Federal Register

Friday,
August 7, 2009

Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 412

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1538–F]

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: Final rule.

SUMMARY: This final rule updates 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 revising existing policies regarding the IRF PPS within the authority granted under section 1886(j) of the Act.

DATES: *Effective Date.* The provisions of the final rule are effective October 1, 2009, except for the amendments to § 412.23, § 412.29, and § 412.622 which are effective January 1, 2010.

Applicability Date. The amendments to § 412.23, § 412.29, and § 412.622 are applicable to IRF discharges occurring on or after January 1, 2010. The updated IRF prospective payment rates are applicable for IRF discharges occurring on or after October 1, 2009 and on or before September 30, 2010 (FY 2010).

FOR FURTHER INFORMATION CONTACT: Susanne Seagrave, (410) 786–0044, for information regarding the payment policies.

Julie Stankivic, (410) 786–5725, for general information regarding the proposed rule.

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

SUPPLEMENTARY INFORMATION:

Table of Contents

I. Background
A. Historical Overview of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)
B. Operational Overview of the Current IRF PPS
II. Summary of Provisions of the Proposed Rule
A. Proposed Updates to the IRF PPS for Federal Fiscal Year (FY) 2010
B. Proposed Revisions to Existing Regulation Text
C. Proposed New Regulation Text
D. Proposed Rescission of Outdated HCFAR–85–2–1
III. Analysis of and Responses to Public Comments
IV. Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2010
V. Updates to the Facility-Level Adjustment Factors for FY 2010
A. Updates to the Adjustment Factors for FY 2010
B. Budget Neutrality Methodology for the Updates to the IRF Facility-Level Adjustment Factors
VI. FY 2010 IRF PPS Federal Prospective Payment Rates
A. Market Basket Increase Factor and Labor-Related Share for FY 2010
B. Area Wage Adjustment
C. Description of the Final IRF Standard Payment Conversion Factor and Payment Rates for FY 2010
D. Example of the Methodology for Adjusting the Federal Prospective Payment Rates
VII. Update to Payments for High-Cost Outliers Under the IRF PPS
A. Update to the Outlier Threshold Amount for FY 2010
B. Update to the IRF Cost-to-Charge Ratio Ceilings
VIII. Inpatient Rehabilitation Facility (IRF) Coverage Requirements
A. Requirements for the Preadmission Screening
B. Requirement for a Post-Admission Physician Evaluation
C. Requirement for an Individualized Overall Plan of Care
D. Requirements for Evaluating the Appropriateness of an IRF Admission
E. Requirements for the Interdisciplinary Team Meetings
F. Requirement for Physician Supervision
G. Requirement Regarding Initiation of Therapy Services
H. Provision of Group Therapies in IRFs
I. Clarifying and Conforming Amendments
J. HCFAR 85–2 Ruling
IX. Revisions to the Regulation Text To Require IRFs To Submit Patient Assessments on Medicare Advantage Patients for Use in the ''60 Percent Rule'' Calculations
A. Background on the ''60 Percent Rule'' Calculations
B. Requirement To Submit Assessment Data on Medicare Advantage Patients
X. Miscellaneous Comments
XI. Provisions of the Final Rule
A. Payment Provision Changes
B. Regulatory Text Changes
XII. Collection of Information Requirements
XIII. Regulatory Impact Analysis
A. Overall Impact
B. Anticipated Effects of the Final Rule
C. Alternatives Considered
D. Accounting Statement
E. Conclusion
Regulation Text
Addendum
Acronyms

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

ADC Average Daily Census
ASCA Administrative Simplification Compliance Act, Public Law 107–105
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 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, Public Law 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, Public Law 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, Public Law 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), Public Law 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), Public Law 106–113, and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Public Law 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 would continue to reflect as accurately as possible the costs of care. For a detailed discussion of the FY 2007 policy revisions, please refer to the FY 2007 IRF PPS final rule (71 FR 48354).

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

After publication of the FY 2008 IRF PPS final rule (72 FR 44284), section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 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), Public Law 104–191, compliant electronic claim or, if the Administrative Simplification Compliance Act (ASCA), Public Law 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

As discussed in the FY 2010 IRF PPS proposed rule (74 FR 21052), we proposed 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 of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21055 through 21059).
- 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 of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21059 through 21062).
- Update the FY 2010 IRF PPS payment rates by the proposed market basket, as discussed in section V.A of the FY 2010 IRF PPS proposed rule (74 FR 21052 at 21062).
- 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 of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21062 through 21063).
- Update the outlier threshold amount for FY 2010, as discussed in section VI.A of the FY 2010 IRF PPS proposed rule (74 FR 21052 at 21066).

B. Proposed Revisions to Existing Regulation Text

- Relocate and revise the criteria for admission to 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 of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21067 through 21071).

• Revise the section heading at § 412.29 to include inpatient rehabilitation hospitals, as described in section VII of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21067 through 21071).

• Relocate and revise the existing requirements at § 412.29(b) through (f) that describe the admission 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 of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21067 through 21071).

• Revise the section heading at § 412.30, as described in section VII of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21067 through 21071).

• 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 of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21071 through 21073).

• Remove § 412.614(a)(3) that provides for an exception in the transmission of IRF–PAI data to CMS, as described in section VIII of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21071 through 21073).

• 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 of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21071 through 21073).

• Revise the heading at § 412.614(d)(1) to ''Medicare Part A fee-for-service data,'' as described in section VIII of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21071 through 21073).

• 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), as described in section VIII of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21071 through 21073).

• Redesignate paragraph § 412.614(d)(2) as § 412.614(d)(1)(b), as described in section VIII of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21071 through 21073).

C. Proposed New Regulation Text

• Revise § 412.29, as described in section VII of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21067 through 21071), to include the requirements for admission to an IRF.

• Add a new introductory paragraph at § 412.30 that includes the requirements previously found in § 412.29(a) (describing the admission requirements for new and converted rehabilitation units), as described in section VII of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21067 through 21071).

• 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 of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21067 through 21071).

• 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 of the FY 2010 IRF PPS proposed rule (74 FR 21052, 21071 through 21073).

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 guidance to implement the new regulations adopted under this final rule, as described in section VII of the FY 2010 IRF PPS proposed rule (74 FR 21052 at 21071).

III. Analysis of and Responses to Public Comments

We received approximately 686 timely responses, many of which contained multiple comments on the FY 2010 IRF PPS proposed rule (74 FR 21052) from the public. We received comments from various trade associations, inpatient rehabilitation facilities, individual physicians, therapists, clinicians, health care industry organizations, and health care consulting firms. The following section, arranged by subject area, includes a summary of the public comments that we received, and our responses.

IV. Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 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 the FY 2010 IRF PPS proposed rule (74 FR 21052, 21055 through 21059), we proposed to update the CMG relative weights and average length of stay values for FY 2010 using the most recent available data (at that time, FY 2007 IRF claims and cost report data) to ensure that IRF PPS payments fully reflect recent changes in IRF utilization due to the 60 percent rule and medical review activities. To ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs, we are updating the CMG relative weights and average length of stay values for FY 2010 in this final rule using FY 2008 IRF claims and FY 2007 IRF cost report data. These data are the most current and complete data available at this time. At this time, only about 20 percent of the FY 2008 IRF cost report data are available for analysis, but the majority of the FY 2008 IRF claims data are available for analysis.

We have used 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 final 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 weights 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 are revising the CMG relative weights for FY 2010 in such a way that total estimated aggregate payments to IRFs for FY 2010 are estimated to be the same with or without the changes (that is, in a budget neutral manner) by applying a budget neutrality factor to the standard payment amount. To calculate the appropriate budget neutrality factor for use in updating the FY 2010 CMG relative weights, we use the following steps:

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

Step 2. Apply the 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 budget neutrality factor (1.0020) that maintains the same total estimated aggregate payments in FY 2010 with and without the changes to the CMG relative weights.

Step 4. Apply the budget neutrality factor (1.0020) to the FY 2009 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

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

Note that the budget neutrality factor that we use to update the CMG relative weights for FY 2010 changed from 1.0004 in the proposed rule to 1.0020 in this final rule due to the use of updated FY 2008 IRF claims data in this final rule.

We received 7 comments on the proposed updates to the CMG relative weights and average length of stay values, which are summarized below.

Comment: The vast majority of commenters supported the proposed update to the CMG relative weights and average length of stay values. However, most suggested that CMS use FY 2008 IRF claims and cost report data in updating the CMG relative weights and average length of stay values for the final rule, saying that the effects of recent changes in the 60 percent rule and the IRF medical necessity review activities are continuing to be realized through FY 2008 and early FY 2009. Several commenters said that we should continue to update the CMG relative weights and average length of stay values annually to reflect changes in IRF costs and utilization that occur over time.

Response: We appreciate the commenters' suggestions for updating the data used in the analysis of the CMG relative weights for FY 2010, and we agree that we should continue to use the most recent available data for our analyses of the CMG relative weights. However, only about 20 percent of the FY 2008 IRF cost reports are available for analysis at this time, and we do not believe that 20 percent is a large enough or representative enough sample of all IRFs on which to base our updates. Thus, for this final rule, we have continued to use the most recent available data, which are the FY 2008 IRF claims and FY 2007 IRF cost report data. We will continue to update the CMG relative weights and average length of stay values in the future, as appropriate, using the most recent available data.

Comment: One commenter requested that CMS seek additional sources of cost information, such as the Cost Resource Utilization (CRU) Tool data from the Post Acute Care Payment Reform Demonstration (PAC PRD), to address issues of relative weight compression in future updates to the CMG relative weights.

Response: We appreciate the commenter's suggestion, and will consider this suggestion for future analyses once the CRU data are complete and available for analysis.

Comment: One commenter stated a concern that the proposed update to the CMG relative weights for FY 2010 would result in a slight decrease in the average payment per case for IRFs and would increase payments for certain diagnoses while decreasing payments for other diagnoses.

Response: Consistent with the way that we applied updates to the CMG relative weights and average length of stay values 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 are updating the CMG relative weights and average length of stay values in this final rule in a budget-neutral manner, so that estimated aggregate payments to IRFs do not increase or decrease as a result of these updates. Thus, we apply a budget-neutrality factor of 1.0020 to increase the standard payment conversion factor (as described in section VI.C of this final rule) to counteract any estimated decrease in aggregate IRF payments as a result of the updates to the CMG relative weights and average length of stay values.

Further, as we stated in the FY 2010 IRF PPS proposed rule (74 FR 21052 at 21059), the updates are generally expected to result in some increases and some decreases to the CMG relative weight values. Changes in the relative weights are, by definition, distributional and, therefore, the fact that the updates shown in Table 1 increase IRF payments to some diagnoses and decrease IRF payments to other diagnoses is to be expected. The intent of these changes is to ensure that the relative payments assigned to the CMGs and tiers continue to reflect the relative costs of caring for different types of patients in IRFs.

Comment: Several commenters requested that we reiterate that the average length of stay values are not intended to be used as clinical guidelines for patient care, but are only used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment.

Response: We agree with this comment, and we already stated that the purpose of the average length of stay values is to determine when an IRF discharge meets the definition of a short-stay transfer in the FY 2010 IRF PPS proposed rule (74 FR 21052 at 21056). As the commenter notes, the average length of stay values are not intended to be used as clinical guidelines for patient care.

Comment: One commenter suggested that we consider alternative methodologies for updating the CMG relative weights in the future to improve their ability to predict IRFs' cost per case, and expressed a concern about the need to update the weighted motor score methodology used to classify IRF patients into CMGs that was finalized in the FY 2006 IRF PPS final rule (70 FR 47880 at 47900).

Response: We appreciate the commenter's suggestions regarding alternative methodologies for analyzing future updates to the CMG relative weights, and will review them carefully. We will also take into account the commenter's suggestion that we update the weights used in the motor score calculation in the future.

Final Decision: After carefully considering all of the comments that we received on the proposed updates to the CMG relative weights and average length of stay values, we are implementing the FY 2010 updates to the CMG relative weights and average length of stay values presented in Table

1 below (which are different from the relative weights and average length of stay values that we had proposed because these final values are based on analysis of updated FY 2008 data).

BILLING CODE 4120–01–P

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

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0101	Stroke M>51.05	0.7547	0.7070	0.6484	0.6128	9	11	9	9
0102	Stroke M>44.45 and M<51.05 and C>18.5	0.9248	0.8663	0.7945	0.7509	11	12	11	10
0103	Stroke M>44.45 and M<51.05 and C<18.5	1.0798	1.0115	0.9277	0.8768	12	14	12	12
0104	Stroke M>38.85 and M<44.45	1.1632	1.0897	0.9993	0.9446	13	14	13	13
0105	Stroke M>34.25 and M<38.85	1.3697	1.2831	1.1767	1.1122	16	17	15	14
0106	Stroke M>30.05 and M<34.25	1.5778	1.4780	1.3555	1.2812	18	18	17	17
0107	Stroke M>26.15 and M<30.05	1.8232	1.7079	1.5663	1.4805	20	20	19	19
0108	Stroke M<26.15 and A>84.5	2.2072	2.0677	1.8963	1.7923	28	27	23	23
0109	Stroke M>22.35 and M<26.15 and A<84.5	2.0752	1.9440	1.7828	1.6851	21	23	22	21
0110	Stroke M<22.35 and A<84.5	2.6145	2.4492	2.2462	2.1230	30	30	27	26
0201	Traumatic brain injury M>53.35 and C>23.5	0.7044	0.6324	0.5749	0.5228	10	10	7	8
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5	0.9464	0.8496	0.7724	0.7024	13	12	10	10
0203	Traumatic brain injury M>44.25 and C<23.5	1.1598	1.0412	0.9466	0.8608	15	15	13	13
0204	Traumatic brain injury M>40.65 and M<44.25	1.2420	1.1150	1.0137	0.9218	14	15	14	12

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0205	Traumatic brain injury M>28.75 and M<40.65	1.5061	1.3521	1.2292	1.1178	17	17	16	15
0206	Traumatic brain injury M>22.05 and M<28.75	1.9079	1.7128	1.5571	1.4160	22	21	20	18
0207	Traumatic brain injury M<22.05	2.5472	2.2867	2.0789	1.8905	37	31	26	23
0301	Non-traumatic brain injury M>41.05	1.0683	0.9575	0.8477	0.7721	12	12	11	11
0302	Non-traumatic brain injury M>35.05 and M<41.05	1.3496	1.2096	1.0709	0.9754	14	14	13	13
0303	Non-traumatic brain injury M>26.15 and M<35.05	1.6614	1.4890	1.3183	1.2007	17	19	16	15
0304	Non-traumatic brain injury M<26.15	2.2573	2.0231	1.7911	1.6313	27	25	22	20
0401	Traumatic spinal cord injury M>48.45	0.8379	0.8379	0.8024	0.6847	13	15	12	10
0402	Traumatic spinal cord injury M>30.35 and M<48.45	1.1895	1.1895	1.1391	0.9721	16	19	15	13
0403	Traumatic spinal cord injury M>16.05 and M<30.35	2.0099	2.0099	1.9247	1.6425	26	28	23	21
0404	Traumatic spinal cord injury M<16.05 and A>63.5	3.8858	3.8858	3.7211	3.1755	56	42	43	38
0405	Traumatic spinal cord injury M<16.05 and A<63.5	3.1262	3.1262	2.9937	2.5547	55	32	35	30
0501	Non-traumatic spinal cord injury M>51.35	0.7616	0.6599	0.5838	0.5179	10	0	8	8
0502	Non-traumatic spinal cord injury M>40.15 and M<51.35	1.0612	0.9195	0.8135	0.7215	14	12	11	10
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15	1.3894	1.2039	1.0651	0.9447	17	16	14	13

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25	1.6460	1.4262	1.2618	1.1192	15	18	17	15
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25	1.9416	1.6824	1.4884	1.3202	22	21	19	17
0506	Non-traumatic spinal cord injury M<23.75	2.6752	2.3181	2.0507	1.8190	33	29	25	23
0601	Neurological M>47.75	0.9079	0.7936	0.7252	0.6526	10	10	10	9
0602	Neurological M>37.35 and M<47.75	1.1964	1.0457	0.9557	0.8600	13	13	12	12
0603	Neurological M>25.85 and M<37.35	1.5487	1.3537	1.2371	1.1133	16	17	15	15
0604	Neurological M<25.85	2.0568	1.7978	1.6430	1.4785	23	21	20	18
0701	Fracture of lower extremity M>42.15	0.8702	0.7747	0.7379	0.6601	10	12	10	9
0702	Fracture of lower extremity M>34.15 and M<42.15	1.1408	1.0155	0.9672	0.8654	13	14	13	12
0703	Fracture of lower extremity M>28.15 and M<34.15	1.3841	1.2322	1.1736	1.0499	15	16	15	14
0704	Fracture of lower extremity M<28.15	1.7922	1.5954	1.5195	1.3595	19	20	19	18
0801	Replacement of lower extremity joint M>49.55	0.6603	0.5680	0.5186	0.4679	8	8	7	7
0802	Replacement of lower extremity joint M>37.05 and M<49.55	0.8900	0.7656	0.6990	0.6306	10	10	9	9
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5	1.2404	1.0670	0.9742	0.8789	13	13	13	12

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5	1.1147	0.9589	0.8755	0.7899	12	13	11	11
0805	Replacement of lower extremity joint M>22.05 and M<28.65	1.3882	1.1942	1.0903	0.9837	15	15	14	13
0806	Replacement of lower extremity joint M<22.05	1.7094	1.4704	1.3425	1.2112	21	19	16	15
0901	Other orthopedic M>44.75	0.8744	0.7256	0.6690	0.5945	10	10	10	9
0902	Other orthopedic M>34.35 and M<44.75	1.1750	0.9751	0.8990	0.7990	13	13	12	11
0903	Other orthopedic M>24.15 and M<34.35	1.5357	1.2743	1.1749	1.0442	17	16	15	14
0904	Other orthopedic M<24.15	2.0218	1.6777	1.5469	1.3747	21	21	19	18
1001	Amputation, lower extremity M>47.65	0.9314	0.9162	0.7703	0.6994	12	12	10	10
1002	Amputation, lower extremity M>36.25 and M<47.65	1.2475	1.2272	1.0317	0.9368	14	15	13	12
1003	Amputation, lower extremity M<36.25	1.8395	1.8096	1.5214	1.3814	19	22	19	17
1101	Amputation, non-lower extremity M>36.35	1.1323	1.1323	0.9618	0.9618	12	13	12	12
1102	Amputation, non-lower extremity M<36.35	1.6810	1.6810	1.4278	1.4278	18	16	18	17
1201	Osteoarthritis M>37.65	1.2737	0.9024	0.8095	0.7219	13	12	11	10
1202	Osteoarthritis M>30.75 and M<37.65	1.6740	1.1860	1.0640	0.9488	17	15	13	13

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
1203	Osteoarthritis M<30.75	2.0644	1.4626	1.3121	1.1701	19	19	16	15
1301	Rheumatoid, other arthritis M>36.35	1.1201	0.9897	0.8552	0.7627	11	13	11	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35	1.5625	1.3806	1.1930	1.0639	19	16	15	14
1303	Rheumatoid, other arthritis M<26.15	1.9952	1.7629	1.5234	1.3586	21	21	19	17
1401	Cardiac M>48.85	0.8543	0.7306	0.6525	0.5844	9	11	9	8
1402	Cardiac M>38.55 and M<48.85	1.1508	0.9843	0.8790	0.7872	13	13	11	11
1403	Cardiac M>31.15 and M<38.55	1.4297	1.2227	1.0920	0.9779	15	15	14	13
1404	Cardiac M<31.15	1.8388	1.5726	1.4045	1.2578	21	20	17	16
1501	Pulmonary M>49.25	0.8881	0.7955	0.7220	0.6810	11	11	9	9
1502	Pulmonary M>39.05 and M<49.25	1.1946	1.0700	0.9712	0.9160	13	13	12	11
1503	Pulmonary M>29.15 and M<39.05	1.4919	1.3363	1.2129	1.1440	19	16	14	14
1504	Pulmonary M<29.15	1.9427	1.7401	1.5794	1.4896	24	21	19	17
1601	Pain syndrome M>37.15	1.0011	0.8966	0.7933	0.7037	11	11	11	10
1602	Pain syndrome M>26.75 and M<37.15	1.3455	1.2051	1.0662	0.9458	17	15	13	13
1603	Pain syndrome M<26.75	1.7719	1.5870	1.4041	1.2455	20	21	17	16
1701	Major multiple trauma without brain or spinal cord injury M>39.25	1.0866	0.8833	0.8509	0.7390	12	12	12	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25	1.4057	1.1427	1.1008	0.9561	16	14	15	13

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05	1.7152	1.3942	1.3431	1.1666	18	16	16	15
1704	Major multiple trauma without brain or spinal cord injury M<25.55	2.1965	1.7855	1.7201	1.4939	26	24	21	19
1801	Major multiple trauma with brain or spinal cord injury M>40.85	1.0498	0.9320	0.8596	0.7669	13	13	12	11
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85	1.6516	1.4663	1.3524	1.2065	19	18	18	16
1803	Major multiple trauma with brain or spinal cord injury M<23.05	2.9807	2.6463	2.4407	2.1775	40	28	32	26
1901	Guillain Barre M>35.95	1.2102	1.1999	0.9860	0.9111	13	13	13	12
1902	Guillain Barre M>18.05 and M<35.95	2.2177	2.1989	1.8068	1.6696	23	21	20	22
1903	Guillain Barre M<18.05	3.7532	3.7214	3.0578	2.8255	45	28	38	35
2001	Miscellaneous M>49.15	0.8572	0.7395	0.6649	0.5994	10	9	9	8
2002	Miscellaneous M>38.75 and M<49.15	1.1403	0.9838	0.8846	0.7974	12	13	11	11
2003	Miscellaneous M>27.85 and M<38.75	1.4695	1.2678	1.1399	1.0277	15	16	14	13
2004	Miscellaneous M<27.85	1.9848	1.7124	1.5396	1.3880	23	21	19	17
2101	Burns M>0	2.8551	2.8551	2.0858	1.5110	35	28	25	16
5001	Short-stay cases, length of stay is 3 days or fewer				0.1429				3

CMG	CMG Description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier1	Tier2	Tier3	None	Tier1	Tier2	Tier3	None
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.6001				8
5102	Expired, orthopedic, length of stay is 14 days or more				1.5188				20
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.6998				8
5104	Expired, not orthopedic, length of stay is 16 days or more				1.8258				24

BILLING CODE 4120–01–C

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

A. Updates to the Adjustment Factors for FY 2010

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 2010 IRF PPS proposed rule (74 FR 21052, 21059 through 21062), we proposed to update the adjustment factors for calculating the rural, LIP, and teaching status adjustments based on the most recent three years worth of IRF claims data (at that time, FY 2005, FY 2006, and FY 2007) and the most recent available corresponding IRF cost report data. Note that, for each IRF claim, we used the corresponding year's cost report data, when available. In the rare instances in which the corresponding year's cost report data were not available, we used the most recent available cost report data. For example, since cost report years are determined by the start date of the cost report, a hypothetical IRF's cost reporting period from July 1, 2007 through June 30, 2008 would be referred to as an ''FY 2007'' cost report. However, the data from this FY 2007 cost report would appropriately be matched to IRF discharges occurring from October 1, 2007 through June 30, 2008 (i.e., during FY 2008) because these claims would fall during the period of time covered by the IRF's ''FY 2007'' cost report year. In the case of FY 2008 claims that would appropriately match to an IRF's FY 2008 cost report year, we used the FY 2008 cost report data when available. In instances in which the matching FY 2008 cost report data were not available, we used the most recent available data, which in these cases was the FY 2007 cost report data.

For this final rule, as many commenters suggested, we are updating the rural, LIP, and teaching status adjustment factors using more recent data (FY 2006, FY 2007, and FY 2008 claims data and the corresponding year's cost report data or, if unavailable, the most recent available cost report data). We note, however, that we only have about 20 percent of the IRF cost reports from FY 2008 available for analysis at this time, so although we did use the FY 2008 cost report data that we had available, in some cases we had to use a prior year's cost report data to match to some of the FY 2008 IRF claims, as discussed above. Although the adjustment factors for the rural and LIP adjustments that we estimate in this final rule using updated data (18.4 percent and 0.4613, respectively) do not differ substantially from the adjustment factors that we calculated using the methods set forth in the proposed rule (18.27 percent and 0.4372, respectively), the teaching status adjustment factor that we calculate in this final rule using updated data (0.6876) is significantly lower than the teaching status adjustment factor that we calculated in the proposed rule (1.0494). This is due to the relatively large year-to-year fluctuations in the teaching status adjustment factor noted in the proposed rule (74 FR 21052 at 21061).

We believe that it is necessary to update these adjustment factors at this time because the adjustment factors that are being used currently to calculate the rural, LIP, and teaching status adjustments are based on FY 2003 data (as finalized in the FY 2006 IRF PPS final rule (70 FR 47880, 47928 through 47934)), and the FY 2003 data do not reflect recent changes in IRF patient populations resulting from the 60 percent rule and medical review activities.

The current adjustment factors for the rural, LIP, and teaching status adjustments in the FY 2006 IRF PPS final rule (70 FR 47928 through 47934) are based on regression analysis by the RAND Corporation (RAND) using FY 2003 IRF claims and cost report data. In the FY 2010 IRF PPS proposed rule (74 FR 21052, 21059 through 21062), we proposed to use the same methodology RAND used in computing these

adjustment factors. However, we proposed to compute the adjustment factors using three consecutive years of claims data and the corresponding year's cost report data or, when not available, the most recent available cost report data and to average the calculated adjustment factors for all three years to develop the proposed rural, LIP, and teaching status adjustment factors for FY 2010. As discussed in the FY 2010 IRF PPS proposed rule (74 FR 21052, 21059 through 21061), 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 provide a more stable adjustment factor, enabling IRFs to project their future Medicare payments more accurately. We analyzed the suggestion and agree that a three year average of the adjustment factors would promote more stability in the adjustment factors over time, which we believe will benefit IRFs by ensuring reduced variation from year to year and facilitating IRFs' long-term budgetary planning processes.

We received 12 comments on the proposed updates to the rural, LIP, and teaching status adjustment factors for FY 2010, which are summarized below.

Comment: The commenters overwhelmingly supported the proposed three-year moving average approach to updating the rural, LIP, and teaching status adjustment factors, saying that this approach makes payments to IRFs more stable and predictable over time. The commenters further requested that CMS continue to use this methodology to update these facility-level adjustment factors annually in the future to ensure that they continue to reflect the costs of care in IRFs.

Response: We agree that using the three-year moving average approach will provide greater stability and predictability of Medicare payments for IRFs, and will finalize this methodology to update the facility-level adjustment factors for FY 2010 and future years.

Comment: One commenter expressed concerns about the proposed decrease in the rural adjustment factor for FY 2010 and asked us to explain what cost factors we believe may have caused the estimated decrease in the rural adjustment factor.

Response: We believe that it is important to adjust payments for rural IRFs to reflect the higher costs that IRFs in rural areas incur for providing services in these areas. However, the results of our analysis using the most recent available data and the three-year moving average approach indicate that a rural adjustment factor of 18.4 percent more accurately reflects the current costs of providing IRF services in rural areas.

Further, we believe that the estimated decrease in the rural adjustment factor for FY 2010 (from 21.3 percent to 18.4 percent) is, in part, the result of improvements we made to the IRF classification system in the FY 2006 and FY 2007 IRF PPS final rules (70 FR 47880, 47886 through 47904 and 71 FR 48354, 48373 through 48374). Those improvements were designed to account more appropriately for the variation in costs among different types of IRF patients. To the extent that some of the differences in costs that we previously observed between rural and urban IRFs were the result of differences in patient populations, better accounting for the variations in costs among patients may have reduced the need to account for differences in costs between rural and urban IRFs.

Comment: The Medicare Payment Advisory Commission (MedPAC) suggested that CMS conduct research on the IRF teaching status adjustment to determine why the teaching status adjustment factor appears to vary so much from year to year, and to evaluate the accuracy and reliability of the adjustment. In the meantime, MedPAC suggested that CMS consider alternatives to the 3-year moving average approach, such as maintaining the IRF teaching adjustment at its FY 2009 level, capping the adjustment at the level currently in place for IPPS hospitals or inpatient psychiatric facilities (IPFs), or capping the adjustment at a level equal to MedPAC's estimate of the empirically justified IME adjustment for IPPS hospitals. MedPAC notes that the purpose of these alternatives would be to either maintain the teaching status adjustment at its current level or reduce the adjustment.

Response: As we reported in the FY 2010 IRF PPS proposed rule (74 FR 21052 at 21061), we estimate that the teaching status adjustment factors would be 1.5155, 0.6732, and 1.0451 using FY 2005, FY 2006, and FY 2007 data, respectively. In addition, for this final rule, we estimate that the teaching status adjustment factor would be 0.4045 using FY 2008 data. We are still analyzing the reasons for such large fluctuations in the teaching status adjustment factors from year to year. However, we believe that it may be due, in part, to relatively large fluctuations in the teaching variable (number of interns and residents divided by the average daily census) that we observe in the data between FY 2005 and FY 2008. On average, the teaching variable for all teaching IRFs was 0.1164, 0.1207, 0.1160, and 0.1295 in FYs 2005, 2006, 2007, and 2008, respectively. We believe that this variation may reflect provider responses to the implementation of the IRF teaching status adjustment in FY 2006, and that we may see less variation over time as IRFs adjust to this new payment adjustment.

However, to mitigate the impact on payments of annual fluctuations in the facility-level adjustment factors, we have proposed to use and, by this rule, adopt a three-year moving average approach instead of using only one year's worth of data to calculate the rural, LIP, and teaching status adjustment factors for FY 2010. Using the 3-year moving average approach and updated IRF claims data from FYs 2006 through 2008, we calculate a teaching status adjustment factor for this final rule of 0.6876, which is less than the factor 0.9012 that was applied to IRF PPS payments from FY 2006 through FY 2009. Since the teaching status adjustment factor for this final rule is lower than the current factor, we do not believe that it is necessary to consider the alternative ''capping'' methodologies suggested by MedPAC at this time. However, we will continue to monitor the data and work with MedPAC to analyze the reasons for the year-to-year fluctuations.

Comment: Several commenters requested that we use FY 2008 IRF claims and cost report data to update the facility-level adjustment factors for FY 2010.

Response: We appreciate the commenters' suggestions for updating the data used in the analysis of the IRF facility-level adjustment factors for FY 2010, and we agree that we should continue to use the most recent available data for these analyses. However, only about 20 percent of the FY 2008 IRF cost reports are available for analysis at this time. Thus, for this final rule, we have continued to use the most recent available data, which are the FY 2006, FY 2007, and FY 2008 IRF claims data and the corresponding year's cost report data or, if unavailable, the most recent available cost report data.

Final Decision: After carefully considering all of the comments that we received on the proposed updates to the rural, LIP, and teaching status adjustment factors for FY 2010, including the overwhelming support for the proposed use of a three-year moving average approach to calculating these adjustment factors, we are finalizing the following updates to the rural, LIP, and teaching status adjustment factors for FY 2010. Note that these updated

adjustment factors were calculated using the same methodology RAND used in calculating the current adjustment factors but using updated FY 2006, FY 2007, and 2008 IRF claims data and the corresponding year's cost report data or, if unavailable, the most recent available cost report data. IRF PPS payments to IRFs in rural areas will be increased by 18.4 percent for FY 2010. IRF PPS payments will be adjusted for FY 2010 to account for the percentage of low-income patients that an IRF treats using the updated LIP adjustment formula of (1 + disproportionate share hospital (DSH) patient percentage) raised to the power of (0.4613), where the DSH patient percentage for each IRF =

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

Finally, IRF PPS payments to eligible IRFs that qualify for the teaching status adjustment will be adjusted by the following updated formula for FY 2010: (1 + full-time equivalent (FTE) residents/average daily census) raised to the power of (0.6876). Note that the rural, LIP, and teaching status adjustment factors for FY 2010 differ from those proposed in the FY 2010 IRF PPS proposed rule (74 FR 21052, 21060 through 21061) due to the use of updated data in this final rule.

To calculate the updates to the rural, LIP, and teaching status adjustment factors for FY 2010, we used the following steps:

[Steps 1 and 2 are performed independently for each of three years of IRF claims data: FY 2006, FY 2007, and FY 2008]

Step 1. Calculate the average cost per case for each IRF in the IRF claims data using the corresponding year's cost report data or, if unavailable, the most recent available cost report data, as described above.

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 using logarithms for the rural adjustment coefficient (because the rural variable is 1 if the facility is rural and zero otherwise). To compute the LIP and teaching status adjustment factors, we convert these factors back out of the logarithmic form.

B. 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 are updating 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 will be the same with or without the updates (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 budget neutrality factors used to update the rural, LIP, and teaching status adjustment factors, we used the following steps:

Step 1. Using the most recent available data (currently FY 2008), calculate the estimated total amount of IRF PPS payments that would be made in FY 2010 (without applying the update 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 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 budget neutrality factor (1.0023) that would maintain the same total estimated aggregate payments in FY 2010 with and without the update 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 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 budget neutrality factor (1.0192) that would maintain the same total estimated aggregate payments in FY 2010 with and without the update 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 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 budget neutrality factor (1.0037) that would maintain the same total estimated aggregate payments in FY 2010 with and without the update to the teaching status adjustment factor.

Step 8. Apply the 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 budget neutrality factors for the wage adjustment and the CMG relative weights.

The budget neutrality factors for the updates to the rural, LIP, and teaching status adjustment factors in this final rule differ from those described in the proposed rule (74 FR 21052, 21061 through 21062) due to the use of updated data for the analysis in this final rule.

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

VI. FY 2010 IRF PPS Federal Prospective Payment Rates

A. 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 updating IRF PPS payments by 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).

For this final rule, we have used 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 second quarter of 2009 of the 2002-based RPL market basket, the FY 2010 IRF market basket increase factor is 2.5 percent. IHS Global Insight is an economic and financial forecasting firm that contracts with CMS to forecast the components of providers' market baskets.

Also, using the methodology described in the FY 2006 IRF PPS final rule (70 FR 47880, 47908 through 47917), we are updating the IRF labor-related share for FY 2010. Using this method and the IHS Global Insight, Inc. forecast for the second 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 final rule reflects IHS Global Insight's second quarter 2009 forecast of the 2002-based RPL market basket. As shown in Table 2, the FY 2010 labor-related share is 75.779 percent.

TABLE 2—FY 2010 IRF RPL LABOR-RELATED SHARE RELATIVE IMPORTANCE

Cost category	FY 2010 IRF labor-related share relative importance
Wages and salaries	52.892
Employee benefits	13.949
Professional fees	2.873
All other labor intensive services	2.127
Subtotal	71.841
Labor-related share of capital costs (.46)	3.938
Total	75.779

Source: IHS GLOBAL INSIGHT, INC, 2nd QTR, 2009; @USMACRO/CONTROL0609 @CISSIM/TL0509.SIM Historical Data through 1st QTR, 2009.

We received 10 comments on the proposed updates to the IRF market basket increase factor and labor-related share for FY 2010, which are summarized below.

Comment: One commenter supported the creation of a stand-alone IRF market basket based on both freestanding and hospital-based cost report data. The commenter offered the following suggestions that CMS could pursue in order to account for the differences in costs between the two facility types.

Those suggestions included:

1. To survey a random sample of facilities to assess the presence of the array of rehabilitation services that may be available through the freestanding IRF as compared to a hospital-based IRF.

2. To conduct detailed interviews of the Chief Financial Officers (CFOs) of freestanding versus hospital based units to understand the differences in the ways IRF costs are accounted for in cost reports.

Response: We appreciate the commenter's response concerning the stand-alone IRF market basket and the suggestions that were provided. CMS will take the suggestions into consideration as we continue to research the differences between hospital-based and freestanding facilities.

Comment: Several commenters noted that the use of 2002 data is inappropriate because of major changes to IRF case mix and patient severity and requested CMS update the cost weights of the existing RPL market basket to a more recent base year.

Response: We recognize the commenters' concerns regarding the continued use of 2002 data in the RPL market basket. We have focused our recent efforts on comparing and contrasting the costs and cost structures of freestanding and hospital-based IRFs, including the effects of changes to case mix and patient severity over the last several years. We will consider the suggestions that we received during the comment period to better understand those differences (and further investigate the appropriateness of creating a stand-alone IRF market basket), as well as examine the appropriateness of rebasing and revising the RPL market basket.

Comment: One commenter noted that the data used to calculate the RPL market basket are obtained from freestanding IRFs, freestanding IPFs, and LTCHs. The commenter expressed the concern that each facility type requires different resources and thus combining the three types of facilities distorts the cost structures of IRFs. This commenter also suggested incorporating the most recent available data into the market basket.

Response: CMS recognizes the existence of differences in cost structures across freestanding IPFs, freestanding IRFs, and LTCHs. However, pending further research into the viability of creating a stand-alone IRF market basket, we feel that it is appropriate to continue to use the current 2002-based RPL market basket to update IRF payments. We will examine the appropriateness of rebasing and revising the RPL market basket for the future.

Comment: Several commenters offered that one reason for the difference between freestanding and hospital-based IRFs cost structures is that most hospital-based units are smaller than freestanding IRFs. For example, one commenter indicated that hospital-based IRFs have nearly two-thirds fewer discharges than freestanding IRFs. Thus, the commenters claimed that hospital-based IRFs may be unable to achieve the same level of economies of scale as freestanding IRFs can.

Response: We have noted that cost differences between hospital-based and freestanding IRFs may be due to the volume of care that hospital-based facilities provide relative to freestanding facilities. In an attempt to control for differences in the volume of services, we have compared costs per discharge and costs per day between the two facility types and continue to find differences in their overall cost levels. Notably, CMS feels that, all other things held constant, differing volumes may not necessarily explain differing cost structures as the cost weights reflect the relative expense of one category to another within a facility. We will continue to evaluate our findings related to these metrics with new data as it becomes available.

Comment: One commenter mentioned that one contributing cause of the difference in cost structures between freestanding and hospital-based IRFs is the issue of costs being allocated down from the IPPS hospital to the hospital-based IRF unit.

Response: We share the commenter's concern that overhead costs from the host hospital may be skewing the hospital-based unit's costs and cost structure. One of the main reasons why CMS has historically relied on Medicare cost report data from freestanding facilities to construct the market baskets is our concern over the distribution of the host hospital's overhead costs to the sub-provider units. We will continue to investigate the allocation of overhead

costs from the host hospital to the hospital-based IRF unit.

Comment: One commenter acknowledged that seeking outside input regarding differences in cost structures between hospital-based and freestanding IRFs is appropriate. However, the commenter urged CMS to proceed with caution as it may be difficult for CMS to confirm that the methods used to collect outside data are sound and that the data are representative of the industry as a whole. The commenter also stated that CMS should ultimately determine whether the market basket should in fact be based on the cost structure of hospital-based and freestanding IRFs instead of just one type of facility if the higher costs cannot be explained by differences in case mix and other patient characteristics.

Response: As stated in the proposed rule, we do not feel it is appropriate to move forward on the creation of a stand-alone IRF market basket until such time that we can adequately explain the differences in costs and cost structures between hospital-based IRFs and freestanding IRFs. We agree with the commenter that any information from the public should be carefully examined. We reached out to the public for information to help us better understand these differences, but we agree with the commenter that regardless of the information we receive, we will have to evaluate thoroughly the appropriateness and independent nature of any data provided.

Comment: A couple of commenters stated that hospital-based IRFs experience different levels of costs due to the types of patients admitted and services that occur during the IRF hospitalization. They commented that hospital-based IRFs receive more medically fragile patients due to the unit's immediate access to a variety of physician specialties and specialized treatments. The commenter suggested investigating the ICD–9 code differences between hospital-based and freestanding IRFs.

Response: We have looked into case mix differences between free-standing and hospital-based facilities. The average case mix is lower in hospital-based units than in freestanding units for the years we examined (2005–2007). We will continue to monitor differences in case mix (as we believe case-mix indexes for freestanding and hospital-based facilities account for the differences in patient severity). We will also explore the viability of an ICD–9 code analysis.

Comment: One commenter supports CMS in the endeavor of creating a stand-alone IRF market basket to replace the RPL market basket. The commenter expressed willingness to assist the agency in its analysis. The commenter provided the following recommendations for future research:

- To examine the cost differences between freestanding and hospital-based IRFs, as well as the differences between IRFs and other hospitals such as Inpatient Psychiatric Hospitals (IPFs) and Long Term Care Facilities.
- To determine to what extent fewer economies-of-scale and cost allocation differences account for cost differences between freestanding and hospital-based IRFs.
- To determine whether different classes of IRFs have different provider-to-patient ratios.
- To investigate if differences in patient severity exist between the two classes of facilities and if so, to what extent does higher severity correlate with higher nursing and rehabilitation costs.

Response: We appreciate the response concerning the stand-alone IRF market basket and the suggestions the commenter provided. We will be continuing our efforts to study cost differences between hospital-based and freestanding IRFs, as well as differences between IRFs, IPFs, and Long-Term Care Hospitals. We have attempted to control for differences in volume between the freestanding and hospital-based IRFs by analyzing costs per discharge and costs per day. As yet, controlling for patient volume using these metrics has not yielded very much insight into the differences. We will continue to examine other ways to determine if economies of scale are able to provide explanatory information on the differences we observe. Finally, we will look more in-depth at the commenter's additional suggestions.

Comment: One commenter had concerns regarding the lower than usual increase in the 2010 market basket update. The commenter asserts that health care organizations are still required to provide the same care to patients as in more economically stable periods and feels that it is unsafe to assume that hospitals can operate at a lower level of costs while providing the same high level of care simply because the inflation indicators predict a slowing economy.

The commenter supports the American Hospital Association's (AHA's) suggestion that CMS should make the required market basket adjustments without revising the price proxies used in the calculation which indicate potentially lower costs to the hospitals.

Response: The 2.5 percent update found in this final rule does not assume a lower cost level from the prior year for the IRF industry. The intent of the RPL market basket is to estimate the input price pressures that providers will face in their respective payment years. The projected RPL market basket of 2.5 percent, then, reflects our most recent price projections for the various goods and services that IRF providers require in order to provide inpatient rehabilitation services in FY 2010.

Additionally, the commenter noted that IRFs have more patients without insurance and are likely to incur a higher level of bad debt. This comment is outside the scope of the market basket update, since bad debt is reimbursed outside of the market basket update factor.

Lastly, we think the commenter may have confused the AHA comments with regard to the IPPS market basket and the revision of various price proxies. IRF facilities will continue to receive a market basket update based on the RPL market basket. We have not made any technical changes to the composition of the RPL market basket. As such, the commenter's request that CMS should not revise the price proxies for this market basket is not applicable.

Comment: One commenter noted concern with the way CMS estimates the labor-related share for IRF facilities. The commenter specifically expressed concern that the price proxies are based on FY 2002 data and prior to that were last updated in FY 1992. This commenter feels that the 2002 data do not reflect the effects of the 60-percent rule, implemented in CY 2004, and recommends that CMS update the price proxies more frequently to ensure the labor share is accurately calculated.

Response: We believe the commenter may be confusing the term price proxy with the term cost weight. We will assume for purposes of this response that the commenter intended to use the word cost weight rather than price proxy. We assume this confusion because the price proxies are not based on FY 2002 data, and, while the LRS is based on the relative importance (a combination of the cost weight and price proxies), it is not based solely on price proxies. Our price proxy projections are updated on a quarterly basis. Price proxies are subject to revision under limited circumstances. A revision to a price proxy in a market basket could occur if the price index is discontinued or if the agency producing the price proxy (usually the Bureau of Labor Statistics) pulls an index from publication for statistical viability reasons. If an index is discontinued,

then CMS would have to find a replacement price proxy. Normally, revisions to the price indexes included in a market basket are only made when the market basket is rebased.

Regarding the 60-percent rule, we are sensitive to the potential impact that the implementation of this rule may have on the cost structures of certain providers. As noted in a previous comment, we have focused our recent efforts on comparing and contrasting the costs and cost structures of freestanding and hospital-based IRFs. We will be continuing that analysis, as well as exploring the appropriateness of rebasing and revising the market basket used to update IRF payments whether that is in the form of the RPL market basket or a stand-alone IRF market basket.

Final Decision: We will update IRF PPS payments by a market basket increase factor (of 2.5 percent for FY 2010) based upon the most current data available, in accordance with section 1886(j)(3)(A)(i) of the Act. Further, we will update the IRF labor-related share using our current methodology and the most recent available data. Thus, for this final rule, the labor-related share is 75.779 percent. This is based on the IHS Global Insight Inc. forecast for the second quarter of 2009 (2009Q2) with historical data through the first quarter of 2009 (2009Q1).

As we noted in the proposed rule (74 FR 21052 at 21062), we are interested in exploring the possibility of creating a stand-alone IRF market basket that reflects the cost structures of only IRF providers. As part of our consideration of a stand-alone IRF market basket, we solicited information from the public in the proposed rule that might help us to better understand the underlying reasons for the variations in cost structure between freestanding and hospital-based IRFs. Due to the need for further research regarding the differences in costs and cost structures between hospital-based IRFs and freestanding IRFs, we are not pursuing a stand-alone IRF market basket at this time.

B. 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).

In the FY 2010 IRF PPS proposed rule (74 FR 21052, 21062 through 21063), we proposed 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. Thus, we proposed 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 proposed 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, we proposed to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage data used to determine the current IRF PPS wage index. The changes were nominal and did not represent substantive changes to the CBSA-based designations. Specifically, OMB added or deleted certain CBSA numbers and revised certain titles. The OMB bulletins are available 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 final rule, we multiply the unadjusted Federal payment rate for IRFs by the FY 2010 RPL labor-related share (75.779 percent) to determine the labor-related portion of the standard payment amount. We then multiply the labor-related portion by the applicable IRF wage index from the tables in the addendum to this final rule. Table 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 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 use the listed steps to ensure that the FY 2010 IRF standard payment conversion factor reflects the update to the 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 FY 2010 budget neutral wage adjustment factor of 1.0011.

Step 4. Apply the 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 FY 2010 standard payment conversion factor.

We received 3 comments on the proposed FY 2010 IRF PPS wage index, which are summarized below.

Comment: Several commenters recommended that we consider wage index policies under the current IPPS because IRFs compete in a similar labor pool as acute care hospitals. The IPPS wage index policies would allow IRFs to benefit from the IPPS reclassification and/or floor policies. Several commenters also recommended that CMS conduct further analysis of the wage index methodology to ensure that fluctuations in the annual wage index for hospitals are minimized, that all future updates match the costs of labor in the market, that IRF's occupational mix is appropriately recognized, and that payments are ''smoothed'' across geography and across time.

Response: We note that the IRF PPS does not account for geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act and does not apply the ''rural floor'' under section 4410 of Public Law 105–33

(BBA). Because we do not have an IRF specific wage index, we are unable to determine at this time the degree, if any, to which a geographic reclassification adjustment under the IRF PPS is appropriate. Furthermore, we believe the ''rural floor'' is applicable only to the acute care hospital payment system. The rationale for our current wage index policies is fully described in the FY 2006 final rule (70 FR 47880, 47926 through 47928).

In addition, we reviewed the Medicare Payment Advisory Commission's (MedPAC) wage index recommendations as discussed in MedPAC's June 2007 report titled, ''Report to Congress: Promoting Greater Efficiency in Medicare.'' Although some commenters recommended that we adopt the IPPS wage index policies such as reclassification and floor policies, we note that MedPAC's June 2007 report to Congress recommends that Congress ''repeal the existing hospital wage index statute, including reclassification and exceptions, and give the Secretary authority to establish new wage index systems.'' We believe that adopting the IPPS wage index policies, such as reclassification or floor, would not be prudent at this time because MedPAC suggests that the reclassification and exception policies in the IPPS wage index alters the wage index values for one-third of IPPS hospitals. In addition, MedPAC found that the exceptions may lead to anomalies in the wage index. By adopting the IPPS reclassifications and exceptions at this time, the IRF PPS wage index could be vulnerable to similar issues that MedPAC identified in the June 2007 Report to Congress. However, we will continue to review and consider MedPAC's recommendations on a refined or an alternative wage index methodology for the IRF PPS in future years.

In addition, we have research currently under way to examine alternatives to the wage index methodology, including the issues the commenters mentioned about ensuring that the wage index minimizes fluctuations, matches the costs of labor in the market, and provides for a single wage index policy. Section 106(b)(2) of the MIEA–TRHCA instructed the Secretary of Health and Human Services to take into account MedPAC's recommendations on the Medicare wage index classification system and to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. The proposal (or proposals) were to consider each of the following:

- Problems associated with the definition of labor markets for the wage index adjustments.
- The modification or elimination of geographic reclassifications and other adjustments.
- The use of Bureau of Labor Statistics data or other data or methodologies to calculate relative wages for each geographic area.
- Minimizing variations in wage index adjustments between and within MSAs and statewide rural areas.
- The feasibility of applying all components of CMS's proposal to other settings.
- Methods to minimize the volatility of wage index adjustments while maintaining the principle of budget neutrality.
- The effect that the implementation of the proposal would have on health care providers in each region of the country.
- Methods for implementing the proposal(s), including methods to phase in such implementations.
- Issues relating to occupational mix, such as staffing practices and any evidence on quality of care and patient safety, including any recommendations for alternative calculations to the occupational mix.

To assist us in meeting the requirements of section 106(b)(2) of Public Law 109–432, in February 2008 we awarded a contract to Acumen, LLC. The contractor conducted a study of both the current methodology used to construct the Medicare wage index and the recommendations reported to Congress by MedPAC. Part 1 of Acumen's final report, which analyses the strengths and weaknesses of the data sources used to construct the CMS and MedPAC indexes, is available online at *http://www.acumenllc.com/reports/cms*. MedPAC's recommendations were presented in the FY 2009 IPPS final rule (*http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf*). We plan to monitor these efforts and the impact or influence they may have to the IRF PPS wage index.

Final Decision: We will continue to use the policies and methodologies described in the FY 2009 IRF PPS final rule relating to the labor market area definitions and the wage index methodology for areas with wage data. Therefore, this final rule continues to use the Core-Based Statistical Area (CBSA) labor market area definitions and the pre-reclassification and pre-floor hospital wage index data based on 2005 cost report data. We discuss the final standard payment conversion factor for FY 2010 in the next section.

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

To calculate the final 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 (2.5 percent) to the standard payment conversion factor for FY 2009 ($12,958), which would equal $13,282. Then, we apply the budget neutrality factor for the FY 2010 wage index and labor related share of 1.0011, which would result in a standard payment amount of $13,297. Then, we apply the budget neutrality factor for the revised CMG relative weights of 1.0020, which would result in a standard payment amount of $13,324. Finally, we apply the budget neutrality factors for the updates to the rural, LIP, and IRF teaching status adjustments of 1.0023, 1.0192, and 1.0037, respectively, which would result in the final FY 2010 standard payment conversion factor of $13,661.

BILLING CODE 4120–01–P

Table 3: Calculations to Determine the Final 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	x 1.0250
Budget Neutrality Factor for the Wage Index and Labor-Related Share	x 1.0011
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x 1.0020
Budget Neutrality Factor for the Update to the Rural Adjustment Factor	x 1.0023
Budget Neutrality Factor for the Update to the LIP Adjustment Factor	X 1.0192
Budget Neutrality Factor for the Update to the Teaching Status Adjustment Factor	x 1.0037
Final FY 2010 Standard Payment Conversion Factor	= $13,661

After the application of the CMG relative weights described in section IV of this final rule, the resulting unadjusted IRF prospective payment rates for FY 2010 are shown below in Table 4, ''FY 2010 Payment Rates.''

Table 4: FY 2010 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	$10,309.96	$ 9,658.33	$ 8,857.79	$ 8,371.46
0102	$12,633.69	$11,834.52	$10,853.66	$10,258.04
0103	$14,751.15	$13,818.10	$12,673.31	$11,977.96
0104	$15,890.48	$14,886.39	$13,651.44	$12,904.18
0105	$18,711.47	$17,528.43	$16,074.90	$15,193.76
0106	$21,554.33	$20,190.96	$18,517.49	$17,502.47
0107	$24,906.74	$23,331.62	$21,397.22	$20,225.11
0108	$30,152.56	$28,246.85	$25,905.35	$24,484.61
0109	$28,349.31	$26,556.98	$24,354.83	$23,020.15
0110	$35,716.68	$33,458.52	$30,685.34	$29,002.30
0201	$9,622.81	$ 8,639.22	$ 7,853.71	$ 7,141.97
0202	$12,928.77	$11,606.39	$10,551.76	$ 9,595.49
0203	$15,844.03	$14,223.83	$12,931.50	$11,759.39
0204	$16,966.96	$15,232.02	$13,848.16	$12,592.71
0205	$20,574.83	$18,471.04	$16,792.10	$15,270.27
0206	$26,063.82	$23,398.56	$21,271.54	$19,343.98
0207	$34,797.30	$31,238.61	$28,399.85	$25,826.12
0301	$14,594.05	$13,080.41	$11,580.43	$10,547.66
0302	$18,436.89	$16,524.35	$14,629.56	$13,324.94
0303	$22,696.39	$20,341.23	$18,009.30	$16,402.76
0304	$30,836.98	$27,637.57	$24,468.22	$22,285.19
0401	$11,446.55	$11,446.55	$10,961.59	$ 9,353.69
0402	$16,249.76	$16,249.76	$15,561.25	$13,279.86

Table 4: FY 2010 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0403	$27,457.24	$27,457.24	$26,293.33	$22,438.19
0404	$53,083.91	$53,083.91	$50,833.95	$43,380.51
0405	$42,707.02	$42,707.02	$40,896.94	$34,899.76
0501	$10,404.22	$9,014.89	$7,975.29	$7,075.03
0502	$14,497.05	$12,561.29	$11,113.22	$9,856.41
0503	$18,980.59	$16,446.48	$14,550.33	$12,905.55
0504	$22,486.01	$19,483.32	$17,237.45	$15,289.39
0505	$26,524.20	$22,983.27	$20,333.03	$18,035.25
0506	$36,545.91	$31,667.56	$28,014.61	$24,849.36
0601	$12,402.82	$10,841.37	$ 9,906.96	$ 8,915.17
0602	$16,344.02	$14,285.31	$13,055.82	$11,748.46
0603	$21,156.79	$18,492.90	$16,900.02	$15,208.79
0604	$28,097.94	$24,559.75	$22,445.02	$20,197.79
0701	$11,887.80	$10,583.18	$10,080.45	$ 9,017.63
0702	$15,584.47	$13,872.75	$13,212.92	$11,822.23
0703	$18,908.19	$16,833.08	$16,032.55	$14,342.68
0704	$24,483.24	$21,794.76	$20,757.89	$18,572.13
0801	$9,020.36	$ 7,759.45	$ 7,084.59	$ 6,391.98
0802	$12,158.29	$10,458.86	$ 9,549.04	$ 8,614.63
0803	$16,945.10	$14,576.29	$13,308.55	$12,006.65
0804	$15,227.92	$13,099.53	$11,960.21	$10,790.82
0805	$18,964.20	$16,313.97	$14,894.59	$13,438.33
0806	$23,352.11	$20,087.13	$18,339.89	$16,546.20
0901	$11,945.18	$ 9,912.42	$ 9,139.21	$ 8,121.46

Table 4: FY 2010 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0902	$16,051.68	$13,320.84	$12,281.24	$10,915.14
0903	$20,979.20	$17,408.21	$16,050.31	$14,264.82
0904	$27,619.81	$22,919.06	$21,132.20	$18,779.78
1001	$12,723.86	$12,516.21	$10,523.07	$ 9,554.50
1002	$17,042.10	$16,764.78	$14,094.05	$12,797.62
1003	$25,129.41	$24,720.95	$20,783.85	$18,871.31
1101	$15,468.35	$15,468.35	$13,139.15	$13,139.15
1102	$22,964.14	$22,964.14	$19,505.18	$19,505.18
1201	$17,400.02	$12,327.69	$11,058.58	$ 9,861.88
1202	$22,868.51	$16,201.95	$14,535.30	$12,961.56
1203	$28,201.77	$19,980.58	$17,924.60	$15,984.74
1301	$15,301.69	$13,520.29	$11,682.89	$10,419.24
1302	$21,345.31	$18,860.38	$16,297.57	$14,533.94
1303	$27,256.43	$24,082.98	$20,811.17	$18,559.83
1401	$11,670.59	$ 9,980.73	$ 8,913.80	$ 7,983.49
1402	$15,721.08	$13,446.52	$12,008.02	$10,753.94
1403	$19,531.13	$16,703.30	$14,917.81	$13,359.09
1404	$25,119.85	$21,483.29	$19,186.87	$17,182.81
1501	$12,132.33	$10,867.33	$ 9,863.24	$ 9,303.14
1502	$16,319.43	$14,617.27	$13,267.56	$12,513.48
1503	$20,380.85	$18,255.19	$16,569.43	$15,628.18
1504	$26,539.22	$23,771.51	$21,576.18	$20,349.43
1601	$13,676.03	$12,248.45	$10,837.27	$ 9,613.25
1602	$18,380.88	$16,462.87	$14,565.36	$12,920.57

Table 4: FY 2010 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1603	$24,205.93	$21,680.01	$19,181.41	$17,014.78
1701	$14,844.04	$12,066.76	$11,624.14	$10,095.48
1702	$19,203.27	$15,610.42	$15,038.03	$13,061.28
1703	$23,431.35	$19,046.17	$18,348.09	$15,936.92
1704	$30,006.39	$24,391.72	$23,498.29	$20,408.17
1801	$14,341.32	$12,732.05	$11,743.00	$10,476.62
1802	$22,562.51	$20,031.12	$18,475.14	$16,482.00
1803	$40,719.34	$36,151.10	$33,342.40	$29,746.83
1901	$16,532.54	$16,391.83	$13,469.75	$12,446.54
1902	$30,296.00	$30,039.17	$24,682.69	$22,808.41
1903	$51,272.47	$50,838.05	$41,772.61	$38,599.16
2001	$11,710.21	$10,102.31	$ 9,083.20	$ 8,188.40
2002	$15,577.64	$13,439.69	$12,084.52	$10,893.28
2003	$20,074.84	$17,319.42	$15,572.17	$14,039.41
2004	$27,114.35	$23,393.10	$21,032.48	$18,961.47
2101	$39,003.52	$39,003.52	$28,494.11	$20,641.77
5001	$ -	$ -	$ -	$ 1,952.16
5101	$ -	$ -	$ -	$ 8,197.97
5102	$ -	$ -	$ -	$20,748.33
5103	$ -	$ -	$ -	$ 9,559.97
5104	$ -	$ -	$ -	$24,942.25

BILLING CODE 4120–01–C

We received 4 comments on the proposed standard payment conversion factor and payment rates for FY 2010, which are summarized below.

Comment: Several commenters suggested that we add the estimated market basket increases for FYs 2008 and 2009 back into the standard payment conversion factor before we update it for FY 2010.

Response: We do not believe that this is the intent of the statute. As discussed above, 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. For subsequent fiscal years, 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, this increase factor shall be used to update the IRF Federal prospective payment rates for each FY. In accordance with these provisions of the statute, we will update IRF PPS payments by a market basket increase factor for FY 2010 based upon the most current available data.

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

Table 5 illustrates the methodology for adjusting the Federal prospective payments (as described in sections VI.A through VI.C of this final rule). The examples below are based on two hypothetical Medicare beneficiaries, both classified into CMG 0110 (without comorbidities). The unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) appears in Table 4 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 1.0228), a wage index of 0.8473, and a rural adjustment of 18.4 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0666), a wage index of 0.9249, and a teaching status adjustment of 0.0610.

To calculate each IRF's labor and non-labor portion of the Federal prospective payment, we begin by taking the unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) from Table 4 above. Then, we multiply the estimated labor-related share (75.779) described in section VI.A of this final rule by the unadjusted Federal prospective payment rate. To determine the non-labor portion of the Federal prospective payment rate, we subtract the labor portion of the Federal payment from the unadjusted Federal prospective payment.

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

Adjusting the wage-adjusted Federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted Federal prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (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 5 illustrates the components of the adjusted payment calculation.

BILLING CODE 4120–01–P

Table 5: Example of Computing the IRF FY 2010 Federal Prospective Payment

Steps		Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)	
1	Unadjusted Federal Prospective Payment		$29,002.30		$ 29,002.30
2	Labor Share	X	0.75779	X	0.75779
3	Labor Portion of Federal Payment	=	$21,977.65	=	$21,977.65
4	CBSA Based Wage Index (shown in the Addendum , Tables 1 and 2)	X	0.8473	X	0.9249
5	Wage-Adjusted Amount	=	$18,621.67	=	$20,327.13
6	Nonlabor Amount	+	$7,024.65	+	$7,024.65
7	Wage-Adjusted Federal Payment	=	$25,646.31	=	$27,351.78
8	Rural Adjustment	X	1.184	X	1.000
9	Wage- and Rural- Adjusted Federal Payment	=	$30,365.23	=	$27,351.78
10	LIP Adjustment	X	1.0228	X	1.0666
11	FY 2010 Wage-, Rural- and LIP-Adjusted Federal Prospective Payment Rate	=	$31,057.56	=	$29,173.41
12	FY 2010 Wage- and Rural-Adjusted Federal Prospective Payment		$30,365.23		$27,351.78
13	Teaching Status Adjustment	X	0.000	X	0.0610
14	Teaching Status Adjustment Amount	=	$0.00	=	$1,668.46
15	FY2010 Wage-, Rural-, and LIP-Adjusted Federal Prospective Payment Rate	+	$31,057.56	+	$29,173.41
16	Total FY 2010 Adjusted Federal Prospective Payment	=	$31,057.56	=	$30,841.87

BILLING CODE 4120–01–C

Thus, the adjusted payment for Facility A would be $31,057.56 and the adjusted payment for Facility B would be $30,841.87.

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

A. 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.

In the FY 2010 IRF PPS proposed rule (74 FR 21052 at 21066), we proposed to use updated data for calculating the high-cost outlier threshold amount. Specifically, we proposed 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.

Updated analysis of FY 2008 claims data using the same methodology that we used to set the initial outlier threshold amount in FY 2002 shows that IRF outlier payments as a percentage of total estimated payments are 3 percent in FY 2009. Therefore, since we estimate that we have achieved the target percentage in FY 2009, we are adjusting the outlier threshold amount in this final rule solely to account for the 2.5 percent market basket adjustment for FY 2010 (as discussed in section VI.A of this rule) and the FY 2010 updates to the facility-level adjustments (as discussed in section V of this rule) so that we will continue to maintain estimated outlier payments at 3 percent of total estimated aggregate IRF payments for FY 2010.

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

In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR 45674, 45692 through 45694), we apply a ceiling to IRFs' cost-to-charge ratios (CCRs). Using the methodology described in that final rule, we proposed in the FY 2010 IRF PPS proposed rule (74 FR 21052, 21066 through 21067) 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 estimated a national average CCR of 0.622 for rural IRFs, which we calculate by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, we estimate a national CCR of 0.494 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 final 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 suggest that these older data do not adequately reflect the current cost of care.

In addition, in light of the analysis described below, we are setting the national CCR ceiling at 3 standard deviations above the mean CCR. The national CCR ceiling is set at 1.61 for FY 2010. This means that, if an individual IRF's CCR exceeds this ceiling of 1.61 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 calculated 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 received 4 comments on the proposed update to payments for high-cost outliers under the IRF PPS, which are summarized below.

Comment: The majority of commenters said that they support maintaining estimated outlier payments at 3 percent of total estimated payments for FY 2010. However, one commenter suggested that we reduce the estimated percentage of outlier payments to 1.5 percent or that we ''hold back'' a proportion of outlier payments from certain IRFs, particularly those IRFs that might have higher costs because of decreases in patient volumes. This commenter expressed concerns that the IRF outlier policy may be inadvertently rewarding IRFs for inefficiencies and suggested that we conduct an analysis of the distribution of outlier payments among IRFs.

Response: We will continue to monitor our IRF outlier policies to ensure that they continue to compensate IRFs for treating unusually high-cost patients and, thereby, promote access to care for patients who are likely to require unusually high-cost care. At this time, however, we do not have any indications to suggest that the outlier pool would be better set at 1.5 percent than at 3 percent, or that it would be appropriate to ''hold back'' outlier payments from individual IRFs. To the extent that patient volumes in some IRFs have been declining due to recent changes in the 60 percent rule and increased medical review activities, and that such declines in patient volumes may have led to temporary cost increases (due to the allocation of fixed costs across a smaller number of patients), we believe that the patient volumes will soon stabilize and that fixed costs will decline once IRFs have had time to adapt to the changes. However, we will carefully consider this commenter's suggestions, and will consider proposing additional refinements to the IRF outlier policies in the future if we find that such refinements are necessary.

Comment: Several commenters suggested that we use the FY 2008 IRF claims data to estimate the IRF outlier threshold amount for FY 2010.

Response: We agree that we should use the most recent available data to estimate the IRF outlier threshold amount for FY 2010, and have therefore used the FY 2008 IRF claims data in the analysis for this final rule.

Comment: One commenter requested that CMS provide additional information to the public in the future to allow the IRF industry and external researchers to conduct a more thorough review of CMS's proposed updates to the outlier threshold amount and to verify our estimates of outlier payments

as a percentage of total payments for FY 2010. This commenter also requested that we report the actual outlier payments and outlier payments as a percentage of total payments for each FY in this final rule.

Response: We will continue to provide as much information as possible to allow the public to analyze and evaluate our proposed updates to the IRF outlier threshold amount. In Table 6 below, we provide the requested information, by FY.

TABLE 6—IRF OUTLIER PAYMENTS AND OUTLIER PAYMENTS AS A PERCENTAGE OF TOTAL PAYMENTS

Fiscal year	Outlier payments	Outlier payments as a percentage of total payments
2003	204,193,300	3.3
2004	127,308,080	1.9
2005	116,534,084	1.8
2006	247,632,386	4.0
2007	267,474,895	4.5
2008	248,047,991	4.2

Comment: One commenter suggested that we adopt the same methodology for modeling charge increases and cost-to-charge ratio (CCR) changes in the IRF PPS that we are currently using for IPPS hospitals.

Response: As we noted in the FY 2008 IRF PPS final rule (72 FR 44284 at 44304), we considered adopting the same methodology described in the FY 2007 IPPS final rule (71 FR 47870, 48150 though 48151) for projecting cost and charge growth for IRFs. However, we discovered that the accuracy of the projections depends on the case mix of patients in the facilities remaining similar from year to year, as it does in IPPS hospitals. As many of the commenters on the FY 2009 IRF PPS proposed rule noted, the case mix of patients in IRFs was continuing to change through at least the middle of FY 2008 in response to the 60 percent rule and recent medical review activities. In analyzing the data, we discovered that we could get inaccurate results if we based future projections of cost and charge growth on data from years in which IRFs were experiencing fluctuations in case mix. Thus, since the most recent available IRF claims data for analysis in this final rule are the FY 2008 IRF claims data, and since we are still seeing evidence of case mix changes in these data, we do not believe that adopting the suggested methodology would be prudent at this time. We believe that a better approach would be to wait until the IRF case mix has stabilized before we attempt to project cost and charge growth using the suggested methodology. Otherwise, the changes occurring in IRFs all at once, including changes in IRFs' charges, costs, and case mix, could compromise the accuracy of our results. For the reasons described above, our analysis shows that using the same methodology we used previously for updating the outlier threshold amount for FY 2010 is the best approach at this time. However, we will carefully consider the commenter's suggestions as we investigate alternative approaches for projecting IRF cost and charge growth in estimating future updates to the IRF outlier threshold amount.

Final Decision: Based on careful consideration of the comments that we received on the proposed update to the outlier threshold amount for FY 2010 and based on updated analysis of the FY 2008 data, we are finalizing our decision to update the outlier threshold amount for FY 2010 to $10,652. In addition, we did not receive any comments on the IRF cost-to-charge ratio ceiling. Based on our proposed policy and the reasons set forth in the proposed rule (74 FR 21052, 21066 through 21067), we are finalizing the national average urban CCR at 0.494 and the national average rural CCR at 0.622. We are also finalizing our estimate of the IRF national CCR ceiling at 1.61 for FY 2010.

VIII. Inpatient Rehabilitation Facility (IRF) Coverage Requirements

In the FY 2010 proposed rule (74 FR 21052, 21067 through 21071), we proposed IRF coverage requirements and technical revisions to certain other IRF requirements to reflect changes that have occurred in medical practice during the past 25 years and the implementation of the IRF PPS. In light of those proposals, we also proposed to rescind the outdated HCFA Ruling 85–2. We also noted that we anticipated issuing new manual provisions to provide further guidance on the proposed rules if the changes were ultimately finalized, and expressly welcomed comments on the draft of those manual provisions on our Web site.

As we discussed in the proposed rule, the policies that currently govern IRFs were developed more than 25 years ago, and were designed to provide coverage criteria 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. In recognition of the need to provide new coverage criteria, CMS assembled an internal workgroup in June 2007 to determine how best to clarify the criteria. 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). We also considered comments that we received from industry groups in response to the FY 2009 IRF PPS proposed rule (73 FR 22674) and in response to industry input solicited by CMS contractors who are preparing the IRF Report to Congress mandated by section 115(c)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Public Law 110–173.

After carefully considering all of the input that we received from the workgroup and from stakeholders, we proposed a number of changes to the regulation text in § 412.23 and § 412.29, which were designed to clarify our expectations regarding IRF coverage criteria. We discussed our proposals and suggested regulatory text to implement those proposals.

Unfortunately, though we never intended for these criteria to be used in determining whether facilities could be classified as IRFs, the combining of § 412.23 and § 412.29 and the placement of the proposed IRF coverage requirements in § 412.29, which discusses the requirements for rehabilitation units to be excluded from the IPPS and instead be paid under the IRF PPS, led several commenters to incorrectly conclude that the proposed coverage requirements would affect classification of an IRF. This was not our intent. To respond to these comments and to eliminate confusion on this point, we are creating a new regulatory section at newly created § 412.622(a)(3), § 412.622(a)(4), and § 412.622(a)(5), in which we will place the new IRF coverage requirements that will be used to determine whether individual IRF claims are for reasonable and necessary services under section 1862(a)(1) of the Act. These new coverage requirements will not be used to determine whether a facility can be paid under the IRF PPS. However, certain of the requirements in the newly created § 412.622(a)(3), § 412.622(a)(4), and § 412.622(a)(5) mirror the concepts

in the long-standing facility classification requirements in the existing § 412.23 and § 412.29, such as the need to have a preadmission screening process in place for all IRF patients, the need to provide close medical supervision by qualified personnel, the need to have a plan of treatment for all IRF patients, and the need to use a ''multidisciplinary'' approach to care. In this final rule, we will only make technical corrections to those provisions governing facility classification at § 412.23 and § 412.29 to resolve any inconsistencies between the new IRF coverage criteria applicable to individual claims and the existing IRF classification requirements. The facility classification requirements at § 412.23 and § 412.29 will not be used to review individual IRF claims. The details of the regulatory changes that we are making in this final rule are in the section labeled ''Final Decision'' below.

We received 58 comments on our overall approach to updating the IRF coverage requirements, which are summarized below.

Comment: Several commenters supported our efforts to clarify the IRF coverage criteria, with the Medicare Payment Advisory Commission (MedPAC) indicating that the new criteria are a ''positive step forward'' in providing a clearer set of expectations and placing the focus more on patients' functional needs. However, several commenters expressed concerns about the regulatory text that had been proposed to implement these proposals, and the authorities that we had cited in the proposed rule. They especially noted that, despite having proposed coverage criteria, we had failed to include section 1862 of the Act in our list of authorities. Other commenters suggested, due to a misunderstanding of our statements about our intent to issue manual guidance to implement the proposed regulations once they were finalized, that we had not met the requirements of the Administrative Procedure Act in our proposal to rescind HCFAR 85–2.

Response: We believe the commenters have misunderstood the approach that we are using to make these updates to the IRF coverage criteria. We are not rescinding HCFAR 85–2 and replacing it with revised manual provisions (in Chapter 1, Section 110 of the MBPM). Rather, we are using standard rulemaking procedures to replace HCFAR 85–2 with updated regulatory provisions that contain the substantive changes to the coverage criteria. Consistent with the APA requirements, we will rescind the prior standard (HCFAR 85–2) in a future notice to be issued prior to implementation of the new legal standards that are established under this final rule. Once the updated regulatory provisions are in effect, we will issue revised manual provisions that interpret the new regulatory provisions. The revised manual provisions will not contain substantive requirements beyond those that are in the regulations. We do, however, agree that we should have included section 1862 of the Act in our list of authorities in the proposed rule. We appreciate the commenters bringing this inadvertent omission to our attention. We have corrected this omission in the authorities list in this final rule.

Comment: Several commenters expressed concerns that an IRF's failure to meet the proposed coverage criteria would not only result in denial of an individual claim, but would also possibly result in a facility not being eligible for classification as an IRF. Some commenters questioned whether we were, in effect, changing the ''60 percent rule.'' If so, they suggested that CMS consider alternative ways of amending the ''60 percent rule'' and distinguishing IRFs from IPPS hospitals. These commenters also suggested that we clarify that the IRF classification requirements are based on different statutory authority than the IRF coverage criteria and that the IRF coverage criteria are not used to determine IRF classifications.

Response: As noted above, we did not intend for any of the proposed coverage criteria to have any bearing on the exclusion of facilities from the IPPS, the requirements for the classification of facilities as IRFs, or the 60 percent rule. The proposed regulatory coverage criteria were intended to update IRF coverage criteria, not IRF classification criteria. Unfortunately, the placement of these draft coverage criteria in the proposed regulatory text, especially in concert with some words that were inadvertently used in the preamble discussion (we did, unfortunately, make a reference to ''exclusion'' and ''classification requirements'' in our discussion of the proposed coverage criteria; however, we believe the majority of the discussion conveys that we were discussing coverage, not classification) led many commenters to incorrectly conclude that we were proposing to make compliance with coverage criteria a component of the IRF classification requirements.

To eliminate any further confusion regarding this point, we are creating § 412.622(a)(3), § 412.622(a)(4), and § 412.622(a)(5), which contain the new coverage criteria regulations that are adopted under this rule.

Further, we agree with the commenters that the IRF coverage criteria and the IRF classification requirements are different and are based on different statutory authority. We also agree that the IRF coverage criteria are not used to determine IRF classification. To be clear, in this final rule we are adopting new regulatory IRF coverage criteria. We do not intend for any IRF to lose its classification status because an individual patient does not meet the IRF coverage criteria. Failure to meet the coverage criteria in a particular case will only result in the denial of the IRF's claim for the services provided to that patient, not in a change in the classification of the facility.

Comment: Several commenters suggested that we delay implementation of the new regulations and manual instructions regarding the IRF medical necessity criteria to give IRFs adequate time to adapt their internal processes to the changes. These commenters also suggested that the additional time would allow CMS to conduct training on the changes, to hold provider education conference calls similar to the conference calls that we conducted in 2002 when the IRF PPS went into effect, and to hold additional meetings with stakeholders to further refine the regulations.

Response: We believe that it is critical to adopt regulatory IRF coverage criteria as quickly as possible to provide clear and updated rules that all stakeholders can easily understand and follow. However, we agree that a delay in the implementation of the new regulations, and the manual instructions that will be issued to provide further guidance on the substantive requirements contained therein, until January 1, 2010 is reasonable. This would allow IRFs more time to adjust their internal processes and procedures to accommodate the new rules. The delayed implementation would also allow time for CMS to conduct thorough training and education outreach on the new regulations, which will benefit all stakeholders by promoting a shared understanding of the new regulations.

Although we understand the commenters' concerns about the need for stakeholder input into these policies, we have already incorporated substantial input from the public in the development of these policies. As we noted in the FY 2010 proposed rule (74 FR 21052 at 21067), we received substantial input from the public on the medical necessity criteria from a town hall meeting and Technical Expert Panel that we conducted in February 2009 in response to the mandated analysis of IRF access and utilization issues

contained in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Public Law 110–173, section 155(c)(1). Even though the town hall meeting and the Technical Expert Panel were supposed to be focused on developing alternatives to the criteria for classifying an IRF, particularly refinements to the 60 percent rule, in many cases participants instead provided CMS with information and suggestions concerning the criteria for establishing the medical necessity of IRF admissions, which we considered in the development of the proposed updates to the regulation. In addition, we received additional input from the public in the comments that we received on the FY 2010 IRF PPS proposed rule. Thus, we do not believe that it is necessary to conduct further meetings prior to finalizing the proposed regulations. However, we will continue to conduct additional meetings with stakeholders and provide training and education to promote a shared understanding of the new regulations. We appreciate the suggestions regarding the provider education conference calls and plan to include these calls as part of our training and public outreach on these new regulations.

Comment: Several commenters expressed concern that rescinding HCFAR 85–2 prior to issuing manual revisions would negatively affect IRF claims denials that are currently being reviewed by Administrative Law Judges (ALJs).

Response: To alleviate the commenters' concerns, we will rescind HCFAR 85–2 in a future notice that will be issued prior to implementation of the new regulatory provisions. We plan to issue new manual guidance that will interpret the new regulations at that time as well. The new regulatory provisions will become effective for IRF discharges occurring on or after January 1, 2010. Thus, HCFAR 85–2 will continue to apply for all IRF discharges that occur prior to January 1, 2010. Once the updated regulations become effective, ALJs will be able to use the new, clarified regulations. We believe that simplifying and clarifying the rules will make the rules easier for all stakeholders, including ALJs, IRFs, and Medicare contractors, to understand and to follow. In so doing, we believe that the updated regulations will reduce the number of disputed IRF claims denials that will be appealed to the ALJ level.

Comment: Several commenters suggested that we provide the scientific bases for the new regulations and a list of the people with whom we consulted in developing the new regulations.

Response: As the new regulations are intended merely to update and clarify the prior IRF medical review policies, we focused on updating the regulations to reflect current industry practices that we believe enhance the quality of care for patients, not on establishing the scientific basis for medical treatment.

We do not publish comprehensive lists of the numerous employees who participate in the collaborative policy development process. We do, however, indicate the names of the lead analysts. Please see the section labeled ''For Further Information Contact'' at the beginning of this final rule for the names and contact information of the lead analysts on this rule. Please contact the lead analysts for further information.

Comment: One commenter suggested that we include all IRF medical necessity requirements in both the regulation text and the manual instructions, so that the regulation text and the manual instructions would both be revised together through rulemaking.

Response: As we indicated above, we are using standard rulemaking procedures to implement regulatory provisions governing the coverage criteria for IRF services. Once the regulatory provisions are finalized, we will issue revised manual provisions that provide detailed guidance on the new regulatory provisions. As these manual provisions will not contain substantive requirements, there is no need to promulgate the manual provisions through the rulemaking process. As noted in the proposed rule, however, we solicited and carefully considered comments on the draft manual provisions submitted outside of this APA rulemaking process.

Comment: One commenter suggested that, given the complexity of the proposed changes to the regulation, we should provide for an additional 60-day comment period to allow the public an additional opportunity to comment on the changes.

Response: We do not believe that the proposed changes to the regulation were extraordinarily complex, relative to the regulations that we typically issue for IRFs and other Medicare payment systems. Thus, we believe that one 60-day comment period was adequate to provide for public comment on these issues.

Comment: One commenter suggested that we provide ''justifiable exceptions'' to all of the required timelines for the preadmission screening, the post-admission physician evaluation, and the overall individualized plan of care.

Response: We agree that there should be exceptions to these timelines in the case of extraordinary events, such as natural disasters or other states of emergency, that are beyond the control of the IRF. In such instances, we would consider the appropriateness of using established mechanisms for waiving or modifying certain Medicare requirements such as section 1135 of the Act (under which the Secretary might permit a temporary modification of the timeline during the ''emergency period'' under section 1135 (g)(1) of the Act). The preadmission screenings, post-admission physician evaluations, and individualized overall plans of care are part of an IRF's standard operating procedures. Thus, in non-emergency situations, we expect that each IRF will develop its own protocols to ensure timely completion of these documents.

A. Requirements for the Preadmission Screening

As discussed in the FY 2010 proposed rule, we believe that a comprehensive preadmission screening process is the key factor in initially identifying appropriate candidates for IRF care. For this reason, we proposed to clarify our expectations regarding the scope of the preadmission assessment and to require documentation of the clinical evaluation process that forms the basis of the admission decision.

In addition, to ensure that IRF patients receive close medical supervision, we proposed to require an evaluation of each patient's risk for clinical and rehabilitation complications as part of the preadmission screening.

To capture the preadmission screening information as close as possible to the actual time of the IRF admission, we proposed to require that the preadmission screening be conducted by qualified clinicians designated by a rehabilitation physician within the 48 hours immediately preceding the IRF admission, and we proposed to require that the preadmission screening documentation be retained in the patient's medical record.

We also proposed to require that a rehabilitation physician review and document his or her concurrence with the findings and results of the preadmission screening.

Finally, we proposed to eliminate the 3 to 10 day post-admission assessment, which was used under the guidance documents that predated the regulations adopted under this rule for after-the-fact proof of medical necessity.

We received 27 comments on the proposed requirement for the preadmission screening, which are summarized below.

Comment: While several commenters expressed support for the proposed preadmission screening requirement, a few commenters said that the level of detail that we are proposing for this requirement exceeds what is typically included in a preadmission screening. One commenter indicated that acute care hospital staff generally are not trained to assess all of the components of the patient's condition that we proposed to require be included in the preadmission screening, and that the level of evaluation that we are suggesting is best performed by the rehabilitation physician in the IRF.

Response: As noted in the FY 2010 proposed rule (74 FR 21052 at 21068), we believe that a comprehensive preadmission screening process is the key factor in initially identifying appropriate candidates for IRF care. As we are placing more weight on the rehabilitation physician's decision to admit the patient to the IRF, we believe that it is important to require that the rehabilitation physician document the reasoning behind this decision, to enable medical reviewers to understand the rationale for the decision. We realize that this level of detail may exceed what some IRFs may have included in the patient's medical record in the past, but we believe that it will benefit both the IRFs and the Medicare contractors who are reviewing IRF claims to have the rationale for the reasoning behind the admission decision recorded in each patient's medical record.

We agree that the assessment would best be performed by the rehabilitation physician or IRF clinical staff designated by the rehabilitation physician. We believe that the commenter may have misunderstood our proposal in that we do not expect the acute care hospital staff to be performing the preadmission screenings for the IRF.

Comment: Several commenters suggested that the clinical staff performing the preadmission screenings should be ''qualified and competent,'' but not ''licensed,'' because State licensure laws differ and preadmission screenings are generally not included in clinicians' scopes of practice. Several commenters also suggested that we allow non-clinical personnel to conduct the preadmission screening, as is the current practice in some IRFs. Further, several commenters suggested that we allow any licensed physician to review and document his or her concurrence with the results of the preadmission screening.

Response: We disagree. Given the complexity and the comprehensive nature of the preadmission screenings that are required to determine the appropriateness of an IRF admission, we believe that a comprehensive preadmission screening process is the key factor in initially identifying appropriate candidates for IRF care. As such, we believe that the IRF personnel involved in collecting the information for the preadmission screening must be appropriately trained and qualified to assess the patient's medical and functional status, assess the risk for clinical and rehabilitation complications, and assess other aspects of the patient's condition both medically and functionally. We do not agree that non-clinical personnel can adequately perform these assessments. Further, we believe that only a licensed rehabilitation physician with training and experience in medical rehabilitation should be making the IRF admission decision.

Comment: Several commenters expressed concerns that the requirement for the preadmission screening to be conducted within the 48 hours immediately preceding the IRF admission would preclude IRFs from performing the preadmission screening on the patients earlier in their acute care hospital stay, as is the practice in some IRFs. They suggested that we allow for the possibility that IRFs could update their preadmission screenings within the 48 hours immediately preceding the IRF admission and have this count toward meeting the preadmission screening requirement. One commenter suggested that we require that the preadmission screening be conducted within the 96 hours immediately preceding the IRF admission, rather than 48 hours.

Response: We agree with the commenters that the requirement as proposed could preclude IRFs from performing preadmission screenings on patients earlier in their acute care hospital stays, and we agree that performing these preadmission screenings earlier in the acute care hospital stays could, in some cases, be beneficial to the patients. For this reason, we are changing the requirement to allow for a comprehensive preadmission screening that includes all of the required elements to be performed more than 48 hours immediately preceding the IRF admission, as long as an update is conducted in person or by telephone within 48 hours prior to the admission and documented in the patient's medical record to update the patient's medical and functional status. To be clear, a comprehensive preadmission screening conducted entirely by telephone without transmission of the patient's acute care hospital records (if the patient is being transferred from the acute care hospital) and a review of those records by licensed clinical staff in the IRF is not acceptable. However, if the comprehensive preadmission screening is completed more than 48 hours prior to the IRF admission, the required update within 48 hours of the admission may be completed by telephone.

We do not believe that permitting the entire preadmission screening to be conducted within the 96 hours immediately preceding the IRF admission, without the benefit of a more recent update, would provide sufficiently current information on the patient's medical and functional status to allow the rehabilitation physician to make an appropriate admission decision.

Comment: Several commenters expressed concerns about eliminating the 3-day to 10-day inpatient assessment period for determining whether an IRF admission is appropriate, indicating that IRFs often require several days after an IRF admission to assess whether the patient can participate in and benefit from the intensive rehabilitation therapy provided in IRFs.

Response: We disagree. The current average length of stay for IRF patients is only about 13 days, and the average length of stay for many orthopedic patients treated in IRFs is only about 8 days. Given this, we believe that it is no longer appropriate to allow up to 10 days in an IRF merely to assess the patient. At that point, the average IRF patient would already be preparing to be discharged.

In addition, we believe that, in today's clinical environment, licensed physicians with training and experience in rehabilitation are able to assess a patient prior to admission to an IRF and determine whether there is a reasonable expectation that the patient can participate in and benefit from treatment in an IRF. In the unusual instance that the rehabilitation physician's reasonable expectation prior to admission is not realized once the patient is admitted to the IRF, we are allowing the IRF to begin making arrangements to transfer the patient to another setting of care and to receive the short stay outlier payment for IRF stays of 3 days or less (instead of having the entire claim denied), as long as the reasons for the change in the patient's status before and after admission are well-documented in the patient's medical record.

B. Requirement for a Post-Admission Physician Evaluation

We proposed to add a requirement for a post-admission evaluation by a rehabilitation physician within 24 hours of admission. The purpose of the proposed post-admission evaluation would be 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 would be completed with input from all of the interdisciplinary team members in the overall plan of care. We also proposed to require that this document be retained in the patient's medical record.

We received 21 comments on the proposed requirement for a post-admission physician evaluation, which are summarized below.

Comment: Several commenters suggested that we allow the physician's history and physical (H&P) to satisfy the requirement for the post-admission physician evaluation.

Response: While the H&P is a significant component of the admission process, the post-admission evaluation performed by the rehabilitation physician is meant to include additional information that goes beyond that typically found in an H&P. Not only is the post-admission evaluation intended to provide a review of the medical history of the patient and validate the patient's condition on admission, it also provides guidance as to whether or not it is safe to initiate the patient's therapy program and it supports the medical necessity of the IRF admission. For example, it would be useful for the post-admission physician evaluation to (1) describe the clinical rehabilitation complications for which the patient is at risk, and the specific plan to avoid them, (2) describe the adverse medical conditions that might be created due to the patient's comorbidities and the rigours of the intensive rehabilitation program, and the methods that might be used to avoid them, and (3) predict the functional goals to be achieved within the medical limitations of the patient. As such, it is a combination medical/functional resource for all team members in the care of the patient as they prepare to contribute to the individualized overall plan of care.

Comment: Several commenters suggested that other licensed independent practitioners (LIPs), other than the rehabilitation physician, be allowed to complete the post-admission evaluation.

Response: Although LIPs, in many instances, complete H&Ps on IRF patients upon admission to the IRF in order to write the medical orders, the post-admission physician evaluation requirements go beyond an H&P (as discussed above). Thus, we believe that the post-admission physician evaluation requires the unique training and experience of the rehabilitation physician, as he or she performs a hands-on evaluation of the patient.

Comment: Several commenters expressed concerns that the post-admission physician evaluation would be difficult to complete with input from the interdisciplinary team within 24 hours of the patient's admission to the IRF, and that we should therefore extend the requirement for completion to either 36 hours or 3 days after the patient's admission to the IRF. Additionally, one commenter suggested that there is no need for a post-admission physician evaluation simply to document that there have been no changes in the patient since the preadmission screening, and that the post-admission evaluation would therefore not be beneficial or cost-effective.

Response: We agree with the commenters that it may be difficult for the rehabilitation physician to obtain input from all of the interdisciplinary team members in time to incorporate this information into the post-admission physician evaluation. For this reason, we are removing the requirement that the rehabilitation physician obtain input from the interdisciplinary team in completing the post-admission physician evaluation. However, we continue to believe that it would be in the best interest of the patient for the rehabilitation physician to consider any input that is available from the interdisciplinary team members in completing the post-admission physician evaluation.

As we indicated in the FY 2010 proposed rule (74 FR 21052 at 21070), we believe that rehabilitation therapy services should begin as soon as possible after a patient is admitted to an IRF, thereby increasing the patient's potential for achieving functional goals. For this reason, we believe that it is necessary for a patient to be seen by a rehabilitation physician within 24 hours of the patient's admission. Therefore, we disagree that the post-admission physician evaluation should be allowed to occur 36 hours or 3 days later. If there are no changes in the patient since the preadmission screening, then the patient's condition should be relatively easy for the rehabilitation physician to document. However, if there have been changes in the patient's medical or functional status, or any other changes in the patient's condition or status, from that noted in the preadmission screening, documentation of these changes and the reasons for these changes is important in determining the continued appropriateness of the IRF admission.

Comment: One commenter asked for clarification regarding whether the post-admission physician evaluation requirement affects the IRF–PAI assessment reference date or the requirements for completing the IRF–PAI. Specifically, the commenter asked whether the IRF–PAI must now be completed prior to the patient's admission to the IRF.

Response: The post-admission physician evaluation requirement does not affect the IRF–PAI assessment reference date or the requirements for completing the IRF–PAI (as described in § 412.610(a)(1)). The IRF–PAI cannot be completed prior to the patient's admission to the IRF. The IRF–PAI must be completed by the end of the fourth day after the patient's admission to the IRF, and should be based on information obtained during the first 3 days following the IRF admission.

C. Requirement for an 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 IRF 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. Thus, we proposed 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.

We received 17 comments on the proposed requirement for an individualized overall plan of care, which are summarized below.

Comment: Several commenters suggested that requiring the individualized overall plan of care to be completed within 72 hours of the patient's admission to the IRF was unrealistic, especially given that IRFs are required to complete the IRF patient assessment instruments (IRF–PAIs) for each patient by the end of the patient's fourth day in the IRF. Several commenters suggested alternative requirements, such as adopting the same timing for the individualized overall plan of care that we require for completing the IRF–PAI (as described in § 412.610(a)(1)), extending the period of

time for completing the overall plan of care to 96 hours and requiring it to be finalized at the first interdisciplinary team meeting, and requiring the overall plan of care to be finalized within the first 5 days of admission.

Response: We agree that requiring the individualized overall plan of care to be completed by the end of the fourth day following the patient's admission to the IRF would allow all of the information from the IRF–PAI to be incorporated into the patient's overall plan of care, thereby enriching the patient's overall plan of care. Thus, we are adopting the timeline suggested by several of the commenters and are requiring that the overall plan of care be completed by the end of the fourth day following the patient's admission to the IRF. We believe that the commenters' suggestions for longer timeframes would unnecessarily delay the initiation of treatment in the IRF and would, thereby, limit patients' potential for achieving functional outcomes.

Comment: Several commenters suggested that we require the first interdisciplinary team meeting to be conducted within the first 4 days following the patient's admission to the IRF to develop the individualized overall plan of care and to adequately reflect the importance of the contributions of the interdisciplinary team to the care planning process.

Response: Although we believe that conducting the first interdisciplinary team meeting for each IRF patient within the first 4 days of admission to develop the overall plan of care would be a good practice in IRFs, we do not believe that a team meeting is the only way to develop an overall plan of care. As long as all of the required elements for the overall plan of care are present in the patient's medical record, we believe that it should be left up to each individual IRF to determine the best method for developing the patient's overall plan of care.

Comment: One commenter suggested that we provide examples of overall individualized plans of care for patients with specific conditions.

Response: We believe that it is important to note that the overall plan of care for each IRF patient should be individualized to that patient's unique care needs. Thus, we do not believe that it is appropriate to provide such examples.

D. Requirements for Evaluating the Appropriateness of an IRF Admission

In the FY 2010 proposed rule (74 FR 21052 at 21069), we also proposed to require that the comprehensive preadmission screening include an evaluation of the following proposed requirements that a patient must meet to be admitted to an IRF:

1. Whether the patient's condition is sufficiently stable 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, meaning that the patient 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.

3. Whether the patient requires the intensive services of an inpatient rehabilitation setting, which is typically measured by whether the patient generally requires and can 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.

We received 58 comments on the proposed requirements for evaluating the appropriateness of an IRF admission, which are summarized below.

Comment: Several commenters suggested that we further define what we mean by a patient's condition being ''sufficiently stable'' to actively participate in an intensive rehabilitation program. Many of these commenters expressed concerns that we may not be adequately recognizing that IRFs provide an inpatient level of care, similar to that provided in acute care hospitals. In addition, one commenter expressed the concern that the new regulations would mean that patients would have to remain in the acute care hospital longer until their conditions stabilized, which would delay the initiation of therapy services. Another commenter expressed the concern that the new regulations would inappropriately penalize IRFs for fluctuations in a patient's condition. One commenter suggested that we revise the regulation to require that a patient's condition be sufficiently stable ''at the time that rehabilitation services are provided,'' while another commenter suggested that we require that all services that are considered part of the acute care hospital's Medical Severity-Diagnostic Related Group (MS–DRG) payment bundle be completed prior to transfer to the IRF. A third commenter suggested that the determining factor of medical stability should be whether the patient can participate in the intensive rehabilitation therapy program provided in an IRF, at the same time that the IRF manages the patient's medical issues.

Response: We agree with the commenters that IRFs provide a hospital-level of care, with a focus on providing post-acute rehabilitation therapy services. However, we do not believe that patients should be transferred to IRFs before their medical conditions are sufficiently stable to enable them to participate in the intensive rehabilitation therapy program provided in IRFs. Specifically, we mean that, at the time of admission to the IRF, there must be a reasonable expectation that the patient is able to tolerate and benefit from the intensive rehabilitation services as generally prescribed in this rule so that he or she can progressively make the improvements needed to achieve results of practical value towards his or her functional capacity or adaptation to impairment. However, we note that this does not mean that patients' medical conditions will be fully resolved when they are admitted to IRFs. As one of the commenters summarized, we are requiring that a patient's medical condition be such that it can be successfully managed in the IRF setting *at the same time* that the patient is participating in the intensive rehabilitation therapy program provided in an IRF.

Comment: Several commenters expressed concerns that we would be imposing too high a standard in requiring the IRF to demonstrate that each patient it admits meets the IRF coverage criteria ''at the time of admission.'' The commenters suggested, instead, that we require the IRF to demonstrate a *reasonable expectation* at the time of admission that the patients would meet the IRF coverage criteria. Alternatively, several commenters suggested that we instead require that the patient meet the IRF coverage criteria by the assessment reference date for the IRF–PAI (that is, by the fourth day following admission to the IRF) or by the time that therapy is initiated.

Response: We agree with several of the commenters that a reasonable expectation that the patient meets the IRF coverage criteria at the time of admission is sufficient, and are therefore clarifying the language to read, ''The facility must ensure that there is a reasonable expectation that each patient it admits meets the following requirements at the time of admission—.'' This language better reflects our intention in proposing this policy. We note that the detailed reasoning behind this reasonable expectation must be documented in the

preadmission screening, and that it must be supported by the information in the post-admission physician evaluation and the overall individualized plan of care. We do not believe that it is appropriate to provide 4 days (at which point the IRF would generally receive a full CMG payment for the patient) or an undefined amount of time for the IRF to determine whether the patient meets the IRF medical necessity criteria. This determination should be made at the time of admission to the IRF.

Comment: Several commenters expressed concerns that the ''3-hour rule'' could preclude access to IRF care for certain patients who, for one reason or another, cannot participate in at least 3 hours of intensive therapy at least 5 days per week, but who nonetheless could benefit from treatment in an IRF. Several of these commenters suggested that this rule would violate *Hooper* v. *Sullivan,* No H–80–99 (PCD) (D Conn. July 20, 1989). For this reason, some commenters suggested that we allow exceptions to this rule for patients who need other rehabilitation services, but cannot tolerate 3 hours per day of physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy. Some commenters also suggested that we allow for exceptions to this rule for patients who require a lower intensity of therapy services but for whom an IRF admission is the only way that they can participate in a lower intensity of therapy services. In addition, one of the commenters suggested that, in some cases, we should provide more flexibility for meeting the needs of the individual patient by requiring instead that the IRF provide intensive therapy at least 15 hours per week, to be averaged over the week as necessary.

Response: We believe that patients admitted to IRFs should generally require and be reasonably expected to benefit from the *intensive* rehabilitation therapy services that are uniquely provided in IRFs. If patients do not need the intensity of services uniquely provided in IRFs, or benefit from them, then it is not clear to us why they would be admitted to an IRF.

By order of the Court in *Hooper* v. *Sullivan,* rules of thumb cannot serve as the basis of a coverage denial. In keeping with this ruling, the reasonable and necessary test for coverage of an IRF stay is whether the patient received, and could be expected to benefit from, ''intensive rehabilitation services.'' Please refer to section 110 of the Medicare Benefit Policy Manual, once the revisions that we anticipate issuing on January 1, 2010 have been published, for more specific guidance on what type of information to include when documenting an individualized overall plan of care. Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, we do not intend for this to be the only way such intensity can be demonstrated (that is, we do not intend for this measure to be used as a ''rule of thumb'' for denying an IRF claim). Rather, we suggest that this is one generally accepted way of demonstrating the intensity of services provided in an IRF.

We agree with several of the commenters that the intensity of therapy provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7-consecutive day period starting from the date of admission). For example, if a hypothetical IRF patient was admitted to an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of 4 hours of therapy 3 days per week and 1½ hours of therapy on 2 (or more) other days per week in order to accommodate his or her chemotherapy schedule. Thus, IRFs may also demonstrate a patient's need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a 7 consecutive day period starting from the date of admission), as long as the reasons for the patient's periodic need for this program of intensive rehabilitation is well-documented in the patient's medical record and the overall amount of therapy is ''intensive'' and can reasonably be expected to benefit the patient. We will monitor the appropriateness of instances where IRFs demonstrate the required level of intensity in this way.

In addition, we note that we will provide guidance in our manuals on additional instances in which we might find that the patient is receiving intensive rehabilitation therapy services despite not receiving the generally expected intensity of therapy services for a brief period of time.

Comment: Several commenters suggested that we include other services, such as recreational therapy, music therapy, respiratory therapy, psychology, and neuropsychology, on the list of therapy services that IRFs must provide, as needed, under § 412.23(b)(4) and § 412.29(c). These commenters also suggested that we specify in the new requirements whether ''other rehabilitative services,'' such as recreational therapy, music therapy, or respiratory therapy, can be used to meet the intensity of therapy requirements, if they are medical necessary and ordered by a physician.

Response: While we believe that IRFs should provide, as needed, psychological and neuropsychological services to IRF patients, these services are separately billable under Medicare Part B, as described in § 411.15(m)(3)(i) and § 411.15(m)(3)(v), and are not included in the IRF PPS payment. Thus, while we would expect the IRF to provide appropriate medical oversight of any medical or psychiatric problem that is present on admission or develops during the stay (in accordance with the overall hospital Conditions of Participation at § 482.12(c)(1)(i), (c)(1)(vi), and (c)(4)), psychological and neuropsychological services furnished pursuant to this responsibility would not be considered part of the required intensity of therapy services that Medicare pays for under the Part A benefit that includes payment for IRF PPS services.

Further, we do not believe that it is appropriate to mandate that all IRFs provide recreational therapy, music therapy, or respiratory therapy services to all IRF patients, as such services may be beneficial to some, but not all, patients as an *adjunct* to other, primary types of therapy services provided in an IRF (physical therapy, occupational therapy, speech-language pathology, and prosthetics/orthotics therapy). However, we do not believe that they should replace the provision of these four core skilled therapy services. Thus, we believe that it should be left to each individual IRF to determine whether offering recreational therapy, music therapy, or respiratory therapy is the best way to achieve the desired patient care outcomes. While we are not adding these therapies to the list of required therapy services in IRFs, we do recognize that they are Medicare-covered services in IRFs if the medical necessity is well documented by the rehabilitation physician in the medical record and is ordered by the rehabilitation physician as part of the overall plan of care for the patient. However, consistent with our long-standing policies and standard practices, these therapy activities are not used to demonstrate that a patient has received intensive therapy services.

Comment: Several commenters indicated that the term ''of practical value to the patient'' when referring to the level of functional improvement that a patient may be expected to attain in an IRF is subjective, and suggested that we address improvement in the patient's ''quality of life'' instead.

Response: We believe that it will generally be apparent from the documentation by the rehabilitation physician whether there is a reasonable expectation that a particular functional improvement or adaptation to impairment will be of practical value to the patient, within the context of his or her individual situation. Quality of life, a more global term, is influenced by many factors that are unique to the patient, but which may or may not be able to be fully addressed during an IRF stay.

E. Requirements for the Interdisciplinary Team Meetings

Since an interdisciplinary approach to care is such a hallmark of the care provided in the IRF setting, we proposed to modify the terminology that we use throughout the IRF requirements to specify an ''interdisciplinary'' approach to care rather than a ''multidisciplinary'' approach. Further, since the length of many IRF stays has decreased significantly in recent years, we proposed to require that the interdisciplinary team meetings occur at least once per week throughout each IRF stay (instead of at least once every two weeks, as the previous regulations stated).

Also, to improve the effectiveness and coordination of the care provided to IRF patients and to better reflect best practices in IRFs, we proposed to broaden the requirements regarding the professional personnel that are expected to participate in the interdisciplinary team meetings. We proposed 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 indicated in the proposed rule that 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 proposed to require that the rehabilitation physician document concurrence with all decisions made by the interdisciplinary team at each meeting.

As discussed above, we also proposed to require that the interdisciplinary team include registered nurses with specialized training or experience in rehabilitation. However, we proposed to eliminate the requirement that IRFs demonstrate that the patients need 24-hour rehabilitation nursing care because we believe that the patient's need for this care would already be identified by the clinical risk factors documented in the patient's medical record. However, as discussed below, several of the commenters misinterpreted our proposed elimination of this admission criterion as an indication that CMS was no longer valuing rehabilitation nursing in IRFs. We emphasize that it was not our intention to diminish the value of rehabilitation nursing in IRFs; we merely believe that this requirement should be a facility requirement rather than an IRF admission criterion.

We received 10 comments on the proposed requirements for the interdisciplinary team meetings, which are summarized below.

Comment: The majority of commenters agreed that weekly interdisciplinary team meetings were the standard of care in IRFs today, and therefore supported this policy. However, one commenter suggested that this requirement would remove the flexibility and individualization in IRFs. This commenter indicated that communication among disciplines in an IRF is ongoing and often informal, and that the requirement for a representative of every treating discipline to be present at every team meeting is excessive. The commenter suggested that the presence of one appointed therapist with knowledge of the patient's progress would be sufficient for the team meeting.

Response: As discussed in the FY 2010 proposed rule (74 FR 21052 at 21070), the purpose of the interdisciplinary team meeting is to foster communication among disciplines to establish, prioritize, and achieve treatment goals. Though we agree that informal communications among the disciplines on a daily basis are beneficial for the patient, we believe that it is important to require that all treating disciplines meet formally at least once per week to maximize the patient's potential for meeting the treatment goals.

Comment: Several commenters expressed concerns about the removal of the 24-hour rehabilitation nursing requirement from the IRF coverage criteria, indicating that we were not sufficiently recognizing the value of rehabilitation nursing in IRFs.

Response: As discussed above, we proposed to require that the interdisciplinary team include registered nurses with specialized training or experience in rehabilitation. However, we proposed to eliminate this as a coverage criterion because we believe that this criterion should be a facility-level requirement rather than a patient admission criterion. As a coverage criterion, the patient's need for this care would already be identified by the clinical risk factors documented in the patient's medical record.

Comment: One commenter asked for clarification regarding whether the first team conference would be required to be conducted within the first 72 hours of the patient's admission to the IRF in order to develop the overall individualized plan of care, or whether it would be required to be conducted within the first four days of admission to correspond with the completion of the IRF–PAI.

Response: We are merely requiring the first team conference to occur within the first week of the patient's admission to the IRF. While we believe that it may be good practice to conduct the first team meeting within the first 4 days to develop the overall individualized plan of care, we believe that there may be other ways of developing the overall individualized plan of care, and we believe that IRFs should have the flexibility to develop this documentation using whatever internal processes they believe are most appropriate.

F. Requirement for Physician Supervision

One of the primary reasons for a patient to receive rehabilitation therapy services in an inpatient hospital (that is, IRF) setting is that the patient's medical conditions require close medical supervision. In the past, the definition of close medical supervision has been vague. During the past 25 years, it was often assumed that ''close medical supervision'' was demonstrated by frequent changes in orders due to a patient's fluctuating medical status. Currently, however, patients' medical conditions can be more effectively managed so that they are less likely to

fluctuate and interfere with the rigorous program of therapies provided in an IRF.

In addition, the medical complexity of rehabilitation patients has increased over time and they often require the services of multiple physicians to manage their medical conditions and ensure that they are able to maximize their rehabilitation potential in the IRF. Therefore, while multiple specialists may visit the patient at the IRF, we believe that it is the unique responsibility of the rehabilitation physician to coordinate the patient's medical needs with his or her functional rehabilitation needs while in the facility. Thus, we proposed to require that a rehabilitation physician conduct face-to-face visits with the patient at least 3 days per week throughout the patient's IRF stay 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 intensive rehabilitation program provided in the IRF.

We received 7 comments on the proposed requirement for physician supervision, which are summarized below.

Comment: Several commenters stated that the requirement for a minimum of 3 face-to-face visits with the rehabilitation physician per week was reasonable. However, several commenters noted further that a reasonable standard of care would require physicians to see an IRF patient on a more frequent basis.

Response: We believe that each patient in an IRF requires an individualized standard of care. We also acknowledge that each IRF can develop its own standards as to what specialists are available to provide medical services to its patients and the frequency of their visitation that supports patient safety. However, our proposal refers only to our belief that a rehabilitation physician is that professional who is uniquely qualified to assess all aspects of the patient's medical condition (with input from others as needed) and apply this knowledge to modify or advance the program of therapies that the patient is receiving in the IRF to provide for a desirable functional outcome. We believe that consideration or reassessment of the patient's functional goals at least 3 times per week by the rehabilitation physician and his or her documentation of these visits in the medical record is the minimum standard that should be applied in an IRF. All IRFs may increase the frequency of the physician visits as they believe best serves their patient populations.

G. Requirement Regarding Initiation of Therapy Services

In addition to the proposed regulatory changes discussed above, we proposed to require that the required therapy treatments begin within 36 hours after the patient's admission to the IRF.

We received 9 comments on the proposed requirement regarding the initiation of therapy services, which are summarized below.

Comment: Several commenters expressed concerns about the requirement that therapies be initiated within 36 hours of admission to the IRF. They indicated that this would require therapies to be initiated by 4 a.m. on Sunday for patients admitted to the IRF at 4 p.m. on Friday, and that this would be unrealistic. They also indicated that therapy staff generally do not treat patients on weekends, and that this provision would create staffing problems for IRFs. For this reason, the commenters suggested that we either leave it to the physician's judgment to determine when therapy treatments should begin, require therapy to be initiated within a ''reasonable period of time'' from admission to the IRF, or require that therapy be initiated within 36 or 48 hours from midnight of the day of admission.

Response: IRFs are a specialized type of hospital and, like acute care hospitals, are supposed to provide services 7 days a week. Therefore, just as we do not believe that patients who are admitted to acute care hospitals on Friday should have to wait until Monday to have their acute care needs met, we also do not believe that IRF patients who are admitted to IRFs on Friday should have to wait until Monday to have their rehabilitation therapy needs met. Given that the average length of stay in IRFs is only about 13 days, and that the average length of stay for certain orthopedic patients is only about 8 days, we believe that it would be unreasonable for an IRF not to provide rehabilitation therapies to patients on the weekend, as this would mean that patients would not be participating in therapies for a significant portion of their stay in the IRF. Further, since patients' potential for functional recovery often depends on initiating rehabilitation therapies as early as possible, we believe that it is essential that IRFs provide rehabilitation therapy on weekends to ensure that patients are able to maximize their functional goals.

Thus, our intent is to require IRFs to initiate rehabilitation therapies as soon as possible after admission to the IRF. We had proposed to require that IRFs initiate therapy no later than 36 hours after a patient's admission to the IRF. However, some commenters suggested that this would mean that patients admitted to IRFs at 4 p.m. on Friday would need to being therapy by 4 a.m. on Sunday, and that this would effectively require IRFs to begin therapies on Saturday. As it was not our intention to be this restrictive, we are instead requiring that IRFs initiate therapies for all patients within 36 hours from midnight of the day of admission. So, for example, a hypothetical patient admitted to the IRF at 4 p.m. on Friday would need to begin therapies by noon on Sunday.

Comment: Several commenters suggested that we specify whether therapy evaluations would satisfy the requirement for the initiation of therapy.

Response: Therapy evaluations would satisfy the requirement for therapy to be initiated within 36 hours from midnight of the day of admission.

H. Provision of Group Therapies in IRFs

As we discussed in the FY 2010 proposed rule (74 FR 21052, 21070 through 21071), 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. It has come to our attention that some IRFs are providing essentially all ''group therapy'' to their patients. We believe that group therapies may 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 which should be the standard of care in therapy service provided to IRF patients. We believe that group therapy 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 solicited comments on the types of patients for which group therapy may be appropriate, and the specific amounts of group therapies instead of one-on-one therapies that may be beneficial for these types of patients. We stated that we anticipated using this information to assess the appropriate use of group therapies in IRFs and that we might create standards for group therapies in IRFs.

We received 32 comments regarding our request for 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.

Comment: A majority of the commenters stated that group therapies do have an important role in the provision of therapies in IRFs, but they also suggested that the amount of group therapies provided in IRFs should be limited in some way. Many commenters agreed that group therapies are a good adjunct to one-on-one therapies, but should not be the primary source of therapy services provided in IRFs. Several commenters suggested that the size of the groups should not exceed 2 to 4 patients for every one licensed therapist, and that the groups should be comprised of patients with similar diagnoses. Commenters generally suggested that we conduct further research and consult with experts before proposing standards for the provision of group therapies in IRFs.

Response: As we have stated, the standard of care for IRF patients is individualized therapy. Group therapies serve as an adjunct to individual therapies. In those instances in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record. We plan to consider the adoption of specific standards on the use of group therapies at a future date. We appreciate the information that the commenters provided.

I. Clarifying and Conforming Amendments

In the FY 2010 proposed rule (74 FR 21052, 21080 through 21081), we proposed revisions to § 412.23 and § 412.29 to combine the facility classification requirements for rehabilitation hospitals and rehabilitation units of acute care hospitals into one section at § 412.29, and to add the new coverage requirements to § 412.29. However, upon reviewing the comments that we received on the proposed rule, we realized that combining the requirements for hospital-based and freestanding IRFs into one section, and including coverage requirements in that same section, resulted in some confusion about whether and to what extent the facility requirements were being altered, and whether we were making coverage criteria a classification requirement. To eliminate this confusion, we are retaining the separate sections at § 412.23 and § 412.29 (governing facility requirements for rehabilitation hospitals and rehabilitation units, respectively) and making conforming changes to these two sections to mirror the new coverage criteria, which appear in the new sections § 412.622(a)(3), § 412.622(a)(4), and § 412.622(a)(5). However, the facility criteria requirements, as modified, will be retained in § 412.23 and § 412.29. These facility criteria will not be used to determine whether individual IRF claims are for services that are reasonable and necessary under section 1862(a)(1) of the Act. The conforming changes, which we are making to the identical text in both § 412.23 and § 412.29 are:

- To remove the words ''or assessment'' from § 412.23(b)(3) and § 412.29(b) to indicate that we are no longer providing for a 3 to 10 day inpatient assessment period after admission to assess the appropriateness of the IRF admission, as discussed above.
- To amend paragraphs § 412.23(b)(4) and § 412.29(c) to require that IRFs ''furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.'' This amendment is in response to comments, as discussed above. To replace the word ''multidisciplinary'' with the word ''interdisciplinary'' in § 412.23(b)(7) and § 412.29(e) to make the terminology consistent with the new IRF coverage criteria in the newly created § 412.622(a)(3), § 412.622(a)(4), and § 412.622(a)(5). To require, in both § 412.23(b)(7) and § 412.29(e), that the interdisciplinary team meetings occur at least once per week to be consistent with the new IRF coverage criteria in the newly created § 412.622(a)(3), § 412.622(a)(4), and § 412.622(a)(5).

To eliminate any further confusion about whether we are promulgating new IRF coverage requirements or new facility classification requirements in this final rule, we are withdrawing all other proposed changes to § 412.23 and § 412.29 at this time.

J. HCFAR 85–2 Ruling

As noted previously, the HCFAR is outdated and inconsistent with the IRF PPS. The adoption of the proposed coverage criteria would establish a new legal framework. These new regulatory requirements would not mirror the provisions in HCFAR 85–2. Therefore, to prevent further confusion over which document provides instructions on the IRF PPS regulations, we proposed that HCFAR 85–2 would be rescinded and new manual provisions offering guidance on the new regulatory coverage criteria would be issued. In light of the adoption of a new regulatory framework under this final rule, it is appropriate to rescind HCFAR 85–2. We now realize, however, that the rescission needs to be done through issuance of a notice in the **Federal Register**. Thus, we will issue a notice in the **Federal Register** at a future date to notify the public of the rescission of HCFAR 85–2, effective for IRF discharges occurring on or after January 1, 2010. We anticipate that the new regulatory requirements that are adopted by this rule, once implemented, will be further interpreted by new manual provisions that will be placed in Chapter 1, Section 110 of the MBPM.

We received 14 comments on the proposed rescission of HCFAR 85–2, which are summarized below.

Comment: Several commenters expressed concern that rescinding HCFAR 85–2 prior to issuing manual revisions would negatively affect IRF claims denials that are currently being reviewed by ALJs.

Response: We will rescind HCFAR 85–2 in a future notice issued in the **Federal Register** prior to the implementation of the new regulatory provisions. We anticipate issuing manual guidance that will interpret the new regulations. The new regulatory provisions will become effective for IRF discharges occurring on or after January 1, 2010. Thus, as we will discuss in a future notice to be issued in the **Federal Register**, HCFAR 85–2 will continue to apply for all IRF discharges that occur prior to January 1, 2010. Once the updated regulations become effective, ALJs will be able to use the new, clarified regulations. We believe that simplifying and clarifying the rules will make the rules easier for all stakeholders, including ALJs, IRFs, and Medicare contractors, to understand and to follow. In so doing, we believe that the updated regulations will reduce the number of disputed IRF claims denials that will be appealed to the ALJ level.

Final Decision: After carefully considering all of the comments we received on the proposed updates to the IRF coverage requirements, we are finalizing the regulation text changes as proposed, except for the revisions in response to comment indicated below. In addition, to eliminate any confusion that these coverage requirements are requirements for determining whether an IRF claim meets the reasonable and necessary provision of the statute rather than facility classification requirements, we are moving these coverage requirements to a newly created § 412.622(a)(3), § 412.622(a)(4), and § 412.622(a)(5). Finally, we will rescind

HCFAR 85–2 in a future notice to be issued in the **Federal Register**.

We are adding requirements to § 412.622(a) as shown in the regulatory text of this final rule.

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

A. Background on 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, among other things, the requirements in § 412.23(b)(2). According to this section, at least 60 percent of an IRF's total inpatient population must require intensive rehabilitative services for treatment of one or more of 13 specified conditions.

The instructions that we provide to Medicare contractors in Chapter 3, section 140 of the Medicare Claims Processing Manual, Internet-Only Manual (IOM) Pub. 100–04, provide for two methodologies that Medicare contractors may use to determine whether an IRF's patient population meets the requirements in § 412.23(b)(2). We refer to the first of these two methodologies as the ''presumptive methodology.'' This methodology uses 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 § 412.23(b)(2) specifies that an IRF's total inpatient population must meet the 60 percent rule requirements, this method examines only the Medicare patient data and extrapolates from this the compliance percentage for the IRF's entire inpatient population. The presumptive methodology uses computer software to examine each IRF–PAI for the presence of particular diagnostic codes that indicate whether a patient has one of the 13 medical conditions listed in § 412.23(b)(2)(ii). If the computer software determines that the patient has one or more of the diagnostic codes that represent 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 IRF's compliance percentage; otherwise, the patient is not counted. Once the computer software has examined all of the IRF–PAIs submitted by a particular IRF, the computer software computes the presumptive compliance percentage for that IRF. The percentage that the software computes is equal to the total number of IRF–PAIs with one or more diagnostic codes representing the 13 medical conditions listed in § 412.23(b)(2)(ii) divided by the total number of IRF–PAIs submitted by the IRF. This becomes the IRF's presumptive compliance percentage, which is then compared with the required minimum compliance percentage to determine whether the IRF 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 when the Medicare contractor has verified that the IRF'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 IRF's Medicare Part A fee-for-service inpatient population must be at least 50 percent or more of the IRF's total inpatient population. If the IRF's Medicare Part A fee-for-service inpatient population is less than 50 percent of the IRF's total inpatient population, then we cannot verify that the IRF–PAI data are representative of the IRF's total inpatient population. Therefore, in these situations, we require the Medicare contractors to use the second of the 2 methodologies to determine the IRF'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 IRF's total inpatient population (which may consist of all of the IRF's medical records if the IRF has 100 or fewer inpatients during the review period) to determine the IRF's compliance percentage. The medical review methodology may be used at any time at the discretion of the Medicare contractor, but we specifically require its use if the IRF's Medicare Part A fee-for-service inpatient population is less than 50 percent of the IRF's total inpatient population (as described above) or if the IRF fails to meet the minimum compliance percentage using the presumptive methodology.

B. Requirement To Submit Assessment Data on Medicare Advantage Patients

As described above, the presumptive methodology relies on the IRF–PAI data that is submitted under § 412.604 and § 412.618. To use the presumptive methodology, the Medicare Part A fee-for-service inpatient population must make up at least 50 percent or more of the IRF'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 for whom the presumptive methodology can be used.

Thus, although we have not required IRFs to submit IRF–PAI data on MA patients until now, we proposed in the FY 2010 IRF PPS proposed rule (74 FR 21052, 21071 through 21073) to revise the regulation text in § 412.604, § 412.606, § 412.610, § 412.614, and § 412.618 to require that IRFs submit IRF–PAI data on all of their MA patients to facilitate better calculations under the 60 percent rule. Where an IRF fails to submit all MA IRF PAIs, we proposed that CMS would 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 proposed to remove § 412.614(a)(3) of the regulations that formerly allowed IRFs not to submit IRF–PAI's for Medicare patients for whom they were not seeking payment from Medicare. However, we specifically solicited comments on whether requiring IRFs to submit IRF–PAI data on all of their MA patients would be the best way to ensure the integrity of the compliance review process.

Requiring IRFs to submit IRF–PAIs for all of their MA inpatients, in addition to all of their Medicare Part A fee-for-service inpatients, will allow Medicare contractors to begin using the presumptive methodology to determine IRFs' compliance percentages when the Part A fee-for-service and MA inpatient populations combined are more than 50 percent of their total inpatient populations. We proposed 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 proposed 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).

We received 21 comments on the proposed revisions to the regulation text to require IRFs to submit patient

assessments on MA patients for use in the 60 percent rule calculations, which are summarized below.

Comment: The majority of commenters supported the proposed change to the regulation text to allow Medicare Advantage patients to be counted in the 60 percent rule calculations. However, individual commenters offered differing suggestions regarding the effective date of the proposed change. One commenter suggested that CMS delay implementing the new reporting requirements until at least FY 2011; another commenter suggested rapid implementation of this requirement so that the MA IRF–PAIs could be used in the 60 percent compliance calculations for current compliance review periods that are already underway as of October 1, 2009; and a third commenter suggested that the change should be made effective for compliance review periods beginning on or after October 1, 2009.

Response: We agree with the commenters that it is important to recognize the increasing population of MA patients in many areas. We also agree that this change will make the compliance reviews easier for certain IRFs with high percentages of MA patients and for the fiscal intermediaries or Medicare Administrative Contractors that review these IRFs' compliance with the 60 percent rule. Further, we agree with one of the commenter's suggestions that the change should be made effective for compliance review periods beginning on or after October 1, 2009 and we are adopting this effective date.

Comment: Several commenters suggested that the proposed policy to not use any of an IRF's MA IRF–PAIs in the compliance calculations if the IRF does not submit all of them is overly strict, and that we should allow for some reasonable exceptions. Many of these commenters also objected to the proposed removal of the exception for submission of IRF–PAIs on Part A fee-for-service patients. However, one commenter supported the proposed requirements for submitting all of the MA IRF–PAIs, indicating that it was a ''fair and equitable'' policy that would avoid ''cherry-picking'' and reduce the creation of unfair advantages among IRFs.

Response: As we did not receive any specific suggestions regarding a better way of ensuring the integrity of the compliance review process, we believe that requiring IRFs to submit IRF–PAIs on all of their MA patients and not including MA patients in the compliance calculations for those IRFs that do not submit all of their MA IRF–PAIs is the only way to ensure the integrity of the compliance review process.

Comment: One commenter said that IRFs might not always know the Medicare identification numbers for their MA patients, and suggested that we provide a way for IRFs to send the IRF–PAI data on MA patients without the Medicare identification number.

Response: To preserve the integrity of the compliance percentage review process, we believe that it is important to require that the patient's Medicare identification number be recorded on the IRF–PAI for MA patients. Having the Medicare identification numbers on the IRF–PAIs will allow us to verify the information that we obtain from the MA IRF–PAIs with the MA claims that hospitals are required to submit to CMS for informational purposes. Currently, all IPPS hospitals, IRFs, and long-term care hospitals (LTCHs) are required to submit abbreviated Medicare claims on their MA patients for use in the DSH and LIP adjustment calculations. To enable IRFs to submit the required MA claims, the Medicare managed care organizations are already providing IRFs with the Medicare beneficiary identification numbers anytime an MA patient is admitted to the IRF. Since IRFs are already obtaining this information for the MA claims, we do not believe that it will be a problem for IRFs to record this same information on the IRF–PAIs.

Comment: One commenter suggested that we change the wording in § 412.606(c)(1) to recognize that multiple clinicians may provide information for completing an IRF–PAI, rather than specifying that only a single clinician may complete it.

Response: We agree with the commenter and are making the suggested change.

Comment: One commenter suggested that we revise the presumptive methodology calculation to include non-Medicare patients, including patients that pay for their own IRF care.

Response: We will consider the commenter's suggestion. However, we do not believe that we have the authority to require IRFs to submit IRF–PAIs on non-Medicare patients.

Comment: Several commenters objected to the different record retention requirements for the IRF–PAIs on Part A fee-for-service patients and those on MA patients.

Response: As noted previously, we proposed 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 proposed 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). We believe that the proposed IRF–PAI record retention requirements are the only way to maintain consistency with the different record retention requirements in each of these two sections of the regulation.

Comment: Several commenters suggested that we consider exceptions to the proposed penalty for late submission of the Medicare Advantage IRF–PAIs and that the exceptions should apply to both Medicare and Medicare Advantage patients. One commenter indicated that it would be completely unreasonable for CMS to impose the penalty of total exclusion of the Medicare Advantage IRF–PAI data based on one late submission.

Response: We understand the concerns expressed by the commenters and agree that a limited exception to this policy is warranted. We currently provide for a limited exception to the application of the IRF–PAI penalty for late submission under § 412.614(e). In this final rule, we will amend section 412.614(e) to include late transmission of MA IRF–PAIs, thereby providing for a limited exception to the penalty for late transmission of the MA IRF–PAIs due to extraordinary situations that are beyond the control of the IRF.

Final Decision: After carefully considering the comments that we received on the 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, we are finalizing the following revisions to the regulation text in § 412.604, § 412.606, § 412.610, § 412.614, and § 412.618. Specifically, we are adding Medicare Part C (Medicare Advantage) patients to the patients for whom IRFs must complete and submit an IRF–PAI, removing 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 rejecting MA IRF–PAI data that is not complete. Thus, we are finalizing the changes to the regulation text as follows:

- In § 412.604(c), we are adding 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 are adding the phrase ''and Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatients.'' The paragraph reads 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 are adding 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 are adding the phrase ''and Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatient.'' The paragraph reads 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 are adding the phrase ''or Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatient.'' The paragraph reads 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 are adding the phrase ''or Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''patient's.'' The paragraph reads 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 are adding the phrase ''or Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''hospitalization.'' The paragraph reads 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 are adding the phrase ''or Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatient,'' so that the resulting paragraph reads as follows: ''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 are adding the phrase ''and Medicare Part C (Medicare Advantage) patients within the previous 10 years'' after ''5 years'' and before ''either,'' and also adding the phrase ''and produce upon request to CMS or its contractors'' after ''obtain.'' The paragraph reads 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.'' This maintains consistency with the 5-year record retention requirements for IRF–PAIs completed on Medicare Part A fee-for-service patients specified in § 412.610(f) and the 10-year record retention requirements for Medicare Part C (Medicare Advantage) records specified in § 422.504(d)(1)(ii).

• In § 412.614(a), we are adding the phrase ''and Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatient,'' the paragraph reads 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 are removing § 412.614(a)(3).

• In § 412.614(b)(1), we are adding the phrase ''and Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''inpatient,'' the paragraph reads 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 are revising § 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 are revising § 412.614(d)(1) to read, ''Medicare Part A fee-for-service data.''

• We are making a technical correction to the paragraph formerly designated as § 412.614(d)(1) and assigning the revised language to a new paragraph § 412.614(d)(1)(a), which reads 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 are redesignating paragraph § 412.614(d)(2) as § 412.614(d)(1)(b).

• We are adding a new paragraph § 412.614(d)(2), which reads 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).''

• We are revising the second sentence in paragraph § 412.614(e). The sentence reads as follows ''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.''

• In the introductory paragraph of § 412.618, we are adding the phrase ''or Medicare Part C (Medicare Advantage)'' after ''fee-for-service'' and before ''patient.'' The paragraph reads 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: * * *''

X. Miscellaneous Comments

Comment: A commenter indicated that posting extensive changes to the

long-standing policies in the Medicare Benefit Policy Manual on our Web site for comment may violate the APA, and they specifically cited *Alaska Professional Hunters Association, Inc.* v. *Federal Aviation Administration,* 177 F.3d 1030 (June 4, 1999).

Response: We disagree with the commenter that the procedures used to seek the public's input on the new draft manual provisions that will, when finalized, be placed in Section 110 of MBPM, and the proposal to rescind HCFAR 85–2, violate the APA. We proposed regulatory changes related to IRF coverage policy through the FY 2010 IRF proposed rule. These regulatory changes are being finalized through this final rule with an implementation date of January 1, 2010. These regulatory provisions replace the policies outlined in HCFAR 85–2. We will therefore issue a notice in the **Federal Register** at a future date to rescind HCFAR 85–2, effective on the date on which the replacement regulations will take effect. While we anticipate release of new manual provisions that will interpret the new regulations on that same date, the substantive provisions in the regulations, not the interpretive guidance in the manuals, will replace HCFAR 85–2. Full notice and comment rulemaking was used to adopt these regulations, in accordance with the APA.

Thus, we believe that, in rescinding the prior standard (HCFAR 85–2) in a future notice to be issued in the **Federal Register** and replacing it with new legal standards in regulations, and promulgating updated manual provisions after consideration of public comments to the proposed rule, we are in compliance with all applicable and necessary notice and comment processes. Furthermore, by accepting comments on the draft manual through our Web site, and publicizing our interest in receiving comments through that mechanism in the proposed rule, we exceeded the legal requirements for seeking public comment on our draft policies.

Comment: Several commenters expressed concerns that the proposed rule did not include a requirement for rehabilitation nursing. They stated that the importance of the rehabilitation nursing staff to carry out medical management interventions, repetition of functional mobility techniques as taught by the licensed therapists throughout the patient's stay, education in disease management and illness prevention related to a patient's unique presentation of diagnosis, family training, and education cannot be underestimated in the IRF patient's potential for functional improvement. One commenter suggested that CMS revise the existing requirement to require the use of certified registered rehabilitation nurses.

Response: While we agree with the commenters on the importance of rehabilitation nursing, as well as the need to ensure that patients are attended to by licensed staff with experience in rehabilitation nursing, we do not agree that the requirements for rehabilitation nursing should be included as an IRF admission criterion. Instead, we believe that the use of rehabilitation nurses is a staffing requirement that would be included in Conditions of Participation for IRFs. We are actively working on such Conditions and expect to release a proposed rule in the near future.

Comment: One commenter requested clarification on whether payments to an IRF are reduced when patients are transferred to a SNF. The commenter stated that, occasionally, a patient will be making steady progress toward goals even up to four weeks after admission, when family members suddenly change their minds about their ability to care for their loved one at home. The commenter suggested that, if the IRF keeps the patient beyond the average length of stay for that CMG with the intention of discharging the patient to a home or community-based setting, the IRF payment for the patient should not be reduced.

Response: In the scenario that the commenter described, the IRF payment for the patient would not be reduced, as long as the patient meets the IRF coverage criteria. According to the regulations, if the patient meets the IRF coverage criteria and the patient's length of stay in the IRF is longer than the average length of stay for the patient's CMG and tier, the IRF will receive the full CMG payment for the patient regardless of whether the patient is discharged to a SNF.

Comment: One commenter suggested that we clarify the composition of prosthetic and orthotic services as well as the specific qualifications of those individuals that provide these services.

Response: An IRF is required to meet the Hospital Conditions of Participation. This means that, among other things, a governing body is required to be responsible for the services furnished in an IRF, including prosthetic and orthotic services, whether or not they are furnished under contract. These services must meet the general Medicare requirements, which include requirements for the professional standards for those providing the service.

Comment: One commenter suggested that CMS clarify the appeals process for challenging removal of a facility from the IRF PPS. The commenter proposed removing IRFs only for the cost reporting period following an unfavorable decision by the Provider Reimbursement Review Board (PRRB) or the CMS Administrator.

Response: It is the responsibility of the CMS Regional Office to notify the IRF prior to the beginning of its next cost reporting period if the facility has failed to meet the IRF classification requirements. This determination may be appealed to the PRRB. However, an IRF does not retain its IRF classification status during the appeal process. The process for appealing an IRF declassification is described in 42 CFR section 405, in Subpart R of the regulations.

Comment: The Commission on Accreditation of Rehabilitation Facilities (CARF) indicated that, due to the thoroughness of the CARF survey procedure involving peer review and the presumption that a facility with such accreditation meets the majority of the classification criteria (with the ability to adjust the required criteria), it would be appropriate for CMS to give accreditation a more robust role in determining IRF classification. Therefore, they suggested that CMS should give the CARF (and other accrediting bodies as appropriate) the responsibility for evaluating a facility's full compliance with the exclusion criteria through its ongoing on-site survey and peer review processes. In the CARF's view, any facility that is able to obtain and maintain CARF accreditation should be deemed to qualify as an IRF for purposes of reimbursement under the IRF PPS. Otherwise, the CARF suggested that the current guidance in the State Operations Manual, which creates a presumption of satisfaction of the exclusion criteria for accredited facilities and programs, should be maintained.

Response: The regulations at § 412.23(b) set forth the criteria used by Medicare's contractors to determine if a hospital is excluded from the IPPS for purposes of payment under the Medicare program. One of these criteria, commonly known as the ''60 percent rule,'' focuses on the medical conditions of patients admitted to an IRF. The CARF accreditation criteria serve a different function in that they define the facility's capacity to deliver services rather than describing the patients being served. As we have stated above, we are actively working on Conditions of Participation for IRFs and expect to release a proposed rule in the near

future. Thus, we believe that any role that the CARF might assume in determining IRF classifications in the future would be related to deeming authority under these ''Conditions.''

Comment: One commenter suggested that we clarify whether the services of aides may, in some instances, be used to satisfy the ''3 hour rule'' in IRFs. The commenter stated that, in other Medicare programs such as therapy reimbursed under Part B or through the SNF PPS, aides cannot provide skilled therapy, and the role of aides is limited to the provision of support services.

Response: Therapy aides are authorized to perform support services for licensed and/or certified skilled therapy practitioners. Services performed by aides may be a useful adjunct to the overall rehabilitation program. However, therapy aide services are not considered skilled, and would not meet the IRF intensity of therapy criterion used to evaluate the appropriateness of IRF care.

Comment: One commenter suggested that we clarify, with examples, when Medicare coverage for an IRF stay is no longer considered reasonable and necessary.

Response: Under the IRF PPS, we generally make one CMG payment to an IRF for each Medicare discharge that is considered reasonable and necessary under section 1862(a)(1) of the Act. This per discharge payment covers the inpatient operating and capital costs of furnishing covered rehabilitation services to a Medicare patient throughout the patient's entire IRF stay. Thus, defining the formal end of an IRF stay is less important than it would be if we were making payments by the day. However, we believe that an IRF stay should generally end when the patient no longer requires or can reasonably be expected to benefit significantly from the services provided in an IRF. This typically, though not in all cases, occurs when the patient is ready to return home or to a community-based environment. We recognize that, in certain limited instances, the patient may need to be discharged to another institutional setting of care, but we believe that this would be a rare occurrence.

Comment: One commenter suggested that we clarify whether IRF claim denials can be made exclusively by non-physician reviewers, without a final determination being made by a physician reviewer.

Response: Medicare's contractors (including, but not limited to, fiscal intermediaries, Medicare Administrative Contractors (MACs), and Recovery Audit Contractors (RACs)) are responsible for reviewing IRF claims to ensure that they meet the reasonable and necessary requirements for payment of Medicare services under section 1862(a)(1) of the Act. Medicare's contractors typically use non-physician reviewers, such as nurses or therapists, to review Medicare claims, under the supervision of physician medical directors. Though we do not have a formal process for the physician medical directors to make the ''final determinations'' on all IRF claims denials, they are actively involved in overseeing the reviews and ensuring the integrity of the medical review process.

XI. Provisions in the Final Rule

In this final rule, we are adopting the provisions as set forth in the FY 2010 IRF proposed rule (74 FR 21052), except as noted elsewhere in the preamble. Specifically:

A. Payment Provision Changes

- We will 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 IV of this final rule.
- We will 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 V of this final rule.
- We will update the FY 2010 IRF PPS payment rates by the proposed market basket, as discussed in section VI.A of this final rule.
- We will update the FY 2010 IRF PPS payment rates by the wage index and labor-related share in a budget neutral manner, as discussed in sections VI.A and B of this final rule.
- We will update the outlier threshold amount for FY 2010, as discussed in section VII.A of this final rule.
- We will update the cost-to-charge ratio ceiling and the national average urban and rural cost-to-charge ratios for purposes of determining the outlier payments under the IRF PPS for FY 2010, as discussed in section VII.B of this final rule.

B. Regulatory Text Changes

- We will remove the words ''or assessment'' from § 412.23(b)(3) and § 412.29(b) to indicate that we are no longer providing for a 3 to 10 day inpatient assessment period after admission to an IRF to assess the appropriateness of the IRF admission, as discussed in section VIII.A of this final rule.
- We will amend paragraphs § 412.23(b)(4) and § 412.29(c) to require that IRFs ''furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services,'' as discussed in section VIII.I of this final rule.
- We will replace the word ''multidisciplinary'' with the word ''interdisciplinary'' in § 412.23(b)(7) and § 412.29(e) to make the terminology consistent with the new IRF coverage criteria in § 412.622(a), as discussed in section VIII.E of this final rule.
- We will require, in both § 412.23(b)(7) and § 412.29(e), that the interdisciplinary team meetings occur at least once per week (rather than once every two weeks) to be consistent with the new IRF coverage criteria in § 412.622(a), as discussed in section VIII.E of this final rule.
- We will add new paragraphs (3), (4), and (5) to § 412.622(a) to implement new IRF coverage requirements, as discussed in section VIII of this final rule.
- With respect to § 412.604, § 412.606, § 412.610, § 412.614 and § 412.618, we will revise the regulation text as described in section IX.B of this final rule.
- With respect to § 412.614(a), we will remove subparagraph (3) as described in section IX.B of this final rule.
- With respect to § 412.614(d), we are making a technical correction to the paragraph formerly designated as paragraph (1) and assigning the revised language to a new paragraph (1)(a), redesignating paragraph (2) as (1)(b), and adding a new paragraph (2), as described in section IX.B of this final rule.

XII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-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 412.604 Conditions for Payment Under the Prospective Payment System for Inpatient Rehabilitation Facilities

Section 412.604(c) states that for each Medicare Part A fee-for-service patient admitted to or discharged from an IRF on or after January 1, 2002, the IRF 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.

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 states that an IRF 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.

The burden for completing 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

Section 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 assessment 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.

Section 412.622 IRF Coverage Criteria

Section 412.622(a)(4)(i) requires that a comprehensive screening meet all of the requirements in paragraphs (A) through (E). Section 412(a)(4)(i)(D) requires the physician to document his or her concurrence with the findings and results of the preadmission screening. Section 412(a)(4)(i)(E) requires that the preadmission screening be retained in the patient's medical record.

The burden associated with these requirements is the time and effort put forth by the rehabilitation physician to document his or her concurrence with the preadmission findings and the results of the preadmission screening and retain the information in the patient's medical record. The burden associated with these requirements 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 these 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 412.622(a)(4)(ii) is consistent with the existing Hospital CoP requirement at § 482.24(c)(2) which requires the facility to have and utilize a post-admission evaluation process. The post-admission evaluation process requires that a rehabilitation physician complete a post-admission evaluation for each patient within 24 hours of that patient's 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, § 482.24(c)(2) requires that the post-admission physician evaluation be retained in the patient's medical record in keeping with the Hospital CoPs.

The burden associated with these requirements is 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 care plan, and retain the information in the patient's medical record. The burden associated with these requirements is consistent with the ''Condition of Participation: Medical record services,'' that is already applicable to Medicare participating hospitals. The burden associated with this requirement is currently approved under OMB# 0938–0328. As stated in the approved Hospital CoPs Supporting Statement, we believe that these 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.

The requirements in section 412.622 (a)(4)(iii) regarding an individualized plan of care are consistent with the existing Hospital CoPs at § 482.56(b) to develop an overall plan of care for each IRF admission. Similarly, the individualized plan of care required by 412.622(a)(4)(iii)(A) 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 requirements is 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 requirements is in keeping with the ''Condition of Participation: Medical record services,'' and ''Condition of Participation: Rehabilitation services. 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 these 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 412.622(a)(5) requires 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. It also requires that the rehabilitation physician document his or her concurrence with the results and findings of the team meeting and that documentation of the weekly meetings be retained in the patient's medical record.

The burden associated with these requirements is the time spent documenting the weekly meetings and the concurrence of the rehabilitation physician with the results and findings of the team meeting and retaining the information in the patient's medical record. The burden associated with these proposed requirements is consistent 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.

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):

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

2. Submit your written comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, *Attention:* CMS Desk Officer, [CMS–1538–F], *Fax:* (202) 395–7245; or *E-mail: OIRA_submission@omb.eop.gov*.

XIII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this final 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 final 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 changes for estimated FY 2010 payments compared to estimated FY 2009 payments will be an increase of approximately $145 million due to the update to the payment rates.

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 at *http://www.sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf*, 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 final rule on all IRFs is to increase estimated payments by about 2.5 percent, with an estimated positive increase in payments of 3 percent or higher for some categories of IRFs (such as urban IRFs in the East South Central, West North Central, West South Central, Mountain and Pacific regions) and an estimated decrease in payments of 3.8 percent for the 17 IRFs that have a resident to ADC ratio greater than 19 percent. Thus, we anticipate that this final rule would have a significant impact on a substantial number of small entities. Medicare fiscal intermediaries and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 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 final rule will not have an adverse impact on rural hospitals based on the data of the 184 rural units and 21 rural hospitals in our database of 1,181 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 final 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 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 final rule will not have a substantial effect on State and local governments, preempt State law, or otherwise have a Federalism implication.

B. Anticipated Effects of the Final Rule

1. Basis and Methodology of Estimates

This final rule sets forth updates of the IRF PPS rates contained in the FY 2009 final rule and 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 will be a net increase of $145 million in payments to IRF providers. The impact analysis in Table 7 of this final rule represents the projected effects of the final policy changes in the IRF PPS for FY 2010 compared with estimated IRF PPS payments in FY 2009 without the policy changes. We determine the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in 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 implementing a number of standard annual revisions and clarifications mentioned elsewhere in this final rule (for example, the update to the wage and market basket indexes used to adjust the Federal rates). We estimate that these revisions would increase payments to IRFs by approximately $145 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 effects of the changes that impact IRF PPS payment rates are shown in Table 7. The following changes that affect the IRF PPS payment rates are discussed separately below:

- The effects of the update to the outlier threshold amount, 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 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 budget-neutral changes to the facility-level adjustment factors, as permitted under section 1886(j)(3)(A)(v) of the Act.
- The total change in estimated payments based on the FY 2010 policy changes relative to estimated FY 2009 payments without the policy changes.

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 1,181 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 976 IRFs located in urban areas included in our analysis. Among these, there are 776 IRF units of hospitals located in urban areas and 200 freestanding IRF hospitals located in urban areas. There are 205 IRFs located in rural areas included in our analysis. Among these, there are 184 IRF units of hospitals located in rural areas and 21 freestanding IRF hospitals located in rural areas. There are 390 for-profit IRFs. Among these, there are 321 IRFs in urban areas and 69 IRFs in rural areas. There are 724 non-profit IRFs. Among these, there are 603 urban IRFs and 121 rural IRFs. There are 67 government-owned IRFs. Among these, there are 52 urban IRFs and 15 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 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 2008 analysis file.

Column (3) shows the number of cases in each category in our FY 2008 analysis file.

Column (4) shows the estimated effect of the adjustment to the outlier threshold amount.

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 changes reflected in this final rule for FY 2010, to our estimates of payments per discharge in FY 2009(without these changes).

The average estimated increase for all IRFs is approximately 2.5 percent, which is entirely due to the market basket update. Since the update to the outlier threshold amount does not impact aggregate payments this year, and since we are making the remainder of the changes outlined in this final rule in a budget-neutral manner, the other changes being made in this final rule will not affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they will affect the estimated distribution of payments among providers.

BILLING CODE 4120–01–P

Table 7: IRF Impact Table for FY 2010

Facility Classification	Number of IRFs	Number of cases	Outlier	Market Basket	FY2010 CBSA wage index and labor-share	CMG	Facility Adjustments	Total Percent Change
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Total	1,181	373,746	0.0	2.5	0.0	0.0	0.0	2.5
Urban unit	776	196,614	0.0	2.5	0.0	-0.1	0.0	2.5
Rural unit	184	29,665	0.0	2.5	0.1	-0.1	-1.3	1.2
Urban hospital	200	141,020	0.0	2.5	0.0	0.1	0.3	2.9
Rural hospital	21	6,447	0.0	2.5	0.1	0.1	-1.6	1.0
Urban For-Profit	321	135,747	0.0	2.5	0.1	0.1	0.3	3.1
Rural For-Profit	69	13,565	0.0	2.5	0.0	0.0	-1.5	1.0
Urban Non-Profit	603	187,401	0.0	2.5	-0.1	-0.1	0.2	2.5
Rural Non-Profit	121	20,186	0.0	2.5	0.1	-0.1	-1.3	1.2
Urban Government	52	14,486	0.0	2.5	0.2	-0.1	-1.6	1.0
Rural Government	15	2,361	0.0	2.5	0.5	-0.1	-1.5	1.3
Urban	976	337,634	0.0	2.5	0.0	0.0	0.2	2.7
Rural	205	36,112	0.0	2.5	0.1	0.0	-1.4	1.1
Urban by region								
Urban New England	31	16,001	0.0	2.5	-0.1	0.1	0.4	2.9
Urban Middle Atlantic	150	62,465	0.0	2.5	-0.3	-0.1	-0.1	2.1
Urban South Atlantic	129	57,543	0.0	2.5	-0.1	0.0	-0.3	2.1
Urban East North Central	193	56,394	0.0	2.5	-0.6	0.0	0.3	2.2
Urban East South Central	53	25,292	0.0	2.5	-0.1	0.0	0.7	3.2
Urban West North Central	71	16,823	0.0	2.5	0.4	0.0	0.2	3.2
Urban West South Central	174	59,695	0.0	2.5	0.0	0.0	0.6	3.2
Urban Mountain	70	21,794	0.0	2.5	0.3	0.1	0.6	3.6
Urban Pacific	105	21,627	0.0	2.5	1.4	0.0	-0.7	3.3
Rural by region								
Rural New England	6	1,422	0.0	2.5	-0.5	-0.1	-0.7	1.2
Rural Middle Atlantic	16	3,429	0.0	2.5	-0.2	-0.1	-0.9	1.3
Rural South Atlantic	26	5,339	0.0	2.5	-0.2	0.0	-1.5	0.8
Rural East North Central	34	6,253	0.0	2.5	-0.5	0.0	-1.1	0.9
Rural East South Central	22	3,831	0.0	2.5	-0.2	-0.1	-2.1	0.1
Rural West North Central	36	4,916	0.0	2.5	0.5	0.0	-1.1	1.8
Rural West South Central	52	9,686	0.0	2.5	0.8	0.0	-1.8	1.5
Rural Mountain	8	742	0.0	2.5	-0.4	0.0	-0.8	1.3
Rural Pacific	5	494	0.1	2.5	0.6	-0.3	-0.6	2.3
Teaching Status								
Non-teaching	1,060	322,431	0.0	2.5	0.0	0.0	0.4	3.0
Resident to ADC less than 10%	69	34,113	0.0	2.5	-0.2	0.0	-0.9	1.4
Resident to ADC 10%-19%	35	10,543	0.0	2.5	-0.8	0.0	-2.8	-1.2
Resident to ADC greater than 19%	17	6,659	0.0	2.5	0.1	0.0	-6.3	-3.8

BILLING CODE 4120–01–C

3. Impact of the Update to the Outlier Threshold Amount

The outlier threshold adjustment is presented in column 4 of Table 7. We estimate that IRF outlier payments as a percentage of total estimated IRF payments are 3 percent in FY 2009. Therefore, since we estimate that we have achieved the target percentage in FY 2009, we are adjusting the outlier threshold amount in this final rule solely to account for the 2.5 percent market basket adjustment for FY 2010 (as discussed in section VI.A of this final rule) and the FY 2010 updates to the facility-level adjustments (as discussed in section V of this final rule) so that we will continue to maintain estimated outlier payments at 3 percent of total estimated aggregate IRF payments for FY 2010.

Since we estimate that we achieved the 3 percent target in FY 2009, and that estimated outlier payments will continue to equal 3 percent of total estimated payments in FY 2010, there is no overall impact on FY 2010 aggregate payments from this update. However, we estimate slight impacts on individual groups of IRFs, which are so small that they round to 0.0 percent. However, Medicare pays an unusually high percentage of outlier payments (8.3 percent) to rural IRFs in the Pacific region. Thus, the estimated impact of the update to the outlier threshold amount for FY 2010 just rounds to 0.1 percent for these 5 IRFs.

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

The market basket update to the IRF PPS payment rates is presented in column 5 of Table 7. In the aggregate the update would result in a 2.5 percent increase in overall estimated payments to IRFs.

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

In column 6 of Table 7, we present the effects of the budget neutral update of the wage index and labor-related share. The changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related share portion of payments, so the changes in the two have a combined effect on payments to providers. As discussed in section VI.A of this final rule, the labor-related share increased from 75.464 percent in FY 2009 to 75.779 percent in FY 2010.

In the aggregate and for all urban IRFs, we do not estimate that these changes will affect overall estimated payments to IRFs. However, we estimate that these changes will have small distributional effects. We estimate a 0.1 percent increase in payments to rural IRFs, with the largest increase in payments of 1.4 percent for urban IRFs in the Pacific region. We estimate the largest decrease in payments from the 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 Update to the CMG Relative Weights and Average Length of Stay Values

In column 7 of Table 7, we present the effects of the budget neutral update of the CMG relative weights and average length of stay values. In the aggregate we do not estimate that these changes will affect overall estimated payments to IRFs. However, these changes have small distributional effects, with the largest effect being a decrease in payments of 0.3 percent to IRFs in the Rural Pacific region.

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

In column 8 of Table 7, we present the effects of the budget neutral update to the rural, LIP, and teaching status adjustment factors. In the aggregate, we do not estimate that these changes will affect overall estimated payments to IRFs. However, we estimate that these changes will have small distributional effects. We estimate the largest increase in payments to be a 0.7 percent increase for urban IRFs in the East South Central region. We estimate the largest decrease in payments to be a 6.3 percent decrease for teaching IRFs with a resident to ADC ratio greater than 19 percent. The estimated decrease in payments for teaching IRFs, of between 0.9 percent and 6.3 percent depending on the IRF's intern and resident to average daily census ratio, is caused by the decrease in the teaching status adjustment factor from 0.9012 to 0.6876, as discussed in section V of this final rule. We also estimate decreases in payments to rural IRFs due to the decrease in the rural adjustment from 21.3 percent in FY 2009 to 18.4 percent in FY 2010, and slight distributional effects among facilities due to the decrease in the LIP adjustment factor from 0.6229 in FY 2009 to 0.4613 in FY 2010. Both the rural and the LIP adjustment factors are discussed in section V.A of this final rule.

C. Alternatives Considered

Because we have determined that this final 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 final 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 2.5 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 updates to the rural, LIP, and teaching status adjustment

factors, we considered either basing them on an analysis of FY 2008 data alone, or averaging the adjustment factors based on the most recent three years of data (FYs 2006, 2007, and 2008). 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, we needed to update the outlier threshold amount to account for the 2.5 percent market basket increase to IRF PPS payments and the effects of the changes to the facility-level adjustment factors to maintain estimated outlier payments at 3 percent of estimated total payments for FY 2010. 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 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 final rule. This table provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the changes presented in this final rule based on the data for 1,181 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.	$145 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 2.5 percent, compared with those in FY 2009, as reflected in column 9 of Table 7. IRF payments are estimated to increase 2.7 percent in urban areas and 1.1 percent in rural areas, per discharge compared with FY 2009. Payments to rehabilitation units in urban areas are estimated to increase 2.5 percent per discharge. Payments to rehabilitation freestanding hospitals in urban areas are estimated to increase 2.9 percent per discharge. Payments to rehabilitation units in rural areas are estimated to increase 1.2 percent per discharge, while payments to freestanding rehabilitation hospitals in rural areas are estimated to increase 1.0 percent per discharge.

Overall, the largest payment increase is estimated at 3.6 percent for urban IRFs in the Mountain region. Teaching IRFs with a resident to ADC ratio greater than 19 percent are estimated to have the largest decrease of 3.8 percent in payments.

We received 1 comment on the regulatory impact analysis, which is summarized below.

Comment: One commenter indicated that the information provided in the regulatory impact analysis for the proposed rule was not sufficient to allow the public to calculate the impacts for individual IRFs. This commenter suggested that we add additional columns, including information about the FY 2009 estimated average weight per discharge, the FY 2009 estimated outlier payments, and the FY 2009 total estimated payments to the IRF rate setting file that we post on the IRF PPS Web site in conjunction with each proposed and final rule.

Response: To provide as much information as possible to enable the public to analyze the impacts of our policies, we will add the suggested information to the IRF rate setting file that we will post on the IRF PPS Web site at *http://www.cms.hhs.gov/InpatientRehabFacPPS/07_DataFiles.asp#TopOfPage* in conjunction with this final rule.

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 amends 42 CFR chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 is amended to read as follows:

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

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

■ 2. Section 412.23 is amended by—

■ A. Revising paragraph (b)(3).

■ B. Revising paragraph (b)(4).

■ C. Revising paragraph (b)(7).

The revisions read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(b) * * *

(3) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program.

(4) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

* * * * *

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

* * * * *

■ 3. Section 412.29 is amended by—

■ A. Revising paragraph (b).

■ B. Revising paragraph (c).

■ C. Revising paragraph (e).

The revisions read as follows:

§ 412.29 Excluded rehabilitation units: Additional requirements.

* * * * *

(b) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program.

(c) Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

* * * * *

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

* * * * *

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

■ 4. 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.

* * * * *

■ 5. 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.

* * * * *

■ 6. 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.

■ 7. 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.

■ 8. 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:

* * * * *

■ 9. Section 412.622 is amended by adding paragraphs (a)(3) through (a)(5) to read as follows:

§ 412.622 Basis of payment.

(a) * * *

(3) *IRF coverage criteria.* In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation that the patient meets all of the following requirements at the time of the patient's admission to the IRF—

(i) Requires the active and ongoing therapeutic intervention of multiple 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, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of 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. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF.

(iii) Is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program that is described in paragraph (a)(3)(ii) of this section.

(iv) Requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-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.

(4) *Documentation.* To document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in paragraph (a)(3) of this section at the time of admission, the patient's medical record at the IRF must contain the following documentation—

(i) A comprehensive preadmission screening that meets all of the following requirements—

(A) It is conducted by a licensed or certified clinician(s) designated by a rehabilitation physician described in paragraph (a)(3)(iv) of this section within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to update the patient's medical and functional status within the

48 hours immediately preceding the IRF admission and is documented in the patient's medical record.

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

(C) It serves as the basis for the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary in paragraph (a)(3) of this section.

(D) 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.

(E) It is retained in the patient's medical record at the IRF.

(ii) A post-admission physician evaluation that meets all of the following requirements—

(A) It is completed by a rehabilitation physician within 24 hours of the patient's admission to the IRF.

(B) It documents the patient's status on admission to the IRF, includes a comparison with the information noted in the preadmission screening documentation, and serves as the basis for the development of the overall individualized plan of care.

(C) It is retained in the patient's medical record at the IRF.

(iii) An individualized overall plan of care for the patient that meets all of the following requirements—

(A) It is developed by a rehabilitation physician, as defined in paragraph (a)(3)(iv) of this section, with input from the interdisciplinary team within 4 days of the patient's admission to the IRF.

(B) It is retained in the patient's medical record at the IRF.

(5) *Interdisciplinary team approach to care.* In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, the patient must require an interdisciplinary team approach to care, as evidenced by documentation in the patient's medical record of weekly interdisciplinary team meetings that meet all of the following requirements—

(A) The team meetings are led by a rehabilitation physician as defined in paragraph (a)(3)(iv) of this section, 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.

(B) The team meetings occur 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.

(C) The results and findings of the team meetings, and the concurrence by the rehabilitation physician with those results and findings, are retained in the patient's medical record.

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

Dated: July 20, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 30, 2009.

Kathleen Sebelius,

Secretary.

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

Addendum

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

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

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

BILLING CODE 4120–01–P

TABLE 1 - 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
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
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9440

CBSA Code	Urban Area (Constituent Counties)	Wage Index
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
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
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
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
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
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
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
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
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
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
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 Mayaguez 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
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
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
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
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
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
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
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 - 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
29	Nevada	0.9382

State Code	Nonurban Area	Wage Index
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.

[FR Doc. E9–18616 Filed 7–31–09; 4:15 pm]

BILLING CODE 4120–01–C