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42 CFR Part 412

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1624–P]

RIN 0938–AS45

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2016

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for federal fiscal year (FY) 2016 as required by the statute. We are also proposing to adopt an IRF-specific market basket that reflects the cost structures of only IRF providers, phase in the revised wage index changes, and revise and update quality measures and reporting requirements under the IRF quality reporting program (QRP).

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 22, 2015.

ADDRESSES: In commenting, please refer to file code CMS–1624–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1624–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1624–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT:

Gwendolyn Johnson, (410) 786–6954, for general information.

Charles Padgett, (410) 786–2811, for information about the quality reporting program.

Kadie Thomas, (410) 786–0468, or Susanne Seagrave, (410) 786–0044, for information about the payment policies and the proposed payment rates.

Catherine Kraemer, (410) 786–0179, for information about the revised wage index.

Bridget Dickensheets, (410) 786–8670, or Heidi Oumarou, (410) 786–7942, for information about the IRF-specific market basket.

SUPPLEMENTARY INFORMATION: The IRF PPS Addenda along with other supporting documents and tables referenced in this proposed rule are available through the Internet on the CMS Web site at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/*.

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

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

Executive Summary

A. Purpose

This proposed rule would update the payment rates for IRFs for FY 2016 (that is, for discharges occurring on or after October 1, 2015, and on or before September 30, 2016) 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 PPS's case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year. This proposed rule would also revise and update quality measures and reporting requirements under the IRF QRP.

B. Summary of Major Provisions

In this proposed rule, we use the methods described in the FY 2015 IRF PPS final rule (79 FR 45872) to propose updates to the federal prospective payment rates for FY 2016 using updated FY 2014 IRF claims and the most recent available IRF cost report data. We are also proposing to adopt an IRF-specific market basket that reflects the cost structures of only IRF providers. We are proposing that the IRF-specific market basket will be used to update the IRF PPS base payment rate and to determine the FY 2016 labor-related share. We are also proposing to phase in the revised wage index changes, and revise and update quality measures and reporting requirements under the IRF QRP.

C. Summary of Impacts

Provision Description	Transfers
FY 2016 IRF PPS payment rate update	The overall economic impact of this proposed rule is an estimated $130 million in increased payments from the Federal government to IRFs during FY 2016.
Provision Description	**Costs**
New quality reporting program requirements	The total costs in FY 2016 for IRFs as a result of the proposed new quality reporting requirements are estimated to be $24,042,291.01.

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

Table of Contents

Acronyms, Abbreviations, and Short Forms

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

The Act The Social Security Act
ADC Average Daily Census
The Affordable Care Act Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010)
AHA American Hospital Association
AHE Average Hourly Earnings
AHIMA American Health Information Management Association
ASAP Assessment Submission and Processing
ASCA Administrative Simplification Compliance Act (Pub. L. 107–105, enacted on December 27, 2002)
BEA Bureau of Economic Analysis
BLS U.S. Bureau of Labor Statistics
CAH Critical Access Hospitals
CARE Continuity Assessment Record and Evaluation
CAUTI Catheter-Associated Urinary Tract Infection
CBSA Core-Based Statistical Area
CCR Cost-to-Charge Ratio
CDC The Centers for Disease Control and Prevention
CDI *Clostridium difficile* Infection
CFR Code of Federal Regulations
CMG Case-Mix Group
CMS Centers for Medicare & Medicaid Services
CPI Consumer Price Index
DSH Disproportionate Share Hospital
DSH PP Disproportionate Share Patient Percentage
ECI Employment Cost Index
EHR Electronic Health Record
ESRD End-Stage Renal Disease
FFS Fee-for-Service
FR Federal Register
FY Federal Fiscal Year
GDP Gross Domestic Product
HAI Healthcare Associated Infection
HCP Health Care Personnel
HHS U.S. Department of Health & Human Services
HIE Health Information Exchange
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, enacted on August 21, 1996)
HOMER Home Office Medicare Records
ICD–9–CM International Classification of Diseases, 9th Revision, Clinical Modification
ICD–10–CM International Classification of Diseases, 10th Revision, Clinical Modification
IGI IHS Global Insight
IMPACT Act Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113–185, enacted on October 6, 2014)
I–O Input-Output
IPF Inpatient Psychiatric Facility
IQR Inpatient Quality Reporting Program
IRF Inpatient Rehabilitation Facility
IRF–PAI Inpatient Rehabilitation Facility-Patient Assessment Instrument
IRF PPS Inpatient Rehabilitation Facility Prospective Payment System
IRF QRP Inpatient Rehabilitation Facility Quality Reporting Program

IRVEN Inpatient Rehabilitation Validation and Entry
LIP Low-Income Percentage
LOS Length of Stay
LPN Licensed Practical Nurse
LTCH Long-Term Care Hospital
MAC Medicare Administrative Contractor
MAP Measure Applications Partnership
MA (Medicare Part C) Medicare Advantage
MedPAC Medicare Payment Advisory Commission
MDS Minimum Data Set
MFP Multifactor Productivity
MLN Medicare Learning Network
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173, enacted on December 29, 2007)
MRSA Methicillin-Resistant *Staphylococcus aureus*
MSA Metropolitan Statistical Area
MUC Measures under Consideration
NAICS North American Industry Classification System
NHSN National Healthcare Safety Network
NPP National Priorities Partnership
NPUAP National Pressure Ulcer Advisory Panel
NQF National Quality Forum
OMB Office of Management and Budget
ONC Office of the National Coordinator for Health Information Technology
OT Occupational Therapists
PAC Post-Acute Care
PAI Patient Assessment Instrument
PLI Professional Liability Insurance
POA Present on Admission
PPI Producer Price Index
PPS Prospective Payment System
PRA Paperwork Reduction Act of 1995 (Pub. L. 104–13, enacted on May 22, 1995)
PRRB Provider Reimbursement Review Board
PT Physical Therapist
QIES Quality Improvement Evaluation System
QM Quality Measure
QRP Quality Reporting Program
RIA Regulatory Impact Analysis
RIC Rehabilitation Impairment Category
RFA Regulatory Flexibility Act (Pub. L. 96–354, enacted on September 19, 1980)
RN Registered Nurse
RPL Rehabilitation, Psychiatric, and Long-Term Care market basket
RSRR Risk-standardized readmission rate
SDTI Suspected Deep Tissue Injuries
SIR Standardized Infection Ratio
SLP Speech-Language Pathologist
SOC Standard Occupational Classification System
SNF Skilled Nursing Facilities
SRR Standardized Risk Ratio
SSI Supplemental Security Income
TEP Technical Expert Panel

I. Background

A. Historical Overview of the IRF PPS

Section 1886(j) of the Act provides for the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (collectively, 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 2015.

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 IRFs' 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 IRFs 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 which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html*. The Web site may be accessed to download or view publications, software, data specifications, educational materials, and other information pertinent to the IRF PPS.

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

2006 IRF PPS final rule in this final rule also includes the provisions effective in the correcting amendments. For a detailed discussion of the final key policy changes for FY 2006, please refer to the FY 2006 IRF PPS final rule (70 FR 47880 and 70 FR 57166).

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

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

After publication of the FY 2008 IRF PPS final rule (72 FR 44284), section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173, enacted on December 29, 2007) (MMSEA), amended section 1886(j)(3)(C) of the Act to apply a zero percent increase factor for FYs 2008 and 2009, effective for IRF discharges occurring on or after April 1, 2008. Section 1886(j)(3)(C) of the Act required the Secretary to develop an increase factor to update the IRF federal prospective payment rates for each FY. Based on the legislative change to the increase factor, we revised the FY 2008 federal prospective payment rates for IRF discharges occurring on or after April 1, 2008. Thus, the final FY 2008 IRF federal prospective payment rates that were published in the FY 2008 IRF PPS final rule (72 FR 44284) were effective for discharges occurring on or after October 1, 2007, and on or before March 31, 2008; and the revised FY 2008 IRF federal prospective payment rates were effective for discharges occurring on or after April 1, 2008, and on or before September 30, 2008. The revised FY 2008 federal prospective payment rates are available on the CMS Web site at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html*.

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

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

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

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

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

Sections 1886(j)(3)(c)(ii)(II) and 1886(j)(3)(D)(i) of the Act also required the Secretary to reduce the market basket increase factor in FY 2011 by a

0.25 percentage point adjustment. The FY 2011 IRF PPS notice (75 FR 42836) and the correcting amendments to the FY 2011 IRF PPS notice (75 FR 70013) described the required adjustments to the FY 2011 and FY 2010 IRF PPS federal prospective payment rates and outlier threshold amount for IRF discharges occurring on or after April 1, 2010, and on or before September 30, 2011. It also updated the FY 2011 federal prospective payment rates, the CMG relative weights, and the average length of stay values. Any reference to the FY 2011 IRF PPS notice in this final rule also includes the provisions effective in the correcting amendments. For more information on the FY 2010 and FY 2011 adjustments or the updates for FY 2011, please refer to the FY 2011 IRF PPS notice (75 FR 42836 and 75 FR 70013).

In the FY 2012 IRF PPS final rule (76 FR 47836), we updated the IRF federal prospective payment rates, rebased and revised the RPL market basket, and established a new quality reporting program for IRFs in accordance with section 1886(j)(7) of the Act. We also revised regulation text for the purpose of updating and providing greater clarity. For more information on the policy changes implemented for FY 2012, please refer to the FY 2012 IRF PPS final rule (76 FR 47836), in which we published the final FY 2012 IRF federal prospective payment rates.

The FY 2013 IRF PPS notice (77 FR 44618) described the required adjustments to the FY 2013 federal prospective payment rates and outlier threshold amount for IRF discharges occurring on or after October 1, 2012, and on or before September 30, 2013. It also updated the FY 2013 federal prospective payment rates, the CMG relative weights, and the average length of stay values. For more information on the updates for FY 2013, please refer to the FY 2013 IRF PPS notice (77 FR 44618).

In the FY 2014 IRF PPS final rule (78 FR 47860), we updated the federal prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also updated the facility-level adjustment factors using an enhanced estimation methodology, revised the list of diagnosis codes that count toward an IRF's 60 percent rule compliance calculation to determine ''presumptive compliance,'' revised sections of the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI), revised requirements for acute care hospitals that have IRF units, clarified the IRF regulation text regarding limitation of review, updated references to previously changed sections in the regulations text, and revised and updated quality measures and reporting requirements under the IRF quality reporting program. For more information on the policy changes implemented for FY 2014, please refer to the FY 2014 IRF PPS final rule (78 FR 47860), in which we published the final FY 2014 IRF federal prospective payment rates.

In the FY 2015 IRF PPS final rule (79 FR 45872), we updated the federal prospective payment rates, the CMG relative weights, and the outlier threshold amount. We also further revised the list of diagnosis codes that count toward an IRF's 60 percent rule compliance calculation to determine ''presumptive compliance,'' revised sections of the IRF–PAI, and revised and updated quality measures and reporting requirements under the IRF quality reporting program. For more information on the policy changes implemented for FY 2015, please refer to the FY 2015 IRF PPS final rule (79 FR 45872) and the FY 2015 IRF PPS correction notice (79 FR 59121).

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

The Affordable Care Act included several provisions that affect the IRF PPS in FYs 2012 and beyond. In addition to what was previously discussed, section 3401(d) of the Affordable Care Act also added section 1886(j)(3)(C)(ii)(I) (providing for a ''productivity adjustment'' for fiscal year 2012 and each subsequent fiscal year). The productivity adjustment for FY 2016 is discussed in section V.D. of this proposed rule. Section 3401(d) of the Affordable Care Act requires an additional 0.2 percentage point adjustment to the IRF increase factor for FY 2016, as discussed in section V.D. of this proposed rule. Section 1886(j)(3)(C)(ii)(II) of the Act notes that the application of these adjustments to the market basket update may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year.

Section 3004(b) of the Affordable Care Act also addressed the IRF PPS program. It reassigned the previously designated section 1886(j)(7) of the Act to section 1886(j)(8) and inserted a new section 1886(j)(7), which contains requirements for the Secretary to establish a quality reporting program for IRFs. Under that program, data must be submitted in a form and manner and at a time specified by the Secretary. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Act requires the application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. Application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

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

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

C. Operational Overview of the Current IRF PPS

As described in the FY 2002 IRF PPS final rule, upon the admission and discharge of a Medicare Part A Fee-for-Service patient, the IRF is required to complete the appropriate sections of a patient assessment instrument (PAI), designated as the IRF–PAI. In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each Medicare Part C (Medicare Advantage) patient, as described in the FY 2010 IRF PPS final rule. All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the Grouper software. The Grouper software uses specific IRF–PAI data elements to classify (or group) patients into distinct

CMGs and account for the existence of any relevant comorbidities.

The Grouper software produces a 5-character CMG number. The first character is an alphabetic character that indicates the comorbidity tier. The last 4 characters are numeric characters that represent the distinct CMG number. Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the Grouper software, are available on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html*.

Once a Medicare Fee-for-Service Part A patient is discharged, the IRF submits a Medicare claim as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, enacted on August 21, 1996) (HIPAA) compliant electronic claim or, if the Administrative Simplification Compliance Act of 2002 (Pub. L. 107–105, enacted on December 27, 2002) (ASCA) permits, a paper claim (a UB–04 or a CMS–1450 as appropriate) using the five-character CMG number and sends it to the appropriate Medicare Administrative Contractor (MAC). In addition, once a Medicare Advantage patient is discharged, in accordance with the Medicare Claims Processing Manual, chapter 3, section 20.3 (Pub. 100–04), hospitals (including IRFs) must submit an informational-only bill (TOB 111), which includes Condition Code 04 to their MAC. This will ensure that the Medicare Advantage days are included in the hospital's Supplemental Security Income (SSI) ratio (used in calculating the IRF low-income percentage adjustment) for Fiscal Year 2007 and beyond. Claims submitted to Medicare must comply with both ASCA and HIPAA.

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

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

The 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 teaching status adjustment that became effective as of FY 2006, as discussed in the FY 2006 IRF PPS final rule (70 FR 47880).

II. Summary of Provisions of the Proposed Rule

In this proposed rule, we propose to update the IRF federal prospective payment rates, adopt an IRF-specific market basket that will be used to determine the market basket update and labor-related share, phase in the revised wage index changes, and revise and update quality measures and reporting requirements under the IRF QRP.

The proposed updates to the IRF federal prospective payment rates for FY 2016 are as follows:

- Update the FY 2016 IRF PPS relative weights and average length of stay values using the most current and complete Medicare claims and cost report data in a budget-neutral manner, as discussed in section III of this proposed rule.
- Describe the continued use of FY 2014 facility-level adjustment factors as discussed in section IV of this proposed rule.
- Adopt the proposed IRF-specific market basket, as discussed in section V of this proposed rule.
- Update the FY 2016 IRF PPS payment rates by the proposed market basket increase factor, based upon the most current data available, with a 0.2 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(iv) of the Act and a proposed productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section V of this proposed rule.
- Update the FY 2016 IRF PPS payment rates by the FY 2016 wage index and the labor-related share in a budget-neutral manner and discuss the proposed wage adjustment transition as discussed in section V of this proposed rule.
- Describe the calculation of the IRF standard payment conversion factor for FY 2016, as discussed in section V of this proposed rule.
- Update the outlier threshold amount for FY 2016, as discussed in section VI of this proposed rule.
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2016, as discussed in section VI of this proposed rule.
- Discuss implementation of International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for the IRF PPS as discussed in section VII of this proposed rule.
- Describe proposed revisions and updates to quality measures and reporting requirements under the quality reporting program for IRFs in accordance with section 1886(j)(7) of the Act, as discussed in section VIII of this proposed rule.

III. Proposed Update to the CMG Relative Weights and Average Length of Stay Values for FY 2016

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

In this proposed rule, we propose to update the CMG relative weights and average length of stay values for FY 2016. As required by statute, we always

use the most recent available data to update the CMG relative weights and average lengths of stay. For FY 2016, we propose to use the FY 2014 IRF claims and FY 2013 IRF cost report data. These data are the most current and complete data available at this time. Currently, only a small portion of the FY 2014 IRF cost report data are available for analysis, but the majority of the FY 2014 IRF claims data are available for analysis.

In this proposed rule, we propose to apply these data using the same methodologies that we have used to update the CMG relative weights and average length of stay values each fiscal year since we implemented an update to the methodology to use the more detailed CCR data from the cost reports of IRF subprovider units of primary acute care hospitals, instead of CCR data from the associated primary care hospitals, to calculate IRFs' average costs per case, as discussed in the FY 2009 IRF PPS final rule (73 FR 46372). In calculating the CMG relative weights, we use a hospital-specific relative value method to estimate operating (routine and ancillary services) and capital costs of IRFs. The process used to calculate the CMG relative weights for this proposed rule is as follows:

Step 1. We estimate the effects that comorbidities have on costs.

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

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

Step 4. We normalize the FY 2016 CMG relative weights to the same average CMG relative weight from the CMG relative weights implemented in the FY 2015 IRF PPS final rule (79 FR 45872).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we propose to update the CMG relative weights for FY 2016 in such a way that total estimated aggregate payments to IRFs for FY 2016 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget neutrality factor to the standard payment amount. To calculate the appropriate budget neutrality factor for use in updating the FY 2016 CMG relative weights, we use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2016 (with no changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2016 by applying the changes to the CMG relative weights (as discussed in this proposed rule).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the budget neutrality factor (1.0000) that would maintain the same total estimated aggregate payments in FY 2016 with and without the changes to the CMG relative weights.

Step 4. Apply the budget neutrality factor (1.0000) to the FY 2015 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V.G. of this proposed rule, we discuss the proposed use of the existing methodology to calculate the standard payment conversion factor for FY 2016.

Table 1, ''Relative Weights and Average Length of Stay Values for Case-Mix Groups,'' presents the CMGs, the comorbidity tiers, the corresponding relative weights, and the average length of stay values for each CMG and tier for FY 2016. The average length of stay for each CMG is used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment.

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

CMG	CMG description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0101	Stroke, M>51.05	0.8074	0.7072	0.6585	0.6300	10	9	9	8
0102	Stroke, M>44.45 and M<51.05 and C>18.5.	1.0213	0.8946	0.8329	0.7968	11	10	10	10
0103	Stroke, M>44.45 and M<51.05 and C<18.5.	1.1406	0.9991	0.9302	0.8899	12	13	12	11
0104	Stroke, M>38.85 and M<44.45	1.2382	1.0846	1.0098	0.9661	13	13	12	12
0105	Stroke, M>34.25 and M<38.85	1.4520	1.2718	1.1841	1.1329	14	15	14	14
0106	Stroke, M>30.05 and M<34.25	1.6190	1.4181	1.3204	1.2632	16	16	15	15
0107	Stroke, M>26.15 and M<30.05	1.8114	1.5867	1.4773	1.4133	18	17	17	17
0108	Stroke, M<26.15 and A>84.5	2.2985	2.0133	1.8745	1.7933	24	23	21	21
0109	Stroke, M>22.35 and M<26.15 and A<84.5.	2.0987	1.8383	1.7115	1.6374	21	20	19	19
0110	Stroke, M<22.35 and A<84.5	2.7572	2.4151	2.2486	2.1512	27	27	24	24
0201	Traumatic brain injury, M>53.35 and C>23.5.	0.8167	0.6711	0.6056	0.5721	10	9	8	8
0202	Traumatic brain injury, M>44.25 and M<53.35 and C>23.5.	1.0578	0.8692	0.7844	0.7410	11	11	10	9
0203	Traumatic brain injury, M>44.25 and C<23.5.	1.2056	0.9906	0.8939	0.8445	11	12	10	11
0204	Traumatic brain injury, M>40.65 and M<44.25.	1.3276	1.0909	0.9844	0.9300	13	12	11	11
0205	Traumatic brain injury, M>28.75 and M<40.65.	1.5856	1.3028	1.1757	1.1107	15	15	14	13
0206	Traumatic brain injury, M>22.05 and M<28.75.	1.8996	1.5609	1.4086	1.3306	17	18	17	15
0207	Traumatic brain injury, M<22.05	2.5249	2.0746	1.8722	1.7687	30	24	20	19
0301	Non-traumatic brain injury, M>41.05	1.1140	0.9299	0.8528	0.7958	10	11	10	10
0302	Non-traumatic brain injury, M>35.05 and M<41.05.	1.3920	1.1620	1.0656	0.9943	13	13	12	12
0303	Non-traumatic brain injury, M>26.15 and M<35.05.	1.6177	1.3504	1.2384	1.1556	16	15	14	14

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

CMG	CMG description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
0304	Non-traumatic brain injury, M<26.15	2.1480	1.7930	1.6443	1.5344	22	20	18	17
0401	Traumatic spinal cord injury, M>48.45	0.9962	0.8479	0.7764	0.7177	10	10	9	10
0402	Traumatic spinal cord injury, M>30.35 and M<48.45.	1.4305	1.2175	1.1149	1.0306	14	14	14	13
0403	Traumatic spinal cord injury, M>16.05 and M<30.35.	2.2868	1.9463	1.7823	1.6475	27	22	19	20
0404	Traumatic spinal cord injury, M<16.05 and A>63.5.	3.8616	3.2865	3.0096	2.7820	44	36	32	33
0405	Traumatic spinal cord injury, M<16.05 and A<63.5.	3.4241	2.9142	2.6687	2.4668	41	34	29	28
0501	Non-traumatic spinal cord injury, M>51.35.	0.8671	0.6910	0.6416	0.5890	9	7	8	8
0502	Non-traumatic spinal cord injury, M>40.15 and M<51.35.	1.1417	0.9098	0.8448	0.7754	12	11	10	10
0503	Non-traumatic spinal cord injury, M>31.25 and M<40.15.	1.4429	1.1499	1.0676	0.9800	14	13	13	12
0504	Non-traumatic spinal cord injury, M>29.25 and M<31.25.	1.6605	1.3232	1.2286	1.1278	16	16	14	13
0505	Non-traumatic spinal cord injury, M>23.75 and M<29.25.	1.9434	1.5487	1.4379	1.3200	19	17	16	16
0506	Non-traumatic spinal cord injury, M<23.75.	2.7170	2.1652	2.0104	1.8454	27	24	22	21
0601	Neurological, M>47.75	1.0388	0.8197	0.7649	0.6911	10	10	9	9
0602	Neurological, M>37.35 and M<47.75	1.3344	1.0529	0.9825	0.8878	12	12	11	11
0603	Neurological, M>25.85 and M<37.35	1.6570	1.3074	1.2201	1.1024	15	14	13	13
0604	Neurological, M<25.85	2.1771	1.7178	1.6031	1.4485	20	18	17	16
0701	Fracture of lower extremity, M>42.15	0.9663	0.8091	0.7663	0.6961	11	9	9	9
0702	Fracture of lower extremity, M>34.15 and M<42.15.	1.2542	1.0502	0.9947	0.9035	13	12	12	11
0703	Fracture of lower extremity, M>28.15 and M<34.15.	1.5016	1.2574	1.1909	1.0817	14	14	14	13
0704	Fracture of lower extremity, M<28.15	1.9536	1.6359	1.5494	1.4073	18	18	17	16
0801	Replacement of lower extremity joint, M>49.55.	0.8023	0.6319	0.5733	0.5295	8	8	7	7
0802	Replacement of lower extremity joint, M>37.05 and M<49.55.	1.0579	0.8332	0.7560	0.6981	10	10	9	9
0803	Replacement of lower extremity joint, M>28.65 and M<37.05 and A>83.5.	1.4254	1.1227	1.0186	0.9407	13	12	12	11
0804	Replacement of lower extremity joint, M>28.65 and M<37.05 and A<83.5.	1.2747	1.0040	0.9109	0.8412	12	11	11	10
0805	Replacement of lower extremity joint, M>22.05 and M<28.65.	1.5372	1.2107	1.0985	1.0145	15	14	12	12
0806	Replacement of lower extremity joint, M<22.05.	1.9126	1.5064	1.3668	1.2622	17	17	15	14
0901	Other orthopedic, M>44.75	0.9548	0.7679	0.7038	0.6416	10	9	9	8
0902	Other orthopedic, M>34.35 and M<44.75.	1.2720	1.0231	0.9377	0.8547	13	12	11	11
0903	Other orthopedic, M>24.15 and M<34.35.	1.5872	1.2767	1.1701	1.0666	14	14	13	13
0904	Other orthopedic, M<24.15	2.0061	1.6136	1.4789	1.3481	19	18	16	16
1001	Amputation, lower extremity, M>47.65	1.0786	0.9456	0.8420	0.7598	11	11	10	10
1002	Amputation, lower extremity, M>36.25 and M<47.65.	1.3378	1.1728	1.0443	0.9423	13	12	12	11
1003	Amputation, lower extremity, M<36.25	1.9202	1.6835	1.4990	1.3526	18	19	17	16
1101	Amputation, non-lower extremity, M>36.35.	1.3537	1.3537	1.0753	1.0104	13	13	12	11
1102	Amputation, non-lower extremity, M<36.35.	1.7741	1.7741	1.4093	1.3242	16	19	15	16
1201	Osteoarthritis, M>37.65	0.9828	0.9542	0.8689	0.8106	9	11	10	10
1202	Osteoarthritis, M>30.75 and M<37.65	1.1972	1.1624	1.0585	0.9875	11	14	13	12
1203	Osteoarthritis, M<30.75	1.4863	1.4431	1.3140	1.2259	14	16	15	14
1301	Rheumatoid, other arthritis, M>36.35	1.1640	0.9591	0.9044	0.8258	9	11	10	10
1302	Rheumatoid, other arthritis, M>26.15 and M<36.35.	1.4812	1.2205	1.1509	1.0509	15	13	13	13
1303	Rheumatoid, other arthritis, M<26.15	1.9711	1.6241	1.5314	1.3984	21	18	17	16
1401	Cardiac, M>48.85	0.9070	0.7454	0.6741	0.6066	9	9	8	8
1402	Cardiac, M>38.55 and M<48.85	1.2037	0.9893	0.8946	0.8050	11	11	11	10
1403	Cardiac, M>31.15 and M<38.55	1.4509	1.1924	1.0783	0.9703	13	13	12	12
1404	Cardiac, M<31.15	1.8350	1.5081	1.3637	1.2271	17	16	15	14
1501	Pulmonary, M>49.25	1.0508	0.8465	0.7794	0.7499	11	10	9	9

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

CMG	CMG description (M=motor, C=cognitive, A=age)	Relative weight				Average length of stay			
		Tier 1	Tier 2	Tier 3	None	Tier 1	Tier 2	Tier 3	None
1502	Pulmonary, M>39.05 and M<49.25	1.3338	1.0745	0.9893	0.9519	12	12	11	11
1503	Pulmonary, M>29.15 and M<39.05	1.6182	1.3036	1.2002	1.1549	15	13	13	13
1504	Pulmonary, M<29.15	2.0127	1.6215	1.4928	1.4364	21	17	15	15
1601	Pain syndrome, M>37.15	1.1408	0.8388	0.8240	0.7577	11	10	10	9
1602	Pain syndrome, M>26.75 and M<37.15	1.4837	1.0909	1.0718	0.9854	14	12	12	12
1603	Pain syndrome, M<26.75	1.9166	1.4093	1.3845	1.2730	15	15	15	15
1701	Major multiple trauma without brain or spinal cord injury, M>39.25.	1.0739	0.9109	0.8312	0.7736	10	10	11	9
1702	Major multiple trauma without brain or spinal cord injury, M>31.05 and M<39.25.	1.3886	1.1779	1.0748	1.0002	13	14	12	12
1703	Major multiple trauma without brain or spinal cord injury, M>25.55 and M<31.05.	1.5890	1.3479	1.2299	1.1446	19	15	14	14
1704	Major multiple trauma without brain or spinal cord injury, M<25.55.	2.0894	1.7724	1.6172	1.5051	21	20	18	17
1801	Major multiple trauma with brain or spinal cord injury, M>40.85.	1.2728	0.9643	0.8811	0.7840	14	12	11	10
1802	Major multiple trauma with brain or spinal cord injury, M>23.05 and M<40.85.	1.8675	1.4148	1.2928	1.1503	19	17	15	14
1803	Major multiple trauma with brain or spinal cord injury, M<23.05.	3.0253	2.2920	2.0942	1.8635	31	26	21	21
1901	Guillain Barre, M>35.95	1.1501	0.9999	0.9724	0.8501	15	11	11	11
1902	Guillain Barre, M>18.05 and M<35.95	2.2469	1.9534	1.8997	1.6609	25	22	21	20
1903	Guillain Barre, M<18.05	3.6057	3.1347	3.0485	2.6652	48	31	28	30
2001	Miscellaneous, M>49.15	0.9280	0.7626	0.7034	0.6367	9	9	9	8
2002	Miscellaneous, M>38.75 and M<49.15	1.2002	0.9863	0.9097	0.8235	11	11	10	10
2003	Miscellaneous, M>27.85 and M<38.75	1.4940	1.2277	1.1324	1.0250	14	14	13	12
2004	Miscellaneous, M<27.85	1.9243	1.5813	1.4586	1.3203	18	17	16	15
2101	Burns, M>0	1.6922	1.6922	1.3135	1.2742	18	19	15	15
5001	Short-stay cases, length of stay is 3 days or fewer.				0.1562				2
5101	Expired, orthopedic, length of stay is 13 days or fewer.				0.7204				8
5102	Expired, orthopedic, length of stay is 14 days or more.				1.6962				18
5103	Expired, not orthopedic, length of stay is 15 days or fewer.				0.7928				9
5104	Expired, not orthopedic, length of stay is 16 days or more.				1.9018				20

Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 2 shows how we estimate that the application of the proposed revisions for FY 2016 would affect particular CMG relative weight values, which would affect the overall distribution of payments within CMGs and tiers. Note that, because we propose to implement the CMG relative weight revisions in a budget-neutral manner (as previously described), total estimated aggregate payments to IRFs for FY 2016 would not be affected as a result of the proposed CMG relative weight revisions. However, the proposed revisions would affect the distribution of payments within CMGs and tiers.

TABLE 2—DISTRIBUTIONAL EFFECTS OF THE CHANGES TO THE CMG RELATIVE WEIGHTS

[FY 2015 values compared with FY 2016 values]

Percentage change	Number of cases affected	Percentage of cases affected
Increased by 15% or more	157	0.0
Increased by between 5% and 15%	2,292	0.6
Changed by less than 5%	353,020	99.0
Decreased by between 5% and 15%	1,195	0.3
Decreased by 15% or more	63	0.0

As Table 2 shows, 99 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the proposed revisions for FY 2016. The largest estimated increase in the proposed CMG relative weight values that affects the largest number of

IRF discharges would be a 0.2 percent increase in the CMG relative weight value for CMG 0704—Fracture of lower extremity, with a motor score less than 28.15-in the ''no comorbidity'' tier. In the FY 2014 claims data, 17,812 IRF discharges (5.0 percent of all IRF discharges) were classified into this CMG and tier.

The largest decrease in a CMG relative weight value affecting the largest number of IRF cases would be a 0.8 percent decrease in the CMG relative weight for CMG 0604—Neurological, with a motor score less than 25.85-in the ''no comorbidity'' tier. In the FY 2014 IRF claims data, this change would have affected 8,544 cases (2.4 percent of all IRF cases).

The proposed changes in the average length of stay values for FY 2016, compared with the FY 2015 average length of stay values, are small and do not show any particular trends in IRF length of stay patterns.

We invite public comment on our proposed update to the CMG relative weights and average length of stay values for FY 2016.

IV. Continued Use of FY 2014 Facility-Level Adjustment Factors

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

Based on the substantive changes to the facility-level adjustment factors that were adopted in the FY 2014 final rule (79 FR 45872, 45882 through 45883), we froze the facility-level adjustment factors at the FY 2014 levels for FY 2015 and all subsequent years. For FY 2016, we will continue to hold the adjustment factors at the FY 2014 levels as we continue to monitor the most current IRF claims data available and continue to evaluate and monitor the effects of the FY 2014 changes.

V. Proposed FY 2016 IRF PPS Payment Update

A. Background

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 1886(j)(3)(C)(ii)(I) of the Act requires the application of a productivity adjustment, as described below. In addition, sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(iv) of the Act require the application of a 0.2 percentage point reduction to the market basket increase factor for FY 2016. Thus, in this proposed rule, we propose to update the IRF PPS payments for FY 2016 by a market basket increase factor based upon the most current data available, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.2 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(iv) of the Act.

We have utilized various market baskets through the years in the IRF PPS program. When we implemented the IRF PPS in January 2002, it used the Excluded Hospital with Capital market basket (which was based on 1992 Medicare cost reports for Medicare participating IRFs, IPFs, LTCHs, cancer hospitals, and children's hospitals) as an ''input price index'' (66 FR 41427 through 41430). Although ''market basket'' technically describes the mix of goods and services used in providing health care at a given point in time, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies) derived from that market basket. Accordingly, the term ''market basket,'' as used in this document, refers to an input price index.

Beginning with the FY 2006 IRF PPS final rule (70 FR 47908), we adopted a 2002-based RPL market basket for the IRF PPS. This market basket reflected the operating and capital cost structures for freestanding IRFs, freestanding IPFs, and LTCHs. Cancer and children's hospitals were excluded from the RPL market basket because their payments are based entirely on reasonable costs subject to rate-of-increase limits established under the authority of section 1886(b) of the Act and not through a PPS. Also, the 2002 cost structures for cancer and children's hospitals were noticeably different than the cost structures of freestanding IRFs, freestanding IPFs, and LTCHs. See the FY 2006 IRF PPS final rule (70 FR 47908) for a complete discussion of the 2002-based RPL market basket.

In the FY 2010 IRF proposed rule (74 FR 21062), we expressed an interest in exploring the feasibility of creating a stand-alone IRF, or IRF-specific, market basket that reflects the cost structures of only IRF providers. But, as we noted in that discussion, Medicare cost report data revealed differences between cost levels and cost structures for freestanding and hospital-based IRF facilities. As we were unable at that time to fully understand these differences even after reviewing explanatory variables such as geographic variation, case mix, urban/rural status, share of low income patients, teaching status, and outliers (short stay and high-cost), we noted that we would continue to research ways to reconcile the differences and solicited public comment for additional information that might help us to better understand the reasons for the observed variations (74 FR 21062). We summarized the public comments we received and our responses in the FY 2010 IRF PPS final rule (74 FR 39762, 39776 through 39778). Despite receiving comments from the public on this issue, however, we were still unable to sufficiently reconcile the observed variations, and, therefore, were unable to establish a stand-alone IRF market basket at that time.

Beginning with the FY 2012 IRF PPS, payments were updated using a 2008-based RPL market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding IPFs, and LTCHs (76 FR 47849 through 47860). In doing so, we also used a more specific composite chemical price proxy; broke the professional fees cost category into two separate categories (Labor-related and Nonlabor-related); and added two additional cost categories (Administrative and Business Support Services and Financial Services), which were previously included in the residual All Other cost category. The FY 2012 IRF PPS proposed rule (76 FR 24229 through 24241) and FY 2012 IRF PPS final rule (76 FR 47849 through 47860) contain a complete discussion of the development of the 2008-based RPL market basket.

We have continued to work on addressing our concerns regarding the development of a stand-alone IRF market basket since our FY 2010 rulemaking cycle and, for the reasons described below, we believe using data from hospital-based and freestanding providers to derive the market basket cost weights despite their differences in cost levels and cost structures. Therefore, for FY 2016, we are proposing to create and adopt a 2012-based IRF market basket, using Medicare cost report data for both freestanding and hospital-based IRFs. In

the following discussion, we provide an overview of the proposed market basket and describe the methodologies used to determine the operating and capital portions of the proposed 2012-based IRF market basket.

B. Overview of the Proposed 2012-Based IRF Market Basket

The proposed 2012-based IRF market basket is a fixed-weight, Laspeyres-type price index. A Laspeyres price index measures the change in price, over time, of the same mix of goods and services purchased in the base period. Any changes in the quantity or mix of goods and services (that is, intensity) purchased over time relative to a base period are not measured.

The index itself is constructed in 3 steps. First, a base period is selected (in this proposed rule the base period is FY 2012), total base period costs are estimated for a set of mutually exclusive and exhaustive cost categories, and the proportion of total costs that each cost category represents is calculated. These proportions are called cost weights. Second, each cost category is matched to an appropriate price or wage variable, referred to as a price proxy. In nearly every instance where we have selected price proxies for the various market baskets, these price proxies are derived from publicly available statistical series that are published on a consistent schedule (preferably at least on a quarterly basis). In cases where a publicly available price series is not available (for example, a price index for malpractice insurance), we have collected price data from other sources and subsequently developed our own index to capture changes in prices for these types of costs. Finally, the cost weight for each cost category is multiplied by the established price proxy. The sum of these products (that is, the cost weights multiplied by their price levels) for all cost categories yields the composite index level of the market basket for the given time period. Repeating this step for other periods produces a series of market basket levels over time. Dividing the composite index level of one period by the composite index level for an earlier period produces a rate of growth in the input price index over that timeframe.

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

C. Creating an IRF-Specific Market Basket

As discussed in section V.A of this proposed rule, we have been exploring the possibility of creating a stand-alone, or IRF-specific, market basket that reflects the cost structures of only IRF providers. The major cost weights for the 2008-based RPL market basket were calculated using Medicare cost report data for those providers that complete a stand-alone Medicare cost report. We define a ''major cost weight'' as one for which we are able to obtain data from the Medicare cost report for that particular cost category (for example, Wages and Salaries). However, the Medicare cost report data does not collect detailed input cost data for the more detailed cost categories for which we would like to capture input price pressures (for example, Chemicals). Therefore, a public data source is used to identify the costs associated with these more detailed cost categories. For the 2008-based RPL market basket, we used only data from stand-alone Medicare cost reports due to concerns regarding our ability to incorporate Medicare cost report data for hospital-based providers. In the FY 2015 IRF PPS final rule (79 FR 45884 through 45886), we presented several of these concerns (as restated below) but explained that we would continue to research the possibility of creating an IRF-specific market basket to update IRF PPS payments.

Since the FY 2015 IRF PPS final rule, we have performed additional research on the Medicare cost report data available for hospital-based IRFs and evaluated these concerns. We subsequently concluded from this research that Medicare cost report data for both hospital-based IRFs and freestanding IRFs can be used to calculate the major market basket cost weights for a stand-alone IRF market basket. We have developed a detailed methodology to derive market basket cost weights that are representative of the universe of IRF providers. We believe the use of this proposed 2012-based IRF market basket is a technical improvement over the RPL market basket that is currently used to update IRF PPS payments. As a result, in this FY 2016 IRF PPS proposed rule, we are proposing to adopt a 2012-based IRF market basket that reflects data for both freestanding and hospital-based IRFs. Below we discuss our prior concerns and provide reasons for why we believe it is technically feasible to create a stand-alone IRF market basket using Medicare cost report data for both hospital-based and freestanding IRFs.

One concern discussed in the FY 2015 IRF PPS final rule (79 FR 45884) was that the cost level differences for hospital-based IRFs relative to freestanding IRFs were not readily explained by the specific characteristics of the individual providers and/or the patients that they served (for example, characteristics related to case mix, urban/rural status, or teaching status). To address this concern, we used regression analysis to evaluate the effect of including hospital-based IRF Medicare cost report data in the calculation of cost distributions (which refers to how costs for certain categories relate to total costs for a particular provider). A more detailed description of these regression models can be found in the FY 2015 IRF final rule (79 FR 45884 through 45885). Based on this analysis, we concluded that the inclusion of those IRF providers with unexplained variability in costs would not significantly impact the cost weights and, therefore, should not be a major cause of concern.

Another concern regarding the incorporation of hospital-based IRF data into the calculation of the market basket cost weights was the complexity of the Medicare cost report data for these providers. The freestanding IRFs independently submit a Medicare cost report for their facilities, making it relatively straightforward to obtain the cost categories necessary to determine the major market basket cost weights for such facilities. However, Medicare cost report data submitted for a hospital-based IRF are embedded in the Medicare cost report submitted for the entire hospital facility in which the IRF is located. To use Medicare cost report data from these providers, we needed to determine the appropriate adjustments to apply to the data to ensure that the cost weights we use would represent only the hospital-based IRF (not the hospital as a whole). Over the past year, we worked to develop detailed methodologies to calculate the major cost weights for both freestanding and

hospital-based IRFs. We believe that our proposed methodologies and the resulting cost weights, described in section V.C.1 of this proposed rule, are reasonable and appropriate, but, as noted in that section, we welcome public comments on these proposals.

We also evaluated the differences in cost weights for hospital-based and freestanding IRFs and found the most significant differences occurred for salary and pharmaceutical costs. Specifically, the hospital-based IRF salary cost shares tend to be lower than those of freestanding IRFs while hospital-based IRF pharmaceutical cost shares tend to be higher than those of freestanding IRFs. Our proposed methodology for deriving costs for each of these categories can be found in section V.C.1 of this proposed rule. We will continue to research and monitor these cost shares to ensure these differences are explainable.

In summary, our research over the past year allowed us to evaluate the appropriateness of including hospital-based IRF data in the calculation of the major cost weights for an IRF market basket. We believe that the proposed methodologies described below give us the ability to create a stand-alone IRF market basket that reflects the cost structure of the universe of IRF providers. Therefore, we believe that the use of this proposed 2012-based IRF market basket to update IRF PPS payments is a technical improvement over the current 2008-based RPL market basket, as the major cost weights are based on Medicare cost report data from both freestanding and hospital-based IRFs and do not include costs from either IPF or LTCH providers, which could have a different cost structure than IRFs.

1. Development of Cost Categories and Weights for the Proposed 2012-Based IRF Market Basket

a. Use of Medicare Cost Report Data

The proposed 2012-based IRF market basket consists of seven major cost categories derived from the FY 2012 Medicare cost reports (CMS Form 2552–10) for freestanding and hospital-based IRFs, consisting of Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, Professional Liability Insurance (PLI), Capital, and a residual category. The residual category reflects all remaining costs that are not captured in the other six cost categories. The FY 2012 cost reports include providers whose cost reporting period began on or after October 1, 2011, and prior to September 30, 2012. We selected FY 2012 as the base year because the Medicare cost reports for that year were the most recent, complete set of Medicare cost report data available for IRFs at the time of development of the proposed IRF market basket.

Since our goal was to establish cost weights that were reflective of case mix and practice patterns associated with the services IRFs provide to Medicare beneficiaries, we limited the cost reports used to establish the 2012-based IRF market basket to those from facilities that had a Medicare average length of stay (LOS) that was relatively similar to their facility average LOS. We believe that this trim eliminates statistical outliers and ensures a more accurate market basket that reflects the costs generally incurred during a Medicare-covered stay. We defined the Medicare average LOS for freestanding IRFs based on what the IRFs reported on line 14 of Worksheet S–3, Part I. We defined the Medicare average LOS for hospital-based IRFs based on what was reported on line 17 of Worksheet S–3, Part I. We then used the cost reports from IRFs with a Medicare average LOS within 15 percent (that is, 15 percent higher or lower) than the facility average LOS for IRFs to establish the 2012-based IRF market basket. We apply this LOS edit to the data for IRFs to exclude providers that serve a population whose LOS would indicate that the patients served are not consistent with a LOS of a typical Medicare patient. This process resulted in the exclusion of about eight percent of the freestanding and hospital-based IRF Medicare cost reports. Of those excluded, about 18 percent were freestanding IRFs and 82 percent were hospital-based IRFs. This ratio is relatively consistent with the ratio of the universe of freestanding to hospital-based IRF providers. In the FY 2012 IRF PPS final rule (76 FR 47850), the same process was used to derive the 2008-based RPL market basket.

We then used the cost reports for IRFs that were not excluded through this process to calculate the costs for six of the seven major cost categories (Wages and Salaries, Employee Benefits, Contract Labor, Professional Liability Insurance, Pharmaceuticals, and Capital) for the market basket.

Similar to the 2008-based RPL market basket major cost weights, the resulting 2012-based IRF market basket cost weights reflect Medicare allowable costs (routine, ancillary and capital)—costs that are eligible for reimbursement through the IRF PPS. We propose to define Medicare allowable costs for freestanding facilities as cost centers (CMS Form 2552–10): 30 through 35, 50 through 76 (excluding 52 and 75), 90 through 91 and 93. We propose to define Medicare allowable costs for hospital-based facilities as cost centers (CMS Form 2552–10): 40, 50 through 76 (excluding 52 and 75), 90 through 91 and 93.

For freestanding IRFs, total Medicare allowable costs would be equal to the total costs as reported on Worksheet B, part I, column 26. For hospital-based IRFs, total Medicare allowable costs would be equal to total costs for the IRF inpatient unit after the allocation of overhead costs (Worksheet B, part I, column 26, line 41) and a proportion of total ancillary costs. We calculated the portion of ancillary costs attributable to the hospital-based IRF for a given ancillary cost center by multiplying total facility ancillary costs for the specific cost center (as reported on Worksheet B, Part I, column 26) by the ratio of IRF Medicare ancillary costs for the cost center (as reported on Worksheet D–3, column 3 for hospital-based IRFs) to total Medicare ancillary costs for the cost center (equal to the sum of Worksheet D–3, column 3 for all relevant PPS (that is, IPPS, IRF, IPF and SNF)). We propose to use these methods to derive levels of total costs for IRF providers. With this work complete, we then set about deriving cost levels for six of the seven major cost categories.

(i) Wages and Salaries Costs

For freestanding IRFs, Wages and Salaries costs are derived as the sum of inpatient salaries, ancillary salaries and a proportion of overhead (or general service cost center) salaries as reported on Worksheet A, column 1. Since overhead salary costs are attributable to the entire IRF, we only include the proportion attributable to the Medicare allowable cost centers. We estimate the proportion of overhead salaries that are attributed to Medicare allowable costs centers by multiplying the ratio of Medicare allowable area salaries to total salaries (Worksheet A, column 1, line 200) times total overhead salaries. In the FY 2012 IRF PPS final rule (76 FR 47850), a similar methodology was used to derive Wages and Salaries costs in the 2008-based RPL market basket.

For hospital-based IRFs, Wages and Salaries costs are derived as the sum of inpatient unit wages and salaries (Worksheet A, column 1, line 41) and a portion of salary costs attributable to total facility ancillary and overhead cost centers as these cost centers are shared with the entire facility. We calculate the portion of ancillary salaries attributable to the hospital-based IRF for a given ancillary cost center by multiplying total facility ancillary salary costs for the specific cost center (as reported on Worksheet A, column 1) by the ratio of

IRF Medicare ancillary costs for the cost center (as reported on Worksheet D–3, column 3 for hospital-based IRFs) to total Medicare ancillary costs for the cost center (equal to the sum of Worksheet D–3, column 3 for all relevant PPS units [that is, IPPS, IRF, IPF and SNF]). For example, if hospital-based IRF Medicare physical therapy costs represent 30 percent of the total Medicare physical therapy costs for the entire facility, then 30 percent of total facility physical therapy salaries (as reported in Worksheet A, column 1, line 66) would be attributable to the hospital-based IRF. We believe it is appropriate to use only a portion of the ancillary costs in the market basket cost weight calculations since the hospital-based IRF only utilizes a portion of the facility's ancillary services. We believe the ratio of reported IRF Medicare costs to reported total Medicare costs provides a reasonable estimate of the ancillary services utilized, and costs incurred, by the hospital-based IRF.

We calculate the portion of overhead salary costs attributable to hospital-based IRFs by multiplying the total overhead costs attributable to the hospital-based IRF (sum of columns 4–18 on Worksheet B, part I, line 41) by the ratio of total facility overhead salaries (as reported on Worksheet A, column 1, lines 4–18) to total facility overhead costs (as reported on Worksheet A, column 7, lines 4–18). This methodology assumes the proportion of total costs related to salaries for the overhead cost center is similar for all inpatient units (that is, acute inpatient or inpatient rehabilitation). Since the 2008-based RPL market basket did not include hospital-based providers, this proposed methodology cannot be compared to the derivation of Wages and Salaries costs in the RPL market basket.

(ii) Employee Benefits Costs

Effective with our implementation of CMS Form 2552–10, we began collecting Employee Benefits and Contract Labor data on Worksheet S–3, Part V. Previously, with CMS Form 2540–96, Employee Benefits and Contract Labor data were reported on Worksheet S–3, part II, which was applicable to only IPPS providers and, therefore, these data were not available for the derivation of the RPL market basket. Due to the lack of such data, the Employee Benefits cost weight for the 2008-based RPL market basket was derived by multiplying the 2008-based RPL market basket Wages and Salaries cost weight by the ratio of the IPPS hospital market basket Employee Benefits cost weight to the IPPS hospital market basket Wages and Salaries cost weight. Similarly, the Contract Labor cost weight for the 2008-based RPL market basket was derived by multiplying the 2008-based RPL market basket Wages and Salaries cost weight by the ratio of the IPPS hospital market basket Contract Labor cost weight to the IPPS hospital market basket Wages and Salaries cost weight (*see* FY 2012 IRF PPS final rule (76 FR 47850 through 47851)).

For FY 2012 Medicare cost report data, while there were providers that did report data on Worksheet S–3, part V, many providers did not complete this worksheet. However, our analysis indicates that we had a large enough sample to enable us to produce a reasonable Employee Benefits cost weight. Specifically, we found that when we recalculated the cost weight after weighting to reflect the characteristics of the universe of IRF providers (freestanding and hospital-based), it did not have a material effect on the resulting cost weight. We continue to encourage all providers to report these data on the Medicare cost report.

For freestanding IRFs, Employee Benefits costs are equal to the data reported on Worksheet S–3, Part V, line 2, column 2.

For hospital-based IRFs, we calculate total benefits as the sum of benefit costs reported on Worksheet S–3 Part V, line 4, column 2, and a portion of ancillary benefits and overhead benefits for the total facility. Ancillary benefits attributable to the hospital-based IRF are calculated by multiplying ancillary salaries for the hospital-based IRF as determined in the derivation of Wages and Salaries for the hospital-based IRF by the ratio of total facility benefits to total facility salaries. Similarly, overhead benefits attributable to the hospital-based IRF are calculated by multiplying overhead salaries for the hospital-based IRF as determined in the derivation of Wages and Salaries for the hospital-based IRF by the ratio of total facility benefits to total facility salaries.

(iii) Contract Labor Costs

Similar to the RPL and IPPS market baskets, Contract Labor costs are primarily associated with direct patient care services. Contract labor costs for services such as accounting, billing, and legal are estimated using other government data sources. As previously discussed in the Employee Benefits section, we now have data reported on Worksheet S–3, Part V that we can use to derive the Contract Labor cost weight for the 2012-based IRF market basket. As previously noted, for FY 2012 Medicare cost report data, while there were providers that did report data on Worksheet S–3, part V, many providers did not complete this worksheet. However, our analysis indicates that we had a large enough sample to enable us to produce a reasonable Contract Labor cost weight. Specifically, we found that when we recalculated the cost weight after weighting to reflect the characteristics of the universe of IRF providers (freestanding and hospital-based), it did not have a material effect on the resulting cost weight. We continue to encourage all providers to report these data on the Medicare cost report.

For freestanding IRFs, Contract Labor costs are based on data reported on Worksheet S–3, part V, column 1, line 2, and for hospital-based IRFs, Contract Labor costs are based on line 4 of this same worksheet.

(iv) Pharmaceuticals Costs

For freestanding IRFs, pharmaceuticals costs are based on non-salary costs reported on Worksheet A, column 7, less Worksheet A, column 1, for the pharmacy cost center (line 15) and drugs charged to patients cost center (line 73).

For hospital-based IRFs, pharmaceuticals costs are based on a portion of the non-salary pharmacy costs and a portion of the non-salary drugs charged to patient costs reported for the total facility. Non-salary pharmacy costs attributable to the hospital-based IRF are calculated by multiplying total pharmacy costs attributable to the hospital-based IRF (as reported on Worksheet B, column 15, line 41) by the ratio of total non-salary pharmacy costs (Worksheet A, column 2, line 15) to total pharmacy costs (sum of Worksheet A, column 1 and 2 for line 15) for the total facility. Non-salary drugs charged to patient costs attributable to the hospital-based IRF are calculated by multiplying total non-salary drugs charged to patient costs (Worksheet B, part I, column 0, line 73, plus Worksheet B, part I, column 15, line 73, less Worksheet A, column 1, line 73) for the total facility by the ratio of Medicare drugs charged to patient ancillary costs for the IRF unit (as reported on Worksheet D–3 for hospital-based IRFs, line 73, column 3) to total Medicare drugs charged to patient ancillary costs for the total facility (equal to the sum of Worksheet D–3, line 73, column 3, for all relevant PPS (that is, IPPS, IRF, IPF and SNF)).

(v) Professional Liability Insurance Costs

For freestanding IRFs, Professional Liability Insurance (PLI) costs (often referred to as malpractice costs) are equal to premiums, paid losses and self-insurance costs reported on Worksheet S–2, line 118, columns 1 through 3. For hospital-based IRFs, we assume that the PLI weight for the total facility is similar to the hospital-based IRF unit since the only data reported on this worksheet is for the entire facility, as we currently have no means to identify the proportion of total PLI costs that are only attributable to the hospital-based IRF. Therefore, hospital-based IRF PLI costs are equal to total facility PLI (as reported on Worksheet S–2, line 118, columns 1 through 3) divided by total facility costs (as reported on Worksheet A, line 200) times hospital-based IRF Medicare allowable total costs. We welcome comments on this proposed method of deriving the PLI costs for hospital-based IRFs.

(vi) Capital Costs

For freestanding IRFs, capital costs are equal to Medicare allowable capital costs as reported on Worksheet B, Part II, column 26.

For hospital-based IRFs, capital costs are equal to IRF inpatient capital costs (as reported on Worksheet B, part II, column 26, line 41) and a portion of IRF ancillary capital costs. We calculate the portion of ancillary capital costs attributable to the hospital-based IRF for a given cost center by multiplying total facility ancillary capital costs for the specific ancillary cost center (as reported on Worksheet B, Part II, column 26) by the ratio of IRF Medicare ancillary costs for the cost center (as reported on Worksheet D–3, column 3 for hospital-based IRFs) to total Medicare ancillary costs for the cost center (equal to the sum of Worksheet D–3, column 3 for all relevant PPS (that is, IPPS, IRF, IPF and SNF). For example, if hospital-based IRF Medicare physical therapy costs represent 30 percent of the total Medicare physical therapy costs for the entire facility, then 30 percent of total facility physical therapy capital costs (as reported in Worksheet B, part II, column 26, line 66) would be attributable to the hospital-based IRF.

b. Final Major Cost Category Computation

After we derived costs for the six major cost categories for each provider using the Medicare cost report data as previously described, we address data outliers using the following steps. First, we divide the costs for each of the six categories by total Medicare allowable costs calculated for the provider to obtain cost weights for the universe of IRF providers. We then remove those providers whose derived cost weights fall in the top and bottom five percent of provider specific derived cost weights to ensure the removal of outliers. After the outliers have been removed, we sum the costs for each category across all remaining providers. We then divide this by the sum of total Medicare allowable costs across all remaining providers to obtain a cost weight for the proposed 2012-based IRF market basket for the given category. Finally, we calculate the residual ''All Other'' cost weight that reflects all remaining costs that are not captured in the six cost categories listed. See Table 3 for the resulting cost weights for these major cost categories that we obtain from the Medicare cost reports.

TABLE 3—MAJOR COST CATEGORIES AS DERIVED FROM MEDICARE COST REPORTS

Major cost categories	2012-based IRF (percent)	2008-based RPL (percent)
Wages and Salaries	45.5	47.4
Employee Benefits [1]	10.7	12.3
Contract Labor [1]	0.8	2.6
Professional Liability Insurance (Malpractice)	0.9	0.8
Pharmaceuticals	5.1	6.5
Capital	8.6	8.4
All Other	28.4	22.0

* Total may not sum to 100 due to rounding.

[1] Due to the lack of Medicare cost report data, the Employee Benefits and Contract Labor cost weights in the 2008-based RPL market basket were based on the IPPS market basket.

The Wages and Salaries cost weight obtained directly from the Medicare cost reports for the proposed 2012-based IRF market basket is approximately 2 percentage points lower than the Wages and Salaries cost weight for the 2008-based RPL market basket. This is primarily a result of the inclusion of hospital-based IRF data into the 2012-based IRF market basket. The lower Employee Benefits and Contract Labor cost weights in the 2012-based IRF market basket relative to the 2008-based RPL market basket are due to the incorporation of freestanding and hospital-based IRF specific data. The predecessor 2008-based RPL market basket used the IPPS market basket to derive the Employee Benefits and Contract Labor cost weights due to the lack of data on the Medicare cost reports. The lower pharmaceutical cost weight in the proposed 2012-based IRF market basket relative to the 2008-based RPL market basket is mostly due to freestanding IRFs; the hospital-based IRFs pharmaceuticals cost weight is almost twice as large as the freestanding IRF pharmaceuticals cost weight.

As we did for the 2008-based RPL market basket, we propose to allocate the Contract Labor cost weight to the Wages and Salaries and Employee Benefits cost weights based on their relative proportions under the assumption that contract labor costs are comprised of both wages and salaries and employee benefits. The Contract Labor allocation proportion for Wages and Salaries is equal to the Wages and Salaries cost weight as a percent of the sum of the Wages and Salaries cost weight and the Employee Benefits cost weight. This rounded percentage is 81 percent; therefore, we propose to allocate 81 percent of the Contract Labor cost weight to the Wages and Salaries cost weight and 19 percent to the Employee Benefits cost weight. Table 4 shows the Wages and Salaries and Employee Benefit cost weights after Contract Labor cost weight allocation for both the proposed 2012-based IRF market basket and 2008-based RPL market basket.

TABLE 4—WAGES AND SALARIES AND EMPLOYEE BENEFITS COST WEIGHTS AFTER CONTRACT LABOR ALLOCATION

Major cost categories	2012-based IRF	2008-based RPL
Wages and Salaries	46.1	49.4
Employee Benefits	10.9	12.8

c. Derivation of the Detailed Operating Cost Weights

To further divide the ''All Other'' residual cost weight estimated from the FY 2012 Medicare cost report data into more detailed cost categories, we propose to use the 2007 Benchmark Input-Output (I–O) ''Use Tables/Before Redefinitions/Purchaser Value'' for NAICS 622000, Hospitals, published by the Bureau of Economic Analysis (BEA). This data is publicly available at the following Web site: *http://www.bea.gov/industry/io_annual.htm*

The BEA Benchmark I–O data are scheduled for publication every five years with the most recent data available for 2007. The 2007 Benchmark I–O data are derived from the 2007 Economic Census and are the building blocks for BEA's economic accounts. Thus, they represent the most comprehensive and complete set of data on the economic processes or mechanisms by which output is produced and distributed.[1] BEA also produces Annual I–O estimates; however, while based on a similar methodology, these estimates reflect less comprehensive and less detailed data sources and are subject to revision when benchmark data becomes available. Instead of using the less detailed Annual I–O data, we inflate the 2007 Benchmark I–O data forward to 2012 by applying the annual price changes from the respective price proxies to the appropriate market basket cost categories that are obtained from the 2007 Benchmark I–O data. We repeat this practice for each year. We then calculate the cost shares that each cost category represents of the inflated 2012 data. These resulting 2012 cost shares are applied to the All Other residual cost weight to obtain the detailed cost weights for the proposed 2012-based IRF market basket. For example, the cost for Food: Direct Purchases represents 6.5 percent of the sum of the ''All Other'' 2007 Benchmark I–O Hospital Expenditures inflated to 2012; therefore, the Food: Direct Purchases cost weight represents 6.5 percent of the 2012-based IRF market basket's ''All Other'' cost category (28.4 percent), yielding a ''final'' Food: Direct Purchases cost weight of 1.8 percent in the proposed 2012-based IRF market basket (0.065 * 28.4 percent = 1.8 percent).

Using this methodology, we derive eighteen detailed IRF market basket cost category weights from the proposed 2012-based IRF market basket residual cost weight (28.4 percent). These categories are: (1) Electricity, (2) Fuel, Oil, and Gasoline (3) Water & Sewerage (4) Food: Direct Purchases, (5) Food: Contract Services, (6) Chemicals, (7) Medical Instruments, (8) Rubber & Plastics, (9) Paper and Printing Products, (10) Miscellaneous Products, (11) Professional Fees: Labor-related, (12) Administrative and Facilities Support Services, (13) Installation, Maintenance, and Repair, (14) All Other Labor-related Services, (15) Professional Fees: Nonlabor-related, (16) Financial Services, (17) Telephone Services, and (18) All Other Nonlabor-related Services.

d. Derivation of the Detailed Capital Cost Weights

As described in section V.C.1.a.6 of this proposed rule, we are proposing a Capital-Related cost weight of 8.6 percent as obtained from the FY 2012 Medicare cost reports for freestanding and hospital-based IRF providers. We are proposing to then separate this total Capital-Related cost weight into more detailed cost categories.

Using FY 2012 Medicare cost reports, we are able to group Capital-Related costs into the following categories: Depreciation, Interest, Lease, and Other Capital-Related costs. For each of these categories, we are proposing to determine separately for hospital-based IRFs and freestanding IRFs what proportion of total capital-related costs the category represents.

For freestanding IRFs, we are proposing to derive the proportions for Depreciation, Interest, Lease, and Other Capital-related costs using the data reported by the IRF on Worksheet A–7, which is similar to the methodology used for the 2008-based RPL market basket.

For hospital-based IRFs, data for these four categories are not reported separately for the hospital-based IRF; therefore, we are proposing to derive these proportions using data reported on Worksheet A–7 for the total facility. We are assuming the cost shares for the overall hospital are representative for the hospital-based IRF unit. For example, if depreciation costs make up 60 percent of total capital costs for the entire facility, we believe it is reasonable to assume that the hospital-based IRF would also have a 60 percent proportion because it is a unit contained within the total facility.

To combine each detailed capital cost weight for freestanding and hospital-based IRFs into a single capital cost weight for the proposed 2012-based IRF market basket, we are proposing to weight together the shares for each of the categories (Depreciation, Interest, Lease, and Other Capital-related costs) based on the share of total capital costs each provider type represents of the total capital costs for all IRFs for 2012. Applying this methodology, results in proportions of total capital-related costs for Depreciation, Interest, Lease and Other Capital-related costs that are representative of the universe of IRF providers.

We are also proposing to allocate lease costs across each of the remaining detailed capital-related cost categories as was done in the 2008-based RPL market basket. This would result in three primary capital-related cost categories in the proposed 2012-based IRF market basket: Depreciation, Interest, and Other Capital-Related costs. Lease costs are unique in that they are not broken out as a separate cost category in the proposed 2012-based IRF market basket. Rather, we are proposing to proportionally distribute these costs among the cost categories of Depreciation, Interest, and Other Capital-Related, reflecting the assumption that the underlying cost structure of leases is similar to that of capital-related costs in general. As was done under the 2008-based RPL market basket, we are proposing to assume that 10 percent of the lease costs as a proportion of total capital-related costs represents overhead and assign those costs to the Other Capital-Related cost category accordingly. We propose to distribute the remaining lease costs proportionally across the three cost categories (Depreciation, Interest, and Other Capital-Related) based on the proportion that these categories comprise of the sum of the Depreciation,

[1] *http://www.bea.gov/papers/pdf/IOmanual_092906.pdf*

Interest, and Other Capital-related cost categories (excluding lease expenses). This is the same methodology used for the 2008-based RPL market basket. The allocation of these lease expenses are shown in Table 5.

Finally, we are proposing to further divide the Depreciation and Interest cost categories. We are proposing to separate Depreciation into the following two categories: (1) Building and Fixed Equipment and (2) Movable Equipment; and proposing to separate Interest into the following two categories: (1) Government/Nonprofit and (2) For-profit.

To disaggregate the Depreciation cost weight, we need to determine the percent of total Depreciation costs for IRFs that is attributable to Building and Fixed Equipment, which we hereafter refer to as the ''fixed percentage.'' For the proposed 2012-based IRF market basket, we are proposing to use slightly different methods to obtain the fixed percentages for hospital-based IRFs compared to freestanding IRFs.

For freestanding IRFs, we are proposing to use depreciation data from Worksheet A–7 of the FY 2012 Medicare cost reports, similar to the methodology used for the 2008-based RPL market basket. However, for hospital-based IRFs, we determined that the fixed percentage for the entire facility may not be representative of the hospital-based IRF unit due to the entire facility likely employing more sophisticated movable assets that are not utilized by the hospital-based IRF. Therefore, for hospital-based IRFs, we are proposing to calculate a fixed percentage using: (1) Building and fixture capital costs allocated to the hospital-based IRF unit as reported on Worksheet B, part I line 41 and (2) building and fixture capital costs for the top five ancillary cost centers utilized by hospital-based IRFs. We propose to weight these two fixed percentages (inpatient and ancillary) using the proportion that each capital cost type represents of total capital costs in the proposed 2012-based IRF market basket. We are proposing to then weight the fixed percentages for hospital-based and freestanding IRFs together using the proportion of total capital costs each provider type represents.

To disaggregate the Interest cost weight, we need to determine the percent of total interest costs for IRFs that are attributable to government and nonprofit facilities, which we hereafter refer to as the ''nonprofit percentage,'' as price pressures associated with these types of interest costs tend to differ from those for for-profit facilities. For the IRF market basket, we are proposing to use interest costs data from Worksheet A–7 of the FY 2012 Medicare cost reports for both freestanding and hospital-based IRFs, similar to the methodology used for the 2008-based RPL market basket. We are proposing to determine the percent of total interest costs that are attributed to government and nonprofit IRFs separately for hospital-based and freestanding IRFs. We then are proposing to weight the nonprofit percentages for hospital-based and freestanding IRFs together using the proportion of total capital costs that each provider type represents.

Table 5 provides the detailed capital cost shares obtained from the Medicare cost reports. Ultimately, these detailed capital cost shares are applied to the total Capital-Related cost weight determined in section V.C.1.a.6 of this proposed rule to split out the total weight of 8.6 percent into more detailed cost categories and weights.

TABLE 5—DETAILED CAPITAL COST WEIGHTS FOR THE PROPOSED 2012-BASED IRF MARKET BASKET

	Cost shares obtained from medicare cost reports (percent)	Proposed detailed capital cost shares after allocation of lease expenses (percent)
Depreciation	61	74
Building and Fixed Equipment	39	48
Movable Equipment	22	26
Interest	13	16
Government/Nonprofit	8	10
For Profit	5	6
Lease	20	n/a
Other	6	10

e. Proposed 2012-Based IRF Market Basket Cost Categories and Weights

Table 6 shows the cost categories and weights for the proposed 2012-based IRF market basket compared to the 2008-based RPL market basket.

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Table 6 – Proposed 2012-based IRF Cost Weights Compared to 2008-based RPL Cost Weights

Cost Category	Proposed 2012-based IRF Cost Weight	2008-based RPL Cost Weight
Total	**100.0**	**100.0**
Compensation	**57.0**	**62.3**
Wages and Salaries	46.1	49.4
Employee Benefits	10.9	12.8
Utilities	**2.3**	**1.6**
Electricity	1.0	1.1
Fuel, Oil, and Gasoline	1.1	0.4
Water & Sewerage	0.1	0.1
Professional Liability Insurance	**0.9**	**0.8**
All Other Products and Services	**31.2**	**27.0**
All Other Products	**14.0**	**15.6**
Pharmaceuticals	5.1	6.5
Food: Direct Purchases	1.8	3.0
Food: Contract Services	1.1	0.4
Chemicals	0.7	1.1
Medical Instruments	2.5	1.8
Rubber & Plastics	0.6	1.1
Paper and Printing Products	1.2	1.0
Apparel	-	0.2
Machinery and Equipment	-	0.1
Miscellaneous Products	0.9	0.3
All Other Services	**17.2**	**11.4**
Labor-Related Services	**8.8**	**4.7**
Professional Fees: Labor-related	3.8	2.1
Administrative and Facilities Support Services	0.9	0.4
Installation, Maintenance, and Repair	2.1	-
All Other: Labor-related Services	2.0	2.1
Nonlabor-Related Services	**8.5**	**6.7**
Professional Fees: Nonlabor-related	3.4	4.2
Financial services	3.0	0.9
Telephone Services	0.7	0.4
Postage	-	0.6
All Other: Nonlabor-related Services	1.4	0.6

Cost Category	Proposed 2012-based IRF Cost Weight	2008-based RPL Cost Weight
Capital-Related Costs	**8.6**	**8.4**
Depreciation	**6.4**	**5.5**
Fixed Assets	4.1	3.3
Movable Equipment	2.3	2.2
Interest Costs	**1.4**	**2.0**
Government/Nonprofit	0.9	0.7
For Profit	0.5	1.3
Other Capital-Related Costs	**0.8**	**0.9**

* Detail may not add to total due to rounding.

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The proposed 2012-based IRF market basket does not include separate cost categories for Apparel, Machinery & Equipment, and Postage. Due to the small weights associated with these detailed categories and relatively stable price growth in the applicable price proxy, we are proposing to include Apparel and Machinery & Equipment in the Miscellaneous Products cost category and Postage in the All-Other Nonlabor-related Services. We note that these Machinery & Equipment expenses are for equipment that is paid for in a given year and not depreciated over the asset's useful life. Depreciation expenses for movable equipment are reflected in the Capital-related costs of the proposed 2012-based IRF market basket. For the proposed 2012-based IRF market basket, we are also proposing to include a separate cost category for Installation, Maintenance, and Repair.

2. Selection of Price Proxies

After developing the cost weights for the proposed 2012-based IRF market basket, we selected the most appropriate wage and price proxies currently available to represent the rate of price change for each expenditure category. For the majority of the cost weights, we base the price proxies on U.S. Bureau of Labor Statistics (BLS) data and group them into one of the following BLS categories:

- *Employment Cost Indexes.* Employment Cost Indexes (ECIs) measure the rate of change in employment wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. ECIs are superior to Average Hourly Earnings (AHE) as price proxies for input price indexes because they are not affected by shifts in occupation or industry mix, and because they measure pure price change and are available by both occupational group and by industry. The industry ECIs are based on the North American Industry Classification System (NAICS), and the occupational ECIs are based on the Standard Occupational Classification System (SOC).
- *Producer Price Indexes.* Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs are used when the purchases of goods or services are made at the wholesale level.
- *Consumer Price Indexes.* Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by consumers. CPIs are only used when the purchases are similar to those of retail consumers rather than purchases at the wholesale level, or if no appropriate PPIs are available.

We evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance:

- *Reliability.* Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Widely accepted statistical methods ensure that the data were collected and aggregated in a way that can be replicated. Low sampling variability is desirable because it indicates that the sample reflects the typical members of the population. (Sampling variability is variation that occurs by chance because only a sample was surveyed rather than the entire population.)
- *Timeliness.* Timeliness implies that the proxy is published regularly, preferably at least once a quarter. The market baskets are updated quarterly, and therefore, it is important for the underlying price proxies to be up-to-date, reflecting the most recent data available. We believe that using proxies that are published regularly (at least quarterly, whenever possible) helps to ensure that we are using the most recent data available to update the market basket. We strive to use publications that are disseminated frequently, because we believe that this is an optimal way to stay abreast of the most current data available.
- *Availability.* Availability means that the proxy is publicly available. We prefer that our proxies are publicly available because this will help ensure that our market basket updates are as transparent to the public as possible. In addition, this enables the public to be able to obtain the price proxy data on a regular basis.
- *Relevance.* Relevance means that the proxy is applicable and representative of the cost category weight to which it is applied. The CPIs, PPIs, and Employment Cost Index (ECIs) that we have selected to propose in this regulation meet these criteria. Therefore, we believe that they continue to be the best measure of price changes for the cost categories to which they would be applied.

Table 6 lists all price proxies for the proposed 2012-based IRF market basket. Below is a detailed explanation of the price proxies we are proposing for each cost category weight. We note that many of the proxies for the 2012-based IRF market basket are the same as those used for the FY 2008-based RPL market basket. For further discussion on the FY 2008-based RPL market basket, see the FY 2012 IRF final rule (76 FR 47852 through 47860).

a. Price Proxies for the Operating Portion of the Proposed 2012-Based IRF Market Basket

1. Wages and Salaries

We are proposing to continue to use the ECI for Wages and Salaries for All Civilian workers in Hospitals (BLS series code #CIU10262200000000I) to measure the wage rate growth of this cost category. This is the same price proxy used in the 2008-based RPL market basket.

2. Benefits

We are proposing to continue to use the ECI for Total Benefits for All Civilian workers in Hospitals to measure price growth of this category. This ECI is calculated using the ECI for Total Compensation for All Civilian workers in Hospitals (BLS series code # CIU10162200000000I) and the relative importance of wages and salaries within total compensation. This is the same price proxy used in the 2008-based RPL market basket.

3. Electricity

We are proposing to continue to use the PPI for Commercial Electric Power (BLS series code #WPU0542) to measure the price growth of this cost category. This is the same price proxy used in the 2008-based RPL market basket.

4. Fuel, Oil, and Gasoline

We are proposing to change the proxy used for the Fuel, Oil, and Gasoline cost category. The 2008-based RPL market basket uses the PPI for Petroleum Refineries (BLS series code #PCU32411–32411) to proxy these expenses.

For the proposed 2012-based IRF market basket, we are proposing to use a blend of the PPI for Petroleum Refineries and the PPI Commodity for Natural Gas (BLS series code #WPU0531). Our analysis of the Bureau of Economic Analysis' 2007 Benchmark Input-Output data (use table before redefinitions, purchaser's value for NAICS 622000 [Hospitals]), shows that Petroleum Refineries expenses accounts for approximately 70 percent and Natural Gas accounts for approximately 30 percent of the Fuel, Oil, and Gasoline expenses. Therefore, we propose a blend using of 70 percent of the PPI for Petroleum Refineries (BLS series code #PCU32411–32411) and 30 percent of the PPI Commodity for Natural Gas (BLS series code #WPU0531). We believe that these 2 price proxies are the most technically appropriate indices available to measure the price growth of the Fuel, Oil, and Gasoline cost category in the proposed 2012-based IRF market basket.

5. Water and Sewerage

We are proposing to continue to use the CPI for Water and Sewerage Maintenance (BLS series code #CUUR0000SEHG01) to measure the price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

6. Professional Liability Insurance

We are proposing to continue to use the CMS Hospital Professional Liability Index to measure changes in PLI premiums. To generate this index, we collect commercial insurance premiums for a fixed level of coverage while holding non-price factors constant (such as a change in the level of coverage). This is the same proxy used in the 2008-based RPL market basket.

7. Pharmaceuticals

We are proposing to continue to use the PPI for Pharmaceuticals for Human Use, Prescription (BLS series code #WPUSI07003) to measure the price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

8. Food: Direct Purchases

We are proposing to continue to use the PPI for Processed Foods and Feeds (BLS series code #WPU02) to measure the price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

9. Food: Contract Purchases

We are proposing to continue to use the CPI for Food Away From Home (BLS series code #CUUR0000SEFV) to measure the price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

10. Chemicals

We are proposing to continue to use a four part blended PPI composed of the PPI for Industrial Gas Manufacturing (BLS series code PCU325120325120P), the PPI for Other Basic Inorganic Chemical Manufacturing (BLS series code #PCU32518–32518), the PPI for Other Basic Organic Chemical Manufacturing (BLS series code #PCU32519–32519), and the PPI for Soap and Cleaning Compound Manufacturing (BLS series code #PCU32561–32561). We propose updating the blend weights using 2007 Benchmark I–O data, which compared to 2002 Benchmark I–O data is weighted more toward organic chemical products and weighted less toward inorganic chemical products.

Table 7 shows the proposed weights for each of the four PPIs used to create the blended PPI. These are the same four proxies used in the 2008-based RPL market basket; however, the blended PPI weights in the 2008-based RPL market baskets were based on 2002 Benchmark I–O data.

TABLE 7—BLENDED CHEMICAL PPI WEIGHTS

Name	Proposed 2012-based IRF weights (percent)	2008-based RPL weights (percent)	NAICS
PPI for Industrial Gas Manufacturing	32	35	325120
PPI for Other Basic Inorganic Chemical Manufacturing	17	25	325180
PPI for Other Basic Organic Chemical Manufacturing	45	30	325190
PPI for Soap and Cleaning Compound Manufacturing	6	10	325610

11. Medical Instruments

We are proposing to use a blend for the Medical Instruments cost category. The 2007 Benchmark Input-Output data shows an approximate 50/50 split between Surgical and Medical Instruments and Medical and Surgical Appliances and Supplies for this cost category. Therefore, we propose a blend composed of 50 percent of the commodity-based PPI for Surgical and Medical Instruments (BLS code #WPU1562) and 50 percent of the commodity-based PPI for Medical and Surgical Appliances and Supplies (BLS code #WPU1563). The 2008-based RPL market basket uses the single, higher level PPI for Medical, Surgical, and Personal Aid Devices (BLS series code #WPU156).

12. Rubber and Plastics

We are proposing to continue to use the PPI for Rubber and Plastic Products (BLS series code #WPU07) to measure price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

13. Paper and Printing Products

We are proposing to continue to use the PPI for Converted Paper and Paperboard Products (BLS series code #WPU0915) to measure the price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

14. Miscellaneous Products

We are proposing to continue to use the PPI for Finished Goods Less Food and Energy (BLS series code #WPUSOP3500) to measure the price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

15. Professional Fees: Labor-Related

We are proposing to continue to use the ECI for Total Compensation for Private Industry workers in Professional and Related (BLS series code #CIU2010000120000I) to measure the price growth of this category. This is the same proxy used in the 2008-based RPL market basket.

16. Administrative and Facilities Support Services

We are proposing to continue to use the ECI for Total Compensation for Private Industry workers in Office and Administrative Support (BLS series code #CIU2010000220000I) to measure the price growth of this category. This is the same proxy used in the 2008-based RPL market basket.

17. Installation, Maintenance, and Repair

We are proposing to use the ECI for Total Compensation for Civilian workers in Installation, Maintenance, and Repair (BLS series code #CIU10100004300001) to measure the price growth of this new cost category. Previously these costs were included in the All Other: Labor-related Services category and were proxied by the ECI for Total Compensation for Private Industry workers in Service Occupations (BLS series code #CIU2010000300000I). We believe that this index better reflects the price changes of labor associated with maintenance-related services and its incorporation represents a technical improvement to the market basket.

18. All Other: Labor-Related Services

We are proposing to continue to use the ECI for Total Compensation for Private Industry workers in Service Occupations (BLS series code #CIU2010000300000I) to measure the price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

19. Professional Fees: Nonlabor-Related

We are proposing to continue to use the ECI for Total Compensation for Private Industry workers in Professional and Related (BLS series code #CIU2010000120000I) to measure the price growth of this category. This is the same proxy used in the 2008-based RPL market basket.

20. Financial Services

We are proposing to continue to use the ECI for Total Compensation for Private Industry workers in Financial Activities (BLS series code #CIU201520A000000I) to measure the price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

21. Telephone Services

We are proposing to continue to use the CPI for Telephone Services (BLS series code #CUUR0000SEED) to measure the price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

22. All Other: Nonlabor-Related Services

We are proposing to continue to use the CPI for All Items Less Food and Energy (BLS series code #CUUR0000SA0L1E) to measure the price growth of this cost category. This is the same proxy used in the 2008-based RPL market basket.

b. Price Proxies for the Capital Portion of the Proposed 2012-Based IRF Market Basket

1. Capital Price Proxies Prior to Vintage Weighting

We are proposing to apply the same price proxies to the detailed capital-related cost categories as were applied in the 2008-based RPL market basket, which are provided in Table 7 and described below. We are also proposing to continue to vintage weight the capital price proxies for Depreciation and Interest to capture the long-term consumption of capital. This vintage weighting method is similar to the method used for the 2008-based RPL market basket and is described in section V.C.2.b.2 of this proposed rule.

We are proposing to proxy the Depreciation: Building and Fixed Equipment cost category by BEA's Chained Price Index for Nonresidential Construction for Hospitals and Special Care Facilities (BEA Table 5.4.4. Price Indexes for Private Fixed Investment in Structures by Type), the Depreciation: Movable Equipment cost category by the PPI for Machinery and Equipment (BLS series code #WPU11), the Nonprofit Interest cost category by the average yield on domestic municipal bonds (Bond Buyer 20-bond index), the For-profit Interest cost category by the average yield on Moody's Aaa bonds (Federal Reserve), and the Other Capital-Related cost category by the CPI–U for Rent of Primary Residence (BLS series code #CUUS0000SEHA). We believe these are the most appropriate proxies for IRF capital-related costs that meet our selection criteria of relevance, timeliness, availability, and reliability.

2. Vintage Weights for Price Proxies

Because capital is acquired and paid for over time, capital-related expenses in any given year are determined by both past and present purchases of physical and financial capital. The vintage-weighted capital-related portion of the proposed 2012-based IRF market basket is intended to capture the long-term consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the proportion of capital-related purchases attributable to each year of the expected life of building and fixed equipment, movable equipment, and interest. We are proposing to use vintage weights to compute vintage-weighted price changes associated with depreciation and interest expenses.

Capital-related costs are inherently complicated and are determined by complex capital-related purchasing decisions, over time, based on such factors as interest rates and debt financing. In addition, capital is depreciated over time instead of being consumed in the same period it is purchased. By accounting for the vintage nature of capital, we are able to provide an accurate and stable annual measure of price changes. Annual non-vintage price changes for capital are unstable due to the volatility of interest rate changes and, therefore, do not reflect the actual annual price changes for IRF capital-related costs. The capital-related component of the proposed 2012-based IRF market basket reflects the underlying stability of the capital-related acquisition process.

To calculate the vintage weights for depreciation and interest expenses, we first need a time series of capital-related purchases for building and fixed

equipment and movable equipment. We found no single source that provides an appropriate time series of capital-related purchases by hospitals for all of the above components of capital purchases. The early Medicare cost reports did not have sufficient capital-related data to meet this need. Data we obtained from the American Hospital Association (AHA) do not include annual capital-related purchases. However, we are able to obtain data on total expenses back to 1963 from the AHA. Consequently, we are proposing to use data from the AHA Panel Survey and the AHA Annual Survey to obtain a time series of total expenses for hospitals. We are then proposing to use data from the AHA Panel Survey supplemented with the ratio of depreciation to total hospital expenses obtained from the Medicare cost reports to derive a trend of annual depreciation expenses for 1963 through 2012. We propose to separate these depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation as determined earlier. From these annual depreciation amounts we derive annual end-of-year book values for building and fixed equipment and movable equipment using the expected life for each type of asset category. While data is not available that is specific to IRFs, we believe this information for all hospitals serves as a reasonable alternative for the pattern of depreciation for IRFs.

To continue to calculate the vintage weights for depreciation and interest expenses, we also need to account for the expected lives for Building and Fixed Equipment, Movable Equipment, and Interest for the proposed 2012-based IRF market basket. We are proposing to calculate the expected lives using Medicare cost report data from freestanding and hospital-based IRFs. The expected life of any asset can be determined by dividing the value of the asset (excluding fully depreciated assets) by its current year depreciation amount. This calculation yields the estimated expected life of an asset if the rates of depreciation were to continue at current year levels, assuming straight-line depreciation. We are proposing to determine the expected life of building and fixed equipment separately for hospital-based IRFs and freestanding IRFs, and then weight these expected lives using the percent of total capital costs each provider type represents. We are proposing to apply a similar method for movable equipment. Using these proposed methods, we determined the average expected life of building and fixed equipment to be equal to 23 years, and the average expected life of movable equipment to be equal to 11 years. For the expected life of interest, we believe vintage weights for interest should represent the average expected life of building and fixed equipment because, based on previous research described in the FY 1997 IPPS final rule (61 FR 46198), the expected life of hospital debt instruments and the expected life of buildings and fixed equipment are similar. We note that for the 2008-based RPL market basket, we used FY 2008 Medicare cost reports for IPPS hospitals to determine the expected life of building and fixed equipment and movable equipment (76 FR 51763). The 2008-based RPL market basket was based on an expected average life of building and fixed equipment of 26 years and an expected average life of movable equipment of 11 years, which were both calculated using data for IPPS hospitals.

Multiplying these expected lives by the annual depreciation amounts results in annual year-end asset costs for building and fixed equipment and movable equipment. We then calculate a time series, beginning in 1964, of annual capital purchases by subtracting the previous year's asset costs from the current year's asset costs.

For the building and fixed equipment and movable equipment vintage weights, we are proposing to use the real annual capital-related purchase amounts for each asset type to capture the actual amount of the physical acquisition, net of the effect of price inflation. These real annual capital-related purchase amounts are produced by deflating the nominal annual purchase amount by the associated price proxy as provided earlier in this proposed rule. For the interest vintage weights, we are proposing to use the total nominal annual capital-related purchase amounts to capture the value of the debt instrument (including, but not limited to, mortgages and bonds). Using these capital-related purchase time series specific to each asset type, we are proposing to calculate the vintage weights for building and fixed equipment, for movable equipment, and for interest.

The vintage weights for each asset type are deemed to represent the average purchase pattern of the asset over its expected life (in the case of building and fixed equipment and interest, 23 years, and in the case of movable equipment, 11 years). For each asset type, we used the time series of annual capital-related purchase amounts available from 2012 back to 1964. These data allow us to derive twenty-seven 23-year periods of capital-related purchases for building and fixed equipment and interest, and thirty-nine 11-year periods of capital-related purchases for movable equipment. For each 23-year period for building and fixed equipment and interest, or 11-year period for movable equipment, we calculate annual vintage weights by dividing the capital-related purchase amount in any given year by the total amount of purchases over the entire 23-year or 11-year period. This calculation is done for each year in the 23-year or 11-year period and for each of the periods for which we have data. We then calculate the average vintage weight for a given year of the expected life by taking the average of these vintage weights across the multiple periods of data. The vintage weights for the capital-related portion of the 2008-based RPL market basket and the proposed 2012-based IRF market basket are presented in Table 8.

TABLE 8—2008-BASED RPL MARKET BASKET AND PROPOSED 2012-BASED IRF MARKET BASKET VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Year	Building and fixed equipment		Movable equipment		Interest	
	2012-based 23 years	2008-based 26 years	2012-based 11 years	2008-based 11 years	2012-based 23 years	2008-based 26 years
1	0.029	0.021	0.069	0.071	0.017	0.010
2	0.031	0.023	0.073	0.075	0.019	0.012
3	0.034	0.025	0.077	0.080	0.022	0.014
4	0.036	0.027	0.083	0.083	0.024	0.016
5	0.037	0.028	0.087	0.085	0.026	0.018
6	0.039	0.030	0.091	0.089	0.028	0.020
7	0.040	0.031	0.096	0.092	0.030	0.021

TABLE 8—2008-BASED RPL MARKET BASKET AND PROPOSED 2012-BASED IRF MARKET BASKET VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES—Continued

Year	Building and fixed equipment		Movable equipment		Interest	
	2012-based 23 years	2008-based 26 years	2012-based 11 years	2008-based 11 years	2012-based 23 years	2008-based 26 years
8	0.041	0.033	0.100	0.098	0.032	0.024
9	0.042	0.035	0.103	0.103	0.035	0.026
10	0.044	0.037	0.107	0.109	0.038	0.029
11	0.045	0.039	0.114	0.116	0.040	0.033
12	0.045	0.041	.....	.....	0.042	0.035
13	0.045	0.042	.....	.....	0.044	0.038
14	0.046	0.043	.....	.....	0.046	0.041
15	0.046	0.044	.....	.....	0.048	0.043
16	0.048	0.045	.....	.....	0.053	0.046
17	0.049	0.046	.....	.....	0.057	0.049
18	0.050	0.047	.....	.....	0.060	0.052
19	0.051	0.047	.....	.....	0.063	0.053
20	0.051	0.045	.....	.....	0.066	0.053
21	0.051	0.045	.....	.....	0.067	0.055
22	0.050	0.045	.....	.....	0.069	0.056
23	0.052	0.046	.....	.....	0.073	0.060
24	.....	0.046	.....	.....	.....	0.063
25	.....	0.045	.....	.....	.....	0.064
26	.....	0.046	.....	.....	.....	0.068
Total	1.000	1.000	1.000	1.000	1.000	1.000

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

The process of creating vintage-weighted price proxies requires applying the vintage weights to the price proxy index where the last applied vintage weight in Table 8 is applied to the most recent data point. We have provided on the CMS Web site an example of how the vintage weighting price proxies are calculated, using example vintage weights and example price indices. The example can be found at the following link: *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html* in the zip file titled ''Weight Calculations as described in the IPPS FY 2010 Proposed Rule.''

c. Summary of Price Proxies of the Proposed 2012-Based IRF Market Basket

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Table 9: Price Proxies for the Proposed 2012-based IRF Market Basket

Cost Description	Price Proxies	Weight
Total - IRF12		**100.0%**
Compensation		**57.0%**
Wages and Salaries	ECI for Wages and Salaries for All Civilian workers in Hospitals	46.1%
Employee Benefits	ECI for Total Benefits for All Civilian workers in Hospitals	10.9%
Utilities		**2.3%**
Electricity	PPI for Commercial Electric Power	1.0%
Fuel, Oil, and Gasoline	Blend of the PPI for Petroleum Refineries and PPI for Natural Gas	1.1%
Water & Sewage	CPI-U for Water and Sewerage Maintenance	0.1%
Professional Liability Insurance		**0.9%**
Malpractice	CMS Hospital Professional Liability Insurance Premium Index	0.9%
All Other Products and Services		**31.2%**
All Other Products		**14.0%**
Pharmaceuticals	PPI for Pharmaceuticals for human use, prescription	5.1%
Food: Direct Purchases	PPI for Processed Foods and Feeds	1.8%
Food: Contract Services	CPI-U for Food Away From Home	1.1%
Chemicals	Blend of Chemical PPIs	0.7%
Medical Instruments	Blend of the PPI for Surgical and medical instruments and PPI for Medical and surgical appliances and supplies	2.5%
Rubber & Plastics	PPI for Rubber and Plastic Products	0.6%
Paper and Printing Products	PPI for Converted Paper and Paperboard Products	1.2%
Miscellaneous Products	PPI for Finished Goods Less Food and Energy	0.9%
All Other Services		**17.2%**
Labor-Related Services		**8.8%**
Professional Fees: Labor-related	ECI for Total compensation for Private industry workers in Professional and related	3.8%
Administrative and Facilities Support Services	ECI for Total compensation for Private industry workers in Office and administrative support	0.9%
Installation, Maintenance & Repair	ECI for Total compensation for Civilian workers in Installation, maintenance, and repair	2.1%
All Other: Labor-related Services	ECI for Total compensation for Private industry workers in Service occupations	2.0%
Nonlabor-Related Services		**8.5%**
Professional Fees: Nonlabor-related	ECI for Total compensation for Private industry workers in Professional and related	3.4%
Financial services	ECI for Total compensation for Private industry workers in Financial activities	3.0%
Telephone Services	CPI-U for Telephone Services	0.7%
All Other: Nonlabor-related Services	CPI-U for All Items Less Food and Energy	1.4%
Capital-Related Costs		**8.6%**
Depreciation		**6.4%**
Fixed Assets	BEA chained price index for nonresidential construction for hospitals and special care facilities - vintage weighted (23 years)	4.1%
Movable Equipment	PPI for machinery and equipment - vintage weighted (11 years)	2.3%
Interest Costs		**1.4%**

Cost Description	Price Proxies	Weight
Government/Nonprofit	Average yield on domestic municipal bonds (Bond Buyer 20 bonds) - vintage weighted (23 years)	0.9%
For Profit	Average yield on Moody's Aaa bonds - vintage weighted (23 years)	0.5%
Other Capital-Related Costs	CPI-U for Rent of primary residence	**0.8%**

Note: Totals may not sum to 100.0 percent due to rounding

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D. Proposed FY 2016 Market Basket Update and Productivity Adjustment

1. Proposed FY 2016 Market Basket Update

For FY 2016, we are proposing to use the proposed 2012-based IRF market basket increase factor described in section V.C. of this proposed rule to update the IRF PPS base payment rate. Consistent with historical practice, we estimate the market basket update for the IRF PPS based on IHS Global Insight's forecast using the most recent available data. IHS Global Insight (IGI), Inc. is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets and multifactor productivity (MFP).

Based on IGI's first quarter 2015 forecast with historical data through the fourth quarter of 2014, the projected proposed 2012-based IRF market basket increase factor for FY 2016 would be 2.7 percent. Therefore, consistent with our historical practice of estimating market basket increases based on the best available data, we are proposing a market basket increase factor of 2.7 percent for FY 2016. We are also proposing that if more recent data are subsequently available (for example, a more recent estimate of the market basket) we would use such data, to determine the FY 2016 update in the final rule.

For comparison, the 2008-based RPL market basket is projected to be 2.8 percent in FY 2016; this estimate is based on IGI's first quarter 2015 forecast (with historical data through the fourth quarter of 2014). Table 10 compares the proposed 2012-based IRF market basket and the 2008-based RPL market basket percent changes.

TABLE 10—PROPOSED 2012-BASED IRF MARKET BASKET AND 2008-BASED RPL MARKET BASKET PERCENT CHANGES, FY 2010 THROUGH FY 2018

Fiscal year (FY)	Proposed 2012-based IRF market basket index percent change	2008-based RPL market basket index percent change
Historical data:		
FY 2010	2.1	2.2
FY 2011	2.3	2.5
FY 2012	1.8	2.2
FY 2013	2.0	2.1
FY 2014	1.8	1.8
Average 2010–2014	2.0	2.2
Forecast:		
FY 2015	1.8	2.2
FY 2016	2.7	2.8
FY 2017	3.0	3.0
FY 2018	3.1	3.1
Average 2015–2018	2.7	2.8

Note that these market basket percent changes do not include any further adjustments as may be statutorily required.
Source: IHS Global Insight, Inc. 1st quarter 2015 forecast.

For FY 2016, the proposed 2012-based IRF market basket update (2.7 percent) is a tenth of a percentage point lower than the 2008-based RPL market basket (2.8 percent). The 0.1 percentage point difference stems from the lower Compensation cost weight in the proposed 2012-based IRF market basket (57.0 percent) compared to the 2008-based RPL market basket (62.3 percent) and the lower Pharmaceuticals cost weight in the proposed 2012-based IRF market basket (5.1 percent) compared to the 2008-based RPL market basket (6.5 percent). The downward pressure on the proposed 2012-based IRF market basket update from these two categories is partially offset by the higher All Other Services cost weight in the proposed 2012-based IRF market basket (17.2 percent) compared to the 2008-based RPL market basket (11.4 percent).

2. Proposed Productivity Adjustment

According to Section 1886(j)(3)(C)(i) of the Act, the Secretary shall establish an increase factor based on an appropriate percentage increase in a market basket of goods and services. As described in section V.C and V.D.1. of this proposed rule, we are proposing to estimate the IRF PPS increase factor for FY 2016 based on the proposed 2012-based IRF market basket. Section 1886(j)(3)(C)(ii) of the Act then requires that, after establishing the increase factor for a FY, the Secretary shall reduce such increase factor for FY 2012 and each subsequent FY, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business MFP (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other

annual period) (the ''MFP adjustment''). The BLS publishes the official measure of private nonfarm business MFP. Please see *http://www.bls.gov/mfp* for the BLS historical published MFP data.

MFP is derived by subtracting the contribution of labor and capital input growth from output growth. The projections of the components of MFP are currently produced by IGI, a nationally recognized economic forecasting firm with which CMS contracts to forecast the components of the market basket and MFP. As described in the FY 2012 IRF PPS final rule (76 FR 47836, 47858 through 47859), to generate a forecast of MFP, IGI replicated the MFP measure calculated by the BLS using a series of proxy variables derived from IGI's U.S. macroeconomic models. In the FY 2012 IRF PPS final rule, we identified each of the major MFP component series employed by the BLS to measure MFP as well as provided the corresponding concepts determined to be the best available proxies for the BLS series. Beginning with the FY 2016 rulemaking cycle, the MFP adjustment is calculated using a revised series developed by IGI to proxy the aggregate capital inputs. Specifically, IGI has replaced the Real Effective Capital Stock used for Full Employment GDP with a forecast of BLS aggregate capital inputs recently developed by IGI using a regression model. This series provides a better fit to the BLS capital inputs, as measured by the differences between the actual BLS capital input growth rates and the estimated model growth rates over the historical time period. Therefore, we are using IGI's most recent forecast of the BLS capital inputs series in the MFP calculations beginning with the FY 2016 rulemaking cycle. A complete description of the MFP projection methodology is available on CMS Web site at: *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html.* Although we discuss the IGI changes to the MFP proxy series in this proposed rule, in the future, when IGI makes changes to the MFP methodology, we will announce them on our Web site rather than in the annual rulemaking.

Using IGI's first quarter 2015 forecast, the MFP adjustment for FY 2016 (the 10-year moving average of MFP for the period ending FY 2016) is projected to be 0.6 percent. Thus, in accordance with section 1886(j)(3)(C) of the Act, we propose to base the FY 2016 market basket update, which is used to determine the applicable percentage increase for the IRF payments, on the most recent estimate of the proposed 2012-based IRF market basket (currently estimated to be 2.7 percent based on IGI's first quarter 2015 forecast). We propose to then reduce this percentage increase by the current estimate of the MFP adjustment for FY 2016 of 0.6 percentage point (the 10-year moving average of MFP for the period ending FY 2016 based on IGI's first quarter 2015 forecast). Following application of the MFP, we further reduce the applicable percentage increase by 0.2 percentage point, as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(iv) of the Act. Therefore, the current estimate of the FY 2016 IRF update is 1.9 percent (2.7 percent market basket update, less 0.6 percentage point MFP adjustment, less 0.2 percentage point legislative adjustment). Furthermore, we note that if more recent data are subsequently available (for example, a more recent estimate of the market basket and MFP adjustment), we would use such data to determine the FY 2016 market basket update and MFP adjustment in the final rule.

For FY 2016, the Medicare Payment Advisory Commission (MedPAC) recommends that a 0 percent update be applied to IRF PPS payment rates. As discussed, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary proposes to update IRF PPS payment rates for FY 2015 by an adjusted market basket increase factor of 1.9 percent, as section 1886(j)(3)(C) of the Act does not provide the Secretary with the authority to apply a different update factor to IRF PPS payment rates for FY 2016.

We invite public comment on these proposals.

E. Proposed Labor-Related Share for FY 2016

Section 1886(j)(6) of the Act specifies that the Secretary is to adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under section 1886(j)(3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market. As stated in the FY 2015 IRF PPS final rule (79 FR 45886), the labor-related share for FY 2015 was defined as the sum of the FY 2015 relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor- Related Services, Administrative and Business Support Services, All Other: Labor-related Services, and a portion of the Capital Costs from the 2008-based RPL market basket.

Based on our definition of the labor-related share and the cost categories in the proposed 2012-based IRF market basket, we are proposing to include in the labor-related share for FY 2016 the sum of the FY 2016 relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair, All Other: Labor-related Services, and a portion of the Capital-Related cost weight from the proposed 2012-based IRF market basket. As noted in Section V.C.2.a of this proposed rule, for the proposed 2012-based IRF market basket, we have created a separate cost category for Installation, Maintenance, and Repair services. These expenses were previously included in the ''All Other'' Labor-related Services cost category in the 2008-based RPL market basket, along with other services, including, but not limited to, janitorial, waste management, security, and dry cleaning/laundry services. Because these services tend to be labor-intensive and are mostly performed at the facility (and, therefore, unlikely to be purchased in the national market), we continue to believe that they meet our definition of labor-related services.

Similar to the 2008-based RPL market basket, the proposed 2012-based IRF market basket includes two cost categories for nonmedical Professional fees (including, but not limited to, expenses for legal, accounting, and engineering services). These are Professional Fees: Labor-related and Professional Fees: Nonlabor-related. For the proposed 2012-based IRF market basket, we propose to estimate the labor-related percentage of non-medical professional fees (and assign these expenses to the Professional Fees: Labor-related services cost category) based on the same method that was used to determine the labor-related percentage of professional fees in the 2008-based RPL market basket.

To summarize, the professional services survey found that hospitals purchase the following proportion of these four services outside of their local labor market:

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

We applied each of these percentages to the respective Benchmark I–O cost category underlying the professional fees cost category to determine the Professional Fees: Nonlabor-related costs. The Professional Fees: Labor-related costs were determined to be the difference between the total costs for each Benchmark I–O category and the Professional Fees: Nonlabor-related costs. This is the same methodology that we used to separate the 2008-based RPL market basket professional fees category into Professional Fees: Labor-related and Professional Fees: Nonlabor-related cost categories. For more detail regarding this methodology, see the FY 2012 IRF final rule (76 FR 47861).

In addition to the professional services listed, we also classified expenses under NAICS 55, Management of Companies and Enterprises, into the Professional Fees cost category as was done in the 2008-based RPL market basket. The NAICS 55 data are mostly comprised of corporate, subsidiary, and regional managing offices, or otherwise referred to as home offices. Since many facilities are not located in the same geographic area as their home office, we analyzed data from a variety of sources to determine what proportion of these costs should be appropriately included in the labor-related share. For the 2012-based IRF market basket, we are proposing to derive the home office percentages using data for both freestanding IRF providers and hospital-based IRF providers. In the 2008-based RPL market basket, we used the home office percentages based on the data reported by freestanding IRFs, IPFs, and LTCHs.

Using data primarily from the Medicare cost reports and the Home Office Medicare Records (HOMER) database that provides the address (including city and state) for home offices, we were able to determine that 38 percent of the total number of freestanding and hospital-based IRFs that had home offices had those home offices located in their respective local labor markets—defined as being in the same Metropolitan Statistical Area (MSA).

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

• Group 1—Provider and home office are located in different MSAs.
• Group 2—Provider and home office are located in the same MSA.

We found that 62 percent of the providers with home offices were classified into Group 1 (that is, different MSAs) and, thus, these providers were determined to not be located in the same local labor market as their home office. We found that 38 percent of all providers with home offices were classified into Group 2 (that is, the same MSA). Given these results, we are proposing to classify 38 percent of the Professional Fees costs into the Professional Fees: Labor-related cost category and the remaining 62 percent into the Professional Fees: Nonlabor-related Services cost category. This methodology for apportioning the Professional Fee expenses between Labor-related and Nonlabor-related categories was similar to the method used in the 2008-based RPL market basket. For more details regarding this methodology, see the FY 2012 IRF final rule (76 FR 47860 through 47863).

Using this proposed method and the IHS Global Insight, Inc. first quarter 2015 forecast for the proposed 2012-based IRF market basket, the proposed IRF labor-related share for FY 2016 is the sum of the FY 2016 relative importance of each labor-related cost category. The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2012) and FY 2016. Table 11 compares the proposed FY 2016 labor-related share using the proposed 2012-based IRF market basket relative importance with the FY 2015 labor-related share using the 2008-based RPL market basket.

The sum of the relative importance for FY 2016 operating costs (Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-related Services) is 65.7 percent, as shown in Table 11. We are proposing to specify the labor-related share to one decimal place, which is consistent with the IPPS labor-related share (79 FR 49990) (currently the labor-related share from the RPL market basket is specified to three decimal places).

We are proposing that the portion of Capital that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage applied to the 2008-based RPL market basket. Since the relative importance for Capital-Related Costs is 8.4 percent of the proposed 2012-based IRF market basket in FY 2016, we are proposing to take 46 percent of 8.4 percent to determine the proposed labor-related share of Capital for 2016. The result would be 3.9 percent, which we propose to add to 65.7 percent for the operating cost amount to determine the total proposed labor-related share for FY 2016. Thus, the labor-related share that we propose to use for IRF PPS in FY 2016 would be 69.6 percent. This proposed labor-related share is determined using the same methodology as employed in calculating all previous IRF labor-related shares (see 76 FR 47862). By comparison, the FY 2015 labor-related share under the 2008-based RPL market basket was 69.294 percent. Therefore, the change from the RPL market basket to the IRF market basket has only a minimal impact on the labor-related share for IRF providers.

TABLE 11—PROPOSED IRF LABOR-RELATED SHARE

	FY 2016 proposed labor-related share [1]	FY 2015 final labor-related share [2]
Wages and Salaries	46.0	48.271
Employee Benefits	11.0	12.936
Professional Fees: Labor-related	3.8	2.058
Administrative and Facilities Support Services	0.9	0.415
Installation, Maintenance, and Repair	2.1	.....
All Other: Labor-related Services	1.9	2.061

TABLE 11—PROPOSED IRF LABOR-RELATED SHARE—Continued

	FY 2016 proposed labor-related share [1]	FY 2015 final labor-related share [2]
Subtotal	65.7	65.741
Labor-related portion of capital (46%)	3.9	3.553
Total Labor-Related Share	69.6	69.294

[1] Based on the 2012-based IRF Market Basket, IHS Global Insight, Inc. 1st quarter 2015 forecast.
[2] **Federal Register** 79 FR 45886.

F. Proposed Wage Adjustment

1. Background

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

For FY 2016, we propose to maintain the policies and methodologies described in the FY 2012 IRF PPS final rule (76 FR 47836, 47863 through 47865) related to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we propose to use the CBSA labor market area definitions and the FY 2015 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2015 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2010, and before October 1, 2011 (that is, FY 2011 cost report data).

The labor market designations made by the OMB include some geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the IRF PPS wage index. We propose to continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation for the FY 2016 IRF PPS wage index.

2. Update

The wage index used for the IRF PPS is calculated using the pre-reclassification and pre-floor acute care hospital wage index data and is assigned to the IRF on the basis of the labor market area in which the IRF is geographically located. IRF labor market areas are delineated based on the Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget (OMB). The current CBSA labor market definitions used in FY 2015 are based on OMB standards published on December 27, 2000 (65 FR 82228). As stated in the FY 2015 IRF PPS proposed rule (79 FR 26308) and final rule (79 FR 45871), we intend to consider the inclusion of the 2010 Census-based CBSA changes in the IRF PPS wage index for FY 2016.

On February 28, 2013, OMB issued OMB Bulletin No. 13–01, which established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin is available online at *http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf.* The OMB bulletin provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246 through 37252) and Census Bureau data.

While the revisions OMB published on February 28, 2013 are not as sweeping as the changes made when we adopted the CBSA geographic designations in the FY 2006 IRF PPS final rule, the February 28, 2013 OMB bulletin does contain a number of significant changes. For example, there are new CBSAs, urban counties that become rural, rural counties that become urban, and existing CBSAs that are being split apart. However, because the bulletin was not issued until February 28, 2013, with supporting data not available until later, and because the changes made by the bulletin and their ramifications needed to be extensively reviewed and verified, these changes were not incorporated into the hospital wage index until FY 2015. In the FY 2015 IRF PPS final rule (79 FR 45886), we stated that we intended to consider changes to the wage index based on the most current OMB delineations in this FY 2016 IRF PPS proposed rule. As discussed below, we are proposing to implement the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13–01, for the IRF PPS wage index beginning in FY 2016.

3. Proposed Implementation of New Labor Market Delineations

As discussed in the FY 2015 IRF PPS proposed rule (79 FR 26308) and final rule (79 FR 45871), CMS delayed implementing the new OMB statistical area delineations to allow for sufficient time to assess the new changes. We believe it is important for the IRF PPS to use the latest OMB delineations available to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. While CMS and other stakeholders have explored potential alternatives to the current CBSA-based labor market system (we refer readers to the CMS Web site at *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html*), no consensus has been achieved regarding how best to implement a replacement system. As discussed in the FY 2005 IPPS final rule (69 FR 49027), while we recognize that MSAs are not designed specifically to define labor market areas, we believe they do represent a useful proxy for this purpose. We further believe that using the most current OMB delineations would increase the integrity of the IRF PPS wage index by creating a more

accurate representation of geographic variation in wage levels. We have reviewed our findings and impacts relating to the new OMB delineations, and have concluded that there is no compelling reason to further delay implementation. Because we believe that we have broad authority under section 1886(j)(6) of the Act to determine the labor market areas used for the IRF PPS wage index, and because we also believe that the most current OMB delineations accurately reflect the local economies and wage levels of the areas in which hospitals are currently located, we are proposing to implement the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13–01, for the IRF PPS wage index effective beginning in FY 2016. As discussed below, we are proposing to implement a one-year transition with a blended wage index for all providers and a 3 year phase-out of the rural adjustment for a subset of providers in FY 2016 to assist providers in adapting to the new OMB delineations. We invite comments on this proposal. This proposed transition is discussed in more detail below.

a. Micropolitan Statistical Areas

OMB defines a ''Micropolitan Statistical Area'' as a CBSA associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000 (75 FR 37252). We refer to these as Micropolitan Areas. After extensive impact analysis, consistent with the treatment of these areas under the IPPS as discussed in the FY 2005 IPPS final rule (69 FR 49029 through 49032), CMS determined the best course of action would be to treat Micropolitan Areas as ''rural'' and include them in the calculation of each state's IRF PPS rural wage index. Thus, the IRF PPS statewide rural wage index is determined using IPPS hospital data from hospitals located in non-MSA areas, and the statewide rural wage index is assigned to IRFs located in those areas. Because Micropolitan Areas tend to encompass smaller population centers and contain fewer hospitals than MSAs, we determined that if Micropolitan Areas were to be treated as separate labor market areas, the IRF PPS wage index would have included significantly more single-provider labor market areas. As we explained in the FY 2006 IRF PPS final rule (70 FR 47920 through 47921), recognizing Micropolitan Areas as independent labor markets would generally increase the potential for dramatic shifts in year-to-year wage index values because a single hospital (or group of hospitals) could have a disproportionate effect on the wage index of an area. Dramatic shifts in an area's wage index from year to year are problematic and create instability in the payment levels from year to year, which could make fiscal planning for IRFs difficult if we adopted this approach. For these reasons, we adopted a policy to include Micropolitan Areas in the state's rural wage area for purposes of the IRF PPS wage index, and have continued this policy through the present.

Based upon the new 2010 Decennial Census data, a number of urban counties have switched status and have joined or became Micropolitan Areas, and some counties that once were part of a Micropolitan Area, have become urban. Overall, there are fewer Micropolitan Areas (541) under the new OMB delineations based on the 2010 Census than existed under the latest data from the 2000 Census (581). We believe that the best course of action would be to continue the policy established in the FY 2006 IRF PPS final rule (70 FR 47880) and include Micropolitan Areas in each state's rural wage index. These areas continue to be defined as having relatively small urban cores (populations of 10,000 to 49,999). We do not believe it would be appropriate to calculate a separate wage index for areas that typically may include only a few hospitals for the reasons discussed in the FY 2006 IRF PPS final rule (70 FR 47880), and as previously discussed. Therefore, in conjunction with our proposal to implement the new OMB labor market delineations beginning in FY 2016 and consistent with the treatment of Micropolitan Areas under the IPPS, we are proposing to continue to treat Micropolitan Areas as ''rural'' and to include Micropolitan Areas in the calculation of the state's rural wage index.

b. Urban Counties Becoming Rural

As previously discussed, we are proposing to implement the new OMB statistical area delineations (based upon the 2010 decennial Census data) beginning in FY 2016 for the IRF PPS wage index. Our analysis shows that a total of 37 counties (and county equivalents) that are currently considered part of an urban CBSA would be considered located in a rural area, for IRF PPS payment beginning in FY 2016, if we adopt the new OMB delineations. Table 12 lists the 37 urban counties that would be rural if we finalize our proposal to implement the new OMB delineations.

TABLE 12—COUNTIES THAT WOULD TRANSITION FROM URBAN TO RURAL STATUS

County	State	Previous CBSA	Previous urban area (constituent counties)
Greene County	IN	14020	Bloomington, IN.
Anson County	NC	16740	Charlotte-Gastonia-Rock Hill, NC-SC.
Franklin County	IN	17140	Cincinnati-Middletown, OH-KY-IN.
Stewart County	TN	17300	Clarksville, TN-KY.
Howard County	MO	17860	Columbia, MO.
Delta County	TX	19124	Dallas-Fort Worth-Arlington, TX.
Pittsylvania County	VA	19260	Danville, VA.
Danville City	VA	19260	Danville, VA.
Preble County	OH	19380	Dayton, OH.
Gibson County	IN	21780	Evansville, IN-KY.
Webster County	KY	21780	Evansville, IN-KY.
Franklin County	AR	22900	Fort Smith, AR-OK.
Ionia County	MI	24340	Grand Rapids-Wyoming, MI.
Newaygo County	MI	24340	Grand Rapids-Wyoming, MI.
Greene County	NC	24780	Greenville, NC.
Stone County	MS	25060	Gulfport-Biloxi, MS.
Morgan County	WV	25180	Hagerstown-Martinsburg, MD-WV.
San Jacinto County	TX	26420	Houston-Sugar Land-Baytown, TX.
Franklin County	KS	28140	Kansas City, MO-KS.
Tipton County	IN	29020	Kokomo, IN.

TABLE 12—COUNTIES THAT WOULD TRANSITION FROM URBAN TO RURAL STATUS—Continued

County	State	Previous CBSA	Previous urban area (constituent counties)
Nelson County	KY	31140	Louisville/Jefferson County, KY-IN.
Geary County	KS	31740	Manhattan, KS.
Washington County	OH	37620	Parkersburg-Marietta-Vienna, WV-OH.
Pleasants County	WV	37620	Parkersburg-Marietta-Vienna, WV-OH.
George County	MS	37700	Pascagoula, MS.
Power County	ID	38540	Pocatello, ID.
Cumberland County	VA	40060	Richmond, VA.
King and Queen County	VA	40060	Richmond, VA.
Louisa County	VA	40060	Richmond, VA.
Washington County	MO	41180	St. Louis, MO-IL.
Summit County	UT	41620	Salt Lake City, UT.
Erie County	OH	41780	Sandusky, OH.
Franklin County	MA	44140	Springfield, MA.
Ottawa County	OH	45780	Toledo, OH.
Greene County	AL	46220	Tuscaloosa, AL.
Calhoun County	TX	47020	Victoria, TX.
Surry County	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC.

We are proposing that the wage data for all hospitals located in the counties listed in Table 12 now be considered rural when their respective state's rural wage index value is calculated. This rural wage index value would be used under the IRF PPS.

c. Rural Counties Becoming Urban

Analysis of the new OMB delineations (based upon the 2010 decennial Census data) shows that a total of 105 counties (and county equivalents) that are currently located in rural areas would be located in urban areas, if we finalize our proposal to implement the new OMB delineations. Table 13 below lists the 105 rural counties that would be urban if we finalize this proposal.

TABLE 13—COUNTIES THAT WOULD TRANSITION FROM RURAL TO URBAN STATUS

County	State	New CBSA	Urban area (constituent counties)
Utuado Municipio	PR	10380	Aguadilla-Isabela, PR.
Linn County	OR	10540	Albany, OR.
Oldham County	TX	11100	Amarillo, TX.
Morgan County	GA	12060	Atlanta-Sandy Springs-Roswell, GA.
Lincoln County	GA	12260	Augusta-Richmond County, GA-SC.
Newton County	TX	13140	Beaumont-Port Arthur, TX.
Fayette County	WV	13220	Beckley, WV.
Raleigh County	WV	13220	Beckley, WV.
Golden Valley County	MT	13740	Billings, MT.
Oliver County	ND	13900	Bismarck, ND.
Sioux County	ND	13900	Bismarck, ND.
Floyd County	VI	13980	Blacksburg-Christiansburg-Radford, VA.
De Witt County	IL	14010	Bloomington, IL.
Columbia County	PA	14100	Bloomsburg-Berwick, PA.
Montour County	PA	14100	Bloomsburg-Berwick, PA.
Allen County	KY	14540	Bowling Green, KY.
Butler County	KY	14540	Bowling Green, KY.
St. Mary's County	MD	15680	California-Lexington Park, MD.
Jackson County	IL	16060	Carbondale-Marion, IL.
Williamson County	IL	16060	Carbondale-Marion, IL.
Franklin County	PA	16540	Chambersburg-Waynesboro, PA.
Iredell County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Lincoln County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Rowan County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Chester County	SC	16740	Charlotte-Concord-Gastonia, NC-SC.
Lancaster County	SC	16740	Charlotte-Concord-Gastonia, NC-SC.
Buckingham County	VA	16820	Charlottesville, VA.
Union County	IN	17140	Cincinnati, OH-KY-IN.
Hocking County	OH	18140	Columbus, OH.
Perry County	OH	18140	Columbus, OH.
Walton County	FL	18880	Crestview-Fort Walton Beach-Destin, FL.
Hood County	TX	23104	Dallas-Fort Worth-Arlington, TX.
Somervell County	TX	23104	Dallas-Fort Worth-Arlington, TX.
Baldwin County	AL	19300	Daphne-Fairhope-Foley, AL.
Monroe County	PA	20700	East Stroudsburg, PA.
Hudspeth County	TX	21340	El Paso, TX.
Adams County	PA	23900	Gettysburg, PA.
Hall County	NE	24260	Grand Island, NE.

TABLE 13—COUNTIES THAT WOULD TRANSITION FROM RURAL TO URBAN STATUS—Continued

County	State	New CBSA	Urban area (constituent counties)
Hamilton County	NE	24260	Grand Island, NE.
Howard County	NE	24260	Grand Island, NE.
Merrick County	NE	24260	Grand Island, NE.
Montcalm County	MI	24340	Grand Rapids-Wyoming, MI.
Josephine County	OR	24420	Grants Pass, OR.
Tangipahoa Parish	LA	25220	Hammond, LA.
Beaufort County	SC	25940	Hilton Head Island-Bluffton-Beaufort, SC.
Jasper County	SC	25940	Hilton Head Island-Bluffton-Beaufort, SC.
Citrus County	FL	26140	Homosassa Springs, FL.
Butte County	ID	26820	Idaho Falls, ID.
Yazoo County	MS	27140	Jackson, MS.
Crockett County	TN	27180	Jackson, TN.
Kalawao County	HI	27980	Kahului-Wailuku-Lahaina, HI.
Maui County	HI	27980	Kahului-Wailuku-Lahaina, HI.
Campbell County	TN	28940	Knoxville, TN.
Morgan County	TN	28940	Knoxville, TN.
Roane County	TN	28940	Knoxville, TN.
Acadia Parish	LA	29180	Lafayette, LA.
Iberia Parish	LA	29180	Lafayette, LA.
Vermilion Parish	LA	29180	Lafayette, LA.
Cotton County	OK	30020	Lawton, OK.
Scott County	IN	31140	Louisville/Jefferson County, KY-IN.
Lynn County	TX	31180	Lubbock, TX.
Green County	WI	31540	Madison, WI.
Benton County	MS	32820	Memphis, TN-MS-AR.
Midland County	MI	33220	Midland, MI.
Martin County	TX	33260	Midland, TX.
Le Sueur County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Mille Lacs County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Sibley County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Maury County	TN	34980	Nashville-Davidson-Murfreesboro-Franklin, TN.
Craven County	NC	35100	New Bern, NC.
Jones County	NC	35100	New Bern, NC.
Pamlico County	NC	35100	New Bern, NC.
St. James Parish	LA	35380	New Orleans-Metairie, LA.
Box Elder County	UT	36260	Ogden-Clearfield, UT.
Gulf County	FL	37460	Panama City, FL.
Custer County	SD	39660	Rapid City, SD.
Fillmore County	MN	40340	Rochester, MN.
Yates County	NY	40380	Rochester, NY.
Sussex County	DE	41540	Salisbury, MD-DE.
Worcester County	MA	41540	Salisbury, MD-DE.
Highlands County	FL	42700	Sebring, FL.
Webster Parish	LA	43340	Shreveport-Bossier City, LA.
Cochise County	AZ	43420	Sierra Vista-Douglas, AZ.
Plymouth County	IA	43580	Sioux City, IA-NE-SD.
Union County	SC	43900	Spartanburg, SC.
Pend Oreille County	WA	44060	Spokane-Spokane Valley, WA.
Stevens County	WA	44060	Spokane-Spokane Valley, WA.
Augusta County	VA	44420	Staunton-Waynesboro, VA.
Staunton City	VA	44420	Staunton-Waynesboro, VA.
Waynesboro City	VA	44420	Staunton-Waynesboro, VA.
Little River County	AR	45500	Texarkana, TX-AR.
Sumter County	FL	45540	The Villages, FL.
Pickens County	AL	46220	Tuscaloosa, AL.
Gates County	NC	47260	Virginia Beach-Norfolk-Newport News, VA-NC.
Falls County	TX	47380	Waco, TX.
Columbia County	WA	47460	Walla Walla, WA.
Walla Walla County	WA	47460	Walla Walla, WA.
Peach County	GA	47580	Warner Robins, GA.
Pulaski County	GA	47580	Warner Robins, GA.
Culpeper County	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV.
Rappahannock County	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV.
Jefferson County	NY	48060	Watertown-Fort Drum, NY.
Kingman County	KS	48620	Wichita, KS.
Davidson County	NC	49180	Winston-Salem, NC.
Windham County	CT	49340	Worcester, MA-CT.

We are proposing that when calculating the area wage index, the wage data for hospitals located in these counties would be included in their new respective urban CBSAs.

d. Urban Counties Moving to a Different Urban CBSA

In addition to rural counties becoming urban and urban counties becoming rural, several urban counties would shift from one urban CBSA to another urban CBSA under our proposal to adopt the new OMB delineations. In other cases, applying the new OMB delineations would involve a change only in CBSA name or number, while the CBSA continues to encompass the same constituent counties. For example, CBSA 29140 (Lafayette, IN), would experience both a change to its number and its name, and would become CBSA 29200 (Lafayette-West Lafayette, IN), while all of its three constituent counties would remain the same. We are not discussing these proposed changes in this section because they are inconsequential changes to the IRF PPS wage index. However, in other cases, if we adopt the new OMB delineations, counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs.

In one type of change, an entire CBSA would be subsumed by another CBSA. For example, CBSA 37380 (Palm Coast, FL) currently is a single county (Flagler, FL) CBSA. Flagler County would be a part of CBSA 19660 (Deltona-Daytona Beach-Ormond Beach, FL) under the new OMB delineations.

In another type of change, some CBSAs have counties that would split off to become part of, or to form, entirely new labor market areas. For example, CBSA 37964 (Philadelphia Metropolitan Division of MSA 37980) currently is comprised of five Pennsylvania counties (Bucks, Chester, Delaware, Montgomery, and Philadelphia). Under the new OMB delineations, Montgomery, Bucks, and Chester counties would split off and form the new CBSA 33874 (Montgomery County-Bucks County-Chester County, PA Metropolitan Division of MSA 37980), while Delaware and Philadelphia counties would remain in CBSA 37964.

Finally, in some cases, a CBSA would lose counties to another existing CBSA if we adopt the new OMB delineations. For example, Lincoln County and Putnam County, WV, would move from CBSA 16620 (Charleston, WV) to CBSA 26580 (Huntington-Ashland, WV–KY–OH). CBSA 16620 would still exist in the new labor market delineations with fewer constituent counties. Table 14 lists the urban counties that would move from one urban CBSA to another urban CBSA under the new OMB delineations.

TABLE 14—COUNTIES THAT WOULD CHANGE TO A DIFFERENT CBSA

Prior CBSA	New CBSA	County	State
11300	26900	Madison County	IN
11340	24860	Anderson County	SC
14060	14010	McLean County	IL
37764	15764	Essex County	MA
16620	26580	Lincoln County	WV
16620	26580	Putnam County	WV
16974	20994	DeKalb County	IL
16974	20994	Kane County	IL
21940	41980	Ceiba Municipio	PR
21940	41980	Fajardo Municipio	PR
21940	41980	Luquillo Municipio	PR
26100	24340	Ottawa County	MI
31140	21060	Meade County	KY
34100	28940	Grainger County	TN
35644	35614	Bergen County	NJ
35644	35614	Hudson County	NJ
20764	35614	Middlesex County	NJ
20764	35614	Monmouth County	NJ
20764	35614	Ocean County	NJ
35644	35614	Passaic County	NJ
20764	35084	Somerset County	NJ
35644	35614	Bronx County	NY
35644	35614	Kings County	NY
35644	35614	New York County	NY
35644	20524	Putnam County	NY
35644	35614	Queens County	NY
35644	35614	Richmond County	NY
35644	35614	Rockland County	NY
35644	35614	Westchester County	NY
37380	19660	Flagler County	FL
37700	25060	Jackson County	MS
37964	33874	Bucks County	PA
37964	33874	Chester County	PA
37964	33874	Montgomery County	PA
39100	20524	Dutchess County	NY
39100	35614	Orange County	NY
41884	42034	Marin County	CA
41980	11640	Arecibo Municipio	PR
41980	11640	Camuy Municipio	PR
41980	11640	Hatillo Municipio	PR
41980	11640	Quebradillas Municipio	PR
48900	34820	Brunswick County	NC
49500	38660	Guánica Municipio	PR
49500	38660	Guayanilla Municipio	PR
49500	38660	Peñuelas Municipio	PR
49500	38660	Yauco Municipio	PR

If providers located in these counties move from one CBSA to another under the new OMB delineations, there may be impacts, both negative and positive, upon their specific wage index values. As discussed below, we propose to implement a transition wage index to adjust for these possible impacts.

4. Transition Period

Overall, we believe implementing the new OMB delineations would result in wage index values being more representative of the actual costs of labor in a given area. Further, we recognize that some providers (10 percent) would have a higher wage index due to our proposed implementation of the new labor market area delineations. However, we also recognize that more providers (16 percent) would experience decreases in wage index values as a result of our proposed implementation of the new labor market area delineations. In prior years, we have provided for transition periods when adopting changes that have significant payment implications, particularly large negative impacts. As discussed in the FY 2006 IRF PPS final rule (70 FR 47921 through 47926), we evaluated several options to ease the transition to the new CBSA system.

In implementing the new CBSA delineations for FY 2016, we continue to have similar concerns as those expressed in the FY 2006 IRF PPS final rule. While we believe that implementing the latest OMB labor market area delineations would create a more accurate wage index system, we recognize that IRFs may experience decreases in their wage index as a result of the labor market area changes. Our analysis for the FY 2016 IRF PPS proposed rule indicates that a majority of IRFs either expect no change in the wage index or an increase in the wage index based on the new CBSA delineations. However, we found that 188 facilities will experience a decline in their wage index with 29 facilities experiencing a decline of 5 percent or more based on the CBSA changes. Therefore, we believe it would be appropriate to consider, as we did in FY 2006, whether or not a transition period should be used to implement these proposed changes to the wage index.

We considered having no transition period and fully implementing the proposed new OMB delineations beginning in FY 2016. This would mean that we would adopt the revised OMB delineations for all IRF providers on October 1, 2015. However, this would not provide any time for IRF providers to adapt to the new OMB delineations. As previously discussed, more IRFs would experience a decrease in wage index due to implementation of the proposed new OMB delineations than would experience an increase. Thus, we believe that it would be appropriate to provide for a transition period to mitigate the resulting short-term instability and negative impacts on these IRF providers, and to provide time for these IRFs to adjust to their new labor market area delineations.

Furthermore, in light of the comments received during the FY 2006 rulemaking cycle on our proposal in the FY 2006 IRF PPS proposed rule (70 FR 30238 through 30240) to adopt the new CBSA definitions without a transition period, we continue to believe that a transition period is appropriate. Therefore, we propose a similar transition methodology to that used in FY 2006. Specifically, for the FY 2016 IRF PPS, we are proposing to implement a budget-neutral one-year transition policy. We are proposing that all IRF providers would receive a one-year blended wage index using 50 percent of their FY 2016 wage index based on the proposed new OMB delineations and 50 percent of their FY 2016 wage index based on the OMB delineations used in FY 2015. We are proposing to apply this one-year blended wage index in FY 2016 for all geographic areas to assist providers in adapting to these proposed changes. We believe a one-year, 50/50 blend would mitigate the short-term instability and negative payment impacts due to the proposed implementation of the new OMB delineations. This transition policy would be for a one-year period, going into effect October 1, 2016, and continuing through September 30, 2017.

For FY 2006 it was determined that the transition to the current wage index system would have significant negative impacts upon IRFs that were originally considered rural, but would be considered urban under the new definitions. To alleviate the potentially decreased payments associated with switching from rural status to urban status in calculating the IRF area wage index for FY 2006, we implemented a 3-year budget-neutral phase-out of the rural adjustment for FY 2005 rural IRFs that became urban IRFs in FY 2006 and that experienced a loss in payment because of this redesignation. The 3-year transition period was afforded to these facilities because, as a group, they experienced a significant reduction in payments due to the labor market revisions and the loss of the rural adjustment. This adjustment was in addition to a one-year blended wage index (comprised of a 50/50 blend of the FY 2006 MSA-based wage index and the FY 2006 CBSA-based wage index) for all IRFs.

Our analysis for the FY 2016 proposed rule indicates that 22 IRFs will experience a change in either rural or urban designations. Of these, 19 facilities designated as rural in FY 2015 would be designated as urban in FY 2016. While 16 of these rural IRFs that would be designated as urban under the new CBSA delineations will experience an increase in their wage index, these IRFs will lose the 14.9 percent rural adjustment. In many cases, this loss exceeds the urban CBSA based increase in the wage index. Consistent with the transition policy adopted in FY 2006 (70 FR 47923 through 47927), we considered the appropriateness of applying a 3-year phase-out of the rural adjustment for IRFs located in rural counties that would become urban under the new OMB delineations, given the potentially significant payment impacts for these facilities. We continue to believe, as discussed in the FY 2006 IRF final rule (70 FR 47880), that the phase-out of the rural adjustment transition period for these facilities specifically is appropriate because, as a group, we expect these IRFs would experience a steeper and more abrupt reduction in their payments compared to other IRFs.

Therefore, in addition to the 1-year transition policy noted, we are proposing a budget-neutral three-year phase-out of the rural adjustment for existing FY 2015 rural IRFs that will become urban in FY 2016 and that experience a loss in payments due to changes from the new CBSA delineations. Accordingly, the incremental steps needed to reduce the impact of the loss of the FY 2015 rural adjustment of 14.9 percent will be phased out over FYs 2016, 2017 and 2018. This policy will allow rural IRFs which would be classified as urban in FY 2016 to receive two-thirds of the 2015 rural adjustment for FY 2016, as well as the blended wage index. For FY 2017, these IRFs will receive the full FY 2017 wage index and one-third of the FY 2015 rural adjustment. For FY 2018, these IRFs will receive the full FY 2018 wage index without a rural adjustment. We believe a three-year budget-neutral phase-out of the rural adjustment for IRFs that transition from rural to urban status under the new CBSA delineations would best accomplish the goals of mitigating the loss of the rural adjustment for existing FY 2015 rural IRFs. The purpose of the gradual phase-out of the rural adjustment for these facilities is to alleviate the significant payment implications for existing rural IRFs that may need time to adjust to the

loss of their FY 2015 rural payment adjustment or that experience a reduction in payments solely because of this redesignation. As stated, this policy is specifically for rural IRFs that become urban in FY 2016 and that experience a loss in payments due to changes from the new CBSA delineations. Thus we are not implementing a transition policy for urban facilities that become rural in FY 2016 because these IRFs will receive the full rural adjustment of 14.9 percent beginning October 1, 2015.

For the reasons discussed and based on similar concerns to those we expressed during the FY 2006 rulemaking cycle to the proposed adoption of the new CBSA definitions, we are proposing to implement a three-year budget-neutral phase-out of the rural adjustment for the group of IRFs that during FY 2015 were designated as rural and for FY 2016 are designated as urban under the new CBSA system. This is in addition to implementing a one-year blended wage index for all IRFs. We considered having no transition, but found that a multi-year transition policy would best provide a sufficient buffer for rural IRFs that may experience a reduction in payments due to being designated as urban. We believe that the incremental reduction of the FY 2015 rural adjustment is appropriate to mitigate a significant reduction in per case-payment. Alternative timeframes we considered for phasing out the rural adjustment for IRFs which would transition from rural to urban status in FY 2016, but we believe that a three-year budget-neutral phase-out of the rural adjustment would appropriately mitigate the adverse payment impacts for these IRFs while also ensuring that payment rates for these facilities are set accurately and appropriately. We invite public comment on the proposed policies to adopt the new OMB delineations.

The proposed wage index applicable to FY 2016 is set forth in Table A available on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html*. Table A provides a crosswalk between the FY 2015 wage index for a provider using the current OMB delineations in effect in FY 2015 and the FY 2016 wage index using the proposed revised OMB delineations, as well as the proposed transition wage index values for FY 2016.

To calculate the wage-adjusted facility payment for the payment rates set forth in this proposed rule, we multiply the unadjusted federal payment rate for IRFs by the FY 2016 labor-related share based on the proposed 2012-based IRF market basket (69.6 percent) to determine the labor-related portion of the standard payment amount. We then multiply the labor-related portion by the applicable IRF wage index from the tables in the addendum to this proposed rule. This table is available through the Internet on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html*.

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget-neutral manner. We calculate a budget-neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45689), codified at § 412.624(e)(1), as described in the steps below. We use the listed steps to ensure that the FY 2016 IRF standard payment conversion factor reflects the update to the wage indexes (based on the FY 2011 hospital cost report data) and the labor-related share in a budget-neutral manner:

Step 1. Determine the total amount of the estimated FY 2015 IRF PPS rates, using the FY 2015 standard payment conversion factor and the labor-related share and the wage indexes from FY 2015 (as published in the FY 2015 IRF PPS final rule (79 FR 45871)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the FY 2016 standard payment conversion factor and the FY 2016 proposed 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 2016 budget-neutral wage adjustment factor of 1.0027.

Step 4. Apply the FY 2016 budget-neutral wage adjustment factor from step 3 to the FY 2015 IRF PPS standard payment conversion factor after the application of the adjusted proposed market basket update to determine the FY 2016 standard payment conversion factor.

We discuss the calculation of the standard payment conversion factor for FY 2016 in section V.G of this proposed rule.

We invite public comment on the proposed IRF wage adjustment for FY 2016.

G. Description of the Proposed IRF Standard Payment Conversion Factor and Payment Rates for FY 2016

To calculate the proposed standard payment conversion factor for FY 2016, as illustrated in Table 15, we begin by applying the proposed adjusted market basket increase factor for FY 2016 that was adjusted in accordance with sections 1886(j)(3)(C) and (D) of the Act, to the standard payment conversion factor for FY 2015 ($15,198). Applying the proposed 1.9 percent adjusted market basket increase for FY 2016 to the standard payment conversion factor for FY 2015 of $15,198 yields a standard payment amount of $15,487. Then, we apply the proposed budget neutrality factor for the FY 2016 wage index and labor-related share of 1.0027, which results in a proposed standard payment amount of $15,529. We next apply the proposed budget neutrality factors for the revised CMG relative weights of 1.0000, which results in the proposed standard payment conversion factor of $15,529 for FY 2016.

TABLE 15—CALCULATIONS TO DETERMINE THE PROPOSED FY 2016 STANDARD PAYMENT CONVERSION FACTOR

Explanation for adjustment		Calculations
Standard Payment Conversion Factor for FY 2015		$15,198
Market Basket Increase Factor for FY 2016 (2.7 percent), reduced by 0.6 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and reduced by 0.2 percentage point in accordance with paragraphs 1886(j)(3)(C) and (D) of the Act	×	1.019
Budget Neutrality Factor for the Wage Index and Labor-Related Share	×	1.0027
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	×	1.0000
Proposed FY 2016 Standard Payment Conversion Factor	=	15,529

We invite public comment on the proposed FY 2016 standard payment conversion factor.

After the application of the proposed CMG relative weights described in section III of this proposed rule, to the proposed FY 2016 standard payment conversion factor ($15,529), the resulting proposed unadjusted IRF

prospective payment rates for FY 2016 are shown in Table 16.

TABLE 16—PROPOSED FY 2016 PAYMENT RATES

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
0101	$12,538.11	$10,982.11	$10,225.85	$9,783.27
0102	15,859.77	13,892.24	12,934.10	12,373.51
0103	17,712.38	15,515.02	14,445.08	13,819.26
0104	19,228.01	16,842.75	15,681.18	15,002.57
0105	22,548.11	19,749.78	18,387.89	17,592.80
0106	25,141.45	22,021.67	20,504.49	19,616.23
0107	28,129.23	24,639.86	22,940.99	21,947.14
0108	35,693.41	31,264.54	29,109.11	27,848.16
0109	32,590.71	28,546.96	26,577.88	25,427.18
0110	42,816.56	37,504.09	34,918.51	33,405.98
0201	12,682.53	10,421.51	9,404.36	8,884.14
0202	16,426.58	13,497.81	12,180.95	11,506.99
0203	18,721.76	15,383.03	13,881.37	13,114.24
0204	20,616.30	16,940.59	15,286.75	14,441.97
0205	24,622.78	20,231.18	18,257.45	17,248.06
0206	29,498.89	24,239.22	21,874.15	20,662.89
0207	39,209.17	32,216.46	29,073.39	27,466.14
0301	17,299.31	14,440.42	13,243.13	12,357.98
0302	21,616.37	18,044.70	16,547.70	15,440.48
0303	25,121.26	20,970.36	19,231.11	17,945.31
0304	33,356.29	27,843.50	25,534.33	23,827.70
0401	15,469.99	13,167.04	12,056.72	11,145.16
0402	22,214.23	18,906.56	17,313.28	16,004.19
0403	35,511.72	30,224.09	27,677.34	25,584.03
0404	59,966.79	51,036.06	46,736.08	43,201.68
0405	53,172.85	45,254.61	41,442.24	38,306.94
0501	13,465.20	10,730.54	9,963.41	9,146.58
0502	17,729.46	14,128.28	13,118.90	12,041.19
0503	22,406.79	17,856.80	16,578.76	15,218.42
0504	25,785.90	20,547.97	19,078.93	17,513.61
0505	30,179.06	24,049.76	22,329.15	20,498.28
0506	42,192.29	33,623.39	31,219.50	28,657.22
0601	16,131.53	12,729.12	11,878.13	10,732.09
0602	20,721.90	16,350.48	15,257.24	13,786.65
0603	25,731.55	20,302.61	18,946.93	17,119.17
0604	33,808.19	26,675.72	24,894.54	22,493.76
0701	15,005.67	12,564.51	11,899.87	10,809.74
0702	19,476.47	16,308.56	15,446.70	14,030.45
0703	23,318.35	19,526.16	18,493.49	16,797.72
0704	30,337.45	25,403.89	24,060.63	21,853.96
0801	12,458.92	9,812.78	8,902.78	8,222.61
0802	16,428.13	12,938.76	11,739.92	10,840.79
0803	22,135.04	17,434.41	15,817.84	14,608.13
0804	19,794.82	15,591.12	14,145.37	13,062.99
0805	23,871.18	18,800.96	17,058.61	15,754.17
0806	29,700.77	23,392.89	21,225.04	19,600.70
0901	14,827.09	11,924.72	10,929.31	9,963.41
0902	19,752.89	15,887.72	14,561.54	13,272.64
0903	24,647.63	19,825.87	18,170.48	16,563.23
0904	31,152.73	25,057.59	22,965.84	20,934.64
1001	16,749.58	14,684.22	13,075.42	11,798.93
1002	20,774.70	18,212.41	16,216.93	14,632.98
1003	29,818.79	26,143.07	23,277.97	21,004.53
1101	21,021.61	21,021.61	16,698.33	15,690.50
1102	27,550.00	27,550.00	21,885.02	20,563.50
1201	15,261.90	14,817.77	13,493.15	12,587.81
1202	18,591.32	18,050.91	16,437.45	15,334.89
1203	23,080.75	22,409.90	20,405.11	19,037.00
1301	18,075.76	14,893.86	14,044.43	12,823.85
1302	23,001.55	18,953.14	17,872.33	16,319.43
1303	30,609.21	25,220.65	23,781.11	21,715.75
1401	14,084.80	11,575.32	10,468.10	9,419.89
1402	18,692.26	15,362.84	13,892.24	12,500.85
1403	22,531.03	18,516.78	16,744.92	15,067.79
1404	28,495.72	23,419.28	21,176.90	19,055.64
1501	16,317.87	13,145.30	12,103.30	11,645.20
1502	20,712.58	16,685.91	15,362.84	14,782.06
1503	25,129.03	20,243.60	18,637.91	17,934.44

TABLE 16—PROPOSED FY 2016 PAYMENT RATES—Continued

CMG	Payment rate tier 1	Payment rate tier 2	Payment rate tier 3	Payment rate no comorbidity
1504	31,255.22	25,180.27	23,181.69	22,305.86
1601	17,715.48	13,025.73	12,795.90	11,766.32
1602	23,040.38	16,940.59	16,643.98	15,302.28
1603	29,762.88	21,885.02	21,499.90	19,768.42
1701	16,676.59	14,145.37	12,907.70	12,013.23
1702	21,563.57	18,291.61	16,690.57	15,532.11
1703	24,675.58	20,931.54	19,099.12	17,774.49
1704	32,446.29	27,523.60	25,113.50	23,372.70
1801	19,765.31	14,974.61	13,682.60	12,174.74
1802	29,000.41	21,970.43	20,075.89	17,863.01
1803	46,979.88	35,592.47	32,520.83	28,938.29
1901	17,859.90	15,527.45	15,100.40	13,201.20
1902	34,892.11	30,334.35	29,500.44	25,792.12
1903	55,992.92	48,678.76	47,340.16	41,387.89
2001	14,410.91	11,842.42	10,923.10	9,887.31
2002	18,637.91	15,316.25	14,126.73	12,788.13
2003	23,200.33	19,064.95	17,585.04	15,917.23
2004	29,882.45	24,556.01	22,650.60	20,502.94
2101	26,278.17	26,278.17	20,397.34	19,787.05
5001				2,425.63
5101				11,187.09
5102				26,340.29
5103				12,311.39
5104				29,533.05

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

Table 17 illustrates the methodology for adjusting the proposed federal prospective payments (as described in sections V.A. through V.F. of this proposed rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified into CMG 0110 (without comorbidities). The proposed unadjusted federal prospective payment rate for CMG 0110 (without comorbidities) appears in Table 16.

Example: One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a rural non-teaching hospital has a Disproportionate Share Hospital (DSH) percentage of 5 percent (which would result in a LIP adjustment of 1.0156), a wage index of 0.8416, and a rural adjustment of 14.9 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0454 percent), a wage index of 0.8599, and a teaching status adjustment of 0.0784.

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 16. Then, we multiply the labor-related share for FY 2016 (69.6 percent) described in section V.D. of this proposed rule by the proposed unadjusted federal prospective payment rate. To determine the non-labor portion of the proposed federal prospective payment rate, we subtract the labor portion of the proposed federal payment from the proposed unadjusted federal prospective payment.

To compute the proposed wage-adjusted federal prospective payment, we multiply the labor portion of the proposed federal payment by the appropriate proposed transition wage index, which may be found in Table A. This table is available through the Internet on the CMS Web site at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/*. The resulting figure is the wage-adjusted labor amount. Next, we compute the proposed wage-adjusted federal payment by adding the wage-adjusted labor amount to the non-labor portion.

Adjusting the proposed wage-adjusted federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted federal prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.0784, 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 17 illustrates the components of the adjusted payment calculation.

TABLE 17—EXAMPLE OF COMPUTING THE IRF FY 2016 FEDERAL PROSPECTIVE PAYMENT

Steps			Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)
1	Unadjusted Federal Prospective Payment		$33,405.98		$33,405.98
2	Labor Share	×	0.696	×	0.696
3	Labor Portion of Federal Payment	=	$23,250.56	=	$23,250.56
4	CBSA-Based Wage Index (shown in the Addendum, Tables 1 and 2)	×	0.8416	×	0.8599
5	Wage-Adjusted Amount	=	$19,567.67	=	$19,993.16
6	Non-Labor Amount	+	$ 10,155.42	+	$10,155.42

TABLE 17—EXAMPLE OF COMPUTING THE IRF FY 2016 FEDERAL PROSPECTIVE PAYMENT—Continued

Steps			Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)
7	Wage-Adjusted Federal Payment	=	$29,723.09	=	$30,148.58
8	Rural Adjustment	×	1.149	×	1.000
9	Wage- and Rural-Adjusted Federal Payment	=	$34,151.83	=	$30,148.58
10	LIP Adjustment	×	1.0156	×	1.0454
11	FY 2016 Wage-, Rural- and LIP-Adjusted Federal Prospective Payment Rate	=	$34,684.60	=	$31,517.33
12	FY 2016 Wage- and Rural-Adjusted Federal Prospective Payment		$34,151.83		$30,148.58
13	Teaching Status Adjustment	×	0	×	0.0784
14	Teaching Status Adjustment Amount	=	$0.00	=	$2,363.65
15	FY 2016 Wage-, Rural-, and LIP-Adjusted Federal Prospective Payment Rate	+	$34,684.60	+	$31,517.33
16	Total FY 2016 Adjusted Federal Prospective Payment	=	$34,684.60	=	$33,880.97

Thus, the proposed adjusted payment for Facility A would be $34,684.60, and the proposed adjusted payment for Facility B would be $33,880.97.

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

A. Proposed Update to the Outlier Threshold Amount for FY 2016

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of a case by multiplying the IRF's overall CCR by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, we make an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

In the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), we discussed our rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments. For the 2002 IRF PPS final rule, we analyzed various outlier policies using 3, 4, and 5 percent of the total estimated payments, and we concluded that an outlier policy set at 3 percent of total estimated payments would optimize the extent to which we could reduce the financial risk to IRFs of caring for high-cost patients, while still providing for adequate payments for all other (non-high cost outlier) cases.

Subsequently, we updated the IRF outlier threshold amount in the FYs 2006 through 2015 IRF PPS final rules and the FY 2011 and FY 2013 notices (70 FR 47880, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, 75 FR 42836, 76 FR 47836, 76 FR 59256, and 77 FR 44618, 78 FR 47860, 79 FR 45872, respectively) to maintain estimated outlier payments at 3 percent of total estimated payments. We also stated in the FY 2009 final rule (73 FR 46370 at 46385) that we would continue to analyze the estimated outlier payments for subsequent years and adjust the outlier threshold amount as appropriate to maintain the 3 percent target.

To update the IRF outlier threshold amount for FY 2016, we propose to use FY 2014 claims data and the same methodology that we used to set the initial outlier threshold amount in the FY 2002 IRF PPS final rule (66 FR 41316 and 41362 through 41363), which is also the same methodology that we used to update the outlier threshold amounts for FYs 2006 through 2015. Based on an analysis of this updated data, we estimate that IRF outlier payments as a percentage of total estimated payments are approximately 3.2 percent in FY 2015. Therefore, we propose to update the outlier threshold amount to $9,698 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2016.

We invite public comment on the proposed update to the FY 2016 outlier threshold amount to maintain estimated outlier payments at approximately 3 percent of total estimated IRF payments.

B. Proposed Update to the IRF Cost-to-Charge Ratio Ceiling and Urban/Rural Averages

In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR 45674, 45692 through 45694), we apply a ceiling to IRFs' CCRs. Using the methodology described in that final rule, we propose to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2016, 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 2016, as discussed below.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2016, we propose to estimate a national average CCR of 0.569 for rural IRFs, which we calculated by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, we propose to estimate a national average CCR of 0.437 for urban IRFs, which we calculated by taking an average of the CCRs for all urban IRFs using their most recently submitted cost report data. We apply weights to both of these averages using the IRFs' estimated costs, meaning that the CCRs of IRFs with higher costs factor more heavily into the averages than the CCRs of IRFs with lower costs. For this proposed rule, we have used the most recent available cost report data (FY 2013). This includes all IRFs whose cost reporting periods begin on or after October 1, 2012, and before October 1, 2013. If, for any IRF, the FY 2013 cost report was missing or had an ''as submitted'' status, we used data from a previous fiscal year's (that is, FY 2004 through FY 2012) settled cost report for that IRF. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care.

In accordance with past practice, we propose to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, the proposed national CCR ceiling would be 1.36 for

FY 2016. This means that, if an individual IRF's CCR exceeds this proposed ceiling of 1.36 for FY 2016, we would replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF). We calculated the proposed national CCR ceiling by:

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

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

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

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

The proposed national average rural and urban CCRs and the proposed national CCR ceiling in this section will be updated in the final rule if more recent data becomes available to use in these analyses.

We invite public comment on the proposed update to the IRF CCR ceiling and the urban/rural averages for FY 2016.

VII. ICD–10–CM Implementation for IRF PPS

In the FY 2015 IRF PPS final rule (79 FR 45872), we finalized conversions from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM) to the ICD–10–CM for the IRF PPS, which will be effective when ICD–10–CM becomes the required medical data code set for use on Medicare claims and IRF–PAI submissions. We remind providers of IRF services that the implementation date for ICD–10–CM is October 1, 2015. The ICD–10–CM lists are available for download from the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html*.

VIII. Revisions and Updates to the IRF QRP

A. Background and Statutory Authority

Section 3004(b) of the Affordable Care Act amended section 1886(j)(7) of the Act, requiring the Secretary to establish the IRF QRP. This program applies to freestanding IRFs, as well as IRF units affiliated with either acute care facilities or critical access hospitals (CAHs). Beginning with the FY 2014 payment determination and subsequent years, the Secretary is required to reduce any annual update to the standard federal rate for discharges occurring during such fiscal year by 2 percentage points for any IRF that does not comply with the requirements established by the Secretary.

The Act requires that for the FY 2014 payment determination and subsequent years, each IRF submit data on quality measures specified by the Secretary in a form and manner, and at a time, specified by the Secretary. The Secretary is required to specify quality measures that are endorsed by the entity that holds the contract with the Secretary under section 1890(a) of the Act. This entity is currently the NQF. Information regarding the NQF is available at: *http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx*. The Act authorizes an exception under which the Secretary may specify non-endorsed quality measures for specified areas or medical topics determined appropriate by the Secretary for which a feasible or practical measure has not been endorsed by the NQF, as long as due consideration is given to NQF-endorsed measures or measures adopted by a consensus organization identified by the Secretary.

Additionally, section 2(a) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113–185, enacted on Oct. 6, 2014), amended title XVIII of the Act by adding section 1899B, titled Standardized Post-Acute Care (PAC) Assessment Data for Quality, Payment and Discharge Planning. Section 1899B(c)(1) requires that the Secretary specify not later than the applicable specified application date, as defined in section 1899B(a)(2)(E), quality measures on which IRF providers are required to submit standardized patient assessment data described in section 1899B(b)(1) and other necessary data specified by the Secretary. Section 1899B(c)(2)(A) requires, to the extent possible, the submission of the such quality measure data through the use of a PAC assessment instrument and the modification of such instrument as necessary to enable such use; for IRFs, this requirement refers to the IRF–PAI. In addition, section 1899B(d)(1) requires that the Secretary specify not later than the applicable specified application date, resource use and other measures on which IRF providers are required to submit any necessary data specified by the Secretary, which may include standardized assessment data in addition to claims data. Furthermore, section 2(c)(2) of the IMPACT Act amended section 1886(j)(7) of the Act by adding section 1886(j)(7)(F)(i), which requires IRF providers to submit to the Secretary data on the quality, resource use, and other measures required under sections 1899B(c)(1) and (d)(1) of the Act. Additionally, section 1886(j)(7)(F)(ii) requires that, beginning in FY 2019 and for each subsequent year, providers submit standardized patient assessment data required under section 1899B(b)(1). Under section 1886(j)(7)(F)(iii), the required data must be submitted in the form and manner, and at the time, specified by the Secretary.

Section 1899B(c)(1) and (d)(1) of the Act direct CMS to specify measures that relate to at least five stated quality domains and three stated resource use and other measure domains. The quality measures specified under section 1899B(c)(1) must be with respect to at least the following domains:

- Functional status, cognitive function, and changes in function and cognitive function;
- Skin integrity and changes in skin integrity;
- Medication reconciliation;
- Incidence of major falls; and
- Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual when the individual transitions (1) from a hospital or CAH to another applicable setting, including a PAC provider or the home of the individual, or (2) from a PAC provider to another applicable setting, including a different PAC provider, hospital, CAH, or the home of the individual.

The resource use and other measures specified under section 1899B(d)(1) must be with respect to at least the following domains:

- Resource use measures, including total estimated Medicare spending per beneficiary;
- Discharge to community; and
- Measures to reflect all-condition risk-adjusted potentially preventable hospital readmissions rates.

Sections 1899B(c) and (d) of the Act indicate that data satisfying the eight measure domains in the IMPACT Act is the minimum data reporting requirement. Therefore, we may specify additional measures and additional domains.

Section 1899B(e)(2)(A) of the Act requires that each measure specified by the Secretary under that section be

endorsed by the entity that holds the contract with the Secretary under section 1890(a) of the Act. This entity is currently the NQF. Information regarding the NQF is available at: *http://www.qualityforum.org/Measuring_Performance/Measuring_Performance.aspx.* However, under section 1899B(e)(2)(B), the Secretary may specify a measure that has not been so endorsed in the case of a specified area of medical topic determined appropriate by the Secretary for which a feasible or practical measure has not been endorsed, as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

Section 1899B(e)(3) of the Act mandates the use of the pre-rulemaking process of section 1890A with respect to the measures specified under sections 1899B(c) and (d) and provides that the Secretary may use expedited procedures, such as ad-hoc reviews, as necessary in the case of a measure required with respect to data submissions during the 1-year period before the applicable specified application date. In addition, section 1899B(e)(3)(B)(ii) gives the Secretary the option to waive the pre-rulemaking process for a measure if the pre-rulemaking process (including through the use of expedited procedures) would result in the inability of the Secretary to satisfy any deadline specified in section 1899B with respect to the measure.

Section 1886(j)(7)(E) of the Act requires the Secretary to establish procedures for making data submitted under the IRF QRP available to the public, and section 1899B(g) requires public reporting of the performance of individual providers on the quality, resource use, and other measures beginning not later than 2 years after the applicable specified application date. The Secretary must ensure, including through a process consistent with the provisions of section 1886(b)(3)(B)(viii)(VII), that each IRF is given the opportunity to review the data and information that is to be made public and to submit corrections prior to the publication or posting of this data. Public reporting of data and information under subsection (g)(1) must be consistent with the provisions of section 1886(j)(7)(E). In addition, section 1899B(f)(1), as added by the IMPACT Act, requires the Secretary to make confidential feedback reports available to post-acute providers on their performance on the measures required under section 1899B(c)(1) and (d)(1), beginning 1 year after the applicable specified application date.

For more information on the statutory history of the IRF QRP, please refer to the FY 2015 IRF PPS final rule (79 FR 45908). More information on the IMPACT Act is available at *https://www.govtrack.us/congress/bills/113/hr4994.*

As previously stated, the IMPACT Act adds a new section 1899B to the Act that imposes new data reporting requirements for certain post-acute care (PAC) providers, including IRFs. Sections 1899B(c)(1) and 1899B(d)(1) of the Act collectively require that the Secretary specify quality measures and resource use and other measures with respect to certain domains not later than the specified application date that applies to each measure domain and PAC provider setting. Section 1899B(a)(2)(E) of the Act delineates the specified application dates for each measure domain and PAC provider. The IMPACT Act also amends various sections of the Act, including section 1886(j)(7), to require the Secretary to reduce the otherwise applicable PPS payment to a PAC provider that does not report the new data in a form and manner, and at a time, specified by the Secretary. For IRFs, amended section 1886(j)(7)(A)(i) would require the Secretary to reduce the payment update for any IRF that does not satisfactorily submit the new required data.

Under the current IRF QRP, the general timeline and sequencing of measure implementation occurs as follows: specification of measures; proposal and finalization of measures through notice-and-comment rulemaking; IRF submission of data on the adopted measures; analysis and processing of the submitted data; notification to IRFs regarding their quality reporting compliance with respect to a particular FY; consideration of any reconsideration requests; and imposition of a payment reduction in a particular FY for failure to satisfactorily submit data with respect to that FY. Any payment reductions that are taken with respect to a FY begin approximately one year after the end of the data submission period for that fiscal year and approximately 2 years after we first adopt the measure.

To the extent that the IMPACT Act could be interpreted to shorten this timeline so as to require us to reduce an IRF's PPS payment for failure to satisfactorily submit data on a measure specified under section 1899B(c)(1) or (d)(1) of the Act beginning with the same FY as the specified application date for that measure, such a timeline would not be feasible. The current timeline discussed above reflects operational and other practical constraints, including the time needed to specify and adopt valid and reliable measures, collect the data, and determine whether an IRF has complied with our quality reporting requirements. It also takes into consideration our desire to give IRFs enough notice of new data reporting obligations so that they are prepared to timely start reporting the data. Therefore, we intend to follow the same timing and sequence of events for measures specified under section 1899B(c)(1) and (d)(1) of the Act that we currently follow for other measures specified under the IRF QRP. We intend to specify each of these measures no later than the specified application dates set forth in section 1899B(a)(2)(E) of the Act and propose to adopt them consistent with the requirements in the Act and Administrative Procedure Act. To the extent that we finalize a proposal to adopt a measure for the IRF QRP that satisfies an IMPACT Act measure domain, we intend to require IRFs to report data on the measure for the fiscal year that begins 2 years after the specified application date for that measure. Likewise, we intend to require IRFs to begin reporting any other data specifically required under the IMPACT Act for the FY that begins 2 years after we adopt requirements that would govern the submission of that data.

B. General Considerations Used for Selection of Quality, Resource Use, and Other Measures for the IRF QRP

We refer readers to the FY 2015 IRF PPS final rule (79 FR 45911) for a detailed discussion of the considerations we use for the selection of IRF QRP quality measures. In this proposed rule, we apply the same considerations to the selection of quality, resource use, and other measures required under section 1899B for the IRF QRP, in addition to the considerations discussed below.

The quality measures we are proposing address the measure domains that the Secretary is required to specify under sections 1899B(c)(1) and (d)(1) of the Act. The totality of the measures considered to meet the requirements of the IMPACT Act will evolve, and additional measures will be proposed over time as they become available.

To meet the first specified application date applicable to IRFs under section 1899B(a)(2)(E) of the Act, which is October 1, 2016, we have focused on measures that:

- Correspond to a measure domain in sections 1899B(c)(1) or (d)(1) of the Act and are setting-agnostic: for example,

falls with major injury and the incidence of pressure ulcers;

- Are currently adopted for 1 or more of our PAC quality reporting programs, are already either NQF-endorsed and in use or finalized for use, or already previewed by the Measure Applications Partnership (MAP) with support;
- Minimize added burden on IRFs;
- Minimize or avoid, to the extent feasible, revisions to the existing items in assessment tools currently in use (for example, the IRF–PAI); and
- Where possible, the avoidance duplication of existing assessment items.

In our selection and specification of measures, we employ a transparent process in which we seek input from stakeholders and national experts and engage in a process that allows for pre-rulemaking input on each measure, as required by section 1890A of the Act. This process is based on a private-public partnership, and it occurs via the MAP. The MAP is composed of multi-stakeholder groups convened by the NQF, our current contractor under section 1890 of the Act, to provide input on the selection of quality and efficiency measures described in section 1890(b)(7)(B). The NQF must convene these stakeholders and provide us with the stakeholders' input on the selection of such measures. We, in turn, must take this input into consideration in selecting such measures. In addition, the Secretary must make available to the public by December 1 of each year a list of such measures that the Secretary is considering under Title XVIII of the Act.

As discussed in section VIII.A. of this proposed rule 1899B(e)(3) provides that the pre-rulemaking process required by section 1890A of the Act applies to the measures required under section 1899B, subject to certain exceptions for expedited procedures or, alternatively, waiver of section 1890A.

We initiated an ad hoc MAP process for the review of the quality measures under consideration for proposal, in preparation for adoption of those quality measures into the IRF QRP that are required by the IMPACT Act, and that must be implemented by October 1, 2016. The List of Measures under Consideration (MUC List) under the IMPACT Act was made public on February 5, 2015. Under the IMPACT Act, these measures must be standardized so they can be applied across PAC settings and must correspond to measure domains specified in sections 1899B(c)(1) and (d)(1) of the IMPACT Act. The MAP reviewed each IMPACT Act-related quality measure proposed in this proposed rule for the IRF QRP, in light of its intended cross-setting use. We refer to sections VIII.F. and VIII.G. of this proposed rule for more information on the MAP's recommendations. The MAP's final report, MAP Off-Cycle Deliberations 2015: Measures under Consideration to Implement Provisions of the IMPACT Act: Final Report, is available at *http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx*.

As discussed in section VIII.A. of this proposed rule, section 1899B(j) of the Act, requires that we allow for stakeholder input, such as through town halls, open door forums, and mailbox submissions, before the initial rulemaking process to implement section 1899B. To meet this requirement, we provided the following opportunities for stakeholder input: Our measure development contractor(s) convened a technical expert panel (TEP) that included stakeholder experts and patient representatives on February 3, 2015; we provided 2 separate listening sessions on February 10th and March 24, 2015; we sought public input during the February 9th 2015 ad hoc MAP process provided for the sole purpose of reviewing the measures we are proposing in response to the IMPACT Act. Additionally, we implemented a public mail box for the submission of comments in January, 2015, *PACQuality Initiative@cms.hhs.gov,* which is listed on our post-acute care quality initiatives Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html,* and held a National Stakeholder Special Open Door Forum to seek input on the measures on February 25, 2015. The slides from the Special Open Door Forum are available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html*.

For measures that do not have NQF endorsement, or which are not fully supported by the MAP for the IRF QRP, we are proposing for the IRF QRP for the purposes of satisfying the measure domains required under the IMPACT Act that most closely align with the national priorities identified in the National Quality Strategy (*http://www.ahrq.gov/workingforquality/*) and for which the MAP supports the measure concept. Further discussion as to the importance and high-priority status of these measures in the IRF setting is included under each quality measure proposal in this proposed rule. In addition, for measures not endorsed by the NQF, we have sought, to the extent practicable, to adopt measures that have been endorsed or adopted by a national consensus organization, recommended by multi-stakeholder organizations, and/or developed with the input of providers, purchasers/payers, and other stakeholders.

C. Policy for Retention of IRF QRP Measures Adopted for Previous Payment Determinations

In the CY 2013 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) Payment Systems and Quality Reporting Programs final rule (77 FR 68500 through 68507), we adopted a policy that would allow any quality measure adopted for use in the IRF QRP to remain in effect until the measure was actively removed, suspended, or replaced. For the purpose of streamlining the rulemaking process, when we initially adopt a measure for the IRF QRP for a payment determination, this measure will also be adopted for all subsequent years or until we propose to remove, suspend, or replace the measure. For further information on how measures are considered for removal, suspension, or replacement, please refer to the CY 2013 OPPS/ASC final rule (77 FR 68500 through 68507).

We are not proposing any changes to this policy for retaining IRF QRP measures adopted for previous payment determinations.

D. Policy for Adopting Changes to IRF QRP Measures

In the CY 2013 OPPS/ASC final rule (77 FR 68500 through 68507), we adopted a subregulatory process to incorporate NQF updates to IRF quality measure specifications that do not substantively change the nature of the measure. Substantive changes will be proposed and finalized through rulemaking. Regarding what constitutes a substantive versus a nonsubstantive change, we expect to make this determination on a measure-by-measure basis. Examples of such nonsubstantive changes might include updated diagnosis or procedure codes; medication updates for categories of medications, broadening of age ranges, and changes to exclusions for a measure. The subregulatory process for nonsubstantive changes will include revision of the IRF PAI Manual and posting of updates on CMS Web site at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html*.

Examples of changes that we might consider to be substantive would be those in which the changes are so significant that the measure is no longer the same measure, or when a standard of performance assessed by a measure becomes more stringent, such as changes in acceptable timing of medication, procedure/process, test administration, or expansion of the measure to a new setting.

We are not proposing any changes to this policy for adopting changes to IRF QRP measures.

E. Quality Measures Previously Finalized for and Currently Used in the IRF QRP

1. Measures Finalized in the FY 2012 IRF PPS Final Rule

In the FY 2012 IRF PPS final rule (76 FR 47874 through 47878), we adopted applications of two quality measures for use in the first data reporting cycle of the IRF QRP: (1) An application of Catheter-Associated Urinary Tract Infection (CAUTI) for Intensive Care Unit Patients (NQF#0138); and (2) an application of Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678). We adopted applications of these 2 measures because neither of them, at the time, was endorsed by the NQF for the IRF setting. We also discussed our plans to propose a 30-Day All-Cause Risk-Standardized Post-IRF Discharge Hospital Readmission Measure.

2. Measures Finalized in the CY 2013 OPPS/ASC Final Rule

In the CY 2013 OPPS/ASC final rule (77 FR 68500 through 68507), we adopted:

a. National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure (NQF #0138)

In the CY 2013 OPPS/ASC final rule, we adopted the NHSN CAUTI Outcome Measure (NQF #0138) (replacing an application of this measure that we initially adopted in the FY 2012 IRF PPS (76 FR 47874 through 47886)). Data submission for the NQF-endorsed measure applies to the FY 2015 adjustments to the IRF PPS annual increase factor and all subsequent annual increase factors (77 FR 68504 through 68505). Additional information about this measure can be found at *http://www.qualityforum.org/QPS/0138*. IRFs submit their CAUTI measure data to the Centers for Disease Control and Prevention (CDC) NHSN. Details regarding submission of IRF CAUTI data to the NHSN can be found at the NHSN Web site at *http://www.cdc.gov/nhsn/inpatient-rehab/index.html*.

b. Application of Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678)

In the CY 2013 OPPS/ASC final rule (77 FR 68500 through 68507), we adopted a non-risk-adjusted application of this measure.

3. Measures Finalized in the FY 2014 IRF/PPS Final Rule

For the FY 2016 adjustments to the IRF PPS annual increase factor, we finalized the adoption of one additional measure: Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) (78 FR 47902 through 47921). In addition, for the FY 2017 adjustments to the IRF PPS annual increase factor, we finalized the adoption of three additional quality measures: (1) All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Inpatient Rehabilitation Facilities; (2) Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680); and (3) the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678). In the FY 2014 IRF PPS final rule (78 FR 47912 through 47916), we also adopted a revised version of the IRF–PAI (Version 1.2), which providers began using as of October 1, 2014, for the FY 2017 adjustments to the IRF PPS annual increase factor and subsequent year annual increase factors.

a. Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)

In the FY 2014 IRF PPS final rule (78 FR 47905 through 47906), we adopted the CDC-developed Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) quality measure that is collected by the CDC via the NHSN. We finalized that the Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) measure have its own reporting period to align with the influenza vaccination season, which is defined by the CDC as October 1 (or when the vaccine becomes available) through March 31. We further finalized that IRFs submit their data for this measure to the NHSN (*http://www.cdc.gov/nhsn/*). We also finalized that for the FY 2016 adjustments to the IRF PPS annual increase factor, data collection will cover the period from October 1, 2014 (or when the vaccine becomes available) through March 31, 2015.

Details related to the use of the NHSN for data submission and information on definitions, numerator data, denominator data, data analyses, and measure specifications for the Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) measure can be found at *http://www.cdc.gov/nhsn/inpatient-rehab/hcp-vacc/index.html* and at *http://www.qualityforum.org/QPS/0431*. While IRFs can enter information in NHSN at any point during the influenza vaccination season for the Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) measure, data submission is only required once per influenza vaccination season. We finalized that the final deadline for data submission associated with this quality measure is May 15th of each year.

b. All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge From Inpatient Rehabilitation Facilities (NQF #2502)

In the FY 2014 IRF PPS final rule (78 FR 47906 through 47910), we adopted an All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs. This quality measure estimates the risk-standardized rate of unplanned, all-cause hospital readmissions for cases discharged from an IRF who were readmitted to a short-stay acute care hospital or LTCH, within 30 days of an IRF discharge. We noted that this is a claims-based measure that will not require reporting of new data by IRFs and thus will not be used to determine IRF reporting compliance for the IRF QRP.

c. Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680)

In the FY 2014 IRF PPS final rule (78 FR 47906 through 47911), we adopted the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680) measure for the IRF QRP.

We added the data elements needed for this measure to the ''Quality Indicator'' section of the IRF–PAI Version 1.2, which became effective on October 1, 2014. These data elements are harmonized with data elements (O0250: Influenza Vaccination Status) from the Minimum Data Set (MDS) 3.0 and the LTCH CARE Data Set Version 2.01, and the specifications and data elements for this measure are available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html.*

For purposes of this quality measure, the influenza vaccination season is October 1 (or when the vaccine becomes available) through March 31 each year. We also finalized that for the FY 2017 adjustments to the IRF PPS annual increase factor, data collection covers the period from October 1, 2014 (or when the vaccine becomes available) through March 31, 2015.

The measure specifications for this measure can be found on the CMS Web site at *http://www.qualityforum.org/QPS/0680*.

d. Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678)

In the FY 2014 IRF PPS final rule (78 FR 47911 through 47912), we adopted the NQF-endorsed version of the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678), with data collection beginning October 1, 2014, using the IRF–PAI Version 1.2, for quality reporting affecting the FY 2017 adjustments to the IRF PPS annual increase factor and subsequent year annual increase factors. The measure specifications for this measure can be found on the CMS Web site at *http://www.qualityforum.org/QPS/0678*.

4. Measures Finalized in the FY 2015 IRF–PPS Final Rule

In the FY 2015 IRF–PPS final rule, we adopted two additional quality measures:

a. National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716)

In the FY 2015 IRF PPS final rule (79 FR 45911 through 45913), we adopted the NHSN Facility-Wide Inpatient Hospital-Onset MRSA Bacteremia Outcome Measure (NQF #1716), a measure of hospital-onset unique blood source MRSA laboratory-identified events among all patients in the inpatient rehabilitation facility. This measure was developed by the CDC and is NQF-endorsed. We finalized that data submission would start on January 1, 2015, and that adjustments to the IRF PPS annual increase factor would begin with FY 2017. Data are submitted via the CDC's NHSN. Details related to the procedures for using the NHSN for data submission and information on definitions, numerator data, denominator data, data analyses, and measure specifications for the proposed NHSN Facility-Wide Inpatient Hospital-Onset MRSA Bacteremia Outcome Measure (NQF #1716) can be found at *http://www.qualityforum.org/QPS/1716* and *http://www.cdc.gov/nhsn/inpatient-rehab/mdro-cdi/index.html.*

b. National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure (NQF #1717)

In the FY 2015 IRF PPS final rule (79 FR 45913 through 45914), we adopted the NHSN Facility-Wide Inpatient Hospital-Onset CDI Outcome Measure (NQF #1717), a measure of hospital-onset CDI laboratory-identified events among all inpatients in the facility. This measure was developed by the CDC and is NQF-endorsed. We finalized that data would be submitted starting January 1, 2015, and that adjustments to the IRF PPS annual increase factor would begin with FY 2017. Providers will use the CDC/NHSN data collection and submission framework for reporting of the proposed NHSN Facility-Wide Inpatient Hospital-Onset CDI Outcome Measure (NQF #1717). Details related to the procedures for using the NHSN for data submission and information on definitions, numerator data, denominator data, data analyses, and measure specifications for the proposed NHSN Facility-Wide Inpatient Hospital-Onset CDI Outcome Measure (NQF #1717) can be found at *http://www.qualityforum.org/QPS/1717* and *http://www.cdc.gov/nhsn/inpatient-rehab/mdro-cdi/index.html*.

TABLE 18—QUALITY MEASURES PREVIOUSLY FINALIZED FOR AND CURRENTLY USED IN THE IRF QUALITY REPORTING PROGRAM

NQF Measure ID	Quality measure title	Data submission mechanism
NQF #0138	National Health Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure.	CDC NHSN.
NQF #0431	Influenza Vaccination Coverage among Healthcare Personnel	CDC NHSN.
NQF #0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay).	IRF–PAI.
NQF #0678	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)	IRF–PAI.
NQF #2502	All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from Inpatient Rehabilitation Facilities*.	Claims-based.
NQF #1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure.	CDC NHSN.
NQF #1717	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure..	CDC NHSN.

* Claims-based measure; no additional data submission required by IRFs.

5. Continuation of Previously Adopted IRF QRP Quality Measures for the FY 2018 Payment Determination and Subsequent Years

For the FY 2018 adjustments to the IRF PPS annual increase factor, we are retaining the previously discussed measures: (1) NHSN CAUTI Outcome Measure (NQF #0138); (2) Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680); (3) Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678); (4) All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs (NQF #2502); (5) Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431); (6) NHSN Facility-Wide Inpatient Hospital-Onset MRSA Bacteremia Outcome Measure (NQF #1716), (7) and NHSN Facility-Wide Inpatient Hospital-Onset *CDI* Outcome Measure (NQF #1717) quality measures.

F. Proposal of Previously Adopted IRF QRP Quality Measures for the FY 2018 Payment Determination and Subsequent Years

For the FY 2018 payment determination and subsequent years, we are proposing to adopt two quality measures to reflect NQF endorsement or to meet the requirements of the IMPACT Act: (1) All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs (NQF #2502); and (2) an application of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678). These quality measures are discussed in more detail below.

1. Proposing Quality Measure To Reflect NQF Endorsement: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge From IRFs (NQF #2502)

The All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502) measure was adopted for use in the IRF QRP in the FY 2014 IRF PPS final rule (78 FR 47906 through 47910). We are proposing to adopt this measure for the FY 2018 payment determination and subsequent years to reflect that it is NQF-endorsed for use in the IRF setting as of December 2014. For current specifications of this measure, please visit *http://www.qualityforum.org/QPS/2502*.

As adopted through the FY 2014 IRF PPS final rule, All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502) is a Medicare Fee-For-Service (FFS) claims-based measure. IRFs would not be required to report any additional data to CMS because we would calculate this measure based on claims data that are already reported to the Medicare program for payment purposes. We believe there would be no additional data collection burden on providers resulting from our implementation of All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502) as part of the IRF QRP. In the FY 2014 IRF PPS final rule, we stated that we would provide initial feedback to providers, prior to public reporting of this measure, based on Medicare FFS claims data from CY 2013 and CY 2014.

The description of this measure provided in the FY 2014 IRF PPS final rule (78 FR 47906 through 47910) noted this measure was the ratio of the number of risk-adjusted predicted unplanned readmissions for each individual IRF to the average number of risk-adjusted predicted unplanned readmissions for the same patients treated at the average IRF. This ratio is referred to as the standardized risk ratio (SRR). However, the measure specifications compute the risk-standardized readmission rate (RSRR) for this measure. The RSRR is the SRR multiplied by the overall national raw readmission rate for all IRF stays. The outcome is expressed as a percentage rate rather than a ratio.

This measure, which harmonizes with the Hospital-Wide All-Cause Readmission Measure (NQF #1789) currently in use in the Inpatient Quality Reporting Program, continues to use the CMS Planned Readmission Algorithm as the main component for identifying planned readmissions. This algorithm was refined in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50211 through 50216). The All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502) measure for the IRF QRP will utilize the most recently updated version of the algorithm. A complete description of the CMS Planned Readmission Algorithm, which includes lists of planned diagnoses and procedures, can be found on CMS Web site (*http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html*). The additional post-acute care planned readmission procedures specified for All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502) remain the same as when first adopted through FY 2014 IRF PPS final rule. Documentation on the additional post-acute care planned readmissions for this measure is available at *http://www.qualityforum.org/QPS/2502*. *http://www.qualityforum.org/ProjectMeasures.aspx?projectID=73619*.

We invite public comments in response to our proposal to adopt the NQF-endorsed version of All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502) for the IRF QRP for the FY 2018 payment determination and subsequent years.

2. Quality Measure Addressing the Domain of Skin Integrity and Changes in Skin Integrity: Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)

Section 1899B(c)(1) of the Act directs the Secretary to specify quality measures on which PAC providers are required under the applicable reporting provisions to submit standardized patient assessment data and other necessary data specified by the Secretary with respect to five quality domains, one of which is skin integrity and changes in skin integrity. The specified application date by which the Secretary must specify quality measures to address this domain for IRFs, Skilled Nursing Facilities (SNFs), and LTCHs is October 1, 2016, and for HHAs is January 1, 2017. To satisfy these requirements, we are proposing to adopt the measure Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678) that we have already adopted for the IRF QRP as a cross-setting quality measure that satisfies the domain of skin integrity and changes in skin integrity. The reporting of data for this measure would affect the payment determination for FY 2018 and subsequent years. For the IRF setting, the measure assesses the percent of patients with stage 2 through stage 4 pressure ulcers that are new or worsened since admission.

As described in the FY 2012 IRF PPS final rule (76 FR 47876 through 47878), pressure ulcers are high-cost adverse events and are an important measure of quality. For information on the history and rationale for the relevance, importance, and applicability of this measure in the IRF QRP, we refer readers to the FY 2012 IRF PPS final rule and the FY 2014 IRF PPS final rule (78 FR 47911 through 47912). Details regarding the specifications for this measure are available on the NQF Web site at *http://www.qualityforum.org/QPS/0678*.

The IMPACT Act requires the implementation of quality measures and resource use and other measures that are standardized and interoperable across PAC settings, as well as the reporting of standardized patient assessment data and other necessary data specified by the Secretary. This requirement is in line with the NQF Steering Committee report, which stated ''to understand the impact of pressure ulcers across providers, quality measures addressing prevention, incidence, and prevalence of pressure ulcers must be harmonized and aligned.'' [2] Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) is NQF-endorsed for the IRF setting and has been successfully implemented using a harmonized set of data elements in three PAC settings (IRF, LTCH and SNF). As discussed in section VIII.E. of this proposed rule, an

[2] National Quality Forum. National voluntary consensus standards for developing a framework for measuring quality for prevention and management of pressure ulcers. April 2008. Available from *http://www.qualityforum.org/Projects/Pressure_Ulcers.aspx*.>

application of this measure was adopted for the IRF QRP in the FY 2012 IRF PPS final rule (76 FR 47876 through 47878) for the FY 2014 payment determination and subsequent years, and the current NQF-endorsed version of the measure was finalized in the FY 2014 IRF PPS final rule (78 FR 47911 through 47912) for the FY 2017 payment determination and subsequent years. The measure has been in use in the IRF QRP since October 1, 2012, and currently, IRFs are submitting data for this measure using the IRF–PAI.

The Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) measure was adopted for use in the LTCH QRP in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51748 through 51756) for the FY 2014 payment determination and subsequent years, and has been successfully submitted by LTCHs using the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set since October 2012. It has also been implemented in CMS' Nursing Home Quality Initiative, using the MDS 3.0 since 2011, and is currently reported on CMS' Nursing Home Compare at *http://www.medicare.gov/nursinghomecompare/search.html*.

A TEP convened by our measure development contractor in February 2015 provided input on the measure specifications and the feasibility and clinical appropriateness of implementing the measure as a cross-setting quality measure under the IMPACT Act of 2014, for use across PAC settings, including the IRF setting. The TEP supported the implementation of this measure across PAC providers and also supported our efforts to standardize this measure for cross-provider development. Additionally, the MAP, convened by the NQF, met on February 9, 2015 and provided input to CMS. The MAP supported the use of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678) in the IRF QRP as a cross-setting quality measure to be specified in accordance with the IMPACT Act of 2014. MAP noted that this measure addresses one of its previously identified PAC/LTC core concepts as well as an IMPACT Act domain. More information about the MAP's recommendations for this measure is available at: *http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx*.

We propose that that data collection for Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) (NQF #0678) continue to occur through the quality indicator section of the IRF–PAI submitted through the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. IRFs have been submitting data on the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) measure (NQF #0678) through the quality indicator section of the IRF–PAI since October 2012. For more information on IRF reporting using the QIES ASAP system refer to: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Technical-Information.html*.

In an effort to further harmonize the data elements across PAC providers, we propose an update to the IRF–PAI items used to calculate the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) measure (NQF #0678) to align with the items included in the LTCH CARE Data Set and the MDS 3.0. The proposed modified IRF–PAI items used to identify new or worsened pressure ulcers consist of: M0800A: Worsening in Pressure Ulcer Status Since Admission, Stage 2; M0800B: Worsening in Pressure Ulcer Status Since Admission, Stage 3; and M0800C: Worsening in Pressure Ulcer Status Since Admission, Stage 4. We are not proposing a change to the IRF–PAI items used to risk adjust this quality measure. These items consist of: FIM® Item 39I (Transfers: Bed, Chair, and Wheelchair), FIM® Item 32 (Bowel Frequency of Accidents), I0900A (Peripheral Vascular Disease (PVD)), I0900B (Peripheral Arterial Disease (PAD)), I2900A (Diabetes Mellitus), 25A (Height), and 26A (Weight). More information about the IRF–PAI items is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html*. For more information about the proposed changes to the IRF–PAI, see *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html*.

The specifications and data elements for the Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678), are available in the IRF–PAI training manual at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html*.

We invite public comment on our proposal to specify and adopt Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) for the IRF QRP for the FY 2018 payment determination and subsequent years to fulfill the requirements in the IMPACT Act.

Request for public comments regarding future measure development for Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)

As part of our ongoing measure development efforts, we are considering a future update to the numerator of the quality measure Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678). This update would hold providers accountable for the development of unstageable pressure ulcers, including suspected deep tissue injuries (sDTIs). Under this possible future change, the numerator of the quality measure would be updated to include unstageable pressure ulcers, including sDTIs, that are new or developed in the facility, as well as Stage 1 or 2 pressure ulcers that become unstageable due to slough or eschar (indicating progression to a Stage 3 or 4 pressure ulcer) after admission. At this time, we are not proposing the implementation of this change (that is, including sDTIs and unstageable pressure ulcers in the numerator) in the IRF QRP, but are soliciting public comment on this potential area of measure development.

Our measure development contractor convened a cross-setting pressure ulcer TEP that strongly recommended that we hold providers accountable for the development of new unstageable pressure ulcers by including these pressure ulcers in the numerator of the quality measure. Although the TEP acknowledged that unstageable pressure ulcers, including sDTIs, cannot and should not be assigned a numeric stage, panel members recommended that these be included in the numerator of Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) as a new pressure ulcer if it developed in the facility. The TEP also recommended that a Stage 1 or 2 pressure ulcer that becomes unstageable due to slough or eschar should be considered worsened, because the presence of slough or eschar indicates a full thickness (equivalent to Stage 3 or 4) wound.[3] [4] These

[3] Schwartz, M., Nguyen, K.H., Swinson Evans, T.M., Ignaczak, M.K., Thaker, S., and Bernard, S.L.: Development of a Cross-Setting Quality Measure for Pressure Ulcers: OY2 Information Gathering, Final Report. Centers for Medicare & Medicaid Services, November 2013. Available: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Development-of-a-Cross-Setting-Quality-Measure-for-Pressure-Ulcers-Information-Gathering-Final-Report.pdf*.

recommendations were supported by technical and clinical advisors and the National Pressure Ulcer Advisory Panel (NPUAP).[5] Furthermore, exploratory data analysis conducted by our measure development contractor suggests that the addition of unstageable pressure ulcers, including sDTIs, would increase the observed incidence of new or worsened pressure ulcers at the facility level and may improve the ability of the quality measure to discriminate between poor- and high-performing facilities.

We invite public comment to inform our future measure development efforts to include unstageable pressure ulcers, including sDTIs, in the numerator of the quality measure Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678).

G. Proposed Additional IRF QRP Quality Measures for the FY 2018 Payment Determination and Subsequent Years

We are proposing to adopt 6 additional quality measures beginning with the FY 2018 payment determination. These new proposed quality measures are: (1) An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674); (2) an application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under review); (3) IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; under review); (4) IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review); (5) IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; under review); and (6) IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review).

1. Quality Measure Addressing the Domain of the Incidence of Major Falls: An Application of Percent of Residents Experiencing One or More Falls With Major Injury (Long Stay) (NQF #0674)

Section 1899B(c)(1) of the Act directs the Secretary to specify quality measures on which PAC providers are required under the applicable reporting provisions to submit standardized patient assessment data and other necessary data specified by the Secretary with respect to five quality domains, one of which is the incidence of major falls. The specified application date by which the Secretary must specify quality measures to address this domain for IRFs, SNFs, and LTCHs is October 1, 2016, and for HHAs is January 1, 2019. To satisfy these requirements, we are proposing to adopt an application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay) (NQF #0674) in the IRF QRP as a cross-setting quality measure that addresses the domain of incidence of major falls. Data collection would start on October 1, 2016. The reporting of data for this measure would affect the payment determination for FY 2018 and subsequent years. As described in more detail in section VIII.I.2. of this proposed rule, the proposed first data collection period is 3 months (October 1, 2016 to December 31, 2016), and the proposed subsequent data collection periods are 12-months in length and follow the calendar year (that is, January 1 to December 31). For the IRF setting, this measure would report the percentage of patients who experienced one or more falls with major injury during the IRF stay. This measure was developed by CMS and is NQF-endorsed for long-stay residents of nursing facilities.

Research indicates that fall-related injuries are the most common cause of accidental death in people aged 65 and older, responsible for approximately 41 percent of accidental deaths annually.[6] Rates increase to 70 percent of accidental deaths among individuals aged 75 and older.[7] In addition to death, falls can lead to fracture, soft tissue or head injury, fear of falling, anxiety, and depression.[8] It is estimated that 10 percent to 25 percent of nursing facility resident falls result in fractures and/or hospitalization.[9] For IRFs, a study of 5,062 patients found 367 patients (7.25 percent) had 438 falls. Among these 438 falls, 129 (29.5 percent of the falls) resulted in an injury, of which 25 (19 percent of falls) were serious.[10] A separate study of 754 stroke patients in an IRF reported 117 patients (15.5 percent) experienced 159 falls. Among these 159 falls, 13 (8 percent of falls) resulted in a minor injury, and 3 (2 percent of falls) resulted in a serious injury.[11]

Falls also represent a significant cost burden to the entire health care system, with injurious falls accounting for 6 percent of medical expenses among those age 65 and older.[12] In their 2006 work, *Sorensen et al.* estimate the costs associated with falls of varying severity among nursing home residents. Their work suggests that acute-care costs range from $979 for a typical case with a simple fracture to $14,716 for a typical case with multiple injuries.[13] A similar study of hospitalizations of nursing home residents due to serious fall-related injuries (intracranial bleed, hip fracture, other fracture) found an average cost of $23,723.[14]

According to *Morse,*[15] 78 percent of falls are anticipated physiological falls. Anticipated physiological falls are falls among individuals who scored high on a risk assessment scale, meaning their risk could have been identified in advance of the fall. To date, studies have identified a number of risk factors for falls.[16] [17] [18] [19] [20] [21] [22] [23] [24] The

[4] Schwartz, M., Ignaczak, M.K., Swinson Evans, T.M., Thaker, S., and Smith, L.: The Development of a Cross-Setting Pressure Ulcer Quality Measure: Summary Report on November 15, 2013, Technical Expert Panel Follow-Up Webinar. Centers for Medicare & Medicaid Services, January 2014. Available: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Development-of-a-Cross-Setting-Pressure-Ulcer-Quality-Measure-Summary-Report-on-November-15–2013-Technical-Expert-Pa.pdf.*

[5] Schwartz, M., Nguyen, K.H., Swinson Evans, T.M., Ignaczak, M.K., Thaker, S., and Bernard, S.L.: Development of a Cross-Setting Quality Measure for Pressure Ulcers: OY2 Information Gathering, Final Report. Centers for Medicare & Medicaid Services, November 2013. Available: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/Development-of-a-Cross-Setting-Quality-Measure-for-Pressure-Ulcers-Information-Gathering-Final-Report.pdf.*

[6] Currie LM. Fall and injury prevention. Annu Rev Nurs Res. 2006;24:39–74.

[7] Fuller GF. Falls in the elderly. Am Fam Physician. Apr 1 2000;61(7):2159–2168, 2173–2154.

[8] Premier Inc. Causes of Falls. 2013. Available: *https://www.premierinc.com/quality-safety/toolsservices/safety/topics/falls/causes_of_falls.jsp.*

[9] Vu MQ, Weintraub N, Rubenstein LZ. Falls in the nursing home: are they preventable? J Am Med Dir Assoc. 2004 Nov-Dec; 5(6):401–6. Review.

[10] Frisina PG, Guellnitz R, Alverzo J. A time series analysis of falls and injury in the inpatient rehabilitation setting. Rehab Nurs. 2010; 35(4):141–146.

[11] Rabadi MH, Rabadi FM, Peterson M. An analysis of falls occurring in patients with stroke on an acute rehabilitation unit. Rehab Nurs. 2008; 33(3):104–109.

[12] Tinetti ME, Williams CS. The effect of falls and fall injuries on functioning in community-dwelling older persons. J Gerontol A Biol Sci Med Sci. 1998 Mar;53(2):M112–9.

[13] Sorensen SV, de Lissovoy G, Kunaprayoon D, Resnick B, Rupnow MF, Studenski S. A taxonomy and economic consequence of nursing home falls. Drugs Aging. 2006;23(3):251–62.

[14] Quigley PA, Campbell RR, Bulat T, Olney RL, Buerhaus P, Needleman J. Incidence and cost of serious fall-related injuries in nursing homes. Clin Nurs Res. Feb 2012;21(1):10–23.

[15] Morse, J. M. (2002) Enhancing the safety of hospitalization by reducing patient falls. Am J Infect Control 2002; 30(6): 376–80.

[16] Rothschild JM, Bates DW, Leape LL. Preventable medical injuries in older patients. Arch Intern Med. 2000 Oct 9; 160(18):2717–28.

[17] Morris JN, Moore T, Jones R, et al. Validation of long-term and post-acute care quality indicators.

Continued

identification of such risk factors suggests the potential for health care facilities to reduce and prevent the incidence of falls with injuries for their patients. In light of the evidence previously discussed, we are proposing to adopt an application of the measure Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) for the IRF QRP, with data collection starting on October 1, 2016 and affecting the payment determination for FY 2018 and subsequent years. As described in more detail in section VIII.I.2. of this proposed rule, the proposed first data collection period is 3 months (October 1, 2016 to December 31, 2016), and the proposed subsequent data collection periods are 12-months in length and follow the calendar year (that is, January 1 to December 31).

The IMPACT Act requires the specification of quality measures and resource use and other measures that are standardized and interoperable across PAC settings as well as the reporting of standardized patient assessment data and other necessary data specified by the Secretary. The Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) measure is NQF-endorsed for long-stay residents in nursing homes and has been successfully implemented in nursing facilities for long-stay residents. The NQF-endorsed measure has been in use as part of CMS' Nursing Home Quality Initiative since 2011. In addition, the measure is currently reported on CMS' Nursing Home Compare Web site at *http://www.medicare.gov/nursinghomecompare/search.html*. Further, the measure was adopted for use in the LTCH QRP in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50874 through 50877). In the FY 2015 IPPS/LTCH PPS final rule (79 FR 50290), we revised the data collection period for this measure with data collection to begin starting April 1, 2016.

We reviewed the NQF's consensus endorsed measures and were unable to identify any NQF-endorsed cross-setting quality measures focused on falls with a major injury. We are unaware of any other cross-setting quality measures for falls with major injury that have been endorsed or adopted by another consensus organization. Therefore, we are proposing an application of the measure, the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674), under the Secretary's authority to select non-NQF-endorsed measures.

A TEP convened by our measure development contractor provided input on the measure specifications, including the feasibility and clinical appropriateness of implementing the measure across PAC settings, including the IRF setting. The TEP supported the implementation of this measure across PAC settings, including the IRF setting, and also supported our efforts to standardize this measure for cross-setting development. Additionally, the NQF-convened MAP met on February 9, 2015 and provided input to us on the measure. The MAP conditionally supported the use of an application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674) in the IRF QRP as a cross-setting quality measure. More information about the MAP's recommendations for this measure is available at: *http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx*.

More information on the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay), visit the NQF Web site: *http://www.qualityforum.org/QPS/0674*. Details regarding the changes made to modify the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay), and updated specifications are located at: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information.html*.

We propose that data for this quality measure would be collected using the IRF–PAI with submission through the QIES ASAP system. More information on IRF reporting using the QIES ASAP system is located at the Web site: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html*.

Data collected through a revised IRF–PAI would be used to calculate this quality measure. Consistent with the IRF–PAI reporting requirements, the application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674), will apply to all Medicare patients discharged from IRFs. Data items in the revised IRF–PAI would include: J1800: Any Falls Since Admission, and J1900: Number of Falls Since Admission.

The calculation of the proposed application of the measure would be based on item J1900C: Number of Falls with Major Injury since Admission. The specifications and data elements for the application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674), are available at: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html*. For more information on the proposed data collection and submission timeline for the proposed quality measure, refer to section VIII.I.2 of this proposed rule.

We invite public comment on our proposal to adopt an application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674), with data collection beginning on October 1, 2016, for the IRF QRP for FY 2018 payment determination and subsequent years to fulfill the requirements in the IMPACT Act.

2. Quality Measure Addressing the Domain of Functional Status, Cognitive Function, and Changes in Function and Cognitive Function: Application of Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under review)

Section 1899B(c)(1) of the Act directs the Secretary to specify quality measures on which PAC providers are required under the applicable reporting provisions to submit standardized patient assessment data and other necessary data specified by the Secretary with respect to five quality domains, one of which is functional status, cognitive function, and changes in function and cognitive function. To satisfy these requirements, we are proposing to specify and adopt an application of the quality measure

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CMS Contract No: 500–95–0062/T.O. #4. Cambridge, MA: Abt Associates, Inc., June 2003.

[18] Avidan AY, Fries BE, James ML, Szafara KL, Wright GT, Chervin RD. Insomnia and hypnotic use, recorded in the minimum data set, as predictors of falls and hip fractures in Michigan nursing homes. J Am Geriatr Soc. 2005 Jun; 53(6):955–62.

[19] Fonad E, Wahlin TB, Winblad B, Emami A, Sandmark H. Falls and fall risk among nursing home residents. J Clin Nurs. 2008 Jan; 17(1):126–34.

[20] Currie LM. Fall and injury prevention. Annu Rev Nurs Res. 2006;24:39–74.

[21] Ellis AA, Trent RB. Do the risks and consequences of hospitalized fall injuries among older adults in California vary by type of fall? J Gerontol A Biol Sci Med Sci. Nov 2001;56(11):M686–692.

[22] Chen XL, Liu YH, Chan DK, Shen Q, Van Nguyen H. Chin Med J (Engl). Characteristics associated with falls among the elderly within aged care wards in a tertiary hospital: a retrospective. 2010 Jul;123(13):1668–72.

[23] Frisina PG, Guellnitz R, Alverzo J. A time series analysis of falls and injury in the inpatient rehabilitation setting. Rehabil Nurs. 2010 JulAug;35(4):141–6, 166.

[24] Lee JE, Stokic DS. Risk factors for falls during inpatient rehabilitant Am J Phys Med Rehabil. 2008 May;87(5):341–50; quiz 351, 422.

Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; under review) in the IRF QRP as a cross-setting quality measure that addresses the domain of functional status, cognitive function, and changes in function and cognitive function. The reporting of data for this measure would affect the payment determination for FY 2018 and subsequent years. This quality measure reports the percent of patients with both an admission and a discharge functional assessment and a goal that addresses function.

The National Committee on Vital and Health Statistics, Subcommittee on Health,[25] noted: ''[i]nformation on functional status is becoming increasingly essential for fostering healthy people and a healthy population. Achieving optimal health and well-being for Americans requires an understanding across the life span of the effects of people's health conditions on their ability to do basic activities and participate in life situations, that is, their functional status.'' This statement is supported by research showing that patient functioning is associated with important patient outcomes such as discharge destination and length of stay in inpatient settings,[26] as well as the risk of nursing home placement and hospitalization of older adults living the in community.[27] Functioning is important to patients and their family members.[28] [29] [30]

The majority of patients and residents who receive PAC services, such as care provided by SNFs, HHAs, IRFs and LTCHs, have functional limitations, and many of these patients are at risk for further decline in function due to limited mobility and ambulation.[31] The patient populations treated by SNFs, HHAs, IRFs and LTCHs vary in terms of their functional abilities at the time of the PAC admission and their goals of care. For IRF patients and many SNF residents, treatment goals may include fostering the patient's ability to manage his or her daily activities so that the patient can complete self-care and/or mobility activities as independently as possible, and if feasible, return to a safe, active, and productive life in a community-based setting. For HHA patients, achieving independence within the home environment and promoting community mobility may be the goal of care. For other HHA patients, the goal of care may be to slow the rate of functional decline to allow the person to remain at home and avoid institutionalization.[32] Lastly, in addition to having complex medical care needs for an extended period of time, LTCH patients often have limitations in functioning because of the nature of their conditions, as well as deconditioning due to prolonged bed rest and treatment requirements (for example, ventilator use). The clinical practice guideline *Assessment of Physical Function* [33] recommends that clinicians should document functional status at baseline and over time to validate capacity, decline, or progress. Therefore, assessment of functional status at admission and discharge and establishing a functional goal for discharge as part of the care plan (that is, treatment plan) is an important aspect of patient care in all of these PAC providers.

Given the variation in patient and resident populations across the PAC providers, the functional activities that are typically assessed by clinicians for each type of PAC provider may vary. For example, the activity of rolling left and right in bed is an example of a functional activity that may be most relevant for low-functioning patients or residents who are chronically critically ill. However, certain functional activities, such as eating, oral hygiene, lying to sitting on the side of the bed, toilet transfers, and walking or wheelchair mobility, are important activities for patients and residents in each PAC provider.

Although functional assessment data are currently collected in SNFs, HHAs, IRFs and LTCHs, this data collection has employed different assessment instruments, scales, and item definitions. The data collected cover similar topics, but are not standardized across PAC settings. Further, the different sets of functional assessment items are coupled with different rating scales, making communication about patient functioning challenging when patients transition from one type of provider to another. Collection of standardized functional assessment data across SNFs, HHAs, IRFs and LTCHs, using common data items, would establish a common language for patient functioning, which may facilitate communication and care coordination as patients transition from one type of provider to another. The collection of standardized functional status data may also help improve patient or resident functioning during an episode of care by ensuring that basic daily activities are assessed at the start and end of each episode of care with the aim of determining whether at least one functional goal is established.

The functional assessment items included in the proposed functional status quality measure were originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration version of the CARE Item Set, which was designed to standardize assessment of patients' status across acute and post-acute providers, including SNFs, HHAs, IRFs and LTCHs. The functional status items on the CARE Item Set are daily activities that clinicians typically assess at the time of admission and/or discharge to determine patients' or residents' needs, evaluate patient or resident progress and prepare patients or residents and families for a transition to home or to another provider.

The development of the CARE Item Set and a description and rationale for each item is described in a report entitled ''The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set: Volume 1 of 3.'' [34] Reliability and validity testing were conducted as part of CMS' Post-Acute Care Payment Reform Demonstration, and we concluded that the functional status items have acceptable reliability and

[25] Subcommittee on Health National Committee on Vital and Health Statistics, ''Classifying and Reporting Functional Status'' (2001).

[26] Reistetter TA, Graham JE, Granger CV, Deutsch A, Ottenbacher KJ. Utility of Functional Status for Classifying Community Versus Institutional Discharges after Inpatient Rehabilitation for Stroke. *Archives of Physical Medicine and Rehabilitation,* 2010; 91:345–350.

[27] Miller EA, Weissert WG. Predicting Elderly People's Risk for Nursing Home Placement, Hospitalization, Functional Impairment, and Mortality: A Synthesis. Medical Care Research and Review, 57; 3: 259–297.

[28] Kurz, A. E., Saint-Louis, N., Burke, J. P., & Stineman, M. G. (2008). Exploring the personal reality of disability and recovery: a tool for empowering the rehabilitation process. *Qual Health Res, 18*(1), 90–105.

[29] Kramer, A. M. (1997). Rehabilitation care and outcomes from the patient's perspective. *Med Care, 35*(6 Suppl), JS48–57.

[30] Stineman, M. G., Rist, P. M., Kurichi, J. E., & Maislin, G. (2009). Disability meanings according to patients and clinicians: imagined recovery choice pathways. *Quality of Life Research, 18*(3), 389–398.

[31] Kortebein P, Ferrando A, Lombebeida J, Wolfe R, Evans WJ. Effect of 10 days of bed rest on skeletal muscle in health adults. JAMA; 297(16):1772–4.

[32] Ellenbecker CH, Samia L, Cushman MJ, Alster K. Patient safety and quality in home health care. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Vol 1.

[33] Kresevic DM. Assessment of physical function. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company; 2012. p. 89–103.

[34] Barbara Gage et al., ''The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set'' (RTI International, 2012).

validity. A description of the testing methodology and results are available in several reports, including the report entitled ''The Development and Testing of the Continuity Assessment Record And Evaluation (CARE) Item Set: Final Report On Reliability Testing: Volume 2 of 3'' [35] and the report entitled ''The Development and Testing of The Continuity Assessment Record And Evaluation (CARE) Item Set: Final Report on Care Item Set and Current Assessment Comparisons: Volume 3 of 3.'' [36] The reports are available on CMS' Post-Acute Care Quality Initiatives Web page at: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html*.

The cross-setting function quality measure we are proposing to adopt for the FY 2018 payment determination and subsequent years is a process measure that is an application of the quality measure Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; under review). This quality measure was developed by the CMS. It reports the percent of patients with both an admission and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides documentation that a care plan with a goal has been established for the patient.

This process measure requires the collection of admission and discharge functional status data using standardized clinical assessment items, or data elements, that assess specific functional activities, that is, self-care, mobility activities. The self-care and mobility function activities are coded using a 6-level rating scale that indicates the patient's level of independence with the activity; higher scores indicate more independence. For this quality measure, documentation of a goal for one of the function items reflects that the patient's care plan addresses function. The function goal is recorded at admission for at least one of the standardized self-care or mobility function items using the 6-level rating scale.

To the extent that a patient has an incomplete stay (for example, for the purpose of being admitted to an acute care facility), collection of discharge functional status data might not be feasible. Therefore, for patients with incomplete stays, admission functional status data and at least one treatment goal would be required, discharge functional status data would not be required to be reported.

A TEP convened by our measure development contractor provided input on the technical specifications of this quality measure, including the feasibility of implementing the measure across PAC settings, including the IRF setting. The TEP supported the implementation of this measure across PAC providers and also supported our efforts to standardize this measure for cross-setting use. Additionally, the MAP met on February 9, 2015 and provided input to us on the measure. The MAP conditionally supported the specification of an application of Percent of LTCH Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under review) for use in the IRF QRP as a cross-setting measure. MAP conditionally supported this measure pending NQF-endorsement and resolution of concerns about the use of two different functional status scales for quality reporting and payment purposes. MAP reiterated its support for adding measures addressing function, noting the group's special interest in this PAC/LTC core concept. More information about the MAPs recommendations for this measure is available at: *http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx.*

This quality measure was developed by CMS. The specifications are available for review at the IRF QRP Web site: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html*.

We reviewed the NQF's consensus endorsed measures and were unable to identify any NQF-endorsed cross-setting quality measures focused on assessment of function for PAC patients. We are also unaware of any other cross-setting quality measures for functional assessment that have been endorsed or adopted by another consensus organization. Therefore, we are proposing to specify and adopt this functional assessment measure for use in the IRF QRP for the FY 2018 payment determination and subsequent years under the Secretary's authority to select non-NQF-endorsed measures. As described in more detail in section VIII.I.2, of this proposed rule, the proposed first data collection period is 3 months (October 1, 2016 to December 31, 2016), and the proposed subsequent data collection periods are 12-months in length and follow the calendar year (that is, January 1 to December 31).

We are proposing that data for this proposed quality measure be collected using the IRF–PAI, with submission through the QIES ASAP system. For more information on IRF QRP reporting through the QIES ASAP system, we refer readers to the CMS Web site at:*http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html*.

The measure calculation algorithm is: (1) For each IRF stay, the records of Medicare patients discharged during the 12-month target time period are identified and counted; this count is the denominator; (2) the records of Medicare patients with complete stays are identified, and the number of these patient stays with complete admission functional assessment data and at least one self-care or mobility activity goal and complete discharge functional assessment data is counted; (3) the records of Medicare patients with incomplete stays are identified, and the number of these patient records with complete admission functional status data and at least one self-care or mobility goal is counted; (4) the counts from step 2 (complete IRF stays) and step 3 (incomplete IRF stays) are summed; the sum is the numerator count; and (5) the numerator count is divided by the denominator count to calculate this quality measure.

For purposes of assessment data collection, we propose to add a new section into the IRF–PAI. The new proposed section will include new functional status items that will be used to calculate the application of the Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; under review) quality measure should this proposed measure be adopted. The items to be added to the IRF–PAI, which assess specific self-care and mobility activities, would be based on functional items included in the Post-Acute Care Payment Reform Demonstration version of the CARE Item Set.

The specifications and data elements for the quality measure are available at: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html*.

The proposed function items to be included within the IRF–PAI do not duplicate existing items currently used for data collection within the IRF–PAI. While many of the items to be included have labels that are similar to existing items on the IRF–PAI, there are several

[35] Ibid.

[36] Ibid.

key differences between the 2 assessment item sets that may result in variation in the patient assessment results. Key differences include: (1) The data collection and associated data collection instructions; (2) the rating scales used to score a patient's level of independence; and (3) the item definitions. A description of these differences is provided with the measure specifications on CMS Web site at: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html*.

This measure is calculated at two points in time, at admission and discharge (see Proposed Form, Manner, and Timing of Quality Data Submission section of the rule). The items would assess specific self-care and mobility activities, and would be based on functional items included in the Post-Acute Care Payment Reform Demonstration version of the CARE Item Set. The items have been developed and tested for reliability and validity in SNFs, HHAs, IRFs, and LTCHs. More information pertaining to item testing is available on our Post-Acute Care Quality Initiatives Web page at: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html*.

For more information on the proposed data collection and submission timeline for the proposed quality measure refer to section VIII.I.2, of this proposed rule. Additional information regarding the items to be added to the IRF–PAI may be found on CMS Web site at: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html*.

Lastly, in alignment with the requirements of the IMPACT Act to develop quality measures and standardize data for comparative purposes, we believe that evaluating outcomes across the post-acute settings using standardized data is an important priority. Therefore, in addition to proposing a process-based measure for the domain in the IMPACT Act of ''Functional status, cognitive function, and changes in function and cognitive function'', which is included in this year's proposed rule, we also intend to develop outcomes-based quality measures, including functional status and other quality outcome measures to further satisfy this domain. These measures will be proposed in future rulemaking to assess functional change for each care setting as well as across care settings.

We invite public comments on our proposal to adopt the application of the quality measure Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; under review) for the IRF QRP, with data collection starting on October 1, 2016, for the FY 2018 payment determination and subsequent years.

3. IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; Under Review)

The third quality measure that we are proposing for the FY 2018 payment determination and subsequent years is an outcome measure entitled IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633, under review). This quality measure estimates the risk-adjusted mean change in self-care score between admission and discharge among IRF patients. This measure is being proposed under the authority of section 1886(j)(7)(C) of the Act, and is currently under review by the NQF. A summary of the measure specifications can be accessed on the NQF Web site: *http://www.qualityforum.org/qps/2633*. Detailed specifications for this quality measure can be accessed at: *http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2633*.

IRFs are designed to provide intensive rehabilitation services to patients. Patients seeking care in IRFs are those whose illness, injury, or condition has resulted in a loss of function, and for whom rehabilitative care is expected to help regain that function. Examples of conditions treated in IRFs include stroke, spinal cord injury, hip fracture, brain injury, neurological disorders, and other diagnoses characterized by loss of function.

Given that the primary goal of rehabilitation is improvement in functional status, IRF clinicians have traditionally assessed and documented patients' functional status at admission and discharge to evaluate the effectiveness of the rehabilitation care provided to individual patients, as well as the effectiveness of the rehabilitation unit or hospital overall. Differences in IRF patients' functional outcomes have been found by geographic region, insurance type, and race/ethnicity after adjusting for key patient demographic characteristics and admission clinical status. Therefore, we believe there is an opportunity for improvement in this area. For example, Reistetter [37] examined discharge motor function and functional gain among IRF patients with stroke and found statistically significant differences in functional outcomes by U.S. geographic region, by insurance type, and race/ethnicity group after risk adjustment. O'Brien and colleagues [38] found differences in functional outcomes across race/ethnicity groups in their analysis of Medicare assessment data for patients with stroke after risk adjustment. O'Brien and colleagues [39] also noted that the overall IRF length of stay decreased 1.8 days between 2002 and 2007 and that shorter IRF stays were significantly associated with lower functioning at discharge.

The functional assessment items included in this quality measure were originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration version of the CARE Tool,[40] which was designed to standardize assessment of patients' status across acute and post-acute providers, including IRFs, SNFs, HHAs and LTCHs. The functional status items on the CARE Tool are daily activities that clinicians typically assess at the time of admission and/or discharge to determine patients' needs, evaluate patient progress and prepare patients and families for a transition to home or to another provider.

This outcome measure requires the collection of admission and discharge functional status data by trained clinicians using standardized clinical assessment items, or data elements that assess specific functional self-care activities (for example, eating, oral hygiene, toileting hygiene). The self-care function items are coded using a 6-level rating scale that indicates the patient's level of independence with the activity; higher scores indicate more independence. In addition, this measure requires the collection of risk factors data, such as patient functioning prior to the current reason for admission, bladder continence, communication ability and cognitive function, at the time of admission.

[37] Reistetter TA, Karmarkar AM, Graham JE, et al. Regional variation in stroke rehabilitation outcomes. *Arch Phys Med Rehabil*.95(1):29–38, Jan. 2014.

[38] O'Brien SR, Xue Y, Ingersoll G, et al. Shorter length of stay is associated with worse functional outcomes for medicare beneficiaries with stroke. *Physical Therapy*. 93(12):1592–1602, Dec. 2013.

[39] O'Brien SR, Xue Y, Ingersoll G, et al. Shorter length of stay is associated with worse functional outcomes for medicare beneficiaries with stroke. *Physical Therapy*. 93(12):1592–1602, Dec. 2013.

[40] Barbara Gage et al., ''The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set'' (RTI International, 2012).

This self-care quality measure will also standardize the collection of functional status data, which can improve communication when patients are transferred between providers. Most IRF patients receive care in an acute care hospital prior to the IRF stay, and many IRF patients receive care from another provider after the IRF stay. Use of standardized clinical data to describe a patient´s status across providers can facilitate communication across providers. Rehabilitation programs have traditionally conceptualized functional status in terms of the need for assistance from another person. This is the conceptual basis for the IRF–PAI/FIM®* instrument (used in IRFs), the MDS function items (used in nursing homes), and the Outcome and Assessment Information Set (OASIS) function items (used in home health). However, the functional status items on the IRF–PAI, MDS and OASIS are different; the items, item definitions when items are similar and rating scales are different. In a patient-centered health care system, there is a need for standardized terminology and assessment items because patients often receive care from more than 1 provider. The use of standardized items and terminology facilitates clinicians speaking a common language that can be understood across clinical disciplines and practice settings.

We released draft specifications for the function quality measures, and requested public comment between February 21 and March 14, 2014. We received 40 responses from stakeholders with comments and suggestions during the public comment period and have updated the specifications based on these comments and suggestions. This quality measure was submitted to NQF November 9, 2014 and is currently under review by NQF. A summary of the measure specifications can be accessed at *http://www.qualityforum.org/qps/2633*. The detailed measure specifications are available for review at the NQF Web site: *http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2633*.

Based on the evidence previously discussed, we are proposing to adopt the quality measure entitled IRF Functional Outcome Measure: Change in Self-care Score for Medical Rehabilitation Patients (NQF #2633; under review), for the IRF QRP for the FY 2018 payment determination and subsequent years. As described in more detail in section VIII.I.2. of this proposed rule, the proposed first data collection period is 3 months (October 1, 2016 to December 31, 2016) for the FY 2018 payment determination, and the proposed subsequent data collection periods are 12-months in length and follow the calendar year (that is, January 1 to December 31).

The list of measures under consideration for the IRF QRP, including this quality measure, was released to the public on December 1, 2014, and early comments were submitted between December 1 and December 5, 2014. The MAP met on December 12, 2014, sought public comment on this measure from December 23, 2014 to January 13, 2015, and met on January 26, 2015. The NQF provided the MAP's input to us as required under section 1890A(a)(3) of the Act in the final report, MAP 2015 Considerations for Selection of Measures for Federal Programs: Post-Acute/Long-Term Care, which is available at *http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx*. The MAP conditionally supported this measure. Refer to section VIII.B. of this proposed rule for more information on the MAP.

In section 1886(m)(5)(D)(ii) of the Act, the exception authority provides that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We reviewed the NQF's consensus endorsed measures and were unable to identify any NQF-endorsed quality measures focused on assessment of functional status for patients in the IRF setting. There are related measures, but they are not endorsed for IRFs and several focus on 1 condition (for example, knee or shoulder impairment). We are not aware a of any other quality measures for functional assessment that have been endorsed or adopted by another consensus organization for the IRF setting. Therefore, we are proposing to adopt this measure, IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; under review), for use in the IRF QRP for the FY 2018 payment determination and subsequent years under the Secretary's authority to select non-NQF-endorsed measures.

The specifications and data elements for the quality measure are available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html*. We are proposing that data for the proposed quality measure be collected using the IRF–PAI, with the submission through the QIES ASAP system. For more information on IRF QRP reporting through the QIES ASAP system, refer to CMS Web site at: *http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html*.

We propose to revise the IRF–PAI to include new items that assess functional status and the risk factor items, should this proposed measure be adopted. The function items, which assess specific self-care functional activities, would be based on functional items included in the Post-Acute Care Payment Reform Demonstration version of the CARE Item Set.

We invite public comments on our proposal to adopt the quality measure entitled IRF Functional Outcome Measure: Change in Self-care Score for Medical Rehabilitation Patients (NQF #2633, under review) for the IRF QRP, with data collection starting on October 1, 2016, for the FY 2018 payment determination and subsequent years. Refer to section VIII.I.2. of this proposed rule for more information on the proposed data collection and submission timeline for this proposed quality measure.

4. IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; Under Review)

The fourth quality measure we are proposing for the FY 2018 payment determination and subsequent years is an outcome quality measure entitled IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review). This quality measure estimates the risk-adjusted mean change in mobility score between admission and discharge among IRF patients. This measure is being proposed under the authority of section 1886(j)(7)(C) of the Act, and is currently under review by NQF. A summary of this quality measure can be accessed on the NQF Web site: *http://www.qualityforum.org/qps/2634*. More detailed specifications for this quality measure can be accessed at: *http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2634*.

This outcome measure requires the collection of admission and discharge functional status data by trained clinicians using standardized clinical assessment items, or data elements that assess specific functional mobility activities (for example, toilet transfer

and walking). The mobility function items are coded using a 6-level rating scale that indicates the patient's level of independence with the activity; higher scores indicate more independence. In addition, this measure requires the collection of risk factors data, such as patient functioning prior to the current reason for admission, history of falls, bladder continence, communication ability and cognitive function, at the time of admission.

As noted in the previous section, IRFs provide intensive rehabilitation services to patients with a goal of improving patient functioning.

We released draft specifications for the function quality measures, and requested public comment between February 21 and March 14, 2014. We received 40 responses from stakeholders with comments and suggestions during the public comment period, and have updated the measures specifications based on these comments and suggestions. The quality measure was developed by CMS and was submitted for endorsement review to NQF in November 2014. A summary of the quality measure can be accessed on the NQF Web site: *http://www.qualityforum.org/qps/2634*. More detailed specifications for this quality measure can be accessed at: *http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2634*

Based on the evidence previously discussed, we are proposing to adopt for the IRF QRP for the FY 2018 payment determination and subsequent years the quality measure entitled IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review). As described in more detail in section VIII.I.2. of this proposed rule, the proposed first data collection period is 3 months (October 1, 2016 to December 31, 2016), and the proposed subsequent data collection periods are 12-months in length and follow the calendar year (that is, January 1 to December 31).

The list of measures under consideration for the IRF QRP, including this quality measure, was released to the public on December 1, 2014, and early comments were submitted between December 1 and December 5, 2014. The MAP met on December 9 2014, sought public comment on this measure from December 23, 2014 to January 13, 2015, and met on January 26, 2015. They provided input to us as required under section 1890A(a)(3) of the Act in the final report, MAP 2015 Considerations for Selection of Measures for Federal Programs: Post-Acute/Long-Term Care, which is available at *http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx*. The MAP conditionally supported this measure. Refer to section VIII.B. of this proposed rule for more information on the MAP.

We reviewed the NQF's consensus endorsed measures and were unable to identify any NQF-endorsed quality measures focused on assessment of functional status for patients in the IRF setting. There are related measures—for example, Improvement in ambulation/locomotion (NQF #0167), Improvement in bed transferring (NQF #0175), Functional status change for patients with Knee impairments (NQF #0422), Functional status change for patients with Hip impairments (NQF #423)—but they are not endorsed for IRFs, and several focus on 1 condition (for example, knee or hip impairment). We are not aware of any other quality measures for functional assessment that have been endorsed or adopted by another consensus organization for the IRF setting. Therefore, we are proposing to adopt this measure, IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review), for use in the IRF QRP for the FY 2018 payment determination and subsequent years under the Secretary's authority to select non-NQF-endorsed measures.

The specifications and data elements for the quality measure are available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html*.

We are proposing that data for the proposed quality measure be collected using the IRF–PAI, with submission through the QIES ASAP system. For more information on IRF QRP reporting through the QIES ASAP system, refer to CMS Web site at: *http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html*.

We invite public comments on our proposal to adopt the quality measure entitled IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review) for the IRF QRP, with data collection starting on October 1, 2016, for the FY 2018 payment determination and subsequent years. Refer to section VIII.I.2.of this proposed rule for more information on the proposed data collection and submission timeline for this proposed quality measure.

5. IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; Under Review)

The fifth quality measure we are proposing for the FY 2018 payment determination and subsequent years is an outcome quality measure entitled: IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635, under review). This quality measure estimates the percentage of IRF patients who meet or exceed an expected discharge self-care score. This measure is being proposed under the authority of section 1886(j)(7)(C) of the Act, and is currently under review by NQF. A summary of this quality measure can be accessed on the NQF Web site: *http://www.qualityforum.org/qps/2635*. More detailed specifications for the quality measure can be accessed at: *http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2635*.

This outcome measure requires the collection of admission and discharge functional status data by trained clinicians using standardized clinical assessment items, or data elements that assess specific functional mobility activities (that is, eating, oral hygiene, and dressing). The self-care function items are coded using a 6-level rating scale that indicates the patient's level of independence with the activity; higher scores indicate more independence. In addition, this measure requires the collection of risk factors data, such as patient functioning prior to the current reason for admission, bladder continence, communication ability and cognitive function, at the time of admission. The data collection required for this measure is the same data required to the measure: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2635; under review).

As noted in the previous section, IRFs provide intensive rehabilitation services to patients with a goal of improving patient functioning.

We released draft specifications for the function quality measures, and requested public comment between February 21 and March 14, 2014. We received 40 responses from stakeholders with comments and suggestions during the public comment period, and have updated all four IRF quality measures specifications based on these comments and suggestions. This quality measure was submitted to the NQF on November 9, 2014 and is currently under review by NQF. A summary of this quality measure can be accessed on the NQF Web site: *http://www.qualityforum.org/*

qps/2634. More detailed specifications for this quality measure can be accessed at: *http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2634*.

Based on the evidence previously discussed, we are proposing to adopt for the IRF QRP for the FY 2018 payment determination and subsequent years the quality measure entitled IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; under review).

The list of measures under consideration for the IRF QRP, including this quality measure, was released to the public on December 1, 2014, and early comments were submitted between December 1 and December 5, 2014. The MAP met on December 9, 2014, sought public comment on this measure from December 23, 2014 to January 13, 2015, and met on January 26, 2015. They provided input to us as required under section 1890A(a)(3) of the Act in the final report, MAP 2015 Considerations for Selection of Measures for Federal Programs: Post-Acute/Long-Term Care, which is available at *http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx*. The MAP conditionally supported this measure. Refer to section VIII.B. of this proposed rule for more information on the MAP.

We reviewed the NQF's consensus endorsed measures and were unable to identify any NQF-endorsed quality measures focused on assessment of functional status for patients in the IRF setting. There are related measures, but they are not endorsed for IRFs and several focus on one condition (for example, knee or shoulder impairment). We are not aware of any other quality measures for functional outcomes that have been endorsed or adopted by another consensus organization for the IRF setting. Therefore, we are proposing to adopt this measure, IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; under review), for use in the IRF QRP for the FY 2018 payment determination and subsequent years under the Secretary's authority to select non-NQF-endorsed measures. As described in more detail in section VIII.I.2 of this proposed rule, the proposed first data collection period is 3 months (October 1, 2016 to December 31, 2016), and the proposed subsequent data collection periods are 12-months in length and follow the calendar year (that is, January 1 to December 31).

The specifications and data elements for the quality measure are available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html*.

We are proposing that data for the proposed quality measure be collected using the IRF–PAI, with submission through the QIES ASAP system. For more information on IRF QRP reporting through the QIES ASAP system, refer to CMS Web site at: *http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html*.

We invite public comments on our proposal to adopt the quality measure entitled IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635, under review) for the IRF QRP, with data collection starting on October 1, 2016, for the FY 2018 payment determination and subsequent years. For more information on the proposed data collection and submission timeline for this proposed quality measure, refer to section VIII.I.2, of this proposed rule.

6. IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; Under Review)

The sixth quality measure we are proposing for the FY 2016 implementation and the FY 2018 payment determination and subsequent years is an outcome quality measure entitled: IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review). This quality measure estimates the percentage of IRF patients who meet or exceed an expected discharge mobility score. This measure is being proposed under the authority of section 1886(j)(7)(C) of the Act, and is currently under review by NQF. A summary of this quality measure can be accessed on the NQF Web site: *http://www.qualityforum.org/qps/2636*. More detailed specifications for this quality measure can be accessed at: *http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2636*.

This outcome measure requires the collection of admission and discharge functional status data by trained clinicians using standardized clinical assessment items, or data elements that assess specific functional mobility activities (that is, bed mobility and walking). The mobility function items are coded using a 6-level rating scale that indicates the patient's level of independence with the activity; higher scores indicate more independence. In addition, this measure requires the collection of risk factors data, such as patient functioning prior to the current reason for admission, history of falls, bladder continence, communication ability and cognitive function, at the time of admission. Note that the data collection required for this measure is the same data required to the measure: IRF Functional Outcome Measure: Mobility in Self-Care Score for Medical Rehabilitation Patients (NQF #2634; under review).

As noted in the previous section, IRFs provide intensive rehabilitation services to patients with a goal of improving patient functioning.

We released draft specifications for the function quality measures, and requested public comment between February 21 and March 14, 2014. We received 40 responses from stakeholders with comments and suggestions during the public comment period, and have updated all 4 IRF quality measures specifications based on these comments and suggestions. This quality measure was submitted to the NQF on November 9, 2014 and is currently under review by NQF. A summary of this quality measure can be accessed on the NQF Web site: *http://www.qualityforum.org/qps/2634*. More detailed specifications for this quality measure can be accessed at: *http://www.qualityforum.org/ProjectTemplateDownload.aspx?SubmissionID=2634*.

Based on the evidence discussed earlier, we are proposing to adopt for the IRF QRP for the FY 2018 payment determination and subsequent years the quality measure entitled IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review). As described in more detail in section VIII.I.2. of this proposed rule, the proposed first data collection period is 3 months (October 1, 2016 to December 31, 2016), and the proposed subsequent data collection periods are 12-months in length and follow the calendar year (that is, January 1 to December 31).

The list of measures under consideration for the IRF QRP, including this quality measure, was released to the public on December 1, 2014, and early comments were submitted between December 1 and December 5, 2014. The MAP met on December 9, 2014, sought public comment on this measure from December 23, 2014 to January 13, 2015, and met on January 26, 2015. They provided input to us as required under section 1890A(a)(3) of the Act in the final report, MAP 2015 Considerations for Selection of Measures for Federal Programs: Post-Acute/Long-Term Care, which is available at *http://www.qualityforum.org/Setting_Priorities/*

Partnership/MAP_Final_Reports.aspx. The MAP conditionally supported this measure. Refer to section VIII.B. of this proposed rule for more information on the MAP.

We reviewed the NQF's consensus endorsed measures and were unable to identify any NQF-endorsed quality measures focused on assessment of functional status for patients in the IRF setting. There are related measures, but they are not endorsed for IRFs and several focus on one condition (for example, knee or shoulder impairment). We are not aware of any other quality measures for functional outcomes that have been endorsed or adopted by another consensus organization for the IRF setting. Therefore, we are proposing to adopt this measure, IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review), for use in the IRF QRP for the FY 2018 payment determination and subsequent years under the Secretary's authority to select non-NQF-endorsed measures.

We are proposing that data for this quality measure be collected using the IRF–PAI, with submission through the QIES ASAP system. For more information on IRF QRP reporting through the QIES ASAP system, refer to CMS Web site at: *http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html*.

We invite public comments on our proposal to adopt the quality measure entitled IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review) for the IRF QRP, with data collection starting on October 1, 2016, for the FY 2018 payment determination and subsequent years. Refer to section IX.C.9.c. of this proposed rule for more information on the proposed data collection and submission timeline for this quality measure.

TABLE 19—SUMMARY OF IRF QRP MEASURES AFFECTING THE FY 2017 AND FY 2018 ADJUSTMENTS TO THE IRF PPS ANNUAL INCREASE FACTOR AND SUBSEQUENT YEAR INCREASE FACTORS

Continued IRF QRP Measures Affecting the FY 2017 Adjustments to the IRF PPS Annual Increase Factor and Subsequent Year Increase Factors:

- NQF #0138: National Health Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure +
- NQF #0431: Influenza Vaccination Coverage among Healthcare Personnel +
- NQF #0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)
- NQF #1716: National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure +
- NQF #1717: National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure +
- NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs * ^
- NQF #0678: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) *

Proposed New and Re-Proposed IRF QRP Measures Affecting FY 2018 Adjustments to the IRF PPS Annual Increase Factor and Subsequent Year Increase Factors:

- NQF #2502: All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs * ^
- NQF #0678: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) * (data element source: Pressure ulcer items from the LTCH CARE Data Set) ^^
- NQF #0674: An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (data element source: Falls items from the Minimum Data Set 3.0) ** ^^^
- NQF #2631; under review: An application of Percent of LTCH Patients with a an Admission and Discharge Functional Assessment and a Care Plan that Addressed Function (data element source: Selected function items from the CARE Tool used during the Post-Acute Care Payment Reform Demonstration) *** ^^^
- NQF #2633; under review: IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients ** (data element source: Selected function items from the CARE Tool used during the Post-Acute Care Payment Reform Demonstration) *** ^^^
- NQF #2634; under review: IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (data element source: Selected function items from the CARE Tool used during the Post-Acute Care Payment Reform Demonstration) *** ^^^
- NQF #2635; under review: IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (data element source: Selected function items from the CARE Tool used during the Post-Acute Care Payment Reform Demonstration) *** ^^^
- NQF #2636; under review: IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (data element source: Selected function items from the CARE Tool used during the Post-Acute Care Payment Reform Demonstration) *** ^^^

+ Using CDC/NHSN.
^ Medicare Fee-for-Service claims data.
^^ IRF–PAI items would be modified.
^^^ New IRF–PAI items would be required.
* Re-proposed quality measure for FY 2018 and subsequent years.
** Not NQF-endorsed for the IRF setting.
*** Not NQF-endorsed, CMS submitted the measure for NQF review in November 2014.

H. IRF QRP Quality Measures and Measure Concepts Under Consideration for Future Years

We are inviting public comments on relevance and applicability of each of the quality measures and quality measure concepts listed in Table 20 for future years in the IRF QRP. Specifically, we invite public comments regarding the clinical importance, the feasibility of data collection and implementation to inform and improve quality of care delivered to IRF patients.

TABLE 20: Future Measures and Measure Concepts under Consideration for the IRF Quality Reporting Program

National Quality Strategy Priority: Patient Safety
Venous Thromboembolism Prophylaxis
Medication Reconciliation*
National Quality Strategy Priority: Effective Communication and Coordination of Care
Transfer of health information and care preferences when an individual transitions*
All-Condition Risk-Adjusted Potentially Preventable Hospital Readmission Rates*
National Quality Strategy Priority: Patient- and Caregiver-Centered Care
Discharge to Community*
Patient Experience of Care
Percent of Patients with Moderate to Severe Pain
National Quality Strategy Priority: Affordable Care
Medicare Spending per Beneficiary*

* Indicates that this is a cross-setting measure domain listed in the IMPACT Act of 2014.

I. Proposed Form, Manner, and Timing of Quality Data Submission for the FY 2018 Payment Determination and Subsequent Years

1. Background

Section 1886(j)(7)(C) of the Act requires that, for the FY 2014 payment determination and subsequent years, each IRF submit to the Secretary data on quality measures specified by the Secretary. In addition, section 1886(j)(7)(F) of the Act, as added by the IMPACT Act, requires that, for the FY beginning on the specified application date, as defined in section 1899B(a)(2)(E) of the Act, and each subsequent year, each IRF submit to the Secretary data on measures specified by the Secretary under section 1899B. The data required under section 1886(j)(7)(C) and (F) must be submitted in a form and manner, and at a time, specified by the Secretary. As required by section 1886(j)(7)(A)(i) of the Act, for any IRF that does not submit data in accordance with section 1886(j)(7)(C) and (F) of the Act with respect to a given fiscal year, the annual increase factor for payments for discharges occurring during the fiscal year must be reduced by 2 percentage points.

2. Proposed Timeline for Data Submission Under the IRF QRP for the FY 2018 and FY 2019 Payment Determinations

We propose the following data submission timeline for the quality measures that we have proposed for the FY 2018 adjustments to the IRF PPS annual increase factor. We propose that IRFs would be required to submit IRF–PAI data on discharges occurring between October 1, 2016 and December 31, 2016 (first quarter), for the FY 2018 adjustments to the IRF PPS annual increase factor. For FY 2019, we propose that IRFs would be required to submit data on discharges occurring between January 1, 2017 and December 31, 2017 (1 year). We propose this time frame because we believe this will provide sufficient time for IRFs, and we can put processes and procedures in place to meet the additional quality reporting requirements. Given that these measures are collected via the IRF–PAI, and IRFs are already familiar with the QIES ASAP system, we believe this proposed timeframe will allow IRFs ample opportunity to begin reporting the newly proposed measures, should they be finalized. We also propose that the quarterly data submission deadlines (for submitting IRF–PAI corrections) for the FY 2018 adjustments to the IRF PPS annual increase factor occur approximately 135 days after the end of the quarter, as outlined in the Table 21. Each quarterly deadline would be the date by which all data collected during the preceding quarter would be required to be submitted to us for measures using the IRF–PAI.

We invite public comment on these proposed timelines for data submission for the proposed IRF QRP quality measures for the FY 2018 and FY 2019 adjustments to the IRF PPS annual increase factor.

TABLE 21—DATA COLLECTION TIME FRAME AND SUBMISSION DEADLINES FOR PROPOSED IRF QRP QUALITY DATA FOR MEASURES * USING IRF–PAI AS DATA COLLECTION MECHANISM, FY 2018 ADJUSTMENTS TO THE ANNUAL INCREASE FACTOR

Quarter (calendar year)	Data collection time frame	Deadline submission of IRF–PAI corrections	Annual increase factor affected
Quarter 4 (CY 2016)	October 1, 2016—December 31, 2016	May 15, 2017	FY 2018

* includes data required for the 3 cross-setting IMPACT Act measures.

TABLE 22—DATA COLLECTION TIME FRAME AND SUBMISSION DEADLINES FOR RE-PROPOSED AND ADDITIONAL IRF QRP QUALITY DATA FOR MEASURES USING IRF–PAI AS DATA COLLECTION MECHANISM, FY 2019 ADJUSTMENTS TO THE ANNUAL INCREASE FACTOR

Quarter (calendar year)	Data collection time frame	Deadline submission of IRF–PAI corrections	Annual increase factor affected
Quarter 1 (CY 2017)	January 1, 2017—March 31, 2017	August 15, 2017	FY 2019
Quarter 2 (CY 2017)	April 1, 2017—June 30, 2017	November 15, 2017	FY 2019
Quarter 3 (CY 2017)	July 1, 2017—September 30, 2017	February 15, 2018	FY 2019
Quarter 4 (CY 2017)	October 1, 2017—December 31, 2017	May 15, 2018	FY 2019

3. Proposed Revision to the Previously Adopted Data Collection Timelines and Submission Deadlines

We are proposing that the quality measures in the IRF QRP have a data collection time frame based on the calendar year, unless there is a clinical reason for an alternative data collection time frame. For example, for Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431) and Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) (NQF #0680), the data collection period is tied to the influenza vaccination season. At this time, three of the quality measures submitted via CDC's NHSN (that is, the CAUTI measure [NQF #0138], the MRSA measure [NQF #1716], and the CDI measure [NQF #1717]) use a quarterly data collection time frame based on the calendar year. The pressure ulcer measure [NQF #0678], which is submitted using the IRF–PAI, follows a fiscal year data collection time frame due to the current fiscal-year-based release schedule of the IRF–PAI. The two influenza vaccination quality measures (Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine [NQF #0680], Influenza Vaccination Coverage among Healthcare Personnel [NQF #0431]) use a data collection time frame that is consistent with the influenza vaccination season (that is, October 1 [or when the vaccine becomes available] to March 31).

We are proposing to revise the data collection time frame to follow the calendar year, unless there is a clinical reason for an alternative data collection time frame. We posit this change will simplify the data collection and submission timeframe under the IRF QRP for IRF providers. It would also eliminate the situation in which data collection during a quarter in the same calendar year can affect two different years of annual payment update determination (that is, October 1 to December 31 is first quarter of data collection for quality measures with fiscal year data collection time frame and the last quarter of data collection for quality measures with calendar data collection time frame). If this proposal was implemented, when additional quality measures that use IRF–PAI as the data collection mechanism are adopted for the IRF QRP, the first data collection time frame will be 3 months (October to December) and subsequent data collection timeframe would follow a calendar year data collection time frame.

We invite public comments on our proposal to adopt calendar data collection timeframes, unless there is a clinical reason for an alternative data collection time frame.

4. Proposed Data Submission Mechanisms for the FY 2018 and Subsequent Years Payment Determination for Additional IRF QRP Quality Measures and for Revisions to Previously Adopted Quality Measures

We are proposing that all IRFs would be required to collect data using a revised IRF–PAI Version 1.4 (IRF–PAI 1.4) for the proposed pressure ulcer measure and the additional six quality measures: (1) Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay) ((NQF #0678); (2) an application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674); (3) an application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under review); (4) IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; under review); (5) IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review); (6) IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; under review); and (7) IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review). IRF–PAI Version 1.4 would have modified pressure ulcer items collected at admission and discharge, new fall items collected at discharge, new self-care and mobility functional status items collected at admission and discharge, and new risk factor items for the self-care and mobility measures collected at admission. The proposed IRF–PAI Version 1.4 is available at: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html*

The QIES ASAP system would remain the data submission mechanism for the IRF–PAI. We will release the technical data submission specifications and update the IRF–PAI Training Manual to include items related to the new and updated quality measures in CY 2015. Further information on data submission of the IRF–PAI for the IRF QRP using the QIES ASAP system is available at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html*. We invite public comments on these proposals.

J. Previously Adopted and Proposed Timing for New IRFs To Begin Submitting Quality Data Under the IRF QRP for the FY 2018 Payment Determination and Subsequent Years

In the FY 2015 IRF PPS (79 FR 45918), we finalized that beginning with the FY 2017 payment determination and that of subsequent fiscal years, new IRFs are required to begin reporting data under the IRF QRP requirements no later than the first day of the calendar quarter subsequent to the quarter in which it was designated as operating in the Certification and Survey Provider Enhanced Reports (CASPER) system.

To ensure that all IRFs have a minimum amount of time to prepare to submit quality data to CMS under the requirements of the IRF QRP, beginning

with the FY 2017 payment determination, we are proposing that a new IRF be required to begin reporting quality data under the IRF QRP by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter. For example, if an IRF's CCN notification letter is dated March 15th, then the IRF would be required to begin reporting quality data to CMS beginning on July 1st (March 15 + 30 days = April 14 (quarter 2). The IRF would be required to begin collecting quality data on the first day of the quarter subsequent to quarter 2, which is quarter 3, or July 1st). The collection of quality data would begin on the first day of the calendar year quarter identified as the start date, and would include all IRF admissions and subsequent discharges beginning on, and subsequent to, that day; however, the actual submission of quality data would be required by previously finalized quarterly deadlines, which fall approximately 135 days post the end of each CY quarter. To determine which quality measure data an IRF would need to begin submitting, we refer you to section VIII.E of this proposed rule, as it will vary depending upon the timing of the CY quarter identified as a start date.

We propose to add the IRF QRP participation requirements at § 412.634 and invite public comments on our proposal to the participation requirements for new IRFs.

K. IRF QRP Data Completion Thresholds for the FY 2016 Payment Determination and Subsequent Years

In the FY 2015 IRF PPS final rule (79 FR 45921 through 45923), we finalized IRF QRP thresholds for completeness of IRF data submissions. To ensure that IRFs are meeting an acceptable standard for completeness of submitted data, we finalized the policy that, beginning with the FY 2016 payment determination and for each subsequent year, IRFs must meet or exceed two separate data completeness thresholds: one threshold set at 95 percent for completion of quality measures data collected using the IRF–PAI submitted through the QIES and a second threshold set at 100 percent for quality measures data collected and submitted using the CDC NHSN.

Additionally, we stated that we will apply the same thresholds to all measures adopted as the IRF QRP expands and IRFs begin reporting data on previously finalized measure sets. That is, as we finalize new measures through the regulatory process, IRFs will be held accountable for meeting the previously finalized data completion threshold requirements for each measure until such time that updated threshold requirements are proposed and finalized through a subsequent regulatory cycle.

Further, we finalized the requirement that an IRF must meet or exceed both thresholds to avoid receiving a 2 percentage point reduction to their annual payment update for a given fiscal year, beginning with FY 2016 and for all subsequent payment updates. We are not proposing any changes to these policies. Refer to the FY 2015 IRF PPS final rule (79 FR 45921 through 45923) for a detailed discussion of the finalized IRF QRP data completion requirements.

L. Proposed Suspension of the IRF QRP Data Validation Process for the FY 2016 Payment Determination and Subsequent Years

Validation is intended to provide added assurance of the accuracy of the data that will be reported to the public as required by sections 1886(j)(7)(E) and 1899B(g) of the Act. In the FY 2015 IRF PPS rule (79 FR 45923), we finalized, for the FY 2016 adjustments to the IRF PPS annual increase factor and subsequent years, a process to validate the data submitted for quality purposes. At this time we are proposing to temporarily suspend the implementation of this policy. We are proposing that, through the suspension of this previously finalized policy, data accuracy validation will have no bearing on the applicable FY annual increase factor reduction for FY 2016 and subsequent years unless and until we propose to either reenact this policy, or propose to adopt a new validation policy through future notice-and-comment rulemaking. At this time, we are working to develop a more comprehensive data validation policy that is aligned across the PAC quality reporting programs, and believe that we can implement a policy that increases the efficiency with which data validation is performed. We are also considering ways to reduce the labor and cost burden on IRFs through the development of a new data accuracy validation policy.

We invite comment on our proposal.

M. Previously Adopted and Proposed IRF QRP Submission Exception and Extension Requirements for the FY 2017 Payment Determination and Subsequent Years

In the FY 2014 IRF PPS final rule (78 FR 47920), we finalized a process for IRF providers to request and for us to grant exceptions or extensions for the reporting requirements of the IRF QRP for one or more quarters, beginning with the FY 2015 payment determination and for subsequent years when there are extraordinary circumstances beyond the control of the provider. We also finalized a policy that allows us to grant exemptions or extensions to IRFs that did not request them when it is determined than an extraordinary circumstance affects an entire region or locale.

In the FY 2015 IRF PPS final rule (79 FR 45920 through 45921), we adopted the policies and procedures previously finalized in the FY 2014 IRF PPS final rule for the FY 2017 payment determination and that of subsequent years. We also finalized the policy that grant an exception or extension to IRFs if we determine that a systemic problem with one of our data collection systems directly affected the ability of an IRF to submit data.

We are not proposing any changes to the previously finalized policies and procedures for the FY 2018 payment determination and beyond.

In the FY 2014 IRF PPS final rule and the FY 2015 IRF PPS final rule, we stated that IRFs must submit request an exception or extension by submitting a written request along with all supporting documentation to CMS via email to the IRF QRP mailbox at *IRFQRPReconsiderations@cms.hhs.gov*. We further stated that exception or extension requests sent to us through any other channel would not be considered as a valid request for an exception or extension from the IRF QRP's reporting requirements for any payment determination. To be considered, a request for an exception or extension must contain all of the requirements as outlined on CMS Web site at: *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Reconsideration-and-Exception-and-Extension.html*.

We propose to add the IRF QRP Submission Exception and Extension Requirements at § 412.634. Refer to the FY 2014 IRF PPS final rule (78 FR 47920) and the FY 2015 IRF PPS final rule (79 FR 45920 through 45921) for detailed discussions of the IRF QRP Submission Exception and Extension Requirements.

N. Previously Adopted and Proposed IRF QRP Reconsideration and Appeals Procedures for the FY 2017 Payment Determination and Subsequent Years

At the conclusion of each FY reporting cycle, we review the data received from each IRF to determine if the IRF met the reporting requirements set forth for that reporting cycle. IRFs that are found to be non-compliant will

receive a reduction in the amount of 2 percentage points to their annual payment update for the applicable fiscal year. In the FY 2015 IRF PPS final rule (79 FR 45919 through 45920), we described and adopted an updated process that enables an IRF to request a reconsideration of our initial noncompliance decision in the event that an IRF believes that it was incorrectly identified as being subject to the 2-percentage point reduction to its IRF PPS annual increase factor due to noncompliance with the IRF QRP reporting requirements for a given reporting period.

Any IRF that wishes to submit a reconsideration request must do so by submitting an email to CMS containing all of the requirements listed on the IRF program Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Reconsideration-and-Exception-and-Extension.html*. Email sent to *IRFQRPReconsiderations@cms.hhs.gov* is the only form of submission that will be accepted by us. Any reconsideration requests received through another channel, including U.S. postal service or phone, will not be considered as a valid reconsideration request.

We propose to continue using the IRF QRP Reconsideration and Appeals Procedures that were adopted in the FY 2015 IRF PPS final rule (79 FR 45919 through 45920) for the FY 2017 payment determination and subsequent years with an exception regarding the way in which non-compliant IRFs are notified of this determination.

Currently only IRFs found to be non-compliant with the reporting requirements set forth for a given payment determination received a notification of this finding along with instructions for requesting reconsideration in the form of a certified United States Postal Service (USPS) letter. In an effort to communicate as quickly, efficiently, and broadly as possible with IRFs regarding annual compliance, we are proposing changes to our communications method regarding annual notification of reporting compliance in the IRF QRP. In addition to sending letters via regular USPS mail, beginning with the FY 2016 payment determination and for subsequent fiscal years, we propose to use the QIES as a mechanism to communicate to IRFs regarding their compliance with the reporting requirements for the given reporting cycle.

We propose that all Medicare-certified IRF compliance letters be uploaded into the QIES system for each IRF to access. Instructions to download files from QIES may be found at *https://www.qtso.com/irfpai.html*. We propose to disseminate communications regarding the availability of compliance reports in IRFs' QIES files through routine channels to IRFs and vendors, including, but not limited to, issuing memos, emails, Medicare Learning Network (MLN) announcements, and notices on *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Reconsideration-and-Disaster-Waiver-Requests.html*.

The purpose of the compliance letter is to notify an IRF that it has been identified as either being compliant or non-compliant with the IRF QRP reporting requirements for the given reporting cycle. If the IRF is determined to be non-compliant, then the notification would indicate that the IRF is scheduled to receive a 2 percentage point reduction to its upcoming annual payment update and that it may file a reconsideration request if it disagrees with this finding. IRFs may request a reconsideration of a non-compliance determination through the CMS reconsideration request process. We also propose that the notifications of our decision regarding all received reconsideration requests will be made available through the QIES system. We are not proposing to change the process or requirements for requesting reconsideration. Refer to the FY 2015 IRF PPS final rule (79 FR 45919 through 45920) for a detailed discussion of the IRF QRP Reconsideration and Appeals Procedures.

Below, we include a proposal to publish a list of IRFs who successfully meet the reporting requirements for the applicable payment determination on the IRF QRP Web site *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/*. As proposed below, we would also update the list of IRFs who successfully meet the reporting requirements after all reconsideration requests have been processed on an annual basis.

We propose to add the IRF QRP Reconsideration and Appeal Procedures at § 412.634.

We invite comment on the proposals to change the communication mechanism to the QIES system for the dissemination of compliance notifications and reconsideration decisions and to add these processes at § 412.634.

O. Proposed Public Display of Quality Measure Data for the IRF QRP

Section 1886(j)(7)(E) of the Act requires the Secretary to establish procedures for making the IRF QRP data available to the public. In so doing, the Secretary must ensure that IRFs have the opportunity to review any such data with respect to the IRF prior to its release to the public. Section 1899B(g) of the Act requires the Secretary to establish procedures for making available to the public information regarding the performance of individual PAC providers with respect to the measures required under section 1899B beginning not later than 2 years after the applicable specified application date. The procedures must ensure, including through a process consistent with the process applied under section 1886(b)(3)(B)(viii)(VII) for similar purposes, that each PAC provider has the opportunity to review and submit corrections to the data and information that are to be made public with respect to the PAC provider prior to such data being made public. We propose a policy to display performance information regarding the quality measures, as applicable, required by the IRF QRP by fall 2016 on a CMS Web site, such as the Hospital Compare Web site: *http://www.hospitalcompare.hhs.gov*, after a 30-day preview period. Additional information about preview report content and delivery will be announced on the IRF QRP Web site.

The Hospital Compare Web site is an interactive web tool that assists beneficiaries by providing information on hospital quality of care to those who need to select a hospital. It further serves to encourage beneficiaries to work with their providers to discuss the quality of care provided to patients, thereby providing an additional incentive to providers to improve the quality of care that they furnish. As we have done on other CMS compare Web sites, we will, at some point in the future, report public data using a quality rating system that gives each IRF a rating between 1 and 5 stars. Initially, however, we will not use the 5-star methodology, until such time that we are publically reporting a sufficient number of quality metrics to allow for variation and the differentiation between IRFs using this methodology. Decisions regarding how the rating system will determine a providers star rating and methods used for calculations, as well as a proposed timeline for implementation will be announced via regular IRF QRP communication channels, including listening sessions, memos, email

notification, provider association calls, Open Door Forums, and Web postings. Providers would be notified via CMS listservs, CMS mass emails, and memorandums, IRF QPR Web site announcements and MLN announcements regarding the release of IRF Provider Preview Reports followed by the posting of data.

The initial display of information would contain IRF provider performance on the following three quality measures:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)
- NHSN CAUTI Outcome Measure (NQF #0138)
- All-Cause Unplanned Readmission Measure for 30 Days Post Discharge From IRFs (NQF #2502)

For the first 2 listed measures, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and NHSN CAUTI Outcome Measure (NQF #0138), we propose publicly reporting data beginning with data collected on these measures for discharges beginning January 1, 2015. Rates would be displayed based on 4 rolling quarters of data and would initially be reported using discharges from January 1, 2015 through December 31, 2015, for calculation. As each quarter advances, we would add the subsequent calendar year quarter and remove the earliest calendar year quarter. For example, initially we would use data from discharges occurring from January 1, 2015 through December 31, 2015. The next quarter, we would display performance data using discharges that occurred between the dates of April 1, 2015 through March 31, 2016, etc.

For the measure All-Cause Unplanned Readmission Measure for 30 Days Post Discharge From IRFs (NQF #2502), we propose to publicly report data beginning with data collected for discharges beginning January 1, 2013. Rates would be displayed based on 2 consecutive years of data and would initially be reported using discharges from January 1, 2013 through December 31, 2014. As each calendar year advances, we would add the subsequent calendar year quarter and remove the earliest calendar year quarter.

Calculations for the CAUTI measure adjust for differences in the characteristics of hospitals and patients using a Standardized Infection Ratio (SIR). The SIR is a summary measure that takes into account differences in the types of patients a hospital treats. The SIR may take into account the type of patient care location, laboratory testing methods, hospital affiliation with a medical school, bed size of the hospital, and bed size of specific patient care locations. It compares the actual number of Healthcare Associated Infections (HAIs) in a facility or state to a national benchmark based on previous years of reported data and adjusts the data based on several risk factors. A confidence interval with a lower and upper limit is displayed around each SIR to indicate that there is a high degree of confidence that the true value of the SIR lies within that interval. An SIR with a lower limit that is greater than 1.0 means that there were more HAIs in a facility or state than were predicted, and the facility is classified as ''Worse than the U.S. National Benchmark''. If the SIR has an upper limit that is less than 1, then the facility had fewer HAIs than were predicted and is classified as ''Better than the U.S. National Benchmark''. If the confidence interval includes the value of 1, then there is no statistical difference between the actual number of HAIs and the number predicted, and the facility is classified as ''No Different than U.S. National Benchmark''. If the number of predicted infections is a specific value less than 1, the SIR and confidence interval cannot be calculated.

Calculations for the Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened measure application (NQF #0678) will be risk-adjusted. Resident- or patient-level covariate risk adjustment is performed. Resident- or patient-level covariates are used in a logistic regression model to calculate a resident- or patient-level expected quality measure (QM) score (the probability that the resident or patient will evidence the outcome, given the presence or absence of patient characteristics measured by the covariates). Then, an average of all resident- or patient-level expected QM scores for the facility is calculated to create a facility-level expected QM score. The final facility-level adjusted QM score is based on a calculation which combines the facility-level expected score and the facility level observed score. Additional information about the covariates can be found at: *http://www.qualityforum.org/QPS/QPSTool.aspx?m=213&e=1#qpsPageState=%7B%22TabType%22%3A1,%22TabContentType%22%3A2,%22ItemsToCompare%22%3A%5B%5D,%22StandardID%22%3A213,%22EntityTypeID%22%3A1%7D*.

Finally, calculation for performance on the measure All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502) will also be risk-adjusted. The risk adjustment methodology is available, along with the specifications for this measure, on our IRF Quality Reporting Measures Information Web page at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html*.

We are currently developing reports that will allow providers to view the data that is submitted to CMS via the QIES ASAP system and the CDC's NHSN (Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and NHSN CAUTI Outcome Measure (NQF #0138), respectively). Although initial reports will not allow providers to view this data, subsequent iterations of these reports will also include provider performance on any currently reported quality measure that is calculated based on CMS claims data that we plan on publicly reporting (All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs (NQF #2502)). Although real time results will not be available, the report will refresh all of the data submitted at least once a month. We propose a process to give providers an opportunity to review and correct data submitted to the QIES ASAP system or to the CDC's NHSN system by utilizing that report. Under this proposed process, providers would to have the opportunity to review and correct data they submit on all assessment-based measures. Providers can begin submitting data on the first discharge day of any reporting quarter. Providers are encouraged to submit data early in the submission schedule so that they can identify errors and resubmit data before the quarterly submission deadline. The data would be populated into reports that are updated at least once a month with all data that have been submitted. That report would contain the provider's performance on each measure calculated based on assessment submissions to the QIES ASAP or CDC NHSN system. We believe that the submission deadline timeframe, which is 4.5 months beyond the end of each calendar year quarter, is sufficient time for providers to be able to submit, review data, make corrections to the data, and view their data. We note that the quarterly data submission deadline/timeframe only applies to the quality indicator section of the IRF–PAI, and has no bearing on the current deadline of 27 days that is imposed for payment items. We propose that once the provider has an opportunity to review and correct quarterly data related to measures submitted via the QIES ASAP

or CDC NHSN system, we would consider the provider to have been given the opportunity to review and correct this data. We would not allow patient-level data correction after the submission deadline or for previous years. This is because we must set a deadline to ensure timely computation of measure rates and payment adjustment factors. Before we display this information, providers will be permitted 30 days to review their information as recorded in the QIES ASAP or CDC NHSN system.

In addition to our proposal, we are proposing to publish a list of IRFs who successfully meet the reporting requirements for the applicable payment determination on the IRF QRP Web site *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/*. We propose updating the list after reconsideration requests are processed on an annual basis.

We invite public comment on the listed proposals.

P. Proposed Method for Applying the Reduction to the FY 2016 IRF Increase Factor for IRFs That Fail To Meet the Quality Reporting Requirements

As previously noted, section 1886(j)(7)(A)(i) of the Act requires the application of a 2-percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. In compliance with 1886(j)(7)(A)(i) of the Act, we will apply a 2-percentage point reduction to the applicable FY 2016 market basket increase factor (1.9 percent) in calculating an adjusted FY 2016 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements. As previously noted, application of the 2-percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved. Table 23 shows the calculation of the adjusted FY 2016 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from January 1, 2014, through December 31, 2014.

TABLE 23—CALCULATIONS TO DETERMINE THE ADJUSTED FY 2016 STANDARD PAYMENT CONVERSION FACTOR FOR IRFS THAT FAILED TO MEET THE QUALITY REPORTING REQUIREMENT

Explanation for adjustment		Calculations
Standard Payment Conversion Factor for FY 2015		$15,198
Market Basket Increase Factor for FY 2016 (2.7 percent), reduced by 0.6 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, reduced by 0.2 percentage point in accordance with sections 1886(j)(3)(C) and (D) of the Act and further reduced by 2 percentage points for IRFs that failed to meet the quality reporting requirement	×	0.9990
Budget Neutrality Factor for the Wage Index and Labor-Related Share	×	1.0027
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	×	1.0000
Final Adjusted FY 2016 Standard Payment Conversion Factor	=	15,224

We invite public comment on the proposed method for applying the reduction to the FY 2016 IRF increase factor for IRFs that fail to meet the quality reporting requirements.

IX. Collection of Information Requirements

A. Statutory Requirement for Solicitation of Comments

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

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

This proposed rule makes reference to associated information collections that are not discussed in the regulation text contained in this document.

B. Collection of Information Requirements for Updates Related to the IRF QRP

Failure to submit data required under section 1886(j)(7)(C) and (F) will result in the reduction of the annual update to the standard federal rate for discharges occurring during such fiscal year by 2 percentage points for any IRF that does not comply with the requirements established by the Secretary. At the time that this analysis was prepared, 91, or approximately 8 percent, of the 1166 active Medicare-certified IRFs did not receive the full annual percentage increase for the FY 2015 annual payment update determination. Information is not available to determine the precise number of IRFs that will not meet the requirements to receive the full annual percentage increase for the FY 2016 payment determination.

We believe that the burden associated with the IRF QRP is the time and effort associated with data collection and reporting. As of April 1, 2015, there are approximately 1132 IRFs currently reporting quality data to CMS. In this proposed rule, we are proposing 2 quality measures that have already been adopted for the IRF QRP: (1) All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs (NQF #2502), to establish the newly NQF-endorsed status of this measures; and (2) Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678), to establish its use as a cross-setting measure that addresses the domain of skin integrity, as required by the IMPACT Act of 2014. The All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs is a Medicare claims-based measure; because claims-based measures can be calculated based on data that are already reported to the Medicare program for payment purposes, we believe there will be no additional impact. We also believe that there will be no additional burden

associated with our re-proposal of the measure Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678), as IRFs are already submitting quality data related to this measure.

We are also proposing to adopt 6 additional quality measures. These 6 new proposed quality measures are: (1) An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674); (2) an application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631; under review); (3) IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; under review); (4) IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review); (5) IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; under review); and (6) IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review). Additionally we propose that data for these 6 new measures will be collected and reported using the IRF–PAI (version 1.4).

Our burden calculations take into account all ''new'' items required on the IRF–PAI (version 1.4) to support data collection and reporting for these six proposed measures. New items will be included on the following assessment: IRF–PAI version 1.4 Admission and Discharge assessment. The addition of the new items required to collect the six newly proposed measures is for the purpose of achieving standardization of data elements.

We estimate the additional elements for the six newly proposed measures will take 25.5 minutes of nursing/clinical staff time to report data on admission and 16.0 minutes of nursing/clinical staff time to report data on discharge, for a total of 41.5 minutes. We believe that the additional IRF–PAI items we are proposing will be completed by Registered Nurses (RN), Occupational Therapists (OT), Speech Language Pathologists (SLP) and/or Physical Therapists (PT), depending on the item. We identified the staff type per item based on past LTCH and IRF burden calculations in conjunction with expert opinion. Our assumptions for staff type were based on the categories generally necessary to perform assessment: RN, OT, SLP, and PT. Individual providers determine the staffing resources necessary; therefore, we averaged the national average for these labor types and established a composite cost estimate. This composite estimate was calculated by weighting each salary based on the following breakdown regarding provider types most likely to collect this data: RN 59 percent; OT 11 percent; PT 20 percent; SLP 1 percent. In accordance with OMB control number 0938–0842, we estimate 390,748 discharges from all IRFs annually, with an additional burden of 41.5 minutes. This would equate to 270,267.37 total hours or 238.75 hours per IRF. We believe this work will be completed by RN, OT, PT, and SLP staff, depending on the item. We obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' May 2013 National Occupational Employment and Wage Estimates (*http://www.bls.gov/oes/current/oes_nat.htm*), to account for overhead and fringe benefits, we have doubled the mean hourly wage. Per the U.S. Bureau of Labor and Statistics, the mean hourly wage for a RN is $33.13. However, to account for overhead and fringe benefits, we have double the mean hourly wage, making it $66.26 for an RN. The mean hourly wage for an OT is $37.45, doubled to $74.90 to account for overhead and fringe benefits. The mean hourly wage for a PT is $39.51, doubled to $79.02 to account for overhead and fringe benefits. The mean hourly wage for a SLP is $35.56, doubled to $71.12 to account for overhead and fringe benefits. Given these wages and time estimates, the total cost related to the six newly proposed measures is estimated at $21,239.33 per IRF annually, or $22,529,560.74–$24,042,291.01 for all IRFs annually.

For the discussion purposes, we provided a detailed description of the burden associated with the proposed requirements in section XI. of this proposed rule. However, the burden associated with the aforementioned requirements is exempt from the PRA under the IMPACT Act of 2014. Section 1899B(m) and the sections referenced in section 1899B(a)(2)(B) of the Act exempt modifications that are intended to achieve the standardization of patient assessment data. The requirement and burden will, however, be submitted to OMB for review and approval when the quality measures and the PAC assessment instruments are no longer used to achieve the standardization of patient assessment data.

In section VIII.F of this proposed rule, we are proposing 2 quality measures that have already been adopted for the IRF QRP: (1) All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502), to establish the newly NQF-endorsed status of this measures; and (2) Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678), to establish its use as a cross-setting measure that addresses the domain of skin integrity, as required by the IMPACT Act of 2014. The All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs is a Medicare claims-based measure; because claims-based measures can be calculated based on data that are already reported to the Medicare program for payment purposes, we believe there will be no additional impact as a result of this measure. We also believe that there will be no additional burden associated with our proposal of the measure Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678), as IRFs are already submitting quality data related to this measure.

In section VIII.G of this proposed rule, we are also proposing to adopt six new quality measures. These 6 proposed quality measures are: (1) An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674); (2) an application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under review); (3) IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; under review); (4) IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review); (5) IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; under review); and (6) IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review). Additionally, we propose that data for the six measures will be collected and reported using the IRF–PAI (version 1.4). While the reporting of data on quality measures is an information collection, we believe that the burden associated with modifications to the IRF–PAI discussed in this proposed rule fall under the PRA exceptions provided in 1899B(m) of the Act because they are required to achieve the standardization of patient assessment data. Section 1899B(m) of the Act provides that the PRA does not apply to section 1899B and the sections referenced in section 1899B(a)(2)(B) of the Act that require modification to achieve the standardization of patient assessment data. The requirement and

burden will, however, be submitted to OMB for review and approval when the modifications to the IRF–PAI or other applicable PAC assessment instrument are not used to achieve the standardization of patient assessment data. Additionally, while quality measures 3, 4, 5, and 6 listed are not specifically required by the IMPACT Act, the data elements used to inform those measures are part of larger set of functional status data items that have been added to the IRF–PAI version 1.4, for the purpose of providing standardized data elements under the domain of functional status, which is required by the IMPACT Act. These same data elements are used to inform different quality measures that we have proposed, each with a different outcome.

With regard to quality reporting during extraordinary circumstances, section VIII.M of this proposed rule, proposes to add a previously finalized process that IRFs may request an exception or extension from the FY 2018 payment determination and that of subsequent payment determinations. The request must be submitted by email within 90 days from the date that the extraordinary circumstances occurred.

While the preparation and submission of the request is an information collection, unlike the aforementioned temporary exemption of the data collection requirements for the 6 new quality measures, and the 2 re-proposed quality measures, the request is not expected to be submitted to OMB for formal review and approval since we estimate less than 2 requests (total) per year. Since we estimate fewer than ten respondents annually, the information collection requirement and associated burden is not subject as stated in the implementing regulations of the PRA (5 CFR 1320.3(c)).

As discussed in section VIII.N of this proposed rule, this rule proposes to add a previously finalized process that will enable IRFs to request reconsiderations of our initial non-compliance decision in the event that it believes that it was incorrectly identified as being subject to the 2-percentage point reduction to its annual increase factor due to non-compliance with the IRF QRP reporting requirements. We believe the reconsideration and appeals requirements and the associated burden would be incurred subsequent to an administrative action. In accordance with the implementing regulations for the PRA (5 CFR 1320.4(a)(2) and (c)), the burden associated with any information collected subsequent to the administrative action is exempt from the requirements of the PRA.

If you comment on these information collection and recordkeeping requirements, please submit your comments *electronically* as specified in the **ADDRESSES** section of this proposed rule.

X. Response to Public Comments

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

XI. Regulatory Impact Analysis

A. Statement of Need

This proposed rule updates the IRF prospective payment rates for FY 2016 as required under section 1886(j)(3)(C) of the Act. It responds to section 1886(j)(5) of the Act, which requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the IRF PPS's case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

This proposed rule implements sections 1886(j)(3)(C) and (D) of the Act. Section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a multi-factor productivity adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010 through 2019.

This proposed rule also adopts some policy changes within the statutory discretion afforded to the Secretary under section 1886(j) of the Act. We propose to adopt an IRF-specific market basket, phase in the revised wage index changes, and update quality measures and reporting requirements under the IRF quality reporting program.

B. Overall Impacts

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for a major final rule with economically significant effects ($100 million or more in any 1 year). We estimate the total impact of the proposed policy updates described in this proposed rule by comparing the estimated payments in FY 2016 with those in FY 2015. This analysis results in an estimated $130 million increase for FY 2016 IRF PPS payments. As a result, this proposed rule is designated as economically ''significant'' under section 3(f)(1) of Executive Order 12866, and hence a major rule under the Congressional Review Act. Also, the rule has been reviewed by OMB.

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 having revenues of $7.5 million to $38.5 million or less in any 1 year depending on industry classification, or by being nonprofit organizations that are not dominant in their markets. (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/sites/default/files/files/Size_Standards_Table.pdf,* effective March 26, 2012 and updated on July 14, 2014.) 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 1,100 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 24, we estimate that the net revenue impact of this proposed rule on all IRFs is to increase estimated payments by approximately 1.7 percent. However, we find that certain individual IRF providers would be expected to experience revenue impacts greater than 3 percent. We estimate that approximately 3 IRFs that would transition from urban to rural status as a result of the changes to the delineation of CBSAs issued in OMB Bulletin No. 13–01 would gain the 14.9 percent rural adjustment, and would therefore experience net increases in IRF PPS payments of 15.2 percent. As a result, we anticipate this proposed rule will have a net positive impact on a substantial number of small entities. Medicare Administrative Contractors are not considered to be small entities. Individuals and states are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As discussed in detail below, the rates and policies set forth in this proposed rule will not have a significant impact (not greater than 3 percent) on a substantial number of rural hospitals based on the data of the 145 rural units and 12 rural hospitals in our database of 1,132 IRFs for which data were available.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–04, enacted on March 22, 1995) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2015, that threshold level is approximately $144 million. This proposed rule will not mandate spending costs on state, local, or tribal governments, in the aggregate, or by the private sector, of greater than $144 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, this proposed rule will not have a substantial effect on state and local governments, preempt state law, or otherwise have a federalism implication.

C. Detailed Economic Analysis

1. Basis and Methodology of Estimates

This proposed rule sets forth proposed policy changes and updates to the IRF PPS rates contained in the FY 2015 IRF PPS final rule (79 FR 45872). Specifically, this proposed rule introduces an IRF-specific market basket. This proposed rule also updates the CMG relative weights and average length of stay values, the wage index, and the outlier threshold for high-cost cases. This proposed rule applies a MFP adjustment to the FY 2016 IRF market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.2 percentage point reduction to the FY 2016 IRF market basket increase factor in accordance with sections 1886(j)(3)(C)(ii)(II) and –(D)(iv) of the Act. Further, this proposed rule proposes revisions to the IRF quality reporting requirements that are expected to result in some additional financial effects on IRFs. In addition, section IX of this rule discusses the implementation of the required 2 percentage point reduction of the market basket increase factor for any IRF that fails to meet the IRF quality reporting requirements, in accordance with section 1886(j)(7) of the Act.

We estimate that the impact of the proposed changes and updates described in this proposed rule will be a net estimated increase of $130 million in payments to IRF providers. This estimate does not include the implementation of the required 2 percentage point reduction of the market basket increase factor for any IRF that fails to meet the IRF quality reporting requirements (as discussed in section XI.C.9. of this proposed rule). The impact analysis in Table 24 of this proposed rule represents the projected effects of the updates to IRF PPS payments for FY 2016 compared with the estimated IRF PPS payments in FY 2015. 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 2016, we are proposing standard annual revisions described in this proposed rule (for example, the update to the wage and market basket indexes used to adjust the federal rates). We are also implementing a productivity adjustment to the FY 2016 IRF market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.2 percentage point reduction to the FY 2016 IRF market basket increase factor in accordance with sections 1886(j)(3)(C)(ii)(II) and –(D)(iv) of the Act. We estimate the total increase in payments to IRFs in FY 2016, relative to FY 2015, will be approximately $130 million.

This estimate is derived from the application of the FY 2016 IRF market basket increase factor, as reduced by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.2 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and –(D)(iv) of the Act, which yields an estimated increase in aggregate payments to IRFs of $145 million. Furthermore, there is an additional estimated $15 million decrease in aggregate payments to IRFs due to the proposed update to the outlier threshold amount. Outlier payments are estimated to decrease under this proposal from approximately 3.2 percent in FY 2015 to 3.0 percent in FY 2016. Therefore, summed together, we estimate that these updates will result in a net increase in estimated payments of $130 million from FY 2015 to FY 2016.

The effects of the proposed updates that impact IRF PPS payment rates are shown in Table 24. The following proposed updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the proposed update to the outlier threshold amount, from approximately 3.2 percent to 3.0 percent of total estimated payments for FY 2016, consistent with section 1886(j)(4) of the Act.

• The effects of the proposed annual market basket update (using the IRF market basket) to IRF PPS payment rates, as required by section 1886(j)(3)(A)(i) and sections 1886(j)(3)(C) and –(D) of the Act, including a productivity adjustment in accordance with section 1886(j)(3)(C)(i)(I) of the Act, and a 0.2 percentage point reduction in accordance with sections 1886(j)(3)(C) and –(D) of the Act.

• The effects of applying the proposed budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.

• The effects of the proposed budget-neutral changes to the CMG relative weights and average length of stay values, under the authority of section 1886(j)(2)(C)(i) of the Act.

• The total change in estimated payments based on the proposed FY 2016 payment changes relative to the estimated FY 2015 payments.

2. Description of Table 24

Table 24 categorizes IRFs by geographic location, including urban or rural location, and location for CMS's 9 census divisions (as defined on the cost report) of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities, ownership (otherwise called for-profit, non-profit, and government), by teaching status, and by disproportionate share patient percentage (DSH PP). The top row of Table 24 shows the overall impact on the 1,132 IRFs included in the analysis.

The next 12 rows of Table 24 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 975 IRFs located in urban areas included in our analysis. Among these, there are 739 IRF units of hospitals located in urban areas and 236 freestanding IRF hospitals located in urban areas. There are 157 IRFs located in rural areas included in our analysis. Among these, there are 145 IRF units of hospitals located in rural areas and 12 freestanding IRF hospitals located in rural areas. There are 403 for-profit IRFs. Among these, there are 348 IRFs in urban areas and 55 IRFs in rural areas. There are 658 non-profit IRFs. Among these, there are 566 urban IRFs and 92 rural IRFs. There are 71 government-owned IRFs. Among these, there are 61 urban IRFs and 10 rural IRFs.

The remaining four parts of Table 24 show IRFs grouped by their geographic location within a region, by teaching status, and by DSH PP. First, IRFs located in urban areas are categorized for their location within a particular one of the nine Census geographic regions. Second, IRFs located in rural areas are categorized for their location within a particular one of the nine Census 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. IRFs are then grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent. Finally, IRFs are grouped by DSH PP, including IRFs with zero DSH PP, IRFs with a DSH PP less than 5 percent, IRFs with a DSH PP between 5 and less than 10 percent, IRFs with a DSH PP between 10 and 20 percent, and IRFs with a DSH PP greater than 20 percent.

The estimated impacts of each policy described in this proposed rule to the facility categories listed are shown in the columns of Table 24. The description of each column is as follows:

• Column (1) shows the facility classification categories.

• Column (2) shows the number of IRFs in each category in our FY 2014 analysis file.

• Column (3) shows the number of cases in each category in our FY 2014 analysis file.

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

• Column (5) shows the estimated effect of the proposed update to the IRF PPS payment rates, which includes a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.2 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and –(D)(iv) of the Act.

• Column (6) shows the estimated effect of the proposed update to the IRF labor-related share and wage index, in a budget-neutral manner. This represents the effect of using the most recent wage data available, without taking into account the revised OMB delineations. That is, the impact represented in this column is solely that of updating from the FY 2015 wage index to the FY 2016 wage index without any changes to the OMB delineations.

• Column (7) shows the estimated effect of adopting the updated OMB delineations for wage index purposes for FY 2016 with the proposed blended FY 2016 wage index.

• Column (8) shows the estimated effect of applying the adjustment factor to payments to IRFs in rural areas. It includes the proposed 3 year budget-neutral phase-out of the rural adjustment for rural IRFs that are becoming urban IRFs due to the revised OMB delineations.

• Column (9) shows the estimated effect of the proposed update to the CMG relative weights and average length of stay values, in a budget-neutral manner.

• Column (10) compares our estimates of the payments per discharge, incorporating all of the proposed policies reflected in this proposed rule for FY 2016 to our estimates of payments per discharge in FY 2015.

The average estimated increase for all IRFs is approximately 1.7 percent. This estimated net increase includes the effects of the proposed IRF market basket increase factor for FY 2016 of 2.7 percent, reduced by a productivity adjustment of 0.6 percentage point in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and further reduced by 0.2 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(iv) of the Act. It also includes the approximate 0.2 percent overall decrease in estimated IRF outlier payments from the proposed update to the outlier threshold amount. Since we are making the proposed updates to the IRF wage index and the CMG relative weights in a budget-neutral manner, they will not be expected to affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they will be expected to affect the estimated distribution of payments among providers.

TABLE 24—IRF IMPACT TABLE FOR FY 2016 (COLUMNS 4 THROUGH 10 IN PERCENTAGE)

Facility Classification	Number of IRFs	Number of cases	Outlier	IRF market basket [1]	Wage index	CBSA	Change in rural adjustment [2]	CMG weights	Total percent change
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Total	1,132	390,748	−0.2	1.9	0.0	0.0	0.0	0.0	1.7
Urban unit	739	179,466	−0.4	1.9	0.1	0.0	0.0	0.0	1.6
Rural unit	145	22,721	−0.3	1.9	0.3	−0.2	0.3	0.0	2.0
Urban hospital	236	184,416	−0.1	1.9	−0.1	0.1	0.0	−0.1	1.8
Rural hospital	12	4,145	0.0	1.9	0.2	−0.7	0.0	−0.1	1.3
Urban For-Profit	348	174,797	−0.1	1.9	0.0	0.0	0.0	0.0	1.7
Rural For-Profit	55	9,810	−0.2	1.9	0.1	−0.4	0.2	0.0	1.6
Urban Non-Profit	566	170,965	−0.3	1.9	0.0	0.1	0.0	0.0	1.7
Rural Non-Profit	92	15,588	−0.3	1.9	0.4	−0.3	0.3	0.1	2.1
Urban Government	61	18,120	−0.4	1.9	−0.3	0.0	−0.1	0.1	1.2
Rural Government	10	1,468	−0.3	1.9	0.3	−0.4	0.0	0.1	1.7
Urban	975	363,882	−0.2	1.9	0.0	0.0	0.0	0.0	1.7
Rural	157	26,866	−0.3	1.9	0.3	−0.3	0.3	0.0	1.9
CBSA Change									
Urban to Urban	956	359,798	−0.2	1.9	0.0	0.0	0.0	0.0	1.7
Rural to Rural	154	26,278	−0.3	1.9	0.3	−0.3	0.0	0.0	1.6
Urban to Rural	3	588	−0.6	1.9	0.8	0.8	11.7	0.1	15.2
Rural to Urban	19	4,084	−0.3	1.9	0.7	1.3	−3.7	0.0	−0.2
Urban by region									
Urban New England	31	16,767	−0.1	1.9	0.7	−0.2	0.0	0.0	2.3
Urban Middle Atlantic	143	57,893	−0.2	1.9	0.1	0.4	0.0	0.0	2.2
Urban South Atlantic	146	69,551	−0.2	1.9	−0.3	−0.1	−0.1	0.0	1.2
Urban East North Central	173	51,589	−0.3	1.9	0.2	−0.1	0.0	0.0	1.8
Urban East South Central	53	24,883	−0.1	1.9	−0.3	−0.1	0.0	0.0	1.4
Urban West North Central	73	18,970	−0.3	1.9	0.1	0.0	0.0	0.0	1.7
Urban West South Central	178	73,231	−0.2	1.9	−0.7	0.0	0.0	0.0	1.0
Urban Mountain	77	25,627	−0.2	1.9	0.7	−0.1	0.0	0.0	2.3
Urban Pacific	101	25,371	−0.4	1.9	0.8	−0.1	0.0	0.0	2.2
Rural by region									
Rural New England	5	1,270	−0.2	1.9	0.9	−0.1	0.0	0.0	2.5
Rural Middle Atlantic	12	1,788	−0.2	1.9	2.0	−2.0	0.0	0.1	1.7
Rural South Atlantic	17	4,268	−0.2	1.9	0.2	−0.3	0.3	0.0	1.9
Rural East North Central	31	5,139	−0.3	1.9	−0.1	0.1	1.0	0.0	2.7
Rural East South Central	18	3,228	−0.2	1.9	0.0	−0.2	0.0	0.0	1.6
Rural West North Central	23	2,847	−0.4	1.9	0.4	−0.1	0.0	0.1	1.9
Rural West South Central	42	7,414	−0.2	1.9	0.3	−0.5	0.0	0.0	1.4
Rural Mountain	7	732	−1.0	1.9	−0.2	−0.1	0.0	0.0	0.7
Rural Pacific	2	180	−1.2	1.9	0.8	0.0	0.0	−0.1	1.4
Teaching status									
Non-teaching	1,022	345,856	−0.2	1.9	0.0	0.0	0.0	0.0	1.7
Resident to ADC less than 10%	63	30,362	−0.2	1.9	0.1	−0.2	0.0	0.1	1.7
Resident to ADC 10%–19%	35	12,804	−0.5	1.9	0.2	0.3	0.0	0.0	1.9
Resident to ADC greater than 19%	12	1,726	−0.1	1.9	−0.1	−0.3	0.0	−0.1	1.3
Disproportionate share patient percentage (DSH PP)									
DSH PP = 0%	46	11,760	−0.4	1.9	−0.1	−0.1	0.0	0.0	1.4
DSH PP <5%	186	68,487	−0.2	1.9	0.0	0.4	0.0	0.0	2.0
DSH PP 5%–10%	317	130,224	−0.2	1.9	−0.1	−0.1	0.0	0.0	1.5
DSH PP 10%–20%	356	121,758	−0.2	1.9	0.2	−0.1	0.0	0.0	1.8
DSH PP greater than 20%	227	58,519	−0.3	1.9	0.1	−0.1	0.0	0.0	1.6

[1] This column reflects the impact of the IRF market basket increase factor for FY 2016 (2.7 percent), reduced by 0.6 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and reduced by 0.2 percentage point in accordance with paragraphs 1886(j)(3)(C) and (D) of the Act.

[2] Providers changing from urban to rural status will receive a 14.9 percent rural adjustment, and providers changing from rural to urban status will receive 2/3 of the 14.9 percent rural adjustment in FY 2016. For those changing from urban to rural, the total impact shown is affected by the outlier threshold increasing, which results in smaller outlier payments as part of the total payments. For those changing from rural to urban status, the outlier threshold is being lowered by 2/3 of 14.9 percent, which results in more providers being eligible for outlier payments, increasing the outlier portion of their total payments.

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

The estimated effects of the proposed update to the outlier threshold adjustment are presented in column 4 of Table 24. In the FY 2015 IRF PPS final rule (79 FR 45872), we used FY 2013 IRF claims data (the best, most complete data available at that time) to set the outlier threshold amount for FY 2015 so that estimated outlier payments would

equal 3 percent of total estimated payments for FY 2015.

For this proposed rule, we are updating our analysis using FY 2014 IRF claims data and, based on this updated analysis, we estimate that IRF outlier payments as a percentage of total estimated IRF payments are 3.2 percent in FY 2015. Thus, we propose to adjust the outlier threshold amount in this proposed rule to set total estimated outlier payments equal to 3 percent of total estimated payments in FY 2016. The estimated change in total IRF payments for FY 2016, therefore, includes an approximate 0.2 percent decrease in payments because the estimated outlier portion of total payments is estimated to decrease from approximately 3.2 percent to 3 percent.

The impact of this proposed outlier adjustment update (as shown in column 4 of Table 24) is to decrease estimated overall payments to IRFs by about 0.2 percent. We estimate the largest decrease in payments from the update to the outlier threshold amount to be 1.2 percent for rural IRFs in the Pacific region.

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

The estimated effects of the proposed market basket update to the IRF PPS payment rates are presented in column 5 of Table 24. In the aggregate the proposed update would result in a net 1.9 percent increase in overall estimated payments to IRFs. This net increase reflects the estimated IRF market basket increase factor for FY 2016 of 2.7 percent, reduced by a 0.6 percentage point productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and further reduced by the 0.2 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(iv) of the Act. The market basket increase factor based on the IRF market basket (2.7 percent) is currently estimated to be 0.1 percentage point lower than the RPL market basket (2.8 percent). This lower update is primarily due to the lower cost weights for Compensation and Pharmaceuticals in the proposed IRF market basket.

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

In column 6 of Table 24, we present the effects of the proposed budget-neutral update of the wage index and labor-related share without taking into account the revised OMB delineations, which are presented separately in the next column. The proposed 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 proposed changes in the two have a combined effect on payments to providers. As discussed in section V.D. of this proposed rule, we propose to increase the labor-related share from 69.294 percent in FY 2015 to 69.6 percent in FY 2016.

6. Impact of the Updated OMB Delineations

In column 7 of Table 24, we present the effects of the revised OMB delineations, and the proposed transition to the new delineations using the blended wage index.

In the aggregate, since these proposed updates to the wage index and the labor-related share are applied in a budget-neutral manner as required under section 1886(j)(6) of the Act, we do not estimate that these proposed updates will affect overall estimated payments to IRFs. However, we estimate that these proposed updates will have small distributional effects. For example, we estimate the largest increase in payments from the update to the CBSA wage index and labor-related share of 0.4 percent for urban IRFs in the Middle Atlantic region. We estimate the largest decrease in payments from the proposed update to the CBSA wage index and labor-related share to be a 2.0 percent decrease for rural IRFs in the Middle Atlantic region.

7. Impact of the Phase-Out of the Rural Adjustment for IRFs Transitioning From Rural to Urban Designations

In column 8 of Table 24, we present the effects 3-year phase-out of the rural adjustment for IRFs transitioning from rural to urban status under the new CBSA delineations. Under the IRF PPS, IRFs located in rural areas receive a 14.9 percent adjustment to their payment rates to account for the higher costs incurred in treating beneficiaries in rural areas. Under the new CBSA delineations, we estimate that 19 IRFs will transition from rural to urban status for purposes of the IRF PPS wage index adjustment in FY 2016. Without the proposed phase-out of the rural adjustment, these 19 IRFs would experience an automatic 14.9 percent decrease in payments as a result of this change from rural to urban status in FY 2016. To mitigate the effects of this relatively large decrease in payments, we are proposing to phase-out the rural adjustment for these providers over a 3-year period, as discussed in more detail in section V. of this proposed rule. Thus, we are proposing that these IRF would receive 2/3 of the rural adjustment in FY 2016, 1/3 of the rural adjustment in FY 2017, and none of the rural adjustment in FY 2018, thus giving these IRFs time to adjust to the reduced payments.

Column 8 shows the effect on providers of this budget-neutral phase-out of the rural adjustment for IRFs transitioning from rural to urban status in FY 2016. Under the proposed policy, these providers would only experience a reduction in payments of 1/3 of the 14.9 percent rural adjustment in FY 2016. As we propose to implement this phase-out in a budget-neutral manner, it does not affect aggregate payments to IRFs, but we estimate that this policy would have small effects on the distribution of payments to IRFs. The largest increase in payments to IRFs as a result of the interaction of the rural adjustment with the changes to the CBSA delineations is an 11.7 percent increase to 3 IRFs that transition from urban to rural status under the new CBSA delineations. These 3 IRFs will receive the full 14.9 percent rural adjustment for FY 2016. The largest decrease in payments to IRFs as a result of this proposed policy change is a 3.7 percent decrease in payments to IRFs that transition from rural to urban status under the new CBSA delineations. This is a result of these providers only receiving 2/3 of the 14.9 percent rural adjustment for FY 2016. We note that the decrease in payments to these providers is substantially lessened from what it otherwise would have been as a result of the proposed phase-out of the rural adjustment for these IRFs.

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

In column 9 of Table 24, we present the effects of the proposed budget-neutral update of the CMG relative weights and average length of stay values. In the aggregate, we do not estimate that these updates will affect overall estimated payments of IRFs. However, we do expect these updates to have small distributional effects. The largest estimated increase in payments is a 0.1 percent increase for IRFs in the rural Middle Atlantic and rural West North Central regions. Rural IRFs in the Pacific region are estimated to experience a 0.1 percent decrease in payments due to the CMG relative weights change.

9. Effects of Proposed Requirements for the IRF QRP for FY 2018

In accordance with section 1886(j)(7) of the Act, we will implement a 2 percentage point reduction in the FY 2016 increase factor for IRFs that have failed to report the required quality reporting data to us during the most

recent IRF quality reporting period. In section VIII.P.A of this proposed rule, we discuss the proposed method for applying the 2 percentage point reduction to IRFs that fail to meet the IRF QRP requirements. At the time that this analysis was prepared, 91, or approximately 8 percent, of the 1166 active Medicare-certified IRFs did not receive the full annual percentage increase for the FY 2015 annual payment update determination. Information is not available to determine the precise number of IRFs that will not meet the requirements to receive the full annual percentage increase for the FY 2016 payment determination.

In section VIII.L of this proposed rule, we discuss our proposal to suspend the previously finalized data accuracy validation policy for IRFs. While we cannot estimate the increase in the number of IRFs that will meet IRF QRP compliance standards at this time, we believe that this number will increase due to the temporary suspension of this policy. Thus, we estimate that the suspension of this policy will decrease impact on overall IRF payments, by increasing the rate of compliance, in addition to decreasing the cost of the IRF QRP to each IRF provider by approximately $47,320 per IRF, which was the estimated cost to each IRF provider to the implement the previously finalized policy.

In section VIII.F of this proposed rule, we are proposing 2 quality measures that have already been adopted for the IRF QRP: (1) All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from IRFs (NQF #2502), to establish the newly NQF-endorsed status of this measures; and (2) Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678), to establish its use as a cross-setting measure that addresses the domain of skin integrity, as required by the IMPACT Act of 2014. The All-Cause Unplanned Readmission Measure for 30 Days Post-Discharge from IRFs is a Medicare claims-based measure; because claims-based measures can be calculated based on data that are already reported to the Medicare program for payment purposes, we believe there will be no additional impact as a result of this measure. We also believe that there will be no additional burden associated with our proposal of the measure Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678), which was proposed to establish its use as a cross-setting measure that meets the IMPACT Act requirement of adding a quality measure that stratifies the domain of skin integrity, as IRFs are already submitting quality data related to this measure.

In section VIII.G of this proposed rule, we are also proposing to adopt six new quality measures. The six proposed quality measures are: (1) An application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674); (2) an application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631; under review); (3) IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633; under review); (4) IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634; under review); (5) IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635; under review); and (6) IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636; under review). Additionally, we propose that data for these six measures will be collected and reported using the IRF–PAI (version 1.4). The total cost related to the six proposed measures is estimated at $21,239.33 per IRF annually, or $24,042,291.01 for all IRFs annually. This is an average increase of 124 percent to all IRF providers over the burden discussed in the FY 2015 IRF PPS Final Rule, which included all quality measures that IRFs are required to report under the QRP with the exception of those new quality measures six proposed in this proposed rule.

We intend to continue to closely monitor the effects of this new quality reporting program on IRF providers and help perpetuate successful reporting outcomes through ongoing stakeholder education, national trainings, IRF provider announcements, Web site postings, CMS Open Door Forums, and general and technical help desks.

D. Alternatives Considered

The following is a discussion of the alternatives considered for the IRF PPS updates contained in this proposed rule.

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. In recent years, IRF PPS payment rates have been updated by the RPL market basket. Thus, we did consider updating payments using the RPL market basket increase factor for FY 2016. However, as stated in section V of this proposed rule, we believe the use of an IRF market basket that reflects the cost structure of the universe of IRF providers is a technical improvement over the use of the RPL market basket. The RPL market basket reflects the input costs of two additional provider types: Inpatient Psychiatric Facilities and Long-term Care Hospitals; and also only included data from freestanding providers. On the other hand, the IRF market basket reflects the input costs of only IRF providers and includes the costs from both freestanding and hospital-based IRF providers. We also had indicated our intention of proposing an IRF market basket in the FY 2015 IRF proposed and final rules and received support for moving from an RPL to an IRF market basket. Based on these reasons, we propose to update payments using the IRF market basket increase factor for FY 2016. In addition, as noted previously in this proposed rule, section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a productivity adjustment to the market basket increase factor for FY 2016, and sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(iv) of the Act require the Secretary to apply a 0.2 percentage point reduction to the market basket increase factor for FY 2016. Thus, in accordance with section 1886(j)(3)(C) of the Act, we proposed to update the IRF federal prospective payments in this proposed rule by 1.9 percent (which equals the 2.7 percent estimated IRF market basket increase factor for FY 2016 reduced by a 0.6 percentage point productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act and further reduced by 0.2 percentage point). If we instead proposed to use the RPL market basket, we would have proposed to update the IRF federal prospective payments by 2.0 percent (which equals the 2.8 percent estimated RPL market basket increase factor for FY 2016 reduced by a 0.6 percentage point productivity adjustment and further reduced by 0.2 percentage point).

We considered maintaining the existing CMG relative weights and average length of stay values for FY 2016. However, in light of recently available data and our desire to ensure that the CMG relative weights and average length of stay values are as reflective as possible of recent changes in IRF utilization and case mix, we believe that it is appropriate to propose to update the CMG relative weights and average length of stay values at this time to ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs.

We considered updating facility-level adjustment factors for FY 2016. However, as discussed in more detail in the FY 2015 final rule (79 FR 45872), we believe that freezing the facility-level adjustments at FY 2014 levels for FY 2015 and all subsequent years (unless and until the data indicate that they need to be further updated) will allow us an opportunity to monitor the effects of the substantial changes to the adjustment factors for FY 2014, and will allow IRFs time to adjust to the previous changes.

We considered maintaining the existing outlier threshold amount for FY 2016. However, analysis of updated FY 2014 data indicates that estimated outlier payments would be higher than 3 percent of total estimated payments for FY 2016, by approximately 0.2 percent, unless we updated the outlier threshold amount. Consequently, we propose adjusting the outlier threshold amount in this proposed rule to reflect a 0.2 percent decrease thereby setting the total outlier payments equal to 3 percent, instead of 3.2 percent, of aggregate estimated payments in FY 2016.

We considered a number of options for implementing the new CBSA designations. Overall, we believe implementing the new OMB delineations would result in wage index values being more representative of the actual costs of labor in a given area. Further, we recognize that some providers (10 percent) would have a higher wage index due to our proposed implementation of the new labor market area delineations. However, we also recognize that more providers (16 percent) would experience decreases in wage index values as a result of our proposed implementation of the new labor market area delineations. In prior years, we have provided for transition periods when adopting changes that have significant payment implications, particularly large negative impacts. As discussed in the FY 2006 IRF PPS final rule (70 FR 47921 through 47926), we evaluated several options to ease the transition to the new CBSA system.

In implementing the new CBSA delineations for FY 2016, we continue to have similar concerns as those expressed in the FY 2006 IRF PPS final rule. While we believe that implementing the latest OMB labor market area delineations would create a more accurate wage index system, we recognize that IRFs may experience decreases in their wage index as a result of the labor market area changes. Our analysis for the FY 2016 IRF PPS proposed rule indicates that a majority of IRFs either expect no change in the wage index or an increase in the wage index based on the new CBSA delineations. However, we found that 188 facilities will experience a decline in their wage index with 29 facilities experiencing a decline of 5 percent or more based on the CBSA changes. Therefore, we believe it would be appropriate to consider, as we did in FY 2006, whether or not a transition period should be used to implement these proposed changes to the wage index.

We considered having no transition period and fully implementing the proposed new OMB delineations beginning in FY 2016. This would mean that we would adopt the revised OMB delineations for all IRF providers on October 1, 2015. However, this would not provide any time for IRF providers to adapt to the new OMB delineations. As previously discussed, more IRFs would experience a decrease in wage index due to implementation of the proposed new OMB delineations than would experience an increase. Thus, we believe that it would be appropriate to provide for a transition period to mitigate the resulting short-term instability and negative impacts on these IRF providers, and to provide time for these IRFs to adjust to their new labor market area delineations.

Furthermore, in light of the comments received during the FY 2006 rulemaking cycle on our proposal in the FY 2006 IRF PPS proposed rule (70 FR 30238 through 30240) to adopt the new CBSA definitions without a transition period, we continue to believe that a transition period is appropriate. Therefore, we propose a similar transition methodology to that used in FY 2006. Specifically, for the FY 2016 IRF PPS, we are proposing to implement a budget-neutral one-year transition policy. We are proposing that all IRF providers would receive a one-year blended wage index using 50 percent of their FY 2016 wage index based on the proposed new OMB delineations and 50 percent of their FY 2016 wage index based on the OMB delineations used in FY 2015. We are proposing to apply this one-year blended wage index in FY 2016 for all geographic areas to assist providers in adapting to these proposed changes. We believe a 1-year, 50/50 blend would mitigate the short-term instability and negative payment impacts due to the proposed implementation of the new OMB delineations. This transition policy would be for a one-year period, going into effect October 1, 2016, and continuing through September 30, 2017.

For the reasons previously discussed and based on similar concerns to those we expressed during the FY 2006 rulemaking cycle to the proposed adoption of the new CBSA definitions, we are proposing to implement a three-year budget-neutral phase-out of the rural adjustment for the group of IRFs that during FY 2015 were designated as rural and for FY 2016 are designated as urban under the new CBSA system. This is in addition to implementing a one-year blended wage index for all IRFs. We considered having no transition, but found that a multi-year transition policy would best provide a sufficient buffer for rural IRFs that may experience a reduction in payments due to being designated as urban. We believe that the incremental reduction of the FY 2015 rural adjustment is appropriate to mitigate a significant reduction in per case payment. Alternative timeframes we considered for phasing out the rural adjustment for IRFs which would transition from rural to urban status in FY 2016, but believe that a three-year budget-neutral phase-out of the rural adjustment would appropriately mitigate the adverse payment impacts for these IRFs while also ensuring that payment rates for these providers are set accurately and appropriately.

E. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a004/a-4.pdf*), in Table 25, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table 25 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the proposed updates presented in this proposed rule based on the data for 1,132 IRFs in our database. In addition, Table 25 presents the costs associated with the proposed new IRF quality reporting program for FY 2016.

TABLE 25—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES

Category	Transfers
Change in Estimated Transfers from FY 2015 IRF PPS to FY 2016 IRF PPS	
Annualized Monetized Transfers	$130 million.
From Whom to Whom?	Federal Government to IRF Medicare Providers.
Category	Costs
FY 2016 Cost to Updating the Quality Reporting Program	
Cost for IRFs to Submit Data for the Quality Reporting Program	$24,042,291.01.

F. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2016 are projected to increase by 1.7 percent, compared with the estimated payments in FY 2015, as reflected in column 10 of Table 24. IRF payments per discharge are estimated to increase by 1.7 percent in urban areas and by 1.9 percent in rural areas, compared with estimated FY 2015 payments. Payments per discharge to rehabilitation units are estimated to increase 1.6 percent in urban areas and 2.0 in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 1.8 percent in urban areas and 1.3 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the proposed policies in proposed rule. The largest payment increase is estimated to be a 2.7 percent increase for rural IRFs located in the East North Central region.

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

List of Subjects in 42 CFR Part 412

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

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

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332), sec. 1206 of Pub. L. 113–67, and sec. 112 of Pub. L. 113–93.

■ 2. Section 412.634 is added to read as follows:

§ 412.634 Requirements under the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).

(a) *Participation.* (1) An IRF must begin reporting data under the IRF QRP requirements no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter, which designates the IRF as operating in the Certification and Survey Provider Enhanced Reports (CASPER) system.

(2) [Reserved]

(b) *Submission requirements and payment impact.* (1) IRFs must submit to CMS data on measures specified under sections 1886(j)(7)(D), 1899B(c)(1), and 1899B(d)(1) of the Act, as applicable. Sections 1886(j)(7)(C) and (j)(7)(F)(iii) of the Act require each IRF to submit data on the specified measures in the form and manner, and at a time, specified by the Secretary.

(2) As required by section 1886(j)(7)(A)(i) of the Act, any IRF that does not submit data in accordance with section 1886(j)(7)(C) and (F) of the Act for a given fiscal year will have its annual update to the standard Federal rate for discharges for the IRF during the fiscal year reduced by two percentage points.

(c) *Exception and extension requirements.* (1) An IRF may request and CMS may grant exceptions or extensions to the quality data reporting requirements, for one or more quarters, when there are certain extraordinary circumstances beyond the control of the IRF.

(2) An IRF must request an exception or extension within 30 days of the date that the extraordinary circumstances occurred.

(3) Exception and extension requests must be submitted to CMS from the IRF by sending an email to *IRFQRPReconsiderations@cms.hhs.gov* containing all of the following information:

(i) IRF CMS Certification Number (CCN).

(ii) IRF Business Name.

(iii) IRF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) IRF's reason for requesting the exception or extension.

(vi) Evidence of the impact of extraordinary circumstances, including, but not limited to, photographs, newspaper, and other media articles.

(vii) Date when the IRF believes it will be able to again submit IRF QRP data and a justification for the proposed date.

(4) CMS may grant exceptions or extensions to IRFs without a request if it is determined that one or more of the following has occurred:

(i) An extraordinary circumstance affects an entire region or locale.

(ii) A systemic problem with one of CMS's data collection systems directly affected the ability of an IRF to submit data.

(5) Email is the only form of submission that will be accepted. Any reconsideration requests received through another channel will not be considered as a valid exception or extension request.

(d) *Reconsideration.* (1) IRFs found to be non-compliant with the quality reporting requirements for a particular fiscal year will receive a letter of non-compliance through the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES–ASAP) system, as well as through the United States Postal Service. IRFs must submit reconsideration requests no later than 30 calendar days after the date identified on the letter of non-compliance.

(2) Reconsideration requests must be submitted to CMS by sending an email to *IRFQRPReconsiderations@cms.hhs.gov* containing all of the following information:

(i) IRF CCN.

(ii) IRF Business Name.

(iii) IRF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) CMS identified reason(s) for non-compliance from the non-compliance letter.

(vi) Reason(s) for requesting reconsideration.

(3) The request for reconsideration must be accompanied by supporting documentation demonstrating compliance. This documentation must be submitted electronically as an attachment to the reconsideration request email. Any request for reconsideration that does not contain sufficient evidence of compliance with the IRF QRP requirements will be denied.

(4) Email is the only form of submission that will be accepted. Any reconsideration requests received through another channel will not be considered as a valid exception or extension request.

(5) The QIES–ASAP system and the United States Postal Service will be the two mechanisms used to distribute each IRF's compliance letter, as well as our final decision regarding any reconsideration request received from the IRF.

(e) *Appeals.* (1) An IRF may appeal the decision made by CMS on its reconsideration request by filing with the Provider Reimbursement Review Board (PRRB) under 42 CFR part 405, subpart R.

Dated: April 13, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: April 21, 2015.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

[FR Doc. 2015–09617 Filed 4–23–15; 4:15 pm]

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