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Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1538–P]

RIN 0938–AP56

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2010 (for discharges occurring on or after October 1, 2009 and on or before September 30, 2010) as required under section 1886(j)(3)(C) of the Social Security Act (the Act). Section 1886(j)(5) of the Act requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the IRF prospective payment system's (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 proposing to revise existing policies regarding the IRF PPS within the authority granted under section 1886(j) of the Act.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 29, 2009.

ADDRESSES: In commenting, please refer to file code CMS–1538–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' and enter the file code to find the document accepting comments.

2. *By regular mail.* You may send written comments by regular mail (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1538–P, P.O. Box 8012, Baltimore, MD 21244–8012.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) by express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1538–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–8012.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses.

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

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

b. 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

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

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

FOR FURTHER INFORMATION CONTACT: Julie Stankivic, (410) 786–5725, for general information regarding the proposed rule.

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

Jeanette Kranacs, (410) 786–9385, for information regarding the wage index.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

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

Table of Contents

Acronyms

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

ADC Average Daily Census
ASCA Administrative Simplification Compliance Act, Pub. L. 107–105
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CBSA Core-Based Statistical Area
CCR Cost-to-Charge Ratio
CFR Code of Federal Regulations
CMG Case-Mix Group
DRG Diagnostic Related Group
DSH Disproportionate Share Hospital
FI Fiscal Intermediary
FR Federal Register
FTE Full-time Equivalent
FY Federal Fiscal Year
HCFA Health Care Financing Administration
HHH Hubert H. Humphrey Building
HIPAA Health Insurance Portability and Accountability Act, Pub. L. 104–191
IOM Internet Only Manual
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
MA Medicare Advantage
MAC Medicare Administrative Contractor
MBPM Medicare Benefit Policy Manual
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. 110–173
OMB Office of Management and Budget
PAI Patient Assessment Instrument
PPS Prospective Payment System
QIC Qualified Independent Contractors
RAC Recovery Audit Contractors
RAND RAND Corporation
RFA Regulatory Flexibility Act, Pub. L. 96–354
RIA Regulatory Impact Analysis
RIC Rehabilitation Impairment Category
RPL Rehabilitation, Psychiatric, and Long-Term Care Hospital Market Basket
SCHIP State Children's Health Insurance Program

I. Background

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

Section 4421 of the Balanced Budget Act of 1997 (BBA), Pub. L. 105–33, as amended by section 125 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. 106–113, and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. 106–554, provides for the implementation of a per discharge prospective payment system (PPS) 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 2009.

Under the IRF PPS from FY 2002 through FY 2005, as described in the FY 2002 IRF PPS final rule (66 FR 41316), the Federal prospective payment rates were computed across 100 distinct case-mix groups (CMGs). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed five special CMGs to account for very short stays and for patients who expire in the IRF.

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

We established the Federal PPS rates using a standardized payment conversion factor (formerly referred to as the budget neutral conversion factor). For a detailed discussion of the budget neutral conversion factor, please refer to our FY 2004 IRF PPS final rule (68 FR 45684 through 45685). In the FY 2006 IRF PPS final rule (70 FR 47880), we discussed in detail the methodology for determining the standard payment conversion factor.

We applied the relative weighting factors to the standard payment conversion factor to compute the unadjusted Federal prospective payment rates under the IRF PPS from FYs 2002 through 2005. Within the structure of the payment system, we then made adjustments to account for interrupted stays, transfers, short stays, and deaths. Finally, we applied the applicable adjustments to account for geographic variations in wages (wage index), the percentage of low-income patients, location in a rural area (if applicable), and outlier payments (if applicable) to the IRF's unadjusted Federal prospective payment rates.

For cost reporting periods that began on or after January 1, 2002 and before October 1, 2002, we determined the final prospective payment amounts using the transition methodology prescribed in section 1886(j)(1) of the Act. Under this provision, IRFs transitioning into the PPS were paid a blend of the Federal IRF PPS rate and the payment that the IRF would have received had the IRF PPS not been implemented. This provision also allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the Federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs now consist of 100 percent of the Federal IRF PPS rate.

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

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 OMB's 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 IRF market basket, and updates to the rural, low-income percentage (LIP), and high-cost outlier adjustments. Any reference to the FY 2006 IRF PPS final rule in this proposed rule also includes the provisions effective in the correcting amendments. For a detailed discussion of the final key policy changes for FY 2006, please refer to the FY 2006 IRF PPS final rule (70 FR 47880 and 70 FR 57166).

In the FY 2007 IRF PPS final rule (71 FR 48354), we further refined the IRF PPS case-mix classification system (the CMG relative weights) and the case-level adjustments, to ensure that IRF PPS payments 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 (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 requires 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.hhs.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 increase factor for FY 2009. 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.

B. 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 (PAI), the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI). All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient 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 five-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last four digits represent the distinct CMG number. Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available on the CMS Web site at *http://www.cms.hhs.gov/InpatientRehabFacPPS/06_Software.asp.*

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

Section 3 of the ASCA amends section 1862(a) of the Act by adding paragraph (22) which requires the Medicare program, subject to section 1862(h) of the Act, to deny payment under Part A or Part B for any expenses for items or services ''for which a claim is submitted other than in an electronic form specified by the Secretary.'' Section 1862(h) of the Act, in turn, provides that the Secretary shall waive such denial in situations in which there is no method available for the submission of claims in an electronic form or the entity submitting the claim is a small provider. In addition, the Secretary also has the authority to waive such denial ''in such unusual cases as the Secretary finds appropriate.'' For more information we refer the reader to the final rule, ''Medicare Program; Electronic Submission of Medicare Claims'' (70 FR 71008, November 25, 2005). CMS instructions for the limited number of Medicare claims submitted on paper are available at: (*http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf.*)

Section 3 of the ASCA operates in the context of the administrative simplification provisions of HIPAA, which include, among others, the requirements for transaction standards and code sets codified in 45 CFR, parts 160 and 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered healthcare providers, to conduct covered electronic transactions according to the applicable transaction standards. (See the program claim memoranda issued and published by CMS at: *http://www.cms.hhs.gov/ElectronicBillingEDITrans/* and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600).

The Medicare FI or MAC processes the claim through its software system. This software system includes pricing programming called the ''PRICER'' software. The PRICER software uses the

CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the new teaching status adjustment that became effective as of FY 2006, as discussed in the FY 2006 IRF PPS final rule (70 FR 47880).

II. Summary of Provisions of the Proposed Rule

In this proposed rule, we are proposing updates to the IRF PPS, revisions to existing regulations text for the purpose of providing greater clarity, new regulations text to improve calculation of compliance with the ''60 percent'' rule, and rescission of an outdated Health Care Financing Administration (HFCA) Ruling (HCFAR 85–2–1). These proposals are as follows:

A. Proposed Updates to the IRF PPS for Federal Fiscal Year (FY) 2010

- Update the FY 2010 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.
- Update the FY 2010 IRF facility-level adjustments (rural, LIP, and teaching status adjustments) using the most current and complete Medicare claims and cost report data in a budget neutral manner, as discussed in section IV.
- Update the FY 2010 IRF PPS payment rates by the proposed market basket, as discussed in section V.A.
- Update the FY 2010 IRF PPS payment rates by the proposed wage index and the labor-related share in a budget neutral manner, as discussed in section V.A and V.B.
- Update the outlier threshold amount for FY 2010, as discussed in section VI.A.

B. Proposed Revisions to Existing Regulation Text

- Relocate and revise the criteria to be classified as an inpatient rehabilitation hospital found at existing § 412.23(b)(3) through (b)(7) that describe requirements relating to preadmission screening, close medical supervision, a director of rehabilitation, the plan of care, and a coordinated multidisciplinary team approach. Redesignate paragraphs (b)(8) and (b)(9) of § 412.23 as paragraphs (b)(3) and (b)(4) and revise newly redesignated paragraph (b)(4), as described in section VII.
- Revise the section heading at § 412.29 that describes the additional requirements applicable to inpatient rehabilitation units to include inpatient rehabilitation hospitals, as described in section VII.
- Relocate and revise the existing requirements at § 412.29(b) through (f) that describe the requirements relating to preadmission screening, close medical supervision, a director of rehabilitation, the plan of care, and a coordinated multidisciplinary team approach, as described in section VII.
- Revise the section heading at § 412.30 that describes the requirements applicable to new and converted rehabilitation units, as described in section VII.
- Revise the regulation text in § 412.604, § 412.606, § 412.610. § 412.614 and § 412.618 to require the collection of inpatient rehabilitation facility patient assessment instrument data on Medicare Part C (Medicare Advantage) patients in IRFs for use in the 60 percent rule compliance percentage calculations, as described in section VIII.
- Remove § 412.614(a)(3) that provides for an exception in the transmission of IRF–PAI data to CMS, as described in section VIII.
- Revise the heading at § 412.614(d) to ''Consequences of failure to submit complete and timely IRF–PAI data, as required under paragraph (c) of this section,'' as described in section VIII.
- Revise the heading at § 412.614(d)(1) to ''Medicare Part A fee-for-service data,'' as described in section VIII.
- Redesignate existing subsection (1) as (1)(a) and correct a technical error in the new subsection (1)(a), as described in section VIII.
- Redesignate existing subsection (2) as (1)(b), as described in section VIII.

C. Proposed New Regulation Text

- Revise § 412.29, as described in section VII, to include the additional requirements to be met by inpatient rehabilitation hospitals and units and the requirements for coverage in an IRF.
- Add a new introductory paragraph at § 412.30 that includes the requirements previously found in § 412.29(a) (describing the requirements for new and converted rehabilitation units), as described in section VII.
- Revise § 412.610(f) to require that the IRF provide a copy of the electronic computer file format of the IRF–PAI to the contractor upon request, as described in section VII.
- Add a new paragraph § 412.614(d)(2) to indicate that failure of an IRF to submit IRF–PAI data on all of its Medicare Part C (Medicare Advantage) patients will result in forfeiture of the IRF's ability to have any of its Medicare Part C (Medicare Advantage) data used in the compliance calculations, as described in section VIII.

D. Proposed Rescission of Outdated HCFAR–85–2–1

Rescind HCFA Ruling 85–2–1 entitled ''Medicare Criteria for Medicare Coverage of Inpatient Hospital Rehabilitation Services'' and set forth new coverage criteria applicable to care provided by IRFs, as described in section VIII.

Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2010

As specified in 42 CFR 412.620(b)(1), we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1. Relative weights account for the variance in cost per discharge due to the variance in resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care as well as provider efficiency.

In this proposed rule, we propose to update the CMG relative weights and average length of stay values for FY 2010. Comments on the FY 2009 IRF PPS proposed rule (73 FR 46373) suggested that the data that we used for FY 2009 to update the CMG relative weights and average length of stay values did not fully reflect recent changes in IRF utilization that have occurred because of changes in the IRF compliance percentage and the consequences of recent IRF medical necessity reviews. 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 these recent changes and that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs, we believe that it is appropriate to update the CMG relative weights and average length of stay values at this time.

As required by statute, we always use the most recent available data to update the CMG relative weights and average length of stay values. For FY 2009,

however, those data were the FY 2006 IRF cost report data. As noted above, many commenters on the FY 2009 IRF PPS proposed rule (73 FR 46373) suggested that the FY 2006 IRF cost report data were not fully reflective of the recent IRF utilization changes and that the FY 2007 IRF cost report data would be more reflective of these changes. We were unable to use the FY 2007 IRF cost report data for the FY 2009 final rule (73 FR 46370) because, as we indicated in that rule, only a small portion of the FY 2007 IRF cost reports were available for analysis at that time. Thus, we used the most current and complete IRF cost report data available at that time.

At this time, the majority of FY 2007 IRF cost reports are available for use in analyses in this proposed rule. Thus, we are using FY 2007 cost report data to update the proposed FY 2010 CMG relative weights and average length of stay values in this proposed rule.

In this proposed rule, we propose to use the same methodology that we used to update the CMG relative weights and average length of stay values in the FY 2009 IRF PPS final rule (73 FR 46370). In calculating the CMG relative weights, we use a hospital-specific relative value method to estimate operating (routine and ancillary services) and capital costs of IRFs. The process used to calculate the CMG relative weights for this proposed rule follows below:

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

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

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

Step 4. We normalize the FY 2010 CMG relative weight to the same average CMG relative weight from the CMG relative weights implemented in the FY 2009 IRF PPS final rule (73 FR 46370).

Consistent with the way we implemented changes to the IRF classification system in the FY 2006 IRF PPS final rule (70 FR 47880 and 70 FR 57166), the FY 2007 IRF PPS final rule (71 FR 48354), and the FY 2009 IRF PPS final rule (73 FR 46370), we propose to make changes to the CMG relative weights for FY 2010 in such a way that total estimated aggregate payments to IRFs for FY 2010 would be the same with or without the proposed changes (that is, in a budget neutral manner) by applying a budget neutrality factor to the standard payment amount. To calculate the appropriate proposed budget neutrality factor for use in updating the FY 2010 CMG relative weights, we propose to use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2010 (with no proposed changes to the CMG relative weights).

Step 2. Apply the proposed changes to the CMG relative weights (as discussed above) to calculate the estimated total amount of IRF PPS payments for FY 2010.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the proposed budget neutrality factor (*1.0004*) that would maintain the same total estimated aggregate payments in FY 2010 with and without the proposed changes to the CMG relative weights.

Step 4. Apply the proposed budget neutrality factor (1.0004) to the FY 2009 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V.C of this proposed rule, we discuss the proposed methodology for calculating the standard payment conversion factor for FY 2010.

Table 1 below, ''Proposed Relative Weights and Average Length of Stay Values for Case-Mix Groups,'' presents the CMGs, the comorbidity tiers, the proposed corresponding relative weights, and the proposed average length of stay values for each CMG and tier for FY 2010. The average length of stay for each CMG is used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment. The proposed relative weights and average length of stay values shown in Table 1 are subject to change for the final rule if more recent data become available for use in these analyses.

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

CMG	CMG description (M=motor, C=cognitive, A=age)	Proposed relative weight				Proposed average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0101	Stroke M > 51.05	0.7687	0.7091	0.6360	0.6046	9	10	9	8
0102	Stroke M > 44.45 and M < 51.05 and C > 18.5.	0.9676	0.8926	0.8006	0.7611	11	11	11	10
0103	Stroke M > 44.45 and M < 51.05 and C < 18.5.	1.1434	1.0548	0.9461	0.8994	14	14	12	12
0104	Stroke M > 38.85 and M < 44.45.	1.2167	1.1225	1.0068	0.9570	13	14	13	13
0105	Stroke M > 34.25 and M < 38.85.	1.4313	1.3205	1.1843	1.1258	16	18	15	15
0106	Stroke M > 30.05 and M < 34.25.	1.6634	1.5345	1.3763	1.3083	19	19	17	17
0107	Stroke M > 26.15 and M < 30.05.	1.8955	1.7486	1.5684	1.4909	20	21	19	19
0108	Stroke M < 26.15 and A > 84.5.	2.2786	2.1021	1.8854	1.7922	28	26	23	22
0109	Stroke M > 22.35 and M < 26.15 and A < 84.5.	2.1740	2.0057	1.7989	1.7100	22	23	21	22
0110	Stroke M < 22.35 and A < 84.5.	2.7212	2.5104	2.2516	2.1404	30	30	27	26
0201	Traumatic brain injury M > 53.35 and C > 23.5.	0.7736	0.6581	0.5909	0.5368	11	10	8	8
0202	Traumatic brain injury M > 44.25 and M < 53.35 and C > 23.5.	1.0344	0.8800	0.7901	0.7177	14	11	10	10

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

CMG	CMG description (M=motor, C=cognitive, A=age)	Proposed relative weight				Proposed average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0203	Traumatic brain injury M > 44.25 and C < 23.5.	1.1675	0.9933	0.8918	0.8101	12	13	12	11
0204	Traumatic brain injury M > 40.65 and M < 44.25.	1.2977	1.1040	0.9913	0.9005	15	14	13	12
0205	Traumatic brain injury M > 28.75 and M < 40.65.	1.5866	1.3498	1.2120	1.1009	20	17	16	14
0206	Traumatic brain injury M > 22.05 and M < 28.75.	1.9678	1.6741	1.5032	1.3655	21	21	18	18
0207	Traumatic brain injury M < 22.05.	2.6606	2.2636	2.0324	1.8462	36	28	25	22
0301	Non-traumatic brain injury M > 41.05.	1.1006	0.9303	0.8372	0.7664	12	12	11	10
0302	Non-traumatic brain injury M > 35.05 and M < 41.05.	1.3956	1.1797	1.0615	0.9719	14	15	13	13
0303	Non-traumatic brain injury M > 26.15 and M < 35.05.	1.6795	1.4197	1.2775	1.1696	17	18	16	15
0304	Non-traumatic brain injury M < 26.15.	2.3029	1.9466	1.7517	1.6037	28	23	21	20
0401	Traumatic spinal cord injury M > 48.45.	0.9262	0.7974	0.7669	0.6573	12	12	11	9
0402	Traumatic spinal cord injury M > 30.35 and M < 48.45.	1.3955	1.2013	1.1554	0.9903	17	15	16	13
0403	Traumatic spinal cord injury M > 16.05 and M < 30.35.	2.2854	1.9675	1.8922	1.6218	27	23	23	21
0404	Traumatic spinal cord injury M < 16.05 and A > 63.5.	4.0113	3.4532	3.3211	2.8464	52	40	37	35
0405	Traumatic spinal cord injury M < 16.05 and A < 63.5.	3.0911	2.6610	2.5592	2.1935	45	30	29	27
0501	Non-traumatic spinal cord injury M > 51.35.	0.8120	0.6408	0.5930	0.5226	9	10	8	8
0502	Non-traumatic spinal cord injury M > 40.15 and M < 51.35.	1.1022	0.8698	0.8049	0.7094	13	11	11	10
0503	Non-traumatic spinal cord injury M > 31.25 and M < 40.15.	1.4364	1.1336	1.0491	0.9245	16	14	13	13
0504	Non-traumatic spinal cord injury M > 29.25 and M < 31.25.	1.7306	1.3658	1.2639	1.1139	21	17	16	15
0505	Non-traumatic spinal cord injury M > 23.75 and M < 29.25.	2.0466	1.6151	1.4947	1.3172	23	21	19	17
0506	Non-traumatic spinal cord injury M < 23.75.	2.8482	2.2478	2.0801	1.8332	32	27	26	23
0601	Neurological M > 47.75	0.9213	0.7561	0.7165	0.6517	11	9	10	9
0602	Neurological M > 37.35 and M < 47.75.	1.2343	1.0130	0.9598	0.8730	12	13	12	12
0603	Neurological M > 25.85 and M < 37.35.	1.5714	1.2897	1.2220	1.1115	16	16	15	15
0604	Neurological M < 25.85	2.0876	1.7133	1.6235	1.4766	24	21	20	18
0701	Fracture of lower extremity M > 42.15.	0.9097	0.7723	0.7302	0.6542	11	11	10	9
0702	Fracture of lower extremity M > 34.15 and M < 42.15.	1.2047	1.0228	0.9671	0.8664	14	14	12	12
0703	Fracture of lower extremity M > 28.15 and M < 34.15.	1.4750	1.2523	1.1841	1.0609	16	16	15	14
0704	Fracture of lower extremity M < 28.15.	1.8842	1.5997	1.5126	1.3552	20	20	19	17
0801	Replacement of lower extremity joint M > 49.55.	0.6950	0.5693	0.5176	0.4707	8	7	8	7
0802	Replacement of lower extremity joint M > 37.05 and M < 49.55.	0.9315	0.7631	0.6938	0.6309	10	10	9	9
0803	Replacement of lower extremity joint M > 28.65 and M < 37.05 and A > 83.5.	1.3298	1.0894	0.9904	0.9007	13	13	13	12
0804	Replacement of lower extremity joint M > 28.65 and M < 37.05 and A < 83.5.	1.1654	0.9547	0.8680	0.7893	13	12	11	11

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

CMG	CMG description (M=motor, C=cognitive, A=age)	Proposed relative weight				Proposed average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0805	Replacement of lower extremity joint M > 22.05 and M < 28.65.	1.4552	1.1921	1.0838	0.9856	16	16	13	13
0806	Replacement of lower extremity joint M < 22.05.	1.8041	1.4779	1.3436	1.2219	18	18	17	15
0901	Other orthopedic M > 44.75	0.8415	0.7586	0.6834	0.6029	10	10	9	9
0902	Other orthopedic M > 34.35 and M < 44.75.	1.1248	1.0140	0.9135	0.8059	13	13	12	11
0903	Other orthopedic M > 24.15 and M < 34.35.	1.4546	1.3113	1.1813	1.0422	16	16	15	14
0904	Other orthopedic M < 24.15	1.9249	1.7352	1.5633	1.3791	22	22	19	18
1001	Amputation, lower extremity M > 47.65.	0.9396	0.9140	0.7841	0.7190	11	12	11	10
1002	Amputation, lower extremity M > 36.25 and M < 47.65.	1.2481	1.2141	1.0416	0.9550	14	15	13	12
1003	Amputation, lower extremity M < 36.25.	1.8120	1.7627	1.5122	1.3865	19	22	19	17
1101	Amputation, non-lower extremity M > 36.35.	1.1979	0.9863	0.9863	0.8490	12	12	13	11
1102	Amputation, non-lower extremity M < 36.35.	1.7482	1.4394	1.4394	1.2389	18	18	17	15
1201	Osteoarthritis M > 37.65	1.0475	0.9619	0.8526	0.7588	11	12	11	10
1202	Osteoarthritis M > 30.75 and M < 37.65.	1.3064	1.1998	1.0634	0.9464	14	15	13	13
1203	Osteoarthritis M < 30.75	1.6446	1.5103	1.3387	1.1914	16	18	17	15
1301	Rheumatoid, other arthritis M > 36.35.	1.1050	0.9958	0.8482	0.7584	12	12	11	10
1302	Rheumatoid, other arthritis M > 26.15 and M < 36.35.	1.4925	1.3451	1.1456	1.0243	15	16	14	14
1303	Rheumatoid, other arthritis M < 26.15.	1.9358	1.7445	1.4858	1.3285	24	22	19	17
1401	Cardiac M > 48.85	0.8086	0.7359	0.6488	0.5737	10	10	9	8
1402	Cardiac M > 38.55 and M < 48.85.	1.1101	1.0104	0.8907	0.7877	13	13	12	11
1403	Cardiac M > 31.15 and M < 38.55.	1.3542	1.2325	1.0866	0.9609	15	15	14	13
1404	Cardiac M < 31.15	1.7581	1.6002	1.4107	1.2475	20	20	17	16
1501	Pulmonary M > 49.25	0.9737	0.8538	0.7507	0.7139	11	12	10	10
1502	Pulmonary M > 39.05 and M < 49.25.	1.2407	1.0879	0.9565	0.9097	13	13	12	11
1503	Pulmonary M > 29.15 and M < 39.05.	1.5710	1.3776	1.2112	1.1519	16	17	14	14
1504	Pulmonary M < 29.15	1.9666	1.7245	1.5162	1.4419	22	19	17	17
1601	Pain syndrome M > 37.15	1.0995	0.8921	0.7628	0.7055	13	13	10	10
1602	Pain syndrome M > 26.75 and M < 37.15.	1.4832	1.2034	1.0290	0.9518	16	16	13	13
1603	Pain syndrome M < 26.75	1.9071	1.5473	1.3231	1.2238	21	19	17	16
1701	Major multiple trauma without brain or spinal cord injury M > 39.25.	1.0471	0.9262	0.8483	0.7476	11	12	11	10
1702	Major multiple trauma without brain or spinal cord injury M > 31.05 and M < 39.25.	1.3692	1.2110	1.1092	0.9776	14	15	14	13
1703	Major multiple trauma without brain or spinal cord injury M > 25.55 and M < 31.05.	1.6479	1.4575	1.3350	1.1765	18	17	16	15
1704	Major multiple trauma without brain or spinal cord injury M < 25.55.	2.0704	1.8312	1.6773	1.4782	23	24	21	19
1801	Major multiple trauma with brain or spinal cord injury M > 40.85.	1.2289	0.9679	0.9097	0.7838	16	13	13	11
1802	Major multiple trauma with brain or spinal cord injury M > 23.05 and M < 40.85.	1.8447	1.4528	1.3655	1.1766	19	18	16	15
1803	Major multiple trauma with brain or spinal cord injury M < 23.05.	3.1568	2.4862	2.3367	2.0135	41	31	27	24
1901	Guillain Barre M > 35.95	1.1168	0.9120	0.9120	0.8640	14	11	11	12

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

CMG	CMG description (M=motor, C=cognitive, A=age)	Proposed relative weight				Proposed average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1902	Guillain Barre M > 18.05 and M < 35.95.	2.2757	1.8585	1.8585	1.7607	25	23	25	22
1903	Guillain Barre M < 18.05	3.6152	2.9523	2.9523	2.7970	33	39	41	32
2001	Miscellaneous M > 49.15	0.8798	0.7281	0.6613	0.5922	11	10	9	8
2002	Miscellaneous M > 38.75 and M < 49.15.	1.1850	0.9807	0.8907	0.7977	12	13	12	11
2003	Miscellaneous M > 27.85 and M < 38.75.	1.5208	1.2585	1.1431	1.0236	16	16	14	13
2004	Miscellaneous M < 27.85	2.0336	1.6829	1.5286	1.3688	22	20	19	17
2101	Burns M > 0	2.2605	2.2605	1.9566	1.6843	25	25	25	17
5001	Short-stay cases, length of stay is 3 days or fewer.				0.1465				3
5101	Expired, orthopedic, length of stay is 13 days or fewer.				0.6748				8
5102	Expired, orthopedic, length of stay is 14 days or more.				1.5299				19
5103	Expired, not orthopedic, length of stay is 15 days or fewer.				0.7087				9
5104	Expired, not orthopedic, length of stay is 16 days or more.				1.9990				24

Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 2 shows, overall, how the proposed revisions in this proposed rule would affect particular CMG relative weight values, which affect the overall distribution of payments within CMGs and tiers. Note that, because we propose to implement the CMG relative weight revisions in a budget neutral manner, total estimated aggregate payments to IRFs for FY 2010 would not be affected. However, the proposed revisions would affect the distribution of payments within CMGs and tiers.

TABLE 2—DISTRIBUTIONAL EFFECTS OF THE PROPOSED CHANGES TO THE CMG RELATIVE WEIGHTS (FY 2009 VALUES COMPARED WITH FY 2010 VALUES)

Percentage change	Number of cases affected	Percentage of cases affected
Increased by 5% or more	0	0
Increased by between 0% and 5%	121,702	33
Changed by 0%	72,205	19
Decreased by between 0% and 5%	180,032	48
Decreased by 5% or more	76	0

As Table 2 shows, virtually 100 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the proposed revisions. The largest increase in the proposed CMG relative weight values would be a 2.9 percent increase in the CMG relative weight value for CMG C0405—Traumatic spinal cord injury, motor score less than 16.05 and age less than 63.5—in tier 2. However, based on our analysis of the FY 2007 IRF claims data, this proposed change would only affect 25 cases. The proposed increase affecting the largest number of cases would be a 0.1 percent increase in the CMG relative weight value for CMG A0110—Stroke, motor score less than 22.35 and age less than 84.5—in the ''no comorbidity'' tier. Based on our analysis of the FY 2007 IRF claims data, this change would affect 15,426 cases. The largest percent decrease that would be anticipated from the proposed CMG relative weight values would be an estimated 8.9 percent decrease in the CMG relative weight for CMG D2101—Burns, motor score greater than zero—in tier 3. However, based on our analysis of the FY 2007 IRF claims data, this proposed change would only affect 76 cases. The proposed decrease affecting the largest number of cases would be a 0.1 percent decrease in the CMG relative weight value for CMG A0704—Fracture of lower extremity, motor score less than 28.15—in the ''no comorbidity'' tier. Based on our analysis of the FY 2007 IRF claims data, this change would affect 24,541 cases.

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

IV. Proposed Updates to the Facility-Level Adjustment Factors for FY 2010

A. Background on Facility-Level Adjustments

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 percentage, 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 at 41359), we published the original adjustment factors that were used to calculate an IRF's LIP percentage, and location in a rural area, if applicable. These original adjustment factors were computed by the RAND Corporation (RAND) under contract with CMS. As discussed in the FY 2002 IRF PPS proposed rule (65 FR 66356), RAND used regression analysis to establish these adjustment factors by examining the effects of various facility-level characteristics, including rural location and percentage of low-income patients, on an IRF's average cost per case. Based on RAND's analysis, in the FY 2002 IRF PPS final rule (66 FR at 41359 through 41360) we finalized a rural adjustment factor of 19.14 percent and a LIP adjustment formula of (1 + disproportionate share hospital (DSH) patient percentage) raised to the power of (0.4838), where the DSH patient percentage for each IRF =

$$\frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

(From this point forward when we refer to the ''LIP adjustment factor'', we mean the number to which the standard formula (1 + DSH patient percentage) is raised [in this case, 0.4838].)

In the FY 2006 IRF PPS final rule (70 FR 47880, 47928 through 47934), we updated the adjustment factors for the rural and LIP adjustments and added a new teaching status adjustment. The FY 2006 adjustment factors were based on updated regression analysis by RAND using the same methodology used to develop the rural and LIP adjustment factors for the FY 2002 IRF PPS final rule (66 FR at 41359) and the most current and complete IRF claims and cost report data available at that time (FY 2003). (RAND's analysis for FY 2006 is included in a November 2005 RAND report titled ''Possible Refinements to the Facility-Level Payment Adjustments for the Inpatient Rehabilitation Facility Prospective Payment System,'' which can be downloaded from RAND's Web site at *http://www.rand.org/pubs/technical_reports/TR219/*.) Based on RAND's 2005 analysis, we finalized a rural adjustment factor of 21.3 percent and a LIP adjustment factor of 0.6229 in the FY 2006 IRF PPS final rule (70 FR 47880, 47928 through 47934).

We also described our rationale for implementing a teaching status adjustment for IRFs based on RAND's 2005 analysis in the FY 2006 IRF PPS final rule (70 FR 47880, 47928 through 47932). The IRF teaching status adjustment that was finalized in the FY 2006 IRF PPS final rule (70 FR 47880, 47928 through 47932) was calculated using the following formula for each IRF: (1 + full-time equivalent (FTE) residents/average daily census) raised to the power of (0.9012). (From this point forward when we refer to the ''teaching status adjustment factor'', we mean the number to which the standard formula (1 + FTE residents/average daily census) is raised [in this case, 0.9012]).

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

In this rule, we propose to update the rural, LIP, and teaching status adjustment factors for the IRF PPS based on updated regression analysis using the same regression analysis methodology that was used by RAND to compute the rural and LIP adjustment factors for the FY 2002 IRF PPS final rule (66 FR at 41359) and the rural, LIP, and teaching status adjustment factors for the FY 2006 IRF PPS final rule (70 FR 47880, 47928 through 47934). However, for the reasons discussed below, we are proposing to compute the adjustment factors using three consecutive years of cost report data (FY 2005, FY 2006, and FY 2007) and average the adjustment factors for all three years to develop the proposed rural, LIP, and teaching status adjustment factors for FY 2010.

We received a comment on the FY 2009 IRF PPS proposed rule (73 FR 22674) suggesting that we consider a three-year moving average approach because it would enable IRFs to plan their future Medicare payments more accurately. We analyzed the suggestion and believe that a three year average of the adjustment factors would promote more stability in the adjustment factors over time, which we believe would benefit IRFs by ensuring reduced variation from year to year, thus enabling them to better project future Medicare payments and thereby facilitate IRFs' long-term budgetary planning processes. If, instead, we were to continue to compute the adjustment factors based on only a single year's worth of data (as was done in the FY 2002 and FY 2006 IRF PPS final rules (66 FR at 41359 and 70 FR 47880, 47928 through 47934)), we believe that IRFs would experience unnecessarily large fluctuations in the adjustment factors from year to year. These large fluctuations would reduce the consistency and predictability of IRF PPS payments over time, and could be detrimental to IRFs' long-term planning processes. For this reason, we are proposing the use of a three-year moving average in computing the proposed rural, LIP, and teaching status adjustment factors in this proposed rule.

To study the effects of this proposal over time, we examined the magnitude of changes in the rural, LIP, and teaching status adjustment factors that would occur if we were to compute the proposed adjustment factors based on a single year's worth of data (FY 2007) compared with computing the proposed adjustment factors based on an average of three year's worth of data (FY 2005, FY 2006, and FY 2007). In 2002 the rural adjustment factor was set at 19.14 percent. It was updated in FY 2006 to 21.3 percent based on RAND's regression analysis of FY 2003 Medicare claims and cost report data, as described above. If we were to update the rural adjustment factor for FY 2010 using a single year's worth of data (FY 2007), it would decrease to 17.65 percent. If instead we were to calculate an average adjustment factor by using the most recent three years worth of data (FY 2005, FY 2006, and FY 2007), the rural adjustment factor would instead decrease to 18.27 percent. That is, computing the adjustment factors based on an average of three year's worth of data (FY 2005 through FY 2007) instead of a single year's worth of data (FY 2007) would lead to a smaller decrease in the rural adjustment factor and would thereby mitigate the impact of this change on IRF payments to rural providers, which would benefit rural IRFs in conducting their long-term budgetary planning processes.

Similarly, we examined the effects of the proposed three-year moving average methodology on the magnitude of the LIP adjustment factor for FY 2010. The LIP adjustment factor was 0.4838 in FY 2002. It was updated in FY 2006 to 0.6229 based on RAND's regression

analysis of FY 2003 Medicare claims and cost report data, as described above. If we were to update the LIP adjustment factor for FY 2010 using FY 2007 data, it would decrease to 0.3865. If instead we were to average the adjustment factors derived by using the most recent three years worth of data (FY 2005, FY 2006, and FY 2007), the proposed LIP adjustment factor for FY 2010 would be 0.4372. Thus, computing the LIP adjustment factor based on the most recent three years worth of data (FY 2005, FY 2006, and FY 2007) would result in a smaller decrease in the LIP adjustment factor and would thereby mitigate the impact of this change on IRF payments, which would benefit all IRF providers that receive LIP payments.

Lastly, we examined the effects of the proposed three-year moving average approach on the magnitude of the teaching status adjustment factor for FY 2010. The IRF teaching status adjustment was first implemented in the FY 2006 IRF PPS final rule (70 FR 47880, 47928 through 47932), and the teaching status adjustment factor implemented in FY 2006 was 0.9012. If we were to update the teaching status adjustment factor for FY 2010 using FY 2007 data, it would increase to 1.0451. If instead we were to average the adjustment factors derived by using the most recent three years worth of data (FY 2005, FY 2006, and FY 2007), the proposed teaching status adjustment factor for FY 2010 would be 1.0494. Thus, the proposed teaching status adjustment factor based on the most recent three years worth of data (FY 2005, FY 2006, and FY 2007) would be higher than the teaching status adjustment factor based on one year's worth of data (FY 2007). We note, however, that the teaching status adjustment factor fluctuates significantly from year to year over the three year period (FY 2005 through 2007) that we examined. Using FY 2005, FY 2006, and FY 2007 data, respectively, we estimate that the teaching status adjustment factors would be 1.5155, 0.6732, and 1.0451, respectively. Such extreme volatility in the teaching status adjustment factors demonstrates the benefit to IRF providers of the proposed three year moving average approach because it mitigates the volatility in provider payments from year to year.

Thus, we propose to use the same methodology developed by RAND in computing the rural and LIP adjustment factors for the FY 2002 IRF PPS final rule, and in computing the rural, LIP, and teaching status adjustment factors for the FY 2006 IRF PPS final rule, to update the proposed rural, LIP, and teaching status adjustment factors for FY 2010 in this proposed rule. However, we also propose to compute these updated adjustment factors using each of three years worth of data (FY 2005, FY 2006, and FY 2007) and to average the adjustment factors for these three years to compute the proposed updates to the adjustment factors for this proposed rule. To calculate the proposed updates to the rural, LIP, and teaching status adjustment factors for FY 2010, we propose to use the following steps:

[Steps 1 and 2 are performed independently for each of three years of IRF claims data: FY 2005, FY 2006, and FY 2007.]

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

Step 2. Use logarithmic regression analysis on average cost per case to compute the coefficients for the rural, LIP, and teaching status adjustments.

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

Using the proposed methodology described above, we estimate the proposed rural adjustment factor for FY 2010 to be 18.27 percent, the proposed LIP adjustment factor for FY 2010 to be 0.4372, and the proposed teaching status adjustment factor for FY 2010 to be 1.0494. We note that we had expected that recent improvements in the CMG relative weights implemented in FY 2006, FY 2007, and FY 2009 final rules would more appropriately account for the variation in costs among different types of IRF patients and thereby reduce the need for the facility-level adjustments. This appears to be the case with respect to the decreases in the estimated rural and LIP adjustment factors. The proposed adjustment factors are subject to change for the final rule if more recent data become available for use in these analyses.

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

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

Step 1. Using the most recent available data (currently FY 2007), calculate the estimated total amount of IRF PPS payments that would be made in FY 2010 (without applying the proposed changes to the rural, LIP, or teaching status adjustment factors).

Step 2. Calculate the estimated total amount of IRF PPS payments that would be made in FY 2010 if the proposed update to the rural adjustment factor were applied.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the proposed budget neutrality factor (1.0025) that would maintain the same total estimated aggregate payments in FY 2010 with and without the proposed change to the rural adjustment factor.

Step 4. Calculate the estimated total amount of IRF PPS payments that would be made in FY 2010 if the proposed update to the LIP adjustment factor were applied.

Step 5. Divide the amount calculated in step 1 by the amount calculated in step 4 to determine the proposed budget neutrality factor (1.0221) that would maintain the same total estimated aggregate payments in FY 2010 with and without the proposed change to the LIP adjustment factor.

Step 6. Calculate the estimated total amount of IRF PPS payments that would be made in FY 2010 if the proposed update to the teaching status adjustment factor were applied.

Step 7. Divide the amount calculated in step 1 by the amount calculated in step 6 to determine the proposed budget neutrality factor (0.9980) that would maintain the same total estimated aggregate payments in FY 2010 with and without the proposed change to the teaching status adjustment factor.

Step 8. Apply the proposed budget neutrality factors for the updates to the rural, LIP, and teaching status adjustment factors to the FY 2009 IRF PPS standard payment amount after the application of the proposed budget neutrality factors for the wage

adjustment and the CMG relative weights.

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

In section V.C of this proposed rule, we discuss the proposed methodology for calculating the standard payment conversion factor for FY 2010.

V. Proposed FY 2010 IRF PPS Federal Prospective Payment Rates

A. Proposed Market Basket Increase Factor and Labor-Related Share for FY 2010

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. Section 115 of the 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. In the absence of any such amendment for FY 2010, we are proposing a market basket increase factor based upon the most current data available in accordance with section 1886(j)(3)(A)(i) of the Act.

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 2002-based 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).

Therefore, in FY 2010 we propose to use the same methodology described in the FY 2006 IRF PPS Final Rule (70 FR 47908 through 47917) to compute the FY 2010 market basket increase factor and labor-related share. Using this method and the IHS Global Insight, Inc. forecast for the first quarter of 2009 of the 2002-based RPL market basket, the proposed FY 2010 IRF market basket increase factor would be 2.4 percent. IHS Global Insight is an economic and financial forecasting firm that contracts with CMS to forecast the components of providers' market baskets. In addition, consistent with historical practice, we propose to update the market basket increase factor and labor-related share estimates in the final rule to reflect the most recent available data.

We also propose to continue to use the methodology described in the FY 2006 IRF PPS final rule to update the IRF labor-related share for FY 2010 (70 FR 47880, 47908 through 47917). Using this method and the IHS Global Insight, Inc. forecast for the first quarter of 2009 of the 2002-based RPL market basket, the IRF labor-related share for FY 2010 is the sum of the FY 2010 relative importance of each labor-related cost category. This figure reflects the different rates of price change for these cost categories between the base year (FY 2002) and FY 2010. Consistent with our proposal to update the labor-related share with the most recent available data, the labor-related share for this proposed rule reflects IHS Global Insight's first quarter 2009 forecast of the 2002-based RPL market basket. As shown in Table 3, the proposed FY 2010 labor-related share is currently calculated to be 75.904 percent.

TABLE 3—FY 2010 IRF RPL LABOR-RELATED SHARE RELATIVE IMPORTANCE

Cost category	FY 2010 IRF labor-related share relative importance
Wages and salaries	53.064
Employee benefits	13.880
Professional fees	2.894
All other labor intensive services	2.123
Subtotal	71.961
Labor-related share of capital costs (.46)	3.943
Total	75.904

SOURCE: IHS GLOBAL INSIGHT, INC., 1st QTR, 2009; @USMACRO/CONTROL0209@CISSIM/TL0209.SIM Historical Data through 4th QTR, 2008.

We are interested in exploring the possibility of creating a stand-alone IRF market basket that reflects the cost structures of only IRF providers. To do so, we would propose combining Medicare cost report data from freestanding IRF providers (which is presently incorporated into the RPL market basket) and data from hospital-based IRF providers.

As part of our consideration of a stand-alone IRF market basket, we seek to have a better understanding of differences in costs between freestanding and hospital-based IRFs. An examination of the Medicare cost report data for freestanding and hospital-based IRFs reveals considerable differences in both cost levels and cost structure. We have reviewed several explanatory variables such as geographic variation, case mix, urban/rural status, share of low income patients, teaching status, and outliers (short stay and high-cost); however, we are currently unable to fully understand the observed cost differences between these two types of IRF providers. We believe that further research is required. Having examined the relevant data that is internal to CMS, we welcome any help from the public in the form of additional information, data, or suggested data sources that may help us to better understand the underlying reasons for the variations in cost structure between freestanding and hospital-based IRFs.

B. Proposed Area Wage Adjustment

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs attributable to wages and wage-related costs by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. The Secretary is required to update the 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 adjustments or updates made under section 1886(j)(6) of the Act for a FY are made in a budget neutral manner.

In the FY 2009 IRF PPS final rule (73 FR 46370 at 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 47933).

For FY 2010, we propose to maintain 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 with wage data. The FY 2009 hospital wage index defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget announced in December 2003. It also uses data included in the wage index derived from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other

wage-related documentation. However, the IRF wage index does not include an occupational mix adjustment. In computing the wage index, we derive an average hourly wage for each labor market area and a national average hourly wage. A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts. Therefore, this proposed rule continues to use the CBSA labor market area definitions and the pre-reclassification and pre-floor hospital wage index data based on 2005 cost report data.

The labor market designations made by the Office of Management and Budget (OMB), include some geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the IRF PPS wage index. We propose to continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44284 at 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the FY 2010 IRF PPS wage index.

Additionally, this proposed rule incorporates 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 Online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

To calculate the wage-adjusted facility payment for the payment rates set forth in this proposed rule, we multiply the unadjusted Federal payment rate for IRFs by the proposed FY 2010 RPL labor-related share (75.904 percent) to determine the labor-related portion of the standard payment amount. We then multiply the labor-related portion by the applicable proposed IRF wage index from the tables in the addendum to this rule. Table 1 is for urban areas, and Table 2 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 propose to calculate a budget neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45674 at 45689), codified at § 412.624(e)(1), as described in the steps below. We propose to use the listed steps to ensure that the FY 2010 IRF standard payment conversion factor reflects the update to the proposed wage indexes (based on the FY 2005 hospital cost report data) and the labor-related share in a budget neutral manner:

Step 1. Determine the total amount of the estimated FY 2009 IRF PPS rates, using the FY 2009 standard payment conversion factor and the labor-related share and the wage indexes from FY 2009 (as published in the FY 2009 IRF PPS final rule (73 FR 46370 at 44301, 44298, and 44312 through 44335, respectively)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the FY 2009 standard payment conversion factor and the FY 2010 labor-related share and CBSA urban and rural wage indexes.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the proposed FY 2010 budget neutral wage adjustment factor of 1.0010.

Step 4. Apply the proposed FY 2010 budget neutral wage adjustment factor from step 3 to the FY 2009 IRF PPS standard payment conversion factor after the application of the estimated market basket update to determine the proposed FY 2010 standard payment conversion factor.

C. Description of the Proposed IRF Standard Payment Conversion Factor and Payment Rates for FY 2010

To calculate the proposed standard payment conversion factor for FY 2010, as illustrated in Table 4 below, we begin by applying the estimated market basket increase factor for FY 2010 (2.4 percent) to the standard payment conversion factor for FY 2009 ($12,958), which would equal $13,269. Then, we propose to apply the proposed budget neutrality factor for the FY 2010 wage index and labor related share of 1.0010, which would result in a standard payment amount of $13,282. Then, we propose to apply the proposed budget neutrality factor for the revised CMG relative weights of 1.0004, which would result in a standard payment amount of $13,287. Finally, we propose to apply the proposed budget neutrality factors for the updates to the rural, LIP, and IRF teaching status adjustments of 1.0025, 1.0221, and 0.9980, respectively, which would result in the proposed FY 2010 standard payment conversion factor of $13,587.

TABLE 4—CALCULATIONS TO DETERMINE THE PROPOSED FY 2010 STANDARD PAYMENT CONVERSION FACTOR

Explanation for adjustment	Calculations
Standard Payment Conversion Factor for FY 2009	$12,958
Estimated Market Basket Increase Factor for FY 2010	× 1.0240
Proposed Budget Neutrality Factor for the Wage Index and Labor-Related Share	× 1.0010
Proposed Budget Neutrality Factor for the Revisions to the CMG Relative Weights	× 1.0004
Proposed Budget Neutrality Factor for the Update to the Rural Adjustment Factor	× 1.0025
Proposed Budget Neutrality Factor for the Update to the LIP Adjustment Factor	× 1.0221
Proposed Budget Neutrality Factor for the Update to the Teaching Status Adjustment Factor	× 0.9980
Proposed FY 2010 Standard Payment Conversion Factor	= $13,587

After the application of the proposed CMG relative weights described in section II of this proposed rule, the resulting proposed unadjusted IRF prospective payment rates for FY 2010 are shown below in Table 5, ''Proposed FY 2010 Payment Rates.'' The proposed standard payment conversion factor and the proposed FY 2010 payment rates are subject to change in the final rule if more recent data become available for analysis or if any changes are made to any of the proposed payment policies set forth in this proposed rule.

TABLE 5—PROPOSED FY 2010 PAYMENT RATES

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
0101	$10,444.33	$9,634.54	$8,641.33	$8,214.70
0102	13,146.78	12,127.76	10,877.75	10,341.07
0103	15,535.38	14,331.57	12,854.66	12,220.15
0104	16,531.30	15,251.41	13,679.39	13,002.76
0105	19,447.07	17,941.63	16,091.08	15,296.24
0106	22,600.62	20,849.25	18,699.79	17,775.87
0107	25,754.16	23,758.23	21,309.85	20,256.86
0108	30,959.34	28,561.23	25,616.93	24,350.62
0109	29,538.14	27,251.45	24,441.65	23,233.77
0110	36,972.94	34,108.80	30,592.49	29,081.61
0201	10,510.90	8,941.60	8,028.56	7,293.50
0202	14,054.39	11,956.56	10,735.09	9,751.39
0203	15,862.82	13,495.97	12,116.89	11,006.83
0204	17,631.85	15,000.05	13,468.79	12,235.09
0205	21,557.13	18,339.73	16,467.44	14,957.93
0206	26,736.50	22,746.00	20,423.98	18,553.05
0207	36,149.57	30,755.53	27,614.22	25,084.32
0301	14,953.85	12,639.99	11,375.04	10,413.08
0302	18,962.02	16,028.58	14,422.60	13,205.21
0303	22,819.37	19,289.46	17,357.39	15,891.36
0304	31,289.50	26,448.45	23,800.35	21,789.47
0401	12,584.28	10,834.27	10,419.87	8,930.74
0402	18,960.66	16,322.06	15,698.42	13,455.21
0403	31,051.73	26,732.42	25,709.32	22,035.40
0404	54,501.53	46,918.63	45,123.79	38,674.04
0405	41,998.78	36,155.01	34,771.85	29,803.08
0501	11,032.64	8,706.55	8,057.09	7,100.57
0502	14,975.59	11,817.97	10,936.18	9,638.62
0503	19,516.37	15,402.22	14,254.12	12,561.18
0504	23,513.66	18,557.12	17,172.61	15,134.56
0505	27,807.15	21,944.36	20,308.49	17,896.80
0506	38,698.49	30,540.86	28,262.32	24,907.69
0601	12,517.70	10,273.13	9,735.09	8,854.65
0602	16,770.43	13,763.63	13,040.80	11,861.45
0603	21,350.61	17,523.15	16,603.31	15,101.95
0604	28,364.22	23,278.61	22,058.49	20,062.56
0701	12,360.09	10,493.24	9,921.23	8,888.62
0702	16,368.26	13,896.78	13,139.99	11,771.78
0703	20,040.83	17,015.00	16,088.37	14,414.45
0704	25,600.63	21,735.12	20,551.70	18,413.10
0801	9,442.97	7,735.08	7,032.63	6,395.40
0802	12,656.29	10,368.24	9,426.66	8,572.04
0803	18,067.99	14,801.68	13,456.56	12,237.81
0804	15,834.29	12,971.51	11,793.52	10,724.22
0805	19,771.80	16,197.06	14,725.59	13,391.35
0806	24,512.31	20,080.23	18,255.49	16,601.96
0901	11,433.46	10,307.10	9,285.36	8,191.60
0902	15,282.66	13,777.22	12,411.72	10,949.76
0903	19,763.65	17,816.63	16,050.32	14,160.37
0904	26,153.62	23,576.16	21,240.56	18,737.83
1001	12,766.35	12,418.52	10,653.57	9,769.05
1002	16,957.93	16,495.98	14,152.22	12,975.59
1003	24,619.64	23,949.80	20,546.26	18,838.38
1101	16,275.87	13,400.86	13,400.86	11,535.36
1102	23,752.79	19,557.13	19,557.13	16,832.93
1201	14,232.38	13,069.34	11,584.28	10,309.82
1202	17,750.06	16,301.68	14,448.42	12,858.74
1203	22,345.18	20,520.45	18,188.92	16,187.55
1301	15,013.64	13,529.93	11,524.49	10,304.38
1302	20,278.60	18,275.87	15,565.27	13,917.16
1303	26,301.71	23,702.52	20,187.56	18,050.33
1401	10,986.45	9,998.67	8,815.25	7,794.86
1402	15,082.93	13,728.30	12,101.94	10,702.48
1403	18,399.52	16,745.98	14,763.63	13,055.75
1404	23,887.30	21,741.92	19,167.18	16,949.78
1501	13,229.66	11,600.58	10,199.76	9,699.76
1502	16,857.39	14,781.30	12,995.97	12,360.09
1503	21,345.18	18,717.45	16,456.57	15,650.87
1504	26,720.19	23,430.78	20,600.61	19,591.10
1601	14,938.91	12,120.96	10,364.16	9,585.63
1602	20,152.24	16,350.60	13,981.02	12,932.11

TABLE 5—PROPOSED FY 2010 PAYMENT RATES—Continued

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
1603	25,911.77	21,023.17	17,976.96	16,627.77
1701	14,226.95	12,584.28	11,525.85	10,157.64
1702	18,603.32	16,453.86	15,070.70	13,282.65
1703	22,390.02	19,803.05	18,138.65	15,985.11
1704	28,130.52	24,880.51	22,789.48	20,084.30
1801	16,697.06	13,150.86	12,360.09	10,649.49
1802	25,063.94	19,739.19	18,553.05	15,986.46
1803	42,891.44	33,780.00	31,748.74	27,357.42
1901	15,173.96	12,391.34	12,391.34	11,739.17
1902	30,919.94	25,251.44	25,251.44	23,922.63
1903	49,119.72	40,112.90	40,112.90	38,002.84
2001	11,953.84	9,892.69	8,985.08	8,046.22
2002	16,100.60	13,324.77	12,101.94	10,838.35
2003	20,663.11	17,099.24	15,531.30	13,907.65
2004	27,630.52	22,865.56	20,769.09	18,597.89
2101	30,713.41	30,713.41	26,584.32	22,884.58
5001	.....	.....	.....	1,990.50
5101	.....	.....	.....	9,168.51
5102	.....	.....	.....	20,786.75
5103	.....	.....	.....	9,629.11
5104	.....	.....	.....	27,160.41

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

Table 6 illustrates the methodology for adjusting the proposed Federal prospective payments (as described in sections V.A through V.C of this proposed rule). The examples below are based on two hypothetical Medicare beneficiaries, both classified into CMG 0110 (without comorbidities). The proposed unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) appears in Table 5 above.

One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a rural non-teaching hospital has a DSH percentage of 5 percent (which would result in a LIP adjustment of 1.0216), a wage index of 0.8473, and a rural adjustment of 18.27 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0630), a wage index of 0.9249, and a teaching status adjustment of 0.0706.

To calculate each IRF's labor and non-labor portion of the proposed Federal prospective payment, we begin by taking the proposed unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) from Table 5 above. Then, we multiply the estimated labor-related share (75.904) described in section V.A of this proposed rule by the proposed unadjusted Federal prospective payment rate. To determine the non-labor portion of the proposed Federal prospective payment rate, we subtract the labor portion of the proposed Federal payment from the proposed unadjusted Federal prospective payment.

To compute the proposed wage-adjusted Federal prospective payment, we multiply the labor portion of the proposed Federal payment by the appropriate wage index found in the addendum in Tables 1 and 2. The resulting figure is the wage-adjusted labor amount. Next, we compute the proposed wage-adjusted Federal payment by adding the wage-adjusted labor amount to the non-labor portion.

Adjusting the proposed wage-adjusted Federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted Federal prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (1.0706, 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 6 illustrates the components of the adjusted payment calculation.

TABLE 6—EXAMPLE OF COMPUTING THE PROPOSED IRF FY 2010 FEDERAL PROSPECTIVE PAYMENT

Steps		Rural facility A (Spencer Co., IN)	Urban facility B (Harrison Co., IN)
1	Unadjusted Federal Prospective Payment	$29,081.61	$29,081.61
2	Labor Share	× 0.75904	× 0.75904
3	Labor Portion of Federal Payment	= $22,074.11	= $22,074.11
4	CBSA Based Wage Index (shown in the Addendum, Tables 1 and 2)	× 0.8473	× 0.9249
5	Wage-Adjusted Amount	= $18,703.39	= $20,416.34
6	Nonlabor Amount	+ $7,007.50	+ $7,007.50
7	Wage-Adjusted Federal Payment	= $25,710.89	= $27,423.84
8	Rural Adjustment	× 1.1827	× 1.000
9	Wage- and Rural-Adjusted Federal Payment	= $30,408.27	= $27,423.84
10	LIP Adjustment	× 1.0216	× 1.0630
11	FY 2010 Wage-, Rural- and LIP-Adjusted Federal Prospective Payment Rate	= $31,065.09	= $29,151.55
12	FY 2010 Wage- and Rural-Adjusted Federal Prospective Payment	$30,408.27	$27,423.84

TABLE 6—EXAMPLE OF COMPUTING THE PROPOSED IRF FY 2010 FEDERAL PROSPECTIVE PAYMENT—Continued

Steps		Rural facility A (Spencer Co., IN)	Urban facility B (Harrison Co., IN)
13	Teaching Status Adjustment	× 0.000	× 0.0706
14	Teaching Status Adjustment Amount	= $0.00	= $1,936.12
15	FY2010 Wage-, Rural-, and LIP-Adjusted Federal Prospective Payment Rate	+ $31,065.09	+ $29,151.55
16	Total FY 2010 Adjusted Federal Prospective Payment	= $31,065.09	= $31,087.67

Thus, the proposed adjusted payment for Facility A would be $31,065.09 and the proposed adjusted payment for Facility B would be $31,087.67.

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

A. Proposed Update to the Outlier Threshold Amount for FY 2010

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of a case by multiplying the IRF's overall cost-to-charge ratio (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 41316, 41362 through 41363), we discussed our rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments. 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, 2007, 2008, and 2009 IRF PPS final rules (70 FR 47880, 70 FR 57166, 71 FR 48354, 72 FR 44284, and 73 FR 46370, respectively) to maintain estimated outlier payments at 3 percent of total estimated payments. We also stated in the FY 2009 final rule (FR 73 46287) 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.

For FY 2010, we are proposing to use updated data for calculating the high-cost outlier threshold amount. Specifically, we propose to use FY 2007 claims data using the same methodology that we used to set the initial outlier threshold amount in the FY 2002 IRF PPS final rule (66 FR 41316, 41362 through 41363), which is also the same methodology that we used to update the outlier threshold amounts for FYs 2006 through 2009.

Based on an analysis of updated FY 2007 claims data, we estimate that IRF outlier payments as a percentage of total estimated payments are 2.8 percent in FY 2009.

Based on the updated analysis of the most recent available claims data (FY 2007), we propose to update the outlier threshold amount to $9,976 to maintain estimated outlier payments at 3 percent of total estimated aggregate IRF payments for FY 2010.

The proposed outlier threshold amount of $9,976 for FY 2010 is subject to change in the final rule if more recent data become available for analysis or if any changes are made to any of the other proposed payment policies set forth in this proposed rule.

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

In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR 45674, 45692 through 45694), we apply a ceiling to IRFs' cost-to-charge ratios (CCRs). Using the methodology described in that final rule, we propose to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2010, 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 2010, as discussed below.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2010, we estimate a proposed national average CCR of 0.621 for rural IRFs, which we calculate by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, we estimate a proposed national CCR of 0.493 for urban IRFs, which we calculate by taking an average of the CCRs for all urban IRFs using their most recently submitted cost report data. We apply weights to both of these averages using the IRFs' estimated costs, meaning that the CCRs of IRFs with higher costs factor more heavily into the averages than the CCRs of IRFs with lower costs. For this proposed rule, we have used the most recent available cost report data (FY 2007). This includes all IRFs whose cost reporting periods begin on or after October 1, 2006, and before October 1, 2007. If, for any IRF, the FY 2007 cost report was missing or had an ''as submitted'' status, we used data from a previous fiscal year's settled cost report for that IRF. However, 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 mean that these older data do not adequately reflect the current cost of care.

In addition, in light of the analysis described below, we propose to set the national CCR ceiling at 3 standard deviations above the mean CCR. The national CCR ceiling is set at 1.60 for FY 2010. This means that, if an individual IRF's CCR exceeds this ceiling of 1.60 for FY 2010, we would replace the IRF's CCR with the appropriate national average CCR (either rural or urban, depending on the geographic location of the IRF). We estimate the national CCR ceiling by:

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

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

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

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

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

VII. Inpatient Rehabilitation Facility (IRF) Classification and Payment Requirements

Prior to the introduction of the Inpatient Prospective Payment System (IPPS) in 1983, hospital care was reimbursed on a cost basis. Beneficiaries who required closely supervised, resource intensive rehabilitation services, in addition to the treatment of the acute care condition for which they were hospitalized, generally received these rehabilitation services as part of the same inpatient hospital stay that addressed their acute care needs. With the introduction of the prospective payment methodology, we developed Diagnostic Related Groups (DRGs) for classifying acute hospital stays. We found that DRGs did not fully address the variability of the rehabilitation portion of a hospital stay. Thus, in 1983, we established coverage for post-acute hospital level rehabilitation services that were excluded from the IPPS and reimbursed on a cost basis.

At that time, we established payment requirements that reimbursed rehabilitation units and free-standing rehabilitation hospitals as IRFs rather than as hospitals subject to the IPPS. The payment requirements governing free-standing IRFs can be found in § 412.23. Similar requirements for hospital rehabilitation units classified as IRFs can be found in § 412.29. To provide further guidance on our implementation of § 412.23(b)(3) through (b)(7) and § 412.29(b) through (f), we issued a HCFA Ruling, HCFAR 85–2–1, at 50 FR 31040. It outlines the criteria for Medicare coverage of inpatient hospital rehabilitation services.

These regulatory payment requirements and the policies outlined in HCFAR 85–2 were the basis for the policies currently contained in Chapter 1, Section 110 of the Medicare Benefit Policy Manual (MBPM), which provides further instructions applicable to IRFs. In this rule, we are proposing regulatory changes to certain regulations. The final changes will be incorporated into revised manual provisions that will be placed in an updated Chapter 1, Section 110 of the MBPM. The proposed regulatory changes, and the conforming manual provisions that would provide policy instructions on these regulatory provisions, would reflect the changes that have occurred in medical practice during the past 25 years as well as the implementation of the inpatient rehabilitation facility prospective payment system (IRF PPS). We also propose to rescind the outdated HCFA Ruling 85–2 since it is inconsistent with the current payment system.

A. Analysis of Current IRF Classification and Payment Requirements

The payment requirements and coverage policies that currently govern IRFs were developed more than 25 years ago, and were designed to provide instructions for a small subset of providers furnishing intensive and complex therapy services in a fee-for-service environment to a small segment of patients whose rehabilitation needs could only be safely furnished at a hospital level of care. At that time about 350 IRFs were treating a relatively homogeneous patient group with similar health conditions and deficit levels, that is, approximately 54,000 Medicare patients per year being treated primarily for stroke and other severe neurological disorders. However, advances in health care technology and treatments, in combination with the 2002 introduction of a new IRF PPS, contributed to a rapid increase in the type and volume of IRF services. By 2007, there were over 1,200 IRFs treating approximately 400,000 Medicare cases per year for a broader range of conditions. By 2007, the types of cases being treated in IRFs had also become more heterogeneous as almost a third of IRF patients were treated for orthopedic, rather than neurological, conditions.

Rehabilitation services of varying intensity and duration are beneficial to beneficiaries with a broad range of conditions, but rehabilitation can be provided in a range of settings. It has become apparent that the existing IRF payment requirements and instructions do not always enable us to distinguish between patients who require complex, high intensity rehabilitation care in a hospital environment and those patients whose rehabilitation needs can be met in less intensive settings.

In the absence of clear, up-to-date instructions on determining and documenting the medical necessity of IRF care, different stakeholders (including providers, FIs, and, most recently, Recovery Audit Contractors (RACs)) have developed different and sometimes conflicting interpretations of how our existing payment requirements and policies apply to the determination of IRF medical necessity. Recently, the differing interpretations of these requirements have led to a high volume of IRF claims denials by Medicare contractors as well as concerns about the effects of the claims denials on the IRF industry and on beneficiaries' access to IRF care.

In response to these concerns, CMS assembled an internal workgroup in June 2007 to determine how best to clarify IRF classification and payment requirements and make corresponding revisions to the regulations and manual instructions. The workgroup enlisted the advice of medical directors from within CMS, from several of the fiscal intermediaries, from one of the qualified independent contractors (QICs), and from the National Institutes of Health. These individuals, including general physicians, physiatrists, and therapists, considered how best to identify those patients for whom IRF coverage was intended, that is, patients who both require complex rehabilitation in a hospital environment and could most reasonably be expected to benefit from IRF services.

In addition, we received comments from industry groups in response to the FY 2009 IRF PPS proposed rule (73 FR 22674). These commenters requested that we revise and update IRF coverage policy so that all stakeholders would have a clear understanding of CMS policy and the expectations of CMS contractors charged with performing medical review to validate claims payment.

Finally, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Pub. L. 110–173, mandated at section 115(c)(1) that the Secretary evaluate IRF access and utilization issues. In so doing, section 115(c)(1) of the MMSEA required that the Secretary obtain input from a broad range of stakeholders. While a full report on our findings is beyond the scope of this proposed rule, we have carefully considered those findings and the stakeholder comments in framing this proposed revision to the IRF classification and payment regulations and the conforming amendments to the MBPM. A formal report on our findings in response to section 115(c)(1) of the MMSEA will be included in a Report to Congress.

B. Summary of the Major Proposed Revisions and New Requirements

In this proposed rule, we are proposing to amend certain regulations for the purpose of providing greater clarity and rescind the outdated HCFAR 85–2–1 to ensure that our policies reflect current medical practice and the needs of the current IRF PPS. Proposed changes to the existing classification and payment requirements are presented in sections VII.C and VII.D of this rule. We intend to redraft the corresponding manual provisions found in Chapter 1, § 110 of the MBPM to make conforming changes. A copy of the revised draft of Section 110 of the MBPM has been posted on the Medicare IRF PPS Web site at *http://www.cms.hhs.gov/InpatientRehabFacPPS/02_Spotlight.asp#TopOfPag.*

We encourage stakeholder comment on the proposed changes to the classification and payment requirements. We are also requesting separate comments on the draft revisions to the MBPM. While CMS will address comments on the proposed changes to the regulation in the final rule, it is beyond the scope of the final rule to address all of the separate comments on the draft revisions to the MBPM in the final rule. We will instead address the separate comments on the draft revisions to the MBPM on the Medicare IRF PPS Web site at *http://www.cms.hhs.gov/InpatientRehabFacPPS/02_Spotlight.asp#TopOfPag.*

The IRF PPS is a per-stay, case-mix adjusted prospective payment system. However, the policies on which we base our medical necessity claims reviews for IRFs were developed more than 25 years ago for a cost-based, per diem system. The proposed revisions in this rule recognize that a potential patient's likely post-admission performance is subject to many factors outside the IRF's control. Therefore, these revisions focus on the key decision points that should be considered and documented when making a decision to admit, retain, or discharge a patient. Thus, we focus the proposed regulatory and conforming manual changes on the processes rehabilitation physicians use to make admission, continued stay, and discharge decisions. In sections VII.C through VII.D below, we provide more detail on these revisions and the reasoning behind each of the revisions. In summary, the major proposed revisions are as follows:

1. Redesignating and expanding the existing requirements at § 412.23(b)(4) and § 412.29(c) in a new § 412.29(a) to require that IRFs provide rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology, social services, psychological services, and prosthetic and orthotic services using qualified personnel and adding to those requirements that these services be ordered by a rehabilitation physician.

2. Redesignating and expanding the existing requirements at § 412.23(b)(3) and § 412.29(b) in a new § 412.29(b)(2) to require that IRFs conduct a comprehensive preadmission screening to evaluate the appropriateness of IRF-level care. The requirements for a preadmission screening process are discussed in section VII.C of this rule and detailed instructions are presented in section 110.1.1 of the draft MBPM.

3. Establishing a new post-admission evaluation requirement at § 412.29(c)(1) to document the status of the patient after admission to the IRF, to compare it to that noted in the preadmission screening documentation, and to begin development of the patient's overall plan of care. The overall plan of care would be required to be completed with input from all of the interdisciplinary team members. The preadmission and post-admission evaluations document the appropriateness of an admission and then serve as a basis for the development of the overall plan of care. The requirements for a post-admission evaluation are discussed in section VII.D of this rule, and detailed instructions are presented in section 110.1.2 of the draft MBPM.

4. Redesignating and expanding the existing requirements at § 412.23 (b)(6) and § 412.29(d) for an overall plan of care at the new § 412.29(c)(2) to establish the responsibility of the rehabilitation physician in the care planning process. The requirements for an overall plan of care are discussed in section VII.D of this rule, and detailed instructions are presented in section 110.1.3 of the draft MBPM.

5. Redesignating and revising the regulatory requirements at 412.23(b)(7) and 412.29(e) governing a multidisciplinary team and the required team meetings at the new § 412.29(d) to require an interdisciplinary team, to define the members of the interdisciplinary team, to define the minimum content to be covered at the team meetings, and to specify the expected frequency of the team meetings. We propose to require that team meetings be held at least once every week, rather than once every two weeks. The requirements governing interdisciplinary team meetings are discussed in section VII.E of this rule, and detailed instructions are presented in section 110.2.2 of the draft MBPM.

C. Proposed IRF Admission Requirements

IRFs provide intensive rehabilitation services through a coordinated interdisciplinary team of skilled professionals, based upon physician orders that document the need for intensive rehabilitation services. Thus, we believe that a patient appropriate for admission to an IRF should be able and willing to actively participate in an intensive rehabilitation program that is provided through a coordinated interdisciplinary team approach in an inpatient hospital setting. Further, the patient should also be expected to make measurable improvement that will be of practical value in terms of improving the patient's functional capacity or adaptation to impairments.

We believe that the use of the term ''interdisciplinary team'' instead of ''multidisciplinary team'' (as is currently required at § 412.23(b)(7) and § 412.29(e)) more accurately reflects the care provided in an IRF. A multidisciplinary team approach to care requires only that clinicians representing various rehabilitation disciplines individually work with the patient to achieve an optimal level of functioning. However, with each clinician working independently, the patient loses the benefits of the coordinated care approach offered in IRFs.

In contrast, the interdisciplinary team approach to care requires that treating clinicians interact with each other and the patient to define a set of coordinated goals for the IRF stay and work together in a cooperative manner to deliver the services necessary to achieve these goals. As a result, we believe that the use of an interdisciplinary team instead of a multidisciplinary team will ensure that patients achieve better outcomes. Therefore, we are proposing that the IRF shall ensure that each patient's treatment is managed using a coordinated interdisciplinary approach to treatment.

We believe that patients who have completed their acute care hospital stay, but do not need or are not able or willing to participate in the level of intensive rehabilitation provided in an inpatient setting, should be referred to a less-intensive rehabilitation setting.

We believe that a comprehensive preadmission screening process is the key factor in initially identifying appropriate candidates for IRF care. For this reason, we are proposing (at § 412.29(b)(2)) to clarify our expectations regarding the scope of the preadmission assessment and to require documentation of the clinical evaluation

process that must form the basis of the admission decision. The detailed preadmission screening requirements, including instructions for documenting the decision-making process used to determine the appropriateness of an IRF admission, are presented in detail in the draft MBPM. In accordance with the proposed regulations, the comprehensive preadmission screening must include an evaluation of the following proposed requirements that a patient must meet to be admitted to an IRF (see proposed § 412.29(b)):

1. Whether the patient's condition is sufficiently stable to allow the patient to actively participate in an intensive rehabilitation program.

We recognize that there are strong financial incentives for acute care hospitals to discharge patients whose care is covered by IPPS as quickly as possible to IRFs for post-acute rehabilitation care. We believe that these incentives for early discharge could have negative consequences on patient care and on the total cost of care. For example, patients who are transferred to the IRF setting before they are adequately stabilized may later need to be re-hospitalized for treatment of the same acute condition or a complication that arose during the original hospital stay. Therefore, we are proposing to require that the patient be sufficiently stable at the time of admission to allow the patient to actively participate in an intensive rehabilitation program.

2. Whether the patient has the appropriate therapy needs for placement in an IRF.

Since one of the critical aspects of care provided in an IRF is the provision of interdisciplinary care, we are proposing (at § 412.29(b)(1)(i)) to require that, at the time of admission to the IRF, the patient require the active and ongoing therapeutic intervention of at least two therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

3. Whether the patient requires the intensive services of an inpatient rehabilitation setting.

Another critical aspect of care provided in an IRF, versus another post-acute care setting, is that IRFs generally provide at least 3 hours of therapy per day at least 5 days per week. To conform to this standard, we propose (at § 412.29(b)(1)(ii)) to require that patients generally require and reasonably be expected to actively participate in at least 3 hours of therapy per day at least 5 days per week, and be expected to make measurable improvement that will be of practical value to improve the patient's functional capacity or adaptation to impairments. In addition, we are proposing (at § 412.29(b)(1)(ii)) to require that therapy treatments begin within 36 hours after the patient's admission to the IRF, to conform with IRF best practices and to ensure that the patient's care goals can be met.

Patients who are unwilling or unable to tolerate this intense level of therapy should be referred to another setting of care that is more appropriate to their medical needs, such as SNFs, long-term care hospitals, or home health agencies, where the patient can receive more appropriate levels of rehabilitation therapy and other forms of care.

At the same time, we recognize that a patient's condition may vary during the course of the stay. Therefore, in the MBPM we provide instructions on the procedures that should be followed to document cases in which therapy can be reduced or suspended for brief periods of time.

Also, we note that many IRF patients will medically benefit from more than 3 hours of therapy per day. Therefore, the 3 hour per day requirement is intended to be a minimum number of hours of therapy provided in an IRF, not a maximum. However, for the safety of the patient, we note that the intensity of therapy provided must never exceed the patient's level of tolerance or compromise the patient's safety.

In addition, while the requirement that IRFs ''ensure that the patients receive close medical supervision'' has been in effect since the mid-1980s, it has recently raised confusion among IRFs and Medicare contractors. Since this criterion currently found at 42 CFR 412.23(b)(4) and 412.29(c) has not been well-defined, it has been unclear how an IRF would document that close medical supervision was either needed by a patient or provided by the IRF. The need for physician supervision cannot be inferred retroactively from the presence or absence of an acute medical complication during the IRF stay. Similarly, the need for close medical supervision cannot generally be inferred from the presence or absence of frequent physician orders. Instead, we are proposing to include an evaluation of each patient's risk for clinical complications as part of the preadmission screening. Candidates for IRF admission should be assessed to ascertain the presence of risk factors requiring a level of physician supervision similar to the physician involvement generally expected in an acute inpatient environment, as compared with other settings of care. While the need for physician supervision will vary with each patient, we are proposing that the close medical supervision requirement would generally be met by having a rehabilitation physician, or other licensed treating physician with specialized training and experience in inpatient rehabilitation, conduct face-to-face visits with the patient a minimum of at least 3 days per week throughout the patient's stay. The purpose of the face-to-face visits is 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.

It is critical to capture the preadmission screening information as closely as possible to the actual time of the IRF admission, so that the information provides a reliable picture of the patient's condition at the time of admission. For this reason, we propose to require (at § 412.29(b)(2)(i)) that the preadmission screening be conducted by a qualified clinician(s) designated by a rehabilitation physician within the 48 hours immediately preceding the IRF admission, to give the most accurate picture of the patient upon admission to the IRF. Further, we are proposing to require (at § 412.29(b)(2)(v)) that the preadmission screening documentation must be retained in the patient's medical record. We would expect that the reasons that the IRF clinical staff believe that the patient meets all of the required criteria for admission to the IRF would be included in the preadmission screening documentation. The MBPM will include more detailed instructions on the types of information required by the preadmission screening.

We are also proposing (at § 412.29(b)(2)(iv)) to require that a rehabilitation physician review and document his or her concurrence with the findings and results of the preadmission screening. By ''rehabilitation physician,'' we mean a licensed physician with specialized training and experience in rehabilitation. This requirement ensures that the appropriate admission decision will be made by a physician with specialized knowledge of rehabilitation therapies and will be based on the best available information about the patient's condition.

Finally, since the proposed preadmission screening must be detailed and comprehensive for every patient, we do not believe that there will be a continued need for an extensive post-admission assessment period which, when the current manual was written over two decades ago, was used to evaluate the need for IRF care. Therefore, we intend to delete the post-

admission evaluation period that is currently described in subsection 110.3 of the MBPM (rev. October 1, 2003) and replace it with more detailed instructions on continued stay and discharge policies as demonstrated in the draft MBPM.

By establishing these requirements, we recognize the importance of the professional judgment of a rehabilitation physician in the review of the preadmission screen at the time an admission decision is made. This information is more useful in reviewing the IRF admission decision than aspects of the IRF stay that would either be unknown or outside the control of the rehabilitation physician at the time of admission.

D. Proposed Post-Admission Requirements

It is the IRF's responsibility to initiate care as soon as the patient is admitted. To make accurate care planning decisions, the rehabilitation physician and interdisciplinary care team need to verify that the information obtained during the preadmission screen is still accurate. This post-admission evaluation also documents the physician decision-making process, and will provide additional insight to CMS in the program oversight process.

1. Post-Admission Evaluation: Once a patient has been admitted to an IRF, it is the responsibility of the rehabilitation physician with input from the interdisciplinary team to identify any relevant changes that may have occurred since the preadmission screening. Therefore, consistent with current industry practice, we propose to add a requirement (at § 412.29(c)(1)) for a post-admission evaluation by a rehabilitation physician within 24 hours of admission. The purpose of the post-admission evaluation is to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin development of the patient's expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care. The results of the post-admission evaluation may result in a change from the preadmission conclusion that the patient is appropriate for IRF care. In such cases, appropriate steps should be taken. We propose to require that this document be retained in the patient's medical record. Please see section 110.1.2 of the draft MBPM for more detailed instructions on this proposal.

2. Individualized Overall Plan of Care: The overall plan of care is essential to providing high-quality care in IRFs. Comprehensive planning of the patient's course of treatment in the early stages of the stay leads to a more coordinated delivery of services to the patient, and such coordinated care is a critical aspect of the care provided in IRFs. The current regulations do not define the term ''overall plan of care,'' provide any instructions on the information required in the overall plan of care, or require it to be retained in the patient's medical record. We propose to require retention of the overall plan of care at the new section 412.29(c)(2)(ii). Furthermore, we intend to provide instructions on overall plans of care as seen in section 110.1.3 of the draft manual. Such detail would provide CMS with the information necessary for program review activities.

We believe that it is critical that a rehabilitation physician be responsible for developing the overall plan of care, with substantial input from the interdisciplinary team. We also believe that the physician-generated overall plan of care must be individualized to the unique needs of the patient, to ensure that each patient's individual care goals can be met.

Therefore, we are proposing (at § 412.29(c)(2)) to require that an individualized overall plan of care be developed for each IRF admission by a rehabilitation physician with input from the interdisciplinary team within 72 hours of the patient's admission to the IRF, and be retained in the patient's medical record.

E. Proposed Changes to the Requirements for the Interdisciplinary Team Meeting

As mentioned earlier in this proposed rule, we believe that interdisciplinary services, by definition, cannot be provided by only one discipline. The purpose of the interdisciplinary team meeting is to foster communication among disciplines to establish, prioritize, and achieve treatment goals.

Currently, we require team meetings at least once every two weeks. However, the length of many IRF stays has decreased significantly since this requirement was established. We believe that the biweekly meeting requirement is inadequate to ensure the appropriate establishment and achievement of treatment goals. Therefore, we propose at (§ 412.29(d)(2)) to increase the required frequency of the interdisciplinary team meetings to at least once per week to reflect current best practices in IRFs.

Also, to improve the effectiveness and coordination of the care provided to IRF patients and to better reflect best practices in IRFs, we propose (at § 412.29(d)(1)) to broaden the requirements regarding the professional staff that are expected to participate in the interdisciplinary team meetings. We propose that, at a minimum, the interdisciplinary team must consist of professionals from the following disciplines (each of whom must have current knowledge of the beneficiary as documented in the medical record):

- A rehabilitation physician with specialized training and experience in rehabilitation services;
- A registered nurse with specialized training or experience in rehabilitation;
- A social worker or a case manager (or both); and
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

Although the purpose of the proposed requirement for interdisciplinary team meetings is to allow the exchange of information from all of the different disciplines involved in the patient's care, we believe that it is important to designate one person, specifically the rehabilitation physician, to be responsible for making the final decisions regarding the patient's IRF care. Thus, we are proposing to require (at § 412.29(d)(3)) that the rehabilitation physician document concurrence with all decisions made by the interdisciplinary team at each meeting.

As discussed above, the interdisciplinary team must include registered nurses with training or experience in rehabilitation. We believe that 24-hour nursing care is both a key component of IRF care, and the normal standard of care in IRFs. Further, we believe that requiring registered nurses to have specialized training or experience is warranted considering that IRF patients typically have significant risk factors for medical complications that need to be monitored in an inpatient hospital environment. Thus, it is important to note that under proposed § 412.29(a) the facility must be staffed to provide specialized nursing, regardless of whether any particular patient actually has a complication requiring specialized nursing.

Another critical aspect of IRF care is that rehabilitation therapy services are generally provided to each patient by a licensed or certified therapist working directly with the patient, more commonly known as one-on-one therapy. Anecdotally, we have heard that some IRFs are providing essentially all ''group therapy'' to their patients. We believe that group therapies have a role in patient care in an IRF, but that they should be used in IRFs primarily as an adjunct to one-on-one therapy services, not as the main or only source of therapy services provided to IRF

patients. While we recognize the value of group therapy, we believe that group therapy is typically a lower intensity service that should be considered as a supplement to the intensive individual therapy services generally provided in an IRF. To improve our understanding of when group therapy may be appropriate in IRFs, we specifically solicit comments on the types of patients for which group therapy may be appropriate, and the specific amounts of group instead of one-on-one therapies that may be beneficial for these types of patients. We anticipate using this information to assess the appropriate use of group therapies in IRFs and may create standards for group therapies in IRFs.

F. Proposed Director of Rehabilitation Requirement

We are proposing to retain the existing requirements for a Director of Rehabilitation without change.

G. Clarifying and Conforming Amendments

Since the proposed classification and payment requirements described above will apply to both rehabilitation hospitals and rehabilitation units, we are proposing to consolidate the criteria into one section of the regulations (at revised § 412.29). Thus, we propose to revise the heading of § 412.29 to include rehabilitation hospitals and to relocate the criteria to be classified as an inpatient rehabilitation hospital found at existing § 412.23(b)(3) through (b)(7) to the revised § 412.29. As a result, we propose to redesignate paragraphs (b)(8) and (b)(9) of § 412.23 as paragraphs (b)(3) and (b)(4). Lastly, we propose to make a technical correction to newly redesignated paragraph (b)(4) to ensure that it is consistent with the language found in the introductory paragraph at revised § 412.29 by changing the word ''or'' to the word ''and'' following the words ''specified in § 412.1(a)(1).''

H. Proposed Introductory Paragraph at § 412.30

As a result of the proposed changes to revised § 412.29, we are proposing to relocate the current provisions found at § 412.29(a) to a new introductory paragraph to be inserted at the beginning of § 412.30. The purpose of moving the definitions of a new and converted IRF is to separate them from the proposed requirements for admission and post-admission. Section 412.30 currently only contains regulatory requirements for new and converted rehabilitation units. As amended, it will cover inpatient rehabilitation hospitals and hospital units as well.

I. Proposed Rescission of the HCFAR 85–2 Ruling

As noted previously, the HCFAR is inconsistent with the current payment system. We would therefore like to take this opportunity to propose rescission of this document in order to prevent further confusion over which document provides instructions on the IRF PPS regulations (that document is Chapter 1, Section 110 of the MBPM).

VIII. Proposed Revisions to the Regulation Text To Require IRFs To Submit Patient Assessments on Medicare Advantage Patients for Use in the ''60 Percent Rule'' Calculations

In order to be excluded from the acute care inpatient hospital PPS specified in § 412.1(a)(1) and instead be paid under the IRF PPS, rehabilitation hospitals and units must meet the requirements for classification as an IRF stipulated in subpart B of part 412. In particular, § 412.23(b)(2) specifies that an IRF must meet a minimum percentage requirement that at least 60 percent of the IRF's population has one of the 13 medical conditions listed in § 412.23(b)(2)(ii) as a primary condition or comorbidity in order for the facility to be classified as an IRF. The minimum percentage is known as the ''compliance threshold.''

The instructions that we provide to Medicare contractors in Chapter 3, section 140 of the Medicare Claims Processing Manual, Internet-Only Manual (IOM) Pub. L. 100–04, provide for two methodologies that Medicare contractors may use to determine an IRF's compliance threshold. We refer to the first of these two methodologies as the ''presumptive methodology.'' This methodology makes use of the IRF–PAI information that is submitted for Medicare Part A fee-for-service inpatients under § 412.604 and § 412.618. It is ''presumptive'' in that, while the compliance threshold requirements specify the percent of all patients, this method utilizes Medicare patient data to estimate the compliance percent for the entire IRF patient population. The presumptive methodology uses computer software to examine the IRF–PAIs that each IRF submits to CMS for diagnostic codes that would indicate that a particular IRF patient has one of the 13 medical conditions listed in § 412.23(b)(2)(ii). If the computer software determines that the patient has a diagnostic code that indicates one of the 13 medical conditions listed in § 412.23(b)(2)(ii), then that patient is counted in the presumptive methodology calculation of that facility's compliance percentage; otherwise, the patient is not counted. Once the computer software has examined all of the IRF–PAIs submitted by a particular facility, the computer software computes the presumptive compliance percentage for that facility, which equals the total number of IRF–PAIs for patients with a diagnostic code indicating at least one of the 13 medical conditions listed in § 412.23(b)(2)(ii) divided by the total number of IRF–PAIs submitted by the facility. This becomes the facility's presumptive compliance percentage, which is then compared to the required minimum compliance percentage to determine whether the facility has met the required minimum compliance percentage for the designated compliance review period.

In accordance with IOM instructions in Chapter 3, section 140 of the Medicare Claims Processing Manual, the presumptive methodology described above is used in instances in which the Medicare contractor has verified that the facility's Medicare Part A fee-for-service inpatient population is representative of the facility's total inpatient population. For this to be the case, the IOM instructions specify that the facility's Medicare Part A fee-for-service inpatient population must be at least 50 percent or more of the facility's total inpatient population. If the facility's Medicare Part A fee-for-service inpatient population is less than 50 percent of the facility's total inpatient population, we cannot conclude that the IRF–PAI data are representative of the IRF's aggregate utilization pattern. Therefore, we require the Medicare contractors to use the second of the 2 methodologies to determine the facility's compliance percentage.

The second methodology is commonly known as the ''medical review'' methodology. This methodology requires the Medicare contractor to review a sample of medical records from the facility's total inpatient population. Information from those records is then used in an extrapolation that estimates the facility's compliance percentage. The second methodology may be used at any time at the discretion of the Medicare contractor, but we require its use if the facility's Medicare Part A fee-for-service inpatient population is less than 50 percent of the facility's total inpatient population (as described above) or if the facility fails to meet the minimum compliance percentage using the presumptive methodology. The medical review methodology is time consuming and labor intensive for both providers and contractors. It is most useful when

evaluating facilities with questionable utilization patterns, such as facilities that do not meet the presumptive compliance percentage, and is not efficient as the sole method for evaluating compliance.

As described above, the presumptive methodology relies upon the IRF–PAI data that is submitted under § 412.604 and § 412.618. To be used, the Medicare Part A inpatient population must consist of at least 50 percent or more of the facility's total inpatient population.

Since 2004, however, increasing numbers of Medicare beneficiaries in many areas of the country have been enrolling in Medicare Advantage (MA) plans rather than remaining in the traditional Medicare Part A fee-for-service program. This, in turn, has led to decreases in the number of Medicare Part A fee-for-service inpatients in certain IRFs across the country and has resulted in a reduction in the number of IRFs that can benefit from the presumptive methodology. For this reason, we have received many comments from individual IRFs as well as from IRF industry groups requesting that we allow Medicare Advantage patient data to be used in the presumptive methodology to improve facilities' chances of reaching the required 50 percent or more of the population mark for use of the presumptive methodology.

We agree with the unsolicited comments on the FY 2009 proposed rule that the MA population represents an increasing percentage of the patient populations in IRFs in many areas of the country. We also believe that it is important to update our policies wherever possible to allow for a reasonable means for calculating an IRF's compliance percentage under the 60 percent rule. Although we do not currently require IRFs to submit IRF–PAI data on MA patients, we understand that some IRFs are voluntarily submitting IRF–PAI data on some or all of their MA patients. To ensure that IRFs do not selectively submit IRF–PAI data on only those MA patients that help them in meeting their compliance percentage, we believe that it is essential to require IRFs to submit IRF–PAI data on all of their MA patients. We believe that this is the only way to maintain the integrity of the compliance percentage review process. Therefore, we are proposing to require that IRFs submit IRF–PAI data on all of their MA patients to facilitate better calculations under the 60 percent rule. However, we are seeking comments on whether requiring IRFs to submit IRF–PAI data on all of their MA patients is the best way to ensure the integrity of the compliance review process.

Where an IRF fails to submit all MA IRF PAIs, we propose that CMS will not count the MA patients in the compliance percentage for that IRF. In addition, to ensure that we receive all IRF–PAI data for all Medicare Patients, whether Part A or Part C, we propose to remove § 412.614(a)(3) of the regulations that currently provides for an exception that allows an IRF to not transmit IRF–PAIs for Medicare patients if the IRF does not submit a claim to Medicare for payment.

Thus, we propose to revise the regulation text in § 412.604, § 412.606, § 412.610, § 412.14, and § 412.618 to require IRFs to submit IRF–PAI information to CMS for all MA inpatients in IRFs, in addition to all Medicare Part A fee-for-service inpatients in IRFs. Requiring IRFs to submit IRF–PAI information for all MA inpatients will allow Medicare contractors to use this information to determine facilities' compliance percentages for the IRF 60 percent rule using the presumptive methodology. Note that we are proposing to preserve the long-standing 5 year record retention requirement for the IRF–PAIs completed on Medicare Part A fee-for-service patients, as currently required in § 412.610(f), but we are proposing a 10 year record retention requirement for IRF–PAIs completed on Medicare Part C (Medicare Advantage) patients to maintain consistency with the record retention requirements for Medicare Part C data specified in § 422.504(d).

For this reason, we propose the following revisions to the regulation text in § 412.604, § 412.606, § 412.610, § 412.14, and § 412.618. Specifically, we propose to add Medicare Part C (Medicare Advantage) patients to the patients for whom IRFs must complete and submit an IRF–PAI, remove the paragraph that allows IRFs not to submit IRF PAI data in instances in which the IRF does not submit a claim to Medicare, and reject MA IRF–PAI data that is not complete. The proposed changes to the regulations text are as follows:

- In § 412.604(c), we propose to add the following sentence to the end of the paragraph: ''IRFs must also complete a patient assessment instrument in accordance with § 412.606 for each Medicare Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009.'' Thus, the paragraph would read as follows: ''For each Medicare Part A fee-for-service patient admitted to or discharged from an IRF on or after January 1, 2002, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with § 412.606. IRFs must also complete a patient assessment instrument in accordance with § 412.606 for each Medicare Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009.''
- In § 412.606(b), we propose to add the phrase ''and Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatients.'' The paragraph would read as follows: ''An inpatient rehabilitation facility must use the CMS inpatient rehabilitation facility patient assessment instrument to assess Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatients who—''
- In § 412.606(c)(1), we propose to add a sentence at the end of the existing paragraph that reads as follows: ''IRFs must also complete a patient assessment instrument in accordance with § 412.606 for each Medicare Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009.''
- In § 412.610(a), we propose to add the phrase ''and Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatient.'' The paragraph would read as follows: ''For each Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) inpatient, an inpatient rehabilitation facility must complete a patient assessment instrument as specified in § 412.606 that covers a time period that is in accordance with the assessment schedule specified in paragraph (c) of this section.''
- In § 412.610(b), we propose to add the phrase ''or Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatient.'' The paragraph would read as follows: ''The first day that the Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the patient assessment schedule.''
- In § 412.610(c), we propose to add the phrase ''or Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''patient's.'' The paragraph would read as follows: ''The inpatient rehabilitation facility must complete a patient assessment instrument upon the Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) patient's admission and discharge as specified in paragraphs (c)(1) and (c)(2) of this section.''

• In § 412.610(c)(1)(i)(A), we propose to add the phrase ''or Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''hospitalization.'' The paragraph would read as follows: ''Time period is a span of time that covers calendar days 1 through 3 of the patient's current Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) hospitalization; * * *''

• In § 412.610(c)(2)(ii)(B), we propose to add the phrase ''or Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatient,'' so that the resulting paragraph would read, ''The patient stops being furnished Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) inpatient rehabilitation services.''

• In § 412.610(f), we propose to add the phrase ''and Medicare Part C (Medicare Advantage) patients within the previous 10 years'' after ''5 years'' and before ''either,'' and also add the phrase ''and produce upon request to CMS or its contractors'' after ''obtain.'' The paragraph would read as follows: ''An inpatient rehabilitation facility must maintain all patient assessment data sets completed on Medicare Part A fee-for-service patients within the previous 5 years and Medicare Part C (Medicare Advantage) patients within the previous 10 years either in a paper format in the patient's clinical record or in an electronic computer file format that the inpatient rehabilitation facility can easily obtain and produce upon request to CMS or its contractors.''

• In § 412.614(a), we propose to add the phrase ''and Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatient,'' the paragraph would read as follows: ''The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatient—''

• We propose to remove § 412.614(a)(3).

• In § 412.614(b)(1), we propose to add the phrase ''and Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatient,'' the paragraph would read as follows: ''Electronically transmit complete, accurate, and encoded data from the patient assessment instrument for each Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatient to our patient data system in accordance with the data format specified in paragraph (a) of this section; and * * *''

• We propose to revise § 412.614(d) to read, ''Consequences of failure to submit complete and timely IRF–PAI data, as required under paragraph (c) of this section.''

• We propose to revise § 412.614(d)(1) to read, ''Medicare Part A fee-for-service data.''

• We propose to make a technical correction to the paragraph formerly designated as § 412.614(d)(1) and assign the revised language to a new paragraph § 412.614(d)(1)(a), which would read as follows: ''We assess a penalty when an inpatient rehabilitation facility does not transmit all of the required data from the patient assessment instrument for its Medicare Part A fee-for-service patients to our patient data system in accordance with the transmission timeline in paragraph (c) of this section.

• We propose to redesignate paragraph § 412.614(d)(2) as § 412.614(d)(1)(b).

• We propose to add a new paragraph § 412.614(d)(2), which would read as follows: ''Medicare Part C (Medicare Advantage) data. Failure of the inpatient rehabilitation facility to transmit all of the required patient assessment instrument data for its Medicare Part C (Medicare Advantage) patients to our patient data system in accordance with the transmission timeline in paragraph (c) of this section will result in a forfeiture of the facility's ability to have any of its Medicare Part C (Medicare Advantage) data used in the calculations for determining the facility's compliance with the regulations at § 412.23(b)(2).

• In the introductory paragraph of § 412.618, we propose to add the phrase ''or Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''patient.'' The paragraph would read as follows: ''For purposes of the patient assessment process, if a Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) patient has an interrupted stay, as defined under § 412.602, the following applies: * * *''

In addition, we have received several inquiries concerning the need to include IRF PAIs in the medical record. The IRF PAI was introduced as a payment tool when the IRF PPS was established in 2002. The IRF PAI provides detailed information on each patient's medical condition and rehabilitation status. As such, it is also used by CMS to conduct its program oversight functions. We are therefore proposing to revise § 412.610(f) to require that the IRF maintain all patient assessment data sets completed on Medicare Part A fee-for-service patients within the previous 5-years and Medicare Part C (Medicare Advantage) patients within the previous 10-years either in a paper format in the patient's clinical record or in an electronic computer file format that the inpatient rehabilitation facility can easily obtain and produce upon request to CMS or its contractors. This is meant to clarify any confusion that may have existed previously about whether the IRF–PAI is considered part of the patient's medical record. Note that we are proposing to preserve the long-standing 5-year record retention requirement for the IRF–PAIs completed on Medicare Part A fee-for-service patients, as required in current § 412.610(f), but we are proposing a 10-year record retention requirement for IRF–PAIs completed on Medicare Part C (Medicare Advantage) patients to maintain consistency with the record retention requirements for Medicare Part C data specified in § 422.504(d)(1)(ii).

IX. Collection of Information Requirements

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

• The need for the information collection and its usefulness in carrying out the proper functions of our agency.

• The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 412.29 Excluded Rehabilitation Hospitals and Units: Additional Requirements

In 1983, CMS sought to distinguish rehabilitation hospitals from other hospitals that offer general medical and surgical services, but also provide some rehabilitation services, by developing new regulatory provisions that describe the criteria that hospital must meet to be excluded from the Inpatient Prospective Payment System (IPPS). These criteria relate to the preadmission screening of prospective inpatients, to the types of services that must be furnished by or

made available in the hospital, and to the hospital's management of the rehabilitation services it furnished.

All IPPS hospitals, including excluded rehabilitation hospitals and units, have been and continue to be required to comply with the Hospital Conditions of Participation (CoP) that served as the basis for the excluded criteria established in 1983. In this proposed rule, we propose regulatory provisions that would reinforce the link between the Hospital CoPs for medical records and delivery of inpatient rehabilitation services within the exclusion criteria, and that would promote further understanding of how medical necessity for rehabilitation services provided in IRFs should be established.

As previously discussed in this proposed rule, we are proposing to consolidate the existing exclusion criteria in § 412.23(b)(3) through (7) and § 412.29(b) through (f) into a revised § 412.29 that applies to both rehabilitation hospitals and units. We will then utilize the MPBM to issue guidance on how the documentation requirements relating to the medical record should be used in determining the medical necessity of IRF claims.

Section 412.23(b)(3) and § 412.29(b) currently require IRF facilities to have a preadmission screening process for each potential IRF patient. These requirements would be combined in the proposed § 412.29(b)(2)(iv). The proposed § 412.29(b)(2)(iv) would also require that the rehabilitation physician review and document his or her concurrence with the preadmission screening findings and the admission decision in keeping with the Hospital CoPs at § 482.24(c)(1). Similarly, the preadmission screening findings and admission decision would need to be retained in the patient's medical record, in keeping with the Hospital CoPs at § 482.24(c)(2). The burden associated with these proposed requirements would be the time and effort put forth by the rehabilitation physician to document his or her concurrence with the preadmission findings and the admission decision and retain the information in the patient's medical record. The burden associated with these proposed requirements are in keeping with the ''Condition of Participation: Medical record services,'' that are already applicable to Medicare participating hospitals. The burden associated with these requirements is currently approved under OMB# 0938–0328. As stated in the approved Hospital CoPs Supporting Statement, we believe that the proposed requirements reflect customary and usual business and medical practice. Thus, in accordance with section 1320.3(b)(2) of the Act, the burden is not subject to the PRA.

Proposed section § 412.29(c)(1) would be in keeping with the existing Hospital CoP requirement at § 482.24(c)(2) that requires the facility to have and utilize a post-admission evaluation process. The proposed post admission evaluation process at § 412.29(c)(1) would require that a rehabilitation physician complete a post-admission evaluation for each patient within 24 hours of that patient's admission to the IRF facility in order to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin development of the overall individualized plan of care. Similarly, this proposed section would require that a post-admission physician evaluation be retained in the patient's medical record, in keeping with the Hospital CoPs at § 482.24(c)(2).

The burden associated with these proposed requirements would be the time and effort put forth by the rehabilitation physician to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening document, begin development of the plan of care, and retain the information in the patient's medical record. The burden associated with these proposed requirements are in keeping with the ''Condition of Participation: Medical record services,'' applicable to Medicare participating Hospitals. The burden associated with these requirements is currently approved under OMB# 0938–0328. As stated in the approved ''Hospital CoPs Supporting Statement,'' we believe that the proposed requirements reflect customary and usual business and medical practice. Thus, in accordance with section 1320.3(b)(2) of the Act, the burden is not subject to the PRA.

Proposed § 412.29(c)(2) would be in keeping with the existing requirement at § 412.23(c)(6) to develop an overall plan of care for each IRF admission. Such a proposal is in keeping with the Hospital CoPs at § 482.56(b). Similarly, the individualized plan of care that would be required by proposed § 412.29(c)(2) would be required to be retained in the patient's medical record, as currently required by the Hospital CoPs at § 482.24(c)(2).

The burden associated with these prospective requirements would be the time and effort put forth by the rehabilitation physician to develop the individualized overall plan of care and retain the individualized overall plan of care in the patient's medical record. The burden associated with these proposed requirements are in keeping with the ''Condition of Participation: Medical record services,'' and the ''Standard: Delivery of Services,'' that are already applicable to Medicare participating hospitals. The burden associated with these requirements is currently approved under OMB# 0938–0328. As stated in the approved ''Hospital CoPs Supporting Statement,'' we believe that the purposed requirements reflect customary and usual business and medical practice. The requirement for an individualized plan of care is also an industry standard. Thus, in accordance with section 1320.3(b)(2) of the Act, the burden is not subject to the PRA.

Proposed § 412.29(d)(2) would require the interdisciplinary team to meet at least once per week throughout the duration of the patient's stay to implement appropriate treatment services; review the patient's progress toward stated rehabilitation goals; identify any problems that could impede progress towards those goals; and, where necessary, reassess previously established goals in light of impediments, revise the treatment plan in light of new goals, and monitor continued progress toward those goals. Proposed § 412.23(d)(2) would be in keeping with § 482.24(c)(1) and (c)(2) of the Hospital CoPs.

The proposed requirement for a weekly conference revises the current requirement for bi-weekly meetings to reflect current medical practice and a reduction in the average patient lengths of stay that in turn make more frequent monitoring of patient status an important factor in ensuring adequate patient care. For example, with the average length of stay for many IRF stays under 14 days, a bi-weekly requirement for consultation and coordination of the patient's care would be ineffective. In consulting with clinicians, we have found that more frequent interdisciplinary team meetings are considered to be a currently recognized standard of practice, regardless of payor source. As with all other proposed requirements in this proposed rule, the public may submit comments on this proposed change.

The burden associated with this proposed revised requirement would be the time spent discussing the patient's progress, problems and reassessment/monitoring of continued progress. The burden associated with this proposed requirement is in keeping with the ''Condition of Participation: Medical record services,'' that are already applicable to Medicare participating hospitals. The burden associated with

these requirements is currently approved under OMB# 0938–0328. As stated in the approved ''Hospital CoPs Supporting Statement,'' we believe that the proposed requirements reflect customary and usual business and medical practice. Thus, in accordance with section 1320.3(b)(2) of the Act, the burden is not subject to the PRA.

Proposed § 412.29(d)(3) would require the rehabilitation physician to document concurrence with all decisions made by the interdisciplinary team at each team meeting, which would be in keeping with what is currently required by the Hospital CoPs at § 482.24(c)(1).

The burden associated with this proposed requirement is the time and effort put forth by the rehabilitation physician to document concurrence. The burden associated with this proposed requirement is in keeping with the ''Condition of Participation: Medical record services,'' applicable to Medicare participating hospitals. The burden associated with these requirements is currently approved under OMB# 0938–0328. As stated in the approved ''Hospital CoPs Supporting Statement,'' we believe that the proposed requirements reflect customary and usual business and medical practice. Thus, in accordance with section 1320.3(b)(2) of the Act, the burden is not subject to the PRA.

Section 412.604 Conditions for Payment Under the Prospective Payment System for Inpatient Rehabilitation Facilities

We have proposed to amend § 412.604(c) to add an IRF–PAI requirement for Medicare Part C (Medicare Advantage) patients that are admitted to or discharged from an Inpatient Rehabilitation Facility (IRF) on or after October 1, 2009.

The burden associated with this requirement is the time and effort put forth by each IRF to complete an average of approximately 38 additional patient assessment instruments each year associated with its Medicare Part C patients. We obtained the estimated average number of Medicare Part C patients in each IRF from the American Medical Rehabilitation Providers Association (AMRPA), based on AMRPA's own analysis of the eRehabData® policy database. CMS currently estimates that it takes the IRF 0.75 of an hour to complete a single patient assessment instrument. Therefore, the annual hour burden for each IRF to complete approximately 38 additional patient assessment instruments is 28.5 hours (38 × 0.75). The total annual hour burden for all 1,205 IRFs is 34,342.5 hours (28.5 hours × 1,205 IRFs). The burden estimate for using the patient assessment instrument for Medicare Part A is currently approved under 0938–0842. CMS will revise this currently approved package as necessary to include any additional burden placed on the IRF for submitting the patient assessment instrument for Medicare Advantage patients.

Section 412.606 Patient Assessments

Section 412.606 proposes to require an IRF to use the CMS inpatient rehabilitation facility patient assessment instrument to assess Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatients.

The burden for using the patient assessment instrument for Medicare Part A is currently approved under 0938–0842. CMS will revise this currently approved package as necessary to include any additional burden placed on IRFs for submitting the patient assessment instrument for Medicare Advantage patients.

Section 412.610 Assessment Schedule

Proposed § 412.610(f) states that an IRF must maintain all patient assessment data sets completed on Medicare Part A fee-for-service patients within the previous 5 years and Medicare Part C (Medicare Advantage) patients within the previous 10 years either in a paper format in the patient's clinical record or in an electronic computer file format that the inpatient rehabilitation facility can easily obtain and produce upon request to CMS or its contractors.

The burden for maintaining the patient assessment instrument for Medicare Part A is currently approved under OMB# 0938–0842. CMS will revise this currently approved package as necessary to include any additional burden placed on IRFs for maintaining the patient assessment instrument for Medicare Advantage patients.

Section 412.614 Transmission of Patient Assessment Data

Section 412.614(a) requires that the IRF must encode and transmit patient assessment data to CMS. The burden associated with this requirement is the time staff must take to transmit the data.

CMS currently estimates that it takes the IRF 0.10 of an hour to transmit a single patient assessment instrument. Therefore, the annual hour burden to transmit an average of approximately 38 additional patient assessments instruments per IRF is 3.8 hours (38 × 0.10). The total annual hour burden for all 1,205 IRFs is 4,579 hours (3.8 hours × 1,205 IRFs). The burden estimate for transmitting the patient assessment instrument for Medicare Part A is currently approved under 0938–0842. CMS will revise this currently approved package as necessary to include any additional burden placed on the IRF for transmitting the patient assessment instrument for Medicare Advantage patients.

You may submit comments on these information collection and recordkeeping requirements in one of the following ways (please choose only one of the ways listed):

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

5. Submit your written comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, *Attention:* CMS Desk Officer; *Fax:* (202) 395–7245; or *E-mail: OIRA_submission@omb.eop.gov*.

X. Response to Public Comments

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

XI. Regulatory Impact Analysis

A. Overall Impact

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

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). This proposed rule is a major rule, as defined in Title 5, United States Code, section 804(2),

because we estimate the impact to the Medicare program, and the annual effects to the overall economy, will be more than $100 million. We estimate that the total impact of these proposed changes for estimated FY 2010 payments compared to estimated FY 2009 payments would be an increase of approximately $150 million (this reflects a $140 million increase from the update to the payment rates and a $10 million increase due to the proposed update to the outlier threshold amount to increase estimated outlier payments from approximately 2.8 percent in FY 2009 to 3 percent in FY 2010).

The Regulatory Flexibility Act (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 $7 million to $34.5 million in any one year. (For details, see the Small Business Administration's final rule that set forth size standards for health care industries, at 65 FR 69432, November 17, 2000.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs or the proportion of IRFs' revenue that is derived from Medicare payments. Therefore, we assume that all IRFs (an approximate total of 1,200 IRFs, of which approximately 60 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 7, we estimate that the net revenue impact of this proposed rule on all IRFs is to increase estimated payments by about 2.6 percent, with an estimated positive increase in payments of 3 percent or higher for some categories of IRFs (such as urban IRFs in the Mountain and Pacific regions). Thus, we anticipate that this proposed rule would have a significant impact on a substantial number of small entities. However, there is no negative estimated impact of this proposed rule that is within the significance threshold of 3 to 5 percent, so we believe that this proposed rule would not impose a significant burden on small entities. Medicare fiscal intermediaries and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As discussed in detail below, the rates and policies set forth in this proposed rule will not have an adverse impact on rural hospitals based on the data of the 193 rural units and 21 rural hospitals in our database of 1,205 IRFs for which data were available.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) 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 2009, that threshold level is approximately $133 million. This proposed rule will not impose spending costs on State, local, or tribal governments, in the aggregate, or by the private sector, of $133 million.

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

B. Anticipated Effects of the Proposed Rule

1. Basis and Methodology of Estimates

This proposed rule sets forth updates of the IRF PPS rates contained in the FY 2009 final rule and proposes updates to the CMG relative weights and length of stay values, the facility-level adjustments, the wage index, and the outlier threshold for high-cost cases.

We estimate that the FY 2010 impact would be a net increase of $150 million in payments to IRF providers (this reflects a $140 million estimated increase from the proposed update to the payment rates and a $10 million estimated increase due to the proposed update to the outlier threshold amount to increase the estimated outlier payments from approximately 2.8 percent in FY 2009 to 3.0 percent in FY 2010). The impact analysis in Table 7 of this proposed rule represents the projected effects of the proposed policy changes in the IRF PPS for FY 2010 compared with estimated IRF PPS payments in FY 2009 without the proposed policy changes. We estimate the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these proposed changes, and we do not make adjustments for future changes in such variables as number of discharges or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors because of other changes in the forecasted impact time period. Some examples could be legislative changes made by the Congress to the Medicare program that would impact program funding, or changes specifically related to IRFs. Although some of these changes may not necessarily be specific to the IRF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

In updating the rates for FY 2010, we are proposing a number of standard annual revisions and clarifications mentioned elsewhere in this proposed rule (for example, the update to the wage and market basket indexes used to adjust the Federal rates). We estimate that these proposed revisions would increase payments to IRFs by approximately $140 million (all due to the update to the market basket index, since the update to the wage index is done in a budget neutral manner—as required by statute—and therefore neither increases nor decreases aggregate payments to IRFs).

The aggregate change in estimated payments associated with this proposed rule is estimated to be an increase in payments to IRFs of $150 million for FY 2010. The market basket increase of $140 million and the $10 million increase due to the proposed update to the outlier threshold amount to increase estimated outlier payments from approximately 2.8 percent in FY 2009 to 3.0 percent in FY 2010 would result in a net change in estimated payments from FY 2009 to FY 2010 of $150 million.

The effects of the proposed changes that impact IRF PPS payment rates are shown in Table 7. The following proposed changes that affect the IRF

PPS payment rates are discussed separately below:

- The effects of the proposed update to the outlier threshold amount, from approximately 2.8 to 3.0 percent of total estimated payments for FY 2010, consistent with section 1886(j)(4) of the Act.
- The effects of the annual market basket update (using the RPL market basket) to IRF PPS payment rates, as required by section 1886(j)(3)(A)(i) and section 1886(j)(3)(C) of the Act.
- The effects of applying the budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the proposed budget-neutral changes to the CMG relative weights and length of stay values, under the authority of section 1886(j)(2)(C)(i) of the Act.
- The effects of the proposed budget-neutral changes to the facility-level adjustment factors, as permitted under section 1886(j)(3)(A)(v) of the Act.
- The total proposed change in estimated payments based on the FY 2010 proposed policies relative to estimated FY 2009 payments without the proposed policies.

2. Description of Table 7

The table below categorizes IRFs by geographic location, including urban or rural location, and location with respect to CMS's nine census divisions (as defined on the cost report) of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities, ownership (otherwise called for-profit, non-profit, and government), and by teaching status. The top row of the table shows the overall impact on the 1,205 IRFs included in the analysis.

The next 12 rows of Table 7 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 991 IRFs located in urban areas included in our analysis. Among these, there are 793 IRF units of hospitals located in urban areas and 198 freestanding IRF hospitals located in urban areas. There are 214 IRFs located in rural areas included in our analysis. Among these, there are 193 IRF units of hospitals located in rural areas and 21 freestanding IRF hospitals located in rural areas. There are 398 for-profit IRFs. Among these, there are 324 IRFs in urban areas and 74 IRFs in rural areas. There are 739 non-profit IRFs. Among these, there are 615 urban IRFs and 124 rural IRFs. There are 68 government-owned IRFs. Among these, there are 52 urban IRFs and 16 rural IRFs.

The remaining three parts of Table 7 show IRFs grouped by their geographic location within a region and by teaching status. First, IRFs located in urban areas are categorized with respect to their location within a particular one of the nine CMS geographic regions. Second, IRFs located in rural areas are categorized with respect to their location within a particular one of the nine CMS geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. Finally, IRFs are grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent.

The estimated impacts of each proposed change to the facility categories listed above are shown in the columns of Table 7. 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 2007 analysis file.

Column (3) shows the number of cases in each category in our FY 2007 analysis file.

Column (4) shows the estimated effect of the proposed adjustment to the outlier threshold amount so that estimated outlier payments increase from approximately 2.8 percent in FY 2009 to 3.0 percent of total estimated payments for FY 2010.

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

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

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

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

Column (9) compares our estimates of the payments per discharge, incorporating all of the proposed changes reflected in this proposed rule for FY 2010, to our estimates of payments per discharge in FY 2009 (without these proposed changes).

The average estimated increase for all IRFs is approximately 2.6 percent. This estimated increase includes the effects of the 2.4 percent market basket update. It also includes the 0.2 percent overall estimated increase (the difference between 2.8 percent in FY 2009 and 3.0 percent in FY 2010) in estimated IRF outlier payments from the proposed update to the outlier threshold amount. Because we are making the remainder of the proposed changes outlined in this proposed rule in a budget-neutral manner, they would not affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they would affect the estimated distribution of payments among providers.

TABLE 7—PROPOSED IRF IMPACT TABLE FOR FY 2010

Facility classification	Number of IRFs	Number of cases	Outlier	Market basket	FY 2010 CBSA wage index and labor-share	CMG	Facility adjustments	Total percent change
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Total	1,205	376,418	0.2%	2.4%	0.0%	0.0%	0.0%	2.6%
Urban unit	793	205,883	0.3	2.4	0.0	0.0	0.2	2.9
Rural unit	193	31,249	0.3	2.4	0.1	0.0	−1.9	0.8

TABLE 7—PROPOSED IRF IMPACT TABLE FOR FY 2010—Continued

Facility classification	Number of IRFs	Number of cases	Outlier	Market basket	FY 2010 CBSA wage index and labor-share	CMG	Facility adjustments	Total percent change
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Urban hospital	198	132,879	0.1	2.4	0.0	0.0	0.3	2.8
Rural hospital	21	6,407	0.1	2.4	0.1	0.0	−2.3	0.3
Urban for-profit	324	128,187	0.2	2.4	0.1	0.0	0.1	2.9
Rural for-profit	74	13,477	0.2	2.4	0.0	0.0	−2.2	0.3
Urban Non-Profit	615	195,986	0.3	2.4	−0.1	0.0	0.3	2.8
Rural Non-Profit	124	21,898	0.2	2.4	0.1	0.0	−1.9	0.9
Urban Government	52	14,589	0.5	2.4	0.1	0.0	0.0	3.0
Rural Government	16	2,281	0.5	2.4	0.3	0.0	−1.8	1.4
Urban	991	338,762	0.2	2.4	0.0	0.0	0.2	2.8
Rural	214	37,656	0.2	2.4	0.1	0.0	−2.0	0.7
Urban by region								
Urban New England	32	16,461	0.2	2.4	0.0	0.0	0.2	2.8
Urban Middle Atlantic	156	60,076	0.2	2.4	−0.3	0.0	0.5	2.7
Urban South Atlantic	133	57,429	0.3	2.4	−0.2	0.0	0.1	2.6
Urban East North Central	195	59,475	0.3	2.4	−0.6	0.0	0.6	2.6
Urban East South Central	54	24,565	0.2	2.4	−0.1	0.0	0.4	2.9
Urban West North Central	68	17,166	0.3	2.4	0.4	0.0	0.2	3.3
Urban West South Central	175	58,891	0.2	2.4	0.0	0.0	0.3	3.0
Urban Mountain	71	21,982	0.3	2.4	0.3	0.0	0.2	3.2
Urban Pacific	107	22,717	0.4	2.4	1.5	0.0	−1.1	3.2
Rural by region								
Rural New England	6	1,480	0.4	2.4	−0.3	0.0	−1.5	0.9
Rural Middle Atlantic	18	3,372	0.2	2.4	−0.3	0.0	−1.3	0.9
Rural South Atlantic	26	5,505	0.2	2.4	−0.2	0.0	−2.2	0.2
Rural East North Central	36	6,332	0.2	2.4	−0.5	0.0	−1.7	0.3
Rural East South Central	23	4,078	0.1	2.4	−0.2	0.0	−2.7	−0.4
Rural West North Central	37	5,485	0.3	2.4	0.5	0.0	−1.7	1.4
Rural West South Central	57	10,316	0.2	2.4	0.7	0.0	−2.3	1.0
Rural Mountain	6	592	0.4	2.4	0.3	0.0	−1.8	1.3
Rural Pacific	5	496	0.8	2.4	0.5	0.0	−1.0	2.7
Teaching Status								
Non-teaching	1,087	325,871	0.2	2.4	0.0	0.0	−0.1	2.6
Resident to ADC less than 10%	66	35,237	0.2	2.4	−0.1	0.0	0.0	2.5
Resident to ADC 10%–19%	34	10,178	0.2	2.4	−0.8	0.0	0.4	2.2
Resident to ADC greater than 19%	18	5,132	0.2	2.4	−0.2	0.0	2.4	4.9

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

In the FY 2009 IRF PPS final rule (73 FR 46370), we used FY 2007 patient-level claims data (the best, most complete data available at that time) to set the outlier threshold amount for FY 2009 so that estimated outlier payments would equal 3 percent of total estimated payments for FY 2009. For this proposed rule, we are proposing to update our analysis using more current FY 2007 data. Using the updated FY 2007 data, we now estimate that IRF outlier payments, as a percentage of total estimated payments for FY 2010, decreased from 3 percent using the FY 2007 data to approximately 2.8 percent using the updated FY 2007 data. As a result, we are proposing to adjust the outlier threshold amount for FY 2010 to $9,976, reflecting total estimated outlier payments equal to 3 percent of total estimated payments in FY 2010.

The impact of the proposed update to the outlier threshold amount (as shown in column 4 of Table 7) is to increase estimated overall payments to IRFs by 0.2 percent. We do not estimate that any group of IRFs would experience a decrease in payments from this proposed update. We estimate the largest increase in payments to be a 0.8 percent increase in estimated payments to rural IRF's in the Pacific region.

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

The proposed market basket update to the IRF PPS payment rates is presented in column 5 of Table 7. In the aggregate the proposed update would result in a 2.4 percent increase in overall estimated payments to IRFs.

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

In column 6 of Table 7, we present the effects of the proposed budget neutral update of the wage index and labor-related share. In the aggregate and for all urban IRFs, we do not estimate that these proposed changes would affect

overall estimated payments to IRFs. However, we estimate that these proposed changes would have small distributional effects. We estimate a 0.1 percent increase in payments to rural IRFs, with the largest increase in payments of 1.5 percent for urban IRFs in the Pacific region. We estimate the largest decrease in payments from the proposed update to the CBSA wage index and labor-related share to be a 0.8 percent decrease for IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent.

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

In column 7 of Table 7, we present the effects of the proposed budget neutral update of the CMG relative weights and average length of stay values. In the aggregate and across all hospital groups we do not estimate that these proposed changes would affect overall estimated payments to IRFs.

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

In column 8 of Table 7, we present the effects of the proposed budget neutral update to the rural, LIP, and teaching status adjustment factors. In the aggregate, we do not estimate that these proposed changes would affect overall estimated payments to IRFs. However, we estimate that these proposed changes would have small distributional effects. We estimate the largest increase in payments to be a 2.4 percent increase for IRFs with a resident to ADC ratio greater than 19 percent. We estimate the largest decrease in payments to be a 2.7 percent decrease for rural IRFs in the East South Central region.

C. Alternatives Considered

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

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. As noted in section V of this proposed rule, in the absence of statutory direction on the FY 2010 market basket increase factor, it is our understanding that the Congress requires a full market basket increase factor based upon current data. Thus, we did not consider alternatives to updating payments using the estimated RPL market basket increase factor (currently 2.4 percent) for FY 2010.

We considered maintaining the existing CMG relative weights and average length of stay values for FY 2010. However, several commenters on the FY 2009 IRF PPS proposed rule (73 FR 46373) suggested that the data that we used for FY 2009 to update the CMG relative weights and average length of stay values did not fully reflect recent changes in IRF utilization that have occurred because of changes in the IRF compliance percentage and the consequences of recent IRF medical necessity reviews. 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 these recent changes and that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs, we believe that it is appropriate to update the CMG relative weights and average length of stay values at this time.

We also considered maintaining the existing rural, LIP, and teaching status adjustment factors for FY 2010. However, the current rural, LIP, and teaching status adjustment factors are based on RAND's analysis of FY 2003 data, which are not reflective of recent changes in IRF utilization that have occurred because of changes in the IRF compliance percentage and the consequences of recent IRF medical necessity reviews. Thus, we believe that it is important to update these adjustment factors at this time to ensure that payments to IRFs reflect as accurately as possible the current costs of care in IRFs.

In estimating the proposed updates to the rural, LIP, and teaching status adjustment factors, we considered either basing them on an analysis of FY 2007 data alone, or averaging the adjustment factors based on the most recent three years of data (FYs 2005, 2006, and 2007). We decided to propose the new approach of averaging the adjustment factors based on the most recent three years of data to avoid unnecessarily large fluctuations in the adjustment factors from year to year, and thereby promote the consistency and predictability of IRF PPS payments over time. We believe that this will benefit all IRFs by enabling them to plan their future Medicare payments more accurately.

We considered maintaining the existing outlier threshold amount for FY 2010. However, the proposed update to the outlier threshold amount would have a positive impact on IRF providers and, therefore, on small entities (as shown in Table 7, column 4). Further, analysis of FY 2007 data indicates that estimated outlier payments would not equal 3 percent of estimated total payments for FY 2010 unless we proposed to update the outlier threshold amount. Thus, we believe that this update is appropriate for FY 2010.

In addition, we considered maintaining the existing coverage requirements for IRFs, without clarification. However, these coverage requirements have not been updated in over 20 years and no longer reflect current medical practice or changes that have occurred in IRF utilization and payments as a result of the implementation of the IRF PPS in 2002. We believe that the proposed clarifications would benefit IRFs and Medicare's contractors (including fiscal intermediaries, Medicare Administrative Contractors, and Recovery Audit Contractors) by promoting a more consistent understanding of CMS's IRF coverage policies among stakeholders, thereby leading to fewer disputed IRF claims denials.

Finally, we considered maintaining our current policy of requiring that an IRF's Medicare Part A inpatient population consist of at least 50 percent or more of the facility's total inpatient population before the presumptive methodology can be used to calculate the IRF's compliance percentage under the 60 percent rule. However, increasing numbers of Medicare beneficiaries in many areas of the country have been enrolling in Medicare Advantage (MA) plans rather than remaining in the traditional Medicare Part A fee-for-service program. This, in turn, has led to decreases in the number of Medicare Part A fee-for-service inpatients in certain IRFs across the country and has resulted in a reduction in the number of IRFs that can benefit from the presumptive methodology. We did not anticipate this result when the policy was implemented. In light of these recent trends, we believe that it is appropriate at this time to include the Medicare Advantage patients in the calculations for the purposes of using the presumptive methodology to determine IRFs' compliance with the 60 percent rule requirements.

D. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 8 below, we have prepared an accounting statement showing the classification of the expenditures associated with the

provisions of this proposed rule. This table provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the proposed changes presented in this proposed rule based on the data for 1,205 IRFs in our database. All estimated expenditures are classified as transfers to Medicare providers (that is, IRFs).

TABLE 8—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2009 IRF PPS FISCAL YEAR TO THE 2010 IRF PPS FISCAL YEAR

Category	Transfers
Annualized Monetized Transfers	$150 million.
From Whom to Whom?	Federal Government to IRF Medicare Providers.

E. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2010 are projected to increase by 2.6 percent, compared with those in FY 2009, as reflected in column 9 of Table 7. IRF payments are estimated to increase 2.8 percent in urban areas and 0.7 percent in rural areas, per discharge compared with FY 2009. Payments to rehabilitation units in urban areas are estimated to increase 2.9 percent per discharge. Payments to rehabilitation freestanding hospitals in urban areas are estimated to increase 2.8 percent per discharge. Payments to rehabilitation units in rural areas are estimated to increase 0.8 percent per discharge, while payments to freestanding rehabilitation hospitals in rural areas are estimated to increase 0.3 percent per discharge.

Overall, the largest payment increase is estimated at 4.9 percent for IRFs with a resident to ADC ratio greater than 19 percent. Rural IRFs in the East South Central region are estimated to have a decrease of 0.4 percent in payments.

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

List of Subjects in 42 CFR Part 412

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

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

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 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—

A. Removing paragraphs (b)(3) through (b)(7).

B. Redesignating paragraphs (b)(8) and (b)(9) as paragraphs (b)(3) and (b)(4).

C. Revising newly redesignated paragraph (b)(4).

The revision reads as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(b) * * *

(4) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1) and is paid under the prospective payment system specified in § 412.1(a)(3) for a cost reporting period under paragraph (b)(3) of this section, but the inpatient population it actually treated during that period does not meet the requirements of paragraph (b)(2) of this section, we adjust payments to the hospital retroactively in accordance with the provisions in § 412.130.

* * * * *

3. Section 412.29 is amended by—

A. Revising the section heading.

B. Revising the introductory text.

C. Revising paragraphs (a) through (d).

D. Removing paragraph (e).

E. Redesignating paragraph (f) as paragraph (e).

F. Revising newly redesignated paragraph (e).

The revisions read as follows:

§ 412.29 Excluded rehabilitation hospitals and units: Additional requirements.

In order 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), a rehabilitation hospital or a rehabilitation unit, collectively referred to as ''inpatient rehabilitation facilities,'' must meet the following requirements:

(a) Provide rehabilitation nursing, physical therapy, occupational therapy, plus, as needed, speech-language pathology, social services, psychological services, and prosthetic and orthotic services that—

(1) Are ordered by a rehabilitation physician; that is, a licensed physician with specialized training and experience in rehabilitation.

(2) Require the care of skilled professionals, such as rehabilitation nurses, physical therapists, occupational therapists, speech-language pathologists, prosthetists, orthotists, and neuropsychologists.

(b) Inpatient Rehabilitation Facility Admission Requirements:

(1) The facility must ensure that each patient it admits meets the following requirements at the time of admission—

(i) Requires the active and ongoing therapeutic intervention of at least two therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

(ii) Generally requires and can reasonably be expected to actively participate in at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week and is expected to make measurable improvement that will be of practical value to improve the patient's functional capacity or adaptation to impairments. The required therapy treatments must begin within 36 hours after the patient's admission to the IRF.

(iii) Is sufficiently stable at the time of admission to the IRF to be able to actively participate in an intensive rehabilitation program.

(iv) Requires physician supervision by a rehabilitation physician, as defined in subsection (a)(1), or other licensed treating physician with specialized training and experience in inpatient rehabilitation. Generally, the requirement for medical supervision means that the rehabilitation physician

must conduct fact-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF 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.

(2) The facility must have and utilize a thorough preadmission screening process for each potential patient that meets the following criteria:

(i) It is conducted by a qualified clinician(s) designated by a rehabilitation physician described in paragraph (a)(1) of this section within the 48 hours immediately preceding the IRF admission.

(ii) It includes a detailed and comprehensive review of each prospective patient's condition and medical history.

(iii) It serves as the basis for the initial determination of whether or not the patient meets the IRF admission requirements in paragraph (b) of this section.

(iv) It is used to inform a rehabilitation physician who reviews and documents his or her concurrence with the findings and results of the preadmission screening.

(v) It is retained in the patient's medical record.

(c) Post-Admission Requirements:

(1) *Post-Admission Evaluation.* The facility must have and utilize a post-admission evaluation process in which a rehabilitation physician completes a post-admission evaluation for each patient within 24 hours of that patient's admission to the IRF facility in order to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin development of the overall individualized plan of care. This post-admission physician evaluation is to be retained in the patient's medical record.

(2) *Individualized Overall Plan of Care.* The facility shall ensure that:

(i) An individualized overall plan of care is developed by a rehabilitation physician with input from the interdisciplinary team within 72 hours of the patient's admission to the IRF.

(ii) The individualized overall plan of care is retained in the patient's medical record.

(d) Interdisciplinary Team. The facility shall ensure that each patient's treatment is managed using a coordinated interdisciplinary team approach to treatment.

(1) At a minimum, the interdisciplinary team is to be led by a rehabilitation physician and further consist of a registered nurse with specialized training or experience in rehabilitation; a social worker or case manager (or both); and a licensed or certified therapist from each therapy discipline involved in treating the patient. All team members must have current knowledge of the patient's medical and functional status.

(2) The team must meet at least once per week throughout the duration of the patient's stay to implement appropriate treatment services; review the patient's progress toward stated rehabilitation goals; identify any problems that could impede progress towards those goals; and, where necessary, reassess previously established goals in light of impediments, revise the treatment plan in light of new goals, and monitor continued progress toward those goals.

(3) The rehabilitation physician must document concurrence with all decisions made by the interdisciplinary team at each team meeting.

(e) Director of Rehabilitation. The IRF must have a director of rehabilitation who—

(1) In a rehabilitation hospital provides services to the hospital and its inpatients on a full-time basis, or

(2) In a rehabilitation unit, provides services to the unit and to its inpatients for at least 20 hours per week; and

(3) Meets the definition of a physician as set forth in Section 1861(r) of the Act; and,

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

4. Section 412.30 is amended by—

A. Revising the section heading.

B. Adding new introductory text.

The revision and addition read as follows:

§ 412.30 Exclusion of new and converted rehabilitation units and expansion of units already excluded.

In order 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), a new rehabilitation unit must meet either the requirements for a new unit under § 412.30(b) or a converted unit under § 412.30(c).

* * * * *

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

5. Section 412.604 is amended by revising paragraph (c) to read as follows:

§ 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

* * * * *

(c) *Completion of patient assessment instrument.* For each Medicare Part A fee-for-service patient admitted to or discharged from an IRF on or after January 1, 2002, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with § 412.606. IRFs must also complete a patient assessment instrument in accordance with § 412.606 for each Medicare Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009.

* * * * *

6. Section 412.606 is amended by—

A. Revising paragraph (b) introductory text.

B. Revising paragraph (c)(1).

The revisions read as follows:

§ 412.606 Patient Assessments.

* * * * *

(b) *Patient assessment instrument.* An inpatient rehabilitation facility must use the CMS inpatient rehabilitation facility patient assessment instrument to assess Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatients who—

* * * * *

(c) * * *

(1) A clinician of the inpatient rehabilitation facility must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare Part A fee-for-service inpatient using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of this section as part of his or her patient assessment in accordance with the schedule described in § 412.610. IRFs must also complete a patient assessment instrument in accordance with § 412.606 for each Medicare Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009.

* * * * *

7. Section 412.610 is amended by—

A. Revising paragraph (a).

B. Revising paragraph (b).

C. Revising paragraph (c) introductory text.

D. Revising paragraph (c)(1)(i)(A).

E. Revising paragraph (c)(2)(ii)(B).

F. Revising paragraph (f).

The revisions read as follows:

§ 412.610 Assessment schedule.

(a) *General.* For each Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) inpatient, an inpatient rehabilitation facility must complete a patient assessment instrument as specified in § 412.606 that covers a time period that is in accordance with the assessment

schedule specified in paragraph (c) of this section.

(b) *Starting the assessment schedule day count.* The first day that the Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the patient assessment schedule.

(c) *Assessment schedules and references dates.* The inpatient rehabilitation facility must complete a patient assessment instrument upon the Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) patient's admission and discharge as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) * * *

(i) * * *

(A) Time period is a span of time that covers calendar days 1 through 3 of the patient's current Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) hospitalization;

* * * * *

(2) * * *

(ii) * * *

(B) The patient stops being furnished Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) inpatient rehabilitation services.

* * * * *

(f) *Patient assessment instrument record retention.* An inpatient rehabilitation facility must maintain all patient assessment data sets completed on Medicare Part A fee-for-service patients within the previous 5 years and Medicare Part C (Medicare Advantage) patients within the previous 10 years either in a paper format in the patient's clinical record or in an electronic computer file format that the inpatient rehabilitation facility can easily obtain and produce upon request to CMS or its contractors.

8. Section 412.614 is amended by—

A. Revising paragraph (a) introductory text.

B. Removing paragraph (a)(3).

C. Revising paragraph (b)(1).

D. Revising paragraph (d).

E. Revising paragraph (e).

The revisions read as follows:

§ 412.614 Transmission of patient assessment data.

(a) *Data format*; *General rule.* The inpatient rehabilitation facility must encode and transmit data for each Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatient—

* * * * *

(b) * * *

(1) Electronically transmit complete, accurate, and encoded data from the patient assessment instrument for each Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatient to our patient data system in accordance with the data format specified in paragraph (a) of this section; and

* * * * *

(d) *Consequences of failure to submit complete and timely IRF–PAI data, as required under paragraph (c) of this section.*

(1) *Medicare Part A fee-for-service data.*

(i) We assess a penalty when an inpatient rehabilitation facility does not transmit all of the required data from the patient assessment instrument for its Medicare Part A fee-for-service patients to our patient data system in accordance with the transmission timeline in paragraph (c) of this section.

(ii) If the actual patient assessment data transmission date for a Medicare Part A fee-for-service patient is later than 10 calendar days from the transmission date specified in paragraph (c) of this section, the patient assessment data is considered late and the inpatient rehabilitation facility receives a payment rate than is 25 percent less than the payment rate associated with a case-mix group.

(2) *Medicare Part C (Medicare Advantage) data.* Failure of the inpatient rehabilitation facility to transmit all of the required patient assessment instrument data for its Medicare Part C (Medicare Advantage) patients to our patient data system in accordance with the transmission timeline in paragraph (c) of this section will result in a forfeiture of the facility's ability to have any of its Medicare Part C (Medicare Advantage) data used in the calculations for determining the facility's compliance with the regulations in § 412.23(b)(2).

(e) *Exemption to the consequences for transmitting the IRF–PAI data late.* CMS may waive the consequences of failure to submit complete and timely IRF–PAI data specified in paragraph (d) of this section when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data in accordance with paragraph (c) of this section. Only CMS can determine if a situation encountered by an inpatient rehabilitation facility is extraordinary and qualifies as a situation for waiver of the penalty specified in paragraph (d)(1)(ii) of this section or for waiver of the forfeiture specified in paragraph (d)(2) of this section. An extraordinary situation may be due to, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflect extensive damage to an inpatient facility. An extraordinary situation may be one that produces a data transmission problem that is beyond the control of the inpatient rehabilitation facility, as well as other situations determined by CMS to be beyond the control of the inpatient rehabilitation facility. An extraordinary situation must be fully documented by the inpatient rehabilitation facility.

9. Section 412.618 is amended by revising the introductory text to read as follows.

§ 412.618 Assessment process for interrupted stays.

For purposes of the patient assessment process, if a Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) patient has an interrupted stay, as defined under § 412.602, the following applies:

* * * * *

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

Dated: March 11, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: April 16, 2009.

Charles E. Johnson,

Acting Secretary.

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

Addendum

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

Table 1—Proposed Inpatient Rehabilitation Facility Wage Index for Urban Areas for Discharges Occurring from October 1, 2009 through September 30, 2010

Table 2—Proposed Inpatient Rehabilitation Facility Wage Index for Rural Areas for Discharges Occurring from October 1, 2009 through September 30, 2010.

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TABLE 1 - PROPOSED INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2010

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8097
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	0.3399
10420	Akron, OH Portage County, OH Summit County, OH	0.8917
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8703
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8707

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9210
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8130
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9499
11020	Altoona, PA Blair County, PA	0.8521
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8927
11180	Ames, IA Story County, IA	0.9487
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.1931
11300	Anderson, IN Madison County, IN	0.8760
11340	Anderson, SC Anderson County, SC	0.9570
11460	Ann Arbor, MI Washtenaw County, MI	1.0445
11500	Anniston-Oxford, AL Calhoun County, AL	0.7927

CBSA Code	Urban Area (Constituent Counties)	Wage Index
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9440
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9142
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9591

CBSA Code	Urban Area (Constituent Counties)	Wage Index
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	0.9754
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1973
12220	Auburn-Opelika, AL Lee County, AL	0.7544

CBSA Code	Urban Area (Constituent Counties)	Wage Index
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9615
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9536
12540	Bakersfield, CA Kern County, CA	1.1189
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	1.0055
12620	Bangor, ME Penobscot County, ME	1.0174
12700	Barnstable Town, MA Barnstable County, MA	1.2643

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	0.8163
12980	Battle Creek, MI Calhoun County, MI	1.0120
13020	Bay City, MI Bay County, MI	0.9248
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8479
13380	Bellingham, WA Whatcom County, WA	1.1640
13460	Bend, OR Deschutes County, OR	1.1375
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0548
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8805
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8574

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	0.8792
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7148
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8155
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8979
14060	Bloomington-Normal, IL McLean County, IL	0.9323
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9268
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.1897
14500	Boulder, CO Boulder County, CO	1.0302

CBSA Code	Urban Area (Constituent Counties)	Wage Index
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8388
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	0.9900
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0770
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2868
15180	Brownsville-Harlingen, TX Cameron County, TX	0.8916
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9567
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9537
15500	Burlington, NC Alamance County, NC	0.8736
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9254
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1086
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0346
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8841

CBSA Code	Urban Area (Constituent Counties)	Wage Index
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9396
16180	Carson City, NV Carson City, NV	1.0128
16220	Casper, WY Natrona County, WY	0.9579
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8919
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9461
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8275
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9209
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9595

CBSA Code	Urban Area (Constituent Counties)	Wage Index
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9816
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8878
16940	Cheyenne, WY Laramie County, WY	0.9276
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	1.0399
17020	Chico, CA Butte County, CA	1.0897

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	0.9687
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8298
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8010
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9241
17660	Coeur d'Alene, ID Kootenai County, ID	0.9322

CBSA Code	Urban Area (Constituent Counties)	Wage Index
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9346
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9977
17860	Columbia, MO Boone County, MO Howard County, MO	0.8540
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8933
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8739
18020	Columbus, IN Bartholomew County, IN	0.9739
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	0.9943

CBSA Code	Urban Area (Constituent Counties)	Wage Index
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8598
18700	Corvallis, OR Benton County, OR	1.1304
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.7816
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	0.9945
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8705
19180	Danville, IL Vermilion County, IL	0.9374
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8395
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8435

CBSA Code	Urban Area (Constituent Counties)	Wage Index
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9203
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7803
19500	Decatur, IL Macon County, IL	0.8145
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8890
19740	Denver-Aurora, 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	1.0818
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9535
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9958
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7613

CBSA Code	Urban Area (Constituent Counties)	Wage Index
20100	Dover, DE Kent County, DE	1.0325
20220	Dubuque, IA Dubuque County, IA	0.8380
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0363
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9732
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9668
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1283
20940	El Centro, CA Imperial County, CA	0.8746
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8525
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9568
21300	Elmira, NY Chemung County, NY	0.8247
21340	El Paso, TX El Paso County, TX	0.8694
21500	Erie, PA Erie County, PA	0.8713

CBSA Code	Urban Area (Constituent Counties)	Wage Index
21660	Eugene-Springfield, OR Lane County, OR	1.1061
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8690
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1297
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4061
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8166
22140	Farmington, NM San Juan County, NM	0.8051
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9340
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8970
22380	Flagstaff, AZ Coconino County, AZ	1.1743
22420	Flint, MI Genesee County, MI	1.1425
22500	Florence, SC Darlington County, SC Florence County, SC	0.8130

CBSA Code	Urban Area (Constituent Counties)	Wage Index
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7871
22540	Fond du Lac, WI Fond du Lac County, WI	0.9293
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9867
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	0.9946
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7697
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8769
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9176
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9709
23420	Fresno, CA Fresno County, CA	1.1009
23460	Gadsden, AL Etowah County, AL	0.7983
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9312
23580	Gainesville, GA Hall County, GA	0.9109

CBSA Code	Urban Area (Constituent Counties)	Wage Index
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9250
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8473
24140	Goldsboro, NC Wayne County, NC	0.9143
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7565
24300	Grand Junction, CO Mesa County, CO	0.9812
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9184
24500	Great Falls, MT Cascade County, MT	0.8784
24540	Greeley, CO Weld County, CO	0.9684
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9709
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9011
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9448

CBSA Code	Urban Area (Constituent Counties)	Wage Index
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9961
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3249
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9029
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.8997
25260	Hanford-Corcoran, CA Kings County, CA	1.0870
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9153
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.8894
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1069
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7337

CBSA Code	Urban Area (Constituent Counties)	Wage Index
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8976
25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.9110
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9008
26180	Honolulu, HI Honolulu County, HI	1.1811
26300	Hot Springs, AR Garland County, AR	0.9113
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7758
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	0.9838
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9254
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9082

CBSA Code	Urban Area (Constituent Counties)	Wage Index
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9080
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	0.9908
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9483
27060	Ithaca, NY Tompkins County, NY	0.9614
27100	Jackson, MI Jackson County, MI	0.9309
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8067
27180	Jackson, TN Chester County, TN Madison County, TN	0.8523

CBSA Code	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	0.8999
27340	Jacksonville, NC Onslow County, NC	0.8177
27500	Janesville, WI Rock County, WI	0.9662
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8775
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7971
27780	Johnstown, PA Cambria County, PA	0.7920
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7916
27900	Joplin, MO Jasper County, MO Newton County, MO	0.9406
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0801
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0485

CBSA Code	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	0.9610
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9911
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8765
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7743
28740	Kingston, NY Ulster County, NY	0.9375

CBSA Code	Urban Area (Constituent Counties)	Wage Index
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7881
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9349
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9758
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9221
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8374
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7556
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0389
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	0.9797
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8530
29540	Lancaster, PA Lancaster County, PA	0.9363
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9931

CBSA Code	Urban Area (Constituent Counties)	Wage Index
29700	Laredo, TX Webb County, TX	0.8366
29740	Las Cruces, NM Dona Ana County, NM	0.8929
29820	Las Vegas-Paradise, NV Clark County, NV	1.1971
29940	Lawrence, KS Douglas County, KS	0.8343
30020	Lawton, OK Comanche County, OK	0.8211
30140	Lebanon, PA Lebanon County, PA	0.8954
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9465
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9200
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9110
30620	Lima, OH Allen County, OH	0.9427
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9759

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	0.8672
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8765
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8370
31020	Longview, WA Cowlitz County, WA	1.1207
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2208
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	0.9249
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8731

CBSA Code	Urban Area (Constituent Counties)	Wage Index
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8774
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9570
31460	Madera, CA Madera County, CA	0.7939
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.0967
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0359
31900	Mansfield, OH Richland County, OH	0.9330
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3940
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9009
32780	Medford, OR Jackson County, OR	1.0244

CBSA Code	Urban Area (Constituent Counties)	Wage Index
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9232
32900	Merced, CA Merced County, CA	1.2243
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	0.9830
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9159
33260	Midland, TX Midland County, TX	0.9827
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0080

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	1.1150
33540	Missoula, MT Missoula County, MT	0.8973
33660	Mobile, AL Mobile County, AL	0.7908
33700	Modesto, CA Stanislaus County, CA	1.2194
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7900
33780	Monroe, MI Monroe County, MI	0.8941
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8283
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8528

CBSA Code	Urban Area (Constituent Counties)	Wage Index
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7254
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0292
34620	Muncie, IN Delaware County, IN	0.8489
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0055
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8652
34900	Napa, CA Napa County, CA	1.4520
34940	Naples-Marco Island, FL Collier County, FL	0.9672
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	0.9504
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2453

CBSA Code	Urban Area (Constituent Counties)	Wage Index
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1731
35300	New Haven-Milford, CT New Haven County, CT	1.1742
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	0.9103
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	1.2885
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9066
35980	Norwich-New London, CT New London County, CT	1.1398

CBSA Code	Urban Area (Constituent Counties)	Wage Index
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6092
36100	Ocala, FL Marion County, FL	0.8512
36140	Ocean City, NJ Cape May County, NJ	1.1496
36220	Odessa, TX Ector County, TX	0.9475
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9153
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	0.8724
36500	Olympia, WA Thurston County, WA	1.1537
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	0.9441

CBSA Code	Urban Area (Constituent Counties)	Wage Index
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9111
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9474
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8685
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.1951
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9332
37380	Palm Coast, FL Flagler County, FL	0.8963
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8360
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7867
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8102
37764	Peabody, MA Essex County, MA	1.0747
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8242

CBSA Code	Urban Area (Constituent Counties)	Wage Index
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9038
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0979
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0379
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7926
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8678
38340	Pittsfield, MA Berkshire County, MA	1.0445
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9343

CBSA Code	Urban Area (Constituent Counties)	Wage Index
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4289
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9942
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	1.1456
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9870
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.0920
39140	Prescott, AZ Yavapai County, AZ	1.0221
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	1.0696
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9381

CBSA Code	Urban Area (Constituent Counties)	Wage Index
39380	Pueblo, CO Pueblo County, CO	0.8713
39460	Punta Gorda, FL Charlotte County, FL	0.8976
39540	Racine, WI Racine County, WI	0.9054
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9817
39660	Rapid City, SD Meade County, SD Pennington County, SD	0.9598
39740	Reading, PA Berks County, PA	0.9242
39820	Redding, CA Shasta County, CA	1.3731
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0317

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	0.9363
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1468
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8660
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1214

CBSA Code	Urban Area (Constituent Counties)	Wage Index
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8811
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9835
40484	Rockingham County, NH Rockingham County, NH Strafford County, NH	0.9926
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9031
40660	Rome, GA Floyd County, GA	0.9134
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.3572
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8702
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.0976
41100	St. George, UT Washington County, UT	0.9021
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0380

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9006
41420	Salem, OR Marion County, OR Polk County, OR	1.0884
41500	Salinas, CA Monterey County, CA	1.4987
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9246
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9158
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8424

CBSA Code	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	0.8856
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1538
41780	Sandusky, OH Erie County, OH	0.8870
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5529
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4756
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6141

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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	0.4393

CBSA Code	Urban Area (Constituent Counties)	Wage Index
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.2441
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1993
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.1909
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6429
42140	Santa Fe, NM Santa Fe County, NM	1.0610
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.5528
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9152
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8333
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1755
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9217
43100	Sheboygan, WI Sheboygan County, WI	0.8920
43300	Sherman-Denison, TX Grayson County, TX	0.9024
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8442

CBSA Code	Urban Area (Constituent Counties)	Wage Index
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.8915
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9354
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9761
43900	Spartanburg, SC Spartanburg County, SC	0.9025
44060	Spokane, WA Spokane County, WA	1.0559
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9102
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0405
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8424
44220	Springfield, OH Clark County, OH	0.8876
44300	State College, PA Centre County, PA	0.8937

CBSA Code	Urban Area (Constituent Counties)	Wage Index
44700	Stockton, CA San Joaquin County, CA	1.2015
44940	Sumter, SC Sumter County, SC	0.8257
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9787
45104	Tacoma, WA Pierce County, WA	1.1241
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8964
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.8852
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9085
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8144
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9407

CBSA Code	Urban Area (Constituent Counties)	Wage Index
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8756
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0604
46060	Tucson, AZ Pima County, AZ	0.9229
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8445
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8496
46340	Tyler, TX Smith County, TX	0.8804
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8404
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8027
46700	Vallejo-Fairfield, CA Solano County, CA	1.4359

CBSA Code	Urban Area (Constituent Counties)	Wage Index
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8124
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0366
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	0.8884
47300	Visalia-Porterville, CA Tulare County, CA	1.0144
47380	Waco, TX McLennan County, TX	0.8596
47580	Warner Robins, GA Houston County, GA	0.8989
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9904

CBSA Code	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	1.0827
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8490
48140	Wausau, WI Marathon County, WI	0.9615
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.8079
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	0.9544

CBSA Code	Urban Area (Constituent Counties)	Wage Index
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9757
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6955
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9069
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8832
48700	Williamsport, PA Lycoming County, PA	0.8096
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0696
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9089
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9801
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9016

CBSA Code	Urban Area (Constituent Counties)	Wage Index
49340	Worcester, MA Worcester County, MA	1.0836
49420	Yakima, WA Yakima County, WA	0.9948
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3432
49620	York-Hanover, PA York County, PA	0.9518
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8915
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1137
49740	Yuma, AZ Yuma County, AZ	0.9281

[1] At this time, there are no hospitals located in this urban area on which to base a wage index. We use the average wage index of all of the urban areas within the State to serve as a reasonable proxy.

Table 2 - Proposed Inpatient Rehabilitation Facility Wage Index For Rural Areas For Discharges Occurring From October 1, 2009 Through September 30, 2010

State Code	Nonurban Area	Wage Index
1	Alabama	0.7587
2	Alaska	1.1898
3	Arizona	0.8453
4	Arkansas	0.7473
5	California	1.2275
6	Colorado	0.9570
7	Connecticut	1.1016
8	Delaware	0.9962
10	Florida	0.8504
11	Georgia	0.7612
12	Hawaii	1.0999
13	Idaho	0.7651
14	Illinois	0.8386
15	Indiana	0.8473
16	Iowa	0.8804
17	Kansas	0.8052
18	Kentucky	0.7803
19	Louisiana	0.7447
20	Maine	0.8644
21	Maryland	0.8883
22	Massachusetts[1]	1.1670
23	Michigan	0.8887
24	Minnesota	0.9059
25	Mississippi	0.7584
26	Missouri	0.7982
27	Montana	0.8658
28	Nebraska	0.8730

State Code	Nonurban Area	Wage Index
29	Nevada	0.9382
30	New Hampshire	1.0219
31	New Jersey[1]	-----
32	New Mexico	0.8812
33	New York	0.8145
34	North Carolina	0.8576
35	North Dakota	0.7205
36	Ohio	0.8588
37	Oklahoma	0.7732
38	Oregon	1.0218
39	Pennsylvania	0.8365
40	Puerto Rico1	0.4047
41	Rhode Island[1]	-----
42	South Carolina	0.8538
43	South Dakota	0.8603
44	Tennessee	0.7789
45	Texas	0.7894
46	Utah	0.8267
47	Vermont	1.0079
48	Virgin Islands	0.6971
49	Virginia	0.7861
50	Washington	1.0181
51	West Virginia	0.7503
52	Wisconsin	0.9373
53	Wyoming	0.9315
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 2010. The rural Massachusetts wage index is calculated as the average of all contiguous CBSAs. The Puerto Rico wage index is the same as FY 2009.

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