3926	1.2003	1.1346	16	16	13	13
1504	Pulmonary M < 29.15	1.8840	1.7592	1.5163	1.4333	22	18	17	16
1601	Pain syndrome M > 37.15	1.1177	0.8798	0.7721	0.7217	12	12	10	10
1602	Pain syndrome M > 26.75 and M < 37.15	1.4972	1.1785	1.0342	0.9667	19	13	13	13
1603	Pain syndrome M < 26.75	1.9348	1.5230	1.3365	1.2493	22	18	16	15
1701	Major multiple trauma without brain or spinal cord injury M > 39.25	1.0436	0.9289	0.8430	0.7369	10	11	11	10
1702	Major multiple trauma without brain or spinal cord injury M > 31.05 and M < 39.25	1.3771	1.2256	1.1123	0.9723	13	15	14	13

TABLE 1—RELATIVE WEIGHTS AND AVERAGE LENGTH OF STAY VALUES FOR CASE-MIX GROUPS—Continued

CMG	CMG Description (M = motor, C = cognitive, A = age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1703	Major multiple trauma without brain or spinal cord injury M > 25.55 and M < 31.05	1.6240	1.4454	1.3117	1.1467	15	16	15	15
1704	Major multiple trauma without brain or spinal cord injury M < 25.55	2.0792	1.8505	1.6794	1.4681	26	22	20	18
1801	Major multiple trauma with brain or spinal cord injury M > 40.85	1.2016	0.9858	0.9517	0.8705	14	15	12	11
1802	Major multiple trauma with brain or spinal cord injury M > 23.05 and M < 40.85	1.6515	1.3548	1.3080	1.1964	18	20	15	15
1803	Major multiple trauma with brain or spinal cord injury M < 23.05	2.8314	2.3228	2.2425	2.0512	34	32	26	24
1901	Guillain Barre M > 35.95	1.1498	1.0129	0.9189	0.8923	13	14	12	12
1902	Guillain Barre M > 18.05 and M < 35.95	2.1903	1.9296	1.7504	1.6999	22	22	21	21
1903	Guillain Barre M < 18.05	3.6722	3.2351	2.9348	2.8501	48	29	34	32
2001	Miscellaneous M > 49.15	0.8541	0.7547	0.6766	0.6079	9	10	9	8
2002	Miscellaneous M > 38.75 and M < 49.15	1.1431	1.0100	0.9056	0.8136	12	12	11	10
2003	Miscellaneous M > 27.85 and M < 38.75	1.4435	1.2755	1.1436	1.0274	15	15	13	13
2004	Miscellaneous M < 27.85	1.9356	1.7104	1.5335	1.3777	24	20	18	16
2101	Burns M > 0	2.5153	2.1771	1.7338	1.4053	34	23	19	18
5001	Short-stay cases, length of stay is 3 days or fewer				0.1475				3
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.5856				7
5102	Expired, orthopedic, length of stay is 14 days or more				1.4718				18
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.6970				8
5104	Expired, not orthopedic, length of stay is 16 days or more				1.8778				23

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

A. 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 3 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 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.

Although 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 find 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 use of a weighting methodology, which assigns greater weight to some facilities than to others, applied to the regression analysis used to estimate the facility-level adjustment factors inappropriately exaggerated the differences among different types of IRF facilities. We proposed 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 un-weighted regression analysis.

We received 22 comments on the proposed updates to the facility-level adjustment factors, which are summarized below.

Comment: Several commenters requested that CMS release data that would enable facilities to replicate the calculation of the facility-level adjustment factors, provide more information on how CMS calculates the 3-year moving average, and provide more information on CMS's research and computations used to support an un-weighted regression methodology.

Response: We provided additional information on the calculation of the facility-level adjustment factors on the Inpatient Rehabilitation Facility PPS Web page under the ''Research'' link on the left hand side of the page: *http://www.cms.gov/InpatientRehabFacPPS/09_Research.asp#TopOfPage.* As we stated in the FY 2010 IRF PPS final rule, the 3-year moving average is computed by determining the adjustment factor for each year and then averaging those adjustment factors over 3 years. For FY 2012, we used the adjustment factors generated from our analysis of claims data and the corresponding year's cost report data or, if unavailable, the most recent available cost report data for FY 2008, FY 2009 and FY 2010. Our estimates of the proposed FY 2012 adjustment factors, based on FY 2008, FY 2009, and FY 2010 data, are shown below in Table 2.

TABLE 2—FACILITY-LEVEL ADJUSTMENT FACTORS USING THE UN-WEIGHTED REGRESSION METHODOLOGY, FY 2012 PROPOSED RULE

	FY 2008	FY 2009	FY 2010	FY 2012 proposed
LIP Adjustment Factor	0.1773	0.2158	0.1764	0.1897
Teaching Status Adjustment Factor	0.3554	0.5183	0.6036	0.4888
Rural Adjustment	0.192	0.188	0.182	0.187

Comment: Several commenters supported the proposed update to the facility-level adjustment factors in the FY 2012 proposed rule, including the use of an un-weighted regression methodology to determine the facility-level adjustment factors, stating that they believe the changes will result in a more accurate payment system. However, several other commenters expressed concern about the resulting updates to the teaching status and LIP adjustment factors for FY 2012 from using an un-weighted regression methodology. The commenters stated that the proposed updates would create financial hardships for facilities with teaching programs and a higher disproportionate share of low-income patients. Several of the commenters, including the Medicare Payment Advisory Commission (MedPAC), suggested that CMS defer the implementation of the un-weighted regression methodology and conduct more analysis on the underlying causes of the instability in the teaching status adjustment factor and on the most appropriate methodology for calculating the facility-level adjustment factors. Several other commenters suggested that CMS mitigate the impact of any changes in the facility-level adjustment factors by phasing the changes in over several years, or by capping the amount that a facility adjustment can decrease in a given year.

Response: We agree with the commenters that it is appropriate to defer implementation of the un-weighted regression methodology for an additional year so that we can further analyze some anomalies that appear to exist in the underlying data. We believe that these anomalies are causing the results of the weighted regression methodology to differ substantially from the results of the un-weighted regression methodology. Thus, we believe that the best course of action for FY 2012 is to defer the implementation of the un-weighted regression methodology while we conduct more research into the reasons for these anomalies and alternative ways of computing the facility-level adjustments that will reduce the volatility in the teaching status adjustment factor and provide the most accurate reflection of cost differences among different types of facilities.

Comment: One commenter offered several suggestions on ways to improve the computation of the facility-level adjustment factors without altering the weighting methodology. Those suggestions included: pooling three year's worth of data into a single data set to increase sample size; continuing to use existing weighted regression model, but with added control variables; and matching claims to corresponding cost report data, even if that creates a 3-year lag in the last data year used and the IRF PPS payment year.

Response: We appreciate all of the suggestions that we received on ways to improve our methodology for computing the facility-level adjustments and will take those suggestions under advisement while we continue to research ways to ensure that we are using the best methods to determine the facility-level adjustments.

Final Decision: After carefully considering all of the comments that we received on the proposed updates to the rural, LIP and teaching status adjustment factors for FY 2012, we are holding the facility-level adjustment factors at FY 2011 levels for FY 2012 while we conduct further research on the underlying data and the best methodology for calculating the facility-level adjustment factors. Thus, the facility-level adjustments factors for FY 2012 will be the same as those finalized in the FY 2011 IRF PPS notice (75 FR 42836 at 42848), which were the same as those finalized in the FY 2010 IRF PPS final rule (74 FR 39762 at 39775). For the convenience of the reader, we reiterate the final adjustment factors (from the FY 2010 IRF PPS final rule) as follows: For FY 2012, the IRF PPS payments to IRFs in rural areas will be computed with an 18.4 percent upward adjustment for rural status. IRF PPS payments to eligible IRFs that qualify for the LIP adjustment for FY 2012 will be adjusted using a LIP adjustment formula of (1 + disproportionate share hospital (DSH) patient percentage) raised to the power of (0.4613), where the—

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

Finally, IRF PPS payments to eligible IRFs that qualify for the teaching status adjustment will be adjusted by the following formula for FY 2012: (1 + full-time equivalent (FTE) interns and residents/average daily census) raised to the power of (0.6876).

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

B. 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. FTE Intern and Resident Temporary 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. We have recently implemented a similar temporary cap adjustment policy for the inpatient psychiatric facility (IPF) PPS teaching status adjustment outlined in the rate year 2012 IPF PPS final rule (76 FR 26432 at 26454 through 26456). Consistent with the IPPS and the IPF PPS, in the FY 2012 IRF PPS proposed rule (76 FR 24214), we proposed 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 adopting 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 temporary adjustments to the FTE caps for IPFs.

The cap adjustment will be temporary because it is intern and resident specific and will 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. As under the IPPS policy for displaced interns and residents, the IRF PPS temporary cap adjustment will 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 will not be considered displaced interns and residents for purposes of the IRF temporary cap adjustment policy. We are adopting 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, 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 adopting 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 final rule are met.

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

We will 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 implementing 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 adopting 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 will allow a temporary adjustment to an IRF's FTE cap to reflect interns and residents added because of an IRF's closure. The policy will 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. We will 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.

(b) The IRF that is training the displaced interns and residents from the closed IRF submits a timely request for a temporary adjustment to its FTE cap to its Medicare contractor. Requests generally must be submitted no later than 60 days after the hospital first begins training the displaced interns and residents. In the case of an IRF that is already training the displaced interns and residents as of October 1, 2011, requests must be submitted by December 1, 2011. Requests must document 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 will revert to its original level. Therefore, the temporary adjustment to the FTE cap will 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, 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. Temporary Adjustment to FTE Cap to Reflect Interns and Residents Displaced Due to a Residency Program Closure

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 adopting 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

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 displaced interns and residents from the residency training program of an IRF that closed its program; and
- The IRF that is training the displaced interns and residents from the closed program must submit a timely request for a temporary adjustment to its FTE cap to its Medicare contractor. Requests generally must be submitted no later than 60 days after the IRF begins to train the interns and residents. In the case of an IRF that is already training the displaced interns and residents as of October 1, 2011, requests must be submitted by December 1, 2011. Requests must document 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 temporary adjustment criteria established for closed medical residency training programs at IRFs is similar to the criteria established for closed IRFs. 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)

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
- Submits a timely statement to its Medicare contractor that has been 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. Statements generally must be submitted no later than 60 days after the interns and residents who were in the closed program begin training at another IRF. In the situation where another IRF is already training the displaced interns and residents as of October 1, 2011, statements must be submitted no later than December 1, 2011. The statement must identify the interns and residents who were training at the time of the program's closure, identify the IRFs to which the interns and residents are transferring once the program closes,

and specify the reduction for the applicable program years.

In addition, under this closed program policy, 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 implementing 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.

The cap reduction for the IRF with the closed program will 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.

We received 3 comments on the proposed temporary adjustment to the FTE cap to reflect interns and residents displaced due to an IRF closure or a residency training program closure, which are summarized below.

Comment: One commenter suggested that the proposed temporary adjustment to the FTE cap would be too difficult for CMS to monitor. This commenter also stated that few IRFs with teaching programs have taken displaced interns and residents.

Response: We believe that a policy allowing for temporary adjustments to the FTE caps for IRFs that take displaced interns and residents would be no more difficult to monitor than the similar policy that is already being administered for IPPS hospitals. Although we agree that few IRFs currently take displaced interns and residents, we believe that it is reasonable to allow for temporary adjustments to the FTE caps for those IRFs that do.

Comment: Two commenters strongly supported our proposed policy to allow a temporary adjustment to the intern and resident cap when an IRF accepts interns or residents that are displaced due to an IRF closure or a residency training program closure. However, these commenters requested that CMS modify the proposed policy to allow IRFs to receive the temporary cap adjustment if they are training displaced interns or residents as of October 1, 2011.

Response: We share the commenters' concern for those FTE interns and residents who have been displaced before October 1, 2011 due to closure of an IRF or a residency training program. We carefully considered the commenters' request that CMS modify the IRF temporary cap adjustment policy to allow IRFs that volunteered to train displaced interns and residents before October 1, 2011 to receive the temporary cap adjustment. In keeping with the similar policy for IPPS hospitals, we are revising our proposed policy to allow IRFs to receive temporary cap adjustments for cost reporting periods beginning on or after October 1, 2011 for displaced interns and residents that they are training as of October 1, 2011. For example, if an IRF closed or closed a residency training program on October 1, 2009, then an intern or resident who was in their first program year at that time would likely be in their third program year as of October 1, 2011 and thus would still be in the middle of their training. An IRF that assumed the training of this intern or resident who was displaced by the 2009 IRF or residency training program closure would be eligible to receive a temporary cap adjustment for cost reporting periods beginning on or after October 1, 2011. As noted above, an IRF that is requesting the temporary cap adjustment for the displaced interns and residents that it is training as of October 1, 2011 must submit the required documentation to CMS no later than December 1, 2011.

Final Decision: After carefully considering the comments that we received on the proposed temporary adjustment to the FTE cap to reflect interns and residents displaced due to an IRF closure or the closure of a residency training program, we are implementing the new policy for IRFs as proposed, with the one exception noted above. We will allow IRFs to qualify for the temporary cap adjustment for cost reporting periods beginning on or after October 1, 2011 if they are already training interns and residents displaced by IRF closures or residency program closures that occurred prior to October 1, 2011. In these instances, all required documentation must be received by CMS no later than December 1, 2011. IRFs that meet the criteria will be eligible to receive temporary adjustments to their FTE caps for cost reporting periods beginning on or after October 1, 2011.

VI. FY 2012 IRF PPS Federal Prospective Payment Rates

A. 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 final rule, we are updating 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 rebasing 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 final rule, we 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 VI.A.1 of this final rule, we describe the methodology for rebasing the RPL market basket from a 2002 base year to a 2008 base year, and then in section VI.A.2 of this final rule, we describe the methodology for calculating the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. Finally, in section VI.A.3 of this final rule, we describe the calculation of the market basket increase factor to be used to adjust IRF PPS payments for FY 2012.

1. Rebasing and Revising of the RPL Market Basket Used for IRF PPS 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 FY 2006, 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 (70 FR 47908). 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. A complete discussion of the FY 2002-based RPL market basket can be found in the FY 2006 IRF PPS final rule (70 FR 47908 through 47915).

In the FY 2010 IRF PPS 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 types of providers, both in terms of 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.

In the FY 2012 IRF PPS proposed rule (76 FR 24229), we invited public comment on the possibility of using this type of market basket to update IRF payments in the future.

Comment: One commenter stated that CMS' ongoing work to develop a market basket that reflects freestanding IRF and freestanding IPF data should be research that CMS continues to explore. The commenter also stressed that a separate market basket which excludes LTC hospital costs must be contingent on the availability of reliable data from a representative group of IRF and IPF facilities.

Response: We will consider the commenters' concerns as we continue to investigate the feasibility of developing a market basket derived using data from freestanding IPF and freestanding IRF providers. We agree that before moving away from the existing RPL market basket, we must be confident that we have reliable data gathered from a representative group of IRF and IPF providers. Any change to the market basket used to update IRF payments will also be subject to the rulemaking process.

Comment: One commenter recommended that CMS proceed with caution in its efforts to create a market basket based solely on freestanding IRF and freestanding IPF data. They noted that there are substantial geographic differences in the location of RPL providers. Several commenters requested that CMS share its research with the industry in advance of any proposed rulemaking so that any unintended consequences of a change could be addressed by CMS and stakeholders.

Response: We agree with the commenter's observation that there are substantial geographic differences in the location of IRF and IPF facilities. We would note that the CMS market baskets, including the RPL, necessarily reflect the relative costs of inputs for a given base year at the national level. We will continue to investigate the feasibility of creating a market basket that is nationally representative and is based on IPF and IRF data. Any changes to the market basket, including changes in methodology, would be subject to the rulemaking process.

For this update cycle (FY 2012), we are finalizing our intent to continue to use an RPL market basket based on freestanding IRF, freestanding IPF, and long term care hospital (LTCH) data. We will continue to pursue the feasibility 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.

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

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

The 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 the 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 that 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. Rebasing and Revising of 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 the proposed rule, we proposed 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 proposed 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 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 will 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 proposed 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 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 use a less stringent measure of Medicare LOS for IPFs. For this provider-type, and in order to produce a robust sample size, we will 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 4 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	FY 2008-based RPL market basket (percent)
Wages and salaries	47.371
Professional Liability Insurance (Malpractice)	0.764

TABLE 3—MAJOR COST CATEGORIES AND THEIR RESPECTIVE COST WEIGHTS AS CALCULATED DIRECTLY FROM FY 2008 MEDICARE COST REPORTS—Continued

Major cost categories	FY 2008-based RPL market basket (percent)
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 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 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 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.

Comment: One commenter supported using the latest available data to update the IRF PPS; however, the commenter observed that CMS relied on acute care hospital data for certain items (that is, Employee Benefits, Contract Labor) that were not collected in the RPL settings. The commenter recommend that CMS consider revisions to the cost report data for the RPL settings to collect this information in advance of the next rebasing to allow the use of specific RPL data for all cost categories, weights, and price proxies.

Response: Effective for cost reports beginning on or after May 1, 2010, we finalized a revised Hospital and Hospital Health Care Complex Cost Report, Form CMS 2552–10, which is available for download from the CMS Web page at *http://www.cms.gov/Transmittals/2010Trans/list.asp?intNumPerPage=10* by clicking on the link to CMS Transmittal #R1P240. Form CMS 2552–10 includes a new worksheet (Worksheet S–3, part V) which identifies the contract labor costs and benefit costs for the hospital complex and is applicable to sub-providers and units. We believe that all providers will report this data so that we will be able to include it in future market basket rebasings.

(2) Final Cost Category Computation

As stated previously, for this rebasing we proposed 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 2 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 2 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 breaking 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 section VI.A.1.c.(3) of this final rule. Also, the 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 will include the photo supplies costs in the Chemical cost category weight with other similar chemical products.

We are not changing our definition of the labor-related share. However, we are renaming 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 new labels more accurately reflect the concepts that they are intended to

convey. We are not changing 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 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 are using for the operating portion of the FY 2008-based RPL market basket. The price proxies for the capital portion are described in more detail in the capital methodology section (see section VI.A.1.c.(4) of this final 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—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	FY 2008-based RPL market basket cost weights	FY 2002-based RPL market basket cost weights	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.

TABLE 4—FY 2008-BASED RPL MARKET BASKET COST CATEGORIES, WEIGHTS, AND PRICE PROXIES WITH FY 2002-BASED RPL MARKET BASKET COST WEIGHTS INCLUDED FOR COMPARISON—Continued

Cost categories	FY 2008-based RPL market basket cost weights	FY 2002-based RPL market basket cost weights	FY 2008-based RPL market basket price proxies
(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 [4]	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).
(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 VI.A.1.c.(3).(c).(xviii) and VI.A.1.c.(3).(c).(xxi) of this final 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 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 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 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 FY 2008-based market basket, we 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 use the PPI for Petroleum Refineries (BLS series code PCU324110324110) as the proxy for this cost category.

(v) Water and Sewage

We 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 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 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 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 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 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 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 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 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 changing the price proxy for this cost category to the more aggregated PPI for Medical, Surgical, and Personal Aid Devices.

(xii) Photographic Supplies

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

(xiii) Rubber and Plastics

We 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 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 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 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 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 removes the double-counting of food and energy prices, which are already 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 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 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 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 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 using to use for the Professional Fees: Labor-related cost category.

(xxii) Financial Services

We 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 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 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 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 removes 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 represents a technical improvement to the market basket.

Comment: One commenter observed that the compensation cost weight showed a decline from the FY 2002 to FY 2008 base year. The commenter noted that these reductions may be a result of low salary increases salary freezes or other similar factors and are not necessarily indicative of a reduction in the labor intensity of the services provided by IRFs.

Response: We agree with the commenter that a variety of factors and trends can influence changes in the cost shares of the RPL market basket. Relative to growth in nonlabor costs, slower growth in the cost of labor (due to low salary increases or freezes in salary), could result in a lower cost weight associated with wages and salaries. Likewise, stable growth in labor costs coupled with relatively faster growth in nonlabor costs could also result in a lower cost weight associated with wages and salaries. As the rebased and revised 2008-based RPL market basket's cost weights reflect an updated distribution of costs and represent the best available data, we are finalizing this market basket in this final rule.

(4) 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 FY 2008-based RPL market basket, we 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 total capital cost weight, we first apply the same LOS edits as applied when calculating the operating cost weights as described above in section VI.A.1.c.(1)(a) of this final rule. The resulting 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 3 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 FY 2008-based RPL market basket, we proposed 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 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 VI.A.1.c.(1)(a) of this final 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 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 FY 2008-based RPL market basket reflects 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 reflects 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 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 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 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 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 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 use the same price proxies for the capital portion of the 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).

We received no comments related to the proposed capital portion of the RPL methodology including the selection of cost categories, cost weights, and the price proxies. Therefore, we are finalizing the capital portion of the 2008-based RPL market basket as proposed with no further changes.

(5) FY 2012 RPL Market Basket Update Factor for IRFs

For FY 2012 (that is, beginning October 1, 2011 and ending September 30, 2012), we will use an estimate of the 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 fourth quarter of 2010, the projected market basket increase factor for FY 2012 was 2.8 percent. Consistent with our historical practice of estimating market basket increases based on the best available data, we proposed a market basket increase factor of 2.8 percent for FY 2012. We also proposed that if more recent data became subsequently available (for example, a more recent estimate of the market basket), we would use that data, if appropriate, to determine the FY 2012 update in the final rule.

Based on IGI's second quarter 2011 forecast with history through the first quarter of 2011, the projected market basket update for FY 2012 based on the 2008-based RPL market basket is 2.9 percent.

Using the current FY 2002-based RPL market basket and IGI's second quarter 2011 forecast for the market basket components, the FY 2012 update would be 3.0 percent (before taking into account any statutory adjustments). Table 7 compares the FY 2008-based RPL market basket and the FY 2002-based RPL market basket percent changes.

TABLE 7—FY 2002-BASED AND 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 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	2.7	2.7
FY 2012	3.0	2.9
FY 2013	3.0	2.9
FY 2014	3.0	3.0
Average 2011–2014	2.9	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. 2nd quarter 2011 forecast.

For FY 2012, the FY 2008-based RPL market basket update (2.9 percent) is slightly lower than the FY 2002-based RPL market basket update (3.0 percent). The lower total compensation weight in the 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 market basket update is slightly lower for FY 2012 based on the FY 2008-based RPL market basket relative to the FY 2002-based RPL market basket.

Comment: Several commenters expressed support that CMS update the RPL market basket with more recent cost data. They note that using more up-to-date cost report data (2008) makes the RPL market basket more representative of the costs faced by IRF providers relative to more outdated cost report data (2002).

Response: We agree that the use of more recent cost report data allows for the index to better reflect the actual costs faced by IRF providers. Based on the positive comments received regarding the rebasing of the RPL market basket, we are finalizing our proposal to rebase and revise the index. Based on IGI's second quarter 2011 forecast with history through the first quarter of 2011, the projected market basket update for FY 2012 is 2.9 percent. Therefore, consistent with our historical practice of estimating market basket increases based on the best available data, we are finalizing a market basket update of 2.9 percent for FY 2012.

2. 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 VI.A.1 of this final rule, we estimate the IRF PPS increase factor for FY 2012 based on the 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 cost reporting period, or other annual period) (the ''MFP adjustment''). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. We refer readers to the BLS Web site at *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 non-farm 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 the development of the FY 2012 final rule, the BLS had published a historical time series of private nonfarm business MFP for 1987 through 2010, with 2010 being a preliminary value. Using this historical MFP series and the IGI forecasted series, IGI has developed a forecast of MFP for 2011 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 non-farm establishments adjusted for labor composition,'' and ''real effective capital stock'' series (ranging from 2011 to 2021) are used to ''grow'' the levels of the ''real value-added output,'' ''private non-farm business sector labor input,'' and ''aggregate capital inputs'' 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 3 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, 2 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. 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 start with the FY 2008-based RPL market basket increase factor described above in section VI.A.1. of this final rule and subtract from that the MFP percentage adjustment described in section VI.A.2. of this final rule. Additionally, in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act, we further proposed to reduce the MFP-adjusted IRF PPS increase factor by 0.1 percentage point for FY 2012.

Specifically, in calculating the MFP percentage adjustment, 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 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 was based on the 1st quarter 2011 forecast of the proposed FY 2008-based RPL market basket update, which was estimated to be 2.8 percent. This increase factor was then reduced by the proposed MFP adjustment (the 10-year moving average of MFP for the period ending FY 2012) of 1.2 percentage points, based on the methodology described above and IHS Global Insight's 1st quarter 2011 forecast. The increase factor for FY 2012 was 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 was 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 update the market basket increase factor estimate and the MFP adjustment in this final rule to reflect the most recent available data.

Comment: Several commenters recognized that the productivity adjustment is mandated by law (section 3401(d) of the Affordable Care Act). However, they expressed concern about the negative impact that it could have on IRF providers and the beneficiaries they serve. They recommend that CMS takes steps to mitigate any negative effects caused by the MFP reduction.

Response: Section 3401(d) of the Affordable Care Act mandates that the market basket used to update IRF payments be reduced by a productivity adjustment beginning in FY 2012. As a result, we have no discretionary authority in this area, and we are applying this reduction in this final rule.

Comment: Several commenters stated that the provision of inpatient rehabilitation services is largely dependent on skilled rehabilitation physicians, therapists, nurses, and other highly trained personnel and that efficiencies which might result from use of advanced technology are more limited in this setting than may be observed in the general economy. One commenter noted that many of the treatment plans in the IRF setting do not lend themselves to continual productivity improvements. The commenter stated that it will be challenging for efficient providers, over time, to achieve continued efficiencies at a rate that will be required by ongoing application of productivity adjustments.

Response: We recognize that a complex and sophisticated mix of inputs are required to provide care to IRF patients. However, the agency is required by law to apply the MFP adjustment to provider payments as stipulated by section 3401(d) of the Affordable Care Act.

Comment: Several commenters suggested that CMS carefully monitor the impact that these MFP adjustments will have on the IRF hospital sector and provide feedback to Congress as appropriate.

Response: We will continue to monitor the effect of the MFP adjustments and share the results with policymakers. That practice will continue as we implement other provisions mandated by the Affordable Care Act.

Final Decision: After careful consideration of the public comments, we are finalizing our proposed method for calculating and applying the MFP adjustment. In accordance with section 1886(j)(3)(C) of the Act, as amended by section 3401(d) of the Affordable Care Act, we will base the FY 2012 market basket update, which is used to determine the applicable percentage increase for the IRF payments, on the second quarter 2011 forecast of the FY 2008-based RPL market basket (estimated to be 2.9 percent). This percentage increase will then be reduced by the MFP adjustment (the 10-year moving average of MFP for the period ending FY 2012) of 1.0 percent, which was calculated as described above and based on IGI's second quarter 2011 forecast. Following application of the productivity adjustment, the applicable percentage increase will then be further reduced by 0.1 percentage point, as required by section 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act, as amended by sections 3401(d) of the Affordable Care Act. Therefore the final FY 2012 IRF update is 1.8 percent (2.9 percent market basket update less 1.0 percentage point MFP adjustment less 0.1 percentage point legislative adjustment).

4. 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 the 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 proposed 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 (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 FY 2008-based RPL market basket rebasing, the 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 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 proposed to apportion the NAICS 55 expense data by this percentage. Thus, we proposed 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 method and the IGI forecast for the first quarter 2011 of the FY 2008-based RPL market basket, the proposed IRF labor-related share for FY 2012 was the sum of the FY 2012 relative importance of each labor-related cost category. Consistent with our policy for updating the labor-related share with the most recent available data, the labor-related share for this final rule reflects IGI's second quarter 2011 forecast of the FY 2008-based RPL market basket. Table 9 shows the FY 2012 relative importance labor-related share using the 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 FY 2012 RELATIVE IMPORTANCE LABOR-RELATED SHARE BASED ON THE FY 2008-BASED RPL MARKET BASKET

	FY 2011 relative importance labor-related share [1]	FY 2012 relative importance labor-related share [2]
Wages and Salaries	52.449	48.984
Employee Benefits	13.971	12.998
Professional Fees: Labor-Related	2.855	2.072
Administrative and Business Support Services	.....	0.416
All Other: Labor-Related Services	2.109	2.094
Subtotal	71.384	66.564
Labor-Related Portion of Capital Costs (46%)	3.887	3.635
Total Labor-Related Share	75.271	70.199

[1] Published in the FY 2011 IRF PPS Notice (75 FR 42849) and based on the second quarter 2010 IGI forecast.
[2] Based on the second quarter 2011 IGI forecast.

The labor-related share for FY 2012 is the sum of the 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 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 66.564 percent, as shown in Table 9.

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 7.903 percent of the proposed FY 2008-based RPL market basket in FY 2012, we take 46 percent of 7.903 percent to determine the proposed labor-related share of Capital for FY 2012. The result would be 3.635 percent, which we add to 66.564 percent for the operating cost amount to determine the total labor-related share for FY 2012. Thus, the labor-related share that we use for the IRF PPS in FY 2012 will be 70.199 percent. This labor-related share is determined using the same methodology that we used to calculate all previous IRF labor-related shares.

Comment: One commenter stated that the CMS proposal to no longer include 100 percent of certain types of costs in the labor-related share calculation does not coincide with the application of the area wage index. This commenter noted that costs captured in the ''Other Services'' cost category in the RPL, whether employees, local contractors, national contractors, or home office allocations, represent personal services, which are in essence labor-related. The commenter also noted that the labor-related portion of the base rate is adjusted by the area wage index. The IPPS wage index includes in its calculation of the local (CBSA) wage index not a portion based on location relative to the provider, but 100 percent of the allocated home office wages, benefits, and hours. The commenter noted that the hospital wage index also includes contracted administrative and general services, which would include those categories in CMS' survey such as accounting, legal, *etc.* The commenter suggested that if these costs are included in the IPPS wage index, then they should also be included in full in the labor-related portion of the base rate that will be multiplied by the adjustment factor for the IRF calculation.

Response: We appreciate the commenter's suggestion. However, we disagree that we should allocate 100 percent of service costs as labor-related. The wage index that is applied to the labor-related portion of any payment system measures the variation in labor costs based on geographic differences. Therefore, it is appropriate that the wage index would include all relative cost differences for various labor categories. The labor-related share is defined as the proportion of total costs that are related to, influenced by, or vary with the local labor market. A cost category is defined as labor-related if both the costs of the service are labor-intensive *and* those costs vary with the local labor market. That is, the labor-related share must only include the proportion of costs that are determined to vary with the local labor market. The apportionment of some of the costs associated with various nonmedical professional fees and home office expenses into nonlabor-related categories reflects the findings of our analyses that concluded portions of those costs are purchased (or paid for) beyond the organization's local labor market and thus, are not related to or influenced by the local labor market.

Comment: One commenter expressed concerns regarding the drop in the labor-related share from around 75

percent to 70 percent. The commenter asked CMS to articulate the driving factors contributing to the drop in the estimated labor-related share and consider the appropriateness of those factors.

Response: Of the decrease in the labor-related share from about 75 percent to 70 percent, over 3-quarters of that decrease is the result of the decrease in the compensation cost weight. As displayed in Table 4, the 2008-based RPL market basket compensation cost weight is 62.278 percent while the 2002-based RPL market basket compensation cost weight is 65.877 percent, a decrease of about 3.6 percentage points. The compensation cost weights for both the 2002-based and the 2008-based RPL market baskets were calculated using the Medicare cost reports for freestanding IRFs, IPFs, and LTCHS. We found during our most-recent rebasing process that the compensation cost weight had begun gradually decreasing over the 2003 to 2008 time period. The new labor-related share reflects the most recently available and complete set of Medicare cost reports, and thus reflects the updated and appropriate proportion of costs that are related to, influenced by, or vary with the local labor market for IRFs, IPFs, and LTCHs.

The remaining difference between the 2002-based and the 2008-based labor-related shares is primarily attributable to the classification of costs as labor-related and nonlabor-related using an empirically based apportionment of professional fees and home office costs. We believe the data and methods used to derive this apportionment were technically appropriate and result in a more accurate updated labor-related share.

Comment: One commenter pointed out that Table 9 in the FY 2012 IRF Proposed Rule showed a reduction in the labor-related share of 4.937 percent. The commenter attributed this change to the change in the methodology for how CMS classified professional fees and home office costs. The commenter noted that CMS only counted 19 percent of costs for professional fees and home office costs as labor-related and subject to the area wage index adjustment. The commenter noted their support for the use of new data to ensure the IRF PPS accurately reimburses IRFs for the services they provide, but expressed concern that the survey upon which CMS based its decision to make a change to the labor-related share was conducted with acute care hospitals paid under the IPPS. The commenter expressed concern that the results of the professional fees survey may not accurately reflect the percentage of nonmedical professional services provided by entities outside the local labor market utilized by IRFs. The commenter requested in the future that CMS conduct a study of nonmedical professional services using only IRFs, IPFs, and LTCHs.

Response: The overall proposed labor-related share as shown in Table 9 of the FY 2012 IRF proposed rule (76 FR 24243) showed a decline of 4.937 percent. The commenter attributed the entire change in the labor-related share from the 2002-based RPL market basket to the 2008-based market basket to our change in the professional fees and home office cost labor-related designations. We disagree that this is the principal driver for the decline in the labor-related share. The majority of the decline is based on a decline in relative compensation costs from 2002 to 2008 as reported on the Medicare cost reports. In particular, this accounts for over 3-quarters of the difference in the labor-related share. The remaining decrease in the labor-related share is primarily the result of the treatment of professional fees as labor-related or nonlabor-related. Finally, we did not use 19 percent as the value to determine the professional fees that were purchased within the local labor market. That is the percentage of home office costs that was determined to be purchased within the local labor market. For estimates associated with the apportionment of professional fees, we refer the reader to the discussion of the use of the survey results and how they were applied to determine the labor-related portions. This discussion can be found in the FY 2012 IRF PPS proposed rule at (76 FR at 24241 through 24242). We note that while this survey was conducted using responses from IPPS hospitals, we would expect 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.

Comment: Several commenters recommended that CMS phase-in the change to the labor-related share over a 2 year period to allow IRFs a longer period of time to absorb the impact of this reduction to the labor-related share.

Response: We do not believe that a phase-in of the labor-related share is necessary. We estimate that only 3 IRFs would lose more than 5 percent in payments from this change, with the maximum estimated loss being 7.85 percent. While significant, this is similar to percentage changes in payments due to annual wage index fluctuations, and we do not typically provide phase-ins for the standard wage index fluctuations that occur from year to year.

Final Decision: After consideration of the public comments received, we are finalizing our methodology for calculating the labor-related share for FY 2012 using the 2008-based RPL market basket and the most recent forecast data available at the time of this final rule which is IHS Global Insight Inc.'s second quarter 2011 forecast. This is also the same forecast we are using to derive the FY 2012 market basket update for this final rule. As the updated labor-related share reflects the current proportion of costs that are related to, are influenced by, or vary with the local labor market, we believe it is appropriate to incorporate the results in full into the FY 2012 payment update. Table 9 shows the relative importance of the FY 2012 labor-related share using the FY 2008-based RPL market basket and the FY 2011 relative importance labor-related share using the FY 2002-based RPL market basket.

B. 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 will 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 on which to base the calculation for the FY 2012 IRF PPS wage index.

Additionally, we will 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 final rule, we multiply the unadjusted Federal payment rate for IRFs by the FY 2012 labor-related share based on the FY 2008-based RPL market basket (70.199 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 final 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 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 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 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 FY 2012 budget neutral wage adjustment factor of 0.9988 percent.

Step 4. Apply the 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 FY 2012 standard payment conversion factor.

We received 2 comments on the proposed FY 2012 IRF PPS wage index, which are summarized below.

Comment: Several commenters recommended that CMS develop a new methodology for area wage adjustment that eventually eliminates hospital wage index reclassifications for all hospitals and that reduces the problems associated with unreasonable annual fluctuations in wage indices and across geographic boundaries. These commenters also recommended that CMS consider wage index policies under the current IPPS because IRFs compete in a similar labor pool as acute care hospitals. The IPPS wage index policies would allow IRFs to benefit from the IPPS reclassification and/or floor policies. The commenters further recommended that until a new wage index system is implemented, CMS institute a ''smoothing'' variable to the current process to reduce the fluctuations IRFs annually experience.

Response: We note that the IRF PPS does not account for geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act, and does not apply the ''rural floor'' under section 4410 of the BBA. As we do not have an IRF-specific wage index, we are unable to determine at this time the degree, if any, to which a geographic reclassification adjustment or a ''rural floor'' policy under the IRF PPS is appropriate. The rationale for our current wage index policies is fully described in the FY 2006 final rule (70 FR 47880, 47926 through 47928).

Although some commenters recommended that we adopt the IPPS wage index policies such as reclassification and floor policies, we note that Medicare Payment Advisory Commission (MedPAC's) June 2007 report to the Congress, titled ''Report to Congress: Promoting Greater Efficiency in Medicare,'' recommends that Congress ''repeal the existing hospital wage index statute, including reclassification and exceptions, and give the Secretary authority to establish new wage index systems.'' We believe that adopting the IPPS wage index policies, such as reclassification or floor, would not be prudent at this time because MedPAC suggests that the reclassification and exception policies in the IPPS wage index alters the wage index values for one-third of IPPS hospitals.

As one commenter noted, we have research currently under way to examine alternatives to the wage index methodology, including the issues the commenters mentioned about ensuring that the wage index minimizes fluctuations, matches the costs of labor in the market, and provides for a single wage index policy. Section 3137(b) of the Affordable Care Act requires CMS to submit a report to Congress by December 31, 2011 that includes a plan to reform the hospital wage index system. That report is to take MedPAC's 2009 recommendations on the Medicare wage index classification system into account, and is to include a proposal to revise the IPPS wage index system. MedPAC's recommendations were presented in the FY 2009 IPPS final rule (*http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf*). The proposal is to consider each of the following:

- The use of Bureau of Labor Statistics data or other data or methodologies to calculate relative wages for each geographic areas.
- Minimizing variations in wage index adjustments between and within MSAs and statewide rural areas.
- Methods to minimize the volatility of wage index adjustments while maintaining the principle of budget neutrality.
- The effect that the implementation of the proposal would have on health care providers in each region of the country.
- Issues relating to occupational mix, such as staffing practices and any evidence on quality of care and patient safety, including any recommendations for alternative calculations to the occupational mix.
- The provision of a transition period.

CMS enlisted the help of Acumen, LLC to assist us in meeting the requirements of section 106(b)(2) of the Tax Relief and Health Care Act of 2006 (Pub. L. 109–432, enacted on December 2006) (TRCA). In February 2008, we awarded a Task Order under the Expedited Research and Demonstration Contract to Acumen, LLC. Acumen, LLC conducted a study of both the current methodology used to construct the Medicare wage index and the recommendations reported to Congress

by MedPAC. Parts 1 and 2 of Acumen's final report, which analyzes the strengths and weaknesses of the data sources used to construct the CMS and MedPAC indexes, is available online at *http://www.acumenllc.com/reports/cms.*

MedPAC's recommendations were presented in the FY 2009 IPPS final rule (*http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf*). We plan to monitor the efforts to develop an alternative wage index system for the IPPS closely, and determine the impact or influence they may have to the IRF PPS wage index.

Final Decision: Having considered the public comments received, we have decided to continue to use the policies and methodologies described in the FY 2009 IRF PPS final rule relating to the labor market area definitions and the wage index methodology for areas without wage data. Therefore, this final rule continues to use the Core-Based Statistical Area (CBSA) labor market area definitions and the pre-reclassification and pre-floor hospital wage index data based on 2007 cost report data. However, we will continue to monitor progress on the revisions to the IPPS wage index to identify any policy changes that may be appropriate for IRFs.

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

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

To calculate the standard payment conversion factor for FY 2012, as illustrated in Table 10, we begin by applying the adjusted market basket increase factor for FY 2012 that was adjusted in accordance with sections 1886(j)(3)(C) and (D) of the Act (1.8 percent, or 2.9 percent less a cumulative total adjustment of 1.1 percentage points, as described in section VI.A.3. of this final rule), to the standard payment conversion factor for FY 2011 ($13,860). Applying the 1.8 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 $14,109. Then, we apply the budget neutrality factor for the FY 2012 wage index and labor-related share of 0.9988, which results in a standard payment amount of $14,093. Finally, we apply the budget neutrality factor for the revised CMG relative weights of 0.9988, which results in a final standard payment conversion factor of $14,076 for FY 2012.

TABLE 10—CALCULATIONS TO DETERMINE THE 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 (1.8 percent), which reflects a 2.9 percent market basket increase, reduced by a 1.0 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	×1.018
Budget Neutrality Factor for the Wage Index and Labor-Related Share	×0.9988
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	×0.9988
FY 2012 Standard Payment Conversion Factor	=$14,076

After the application of the CMG relative weights described in section IV of this final rule, to the FY 2012 standard payment conversion factor ($14,076), the resulting unadjusted IRF prospective payment rates for FY 2012 are shown in Table 11, ''FY 2012 Payment Rates.''

TABLE 11—FY 2012 PAYMENT RATES

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
0101	$10,804.74	$10,109.38	$9,080.43	$8,589.18
0102	13,410.21	12,545.94	11,270.65	10,659.75
0103	16,014.27	14,982.49	13,459.47	12,728.93
0104	16,636.42	15,565.24	13,983.10	13,224.40
0105	19,330.57	18,086.25	16,246.52	15,365.36
0106	22,261.19	20,826.85	18,708.41	17,694.94
0107	25,204.49	23,581.52	21,182.97	20,034.37
0108	31,217.75	29,206.29	26,236.26	24,814.58
0109	28,867.06	27,009.03	24,261.39	22,946.70
0110	37,208.50	34,811.36	31,271.24	29,576.49
0201	10,514.77	8,631.40	7,995.17	7,260.40
0202	14,938.86	12,263.01	11,359.33	10,313.49
0203	17,003.81	13,959.17	12,928.81	11,740.79
0204	17,813.18	14,622.15	13,543.93	12,298.20
0205	22,496.26	18,467.71	17,105.16	15,532.87
0206	28,004.20	22,988.92	21,294.17	19,334.79
0207	37,868.66	31,086.85	28,793.87	26,144.76
0301	14,886.78	13,391.91	11,881.55	10,880.75
0302	18,851.99	16,958.76	15,045.84	13,779.00
0303	22,414.62	20,163.87	17,889.19	16,384.46
0304	31,034.76	27,918.34	24,768.13	22,684.88
0401	14,903.67	12,407.99	11,287.54	9,903.87
0402	19,427.70	16,174.73	14,713.64	12,909.10
0403	34,710.01	28,896.62	26,286.93	23,064.93
0404	61,648.66	51,322.50	46,688.68	40,963.98
0405	54,454.41	45,333.17	41,239.86	36,183.77
0501	9,232.45	8,863.66	7,905.08	7,005.63

TABLE 11—FY 2012 PAYMENT RATES—Continued

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
0502	13,815.59	13,263.81	11,829.47	10,483.80
0503	17,538.70	16,837.71	15,016.28	13,308.86
0504	21,146.37	20,301.81	18,105.96	16,046.64
0505	24,714.64	23,726.51	21,160.45	18,754.86
0506	34,636.81	33,253.14	29,656.72	26,284.11
0601	13,311.67	11,249.54	10,260.00	9,274.68
0602	17,617.52	14,888.19	13,580.52	12,275.68
0603	22,752.45	19,227.82	17,538.70	15,853.80
0604	30,167.68	25,494.45	23,254.96	21,021.10
0701	11,262.21	11,087.67	10,678.05	9,532.27
0702	14,737.57	14,508.13	13,973.25	12,472.74
0703	17,734.35	17,457.06	16,813.78	15,007.83
0704	22,919.95	22,562.42	21,731.94	19,396.73
0801	8,086.66	8,086.66	7,536.29	6,880.35
0802	10,873.71	10,873.71	10,133.31	9,252.15
0803	14,992.35	14,992.35	13,971.84	12,755.67
0804	13,241.29	13,241.29	12,340.43	11,266.43
0805	16,305.64	16,305.64	15,195.04	13,873.31
0806	19,909.09	19,909.09	18,553.58	16,939.06
0901	1,918.15	10,500.70	9,502.71	8,608.88
0902	15,939.66	14,045.03	12,709.22	11,514.17
0903	20,414.42	17,987.72	16,277.49	14,747.43
0904	26,450.21	23,305.63	21,090.07	19,108.17
1001	14,547.55	12,790.86	11,428.30	10,213.55
1002	19,102.54	16,794.08	15,005.02	13,411.61
1003	28,222.38	24,813.17	22,169.70	19,814.79
1101	14,581.33	14,581.33	13,831.08	12,980.89
1102	21,938.85	21,938.85	20,808.55	19,530.45
1201	11,404.38	11,404.38	11,407.19	10,782.22
1202	14,869.89	14,869.89	14,872.70	14,057.70
1203	18,342.44	18,342.44	18,345.25	17,340.22
1301	12,579.72	13,673.43	13,673.43	11,094.70
1302	16,566.04	18,006.02	18,006.02	14,609.48
1303	1,411.00	23,271.85	23,271.85	18,882.95
1401	13,246.92	10,606.27	9,378.84	8,482.20
1402	17,789.25	14,242.10	12,593.80	11,390.30
1403	21,484.20	17,200.87	15,210.53	13,756.47
1404	27,828.25	22,279.49	19,702.18	17,818.81
1501	13,527.04	12,630.39	10,886.38	10,290.96
1502	17,023.51	15,896.03	13,701.58	12,951.33
1503	20,992.95	19,602.24	16,895.42	15,970.63
1504	26,519.18	24,762.50	21,343.44	20,175.13
1601	15,732.75	12,384.06	10,868.08	10,158.65
1602	21,074.59	16,588.57	14,557.40	13,607.27
1603	27,234.24	21,437.75	18,812.57	17,585.15
1701	14,689.71	13,075.20	11,866.07	10,372.60
1702	19,384.06	17,251.55	15,656.73	13,686.09
1703	22,859.42	20,345.45	18,463.49	16,140.95
1704	29,266.82	26,047.64	23,639.23	20,664.98
1801	16,913.72	13,876.12	13,396.13	12,253.16
1802	23,246.51	19,070.16	18,411.41	16,840.53
1803	39,854.79	32,695.73	31,565.43	28,872.69
1901	16,184.58	14,257.58	12,934.44	12,560.01
1902	30,830.66	27,161.05	24,638.63	23,927.79
1903	51,689.89	45,537.27	41,310.24	40,118.01
2001	12,022.31	10,623.16	9,523.82	8,556.80
2002	16,090.28	14,216.76	12,747.23	11,452.23
2003	20,318.71	17,953.94	16,097.31	14,461.68
2004	27,245.51	24,075.59	21,585.55	19,392.51
2101	35,405.36	30,644.86	24,404.97	19,781.00
5001				2,076.21
5101				8,242.91
5102				20,717.06
5103				9,810.97
5104				26,431.91

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

Table 12 illustrates the methodology for adjusting the Federal prospective payments (as described in sections VI.A. through VI.C. of this final rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified into CMG 0110 (without comorbidities). The unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) 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 1.0228), a wage index of 0.8391, and a rural adjustment of 18.4 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0666 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 Federal prospective payment, we begin by taking the unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) from Table 11. Then, we multiply the labor-related share for FY 2012 (70.199 percent) described in section VI.A.4 of this final rule by the unadjusted Federal prospective payment rate. To determine the non-labor portion of the Federal prospective payment rate, we subtract the labor portion of the Federal payment from the unadjusted Federal prospective payment.

To compute the wage-adjusted Federal prospective payment, we multiply the labor portion of the 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 wage-adjusted Federal payment by adding the wage-adjusted labor amount to the non-labor portion.

Adjusting the 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 IRF FY 2012 FEDERAL PROSPECTIVE PAYMENT

Steps		Rural facility A (Spencer Co., IN)	Urban facility B (Harrison Co., IN)
1	Unadjusted Federal Prospective Payment	$29,576.49	$29,576.49
2	Labor Share	× 0.70199	× 0.70199
3	Labor Portion of Federal Payment	= $20,762.40	= $20,762.40
4	CBSA Based Wage Index (shown in the Addendum, Tables 1 and 2)	× 0.8391	× 0.8896
5	Wage-Adjusted Amount	= $17,421.73	= $18,470.23
6	Nonlabor Amount	+ $8,814.09	+ $8,814.09
7	Wage-Adjusted Federal Payment	= $26,235.82	= $27,284.32
8	Rural Adjustment	× 1.184	× 1.000
9	Wage- and Rural-Adjusted Federal Payment	= $31,063.21	= $27,284.32
10	LIP Adjustment	× 1.0228	× 1.0666
11	FY 2012 Wage-, Rural-, and LIP-Adjusted Federal Prospective Payment Rate	= $31,771.45	= $29,101.46
12	FY 2012 Wage- and Rural-Adjusted Federal Prospective Payment	$31,063.21	$27,284.32
13	Teaching Status Adjustment	× 0.0000	× 0.0610
14	Teaching Status Adjustment Amount	= $0.00	= $1,664.34
15	FY2012 Wage-, Rural-, and LIP-Adjusted Federal Prospective Payment Rate	+ $31,771.45	+ $29,101.46
16	Total FY 2012 Adjusted Federal Prospective Payment	= $31,771.45	= $30,765.80

Thus, the adjusted payment for Facility A would be $31,771.45 and the adjusted payment for Facility B would be $30,765.80.

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

A. 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 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 the most recent FY 2010 IRF claims data, the IRF outlier payments as a percentage of total estimated payments were approximately 2.6 percent in FY 2011.

We received 3 comments on the update to the outlier threshold amount for FY 2012, which are summarized below:

Comment: One commenter expressed support for continuing to establish outlier payments at 3 percent of total payments. However, several commenters requested more information on why the proposed outlier threshold increased from $11,410 in FY 2011 to $11,822 in the FY 2012 proposed rule when only 2.7 percent of the 3 percent outlier payments were projected to be paid out in FY 2011.

Response: We proposed to move to an un-weighted regression methodology in the FY 2012 proposed rule, which caused a reduction to the LIP and Teaching adjustment factors. Our facility-level adjustment factors are budget neutral, meaning that any reduction in the adjustment factors results in an increase to the standard payment conversion factor. Therefore, the standard payment conversion factor was estimated to increase from $13,860 in FY 2011 to $14,528 in the FY 2012 proposed rule (this has changed to $14,076 in this final rule, as discussed below). The large increase in the proposed standard payment conversion factor resulted in an increase to the outlier threshold, rather than the decrease anticipated by the commenters.

However, as we are not adopting the proposed revisions to the facility-level adjustments in this final rule, the increase in the standard payment conversion factor from FY 2011 to FY 2012 is smaller. The final standard payment conversion factor for FY 2012 is $14,076. Consequently, the FY 2012 outlier threshold that we are finalizing in this final rule is lower than the FY 2011 outlier threshold amount.

Comment: One commenter stated that the calculation of the CCRs in other settings has been identified as a potential reason for those settings' difficulties in establishing an appropriate outlier threshold, which may also be the case for the IRF PPS. The commenter suggested that CMS assess whether this is a problem for the IRF PPS and release more information on the role that the CCRs play in establishing the outlier threshold.

Response: We appreciate the commenter's concerns. However, we do not believe that the calculation of the CCRs creates a problem in setting the outlier threshold for the IRF PPS. In order to set the outlier threshold, we first estimate the cost of a case in the current fiscal year by multiplying an overall facility-specific cost-to-charge ratio by charges and by the market basket for the current fiscal year (without any adjustments). The outlier threshold for the upcoming fiscal year is then calculated by simulating aggregate payments with and without a change in the outlier threshold, and applying an iterative process that accounts for changes in the market basket, wage index and labor-share, CMG relative weights, and facility-level adjustment factors, to determine a threshold for the upcoming fiscal year that would result in outlier payments being equal to 3 percent of total payments under the simulation.

We note, too, that we implemented a new outlier reconciliation process for IRFs (and other settings) beginning April 1, 2011 that we believe will improve the accuracy and reliability of the IRF CCRs. For more information on the new outlier reconciliation process, please view the ''Outlier Reconciliation'' link on the IRF PPS Web site at (*http://www.cms.gov/InpatientRehabFacPPS/03_OutlierR.asp#TopOfPage*).

Comment: One commenter suggested that CMS evaluate the distribution of outlier payments. If CMS determines that low-volume facilities, rather than facilities treating patients of a higher acuity level, are mostly receiving the outlier payments then CMS should reduce the outlier pool and add the amount back to the standard payment conversion factor.

Response: We will continue to monitor our IRF outlier policies to ensure that they appropriately compensate IRFs for treating unusually high-cost patients and, thereby, promote access to care of patients who are likely to require unusually high-cost care. At this time, however, we do not find any indications to suggest that low-volume facilities are disproportionately receiving outlier payments. We believe that the outlier policy of 3 percent of total estimated payments optimizes the extent to which we can encourage facilities to continue to take patients that are likely to have unusually high costs, while still providing adequate payment for all other cases. In addition, as we have explained before, we do not make adjustments to PPS payment rates to account for differences between projected and actual outlier payments in a previous year. We believe that our outlier policies are consistent with the statute and the goals of the prospective payment system, and that they are equitable. We will carefully consider the commenter's suggestions, and will consider proposing additional refinements to the IRF outlier policies in the future if we find that such refinements are necessary.

Final Decision: After carefully considering all of the comments we received on the proposed update to the outlier threshold amount for FY 2012, we are reducing the outlier threshold amount to $10,660 to maintain estimated outlier payments at 3 percent of total estimated aggregate IRF payments for FY 2012.

B. 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 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, the national average CCR for rural IRFs is 0.669, which we calculated by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, the national average CCR for urban IRFs is 0.520, which we calculated 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 final rule, we 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 accordance with past practice, we 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 calculate 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. Calculating 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 did not receive any comments on the proposed updates to the IRF CCR Ceilings.

Final Decision: We did not receive any comments on the IRF cost-to-charge ratio ceiling. Therefore, we are finalizing the national average urban CCR at 0.520, the national average rural CCR at 0.669, and the national CCR ceiling at 1.55 percent for FY 2012.

VIII. 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 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, we match 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). We 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.

We received 2 comments on our stated policy to use the same data matching process as IPPS for calculating the SSI fractions for FYs 2011 and beyond, which are summarized below.

Comment: The commenters supported our use of the same data matching process for IRFs that we use for IPPS. However, one commenter asked whether CMS plans to use the new data matching process for calculating the IRF SSI ratios for any cost reporting periods prior to FY 2011. Specifically, the commenter requested information on whether or not CMS plans to apply the new data matching process to any existing appeals of the IRF SSI ratios, regardless of the cost reporting period.

Response: As we discussed in the FY 2012 IRF PPS proposed rule (76 FR 24214 at 24249 through 24250), in keeping with our long-standing policy of using the same DSH patient percentage used in the acute IPPS DSH adjustment, we will use the same matching process as IPPS for calculating the IRF SSI ratios for FYs 2011 and beyond. The comment about the data matching process for existing appeals of the SSI ratio for cost reporting periods prior to FY 2011 is outside the scope of the FY 2012 IRF PPS proposed rule. We will continue our ongoing analysis to determine the most appropriate methodologies to use in addressing open appeals, in both the IPPS and the IRF settings.

IX. 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.

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 separation of the regulatory sections resulted in unnecessary repetition and confusion about which regulations applied 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)5 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 Medicare rules and requirements for IRFs did 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 final rule we 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). The modifications will eliminate regulations that are no longer necessary under the IRF PPS, and they will enable IRFs to more easily adjust to beneficiary changes in demand for IRF services, which will improve beneficiary access to these services. Many of the modifications will 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 are no longer necessary. As 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 potential savings that may result from these changes. For example, each time an IRF unit submitted a request to add beds to its facility under the prior regulations; the Medicare contractor had to determine whether or not the added IRF beds would be considered ''new.'' To be considered ''new,'' the beds must have been 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) was difficult, and potentially costly, for IRFs that were 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 regulations required Medicare contractors to expend unnecessary resources determining whether the IRF met the second criteria, which required 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 modifications to the regulations in this final rule 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 modifications will 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 revisions to § 412.25(b) will also affect IPFs in similar ways.

A. 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 are revising and consolidating 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 contains the requirements for all IRFs, whether they be freestanding rehabilitation hospitals or rehabilitation units of acute care hospitals (or CAHs). We believe that this will simplify the regulations by consolidating the majority of the requirements for IRFs into just one sub-section of 42 CFR part 412.

Although we are making slight modifications to the regulations in § 412.25(b), as discussed in section IX of this final rule, we are not moving the IRF regulations in § 412.25 to § 412.29 in this final 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. While 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 making modifications to § 412.25, other than the changes to § 412.25(b) as discussed in section IX of this final 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 are replacing the text that was located at § 412.23(b) with text that simply refers the reader to the requirements in § 412.29, and moving the rest of § 412.23(b) and all of § 412.30 to § 412.29. We are leaving 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 are moving 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. Revisions to the Regulations at Proposed § 412.29

As described in section IX.A. of this final rule, we are replacing the text that was located at § 412.23(b) with text that simply refers the reader to the requirements in § 412.29, and moving 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 making revisions to the language from all three of the prior sections, § 412.23(b), § 412.29, and § 412.30. As stated in the prior § 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 revising 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 requirements will now apply equally to both rehabilitation hospitals and rehabilitation units of acute care hospitals (or CAHs), and will be located in § 412.29(c)(1). We believe that 5 calendar years will 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 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, IRFs in these situations will retain their excluded status and will 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 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) will 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, the new owner(s) will not be required to wait for 5 calendar years to reapply to operate a new IRF, but will be required to complete the initial hospital or critical access hospital certification process to participate in Medicare as a new IRF.

Further, we revise the regulations regarding new IRF beds. The regulations formerly in § 412.30(d), which required 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 eliminate these requirements and, instead, state 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. 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 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 requirement is to prevent IRFs from decreasing and increasing bed size every year to avoid having to meet certain requirements. We 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. 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 relaxing the restrictions on a facility's ability to increase its bed size and square footage. Under the revised requirements we are adopting in this final rule in § 412.25(b), an IRF or IPF can 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 at least 30 days before the date of the proposed change, and maintains the information needed to accurately determine costs that are attributable to the excluded units. As we have in prior years, we also include an exception to these requirements for special circumstances. We note that any IRF beds that are added to an existing IRF during the IRF's cost reporting period will only be considered new through the end of that cost reporting period. Further, the new IRF beds will 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. 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), we 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 revisions to § 412.23(b) and § 412.29, we 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 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 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.

We received 12 comments on the proposed updates to the policies in 42 CFR part 412, which are summarized below.

Comment: Several commenters requested that CMS not make the proposed changes to the regulation text in 42 CFR 412.29(d) and (e). Although one commenter agreed with the proposed changes to the regulation text to align portions of the IRF coverage requirements with the corresponding portions of the IRF classification requirements, the rest of the commenters on these provisions expressed concerns. The concerns expressed were primarily that the proposed changes could blur the distinctions between the IRF coverage and the IRF classification requirements, and could potentially lead to inappropriate revocations of an IRF's classification for payment under the IRF PPS based on only a single claim denial (or a small number of claims denials). The commenters suggested that CMS restate its previous position that the failure of an IRF to meet the IRF coverage requirements for one individual case should not be used to declassify an IRF for payment under the IRF PPS. Some of these commenters also asked for further explanation of how these proposed changes would reduce costs for IRFs and for the government.

Response: We agree with the commenters that, as we have stated previously, failure to meet the IRF coverage requirements in one individual case should not be used to decertify an entire facility for payment under the IRF PPS. However, the intent of the proposed revisions is to make the 2 sets of requirements consistent with each other to eliminate any potential for confusion or ambiguity. We believe that we would be remiss in not making it clear that, in the IRF context, we require the preadmission screening documentation to be reviewed and approved by a rehabilitation physician prior to the IRF admission. Under the IRF coverage requirements, this is required for all IRF admissions, so it also must be built into the preadmission screening procedures that all IRFs must have in place. Similarly, we believe that we would be remiss in not clarifying that, in the IRF context, we define close medical supervision to mean at least 3 face-to-face visits per week by a rehabilitation physician to assess the patient both medically and functionally. We established this definition for the IRF coverage requirements in the FY 2010 IRF PPS final rule (74 FR 39762 at 39795 through 39796), and we simply proposed to clarify in § 412.29(e) that the term means the same thing in the IRF classification requirements that it means in the IRF coverage requirements.

Reinforcing the identical concepts (and, in most cases, the identical wording) from the IRF coverage criteria to the IRF classification criteria can only serve to clarify exactly what we mean, so that there is no confusion or ambiguity. In our opinion, this aligns with our stated goals in the FY 2012 IRF PPS proposed rule (76 FR 24214 at 24250) of updating and simplifying the policies, eliminating unnecessary repetition and confusion, and enhancing the consistency between the IRF classification and the IRF coverage requirements. This particular change does not reduce costs for IRFs or for the government, but does promote clarity and consistency among Medicare's regulations.

As we do not intend for an IRF to be declassified for the purposes of receiving payment under the IRF PPS based on a small number of IRF claims denials, we agree with some of the commenters who suggested revisions to the language to focus the requirements on whether the IRFs have the correct processes in place to meet the requirements, rather than on whether the IRFs meet the requirements in each individual case. We agree that failure to meet the IRF coverage requirements in one individual case is not a reason to declassify an entire IRF from receiving payment under the IRF PPS. Thus, we are adopting slight revisions to the regulation text, suggested by commenters, that we believe will clarify that an IRF cannot be declassified as an IRF for failing to meet the coverage criteria in just one or two cases. The revised regulation text is included in the ''Regulation Text'' section of this final rule.

Even though we believe that an IRF should not lose its IRF classification because one individual case (or even a small number of cases) fails to meet the IRF coverage requirements, we note that we do believe that it is reasonable to conclude that an IRF's preadmission screening procedure is not adequate if a large percentage of the IRF's claims are denied because the preadmission screening information was not reviewed and approved by a rehabilitation physician prior to the IRF admission. Similarly, we believe that it is reasonable to conclude that an IRF's procedure for ensuring that patients receive close medical supervision is not adequate if a large proportion of the IRF's claims are denied because the patients were not seen and assessed by a rehabilitation physician at least 3 times per week.

Comment: Several commenters requested that CMS change the regulations to treat the acquisition of an IRF unit the same as the acquisition of a freestanding IRF hospital.

Response: We appreciate the commenters' suggestion and will carefully consider this for the future. However, we believe that this suggestion is outside the scope of the FY 2012 IRF PPS proposed rule (76 FR 24214) because it involves the issue of whether an entity can purchase a hospital's payment status under Medicare. While an entity can purchase physical assets, Medicare payment status is assigned to a particular provider based on a review of the provider's eligibility for payment under a particular Medicare payment system. We do not believe that a facility's Medicare payment status or its provider agreement can be bought, sold, or transferred. If a different hospital other than the one to which the Medicare payment status was assigned wants to obtain the same Medicare payment status, it must apply and demonstrate that it meets the requirements for payment under the particular Medicare payment system.

Comment: While several commenters supported the proposed regulations regarding ''new'' IRFs, changes of ownership, and mergers, some of these commenters requested that CMS specify that certain ''internal corporate restructuring transactions'' not involving external entities are not

changes of ownership. For example, these commenters said that they do not believe that the purchase of a hospital by another hospital, where both hospitals are owned by the same corporate entity, should be treated as a change of ownership for Medicare purposes.

Response: We believe that this suggestion is outside the scope of the FY 2012 IRF PPS proposed rule (76 FR 24214) because it involves how Medicare defines a hospital. For Medicare purposes, hospitals are separate entities if they have separate Medicare provider agreements, regardless of whether they might both be owned by the same corporate entity. If one hospital with a Medicare provider agreement purchases another hospital with a Medicare provider agreement, regardless of whether the hospitals are owned by the same corporate entity or not, Medicare would consider this a change of ownership, which would be governed by the new regulations in 42 CFR 412.29(c)(3) discussed in the ''Regulation Text'' section of this final rule. Similarly, if hospitals with separate Medicare provider agreements merge their operations, regardless of whether they are owned by the same corporate entity or not, then the new regulations regarding mergers in 42 CFR 412.29(c)(4) discussed in the ''Regulation Text'' section of this final rule would apply.

Comment: Several commenters agreed with the proposed changes to § 412.25(b) to allow expansions of bed size or square footage at any time during a cost reporting period. However, some commenters suggested that CMS should allow new IRF units or new IPF units to open and begin being paid under their respective IRF PPS or IPF PPS at any time during a cost reporting period, rather than requiring that they could only begin being paid under the IRF PPS or the IPF PPS at the start of a cost reporting period.

Response: We appreciate the commenters' suggestion that we relax the requirement that IRF and IPF units can only begin being paid under their respective IRF PPS or IPF PPS at the start of a cost reporting period. However, we believe that this suggestion is outside the scope of the FY 2012 IRF PPS proposed rule (76 FR 24214) because we did not propose any changes to the regulations in § 412.25(c). However, we will consider this suggestion for possible inclusion in future rulemaking.

Final Decision: After carefully considering all of the comments we received on the proposed updates to the policies in 42 CFR part 412, we are finalizing the regulation text changes as proposed, except for the following revisions in response to comment:

- Instead of the proposed revision to § 412.29(d), the paragraph will instead read, ''(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. This procedure must ensure that the preadmission screening is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.''
- Instead of the proposed revision to § 412.29(e), the paragraph will instead read, ''(e) Have in effect a procedure to ensure that 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.'' The specific changes to the regulations at 42 CFR part 412 are shown in the ''Regulation Text'' of this final rule.

X. Quality Reporting Program for IRFs

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 Reporting (Hospital OQR) Program), and 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 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 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 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

As described below, we 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' broader goals of targeting high priority conditions and topics, as reflected in the National Quality Strategy released by the Secretary available at (*http://www.healthcare.gov/center/reports/quality03212011a.html#es*) and, ultimately, to 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 selecting 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 proposed for purposes of calculating the FY 2014 Increase Factor for IRFs 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. We 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) 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.'' We reviewed the NQF's consensus endorsed measures, and were unable to identify any NQF-endorsed measures for 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 proposed 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 proposed to adopt the measure under the exception authority provided in section 1886(j)(7)(D)(ii) of the Act, we noted that we intended to seek formal extension of the existing CAUTI measure to the IRF setting.[1]

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[2]. Healthcare-associated UTIs are commonly attributed to catheterization of the urinary tract.

CAUTI can lead to complications such 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 with UTIs[3]. Prevention of CAUTIs is discussed in the CDC/HICPAC document, *Guideline for Prevention of Catheter-associated Urinary Tract Infections*[4]. The NQF-endorsed CAUTI

[1] We inadvertently said in the FY 2012 IRF PPS proposed rule (76 FR 24214) that we (CMS) would ask NQF to formally extend its endorsement of the existing CAUTI measure to the IRF setting. We should have stated that we would ask CDC, as the measure steward, to ask NQF to formally extend its endorsement of the existing CAUTI measure to the IRF setting.

[2] 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.

[3] Ibid.

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

measure we proposed 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 HAIs located at (*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.

We received 23 public comments on the Urinary Catheter-Associated Urinary Tract Infections (CAUTI) quality measure, which are summarized below.

Comment: Several commenters generally acknowledged CAUTI as an important safety and quality issue across care settings. However, several commenters expressed concern with the applicability of this measure to the IRF setting. They stated that the relatively small number of new UTIs in IRFs may reflect that the indicator is not the best choice as a quality indicator in the IRF setting.

Response: Although patients with CAUTI in the IRF setting may be a minority, we believe that the CAUTI measure is an important indicator of quality in IRF settings and that promoting safe care in all settings is an important goal for quality reporting programs. Additionally, it is important to note that the HHS National Action Plan to Prevent HAIs located at *(http://www.hhs.gov/ash/initiatives/hai/actionplan/index.html)* indicated that catheter-associated urinary tract infections are a leading type of HAI that is largely preventable. Also, the technical expert panel that was convened by the CMS contractor that was tasked with assisting with the development of measures identified CAUTI as a high priority issue for IRFs.

Comment: One commenter specifically supported the adoption of CAUTI reporting in the IRF context through the National Healthcare Safety Network (NHSN). They noted that hospitals in their State, including IRFs, have been required by State law-based reporting requirements to use NHSN to report all health care-associated infections since February 2008. The commenter also stated that, based on the health care-associated infection data collected and analyzed in that State, urinary tract infection is the most prevalent type of infection reported in that State's IRFs.

Response: We appreciate the commenter's observation that UTIs are both the most prevalent and preventable form of infection in the IRF setting, and believe that CAUTI is an important quality measure to adopt for the IRF quality reporting program.

Comment: One commenter stated that CAUTI is a much less relevant marker of quality in IRFs with short lengths of stay, where catheters come out almost immediately. The commenter additionally stated that it is sometimes difficult to find supporting documentation of catheter use within transfer documents. The commenter also stated that lack of documentation could lead to additional testing of patients on admission, resulting in increased time burden and cost to IRFs.

Response: We acknowledge the challenges providers may initially encounter in finding supporting documentation in transfer documents of catheter use. However, we believe that implementation of this requirement will encourage better documentation of catheter use over time. The CDC provides educational and outreach materials to help promote communication of such information. Additionally, we believe such information may be provided by other sources, such as the patient. Finally, the specifications for the measure, which are available at *http://www.cdc.gov.nhsn/forms/instr/57_114.pdf,* do not require all patients to be tested on admission. We agree with this approach because clinical experts generally agree that identification of CAUTI rests upon a constellation of patient symptoms, as well as on the results of clinical and laboratory data. Quality care in IRFs requires close medical monitoring of all patients, and we believe that such monitoring will appropriately identify the subset of IRF patients who are most at risk for CAUTI and therefore should be tested.

Comment: Some commenters expressed concern that the CAUTI measure was originally created for use in the inpatient ICU setting and questioned the use of a measure that was not specifically endorsed for the IRF setting. In contrast, another commenter noted that, although the CAUTI measure was originally created for use in the inpatient ICU setting, its use is also well established in other inpatient settings. Moreover, they asserted that this measure is an appropriate measure for the IRF setting. The commenter also said that they were pleased to see that only indwelling catheters are included for this measure, versus ''straight in-and-out'' (intermittent) catheters which are frequently used by spinal cord injury patients who often require extensive IRF services.

Response: We acknowledge that the CAUTI measure, for which CDC is the measure steward, is currently endorsed by NQF for ICUs, and not specifically endorsed for the IRF setting. However, given the importance and preventability of CAUTIs in all settings including IRFs, we proposed to adopt an application of the 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 noted that we would seek NQF endorsement of the measure for application in the IRF setting.

Comment: One commenter urged CMS to refine the CAUTI measure for specific use in IRFs. Additionally this commenter cited the potential need for testing the measure in IRFs and agreed with several other commenters, who recommended delaying reporting CAUTI until CMS obtains NQF endorsement of this measure specifically for the IRF setting.

Response: CAUTI has been well tested in the ICU setting, and we see no reason why the IRF setting would produce different results since presence or absence of CAUTI is not dependent upon setting type, but rather clinical findings, signs, and symptoms.

As stated above, we proposed to adopt the measure under the exception authority provided in section 1886(j)(7)(D)(ii) of the Act, and we note that the quality measure steward, the CDC, is seeking NQF's expansion of its endorsement of the CAUTI measure to IRFs.

Comment: Several commenters expressed concern with potential erroneous attribution of infections that may have resulted from catheter use in a previous setting. However, one commenter expressed support for the CAUTI measure's ''transfer rule exception,'' defined as transfers within an inpatient facility or transfers to a new facility, which may alleviate some of the perceived issues with attribution.

Response: We thank the commenters for their remarks and we acknowledge their concerns. As the commenter noted, the CAUTI measure's ''transfer rule exception'' excludes patients with CAUTI present on admission (POA) or who develop CAUTI within 48 hours of transfer to the IRF setting. Such CAUTIs are attributed to the transferring

location, rather than the admitting location. We believe that this appropriately addresses the potential risk of erroneous attribution for transferred patients. Additional information on the ''Transfer Rule'' can be found at *http://www.cdc.gov/nhsn/PDFs/slides/CAUTI.pdf.*

Comment: Several commenters also expressed their concern with the lack of a ''present on admission'' (POA) indicator, and stated that the absence of a POA indicator may result in incorrect tallies. Additionally, one commenter recommended that CMS pursue development of a timeline and implementation plan for a POA indicator for CAUTI prior to finalizing the proposed IRF measures.

Response: We do not believe that the absence of a POA indicator will lead to erroneous tabulation of UTIs. The ''transfer rule'' that is discussed in the NHSN patient safety module clearly indicates that, ''If the UTI develops in a patient within 48 hours of discharge from a location, indicate the discharging location on the infection report, not the current location of the patient.'' We believe that this guidance allows IRFs to accurately tabulate the number of CAUTIs that develop in the IRF, even without a POA indicator for this measure. However, we will consider working with the CDC to determine whether the application of a claims-based POA indicator in addition to implementation of the ''transfer rule'' would be useful. If our work with the CDC finds that this would potentially be useful, we will consider this for future rulemaking.

Comment: One commenter recommended that health care-associated infection rates and standardized infection rates for IRFs be evaluated separately from any data reported by general acute care hospitals and long term care hospitals.

Response: We appreciate the commenter's concern that health care-associated infection rates and standardized infection rates for IRFs be evaluated separately from any data reported by general acute care hospitals and long term care hospitals. As the IRF quality reporting program is separate from these other quality reporting programs, we do plan to evaluate CAUTI data reported by IRFs separately from CAUTI data reported by hospitals and long term care hospitals.

Comment: Several commenters strongly urged CMS to share how it plans to perform HAI data validation since this was not addressed in the proposed rule.

Response: As we agree that data validation is important, we do plan to perform HAI data validation prior to the public reporting of any HAI data, and are actively working with the CDC regarding their data validation process. As part of this process, we are sharing the public comments that we received on this issue with the CDC. We will continue to work with the CDC to develop an HAI data validation strategy, and will address that aspect of the quality reporting program in future rulemaking.

Comment: Several commenters highlighted the need to risk adjust the CAUTI measure. They also stated that certain patients, such as those with spinal cord injury or neurogenic bladder, were at much higher risk of developing CAUTI than other lower risk patients. Furthermore, several commenters expressed concern that the lack of risk adjustment could possibly lead to unintended consequences such as reduced access to IRFs for higher risk patients. One commenter also recommended the adoption of the CDC definition of symptomatic UTI.

Response: We recognize that risk adjustment is an important consideration for outcome quality measures, and that certain patients may have higher risks for complications such as UTIs. The CAUTI measure specifications use facility type (including IRF) and location type information (including an identifier of whether the facility is a freestanding hospital or a unit of a hospital) for risk adjustment, and these data are captured in the NHSN reporting system. As we take the appropriate access to care in IRFs very seriously, we intend to monitor closely whether the quality reporting program has any unintended consequences on access to care for higher risk patients. Should we find any, we will take appropriate steps to address these issues in future rulemaking. Also, we agree with the commenter's suggestion that we adopt the CDC definition of symptomatic UTI, and are planning to adopt this definition in future rulemaking.

Final Decision: Having carefully considered the comments received, we adopt as final an application of the NQF-endorsed measure that was developed by the CDC for ICUs entitled (NQF #0138) ''Catheter-Associated Urinary Tract Infection [CAUTI] for Intensive Care Unit Patients'' for the IRF setting.

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

The second measure we proposed 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 #0678, formerly assigned as 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 to 4 pressure ulcers that are new or worsened, when assessed at the time of discharge as compared with the patient's condition at admission. We recognized that NQF endorsement of this measure is currently limited to short-stay nursing home patients in the proposed rule, but we noted our belief that this measure is also highly relevant to patients in any setting who are at risk of pressure ulcer development 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 were also unaware of any other measures of pressure ulcers that had been approved by voluntary consensus standards bodies. For these reasons, we proposed 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 stated that we 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.

We received 26 comments on the Percent of Patients with Pressure Ulcers that are New or Worsening quality measure, which are summarized below.

Comment: A few commenters expressed concerns about whether pressure ulcers are really relevant to the IRF setting, citing the small number of

IRF patients that develop a new or worsening pressure ulcer. They stated that more relevant measures were those focusing on the output of the rehabilitative process, such as change in function or discharge to community.

Response: We agree that functional restoration and return to community are also key aims for IRFs and central to patient-centered care. We plan to add such measures through future rulemaking, as the measures are further developed.

However, we believe that the percent of patients with new or worsening pressure ulcers is an important indicator of quality in the IRF setting. Even if the proportion of patients in IRFs with new or worsening pressure ulcers is small, any such cases are particularly troubling given the requirement that IRF patients receive an intensive rehabilitation therapy program throughout their IRF stay, which would tend to require patients to be out-of-bed and active throughout their stay.

Comment: Some commenters expressed concern over the ambiguity of the definition of ''worsening'' pressure ulcers and requested clarification of the definition. Some commenters cited the difficulty in accurately differentiating between worsening pressure ulcers and pressure ulcers that are changing as part of the healing process. Several commenters suggested that ''worsening'' be removed from the description and CMS base the quality measure solely on the appearance of ''new'' pressure ulcers. Some commenters questioned why unstageable pressure ulcers and suspected deep tissue injuries were not included in the measure.

Response: The new or worsening pressure ulcer measure is based on changes in skin integrity between the admission and discharge assessments. Pressure ulcer ''worsening'' is defined in the measure specifications as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1 through 4 (using the staging assessment determinations assigned to each stage; starting at the stage 1, and increasing in severity to stage 4) on the discharge assessment as compared to the admission assessment.

The National Pressure Ulcer Advisory Panel (NPUAP) has specific, well-established clinical criteria for determining the current stage of a wound (stages I through IV). These criteria, which are incorporated into the measure specifications, are used by clinicians in determining whether or not a wound has changed stages, and thereby worsened or improved. We believe that appropriate application of these guidelines should enable clinicians to identify pressure ulcers that have ''worsened''. Thus, we do not believe that the idea of ''worsening'' pressure ulcers should be removed from the measure.

Unstageable wounds, including deep tissue injuries, are not currently included in this measure since the presence of worsening cannot be determined if they are unstageable. Furthermore, a pressure ulcer that presents with slough or eschar cannot be staged, and is not considered worsened. Only after, and if, debridement occurs, whereby dead tissue is removed, can the wound be staged. If after wound debridement, the wound is evaluated to have increased in the stage, the wound is considered worsened.

If the patient was admitted with a deep tissue injury, and/or an unstageable pressure ulcer, the deep tissue injury and/or unstageable pressure ulcer would be documented as present on admission. As stated above, if after debridement the wound is evaluated to have increased in the stage, the wound is considered worsened but is considered to have been present on admission.

Although the presence of new pressure ulcers is an indicator of adverse quality in IRFs, we believe that the presence of worsening pressure ulcers is also an important aspect of the measure because worsening pressure ulcers can indicate a lack of both appropriate medical monitoring and appropriate clinical treatment. In addition, as noted previously, the existence of worsening pressure ulcers in the IRF setting is particularly troubling given the requirement that IRF patients receive an intensive rehabilitation therapy program throughout their IRF stay, which would tend to require patients to be out-of-bed and active throughout their stay. Thus, we believe that it is imperative to include both new and worsening pressure ulcers in the measure.

Comment: Several commenters expressed concern that the proposed measure does not adequately address the issue of pressure ulcers that are present on admission. These commenters recommended that CMS develop a timeline and implementation plan for a POA indicator for the pressure ulcer measure, with consideration of an appropriate attribution window to avoid IRFs being penalized for pressure ulcers that were present on admission or acquired from another facility prior to the IRF admission.

Response: The measure that we are adopting in this final rule is the Percent of Patients with Pressure Ulcers that are New or Worsening between the IRF admission assessment and the discharge assessment. The measure accounts for any relevant pressure ulcers that were present on admission because it requires IRFs to supply data on the number of stage 2, stage 3, and stage 4 pressure ulcers that were present on admission. In addition, the measure asks IRFs to report any pressure ulcers that were present on admission. Thus, we believe that the pressure ulcer measure that we are adopting in this final rule already contains sufficient present on admission information and will not lead to inappropriate attribution to an IRF of a pressure ulcer that developed in another inpatient setting.

Comment: One commenter suggested that CMS harmonize the IRF and the inpatient prospective payment system (IPPS) versions of the pressure ulcer measures so that both capture the same range of wound staging. While the IRF quality reporting program measure includes wound stages 2 though 4, the Hospital IQR Program measure only includes stages 3 through 4.

Response: We agree that harmonizing the measures is a good suggestion. This will take significant development work as the data elements, data sources, and measure specifications differ for the IRF and IPPS quality reporting programs. We will take the commenter's suggestions into consideration for future quality measurement development work, which will be considered for implementation through future rulemaking.

Comment: One commenter suggested that the Pressure Ulcer Scale for Healing Tool (PUSH) tool, which provides clinicians with a scale for assessing wound healing or deterioration, is more appropriate for recording wounds. Another commenter said that they do not recommend the PUSH tool, but recognized its superiority to the proposed measure in that it allows addressing of wound healing in a standardized manner. This commenter also stated that if measurement of pressure ulcers is a quality measure, that the measure used should incorporate the NPUAP guidelines regarding wound healing.

Response: We recognize that the PUSH tool is one of the instruments sometimes used by clinicians to assess healing or deterioration of pressure ulcers. However, CMS developed the New or Worsening Pressure Ulcer measure in consultation with our measure-developer contractor, which further consulted with NPUAP and

other nationally recognized subject matter experts. Based on the input we received from these experts, we believe that the pressure ulcer measure that we are requiring IRFs to report beginning October 1, 2012 most appropriately captures this aspect of care provided in IRFs. In response to the commenter that suggested that any measure of pressure ulcers that is used in the IRF setting should be incorporate the NPUAP guidelines regarding wound staging, we note that the ''New or Worsening Pressure Ulcer'' measure that we are adopting in this final rule does incorporate the NPUAP guidelines regarding wound staging.

Comment: Several commenters objected to the proposed application of a pressure ulcer measure that has been NQF-endorsed for short-stay residents in nursing homes but has not specifically been endorsed for the IRF setting.

Response: We are using the authority to adopt non-NQF endorsed measures in cases where there is not an NQF-endorsed measure for a particular area or topic. We do not believe that there are substantive issues that would make it inappropriate to apply the pressure ulcer measure that has been NQF-endorsed for short-stay nursing home residents to IRFs.

Comment: One commenter suggested that CMS include stage 1 wounds in the pressure ulcer measure. They stated that, if stage 1 wounds are not adequately treated, they will progress to more serious wounds.

Response: We agree with the commenter about the importance of clinicians recognizing the presence of stage 1 wounds and adequately treating them so that they do not progress to more serious wounds. However, based on the CMS contractor's extensive analysis of the issue, in consultation with national subject matter experts, we believe that the additional burden on providers of collecting and reporting information on stage 1 pressure ulcers outweighs the benefits of requiring such reporting. Thus, in an effort to minimize the reporting burden on providers, we have decided not to require reporting on stage 1 pressure ulcers.

Comment: Some commenters stated that patients treated in IRFs have a higher level of medical complexity and receive more intense services than nursing home patients, highlighting the need for CMS to risk adjust the pressure ulcer measure.

Response: We agree that some patients are at higher risk for pressure ulcers than others. The pressure ulcer measure (NQF #0678, formerly assigned as NQF #NH–012–10) that we are adopting for the IRF setting already includes a risk adjustment component. For example, the measure accounts for the higher risk of pressure ulcers among patients with low body mass index (BMI), diabetes, Peripheral Vascular Disease, bowel incontinence, and immobility. These clinical factors are known to increase the risk of pressure ulcer development for patients regardless of their setting of care.

Comment: Several commenters expressed support of CMS' adoption of the NPUAP stance that measurement of pressure ulcers not be based on ''reverse staging''.

Response: We appreciate the commenters for their supportive comments and agree that it is not appropriate to ''reverse-stage'' pressure ulcers because staging only refers to the level of tissue damage. So, for example, a stage 3 pressure ulcer with full thickness tissue loss will always have that amount of damage present. If that pressure ulcer should heal and resurface with a new epithelial layer and later reopen, it is still a stage 3 pressure ulcer, even if it appears to meet the criteria for a stage 2 pressure ulcer.

Final Decision: Having carefully considered the comments, we adopt as final an application of the CMS-developed NQF-endorsed measure for short-stay nursing home patients (NQF #0678, formerly assigned as NQF #NH–012–10) for the IRF setting.

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

In the proposed rule, we stated our intent to propose a 30-day comprehensive all-cause risk-standardized readmission measure when one is developed. Addressing avoidable hospital readmissions is 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 existing literature and solicit input from national experts and conduct analyses on the types and comorbidities of the patients of each setting in order to establish appropriate risk-adjustment for the measures as well as appropriate specification of 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. The IRF readmission 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 received 19 comments on our intent to propose a 30-day Comprehensive All-Cause Risk-Standardized Readmission Measure for IRFs, which are summarized below.

Comment: Several commenters stated that risk adjustment will be an important consideration as CMS develops this readmission measure. Several commenters suggested that only preventable readmissions should be measured, and that planned readmissions should be excluded. Several commenters also stated that the causes of readmissions are complex and that there are no solutions that could be applied globally to reduce readmissions.

Response: We appreciate the input. As indicated, the measure will be risk-standardized. We will take these comments into consideration as we further develop the measure. As part of development, the measure developer will provide an opportunity to the public to comment on specific aspects of the measure, including risk adjustment. Although we agree that the factors that are related to readmission are varied, readmission rates among Medicare beneficiaries are high, and we believe that they can be significantly improved through improved quality.

C. Data Submission Requirements

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

In the proposed rule, we proposed to require that IRFs submit data on the 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 also proposed to require submission of the data elements needed to calculate the Catheter-Associated Urinary Tract Infection measure using the NHSN's standard data submission requirements. The NHSN requires submission of data on HAI events on all patients. Collecting data on all patients will provide CMS with the most robust, 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 proposed 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 proposed to require IRFs to use the specifications and data collection tools for the CAUTI measure as required by CDC as of the time that the data is submitted.

For purposes of calculating the FY 2014 increase factor we proposed to collect data on CAUTI events that occur from October 1, 2012 through December 31, 2012, which we inadvertently misidentified as the ''final fiscal quarter of calendar year 2013.'' We should have identified it as the final quarter of calendar year (CY) 2012. We proposed that all subsequent IRF quality reporting cycles would be based on a full 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 stated that further details regarding data submission and reporting requirements for this measure would be posted on the CMS Web site *http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/* no later than January 31, 2012. IRFs were also encouraged to visit the CDC Web site *http://www.cdc.gov/nhsn/* to review the NHSN enrollment and reporting requirements.

We received 21 comments on the proposed submission requirements for the CAUTI measure, which are summarized below.

Comment: Several commenters expressed concerns about the readiness of the CDC's NHSN infrastructure to accept a greater volume of data by adding IRF reporters.

Response: As reported to us by CDC, the NHSN has undergone a major architectural redesign over the last year in response to the need to scale up to more users, facilities and functionality. It is our understanding that the addition of IRF quality reporting on the NHSN will not unduly strain the system.

Comment: Several commenters expressed concerns with provider burden and resources needed to enroll, train and implement data reporting through the CDC's NHSN. One commenter suggested CMS should move to a single standardized and streamlined quality reporting system and added that training on multiple quality reporting systems would be confusing and time consuming. Another commenter suggested that the IRF–PAI could be modified to collect CAUTI data.

Response: We recognize that there are initial start-up costs and time investments to enroll and complete the required training for reporting through CDC's NHSN. We have factored these costs into the provider burden estimates that we provided in both the FY 2012 IRF PPS proposed rule and in this final rule. We believe that safety benefits will result from this new quality reporting requirement such as the ability to track serious, and at times, life threatening infections like CAUTI. As such, the benefits outweigh the costs. In addition, these costs are primarily incurred during the initial phase of the data reporting, and will be lower in subsequent years. For future rulemaking cycles, we will take into consideration the suggestion that CMS should move to a single standardized and streamlined quality reporting system and potentially consider collecting CAUTI data through an additional modification to the IRF–PAI.

Final Decision: Having carefully considered the comments received on the method of data submission for the measure, we finalize our proposals to require that IRFs submit data on the measure through the Centers for Disease Control (CDC)/National Healthcare Safety Network (NHSN); to require submission of the data elements needed to calculate the measure using the NHSN's standard data submission requirements; to collect quality data related to HAI events on all patients regardless of payor; and to require IRFs to use the specifications and data collection tools for the measure as required by CDC as of the time that the data is submitted. Data collection for the FY 2014 program will pertain to CAUTI events that occur from October 1, 2012 through December 31, 2012 (the last quarter of CY 2012). All subsequent IRF quality reporting cycles will be based on a full calendar year (CY) cycle (that is January 1 through December 31 of the applicable year). 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/* no later than January 31, 2012.

2. 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). Previously the IRF–PAI included optional ''quality indicators'' (QI). To support the standardized collection and calculation of quality measures specifically focused on IRF services, we proposed to modify the IRF–PAI by replacing the optional pressure ulcer items in the previous QI section of the IRF–PAI with mandatory pressure ulcer data elements.

We proposed that IRFs would be required 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 proposed to collect quality data related to new or worsening pressure ulcers on all Medicare patients.

We proposed 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 that we are submitting to OMB for approval 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 set of standardized patient assessment items, now referred to as CARE (Continuity Assessment Record & Evaluation).

The CARE assessment items were 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 proposed data elements are supported by the 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. 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 received 23 comments on the data collection and reporting of new and worsening pressure ulcers for the IRF quality reporting program, which are summarized below.

Comment: One commenter expressed a preference for a claims-based pressure ulcer measure, citing inter-rater reliability concerns with clinicians assessing pressure ulcers at admission and at discharge. Another commenter recommended inclusion of a body diagram to record the location of pressure ulcers. Another commenter expressed concern that the data collection mechanism allows for a count of multiple pressure ulcers and specific stages, but not the sizes of multiple pressure ulcers at the same stage.

Response: Although one of the commenters suggested that we consider collecting data on the pressure ulcer measure on the claims form instead of the IRF–PAI, we do not currently collect this type of patient assessment data on the claim form, nor do we have a mechanism for collecting such data through the IRF claims. Furthermore, even if the data were to be collected through the IRF claim, it would still need to be based on a clinician's assessment of the patient at admission and at discharge from the IRF. Since we currently use the IRF–PAI to collect other sorts of patient assessment data, we believe that this is the most appropriate vehicle for collecting data for the pressure ulcer measure.

We agree that it is good clinical practice to record the location of pressure ulcers in the medical record. However, this is not part of the measure specifications because we do not believe that reporting the location of pressure ulcers to CMS will enhance the usefulness of the New or Worsening Pressure Ulcer quality measure for measuring quality in IRFs. We believe, after extensive consultation with national subject matter experts on wound healing, that recording the overall number of new pressure ulcers and presence (or lack thereof) of worsening pressure ulcers, provides an adequate indication of the quality of care provided in IRFs with regard to skin integrity management and wound healing.

Comment: Several commenters commended CMS on modifications to the IRF–PAI to include pressure ulcer elements that are consistent with the MDS 3.0. They noted that the elements offer clear ulcer staging definitions consistent with NPUAP and the Wound Ostomy and Continence Nurses Society (WOCN).

Response: We thank the commenters for their positive comments with respect to the IRF–PAI modifications.

Comment: Several commenters suggested that any plans to incorporate elements from Continuity Assessment Record and Evaluation (CARE), which was developed for and used in the Post-Acute Care Payment Reform Demonstration, be delayed until the demonstration findings have been reported to Congress and the public has had an opportunity to comment on CARE.

Response: We did not propose to use the CARE instrument to collect this data. The Pressure Ulcer Measure we are adopting, as noted previously, is based on a similar measure generated from data collected through the current MDS 3.0 instrument. This measure is NQF-endorsed for short-stay nursing home residents. We proposed to amend the IRF PAI to replace the prior quality indicator (QI) elements with the data elements needed to generate the pressure ulcer measure. The IRF–PAI that has been submitted to OMB for approval can be downloaded from the IRF PPS Web site at *http://www.cms.gov/InpatientRehabFacPPS/04_IRFPAI.asp#TopOfPage.*

We concluded the PAC–PRD, and data collection using CARE, in December 2010. We plan to submit our Report to Congress by the close of 2011. As we are not proposing the use of CARE at this time, we do not believe there is a need to defer the start of the new IRF quality reporting program pending delivery of the CARE report.

Final Decision: Having carefully considered the comments, we finalize our proposal to require IRFs to submit the data needed to calculate the measure ''Percent of Patients with New or Worsened Pressure Ulcers'' on all Medicare patients to CMS through the modified IRF PAI for all Medicare beneficiaries treated in the IRF setting. Additional details regarding the use of modified IRF–PAI data elements to calculate this measure are currently available on the CMS Web site at *http://www.cms.gov/InpatientRehabFacPPS/04_IRFPAI.asp#TopOfPage.* We will publish the electronic specifications related to reporting the pressure ulcer measure on the CMS Web site *http://www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting/* no later than January 31, 2012.

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

If we adopt a 30-day comprehensive all-cause risk-standardized readmission measure for the IRF quality reporting program, we anticipate being able to use claims data otherwise submitted by the IRF to construct it. We generally anticipate constructing the measure using 3 years of claims data so that the measure rate captures a sufficient number of discharges.

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 proposed to establish procedures to make the data available to the public. As noted in the proposed rule, we do not intend to make individual patient-level

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.

We received 3 comments on public reporting, which are summarized below.

Comment: One commenter supported CMS' proposal to allow IRFs to preview data and measures prior to any information being posted on a Web site. One commenter suggested that CMS provide IRFs with a 30-day preview period prior to publicly posting the data submitted by IRFs under the quality reporting program and that CMS engage in ''user testing'' procedures before posting the information.

Response: We agree with the commenters that it is important to allow IRFs to preview data and measures prior to any information being publicly displayed. 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 a CMS Web site. We will take the commenter's suggestions regarding ''user testing'' into consideration as we develop procedures to publicly report IRF quality data.

Comment: One commenter urged CMS to delay public reporting of the IRF quality data until the second year of reporting to avoid that potential that inaccurate data would be posted based on unintended analytical issues.

Response: We have not at this time proposed a specific date to begin publicly reporting IRF quality data. We will take the commenter's suggestions into account as we develop our plans for future public reporting.

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 initially adopting a limited set of measures for the IRF quality reporting program, 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.

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 skilled nursing facilities (SNFs) for short stay nursing home patients.

Some quality data on short stay nursing home patients in skilled nursing facilities (SNFs) are collected via the MDS 3.0 data collection vehicle. We are currently analyzing these quality data, and expect to have findings by early 2012. Next steps would include analyzing whether any of these measures would be appropriate for application in the IRF setting.

If any of the short stay nursing home measures are appropriate for application to the IRF setting we intend to propose some or all of these measures in the FY 2013 rulemaking cycle. Any measures that we proposed to adopt in through the FY 2013 rulemaking cycle would apply to the payment determination for FY 2015. We expect that any measures proposed in the FY 2013 rulemaking cycle would be collected via the IRF–PAI, and that further changes to this data collection vehicle and the supporting information technology (IT) infrastructure would be necessary. 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 intend to propose that IRFs submit any additional or revised IRF–PAI data elements starting October 1, 2013 through December 31, 2013 for the FY 2015 payment update, but we are considering 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 3-year 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 using a standardized data collection instrument

During the NQF endorsement process for nursing home quality measures, conducted through the NQF's 2010 measures maintenance cycle, 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.

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 1,000 days.
• Incidence of venous thromboembolism (VTE), potentially preventable.*
• Poly-pharmacy related injury.
• Medication errors.*
• Stage III and IV pressure ulcers.**

TABLE 13—POSSIBLE FUTURE MEASURES AND TOPICS FOR THE IRF QUALITY REPORTING PROGRAM—Continued

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, for example, 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 Healthcare Acquired Conditions (HAC) Prevalence Measure.

We received 8 comments on CMS' potential future use of the CARE assessment instrument to collect quality reporting data, which are summarized below.

Comment: Several commenters said that they recognized the value of standardizing assessment data across settings. However, they expressed concerns about CMS' potential future use of CARE as a data collection vehicle in IRFs. These commenters questioned CARE's ability to accurately document medical severity, functional status and other factors related to quality outcomes. In addition, several commenters suggested the need for additional testing of CARE items in IRFs should CMS elect to use CARE.

Response: CARE was developed in response to the Deficit Reduction Act of 2005 which directed CMS to develop a standardized assessment and test it in a demonstration for the purposes of ''costs and outcomes across different post-acute care sites.'' CARE was used in the PAC–PRD to collect over 7,000 assessments in IRFs (as well as long-term care hospitals, nursing homes, home health agencies and acute-care hospitals at discharge) across the country. Items were tested for reliability using two methods—a traditional inter-rater reliability test where 2 clinicians of the same discipline scored the same patient, and a test of reliability examining differences among disciplines in rating the same case. Overall, the vast majority of items had ''good'' to ''very good'' agreement. We will deliver our Report to Congress with findings by the close of 2011.

We received 16 comments on possible Future Measures and Topics for the IRF Quality Reporting Program, which are summarized below.

Comment: The majority of the commenters were supportive of the listed possible future quality measures. Many applauded consideration of measures for functional status, discharge to community, falls with major injuries, incidence of venous thromboembolism (VTE), patient preferences and symptom management. The MedPAC expressed support for the development of a limited number of quality measures in the IRF sector that would focus on outcomes measures when possible and patient safety and experience where applicable. Moreover, MedPAC expressed support for CMS developing and including a hospital readmission measure into the IRF quality reporting program, and encouraged CMS to add a measure of functional improvement given its centrality to IRF care.

Response: We thank the commenters for their input. We appreciate MedPAC's support of our efforts to develop a quality reporting program for IRFs that focuses on outcome measures and patient safety. We will take all comments into consideration for future expansion of the IRF quality reporting program.

Final Decision: After carefully considering the comments we received on the new IRF quality reporting program, we are finalizing the new IRF quality reporting program for the first reporting year, as proposed. In addition, we are submitting the revised IRF–PAI,

which can be downloaded from the IRF PPS Web site at *http://www.cms.gov/InpatientRehabFacPPS/04_IRFPAI.asp#TopOfPage,* to OMB for approval.

We are also re-designating the existing paragraph § 412.624(c)(4) as § 412.624(c)(5) and adding a new paragraph § 412.624(c)(4). The specific changes to the regulations at part 412 are shown in the ''Regulation Text'' of this final rule.

XI. Miscellaneous Comments

Comment: Several commenters requested that CMS use the most recent 3 years of data to review and update the list of comorbidities used to determine the tier payments to ensure that the tier list reflects all conditions that contribute significantly to IRF costs of care. Along these same lines, one commenter suggested that additional tier comorbidity codes might be appropriate for the list if CMS were to require IRFs to provide ''present on admission'' information to verify that the condition had been present on admission and did not occur during the IRF stay.

Response: We appreciate the commenters' suggestions, and will consider these suggestions for future analyses.

Comment: Several commenters requested that CMS provide more data to allow stakeholders to replicate our analyses. Specifically, one commenter requested that CMS amend the MedPAR file to include information on a patient's CMG classification, and provide stakeholders with patient-level IRF–PAI data.

Response: We agree that the public should have access to whatever is necessary to review and comment on our proposed policies and evaluate the impacts of these policies. Some commenters have expressed a belief that the MedPAR files could inform their review of our proposals if it included CMGs. While we are unsure how this information would assist commenters, our policy is to supply whatever data is requested if such disclosure is legally permitted. We are therefore working towards including CMG information on the MedPAR, to the extent that such information will not make the MedPAR a patient-identifiable data file. The commenters also requested that we provide public access to patient-identifiable data, such as the IRF–PAI. We are restricted in our ability to release patient-level data under several privacy and security laws, such as the Privacy Act and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the implementing regulations. For example, the HIPAA Privacy Rule provides that we may only disclose the minimum data necessary to accomplish the purpose of the disclosure (45 CFR 164.502(b)). We did not use IRF–PAI data in our analysis for the FY 2012 IRF PPS proposed and final rules. As such, these data are not relevant to the ability of commenters to review or comment on our proposals. We would violate HIPAA's minimum necessary requirements if we were to release these data for purposes of reviewing and responding to these rules. If identifiable data is used in future rulemaking, we will make data available in accordance with applicable law. Further, if commenters wish to request identifiable data for purposes outside the IRF PPS rulemaking process, we encourage them to use CMS' normal data request process. More information on CMS' data distribution policies is available on CMS's Web site at *http://www.cms.gov/IdentifiableDataFiles/.*

Comment: One commenter suggested that CMS revise the IRF coverage requirements that are described in chapter 1, section 110 of the Medicare Benefit Policy Manual (Pub. L. 100–02) to allow recreational therapy services to count, on a limited basis, towards the intensive rehabilitation therapy requirement in IRFs and also to state that recreational therapy is a covered service in IRFs when the medical necessity is well-documented by the rehabilitation physician in the medical record and is ordered by the rehabilitation physician as part of the overall plan of care for the patient.

Response: As we did not propose any changes to the IRF coverage requirements in § 412.622(a)(3), (4), and (5) that would affect any of the requirements described in chapter 1, section 110 of the Medicare Benefit Policy Manual (Pub. L. 100–02), this comment is outside the scope of the proposed rule. However, as we have indicated before, we do not believe that recreational therapy services should replace the provision of the 4 core skilled therapy services (physical therapy, occupational therapy, speech-language pathology, and prosthetics/orthotics). Thus, we believe it should be left to each individual IRF to determine whether offering recreational therapy is the best way to achieve the desired patient care outcomes. As we have stated previously, recreational therapy is a covered service in IRFs when the medical necessity is well-documented by the rehabilitation physician in the medical record and is ordered by the rehabilitation physician as part of the overall plan of care for the patient.

XII. Provisions of the Final Regulations

In this final rule, we are adopting the provisions as set forth in the FY 2012 IRF PPS proposed rule (76 FR 24214), except as noted elsewhere in the preamble. Specifically:

A. Payment Provision Changes

- We will 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 IV. of this final rule.
- We will hold the FY 2012 IRF facility-level adjustments (rural, LIP, and teaching status adjustments) at FY 2011 levels while we conduct further research on the underlying reasons for the fluctuations in the data, as discussed in section V. of this final rule.
- We will implement 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 V. of this final rule.
- We will update the FY 2012 IRF PPS payment rates by the 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 VI. of this final rule.
- We will 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 VI. of this final rule.
- We will calculate the final IRF Standard Payment Conversion Factor for FY 2012, as discussed in section VI. of this final rule.
- We will update the outlier threshold amount for FY 2012, as discussed in section VII. of this final rule.
- We will update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2012, as discussed in section VII. of this final rule.
- We will 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 VIII. of this final rule.
- We will implement the IRF quality reporting program provisions of section 1886(j)(7) of the Act, as discussed in section X. of this final rule.

B. Proposed Revisions to Existing Regulation Text

In addition, we will revise the existing requirements at § 412.25(b), § 412.25(b)(1), § 412.25(b)(2), and § 412.25(b)(3) that apply to all units that are excluded from the IPPS, as described in section IX. of this final rule. To amend the regulatory reference to conform with these changes, we will also revise the existing requirements at § 412.25(e)(2)(ii)(A), as described in section IX. of this final rule. With the exception of § 412.25(e)(2)(ii)(A), the revisions affect both IRFs and IPFs.

We will also 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 IX. of this final rule.

Finally, we will 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, as described in section X of this final rule.

XIII. 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 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 final rule does not impose any new information collection requirements as outlined in the regulation text. However, this final 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 X.B of this final rule, for purposes of calculating the FY 2014 IRF PPS increase factor, we require IRFs to submit data on 2 quality measures beginning October 1, 2012. 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.

A. Catheter Associated Urinary Tract Infections (CAUTI)

Regarding the collection of data on the first quality measure, Catheter Associated Urinary Tract Infections, we will require as the form and manner of submission for the measure, CAUTI rate per 1,000 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 final rule, we will 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.

While IRFs were not previously required to report data to NHSN, according to the CDC, there are 26 IRFs that already submit data to NHSN either voluntarily or per State mandate. To report data to NHSN, the CDC requires the facility to enroll into the NHSN and take specified training. According to the NHSN Web site, 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 270,000 minutes/4,500 hours (240 minutes x 1,126 IRFs) at an estimated cost of $187,321. This cost is estimated using the average hourly wage of a Registered Nurse which is reported by the U.S. Bureau of Labor 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 or 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 7,776 hours. The estimated cost per IRF is $186.15 per year. Similarly, the estimated total yearly cost across all IRFs is $214,445. 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 34,560 hours. The estimated cost per IRF is $1,247.70 per year. Similarly, the estimated total yearly cost across all IRFs is $1,437,350. These costs are estimated using an hourly wage for a Registered Nurse of $41.59.

B. Pressure Ulcers That Are New or Have Worsened

As stated in section X.C.2 of this final rule, to support the standardized collection and calculation of quality measures specifically focused on IRF services, we modified the IRF–PAI by replacing and harmonizing the pressure ulcer items with data elements similar to those collected through the MDS 3.0 used in nursing homes. Additionally, the MDS 3.0 pressure ulcer items have been harmonized with the 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 (Pub. L. 109–171, enacted on February 8, 2006) (DRA). We believe the modified IRF–PAI pressure ulcer items are consistent with the standardized

data elements now used in the MDS 3.0, and supported by the NPUAP. They will 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. We are replacing the voluntary data items 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 decreases 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 require IRFs to complete as part of the new IRF quality reporting program. Since the time to complete the items that we are removing from the IRF–PAI is the same as the time to complete the new items we added, 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–F, *Fax:* (202) 395–6974; or *E-mail: OIRA_submission@omb.eop.gov.*

XIV. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

We have examined the impacts of this final 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 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 final 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 OMB.

2. Statement of Need

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

This final 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 apply 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 through 2019.

Finally, this final rule discusses the IRF quality measures that we are adopting 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 changes for estimated FY 2012 payments compared to estimated FY 2011 payments would be an increase of approximately $150 million (this reflects a $120 million increase from the update to the payment rates and a $30 million increase due to the update to the outlier threshold amount to increase estimated outlier payments from approximately 2.6 percent in FY 2011 to 3 percent in FY 2012).

4. Detailed Economic Analysis

i. Basis and Methodology of Estimates

This final rule sets forth updates of the IRF PPS rates contained in the FY 2011 notice and updates to the CMG relative weights and average length of stay values, the wage index, and the outlier threshold for high-cost cases. This final rule also implements a 0.1 percentage point reduction to the 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 1.0 percent reduction to the FY 2012 rebased RPL market basket increase factor for the productivity adjustment 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 $150 million in payments to IRF providers (this reflects a $120 million estimated increase from the update to the payment rates and a $30 million estimated increase due to the update to the outlier threshold amount to increase the estimated outlier payments from approximately 2.6 percent in FY 2011 to 3.0 percent in FY 2012). The impact analysis in Table 14 of this final rule represents the projected effects of the policy changes in the IRF PPS for FY

2012 compared with estimated IRF PPS payments in FY 2011 without the 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 changes, and we do not make adjustments for future changes in variables, such as the number of discharges or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because 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 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 implementing a number of standard annual revisions and clarifications mentioned elsewhere in this final rule (for example, the update to the wage index and market basket increase factor used to adjust the Federal rates). We estimate that these revisions will increase payments to IRFs by approximately $120 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 final rule is estimated to be an increase in payments to IRFs of $150 million for FY 2012. The market basket increase of $120 million and the $30 million increase due to the update to the outlier threshold amount to increase estimated outlier payments from approximately 2.6 percent in FY 2011 to 3.0 percent in FY 2012 result in a net change in estimated payments from FY 2011 to FY 2012 of $150 million.

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

- The effects of the update to the outlier threshold amount, from approximately 2.6 to 3.0 percent of total estimated payments for FY 2012, consistent with section 1886(j)(4) of the Act.
- The effects of the 2.9 percent annual market basket update for FY 2012 (using the rebased RPL market basket) to IRF PPS payment rates, as required by sections 1886(j)(3)(A)(i) and 1886(j)(3)(C) of the Act, 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 1.0 percent reduction for the 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 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 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 IRF quality reporting program, beginning in FY 2013.
- The total change in estimated payments based on the FY 2012 policies relative to estimated FY 2011 payments without the policies.

ii. Description of Table 14

Table 14 categorizes IRFs by geographic location, including urban or rural location, and location in one of CMS's 9 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), by teaching status, and by disproportionate share patient percentage (DSH PP). The top row of the table shows the overall impact on the 1,152 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 956 IRFs located in urban areas included in our analysis. Among these, there are 752 IRF units of hospitals located in urban areas and 205 freestanding IRF hospitals located in urban areas. There are 195 IRFs located in rural areas included in our analysis. Among these, there are 175 IRF units of hospitals located in rural areas and 20 freestanding IRF hospitals located in rural areas. There are 380 for-profit IRFs. Among these, there are 317 IRFs in urban areas and 63 IRFs in rural areas. There are 718 non-profit IRFs. Among these, there are 596 urban IRFs and 122 rural IRFs. There are 54 government-owned IRFs. Among these, there are 44 urban IRFs and 10 rural IRFs.

The remaining three parts of Table 14 show IRFs grouped by their geographic location within a region, by teaching status, and by DSH PP. First, IRFs located in urban areas are categorized to their location within one of the 9 CMS geographic regions. Second, IRFs located in rural areas are categorized to their location within one of the 9 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. Third, IRFs are grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to Average Daily Census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent. Finally, IRFs are grouped by DSH PP, including IRFs with zero DSH PP, IRFs with a DSH PP less than 5 percent, IRFs with a DSH PP between 5 percent and 10 percent, IRFs with a DSH PP between 10 percent and 20 percent, and IRFs with a DSH PP greater than 20 percent.

The estimated impacts of each 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 adjustment to the outlier threshold amount so that estimated outlier payments increase from approximately 2.6 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) compares our estimates of the payments per discharge, incorporating all of the proposed changes reflected in this final rule for FY 2012, to our estimates of payments per discharge in FY 2011 (without these changes).

The average estimated increase for all IRFs is approximately 2.2 percent. This estimated increase includes the effects of the 1.8 percent market basket update, which is derived from a 2.9 percent rebased market basket update 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 reduced by a 1.0 percentage point productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. It also includes the 0.4 percent overall estimated increase (the difference between 2.6 percent in FY 2011 and 3.0 percent in FY 2012) in estimated IRF outlier payments from the update to the outlier threshold amount. Because we are making the remainder of the changes outlined in this final rule in a budget-neutral manner, they will not affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they will affect the estimated distribution of payments among providers.

TABLE 14—IRF IMPACT TABLE FOR FY 2012

Facility classification	Number of IRFs	Number of cases	Outlier	FY 2012 Adjusted market basket increase factor[1]	FY 2012 CBSA wage index and labor-share	CMG	Total percent change
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Total	1,152	397,256	0.4%	1.8%	0.0%	0.0%	2.2
Urban unit	752	200,510	0.6	1.8	−0.1	0.0	2.3
Rural unit	175	27,993	0.5	1.8	0.7	0.1	3.2
Urban hospital	205	162,121	0.2	1.8	0.0	0.0	1.9
Rural hospital	20	6,632	0.2	1.8	1.6	−0.1	3.5
Urban For-Profit	317	151,768	0.2	1.8	0.1	0.0	2.1
Rural For-Profit	63	12,437	0.4	1.8	1.1	0.1	3.4
Urban Non-Profit	596	199,249	0.6	1.8	−0.3	0.0	2.1
Rural Non-Profit	122	20,437	0.5	1.8	0.8	0.0	3.1
Urban Government	44	11,614	0.7	1.8	0.2	0.0	2.8
Rural Government	10	751	0.9	1.8	1.3	0.1	4.1
Urban	957	362,631	0.4	1.8	−0.1	0.0	2.1
Rural	195	34,625	0.5	1.8	0.9	0.1	3.2
Urban by region[2]							
Urban New England	32	16,385	0.4	1.8	−1.2	0.1	1.1
Urban Middle Atlantic	142	66,330	0.3	1.8	−0.7	0.0	1.4
Urban South Atlantic	132	63,773	0.4	1.8	0.0	0.0	2.2
Urban East North Central	188	57,251	0.6	1.8	0.0	0.0	2.4
Urban East South Central	49	26,367	0.2	1.8	0.4	−0.1	2.3
Urban West North Central	73	18,112	0.6	1.8	0.0	0.0	2.4
Urban West South Central	169	66,296	0.4	1.8	0.5	0.0	2.7
Urban Mountain	70	23,827	0.5	1.8	0.2	−0.1	2.3
Urban Pacific	102	24,290	0.7	1.8	−0.3	0.0	2.2
Rural by region[2]	.....	.....	.....	.....	.....	.....	.....
Rural New England	6	1,354	1.0	1.8	0.7	0.1	3.6
Rural Middle Atlantic	16	3,232	0.3	1.8	1.8	0.0	3.9
Rural South Atlantic	25	5,988	0.3	1.8	0.8	0.0	2.9
Rural East North Central	33	5,775	0.4	1.8	0.1	0.1	2.4
Rural East South Central	23	4,016	0.2	1.8	1.4	0.0	3.4
Rural West North Central	31	3,944	0.8	1.8	−0.2	0.1	2.5
Rural West South Central	50	9,259	0.6	1.8	1.6	0.1	4.0
Rural Mountain	7	670	0.6	1.8	0.3	0.1	2.8
Rural Pacific	4	387	1.5	1.8	−0.4	−0.1	2.8
Teaching status							
Non-teaching	1,036	345,421	0.4	1.8	0.1	0.0	2.3
Resident to ADC less than 10%	69	36,843	0.6	1.8	−0.4	0.0	2.0
Resident to ADC 10%–19%	33	12,481	0.6	1.8	−0.3	0.1	2.2
Resident to ADC greater than 19%	14	2,511	0.7	1.8	−0.7	0.0	1.9
Disproportionate share patient percentage (DSH PP)							
DSH PP = 0%	39	10,532	0.5	1.8	0.4	0.0	2.7
DSH PP < 5%	208	62,428	0.4	1.8	−0.2	0.0	2.0
DSH PP 5%–10%	342	134,672	0.3	1.8	0.0	0.0	2.2
DSH PP 10%–20%	330	123,352	0.4	1.8	0.0	0.0	2.2
DSH PP greater than 20%	233	66,272	0.6	1.8	0.0	0.0	2.4

[1] This column reflects the impact of the rebased RPL market basket increase factor for FY 2012 of 1.8 percent, which includes a market basket update of 2.9 percent, 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 1.0 percent reduction for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

[2] A map of States that comprise the 9 geographic regions can be found at: *http://www.census.gov/geo/www/us_regdiv.pdf.*)

iii. Impact of the 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 final rule, we 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 2.6 percent using the updated FY 2010 data. As a result, we adjust the outlier threshold amount for FY 2012 to $10,660, reflecting total estimated outlier payments equal to 3 percent of total estimated payments in FY 2012.

The impact of the update to the outlier threshold amount (as shown in column 4 of Table 14) is to increase estimated overall payments to IRFs by 0.4 percent. We do not estimate that any group of IRFs would experience a decrease in payments from this update. We estimate the largest increase in payments to be a 1.5 percent increase in estimated payments to rural IRFs in the Pacific region.

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

The adjusted market basket update to the IRF PPS payment rates is presented in column 5 of Table 14. In the aggregate the update will result in a net 1.8 percent increase in overall estimated payments to IRFs. This net increase reflects the estimated rebased RPL market basket increase factor for FY 2012 of 2.9 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 reduced by a 1.0 percent productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

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

In column 6 of Table 14, we present the effects of the 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 VI.A.4 of this final rule, the labor-related share decreased from 75.271 percent in FY 2011 to 70.199 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 changes will 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 update to the CBSA wage index and labor-related share to be a 1.2 percent decrease for urban IRFs in the New England region.

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

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

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

In section VIII of this final rule, we note the recent revision of the data matching process that is used to calculate the 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 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 IRF Quality Reporting Program Beginning in FY 2013

As discussed in section X.B of this final rule, we will collect 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 XIII. of this final rule, we estimate that IRFs will incur costs associated with the collection of these data, which we detail below.

a. Catheter Associated Urinary Tract Infections

As stated in section X.C.1. of this final rule, we collect data on the first quality measure, Catheter Associated Urinary Tract Infections, through CDC/NHSN. We do 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 1,126 IRFs (1,152 minus the 26 IRFs that are already reporting data to NHSN) will 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 will take 4 hours at a cost of $41.59 per hour, at an estimated cost per IRF of $166.36 and a total estimated cost across all IRFs of $187,321.

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 1,000 urinary catheter days. We estimate that the first form, the 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 or 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 7,776 hours. The estimated yearly cost per IRF is $186.15 and the estimated total yearly

cost across all IRFs is $214,445. 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 34,560 hours. The estimated cost per IRF is $1,247.70 per year and the estimated total yearly cost across all IRFs is $1,437,350. 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.

b. Pressure Ulcers That Are New or Have Worsened

As stated in section X.C.2 of this final rule, we modified the IRF–PAI by removing the items previously in the ''Quality Indicators'' section and replacing them with pressure ulcer items similar to elements from the 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) 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 will 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. While 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 previously contained a voluntary ''Quality Indicators'' section, which we replaced with the 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 decreases 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 requiring IRFs to complete as part of the new IRF quality reporting program. Since the time to complete the items that we are removing from the IRF–PAI is the same as the time to complete the new items we are adding, 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 final 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 final rule, we 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 rebasing 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. In accordance with the recently amended section 1886(j)(3)(C) of the Act, we are updating IRF Federal prospective payments in this final rule by 1.8 percent (which equals the 2.9 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 1.0 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 considered adjusting the facility-level adjustments (the rural, LIP, and teaching status adjustment) for FY 2012 using updated data and a revised methodology that would remove a weighting factor from the regression analysis that we believe is no longer appropriate. However, we found that the proposed changes to the adjustment factors would cause unusually large reductions in payment for some facilities that are not clearly justified. Thus, we are freezing the IRF facility-level adjustment factors at FY 2011 levels for FY 2012 while we continue to study the underlying anomalies in the data that may be causing some of the instability in the facility-level adjustments and analyze the most appropriate methodology to use to update the facility-level adjustment factors.

We considered maintaining the existing outlier threshold amount for FY 2012. However, the update to the outlier threshold amount will 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, fewer 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 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, we have prepared an accounting statement showing the classification of the transfers associated with the provisions of this final rule. This table provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the changes presented in this final rule based on the data for 1,152 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.	$150 million.

TABLE 15—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS, FROM THE 2011 IRF PPS FISCAL YEAR TO THE 2012 IRF PPS FISCAL YEAR—Continued

Category	Transfers
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 2.2 percent, compared with those in FY 2011, as reflected in column 8 of Table 14. IRF payments are estimated to increase 2.1 percent in urban areas and 3.2 percent in rural areas, per discharge, compared with FY 2011. Payments to rehabilitation units in hospitals in urban areas are estimated to increase 2.3 percent per discharge. Payments to freestanding rehabilitation hospitals in urban areas are estimated to increase 1.9 percent per discharge. Payments to rehabilitation units in hospitals in rural areas are estimated to increase 3.2 percent per discharge, while payments to freestanding rehabilitation hospitals in rural areas are estimated to increase 3.5 percent per discharge.

Overall, the largest payment increase is estimated at 4.1 percent for rural government-owned IRFs and rural IRFs in the West South Central region. We are not estimating any payment decreases for FY 2012.

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 1 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 1,152 IRFs that are in our analysis file, of which approximately 60 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. The HHS 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 final 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 final rule on all IRFs is to increase estimated payments by about 2.2 percent, with an estimated increase in payments of 3 percent or higher for some categories of IRFs (such as both freestanding rehabilitation hospitals located in rural areas and rehabilitation units in hospitals located in rural areas, rural government-owned IRFS and rural IRFs in the New England, Mid-Atlantic, East South Central, and West South Central) and no estimated decreases in payment. Therefore, we estimate that all IRFs will experience a net positive increase in payments. As a result, the Secretary has determined that this final rule will not have a significant impact on a substantial number of small entities. We present, in the Alternatives Considered section XIV.A.5 of this final rule, an analysis of the alternatives we considered for this final 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.

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 175 rural units and 20 rural hospitals in our database of 1,152 IRFs, we estimate that small rural IRF hospitals will receive between 2.4 percent and 4.1 percent higher net payments in FY 2012 due to the provisions in this final 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 final rule will 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 final rule will not impose spending costs on State, local, or Tribal governments, in the aggregate, or by the private sector, of $136 million.

XV. 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 final rule will have no substantial direct effect on State and local governments, preempt State law, or otherwise have Federalism implications.

List of Subjects in 42 CFR Part 412

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

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 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) and to be paid under the prospective payment system specified in § 412.1(a)(3), 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) 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) 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. This procedure must ensure that the preadmission screening is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.

(e) Have in effect a procedure to ensure that 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) and paid under the prospective payment system specified in § 412.1(a)(3) 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.

§ 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. Redesignating paragraph (c)(4) as paragraph (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 FY 2014 and for subsequent FY. Subject to the provisions of paragraphs (c)(4)(i) and (c)(4)(ii) of this section, the applicable increase factor for FY 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: July 21, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 27, 2011.

Kathleen Sebelius,

Secretary, Health and Human Services.

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

BILLING CODE 4120–01–P

Addendum

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

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

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

TABLE A: 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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.8903
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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
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
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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
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
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

	Urban Area (Constituent Counties)	Wage Index
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
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
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

	Urban Area (Constituent Counties)	Wage Index
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0302
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

	Urban Area (Constituent Counties)	Wage Index
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 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

	Urban Area (Constituent Counties)	Wage Index
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
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
44700	Stockton, CA San Joaquin County, CA	1.2644
44940	Sumter, SC Sumter County, SC	0.7860

	Urban Area (Constituent Counties)	Wage Index
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

	Urban Area (Constituent Counties)	Wage Index
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9566
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: 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

State Code	Nonurban Area	Wage Index
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
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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