language interpretation or other reasonable accommodations, should contact Shawn Woodhead Werth, Secretary and Clerk, at (202) 694–1040, at least 72 hours prior to the meeting date.

PERSON TO CONTACT FOR INFORMATION: Judith Ingram, Press Officer, Telephone: (202) 694–1220.

Shawn Woodhead Werth,

Secretary and Clerk of the Commission.

[FR Doc. 2012–18686 Filed 7–26–12; 4:15 pm]

BILLING CODE 6715–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of a Bank or Bank Holding Company

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire shares of a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than August 14, 2012.

A. Federal Reserve Bank of New York (Ivan Hurwitz, Vice President) 33 Liberty Street, New York, New York 10045–0001:

1. *Muhammad Habib, Kusnacht, Switzerland; Hamza Habib, and Khadijah Jumani, both of Dubai, United Arab Emirates; and Fazilat Jumani,* London, England; to retain control of Maham Beteiligungsgessellschaft AG, Zurich, Switzerland, and thereby indirectly retain control of Habib American Bank, New York, New York.

Board of Governors of the Federal Reserve System, July 25, 2012.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 2012–18510 Filed 7–27–12; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Initial Review

The meeting announced below concerns the World Trade Center Health Program Outreach and Education Plan RFA–OH12–1201, initial review.

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting:

Time and Date: 8:00 a.m.–5:00 p.m., August 28, 2012 (Closed).

Place: Embassy Suites—Old Town Alexandria, 1900 Diagonal Road, Alexandria, Virginia 22314, Telephone: (703) 684–5900.

Status: The meeting will be closed to the public in accordance with provisions set forth in Section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters to be Discussed: The meeting will include the initial review, discussion, and evaluation of applications received in response to ''World Trade Center Health Program Outreach and Education Plan RFA–OH12–1201.''

Contact Person for More Information: Nina Turner, Ph.D., Scientific Review Officer, National Institute for Occupational Safety and Health, CDC, 1095 Willowdale Road, Mailstop G800, Morgantown, West Virginia 26505–2845, Telephone: (304) 285–5976.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: July 18, 2012.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2012–18427 Filed 7–27–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1433–N]

RIN 0938–AR21

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2013

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

ACTION: Notice.

SUMMARY: This notice updates the payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2013 (for discharges occurring on or after October 1, 2012 and on or before September 30, 2013) as required under section 1886(j)(3)(C) of the Social Security Act (the Act). Section 1886(j)(5) of the Act requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the IRF prospective payment system's (PPS) case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

DATES: *Effective Date:* The updated IRF prospective payment rates are effective for IRF discharges occurring on or after October 1, 2012 and on or before September 30, 2013 (FY 2013).

FOR FURTHER INFORMATION CONTACT: Gwendolyn Johnson, (410) 786–6954, for general information about the notice. Susanne Seagrave, (410) 786–0044, for information about the payment policies and payment rates.

SUPPLEMENTARY INFORMATION:

Executive Summary

I. Purpose

This notice updates the payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2013 (for discharges occurring on or after October 1, 2012 and on or before September 30, 2013) as required under section 1886(j)(3)(C) of the Social Security Act (the Act). Section 1886(j)(5) of the Act requires the Secretary to publish in the **Federal Register** on or before the August 1 that precedes the start of each fiscal year, the classification and weighting factors for the IRF prospective payment system's (PPS) case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

Summary of Major Provisions

In this notice, we use the methods described in the FY 2012 IRF PPS final rule (76 FR 47836) to update the Federal prospective payment rates for FY 2013 using updated FY 2011 IRF claims and the most recent available IRF cost report data. No policy changes are being proposed in this notice. Furthermore, we explain the self-implementing changes resulting from the provisions in section 1886(j)(3)(C) and (D) of the Act.

Summary of Cost and Benefits

Provision description	Total costs	Total benefits
FY 2013 IRF PPS payment rate update	The overall economic impact of this notice is an estimated $140 million in increased payments to IRFs during FY 2013.	The benefits of this notice include a net increase in payments to IRF providers. Overall, no IRFs are estimated to experience a net decrease in payments as a result of the updates in this notice.

In the past, the Addenda referred to throughout the preamble of our annual IRF PPS proposed and final rules and notices were included in the printed **Federal Register**. However, effective with the FY 2013 IRF notice, the IRF Addenda will no longer appear in the **Federal Register**. Instead these Addenda to the annual proposed and final rules and notices will be available through the Internet. The IRF PPS Addenda along with other supporting documents and tables referenced in this notice are available through the Internet on the CMS Web site at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/*.

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

Table of Contents

I. Background

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

Section 1886(j) of the Social Security Act (the Act) provides for the implementation of a per discharge prospective payment system (PPS) for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (hereinafter referred to as IRFs).

Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not direct graduate medical education costs, costs of approved nursing and allied health education activities, bad debts, and other services or items outside the scope of the IRF PPS. Although a complete discussion of the IRF PPS provisions appears in the original FY 2002 IRF PPS final rule (66 FR 41316) and the FY 2006 IRF PPS final rule (70 FR 47880), we are providing below a general description of the IRF PPS for fiscal years (FYs) 2002 through 2012.

Under the IRF PPS from FY 2002 through FY 2005, as described in the FY 2002 IRF PPS final rule (66 FR 41316), the Federal prospective payment rates were computed across 100 distinct Case-Mix Groups (CMGs). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed 5 special CMGs to account for very short stays and for patients who expire in the IRF.

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

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

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

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

beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs now consist of 100 percent of the Federal IRF PPS rate.

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

Section 1886(j) of the Act confers broad statutory authority upon the Secretary to propose refinements to the IRF PPS. In the FY 2006 IRF PPS final rule (70 FR 47880) and in correcting amendments to the FY 2006 IRF PPS final rule (70 FR 57166) that we published on September 30, 2005, we finalized a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. These refinements included the adoption of the Office of Management and Budget's (OMB) Core-Based Statistical Area (CBSA) market definitions, modifications to the CMGs, tier comorbidities, and CMG relative weights, implementation of a new teaching status adjustment for IRFs, revision and rebasing of the market basket index used to update IRF payments, and updates to the rural, low-income percentage (LIP), and high-cost outlier adjustments. Beginning with the FY 2006 IRF PPS final rule (70 FR 47908 through 47917) until it was rebased and revised in the FY 2012 IRF PPS final rule (76 FR 47838), the IRF PPS used the 2002-based market basket as the market basket index to reflect 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 notice 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 (MMSEA, Pub. L. 110–173, enacted December 29, 2007), amended section 1886(j)(3)(C) of the Act to apply a zero percent increase factor for FYs 2008 and 2009, effective for IRF discharges occurring on or after April 1, 2008. Section 1886(j)(3)(C) of the Act requires the Secretary to develop an increase factor to update the IRF Federal prospective payment rates for each FY. Based on the legislative change to the increase factor, we revised the FY 2008 Federal prospective payment rates for IRF discharges occurring on or after April 1, 2008. Thus, the final FY 2008 IRF Federal prospective payment rates that were published in the FY 2008 IRF PPS final rule (72 FR 44284) were effective for discharges occurring on or after October 1, 2007 and on or before March 31, 2008; and the revised FY 2008 IRF Federal prospective payment rates were effective for discharges occurring on or after April 1, 2008 and on or before September 30, 2008. The revised FY 2008 Federal prospective payment rates are available on the CMS Web site at *http://www.cms.hhs.gov/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, and teaching status adjustment factors, and the outlier threshold; implemented new IRF coverage requirements for determining whether an IRF claim is reasonable and necessary; and revised the regulation text to require IRFs to submit patient assessments on Medicare Advantage (Medicare Part C) patients for use in the 60 percent rule calculations. Any reference to the FY 2010 IRF PPS final rule in this notice 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) (Affordable Care Act), 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)(ii)(I) of the Act requires the Secretary to estimate a multi-factor productivity adjustment to the market basket increase factor, and to apply other adjustments as defined by the Act. The productivity adjustment applies to FYs from 2012 forward. The other adjustments apply to FYs 2010–2019.

Sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(i) of the Act defined the adjustments that were to be applied to the market basket increase factors in FYs 2010 and 2011. Under these provisions, the Secretary was required to reduce the market basket increase factor in FY 2010 by a 0.25 percentage point adjustment. Notwithstanding this provision, in accordance with section 3401(p) of the Affordable Care Act, the adjusted FY 2010 rate was only to be applied to discharges occurring on or after April 1, 2010. Based on the self-implementing legislative changes to

section 1886(j)(3) of the Act, we adjusted the FY 2010 Federal prospective payment rates as required, and applied these rates to IRF discharges occurring on or after April 1, 2010 and on or before September 30, 2010. Thus, the final FY 2010 IRF Federal prospective payment rates that were published in the FY 2010 IRF PPS final rule (74 FR 39762) were used for discharges occurring on or after October 1, 2009 and on or before March 31, 2010; and the adjusted FY 2010 IRF Federal prospective payment rates applied to discharges occurring on or after April 1, 2010 and on or before September 30, 2010. The adjusted FY 2010 Federal prospective payment rates are available on the CMS Web site at *http://www.cms.hhs.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. In order 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. The revised IRF outlier threshold amount for FY 2010 was $10,721.

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

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 regulations 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.

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. Section 3401(d) of the Affordable Care Act also added section 1886(j)(3)(C)(ii)(I) of the Act (providing for a ''productivity adjustment'' for fiscal year 2012 and each subsequent fiscal year). The productivity adjustment and the 0.1 percentage point reduction are both discussed in section V.A. of this notice. Section 1886(j)(3)(C)(ii)(II) of the Act notes that the application of these adjustments to the market basket update may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than payment rates for the preceding fiscal year.

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

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

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

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 Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI). In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each Medicare Part C (Medicare Advantage) patient, as described in the FY 2010 IRF PPS final rule. All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the GROUPER software. The GROUPER software uses specific IRF–PAI data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The GROUPER software produces a five-digit CMG number. The first digit is an alpha-character that indicates the comorbidity tier. The last four digits

represent the distinct CMG number. Free downloads of the Inpatient Rehabilitation Validation and Entry (IRVEN) software product, including the GROUPER software, are available on the CMS Web site at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html.*

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

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

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

The Medicare FI or MAC processes the claim through its software system. This software system includes pricing programming called the ''PRICER'' software. The PRICER software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the 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 Notice

In this notice, we use the methods described in the FY 2012 IRF PPS final rule (76 FR 47836) to update the Federal prospective payment rates for FY 2013 using updated FY 2011 IRF claims and the most recent available IRF cost report data. No policy changes are being proposed in this notice. Furthermore, we explain the self-implementing changes resulting from the provisions in section 1886(j)(3)(C) and (D) of the Act, as described above and in section V.A. of this notice.

In summary, this notice will:

- Update the FY 2013 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 notice.
- Update the FY 2013 IRF PPS payments rates by a market basket increase factor, based upon the most current data available, with a 0.1 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act and a 0.8 percent productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section V.A. of this notice.
- Discuss the Secretary's Recommendation for updating IRF PPS payments for FY 2013, in accordance with the statutory requirements, as described in section V.A. of this notice.
- Update the FY 2013 IRF PPS payment rates by the FY 2013 wage index and the labor-related share in a budget neutral manner, as discussed in sections V.B and V.C of this notice.
- Describe the calculation of the IRF Standard Payment Conversion Factor for FY 2013, as discussed in section V.D of this notice.
- Update the outlier threshold amount for FY 2013, as discussed in section VI.A. of this notice.
- Update the cost-to-charge ratio (CCR) ceilings and urban/rural average CCRs for FY 2013, as discussed in section VI.B. of this notice.

This notice does not contain any revisions to existing regulation text.

III. Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2013

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

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 2013, we used FY 2011 IRF claims and the most recent available IRF cost report data. These data are the most current and most complete data available at this time. Currently, only a small portion of the FY 2011 IRF cost report data are available for analysis, but the majority of the FY 2011 IRF claims data are available for analysis.

We will apply these data using the methodologies that we have used to update the CMG relative weights and average length of stay values in the FY 2010 IRF PPS final rule (74 FR 39762), the FY 2011 notice (75 FR 42836), and the FY 2012 final rule (76 FR 47836). 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 notice is as follows:

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

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

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

Step 4. We normalize the FY 2013 CMG relative weights to the same average CMG relative weight from the CMG relative weights implemented in the FY 2012 IRF PPS final rule (76 FR 47836).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we are updating the CMG relative weights for FY 2013 in such a way that total estimated aggregate payments to IRFs for FY 2013 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 2013 CMG relative weights, we use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2013 (with no changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2013 by applying the changes to the CMG relative weights (as discussed above).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the budget neutrality factor (1.0000) that maintains the same total estimated aggregate payments in FY 2013 with and without the updates to the CMG relative weights.

Step 4. Apply the budget neutrality factor (1.0000) to the FY 2012 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V.D of this notice, we discuss the use of the existing methodology to calculate the standard payment conversion factor for FY 2013.

The CMG relative weights and average length of stay values for FY 2013 are presented in Table 1. 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	0.8027	0.7192	0.6541	0.6254	10	10	9	8
0102	Stroke M>44.45 and M<51.05 and C>18.5.	0.9980	0.8942	0.8132	0.7776	12	10	10	10
0103	Stroke M>44.45 and M<51.05 and C<18.5.	1.1622	1.0414	0.9471	0.9056	12	13	12	12
0104	Stroke M>38.85 and M<44.45	1.2323	1.1041	1.0041	0.9602	13	12	12	12
0105	Stroke M>34.25 and M<38.85	1.4378	1.2883	1.1716	1.1203	15	16	14	14
0106	Stroke M>30.05 and M<34.25	1.6373	1.4670	1.3342	1.2758	17	18	16	16
0107	Stroke M>26.15 and M<30.05	1.8381	1.6469	1.4978	1.4322	18	19	17	18
0108	Stroke M<26.15 and A>84.5	2.2975	2.0585	1.8721	1.7901	23	23	22	21
0109	Stroke M>22.35 and M<26.15 and A<84.5.	2.1226	1.9018	1.7296	1.6539	20	22	20	20
0110	Stroke M<22.35 and A<84.5	2.7303	2.4463	2.2248	2.1274	30	29	25	25
0201	Traumatic brain injury M>53.35 and C>23.5.	0.8313	0.6948	0.6199	0.5869	10	10	8	8
0202	Traumatic brain injury M>44.25 and M<53.35 and C>23.5.	1.0169	0.8499	0.7583	0.7179	12	11	10	10
0203	Traumatic brain injury M>44.25 and C<23.5.	1.1804	0.9865	0.8803	0.8334	14	13	12	11
0204	Traumatic brain injury M>40.65 and M<44.25.	1.2938	1.0813	0.9648	0.9134	14	13	12	12
0205	Traumatic brain injury M>28.75 and M<40.65.	1.5550	1.2996	1.1596	1.0978	16	15	14	14
0206	Traumatic brain injury M>22.05 and M<28.75.	1.9383	1.6200	1.4455	1.3684	20	20	18	17
0207	Traumatic brain injury M<22.05	2.5535	2.1341	1.9042	1.8027	33	25	22	21
0301	Non-traumatic brain injury M>41.05	1.1218	0.9563	0.8462	0.7852	11	12	11	10
0302	Non-traumatic brain injury M>35.05 and M<41.05.	1.4026	1.1957	1.0579	0.9816	14	14	13	12
0303	Non-traumatic brain injury M>26.15 and M<35.05.	1.6605	1.4155	1.2525	1.1621	17	16	15	14
0304	Non-traumatic brain injury M<26.15	2.2065	1.8810	1.6643	1.5443	25	22	19	18
0401	Traumatic spinal cord injury M>48.45	1.0393	0.8778	0.7864	0.7109	13	12	11	10
0402	Traumatic spinal cord injury M>30.35 and M<48.45.	1.4824	1.2521	1.1218	1.0141	17	15	14	13
0403	Traumatic spinal cord injury M>16.05 and M<30.35.	2.3870	2.0161	1.8063	1.6329	31	23	22	20
0404	Traumatic spinal cord injury M<16.05 and A>63.5.	4.3665	3.6881	3.3043	2.9870	60	41	33	35
0405	Traumatic spinal cord injury M<16.05 and A<63.5.	3.3893	2.8627	2.5648	2.3186	41	41	29	24
0501	Non-traumatic spinal cord injury M>51.35	0.8436	0.6828	0.6306	0.5624	9	9	8	8
0502	Non-traumatic spinal cord injury M>40.15 and M<51.35.	1.1283	0.9132	0.8434	0.7521	11	11	11	10
0503	Non-traumatic spinal cord injury M>31.25 and M<40.15.	1.4284	1.1561	1.0677	0.9522	15	14	13	12

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
0504	Non-traumatic spinal cord injury M>29.25 and M<31.25.	1.7220	1.3937	1.2872	1.1479	22	16	15	14
0505	Non-traumatic spinal cord injury M>23.75 and M<29.25.	1.9656	1.5909	1.4693	1.3103	22	18	18	16
0506	Non-traumatic spinal cord injury M<23.75	2.7707	2.2425	2.0711	1.8470	30	26	24	22
0601	Neurological M>47.75	0.9703	0.7915	0.7304	0.6647	10	10	9	9
0602	Neurological M>37.35 and M<47.75	1.2695	1.0356	0.9557	0.8697	13	12	11	11
0603	Neurological M>25.85 and M<37.35	1.6243	1.3250	1.2228	1.1128	16	15	14	14
0604	Neurological M<25.85	2.1537	1.7568	1.6213	1.4755	22	20	18	17
0701	Fracture of lower extremity M>42.15	0.9343	0.7841	0.7481	0.6772	11	10	10	9
0702	Fracture of lower extremity M>34.15 and M<42.15.	1.2477	1.0471	0.9990	0.9044	13	13	12	12
0703	Fracture of lower extremity M>28.15 and M<34.15.	1.4984	1.2575	1.1996	1.0860	16	15	14	14
0704	Fracture of lower extremity M<28.15	1.8994	1.5940	1.5207	1.3767	19	18	18	17
0801	Replacement of lower extremity joint M>49.55.	0.7445	0.6142	0.5608	0.5156	8	8	8	7
0802	Replacement of lower extremity joint M>37.05 and M<49.55.	0.9839	0.8117	0.7412	0.6814	10	10	9	9
0803	Replacement of lower extremity joint M>28.65 and M<37.05 and A>83.5.	1.3381	1.1039	1.0080	0.9266	13	12	13	12
0804	Replacement of lower extremity joint M>28.65 and M<37.05 and A<83.5.	1.1889	0.9807	0.8955	0.8233	13	12	11	10
0805	Replacement of lower extremity joint M>22.05 and M<28.65.	1.4728	1.2150	1.1094	1.0199	15	14	13	13
0806	Replacement of lower extremity joint M<22.05.	1.7966	1.4821	1.3533	1.2441	17	17	15	15
0901	Other orthopedic M>44.75	0.9086	0.7488	0.6954	0.6289	11	10	9	8
0902	Other orthopedic M>34.35 and M<44.75	1.1916	0.9820	0.9120	0.8248	12	12	11	11
0903	Other orthopedic M>24.15 and M<34.35	1.5421	1.2709	1.1803	1.0674	16	15	14	13
0904	Other orthopedic M<24.15	1.9596	1.6149	1.4998	1.3564	20	19	17	16
1001	Amputation, lower extremity M>47.65	1.0168	0.9097	0.8224	0.7491	11	11	10	10
1002	Amputation, lower extremity M>36.25 and M<47.65.	1.2813	1.1464	1.0364	0.9440	14	14	13	12
1003	Amputation, lower extremity M<36.25	1.8523	1.6572	1.4983	1.3647	18	19	17	16
1101	Amputation, non-lower extremity M>36.35.	1.1553	1.1084	1.1084	0.9005	13	18	12	11
1102	Amputation, non-lower extremity M<36.35.	1.6083	1.5429	1.5429	1.2536	17	24	16	16
1201	Osteoarthritis M>37.65	0.9031	0.9031	0.8675	0.8070	9	12	11	10
1202	Osteoarthritis M>30.75 and M<37.65	1.0652	1.0652	1.0232	0.9518	10	13	12	12
1203	Osteoarthritis M<30.75	1.3740	1.3740	1.3199	1.2278	12	17	15	15
1301	Rheumatoid, other arthritis M>36.35	1.2084	1.0270	0.9058	0.8066	13	12	11	10
1302	Rheumatoid, other arthritis M>26.15 and M<36.35.	1.5720	1.3360	1.1783	1.0492	16	15	14	13
1303	Rheumatoid, other arthritis M<26.15	2.0006	1.7003	1.4996	1.3354	19	20	17	16
1401	Cardiac M>48.85	0.8930	0.7627	0.6877	0.6266	9	9	9	8
1402	Cardiac M>38.55 and M<48.85	1.1528	0.9847	0.8877	0.8089	12	12	11	10
1403	Cardiac M>31.15 and M<38.55	1.3890	1.1864	1.0696	0.9747	14	14	13	12
1404	Cardiac M<31.15	1.7811	1.5213	1.3716	1.2498	19	18	16	15
1501	Pulmonary M>49.25	0.9698	0.8491	0.7773	0.7364	10	10	9	9
1502	Pulmonary M>39.05 and M<49.25	1.2118	1.0610	0.9712	0.9201	12	12	11	11
1503	Pulmonary M>29.15 and M<39.05	1.4875	1.3025	1.1922	1.1295	16	14	13	13
1504	Pulmonary M<29.15	1.8834	1.6491	1.5095	1.4301	19	18	16	16
1601	Pain syndrome M>37.15	1.0499	0.9155	0.8350	0.7581	10	11	10	10
1602	Pain syndrome M>26.75 and M<37.15	1.3826	1.2056	1.0997	0.9984	15	14	13	12
1603	Pain syndrome M<26.75	1.7346	1.5124	1.3796	1.2525	14	18	16	15
1701	Major multiple trauma without brain or spinal cord injury M>39.25.	1.0736	0.9323	0.8505	0.7574	11	12	11	10
1702	Major multiple trauma without brain or spinal cord injury M>31.05 and M<39.25.	1.4056	1.2206	1.1136	0.9916	14	15	13	12
1703	Major multiple trauma without brain or spinal cord injury M>25.55 and M<31.05.	1.6353	1.4201	1.2956	1.1537	18	17	15	14
1704	Major multiple trauma without brain or spinal cord injury M<25.55.	2.0887	1.8138	1.6547	1.4735	22	21	19	18
1801	Major multiple trauma with brain or spinal cord injury M>40.85.	1.2365	0.9356	0.8675	0.7592	14	13	12	10

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
1802	Major multiple trauma with brain or spinal cord injury M>23.05 and M<40.85.	1.8710	1.4158	1.3127	1.1488	18	17	16	14
1803	Major multiple trauma with brain or spinal cord injury M<23.05.	3.3167	2.5096	2.3269	2.0364	38	32	25	23
1901	Guillain Barre M>35.95	1.0467	0.9509	0.9185	0.8749	13	12	12	11
1902	Guillain Barre M>18.05 and M<35.95	1.9189	1.7433	1.6839	1.6041	23	20	18	19
1903	Guillain Barre M<18.05	3.3119	3.0088	2.9062	2.7685	41	33	33	34
2001	Miscellaneous M>49.15	0.8744	0.7276	0.6680	0.6095	9	9	9	8
2002	Miscellaneous M>38.75 and M<49.15	1.1796	0.9815	0.9012	0.8222	12	12	11	10
2003	Miscellaneous M>27.85 and M<38.75	1.4817	1.2329	1.1320	1.0328	15	14	13	13
2004	Miscellaneous M<27.85	1.9594	1.6304	1.4970	1.3659	21	19	17	16
2101	Burns M>0	2.1947	1.9009	1.9009	1.6414	24	22	17	17
5001	Short-stay cases, length of stay is 3 days or fewer.				0.1494				3
5101	Expired, orthopedic, length of stay is 13 days or fewer.				0.5866				7
5102	Expired, orthopedic, length of stay is 14 days or more.				1.5325				18
5103	Expired, not orthopedic, length of stay is 15 days or fewer.				0.7091				8
5104	Expired, not orthopedic, length of stay is 16 days or more.				1.9053				22

Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 2 shows how the application of the revisions for FY 2013 will affect particular CMG relative weight values, which affect the overall distribution of payments within CMGs and tiers. Note that, because we are implementing the CMG relative weight revisions in a budget neutral manner (as described above), total estimated aggregate payments to IRFs for FY 2013 will not be affected as a result of the CMG relative weight revisions. However, the revisions will affect the distribution of payments within CMGs and tiers.

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

[FY 2012 values compared with FY 2013 values]

Percentage change	Number of cases affected	Percentage of cases affected
Increased by 15% or more	1,894	0.5
Increased by between 5% and 15%	3,932	1.0
Changed by less than 5%	359,907	95.5
Decreased by between 5% and 15%	11,307	3.0
Decreased by 15% or more	0	0.0

Note: Percentages may not sum to 100% due to rounding.

As Table 2 shows, over 95 percent of all IRF cases are in CMGs and tiers that will experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the revisions for FY 2013. The largest increase in the CMG relative weight values affecting the most cases is a 2.8 percent increase in the CMG relative weight value for CMG 0802—Replacement of Lower Extremity Joint, with a motor score between 37.05 and 49.55—in the ''no comorbidity'' tier. In the FY 2011 data, 9,851 IRF discharges were classified into this CMG and tier. We believe that the higher costs reported by IRFs for this CMG and tier in FY 2011, compared with the costs reported in FY 2010, may continue to reflect the IRF trend away from admitting lower-severity joint replacement cases in favor of higher-severity joint replacement cases. We believe that this may be evidence of a response, at least in part, to Medicare's ''60 percent'' rule, and the increased focus on the medical review of IRF cases. These policies likely increase the complexity of patients being admitted to IRFs, especially among the lower-extremity joint replacement cases with no comorbidities, which often do not meet the 60 percent rule criteria and have been the focus of a lot of the medical review activities.

The largest decrease in a CMG relative weight value affecting the most cases is a 2.3 percent decrease in the CMG relative weight for CMG D2004—Miscellaneous, with motor score less than 27.85. In the FY 2011 IRF claims data, this change affects 6,967 cases.

The changes in the average length of stay values for FY 2013, compared with the FY 2012 average length of stay values, are small and do not show any particular trends in IRF length of stay patterns.

IV. Updates to the Facility-Level Adjustment Factors

Section 1886(j)(3)(A)(v) of the Act confers broad authority upon the Secretary to adjust the per unit payment rate ''by such * * * factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.'' For example, we adjust the Federal prospective payment amount

associated with a CMG to account for facility-level characteristics such as an IRF's LIP percentage, teaching status, and location in a rural area, if applicable, as described in § 412.624(e).

In the FY 2010 IRF PPS final rule (74 FR 39762), we updated the adjustment factors for calculating the rural, LIP, and teaching status adjustments based on the most recent three consecutive years worth of IRF claims data (at that time, FY 2006, FY 2007, and FY 2008) and the most recent available corresponding IRF cost report data. As discussed in the FY 2010 IRF PPS proposed rule (74 FR 21060 through 21061), we observed relatively large year-to-year fluctuations in the underlying data used to compute the adjustment factors, especially the teaching status adjustment factor. Therefore, we implemented a 3-year moving average approach to updating the facility-level adjustment factors in the FY 2010 IRF PPS final rule (74 FR 39762) to provide greater stability and predictability of Medicare payments for IRFs.

Each year, we review the major components of the IRF PPS to maintain and enhance the accuracy of the payment system. For FY 2010, we implemented a change to our methodology that was designed to decrease the IRF PPS volatility by using a 3-year moving average to calculate the facility-level adjustment factors. For FY 2011, we issued a notice to update the payment rates, which did not include any policy changes or changes to the IRF facility-level adjustments. However, in the FY 2012 IRF PPS proposed rule (76 FR 24214 at 24225 through 24226), we analyzed the use of a weighting methodology, which assigns greater weight to some facilities than to others, in the regression analysis used to estimate the facility-level adjustment factors. As we found that this weighting methodology inappropriately exaggerated the cost differences among different types of IRF facilities, we proposed to remove the weighting factor from our analysis and update the IRF facility-level adjustment factors for FY 2012 using an un-weighted regression analysis. However, after carefully considering all of the comments that we received on the proposed FY 2012 updates to the facility-level adjustment factors, we decided to hold the facility-level adjustment factors at FY 2011 levels for FY 2012 in order to conduct further research on the underlying data and the best methodology for calculating the facility-level adjustment factors. We based this decision, in part, on comments we received about the financial hardships that the proposed updates would create for facilities with teaching programs and a higher disproportionate share of low-income patients. Thus, in the FY 2012 final rule (76 FR 47836 at 47845), we held the FY 2012 facility-level adjustment factors at FY 2011 levels. We also stated in the FY 2012 final rule that we would conduct further research on the underlying data and the best methodology for calculating the facility level adjustment factors. Our research efforts are still ongoing, as we continue to consider the best methodology for calculating the facility level adjustment factors. As a result, we are not making changes to the facility-level adjustments for FY 2013.

V. FY 2013 IRF PPS Federal Prospective Payment Rates

A. Market Basket Increase Factor, Productivity Adjustment, Other Adjustment, and Secretary's Recommendation for FY 2013

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services, which is referred to as a market basket index. According to section 1886(j)(3)(A)(i) of the Act, the increase factor shall be used to update the IRF Federal prospective payment rates for each FY. Sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act require the application of a 0.1 percentage point reduction to the market basket increase factor for FYs 2012 and 2013. In addition, section 1886(j)(3)(C)(ii)(I) of the Act requires the application of a productivity adjustment, as described below. Thus, in this notice, we are updating the IRF PPS payments for FY 2013 by a market basket increase factor based upon the most current data available, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, as described below, and a 0.1 percentage point reduction as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act.

For this notice, we have used the same methodology described in the FY 2012 IRF PPS final rule (76 FR 47836 at 47848 through 47863) to compute the FY 2013 market basket increase factor and labor-related share. In that final rule, we rebased the RPL market basket from a 2002 base year to a 2008 base year. Using this method and the IHS Global Insight, Inc. forecast for the second quarter of 2012 of the 2008-based RPL market basket, the FY 2013 RPL market basket increase factor is 2.7 percent. IHS Global Insight (IGI) is an economic and financial forecasting firm that contracts with CMS to forecast the components of providers' market baskets.

In accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and using the methodology described in the FY 2012 IRF PPS final rule (76 FR 47836, 47858 through 47859), we apply a productivity adjustment to the FY 2013 RPL market basket increase factor. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable FY cost reporting period, or other annual period)(the ''MFP adjustment''). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. We refer readers to the BLS Web site at *http://www.bls.gov/mfp* to obtain the historical BLS-published MFP data. The projection of MFP is currently produced by IGI, using the methodology described in the FY 2012 IRF PPS final rule (76 FR 47836, 47859). The MFP adjustment (the 10-year moving average of MFP for the period ending FY 2013) that we apply to the market basket increase factor for FY 2013 is 0.7 percent, which was calculated using the methodology described in the FY 2012 IRF PPS final rule (76 FR 47836, 47858 through 47859) and is based on IGI's second quarter 2012 forecast.

Thus, in accordance with section 1886(j)(3)(C) of the Act, we will base the FY 2013 market basket update, which is used to determine the applicable percentage increase for the IRF payments, on the second quarter 2012 forecast of the FY 2008-based RPL market basket (estimated to be 2.7 percent). This percentage increase is then reduced by the MFP adjustment (the 10-year moving average of MFP for the period ending FY 2013) of 0.7 percent, which was calculated as described in the FY 2012 IRF PPS final rule (76 FR 47836, 47859) and based on IGI's second quarter 2012 forecast. Following application of the productivity adjustment, the applicable percentage increase is further reduced by 0.1 percentage point, as required by sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act. Therefore, the final FY 2013 IRF update is 1.9 percent (2.7 percent market basket update less 0.7 percentage point MFP adjustment less 0.1 percentage point legislative adjustment).

Secretary's Final Recommendation

For FY 2013, the Medicare Payment Advisory Commission (MedPAC) recommends that a 0 percent update be

applied to IRF PPS payment rates for FY 2013. As discussed above, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary is updating IRF PPS payment rates for FY 2013 by an adjusted market basket increase factor of 1.9 percent because 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 2013.

B. Labor-Related Share for FY 2013

Using the methodology described in the FY 2012 IRF PPS final rule (76 FR 47836, 47860 through 47863), we are updating the IRF labor-related share for FY 2013. Using this method and the IHS Global Insight, Inc. forecast for the second quarter of 2012 of the 2008-based RPL market basket, the IRF labor-related share for FY 2013 is the sum of the FY 2013 relative importance of each labor-related cost category. This figure reflects the different rates of price change for these cost categories between the base year (FY 2008) and FY 2013. As shown in Table 3, the FY 2013 labor-related share is 69.981 percent.

TABLE 3—FY 2013 IRF RPL LABOR-RELATED SHARE RELATIVE IMPORTANCE

Cost category	FY 2013 IRF labor-related share relative importance
Wages and Salaries	48.796
Employee Benefits	13.021
Professional Fees: Labor-Related	2.070
Administrative and Business Support Services	0.417
All Other: Labor-Related Services	2.077
SUBTOTAL	66.381
Labor-Related Share of Capital Costs (.46)	3.600
TOTAL	69.981

Source: IHS GLOBAL INSIGHT, INC, 2nd QTR, 2012; Historical Data through 1st QTR, 2012.

C. Area Wage Adjustment

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

In the FY 2009 IRF PPS final rule (73 FR 46378), we maintained the methodology described in the FY 2006 IRF PPS final rule to determine the wage index, labor market area definitions, and hold harmless policy consistent with the rationale outlined in the FY 2006 IRF PPS final rule (70 FR 47880, 47917 through 47933).

For FY 2013, we are maintaining the policies and methodologies described in the FY 2012 IRF PPS final rule relating to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we are using the CBSA labor market area definitions and the FY 2012 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2012 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2007 and before October 1, 2008 (that is, 2008 cost report data).

The labor market designations made by the OMB include some geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the IRF PPS wage index. We will continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the FY 2013 IRF PPS wage index.

If applicable, we will continue to use the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage data used to determine the current IRF PPS wage index. The OMB bulletins are available online at *http://www.whitehouse.gov/omb/bulletins/index.html*.

To calculate the wage-adjusted facility payment for the payment rates set forth in this notice, we multiply the unadjusted Federal payment rate for IRFs by the FY 2013 labor-related share based on the FY 2008-based RPL market basket (69.981 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 notice. These tables are available through the Internet on the CMS Web site at *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/*. Table A is for urban areas and Table B is for rural areas.

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget neutral manner. We calculate a budget neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45689), codified at § 412.624(e)(1), as described in the steps below. We use the listed steps to ensure that the FY 2013 IRF standard payment conversion factor reflects the update to the wage indexes (based on the FY 2008 hospital cost report data) and the labor-related share in a budget neutral manner:

Step 1. Determine the total amount of the estimated FY 2012 IRF PPS rates, using the FY 2012 standard payment conversion factor and the labor-related share and the wage indexes from FY 2012 (as published in the FY 2012 IRF PPS final rule (76 FR 47836)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the FY 2012 standard payment conversion factor and the FY 2013 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 2013 budget neutral wage adjustment factor of 1.0000.

Step 4. Apply the FY 2013 budget neutral wage adjustment factor from step 3 to the FY 2012 IRF PPS standard payment conversion factor after the application of the adjusted market

basket update to determine the FY 2013 standard payment conversion factor.

We discuss the calculation of the standard payment conversion factor for FY 2013 in section V.D. of this notice.

D. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2013

To calculate the standard payment conversion factor for FY 2013, as illustrated in Table 4, we begin by applying the adjusted market basket increase factor for FY 2013 that was adjusted in accordance with sections 1886(j)(3)(C) and (D) of the Act, to the standard payment conversion factor for FY 2012 ($14,076). Applying the 1.9 percent adjusted market basket increase factor for FY 2013 to the revised standard payment conversion factor for FY 2012 of $14,076 yields a standard payment amount of $14,343. Then, we apply the budget neutrality factor for the FY 2013 wage index and labor related share of 1.0000, which keeps the standard payment amount at $14,343. Finally, we apply the budget neutrality factor for the revised CMG relative weights of 1.0000, which results in a final standard payment conversion factor of $14,343 for FY 2013.

TABLE 4—CALCULATIONS TO DETERMINE THE FINAL FY 2013 STANDARD PAYMENT CONVERSION FACTOR

Explanation for adjustment	Calculations
Standard Payment Conversion Factor for FY 2012	$14,076
Market Basket Increase Factor for FY 2013 (2.7 percent), reduced by 0.1 percentage point in accordance with sections 1886(j)(3)(C) and (D) of the Act and a 0.7 percent reduction for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act	× 1.019
Budget Neutrality Factor for the Wage Index and Labor-Related Share	× 1.0000
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	× 1.0000
Final FY 2013 Standard Payment Conversion Factor	= $14,343

After the application of the CMG relative weights described in section III of this notice, the resulting unadjusted IRF prospective payment rates for FY 2013 are shown below in Table 5, ''FY 2013 Payment Rates.''

TABLE 5—FY 2013 PAYMENT RATES

CMG	Payment rate Tier 1	Payment rate Tier 2	Payment rate Tier 3	Payment rate no comorbidity
0101	$11,513.13	$10,315.49	$9,381.76	$8,970.11
0102	14,314.31	12,825.51	11,663.73	11,153.12
0103	16,669.43	14,936.80	13,584.26	12,989.02
0104	17,674.88	15,836.11	14,401.81	13,772.15
0105	20,622.37	18,478.09	16,804.26	16,068.46
0106	23,483.79	21,041.18	19,136.43	18,298.80
0107	26,363.87	23,621.49	21,482.95	20,542.04
0108	32,953.04	29,525.07	26,851.53	25,675.40
0109	30,444.45	27,277.52	24,807.65	23,721.89
0110	39,160.69	35,087.28	31,910.31	30,513.30
0201	11,923.34	9,965.52	8,891.23	8,417.91
0202	14,585.40	12,190.12	10,876.30	10,296.84
0203	16,930.48	14,149.37	12,626.14	11,953.46
0204	18,556.97	15,509.09	13,838.13	13,100.90
0205	22,303.37	18,640.16	16,632.14	15,745.75
0206	27,801.04	23,235.66	20,732.81	19,626.96
0207	36,624.85	30,609.40	27,311.94	25,856.13
0301	16,089.98	13,716.21	12,137.05	11,262.12
0302	20,117.49	17,149.93	15,173.46	14,079.09
0303	23,816.55	20,302.52	17,964.61	16,668.00
0304	31,647.83	26,979.18	23,871.05	22,149.89
0401	14,906.68	12,590.29	11,279.34	10,196.44
0402	21,262.06	17,958.87	16,089.98	14,545.24
0403	34,236.74	28,916.92	25,907.76	23,420.68
0404	62,628.71	52,898.42	47,393.57	42,842.54
0405	48,612.73	41,059.71	36,786.93	33,255.68
0501	12,099.75	9,793.40	9,044.70	8,066.50
0502	16,183.21	13,098.03	12,096.89	10,787.37
0503	20,487.54	16,581.94	15,314.02	13,657.40
0504	24,698.65	19,989.84	18,462.31	16,464.33
0505	28,192.60	22,818.28	21,074.17	18,793.63
0506	39,740.15	32,164.18	29,705.79	26,491.52
0601	13,917.01	11,352.48	10,476.13	9,533.79
0602	18,208.44	14,853.61	13,707.61	12,474.11
0603	23,297.33	19,004.48	17,538.62	15,960.89
0604	30,890.52	25,197.78	23,254.31	21,163.10
0701	13,400.66	11,246.35	10,730.00	9,713.08
0702	17,895.76	15,018.56	14,328.66	12,971.81
0703	21,491.55	18,036.32	17,205.86	15,576.50
0704	27,243.09	22,862.74	21,811.40	19,746.01
0801	10,678.36	8,809.47	8,043.55	7,395.25

TABLE 5—FY 2013 PAYMENT RATES—Continued

CMG	Payment rate Tier 1	Payment rate Tier 2	Payment rate Tier 3	Payment rate no comorbidity
0802	14,112.08	11,642.21	10,631.03	9,773.32
0803	19,192.37	15,833.24	14,457.74	13,290.22
0804	17,052.39	14,066.18	12,844.16	11,808.59
0805	21,124.37	17,426.75	15,912.12	14,628.43
0806	25,768.63	21,257.76	19,410.38	17,844.13
0901	13,032.05	10,740.04	9,974.12	9,020.31
0902	17,091.12	14,084.83	13,080.82	11,830.11
0903	22,118.34	18,228.52	16,929.04	15,309.72
0904	28,106.54	23,162.51	21,511.63	19,454.85
1001	14,583.96	13,047.83	11,795.68	10,744.34
1002	18,377.69	16,442.82	14,865.09	13,539.79
1003	26,567.54	23,769.22	21,490.12	19,573.89
1101	16,570.47	15,897.78	15,897.78	12,915.87
1102	23,067.85	22,129.81	22,129.81	17,980.38
1201	12,953.16	12,953.16	12,442.55	11,574.80
1202	15,278.16	15,278.16	14,675.76	13,651.67
1203	19,707.28	19,707.28	18,931.33	17,610.34
1301	17,332.08	14,730.26	12,991.89	11,569.06
1302	22,547.20	19,162.25	16,900.36	15,048.68
1303	28,694.61	24,387.40	21,508.76	19,153.64
1401	12,808.30	10,939.41	9,863.68	8,987.32
1402	16,534.61	14,123.55	12,732.28	11,602.05
1403	19,922.43	17,016.54	15,341.27	13,980.12
1404	25,546.32	21,820.01	19,672.86	17,925.88
1501	13,909.84	12,178.64	11,148.81	10,562.19
1502	17,380.85	15,217.92	13,929.92	13,196.99
1503	21,335.21	18,681.76	17,099.72	16,200.42
1504	27,013.61	23,653.04	21,650.76	20,511.92
1601	15,058.72	13,131.02	11,976.41	10,873.43
1602	19,830.63	17,291.92	15,773.00	14,320.05
1603	24,879.37	21,692.35	19,787.60	17,964.61
1701	15,398.64	13,371.98	12,198.72	10,863.39
1702	20,160.52	17,507.07	15,972.36	14,222.52
1703	23,455.11	20,368.49	18,582.79	16,547.52
1704	29,958.22	26,015.33	23,733.36	21,134.41
1801	17,735.12	13,419.31	12,442.55	10,889.21
1802	26,835.75	20,306.82	18,828.06	16,477.24
1803	47,571.43	35,995.19	33,374.73	29,208.09
1901	15,012.82	13,638.76	13,174.05	12,548.69
1902	27,522.78	25,004.15	24,152.18	23,007.61
1903	47,502.58	43,155.22	41,683.63	39,708.60
2001	12,541.52	10,435.97	9,581.12	8,742.06
2002	16,919.00	14,077.65	12,925.91	11,792.81
2003	21,252.02	17,683.48	16,236.28	14,813.45
2004	28,103.67	23,384.83	21,471.47	19,591.10
2101	31,478.58	27,264.61	27,264.61	23,542.60
5001	.....	.....	.....	2,142.84
5101	.....	.....	.....	8,413.60
5102	.....	.....	.....	21,980.65
5103	.....	.....	.....	10,170.62
5104	.....	.....	.....	27,327.72

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

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

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 1.0228), a wage index of 0.8551, and a rural adjustment of 18.4 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0666), a wage index of 0.8900, and a teaching status adjustment of 0.0610.

To calculate each IRF's labor and non-labor portion of the Federal prospective payment, we begin by taking the unadjusted Federal prospective payment rate for CMG 0110 (without comorbidities) from Table 5 above. Then, we multiply the labor-related share for FY 2013 (69.981 percent) described in section V.B of this notice by the unadjusted Federal prospective payment rate. To determine the non-labor portion of the Federal prospective payment rate, we subtract the labor

portion of the Federal payment from the unadjusted Federal prospective payment.

To compute the wage-adjusted Federal prospective payment, we multiply the labor portion of the Federal payment by the appropriate wage index found in Table A and Table B. These tables are 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 wage-adjusted Federal payment by adding the wage-adjusted labor amount to the non-labor portion.

Adjusting the wage-adjusted Federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted Federal prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.0610, in this example) by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted Federal prospective payment rates. Table 6 illustrates the components of the adjusted payment calculation.

TABLE 6—EXAMPLE OF COMPUTING THE IRF FY 2013 FEDERAL PROSPECTIVE PAYMENT

Steps		Rural Facility A (Spencer Co., IN)	Urban Facility B (Harrison Co., IN)
1	Unadjusted Federal Prospective Payment	$30,513.30	$30,513.30
2	Labor Share	× 0.69981	× 0.69981
3	Labor Portion of Federal Payment	= $21,353.51	= $21,353.51
4	CBSA Based Wage Index (shown in the Addendum, Tables 1 and 2)	× 0.8551	× 0.8900
5	Wage-Adjusted Amount	= $18,259.39	= $19,004.63
6	Nonlabor Amount	+ $9,159.79	+ $9,159.79
7	Wage-Adjusted Federal Payment	= $27,419.18	= $28,164.41
8	Rural Adjustment	× 1.184	× 1.000
9	Wage- and Rural-Adjusted Federal Payment	= $32,464.30	= $28,164.41
10	LIP Adjustment	× 1.0228	× 1.0666
11	FY 2013 Wage-, Rural- and LIP-Adjusted Federal Prospective Payment Rate	= $33,204.49	= $30,040.16
12	FY 2013 Wage- and Rural-Adjusted Federal Prospective Payment	$32,464.30	$28,164.41
13	Teaching Status Adjustment	× 0	× 0.0610
14	Teaching Status Adjustment Amount	= $0.00	= $1,718.03
15	FY 2013 Wage-, Rural-, and LIP-Adjusted Federal Prospective Payment Rate	+ $33,204.49	+ $30,040.16
16	Total FY 2013 Adjusted Federal Prospective Payment	= $33,204.49	= $31,758.19

Thus, the adjusted payment for Facility A would be $33,204.49 and the adjusted payment for Facility B would be $31,758.19.

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

A. Update to the Outlier Threshold Amount for FY 2013

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 2012 IRF PPS final rules (70 FR 47880, 70 FR 57166, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, 75 FR 42836, 75 FR 42836, and 76 FR 47836, 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 2013, we use FY 2011 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 2012. Based on an analysis of this updated data, we estimate that IRF outlier payments as a percentage of total estimated payments are approximately 2.8 percent in FY 2012. Therefore, we will update the outlier threshold amount to $10,466 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2013.

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

In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR 45674, 45692 through 45694), we apply a ceiling to IRFs' CCRs. Using the methodology described in that final rule, we update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2013, 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 2013, as discussed below.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2013, we estimate a national average CCR of 0.659 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 estimate a national average CCR of 0.514 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 notice, we have used the most recent available cost report data (FY 2010). This includes all IRFs whose cost reporting periods began on or after October 1, 2009, and before October 1, 2010. If, for any IRF, the FY 2010 cost report was missing or had an ''as submitted'' status, we used data from the latest settled cost report for FY 2004 through FY 2009. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care.

In accordance with past practice, we set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, the national CCR ceiling is set at 1.57 for FY 2013. This means that, if an individual IRF's CCR exceeds this ceiling of 1.57 for FY 2013, we would replace the IRF's CCR with the appropriate national average CCR (either rural or urban, depending on the geographic location of the IRF). We calculate the national CCR ceiling by:

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

Step 2. 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.

VII. Collection of Information Requirements

This document does not impose any new information collection requirements. However, it does provide detailed information about a currently approved information collection request pertaining to the IRF PPS. Specifically, section I.C. of this notice references the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI). As stated in section I.C of this notice, IRFs are required to complete the IRF–PAI upon the admission and discharge of a Medicare Part A fee-for-service patients and upon admission and discharge of each Medicare Part C (Medicare Advantage) patient. The IRF–PAI is currently approved under OMB control number: 0938–0842.

VIII. Waiver of Notice and Comment

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect. We can waive this procedure, however, if we find good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest and we incorporate a statement of finding and its reasons in the notice. We find that it is unnecessary to undertake notice and comment rulemaking for the updates in this notice because the updates contained in this Notice do not make any substantive changes in policy, but merely reflect the application of previously established methodologies. In addition, we applied the statutorily-required adjustments to the update to the IRF–PPS increase factor in sections 1886(j)(3)(C) and (D) of the Act in this notice. We find that notice and comment rulemaking is unnecessary to implement these statutory provisions because they are self-implementing provisions of law, not requiring the exercise of any discretion on the part of the Secretary. Finally, in accordance with 1886(e)(5)(B), we noted MEDPAC's recommendations regarding an appropriate update for the FY 2013 IRF PPS, and the Secretary's inability to implement those recommendations due to the requirements in 1886(j) regarding the establishment of an update factor. As such, the Secretary's recommendation (to follow the statutory requirements thereby applying a 1.9 percent update rather than MEDPAC's recommended 0 percent update) need not be published in a proposed and final rule as such publication is unnecessary in the absence of any discretion regarding the establishment of the update factor. Therefore, under 5 U.S.C. 553(b)(3)(B), for good cause, we waive notice and comment procedures.

IX. Regulatory Impact Analysis

A. Statement of Need

This notice updates the IRF prospective payment rates for FY 2013 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 notice also 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.

B. Overall Impact

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

Executive 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 notice with

economically significant effects ($100 million or more in any one year). We estimate the total impact of the updates described in this notice by comparing the estimated payments in FY 2013 with those in FY 2012. This analysis results in an estimated $140 million increase for FY 2013 IRF PPS payments. As a result, this notice is designated as economically ''significant'' under section 3(f)(1) of Executive Order 12866, and hence a major notice under the Congressional Review Act.

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 million to $34.5 million in any 1 year, 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.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs or the proportion of IRFs' revenue that is derived from Medicare payments. Therefore, we assume that all IRFs (an approximate total of 1,200 IRFs, of which approximately 60 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 7, we estimate that the net revenue impact of this notice on all IRFs is to increase estimated payments by approximately 2.1 percent, with three categories of IRFs (6 rural IRFs in the New England region, 29 rural IRFs in the West North Central region, and 8 rural IRFs in the Mountain region) estimated to receive an increase in estimated payments of 3 percent or more (3.2 percent, 3.0 percent, and 3.1, respectively). As a result, we anticipate this notice would have a positive impact on a substantial number of small entities. Medicare fiscal intermediaries, Medicare Administrative Contractors, and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As discussed in detail below, the rates and policies set forth in this notice will not have an adverse impact on rural hospitals based on the data of the 169 rural units and 20 rural hospitals in our database of 1,139 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 one year of $100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold level is approximately $139 million. This notice will not impose spending costs on State, local, or tribal governments, in the aggregate, or by the private sector, of greater than $139 million.

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

C. Anticipated Effects of the Notice

1. Basis and Methodology of Estimates

This notice sets forth updates to the IRF PPS rates contained in the FY 2012 final rule (76 FR 47836). Specifically, this notice sets forth updates to the CMG relative weights and average length of stay values, the wage index, and the outlier threshold for high-cost cases. This notice also applies a productivity adjustment to the FY 2013 RPL market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.1 percentage point reduction to the FY 2013 RPL market basket increase factor in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act.

We estimate that the FY 2013 impact will be a net increase of $140 million in payments to IRF providers. The impact analysis in Table 7 of this notice represents the projected effects of the updates to IRF PPS payments for FY 2013 compared with the estimated IRF PPS payments in FY 2012. 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 2013, we are implementing standard annual revisions described in this notice (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 2013 RPL market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and a 0.1 percentage point reduction to the FY 2013 RPL market basket increase factor in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act. We estimate the total increase in payments to IRFs in FY 2013, relative to FY 2012, will be approximately $140 million.

This estimate is derived from the application of the FY 2013 RPL 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 0.1 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act, which yields an increase of aggregate payments to IRFs of $130 million. Furthermore, there is an additional estimated $10 million increase in aggregate payments to IRFs due to the update in the outlier threshold amount. Outlier payments are estimated to increase from approximately 2.8 percent in FY 2012 to 3.0 percent in FY 2013. Therefore, summed together, these

updates will result in a net increase in estimated payments of $140 million from FY 2012 to FY 2013.

The effects of the updates that impact IRF PPS payment rates are shown in Table 7. The following updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the update to the outlier threshold amount, from approximately 2.8 percent to 3.0 percent of total estimated payments for FY 2013, consistent with section 1886(j)(4) of the Act.
- The effects of the annual market basket update (using the RPL market basket) to IRF PPS payment rates, as required by section 1886(j)(3)(A)(i) and 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 0.1 percentage point reduction in accordance with sections 1886(j)(3)(C) and (D) of the Act.
- The effects of applying the budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the budget-neutral changes to the CMG relative weights and average length of stay values, under the authority of section 1886(j)(2)(C)(i) of the Act.
- The total change in estimated payments based on the FY 2013 payment updates relative to the estimated FY 2012 payments.

2. Description of Table 7

The table below categorizes IRFs by geographic location, including urban or rural location, and location with respect to CMS's nine census divisions (as defined on the cost report) of the country. In addition, the table divides IRFs into those that are separate rehabilitation hospitals (otherwise called freestanding hospitals in this section), those that are rehabilitation units of a hospital (otherwise called hospital units in this section), rural or urban facilities, ownership (otherwise called for-profit, non-profit, and government), by teaching status, and by disproportionate share patient percentage (DSH PP). The top row of the table shows the overall impact on the 1,139 IRFs included in the analysis.

The next 12 rows of Table 7 contain IRFs categorized according to their geographic location, designation as either a freestanding hospital or a unit of a hospital, and by type of ownership; all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and all rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 950 IRFs located in urban areas included in our analysis. Among these, there are 739 IRF units of hospitals located in urban areas and 211 freestanding IRF hospitals located in urban areas. There are 189 IRFs located in rural areas included in our analysis. Among these, there are 169 IRF units of hospitals located in rural areas and 20 freestanding IRF hospitals located in rural areas. There are 383 for-profit IRFs. Among these, there are 324 IRFs in urban areas and 59 IRFs in rural areas. There are 697 non-profit IRFs. Among these, there are 579 urban IRFs and 118 rural IRFs. There are 59 government-owned IRFs. Among these, there are 47 urban IRFs and 12 rural IRFs.

The remaining four parts of Table 7 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 with respect to their location within a particular one of the nine Census geographic regions. Second, IRFs located in rural areas are categorized with respect to 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 payment update described in this notice to the facility categories listed above are shown in the columns of Table 7. The description of each column is as follows:

- Column (1) shows the facility classification categories described above.
- Column (2) shows the number of IRFs in each category in our FY 2011 analysis file.
- Column (3) shows the number of cases in each category in our FY 2011 analysis file.
- Column (4) shows the estimated effect of the adjustment to the outlier threshold amount.
- Column (5) shows the estimated effect of the 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 0.1 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act.
- Column (6) shows the estimated effect of the update to the IRF labor-related share and wage index, in a budget neutral manner.
- Column (7) shows the estimated effect of the update to the CMG relative weights and average length of stay values, in a budget neutral manner.
- Column (8) compares our estimates of the payments per discharge, incorporating all of the payment updates reflected in this notice for FY 2013 to our estimates of payments per discharge in FY 2012.

The average estimated increase for all IRFs is approximately 2.1 percent. This estimated net increase includes the effects of the RPL market basket increase factor for FY 2013 of 2.7 percent, reduced by a productivity adjustment of 0.7 percent in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and further reduced by 0.1 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and (D)(ii) of the Act. It also includes the approximate 0.2 percent overall estimated increase in estimated IRF outlier payments from the update to the outlier threshold amount. Since we are making the updates to the IRF wage index and the CMG relative weights in a budget-neutral manner, they will not affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they will affect the estimated distribution of payments among providers.

TABLE 7—IRF IMPACT TABLE FOR FY 2013

[Columns 4–8 in %]

Facility classification	Number of IRFs	Number of cases	Outlier	Adjusted market basket increase factor for FY 2013 [1]	FY 2013 CBSA wage index and labor-share	CMG	Total percent change
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Total	1,139	377,040	0.2	1.9	0.0	0.0	2.1
Urban unit	739	182,873	0.2	1.9	−0.1	0.1	2.2
Rural unit	169	27,487	0.2	1.9	−0.1	0.2	2.3
Urban hospital	211	160,712	0.1	1.9	0.1	−0.2	1.9
Rural hospital	20	5,968	0.1	1.9	−0.1	−0.1	1.7
Urban For-Profit	324	150,510	0.1	1.9	0.1	−0.1	1.9
Rural For-Profit	59	10,972	0.2	1.9	−0.3	0.1	1.8
Urban Non-Profit	579	180,668	0.2	1.9	0.0	0.1	2.1
Rural Non-Profit	118	20,321	0.2	1.9	0.0	0.2	2.3
Urban Government	47	12,407	0.3	1.9	−0.2	0.0	1.9
Rural Government	12	2,162	0.2	1.9	0.3	0.4	2.8
Urban	950	343,585	0.2	1.9	0.0	0.0	2.0
Rural	189	33,455	0.2	1.9	−0.1	0.2	2.2
Urban by region [2]							
Urban New England	32	15,790	0.1	1.9	0.2	−0.1	2.2
Urban Middle Atlantic	142	58,285	0.1	1.9	0.1	0.1	2.2
Urban South Atlantic	132	62,379	0.1	1.9	−0.1	−0.1	1.8
Urban East North Central	184	53,412	0.2	1.9	−0.3	0.0	1.7
Urban East South Central	50	24,111	0.1	1.9	−0.4	−0.1	1.5
Urban West North Central	72	17,926	0.2	1.9	−0.1	0.1	2.1
Urban West South Central	170	65,263	0.1	1.9	0.5	0.1	2.6
Urban Mountain	68	22,572	0.2	1.9	0.0	−0.1	2.0
Urban Pacific	100	23,847	0.3	1.9	0.1	0.0	2.2
Rural by region [2]							
Rural New England	6	1,279	0.3	1.9	0.9	0.1	3.2
Rural Middle Atlantic	15	2,807	0.1	1.9	−0.2	0.1	1.9
Rural South Atlantic	23	5,699	0.1	1.9	−0.7	0.0	1.4
Rural East North Central	31	5,498	0.1	1.9	−0.3	0.2	1.9
Rural East South Central	23	3,944	0.1	1.9	−0.5	0.2	1.7
Rural West North Central	29	3,857	0.3	1.9	0.5	0.3	3.0
Rural West South Central	50	9,336	0.2	1.9	0.2	0.2	2.5
Rural Mountain	8	656	0.3	1.9	0.3	0.5	3.1
Rural Pacific	4	379	0.6	1.9	0.3	0.1	2.9
Teaching Status							
Non-teaching	1,024	330,504	0.1	1.9	0.0	0.0	2.1
Resident to ADC less than 10%	64	30,956	0.2	1.9	−0.2	0.1	2.0
Resident to ADC 10%–19%	39	13,961	0.2	1.9	0.2	−0.1	2.3
Resident to ADC greater than 19%	12	1,619	0.2	1.9	0.2	0.2	2.5
Disproportionate Share Patient Percentage (DSH PP)							
DSH PP = 0%	49	13,420	0.1	1.9	0.2	0.0	2.3
DSH PP less than 5%	175	51,699	0.2	1.9	0.0	0.1	2.1
DSH PP 5%–10%	347	129,038	0.1	1.9	0.0	0.0	2.0
DSH PP 10%–20%	339	121,832	0.2	1.9	−0.1	0.0	2.0

TABLE 7—IRF IMPACT TABLE FOR FY 2013—Continued

[Columns 4–8 in %]

Facility classification	Number of IRFs	Number of cases	Outlier	Adjusted market basket increase factor for FY 2013 [1]	FY 2013 CBSA wage index and labor-share	CMG	Total percent change
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
DSH PP greater than 20%	229	61,051	0.2	1.9	0.0	−0.1	2.0

[1] This column reflects the impact of the RPL market basket increase factor for FY 2013 of 1.9 percent, which includes a market basket update of 2.7 percent, a 0.1 percentage point reduction in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act and a 0.7 percent reduction for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

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

3. Impact of the Update to the Outlier Threshold Amount

The outlier threshold adjustment is presented in column 4 of Table 7. In the FY 2012 IRF PPS final rule (76 FR 47867 through 47868), we used FY 2010 IRF claims data (the best, most complete data available at that time) to set the outlier threshold amount for FY 2012 so that estimated outlier payments would equal 3 percent of total estimated payments for FY 2012.

For this notice, we are updating our analysis using FY 2011 IRF claims data and, based on this updated analysis, we estimate that IRF outlier payments as a percentage of total estimated IRF payments are 2.8 percent in FY 2012. Thus, we are adjusting the outlier threshold amount in this notice to set total estimated outlier payments equal to 3 percent of total estimated payments in FY 2013. The estimated change in total IRF payments for FY 2013, therefore, includes an approximate 0.2 percent increase in payments because the estimated outlier portion of total payments is estimated to increase from approximately 2.8 percent to 3 percent.

The impact of this outlier adjustment update (as shown in column 4 of Table 7) is to increase estimated overall payments to IRFs by about 0.2 percent. We estimate the largest increase in payments from the update to the outlier threshold amount to be 0.6 percent for rural IRFs in the Pacific region. We do not estimate that any group of IRFs will experience a decrease in payments from this update.

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

The adjusted market basket update to the IRF PPS payment rates is presented in column 5 of Table 7. In the aggregate the update would result in a net 1.9 percent increase in overall estimated payments to IRFs. This net increase reflects the estimated RPL market basket increase factor for FY 2013 of 2.7 percent, reduced by the 0.1 percentage point in accordance with sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act, and further reduced by a 0.7 percent productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

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

In column 6 of Table 7, we present the effects of the budget neutral update of the wage index and labor-related share. The changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related share portion of payments, so the changes in the two have a combined effect on payments to providers. As discussed in section V.B of this notice, the labor-related share decreased from 70.199 percent in FY 2012 to 69.981 percent in FY 2013.

In the aggregate, since these updates to the wage index and the labor-related share are applied in a budget-neutral manner as required under section 1886(j)(6) of the Act, we do not estimate that these updates will affect overall estimated payments to IRFs. However, we estimate that these 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 0.9 percent for rural IRFs in the New England region. We estimate the largest decrease in payments from the update to the CBSA wage index and labor-related share to be a 0.7 percent decrease for rural IRFs in the South Atlantic region.

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

In column 7 of Table 7, we present the effects of the budget neutral update of the CMG relative weights and average length of stay values. In the aggregate we do not estimate that these updates will affect overall estimated payments to IRFs. However, we estimate that these updates will have small distributional effects. The largest estimated decrease in payments as a result of these updates is a 0.2 percent decrease to urban freestanding IRFs. The largest estimated increase in payments as a result of these updates is a 0.5 percent increase to rural IRFs in the Mountain region.

D. Alternatives Considered

As stated in section 1X. B of this notice, the notice results in a positive economic impact on IRFs. The overall impact on all IRFs is an estimated increase in FY 2013 payments of 2.1 percent, relative to FY 2012, with three categories of IRFs (6 rural IRFs in the New England region, 29 rural IRFs in the West North Central region, and 8 rural IRFs in the Mountain region) estimated to receive an increase in estimated payments of 3 percent or more (3.2 percent, 3.0 percent, 3.1 percent, respectively). The following is a discussion of the alternatives considered to the IRF PPS updates contained in this notice.

Section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services. Thus, we did not consider alternatives to updating payments using the estimated RPL market basket increase factor for FY 2013. However, as noted previously in this notice, section 1886(j)(3)(C)(ii)(I) requires the Secretary to apply a productivity adjustment to the market basket increase factor for FY 2013 and sections 1886(j)(3)(C)(ii)(II) and 1886(j)(3)(D)(ii) of the Act require the Secretary to apply a 0.1 percentage point reduction to the market basket increase factor for FY 2013. Thus, in accordance with section 1886(j)(3)(C) of the Act, we are updating IRF Federal prospective payments in this notice by

1.9 percent (which equals the 2.7 percent estimated RPL market basket increase factor for FY 2013 reduced by 0.1 percentage points, and further reduced by a 0.7 percent productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act).

We considered maintaining the existing CMG relative weights and average length of stay values for FY 2013. However, in light of recently available data and our desire to ensure that the CMG relative weights and average length of stay values are as reflective as possible of recent changes in IRF utilization and case mix, we believe that it is appropriate to update the CMG relative weights and average length of stay values at this time to ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs.

We considered maintaining the existing outlier threshold amount for FY 2013. However, analysis of updated FY 2011 data indicates that estimated outlier payments would be lower than 3 percent of total estimated payments for FY 2012, by approximately 0.2 percent, unless we updated the outlier threshold amount. Consequently, we are adjusting the outlier threshold amount in this notice to reflect a 0.2 percent increase thereby setting the total outlier payments equal to 3 percent, instead of 2.8 percent, of aggregate estimated payments in FY 2013.

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 8 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this notice. This table provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the updates presented in this notice based on the data for 1,139 IRFs in our database.

TABLE 8—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2012 IRF PPS FISCAL YEAR TO THE 2013 IRF PPS FISCAL YEAR

Category	Transfers
Annualized Monetized Transfers	$140 million.
From Whom to Whom?	Federal Government to IRF Medicare Providers.

F. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2013 are projected to increase by 2.1 percent, compared with the estimated payments in FY 2012, as reflected in column 8 of Table 7. IRF payments per discharge are estimated to increase 2.0 percent in urban areas and 2.2 percent in rural areas, compared with estimated FY 2012 payments. Payments per discharge to rehabilitation units are estimated to increase 2.2 percent in urban areas and 2.3 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 1.9 percent in urban areas and 1.7 percent in rural areas.

Overall, no IRFs are estimated to experience a net decrease in payments as a result of the updates in this notice. The largest payment increase is estimated to be a 3.2 percent increase for rural IRFs located in the New England region. This is due to the larger than average positive effect of the FY 2013 CBSA wage index and labor-related share updates for rural IRFs in this region.

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

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

Dated: May 10, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 16, 2012.

Kathleen Sebelius,

Secretary.

[FR Doc. 2012–18433 Filed 7–25–12; 4:15 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2012–D–0049]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; Reporting Harmful and Potentially Harmful Constituents in Tobacco Products and Tobacco Smoke Under the Federal Food, Drug, and Cosmetic Act

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under Paperwork Reduction Act of 1995.

DATES: Fax written comments on the collection of information by August 29, 2012.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: FDA Desk Officer, FAX: 202–395–7285, or emailed to *oira_submission@omb.eop.gov.* All comments should be identified with the OMB control number 0910–NEW and title ''Reporting Harmful and Potentially Harmful Constituents in Tobacco Products and Tobacco Smoke Under the Federal Food, Drug, and Cosmetic Act.'' Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Daniel Gittleson, Office of Information Management, Food and Drug Administration, 1350 Piccard Dr., PI50–400B, Rockville, MD 20850, 301–796–5156, *Daniel.Gittleson@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Reporting Harmful and Potentially Harmful Constituents in Tobacco Products and Tobacco Smoke Under the Federal Food, Drug, and Cosmetic Act—(OMB Control Number 0910–NEW)

On June 22, 2009, the President signed the Family Smoking Prevention and Tobacco Control Act (Public Law 111–31) into law. This law amends the Federal Food, Drug, and Cosmetic Act (FD&C Act) and grants FDA authority to