CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
0604	Neurological M <43.50	2.3456	1.7657	1.6552	1.5045	20	18	17	16
0701	Fracture of lower extremity M >=61.50	1.2473	1.0115	0.9585	0.8811	11	12	11	10
0702	Fracture of lower extremity M >=52.50 and M <61.50	1.5595	1.2647	1.1985	1.1016	14	14	13	12
0703	Fracture of lower extremity M >=41.50 and M <52.50	1.8956	1.5373	1.4568	1.3390	17	16	15	15
0704	Fracture of lower extremity M <41.50	2.1660	1.7566	1.6646	1.5300	19	18	17	17
0801	Replacement of lower-extremity joint M >=63.50	1.1268	0.9068	0.8121	0.7564	10	10	9	9
0802	Replacement of lower-extremity joint M >=57.50 and M <63.50	1.3248	1.0661	0.9548	0.8893	12	11	11	10
0803	Replacement of lower-extremity joint M >=51.50 and M <57.50	1.4799	1.1909	1.0666	0.9934	12	13	12	11
0804	Replacement of lower-extremity joint M >=42.50 and M <51.50	1.7056	1.3726	1.2293	1.1449	14	15	13	13
0805	Replacement of lower-extremity joint M <42.50	1.9874	1.5994	1.4324	1.3341	17	17	15	14
0901	Other orthopedic M >=63.50	1.2111	0.9651	0.9133	0.8273	11	11	10	10
0902	Other orthopedic M >=51.50 and M <63.50	1.5078	1.2015	1.1371	1.0301	13	13	12	12
0903	Other orthopedic M >=44.50 and M <51.50	1.7744	1.4139	1.3382	1.2122	15	15	14	14
0904	Other orthopedic M <44.5	2.0373	1.6235	1.5365	1.3918	17	17	16	15
1001	Amputation lower extremity M >=64.50	1.2960	1.0863	0.9748	0.9004	12	13	11	11
1002	Amputation lower extremity M >=55.50 and M <64.50	1.6010	1.3419	1.2042	1.1123	14	15	13	13
1003	Amputation lower extremity M >=47.50 and M <55.50	1.8708	1.5681	1.4072	1.2997	16	17	15	14
1004	Amputation lower extremity M <47.50	2.2049	1.8481	1.6585	1.5318	18	19	17	16
1101	Amputation non-lower extremity M >=58.50	1.2999	1.1583	1.0117	0.9810	12	11	11	13
1102	Amputation non-lower extremity M >=52.50 and M <58.50	1.7367	1.5476	1.3517	1.3107	14	13	14	14
1103	Amputation non-lower extremity M <52.50	1.9515	1.7390	1.5188	1.4728	17	13	15	14
1201	Osteoarthritis M >=61.50	1.4251	0.9495	0.9495	0.8718	11	10	10	10
1202	Osteoarthritis M >=49.50 and M <61.50	1.7907	1.1930	1.1930	1.0954	13	14	13	12
1203	Osteoarthritis M <49.50 and A >=74.50	2.0815	1.3867	1.3867	1.2734	15	14	16	14
1204	Osteoarthritis M <49.50 and A <74.50	2.1877	1.4575	1.4575	1.3383	15	15	15	15
1301	Rheumatoid other arthritis M >=62.50	1.1277	0.9311	0.8839	0.7847	9	11	10	9
1302	Rheumatoid other arthritis M >=51.50 and M <62.50	1.5429	1.2740	1.2094	1.0737	12	13	13	12
1303	Rheumatoid other arthritis M >=44.50 and M <51.50 and A >=64.50	1.7786	1.4686	1.3941	1.2377	14	15	14	14
1304	Rheumatoid other arthritis M <44.50 and A >=64.50	2.0617	1.7024	1.6161	1.4347	14	17	16	16
1305	Rheumatoid other arthritis M <51.50 and A <64.50	2.0876	1.7237	1.6363	1.4527	15	16	16	16
1401	Cardiac M >=68.50	1.1456	0.9392	0.8477	0.7585	10	10	10	9
1402	Cardiac M >=55.50 and M <68.50	1.4391	1.1799	1.0650	0.9529	13	13	11	11
1403	Cardiac M >=45.50 and M <55.50	1.7474	1.4326	1.2931	1.1570	15	15	13	13

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
1404	Cardiac M <45.50	2.0524	1.6827	1.5188	1.3590	18	17	16	14
1501	Pulmonary M >=68.50	1.2905	1.0335	0.9655	0.9262	11	11	10	10
1502	Pulmonary M >=56.50 and M <68.50	1.5913	1.2744	1.1906	1.1421	13	13	12	12
1503	Pulmonary M >=45.50 and M <56.50	1.8476	1.4796	1.3823	1.3261	16	14	13	13
1504	Pulmonary M <45.50	2.1421	1.7154	1.6027	1.5375	22	16	15	14
1601	Pain syndrome M >=65.50	0.9889	0.9889	0.8919	0.8028	9	10	11	9
1602	Pain syndrome M >=58.50 and M <65.50	1.1078	1.1078	0.9991	0.8992	10	11	11	11
1603	Pain syndrome M >=43.50 and M <58.50	1.3538	1.3538	1.2209	1.0989	12	14	13	13
1604	Pain syndrome M <43.50	1.7201	1.7201	1.5513	1.3963	13	15	17	15
1701	Major multiple trauma without brain or spinal cord injury M >=57.50	1.3910	1.0912	0.9919	0.9032	12	13	11	11
1702	Major multiple trauma without brain or spinal cord injury M >=50.50 and M <57.50	1.6988	1.3328	1.2115	1.1031	15	14	13	13
1703	Major multiple trauma without brain or spinal cord injury M >=41.50 and M <50.50	2.0140	1.5799	1.4362	1.3077	18	16	15	15
1704	Major multiple trauma without brain or spinal cord injury M >=36.50 and M <41.50	2.2279	1.7478	1.5888	1.4466	17	19	17	16
1705	Major multiple trauma without brain or spinal cord injury M <36.50	2.4447	1.9179	1.7434	1.5873	23	20	18	17
1801	Major multiple trauma with brain or spinal cord injury M >=67.50	1.2381	0.9821	0.8820	0.8180	14	13	10	10
1802	Major multiple trauma with brain or spinal cord injury M >=55.50 and M <67.50	1.5767	1.2506	1.1232	1.0418	13	15	12	12
1803	Major multiple trauma with brain or spinal cord injury M >=45.50 and M <55.50	1.9345	1.5344	1.3781	1.2782	17	17	15	14
1804	Major multiple trauma with brain or spinal cord injury M >=40.50 and M <45.50	2.2183	1.7596	1.5803	1.4657	22	19	17	16
1805	Major multiple trauma with brain or spinal cord injury M >=30.50 and M <40.50	2.6487	2.1010	1.8869	1.7501	28	23	20	19
1806	Major multiple trauma with brain or spinal cord injury M <30.50	3.4119	2.7063	2.4305	2.2543	37	29	22	25
1901	Guillain-Barré M >=66.50	1.2031	0.9356	0.9226	0.8738	14	12	13	10
1902	Guillain-Barré M >=51.50 and M <66.50	1.6292	1.2670	1.2493	1.1832	18	14	14	14
1903	Guillain-Barré M >=38.50 and M <51.50	2.5939	2.0172	1.9890	1.8838	25	21	21	21
1904	Guillain-Barré M <38.50	3.8189	2.9699	2.9284	2.7735	44	31	29	29
2001	Miscellaneous M >=66.50	1.2118	0.9833	0.9005	0.8282	11	11	10	9
2002	Miscellaneous M >=55.50 and M <66.50	1.4899	1.2090	1.1072	1.0182	13	13	12	11
2003	Miscellaneous M >=46.50 and M <55.50	1.7634	1.4309	1.3105	1.2052	15	15	14	13
2004	Miscellaneous M <46.50 and A >=77.50	1.9847	1.6104	1.4749	1.3564	18	17	15	15

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
2005	Miscellaneous M <46.50 and A <77.50	2.1338	1.7315	1.5858	1.4583	19	18	16	15
2101	Burns M >=52.50	1.8033	1.3711	1.1272	1.1272	17	13	13	14
2102	Burns M <52.50	2.4055	1.8289	1.5036	1.5036	20	21	15	15
5001	Short-stay cases, length of stay is 3 days or fewer				0.1643				2
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.7262				8
5102	Expired, orthopedic, length of stay is 14 days or more				1.8015				19
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.8454				8
5104	Expired, not orthopedic, length of stay is 16 days or more				2.0896				20

Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 3 shows how we estimate that the application of the revisions for FY 2021 would affect particular CMG relative weight values, which would affect the overall distribution of payments within CMGs and tiers. We note that, because we implement the CMG relative weight revisions in a budget-neutral manner (as previously described), total estimated aggregate payments to IRFs for FY 2021 are not affected as a result of the CMG relative weight revisions. However, the revisions affect the distribution of payments within CMGs and tiers.

TABLE 3: Distributional Effects of the Changes to the CMG Relative Weights

Percentage Change in CMG Relative Weights	Number of Cases Affected	Percentage of Cases Affected
Increased by 15% or more	64	0.0%
Increased by between 5% and 15%	1,830	0.4%
Changed by less than 5%	404,940	99.3%
Decreased by between 5% and 15%	1,029	0.3%
Decreased by 15% or more	11	0.0%

As shown in Table 3, 99.3 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the revisions for FY 2021. The changes in the average length of stay values

for FY 2021, compared with the FY 2020 average length of stay values, are small and do not show any particular trends in IRF length of stay patterns.

The comments we received on our proposal to update the CMG relative weights and average length of stay values for FY 2021 are summarized below.

Comment: One commenter expressed concern about the decreases in some of the CMG relative weights and average length of stay values from the proposed updates, and questioned whether the FY 2019 data used to update these values for FY 2021 are reliable and valid. This commenter suggested that CMS freeze the CMG relative weights and average length of stay values at FY 2020 levels. This commenter also requested that CMS provide patient level data to allow stakeholders to analyze and model IRF payments and requested that CMS convene regularly scheduled TEPs to discuss and review payment model analyses. Additionally, this commenter also suggested that CMS should modify Table 3 to reflect the payment impacts of updating the CMG relative weights and requested that CMS provide actual changes in payment instead of changes in percentages, as this would provide more transparency related to the actual changes that IRFs may experience.

Response: The annual updates to the CMG relative weights, which include both increases and decreases to the CMG relative weights, are intended to ensure that IRF payments are aligned as closely as possible with the current costs of care. The relative weights for each of the CMGs and tiers represent the relative costliness of patients in those CMGs and tiers compared with patients in other CMGs and tiers. Additionally, the average length of stay values are only used to determine which cases qualify for the short-stay transfer policy and are not used to determine payments for the non-short-stay transfer cases.

We do not agree that it would be appropriate to freeze the CMG relative weights and average length of stay values at FY 2020 levels because this would require us to base them on older data. Updating these values based on the most recent available data ensures that the IRF

case mix system is as reflective as possible of recent changes in IRF utilization and case mix, thereby ensuring that IRF payments appropriately reflect the relative costs of caring for IRF patients. Freezing these values at FY 2020 levels does not allow us to reflect any changes in IRF utilization and case mix that might have occurred over time. As stated in the FY 2021 IRF PPS proposed rule, the FY 2019 data is the most current and complete data available for updating payments.

We are confident that the data is valid and reliable for use in setting IRF PPS payment rates. CMS's contractor (Research Triangle Institute (RTI)) analyzed 2 year's worth of these data (FYs 2017 and 2018) to determine the extent to which the data could predict resource use in the IRF setting. RTI produced two reports containing their analyses and findings, "Analyses to Inform the Potential use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System (PDF)" (April 2018) and "Analyses to Inform the Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System (PDF)" (March 2019). These reports are both available for download from the IRF PPS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Research.

As most recently discussed in detail in the FY 2020 IRF PPS final rule (84 FR 39054), we believe that these data accurately reflect the severity of the IRF patient population and the associated costs of caring for these patients in the IRF setting. Therefore, we believe it is appropriate to use the FY 2019 data to update the CMG relative weights and average length of stay values for FY 2021 to ensure the case mix system is as reflective as possible of recent changes in IRF utilization and case mix.

With regard to the request for patient-level data, we are unable to make patient assessment and claims data publicly available on the CMS website because these data contain information that can be used to identify individual Medicare beneficiaries. However,

stakeholders may obtain these data through the standard CMS data acquisition and Data Use Agreement (DUA) processes. More information on CMS data acquisition process can be found on the CMS website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/FilesForOrderGenInfo/index.

In addition, with regard to the request for the regularly scheduled TEPs to obtain stakeholder input on the routine annual updates to the CMG relative weights and average length of stay values, we provide the methodology for these updates in the IRF PPS proposed rules each year to enable stakeholders to comment on the methodology and provide any suggestions for updating this methodology. Furthermore, we rarely make changes to this methodology, so we believe that stakeholders have had ample opportunity to comment on this methodology over the years, and we do not believe that there would be added value to convening a TEP to discuss this well-established methodology.

With regard to the comment regarding Table 3, we do not agree with the commenter's suggestion that utilizing changes in payment would more adequately project changes in the CMG relative weight values than examining changes in the relative weight values themselves. We would also like to note that the data files published in conjunction with each proposed and final rule contain estimated facility level payment impacts for each IRF in our analysis file to support transparency and assist providers in determining the payment implications of the policy updates contained in each rule. However, we appreciate the commenter's suggested revisions to Table 3 and will take this comment under advisement for future consideration.

After consideration of the comments we received, we are finalizing our proposal to update the CMG relative weights and average length of stay values for FY 2021, as shown in Table 2 of this final rule. These updates are effective for FY 2021, that is, for discharges occurring on or after October 1, 2020 and on or before September 30, 2021.

VI. FY 2021 IRF PPS Payment Update

A. Background

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services for which payment is made under the IRF PPS. According to section 1886(j)(3)(A)(i) of the Act, the increase factor shall be used to update the IRF prospective payment rates for each FY. Section 1886(j)(3)(C)(ii)(I) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Thus, in the FY 2021 IRF PPS proposed rule (85 FR 22073 through 22074), we proposed to update the IRF PPS payments for FY 2021 by a market basket increase factor as required by section 1886(j)(3)(C) of the Act based upon the most current data available, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

We have utilized various market baskets through the years in the IRF PPS. For a discussion of these market baskets, we refer readers to the FY 2016 IRF PPS final rule (80 FR 47046).

In FY 2016, we finalized the use of a 2012-based IRF market basket, using Medicare cost report (MCR) data for both freestanding and hospital-based IRFs (80 FR 47049 through 47068). Beginning with FY 2020, we finalized a rebased and revised IRF market basket to reflect a 2016 base year. The FY 2020 IRF PPS final rule (84 FR 39071 through 39086) contains a complete discussion of the development of the 2016-based IRF market basket.

B. FY 2021 Market Basket Update and Productivity Adjustment

For FY 2021 (that is, beginning October 1, 2020 and ending September 30, 2021), we proposed to update the IRF PPS payments by a market basket increase factor as required by section 1886(j)(3)(C) of the Act, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. For FY 2021, we proposed to use the same methodology described in the FY 2020 IRF PPS final rule (84 FR 39085) to compute the FY 2021 market

basket increase factor to update the IRF PPS base payment rate.

Consistent with historical practice, we proposed to estimate the market basket update for the IRF PPS based on IHS Global Inc.'s (IGI's) forecast using the most recent available data. IGI is a nationally-recognized economic and financial forecasting firm with which we contract to forecast the components of the market baskets and multifactor productivity (MFP). Based on IGI's fourth quarter 2019 forecast with historical data through the third quarter of 2019, the 2016-based IRF market basket increase factor for FY 2021 was projected to be 2.9 percent. Therefore, we proposed that the 2016-based IRF market basket increase factor for FY 2021 would be 2.9 percent. We proposed that if more recent data became available after the publication of the proposed rule and before the publication of this final rule (for example, a more recent estimate of the market basket update), we would use such data to determine the FY 2021 market basket update in this final rule.

According to section 1886(j)(3)(C)(i) of the Act, the Secretary shall establish an increase factor based on an appropriate percentage increase in a market basket of goods and services. Section 1886(j)(3)(C)(ii) of the Act then requires that, after establishing the increase factor for a FY, the Secretary shall reduce such increase factor for FY 2012 and each subsequent FY, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business MFP (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the "MFP adjustment"). The U.S. Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measure of private nonfarm business MFP. Please see http://www.bls.gov/mfp for the BLS historical published MFP data. A complete description of the MFP projection methodology is available on the CMS website at

https://www.cms.gov/Research-Statistics-Dataand-Systems/Statistics-Trends-andReports/MedicareProgramRatesStats/MarketBasketResearch.html.

Using IGI's fourth quarter 2019 forecast, the 10-year moving average growth of MFP for FY 2021 was projected to be 0.4 percentage point. Thus, in accordance with section 1886(j)(3)(C) of the Act, we proposed to base the FY 2021 market basket update, which is used to determine the applicable percentage increase for the IRF payments, on IGI's fourth quarter 2019 forecast of the 2016-based IRF market basket. We proposed to then reduce this percentage increase by the estimated MFP adjustment for FY 2021 of 0.4 percentage point (the 10-year moving average growth of MFP for the period ending FY 2021 based on IGI's fourth quarter 2019 forecast). Therefore, the proposed FY 2021 IRF update was equal to 2.5 percent (2.9 percent market basket update less 0.4 percentage point MFP adjustment). Furthermore, we proposed that if more recent data became available after the publication of the proposed rule and before the publication of this final rule (for example, a more recent estimate of the market basket and/or MFP), we would use such data to determine the FY 2021 market basket update and MFP adjustment in this final rule.

Based on the more recent data available for this FY 2021 IRF final rule (that is, IGI's second quarter 2020 forecast of the 2016-based IRF market basket rate-of-increase with historical data through the first quarter of 2020), we estimate that the FY 2021 market basket update is 2.4 percent. We note that the fourth quarter 2019 forecast was developed prior to the economic impacts of the Coronavirus disease 2019 (COVID-19) pandemic. This lower update (2.4 percent) for FY 2021 relative to the proposed rule (2.9 percent) is primarily driven by slower anticipated compensation growth for both health-related and other occupations as labor markets are expected to be significantly impacted during the recession that started in February 2020 and throughout the anticipated recovery.

Based on the more recent data available for this FY 2021 IRF final rule, the current

estimate of the 10-year moving average growth of MFP for FY 2021 is -0.1 percentage point. This MFP is based on the most recent macroeconomic outlook from IGI at the time of rulemaking (released June 2020) in order to reflect more current historical economic data. IGI produces monthly macroeconomic forecasts, which include projections of all of the economic series used to derive MFP. In contrast, IGI only produces forecasts of the more detailed price proxies used in the 2016-based IRF market basket on a quarterly basis. Therefore, IGI's second quarter 2020 forecast is the most recent forecast of the 2016-based IRF market basket update.

We note that it has typically been our practice to base the projection of the market basket price proxies and MFP in the final rule on the second quarter IGI forecast. For this FY 2021 IRF PPS final rule, we are using the IGI June macroeconomic forecast for MFP because it is a more recent forecast, and it is important to use more recent data during this period when economic trends, particularly employment and labor productivity, are notably uncertain because of the COVID-19 pandemic. Historically, the MFP adjustment based on the second quarter IGI forecast has been very similar to the MFP adjustment derived with IGI's June macroeconomic forecast. Substantial changes in the macroeconomic indicators in between monthly forecasts are atypical.

Given the unprecedented economic uncertainty as a result of the COVID-19 pandemic, the change in the IGI macroeconomic series used to derive MFP between the IGI second quarter 2020 IGI forecast and the IGI June 2020 macroeconomic forecast is significant. Therefore, we believe it is technically appropriate to use IGI's more recent June 2020 macroeconomic forecast to determine the MFP adjustment for the final rule as it reflects more current historical data. For comparison purposes, the 10-year moving average growth of MFP for FY 2021 is projected to be -0.1 percentage point based on IGI's June 2020 macroeconomic forecast compared to a FY 2021 projected 10-year moving average growth of MFP of 0.7 percentage point based on IGI's second quarter 2020 forecast. Mechanically subtracting the negative 10-year moving average growth of

MFP from the IRF market basket increase factor using the data from the IGI June 2020 macroeconomic forecast would have resulted in a 0.1 percentage point increase in the FY 2021 IRF increase factor. However, under sections 1886(b)(3)(B)(xi)(II) and 1886(j)(3)(C) of the Act, the Secretary is required to reduce (not increase) the IRF market basket increase factor by changes in economy-wide productivity. Accordingly, we will be applying a 0.0 percentage point MFP adjustment to the IRF market basket increase factor. Therefore, the current estimate of the FY 2021 IRF increase factor is equal to 2.4 percent.

For FY 2021, the Medicare Payment Advisory Commission (MedPAC) recommends that we reduce IRF PPS payment rates by 5 percent. As discussed, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary is required to update the IRF PPS payment rates for FY 2021 by an adjusted market basket increase factor which, based on the most recently available data, is 2.4 percent. 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 2021.

The comments we received on the proposed market basket update and productivity adjustment are summarized below.

Comment: One commenter (MedPAC) stated that Medicare's current payment rates for IRFs appear to be more than adequate and therefore recommended that the Congress reduce the IRF payment rate by 5 percent for FY 2021. The commenter appreciated that CMS cited MedPAC's recommendation, even while noting that the Secretary does not have the authority to deviate from statutorily mandated updates.

Response: We appreciate MedPAC's interest in the IRF increase factor. However, we are required to update IRF PPS payments by the market basket update adjusted for productivity, as directed by section 1886(j)(3)(C) of the Act.

Comment: A few commenters supported the proposal to update the market basket and productivity amounts using the latest available data, and encouraged CMS to update these factors using the latest available data as part of the release of the IRF PPS Final Rule. One commenter stated that they were pleased to see an increase in payments to IRFs and further increases to rural providers.

Response: We appreciate the commenters' support for the proposed IRF annual payment update. As noted in the proposed rule, the final update would be based on a more recent forecast of the market basket and MFP adjustment if available. Therefore, incorporating an updated estimate of the market basket update and productivity adjustment in the final rule is consistent with what we have done historically for the IRF PPS as well as other Medicare PPSs as it reflects more current historical data as well as a revised outlook on the forecasted price pressures faced by providers for FY 2021 and inclusive of economic assumptions regarding the expected impacts from the COVID-19 pandemic.

Comment: Several commenters expressed concern about the continued application of the productivity adjustment to IRFs. One commenter stated that while they understand that CMS is bound by statute to reduce the market basket update by a productivity adjustment factor in accordance with the PPACA, they continue to be concerned that IRFs will not have the ability to generate additional productivity gains at a pace matching the productivity of the economy at large on an ongoing, consistent basis as contemplated by the PPACA. In addition, the commenter stated that the recent developments related to the public health emergency due to COVID-19 have resulted in further productivity challenges for IRFs. The commenter respectfully requested that CMS carefully monitor the impact that these productivity adjustments will have on the rehabilitation hospital sector, provide feedback to Congress as appropriate, and reduce the productivity adjustment. A few commenters recommended that CMS continue to

research productivity factors for health care providers and hospitals, and partner with Congress to implement a more appropriate, health care specific productivity adjustment.

Response: We acknowledge the commenters' concerns regarding productivity growth at the economy-wide level and its application to IRFs. As the commenter acknowledges, section 1886(j)(3)(C)(ii)(I) of the Act requires the application of a productivity adjustment to the IRF PPS market basket increase factor. We will continue to monitor the impact of the payment updates on IRF Medicare payment adequacy as well as beneficiary access to care.

As stated in the FY 2020 IRF PPS final rule (84 FR 39087), we would be very interested in better understanding IRF-specific productivity; however, the data elements required to estimate IRF specific multi-factor productivity are not produced at the level of detail that would allow this analysis. We have estimated hospital-sector multi-factor productivity and have published the findings on the CMS website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProductivityMemo2016.pdf

Comment: One commenter stated that while they appreciate this modest increase to the payment rate, it is insufficient to offset the impact of cost inflation, sequestration, and the financial impact IRFs are facing due to COVID-19. The commenter encouraged CMS to consider these additional impacts in the final rule.

Response: Since the publication of the FY 2021 IRF PPS proposed rule, we have incorporated more current historical data and revised forecasts provided by IGI that factor in expected impacts on price and wage pressures from the COVID-19 pandemic. By incorporating the most recent estimates available of the market basket update and productivity adjustment, we believe these data reflect the best available projection of input price inflation faced by IRFs for FY 2021, adjusted for economy-wide productivity, which is required by statute.

After consideration of the comments we received, we are finalizing a FY 2021 IRF update equal to 2.4 percent based on the most recent data available.

C. Labor-Related Share for FY 2021

Section 1886(j)(6) of the Act specifies that the Secretary is to adjust the proportion (as estimated by the Secretary from time to time) of IRFs' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under section 1886(j)(3) of the Act for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We proposed to continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

Based on our definition of the labor-related share and the cost categories in the 2016-based IRF market basket, we proposed to calculate the labor-related share for FY 2021 as the sum of the FY 2021 relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-related Services, and a portion of the Capital-Related relative importance from the 2016-based IRF market basket. For more details regarding the methodology for determining specific cost categories for inclusion in the 2016-based IRF labor-related share, see the FY 2020 IRF PPS final rule (84 FR 39087 through 39089).

The relative importance reflects the different rates of price change for these cost categories between the base year (2016) and FY 2021. Based on IGI's fourth quarter 2019 forecast of the 2016-based IRF market basket, the sum of the FY 2021 relative importance for Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and

Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-related Services was 69.0 percent. We proposed that the portion of Capital-Related costs that are influenced by the local labor market is 46 percent. Since the relative importance for Capital-Related costs was 8.5 percent of the 2016-based IRF market basket for FY 2021, we proposed to take 46 percent of 8.5 percent to determine the labor-related share of Capital-Related costs for FY 2021 of 3.9 percent. Therefore, we proposed a total labor-related share for FY 2021 of 72.9 percent (the sum of 69.0 percent for the labor-related share of operating costs and 3.9 percent for the labor-related share of Capital-Related costs). We proposed that if more recent data became available after publication of the proposed rule and before the publication of this final rule (for example, a more recent estimate of the labor-related share), we would use such data to determine the FY 2021 IRF labor-related share in this final rule.

Based on IGI's second quarter 2020 forecast of the 2016-based IRF market basket, the sum of the FY 2021 relative importance for Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-related Services is 69.1 percent. We proposed that the portion of Capital-Related costs that are influenced by the local labor market is 46 percent. Since the relative importance for Capital-Related costs is 8.5 percent of the 2016-based IRF market basket for FY 2021, we take 46 percent of 8.5 percent to determine the labor-related share of Capital-Related costs for FY 2021 of 3.9 percent. Therefore, the current estimate of the total labor-related share for FY 2021 is equal to 73.0 percent (the sum of 69.1 percent for the labor-related share of operating costs and 3.9 percent for the labor-related share of Capital-Related costs). Table 4 shows the current estimate of the FY 2021 labor-related share and the FY 2020 final labor-related share using the 2016-based IRF market basket relative importance.

TABLE 4: FY 2021 IRF Labor-Related Share and FY 2020 IRF Labor-Related Share

	FY 2021 Labor-Related Share [1]	FY 2020 Final Labor Related Share [2]
Wages and Salaries	48.6	48.1
Employee Benefits	11.4	11.4
Professional Fees: Labor-Related [3]	5.0	5.0
Administrative and Facilities Support Services	0.7	0.8
Installation, Maintenance, and Repair Services	1.6	1.6
All Other: Labor-Related Services	1.8	1.8
Subtotal	**69.1**	**68.7**
Labor-related portion of Capital-Related (46%)	3.9	4.0
Total Labor-Related Share	**73.0**	**72.7**

[1] Based on the 2016-based IRF market basket relative importance, IGI 2nd quarter 2020 forecast.
[2] Based on the 2016-based IRF market basket relative importance as published in the **Federal Register** (84 FR 39089).
[3] Includes all contract advertising and marketing costs and a portion of accounting, architectural, engineering, legal, management consulting, and home office contract labor costs.

The comment we received on the proposed labor related share for FY 2021 is summarized below.

Comment: One commenter opposed the proposed increase in the labor related share because it penalizes any facility that has a wage index less than 1.0. The commenter stated that across the country, there is a growing disparity between high-wage and low-wage states and stated that this proposal will continue to exacerbate that disparity and further harm hospitals in many rural and underserved communities. Unless there is sufficient data to support the labor related share increase, the commenter requested that the percentage from 2020 should carry forward into 2021.

Response: We appreciate the commenter's concern over the increase in the labor-related share; however, we believe it is technically appropriate to use the 2016-based IRF market basket relative importance to determine the labor-related share for FY 2021 as it is based on more recent data regarding price pressures and cost structure of IRFs. Our policy to use the most recent market basket to determine the labor-related share is a policy we have regularly adopted for the IRF PPS, (such as for the FY 2020 IRF PPS final rule (84 FR 39089)), as well as for other PPSs including but not limited to the Inpatient Psychiatric Facility PPS (84 FR 38446) and the Long-

term care hospital PPS (84 FR 42642).

After consideration of the comment we received, we are finalizing the use of the sum of the FY 2021 relative importance for the labor-related cost categories based on the most recent forecast (IGI's second quarter 2020 forecast) of the 2016-based IRF market basket labor-related share cost weights as proposed.

D. Wage Adjustment for FY 2021

1. Background

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

For FY 2021, we proposed to maintain the policies and methodologies described in the FY 2020 IRF PPS final rule (84 FR 39090) related to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we proposed to use the CBSA labor market area definitions and the FY 2021 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2021 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2016, and before October 1, 2017 (that is, FY 2017 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 proposed to continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation for the FY 2021 IRF PPS wage index.

The comments we received on these proposals are summarized below.

Comment: One commenter recommended that CMS repeal the existing hospital wage index and recommended a number of changes to existing wage index policies, but acknowledged that legislative action may be necessary to accomplish some or all of the recommended changes.

Response: We appreciate the commenter's recommendations on implementing wage index reform and the recommended modifications to the IRF PPS wage index polices. We believe that such recommendations should be part of a broader discussion on wage index reform across Medicare payment systems. These recommendations will be taken into consideration while we continue to explore potential wage index alternatives in the future.

Comment: Some commenters who were supportive of using the concurrent year's IPPS wage data requested that CMS adopt IPPS wage index polices under the IRF PPS, including geographic reclassification, the imposition of a rural floor, and adjustments that address wage disparities between high and low wage index hospitals. Additionally, some commenters suggested that discrepancies in wage index policies between the IRF PPS and IPPS settings may impact access to care and competition for labor and requested that CMS ensure parity between wage index policies for all hospitals.

Response: We appreciate the commenters' support for the continued use of the concurrent year's IPPS wage data. However, we note that the IRF PPS does not account for geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act, and does not apply the "rural floor" under section 4410 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33, enacted on August 5, 1997). Furthermore, as we do not have an IRF-specific wage index, we are

unable to determine the degree, if any, to which a geographic reclassification adjustment or a rural floor policy under the IRF PPS would be appropriate. The rationale for our current wage index policies is fully described in the FY 2006 IRF PPS final rule (70 FR 47880, 47926 through 47928).

With regard to the comments requesting that we adopt similar adjustments to address wage disparities between high and low wage index IPPS hospitals under the IRF PPS, we would like to note that the IRF wage index is derived from IPPS wage data. As such, any effects of this policy on the wage data of IPPS hospitals will be extended to the IRF setting, as this data will be used to establish the wage index for IRFs in the future.

We appreciate the commenters' concerns regarding beneficiary access to care and competition for labor resulting from different applicable wage index policies across different settings of care. While CMS and other stakeholders have explored potential alternatives to the current wage index system in the past, no consensus has been achieved regarding how best to implement a replacement system. These concerns will be taken into consideration while we continue to explore potential wage index reforms and monitor IRF wage index policies.

After consideration of the comments we received, we are finalizing our proposed policies as discussed above relating to the wage index.

2. Core-Based Statistical Areas (CBSAs) for the FY 2021 IRF Wage Index

a. Background

The wage index used for the IRF PPS is calculated using the pre-reclassification and pre-floor inpatient PPS (IPPS) wage index data and is assigned to the IRF on the basis of the labor market area in which the IRF is geographically located. IRF labor market areas are delineated based on the CBSAs established by the OMB. The current CBSA delineations (which were implemented for the IRF PPS beginning with FY 2016) are based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13–01. OMB Bulletin No. 13-01

established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published in the June 28, 2010 **Federal Register** (75 FR 37246 through 37252). We refer readers to the FY 2016 IRF PPS final rule (80 FR 47068 through 47076) for a full discussion of our implementation of the OMB labor market area delineations beginning with the FY 2016 wage index.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues updates and revisions to the statistical areas to reflect the recognition of new areas or the addition of counties to existing areas. In some instances, these updates merge formerly separate areas, transfer components of an area from one area to another, or drop components from an area. On July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15-01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013.

In the FY 2018 IRF PPS final rule (82 FR 36250 through 36251), we adopted the updates set forth in OMB Bulletin No. 15–01 effective October 1, 2017, beginning with the FY 2018 IRF wage index. For a complete discussion of the adoption of the updates set forth in OMB Bulletin No. 15–01, we refer readers to the FY 2018 IRF PPS final rule. In the FY 2019 IRF PPS final rule (83 FR 38527), we continued to use the OMB delineations that were adopted beginning with FY 2016 to calculate the area wage indexes, with updates set forth in OMB Bulletin No. 15-01 that we adopted beginning with the FY 2018 wage index.

On August 15, 2017, OMB issued OMB Bulletin No. 17–01, which provided updates to and superseded OMB Bulletin No. 15–01 that was issued on July 15, 2015. The attachments to OMB Bulletin No. 17–01 provide detailed information on the update to statistical areas since July 15, 2015, and are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2014 and July 1, 2015. In the FY 2020 IRF PPS final rule (84 FR 39090 through 39091), we adopted the updates set forth in OMB Bulletin No. 17–01 effective October 1, 2019, beginning with the FY 2020 IRF wage index.

On April 10, 2018, OMB issued OMB Bulletin No. 18-03, which superseded the August 15, 2017 OMB Bulletin No. 17-01, and on September 14, 2018, OMB issued OMB Bulletin No. 18–04, which superseded the April 10, 2018 OMB Bulletin No. 18-03. These bulletins established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf. We note that on March 6, 2020 OMB issued OMB Bulletin 20-01 (available on the web at https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf), but it was not issued in time for development of this rule.

While OMB Bulletin No. 18-04 is not based on new census data, there were some material changes based on the revised OMB delineations. The revisions OMB published on September 14, 2018 contain a number of significant changes. For example, under the new OMB delineations, there would be new CBSAs, urban counties that would become rural, rural counties that would become urban, and existing CBSAs that would be split apart. We discuss these changes in more detail in section VI.D.2.b. of this final rule. We proposed to adopt the updates to the OMB delineations announced in OMB Bulletin No. 18-04 effective beginning with FY

2021 under the IRF PPS. As noted previously, the March 6, 2020 OMB Bulletin 20-01 was not issued in time for development of this rule. While we do not believe that the minor updates included in OMB Bulletin 20-01 will impact the updates to the CBSA-based labor market area delineations, if appropriate, we will propose any updates from this bulletin in the FY 2022 IRF PPS proposed rule.

b. Implementation of New Labor Market Area Delineations

We believe it is important for the IRF PPS to use the latest labor market area delineations available as soon as is reasonably possible to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. We further believe that using the most current delineations possible will increase the integrity of the IRF PPS wage index system by creating a more accurate representation of geographic variations in wage levels. Therefore, we proposed to adopt the new OMB delineations as described in the September 14, 2018 OMB Bulletin No. 18–04, effective beginning with the FY 2021 IRF PPS wage index. We proposed to use these new delineations to calculate area wage indexes in a manner that is generally consistent with the CBSA-based methodologies. As the adoption of the new OMB delineations may have significant negative impacts on the wage index values for certain geographic areas, we also proposed to apply a 5 percent cap on any decrease in an IRF's wage index from the IRF's wage index from the prior FY. This transition is discussed in more detail in section VI.D.3. of this final rule.

(1) Micropolitan Statistical Areas

OMB defines a "Micropolitan Statistical Area" as a CBSA associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000 (75 FR 37252). We refer to these areas as Micropolitan Areas. Since FY 2006, we have treated Micropolitan Areas as rural and include hospitals located in Micropolitan Areas in each State's rural wage index. We refer the reader to the FY 2006 IRF PPS final rule for a complete discussion regarding

treating Micropolitan Areas as rural. Therefore, in conjunction with our proposal to implement the new OMB labor market delineations beginning in FY 2021 and consistent with the treatment of Micropolitan Areas under the IPPS, we proposed to continue to treat Micropolitan Areas as "rural" and to include Micropolitan Areas in the calculation of the state's rural wage index.

(2) Urban Counties That Would Become Rural Under the New OMB Delineations

As previously discussed, we proposed to implement the new OMB labor market area delineations (based upon the 2010 Decennial Census data) beginning in FY 2021. Our analysis shows that a total of 34 counties (and county equivalents) that are currently considered part of an urban CBSA would be considered located in a rural area, beginning in FY 2021, under these new OMB delineations. Table 5 lists the 34 urban counties that will be rural with the implementation of the new OMB delineations.

TABLE 5: Counties That Will Transition from Urban to Rural Status

FIPS County Code	County/County Equivalent	State	Current CBSA	Current CBSA Name
01127	Walker	AL	13820	Birmingham-Hoover, AL
12045	Gulf	FL	37460	Panama City, FL
13007	Baker	GA	10500	Albany, GA
13235	Pulaski	GA	47580	Warner Robins, GA
15005	Kalawao	HI	27980	Kahului-Wailuku-Lahaina, HI
17039	De Witt	IL	14010	Bloomington, IL
17053	Ford	IL	16580	Champaign-Urbana, IL
18143	Scott	IN	31140	Louisville/Jefferson County, KY-IN
18179	Wells	IN	23060	Fort Wayne, IN
19149	Plymouth	IA	43580	Sioux City, IA-NE-SD
20095	Kingman	KS	48620	Wichita, KS
21223	Trimble	KY	31140	Louisville/Jefferson County, KY-IN
22119	Webster	LA	43340	Shreveport-Bossier City, LA
26015	Barry	MI	24340	Grand Rapids-Wyoming, MI
26159	Van Buren	MI	28020	Kalamazoo-Portage, MI
27143	Sibley	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI
28009	Benton	MS	32820	Memphis, TN-MS-AR
29119	Mc Donald	MO	22220	Fayetteville-Springdale-Rogers, AR-MO
30037	Golden Valley	MT	13740	Billings, MT
31081	Hamilton	NE	24260	Grand Island, NE
38085	Sioux	ND	13900	Bismarck, ND
40079	Le Flore	OK	22900	Fort Smith, AR-OK
45087	Union	SC	43900	Spartanburg, SC
46033	Custer	SD	39660	Rapid City, SD
47081	Hickman	TN	34980	Nashville-Davidson--Murfreesboro--Franklin, TN
48007	Aransas	TX	18580	Corpus Christi, TX
48221	Hood	TX	23104	Fort Worth-Arlington, TX
48351	Newton	TX	13140	Beaumont-Port Arthur, TX
48425	Somervell	TX	23104	Fort Worth-Arlington, TX
51029	Buckingham	VA	16820	Charlottesville, VA
51033	Caroline	VA	40060	Richmond, VA
51063	Floyd	VA	13980	Blacksburg-Christiansburg-Radford, VA
53013	Columbia	WA	47460	Walla Walla, WA
53051	Pend Oreille	WA	44060	Spokane-Spokane Valley, WA

We proposed that the wage data for all hospitals located in the counties listed above would now be considered rural, beginning in FY 2021, when calculating their respective State's rural wage index. This rural wage index value would also be used under the IRF PPS. We refer readers to section VI.D.3. of this final rule for a discussion of the wage index transition policy due to these changes.

(3) Rural Counties That Will Become Urban Under the New OMB Delineations

As previously discussed, we are implementing the new OMB labor market area

delineations (based upon the 2010 Decennial Census data) beginning in FY 2021. Analysis of these OMB labor market area delineations shows that a total of 47 counties (and county equivalents) that are currently considered located in rural areas will now be considered located in urban areas under the new OMB delineations. Table 6 lists the 47 rural counties that will be urban with the implementation of the new OMB delineations.

TABLE 6: Counties that Will Transition from Rural to Urban Status

FIPS County Code	County/County Equivalent	State	Proposed CBSA Code	Proposed CBSA Name
01063	Greene	AL	46220	Tuscaloosa, AL
01129	Washington	AL	33660	Mobile, AL
05047	Franklin	AR	22900	Fort Smith, AR-OK
12075	Levy	FL	23540	Gainesville, FL
13259	Stewart	GA	17980	Columbus, GA-AL
13263	Talbot	GA	17980	Columbus, GA-AL
16077	Power	ID	38540	Pocatello, ID
17057	Fulton	IL	37900	Peoria, IL
17087	Johnson	IL	16060	Carbondale-Marion, IL
18047	Franklin	IN	17140	Cincinnati, OH-KY-IN
18121	Parke	IN	45460	Terre Haute, IN
18171	Warren	IN	29200	Lafayette-West Lafayette, IN
19015	Boone	IA	11180	Ames, IA
19099	Jasper	IA	19780	Des Moines-West Des Moines, IA
20061	Geary	KS	31740	Manhattan, KS
21043	Carter	KY	26580	Huntington-Ashland, WV-KY-OH
22007	Assumption	LA	12940	Baton Rouge, LA
22067	Morehouse	LA	33740	Monroe, LA
25011	Franklin	MA	44140	Springfield, MA
26067	Ionia	MI	24340	Grand Rapids-Kentwood, MI
26155	Shiawassee	MI	29620	Lansing-East Lansing, MI
27075	Lake	MN	20260	Duluth, MN-WI
28031	Covington	MS	25620	Hattiesburg, MS
28051	Holmes	MS	27140	Jackson, MS
28131	Stone	MS	25060	Gulfport-Biloxi, MS
29053	Cooper	MO	17860	Columbia, MO
29089	Howard	MO	17860	Columbia, MO
30095	Stillwater	MT	13740	Billings, MT
37007	Anson	NC	16740	Charlotte-Concord-Gastonia, NC-SC
37029	Camden	NC	47260	Virginia Beach-Norfolk-Newport News, VA-NC
37077	Granville	NC	20500	Durham-Chapel Hill, NC
37085	Harnett	NC	22180	Fayetteville, NC
39123	Ottawa	OH	45780	Toledo, OH
45027	Clarendon	SC	44940	Sumter, SC
47053	Gibson	TN	27180	Jackson, TN
47161	Stewart	TN	17300	Clarksville, TN-KY
48203	Harrison	TX	30980	Longview, TX
48431	Sterling	TX	41660	San Angelo, TX
51097	King And Queen	VA	40060	Richmond, VA
51113	Madison	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV
51175	Southampton	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
51620	Franklin City	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
54035	Jackson	WV	16620	Charleston, WV
54065	Morgan	WV	25180	Hagerstown-Martinsburg, MD-WV
55069	Lincoln	WI	48140	Wausau-Weston, WI
72001	Adjuntas	PR	38660	Ponce, PR
72083	Las Marias	PR	32420	Mayagüez, PR

We proposed that when calculating the area wage index, beginning with FY 2021, the

wage data for hospitals located in these counties would be included in their new respective urban CBSAs. Typically, providers located in an urban area receive a higher wage index value than or equal to providers located in their State's rural area. We refer readers to section VI.D.3. of this final rule for a discussion of the wage index transition policy.

(4) Urban Counties That Will Move to a Different Urban CBSA Under the New OMB Delineations

In certain cases, adopting the new OMB delineations involves a change only in CBSA name and/or number, while the CBSA continues to encompass the same constituent counties. For example, CBSA 19380 (Dayton, OH) will experience both a change to its number and its name, and become CBSA 19430 (Dayton-Kettering, OH), while all of its three constituent counties will remain the same. In other cases, only the name of the CBSA will be modified, and none of the currently assigned counties will be reassigned to a different urban CBSA. Table 7 shows the current CBSA code and our proposed CBSA code where we proposed to change either the name or CBSA number only. We are not discussing further in this section these changes because they are inconsequential changes with respect to the IRF PPS wage index.

TABLE 7: Current CBSAs that Will Change CBSA Code or Title

Proposed CBSA Code	Proposed CBSA Title	Current CBSA Code	Current CBSA Title
10540	Albany-Lebanon, OR	10540	Albany, OR
11500	Anniston-Oxford, AL	11500	Anniston-Oxford-Jacksonville, AL
12060	Atlanta-Sandy Springs-Alpharetta, GA	12060	Atlanta-Sandy Springs-Roswell, GA
12420	Austin-Round Rock-Georgetown, TX	12420	Austin-Round Rock, TX
13460	Bend, OR	13460	Bend-Redmond, OR
13980	Blacksburg-Christiansburg, VA	13980	Blacksburg-Christiansburg-Radford, VA
14740	Bremerton-Silverdale-Port Orchard, WA	14740	Bremerton-Silverdale, WA
15380	Buffalo-Cheektowaga, NY	15380	Buffalo-Cheektowaga-Niagara Falls, NY
19430	Dayton-Kettering, OH	19380	Dayton, OH
24340	Grand Rapids-Kentwood, MI	24340	Grand Rapids-Wyoming, MI
24860	Greenville-Anderson, SC	24860	Greenville-Anderson-Mauldin, SC
25060	Gulfport-Biloxi, MS	25060	Gulfport-Biloxi-Pascagoula, MS
25540	Hartford-East Hartford-Middletown, CT	25540	Hartford-West Hartford-East Hartford, CT
25940	Hilton Head Island-Bluffton, SC	25940	Hilton Head Island-Bluffton-Beaufort, SC
28700	Kingsport-Bristol, TN-VA	28700	Kingsport-Bristol-Bristol, TN-VA
31860	Mankato, MN	31860	Mankato-North Mankato, MN
33340	Milwaukee-Waukesha, WI	33340	Milwaukee-Waukesha-West Allis, WI
34940	Naples-Marco Island, FL	34940	Naples-Immokalee-Marco Island, FL
35660	Niles, MI	35660	Niles-Benton Harbor, MI
36084	Oakland-Berkeley-Livermore, CA	36084	Oakland-Hayward-Berkeley, CA
36500	Olympia-Lacey-Tumwater, WA	36500	Olympia-Tumwater, WA
38060	Phoenix-Mesa-Chandler, AZ	38060	Phoenix-Mesa-Scottsdale, AZ
39150	Prescott Valley-Prescott, AZ	39140	Prescott, AZ
23224	Frederick-Gaithersburg-Rockville, MD	43524	Silver Spring-Frederick-Rockville, MD
44420	Staunton, VA	44420	Staunton-Waynesboro, VA
44700	Stockton, CA	44700	Stockton-Lodi, CA
45940	Trenton-Princeton, NJ	45940	Trenton, NJ
46700	Vallejo, CA	46700	Vallejo-Fairfield, CA
47300	Visalia, CA	47300	Visalia-Porterville, CA
48140	Wausau-Weston, WI	48140	Wausau, WI
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	48424	West Palm Beach-Boca Raton-Delray Beach, FL

In some cases, counties will shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. We consider this type of change, where CBSAs are split into multiple new CBSAs, or a CBSA loses one or more counties to another urban CBSA, to be significant modifications.

Table 8 lists the urban counties that will move from one urban CBSA to another or to a newly proposed or modified CBSA due to the implementation of the new OMB delineations.

TABLE 8: Urban Counties that Will Move to a Newly Proposed or Modified CBSA

FIPS County Code	County Name	State	Current CBSA	Current CBSA Name	Proposed CBSA Code	Proposed CBSA Name
17031	Cook	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17043	Du Page	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17063	Grundy	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17093	Kendall	IL	16974	Chicago-Naperville-Arlington Heights, IL	20994	Elgin, IL
17111	Mc Henry	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
17197	Will	IL	16974	Chicago-Naperville-Arlington Heights, IL	16984	Chicago-Naperville-Evanston, IL
34023	Middlesex	NJ	35614	New York-Jersey City-White Plains, NY-NJ	35154	New Brunswick-Lakewood, NJ
34025	Monmouth	NJ	35614	New York-Jersey City-White Plains, NY-NJ	35154	New Brunswick-Lakewood, NJ
34029	Ocean	NJ	35614	New York-Jersey City-White Plains, NY-NJ	35154	New Brunswick-Lakewood, NJ
34035	Somerset	NJ	35084	Newark, NJ-PA	35154	New Brunswick-Lakewood, NJ
36027	Dutchess	NY	20524	Dutchess County-Putnam County, NY	39100	Poughkeepsie-Newburgh-Middletown, NY
36071	Orange	NY	35614	New York-Jersey City-White Plains, NY-NJ	39100	Poughkeepsie-Newburgh-Middletown, NY
36079	Putnam	NY	20524	Dutchess County-Putnam County, NY	35614	New York-Jersey City-White Plains, NY-NJ
47057	Grainger	TN	28940	Knoxville, TN	34100	Morristown, TN
54043	Lincoln	WV	26580	Huntington-Ashland, WV-KY-OH	16620	Charleston, WV
72055	Guanica	PR	38660	Ponce, PR	49500	Yauco, PR
72059	Guayanilla	PR	38660	Ponce, PR	49500	Yauco, PR
72111	Penuelas	PR	38660	Ponce, PR	49500	Yauco, PR
72153	Yauco	PR	38660	Ponce, PR	49500	Yauco, PR

If providers located in these counties move from one CBSA to another under the new OMB delineations, there may be impacts, both negative and positive, upon their specific wage index values. We refer readers to section VI.D.3. of this final rule for a discussion of the wage index transition policy due to these changes.

We believe the revisions to the CBSA-based labor market area delineations as established in OMB Bulletin 18-04 would ensure that the IRF PPS area wage level adjustment most appropriately accounts for and reflects the relative wage levels in the geographic area of the IRF. Therefore, we proposed to adopt the revisions to the CSBA based labor market area delineations

under the IRF PPS, effective October 1, 2020. Accordingly, the proposed FY 2021 IRF PPS wage index values (which are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html) reflect the proposed revisions to the CBSA-based labor market area delineations.

Furthermore, consistent with the requirement at § 412.624(e)(1) that changes to area wage level adjustment are made in a budget neutral manner, we proposed to adopt these revisions to the CSBA based labor market area delineations in a budget neutral manner. The methodology for calculating the budget neutrality factor is discussed in section VI.D.4. of this final rule.

The comments we received on the proposal to adopt the new OMB delineations, effective beginning with the FY 2021 IRF PPS wage index are summarized below.

Comment: Commenters were generally supportive of the adoption of the new delineations; however, two commenters disagreed with the creation of the new "New Brunswick-Lakewood, NJ" CBSA and requested that CMS delay implementing these revisions to the CBSAs until after the 2020 decennial census data is available.

Response: We appreciate the commenters' concerns regarding the impact of implementing the New Brunswick-Lakewood, NJ CBSA designation on their specific counties. While we understand the commenters' concern regarding the potential financial impact, we believe that implementing the revised OMB delineations will create more accurate representations of labor market areas and result in IRF wage index values being more representative of the actual costs of labor in a given area. Moreover, to the extent that providers exist in a labor market area experiencing a decline in relation to the revised OMB delineations, this would mean that these providers were previously being paid in excess of what their reported wage and labor data would suggest is appropriate. We believe that the OMB standards for

delineating Metropolitan and Micropolitan Statistical Areas are appropriate for determining wage area differences and that the values computed under the revised delineations will result in more appropriate payments to providers by more accurately accounting for and reflecting the differences in area wage levels. Therefore, we believe that it is appropriate to implement the new OMB delineations without delay.

After consideration of the comments we received, we are finalizing our proposal to adopt the revised OMB delineations contained in OMB Bulletin 18-04.

3. Transition Policy

Overall, we believe that our proposal to adopt the revised OMB delineations for FY 2021 would result in wage index values being more representative of the actual costs of labor in a given area. However, we also recognize that approximately 5 percent of IRFs would experience decreases in their area wage index values as a result of our proposal to adopt the revised OMB delineations. We also realize that many IRFs would have higher area wage index values under our proposal.

To mitigate the potential impacts of revisions to the OMB delineations on IRFs, we have in the past provided for transition periods when adopting changes that have significant payment implications, particularly large negative impacts. For example, we proposed and finalized budget neutral transition policies to help mitigate negative impacts on IRFs following the adoption of the new CBSA delineations based on the 2010 decennial census data in the FY 2016 IRF PPS final rule (80 FR 47035). Specifically, we implemented a 1-year blended wage index for all IRFs due to our adoption of the revised delineations. This required calculating and comparing two wage indexes for each IRF since that blended wage index was computed as the sum of 50 percent of the FY 2016 IRF PPS wage index values under the FY 2015 CBSA delineations and 50 percent of the FY 2016 IRF PPS wage index values under the FY 2016 new OMB delineations. While we believe that using the new OMB delineations would create a more

accurate payment adjustment for differences in area wage levels, we also recognize that adopting such changes may cause some short-term instability in IRF PPS payments, in particular for IRFs that would be negatively impacted by the proposed adoption of the updates to the OMB delineations. For example, IRF's currently located in CBSA 35614 (New York-Jersey City-White Plains, NY-NJ) that would be located in new CBSA 35154 (New Brunswick-Lakewood, NJ) under the proposed changes to the CBSA-based labor market area delineations would experience a nearly 17 percent decrease in the wage index as a result of the proposed change. Therefore, consistent with past practice we proposed a transition policy to help mitigate any significant negative impacts that IRFs may experience due to our proposal to adopt the revised OMB delineations under the IRF PPS. Specifically, for FY 2021 as a transition, we proposed to apply a 5 percent cap on any decrease in an IRF's wage index from the IRF's wage index from the prior FY. This transition would allow the effects of our proposed adoption of the revised OMB delineations to be phased in over 2 years, where the estimated reduction in an IRF's wage index would be capped at 5 percent in FY 2021 (that is, no cap would be applied to any reductions in the wage index for the second year (FY 2022)). We believe a 5 percent cap on the overall decrease in an IRF's wage index value would be an appropriate transition as it would effectively mitigate any significant decreases in an IRF's wage index for FY 2021.

Furthermore, consistent with the requirement at § 412.624(e)(1) that changes to area wage level adjustment are made in a budget neutral manner, we proposed that this transitional wage index would not result in any change in estimated aggregate IRF PPS payments by applying a budget neutrality factor to the standard payment conversion factor. Our proposed methodology for calculating this budget neutrality factor is discussed in section VI.D.4. of this final rule.

The comments we received on our proposed transition methodology to utilize a 5 percent cap on wage index decreases for FY 2021 are summarized below.

Comment: Commenters were generally supportive of the proposed 5 percent cap transition policy to mitigate the impact of changes to the wage index values. A few commenters suggested the limit should apply to both increases and decreases in the wage index. Commenters also suggested a cap should be applied every year. One commenter requested that CMS incorporate a blended wage index into the transition, consisting of 50 percent of the FY 2020 delineations and 50 percent of the FY 2021 delineations.

Response: We appreciate the comments supporting this transition methodology. Further, we appreciate the commenters' suggestion that the cap on wage index movements of more than 5 percent should also be applied to increases in the wage index. However, as we discussed in the proposed rule, the purpose of the proposed transition policy, as well as those we have implemented in the past, is to help mitigate the significant negative impacts of certain wage index changes, not to curtail the positive impacts of such changes, and thus we do not believe it would be appropriate to apply the 5 percent cap on wage index increases as well. Additionally, we believe that implementing a cap on wage index values each year would undermine the goal of the wage index, which is to improve the accuracy of IRF payments, and would only serve to further delay improving the accuracy of IRF payments. Therefore, while we believe that a transition is necessary to help mitigate some of the negative impact from the revised OMB delineations, we also believe this mitigation must be balanced against the importance of ensuring accurate payments.

Additionally, the use of a 50/50 blended wage index transition would affect all IRF providers. We believe it would be more appropriate to allow IRFs that would experience an increase in their wage index value to receive the full benefit of their increased wage index value, which is intended to reflect accurately the higher labor costs in that area. The utilization of a cap on negative impacts restricts the transition to only those with negative impacts and allows providers who would experience positive impacts to receive the full amount of their wage index

increase. As such, we believe a 5 percent cap on the overall decrease in an IRF's wage index value would be an appropriate transition as it would effectively mitigate any significant decreases in an IRF's wage index for FY 2021.

Comment: One commenter requested that CMS provide the data used to calculate the new wage indices.

Response: The hospital wage data used to derive the IRF PPS wage index are available from the CMS IPPS wage index websites for each respective FY, which can be accessed from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.

After consideration of the comments we received, we are finalizing the proposed transition methodology, which applies a 5 percent cap on any decrease in an IRF's wage index for FY 2021 from the IRF's wage index in FY 2020. This transitional wage index will not result in any change in estimated aggregate IRF PPS payments by applying a budget neutrality factor to the standard payment conversion factor. The methodology for calculating this budget neutrality factor is discussed in section VI.D.4. of this final rule.

4. Wage Adjustment

To calculate the wage-adjusted facility payment for the payment rates set forth in this final rule, we multiply the unadjusted Federal payment rate for IRFs by the FY 2021 labor-related share based on the 2016-based IRF market basket relative importance (73.0 percent) to determine the labor-related portion of the standard payment amount. A full discussion of the calculation of the labor-related share is located in section VI.C. of this final rule. We then multiply the labor-related portion by the applicable IRF wage index. The wage index tables are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html.

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget-neutral manner. We proposed to 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 proposed to use the listed steps to ensure that the FY 2021 IRF standard payment conversion factor reflects the update to the wage indexes (based on the FY 2017 hospital cost report data and taking into account the revisions to the OMB delineations and the transition policy) and the update to the labor-related share, in a budget-neutral manner:

Step 1. Calculate the total amount of estimated IRF PPS payments using the labor-related share and the wage indexes from FY 2020 (as published in the FY 2020 IRF PPS final rule (84 FR 39054)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the FY 2021 wage index values (based on updated hospital wage data and taking into account the changes to geographic labor market area delineations and the transition policy) and the FY 2021 labor-related share of 73.0 percent.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the FY 2021 budget-neutral wage adjustment factor of 1.0013.

Step 4. Apply the budget neutrality factor from step 3 to the FY 2021 IRF PPS standard payment amount after the application of the increase factor to determine the FY 2021 standard payment conversion factor.

We discuss the calculation of the standard payment conversion factor for FY 2021 in section VI.E. of this final rule.

We did not receive any comments on the proposed budget-neutral wage adjustment factor for FY 2021. Therefore, we are finalizing a budget-neutral wage adjustment factor of 1.0013 for FY 2021.

E. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2021

To calculate the standard payment conversion factor for FY 2021, as illustrated in

Table 5, we begin by applying the increase factor for FY 2021, as adjusted in accordance with sections 1886(j)(3)(C) of the Act, to the standard payment conversion factor for FY 2020 ($16,489). Applying the 2.4 percent increase factor for FY 2021 to the standard payment conversion factor for FY 2020 of $16,489 yields a standard payment amount of $16,885. Then, we apply the budget neutrality factor for the FY 2021 wage index (taking into account the revisions to the CBSA delineations and the transition policy), and labor-related share of 1.0013, which results in a standard payment amount of $16,907. We next apply the budget neutrality factor for the CMG relative weights of 0.9970, which results in the standard payment conversion factor of $16,856 for FY 2021.

We did not receive any comments on the proposed calculation of the standard payment conversion factor for FY 2021. Therefore, we are finalizing the IRF standard payment conversion factor of $16,856 for FY 2021.

TABLE 9: Calculations to Determine the FY 2021 Standard Payment Conversion Factor

Explanation for Adjustment	Calculations
Standard Payment Conversion Factor for FY 2020	$16,489
Market Basket Increase Factor for FY 2021 (2.4 percent), reduced by 0.0 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act	x 1.024
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x 1.0013
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x 0.9970
FY 2020 Standard Payment Conversion Factor	= $16,856

After the application of the CMG relative weights described in section V. of this final rule to the FY 2021 standard payment conversion factor ($16,856), the resulting unadjusted IRF prospective payment rates for FY 2021 are shown in Table 10.

TABLE 10: FY 2021 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	$ 17,385.28	$ 14,863.62	$ 13,791.58	$ 13,198.25
0102	$ 22,206.09	$ 18,983.23	$ 17,616.21	$ 16,857.69
0103	$ 28,395.62	$ 24,274.33	$ 22,524.67	$ 21,557.14
0104	$ 36,891.04	$ 31,537.58	$ 29,263.70	$ 28,006.24
0105	$ 41,851.76	$ 35,778.55	$ 33,199.58	$ 31,773.56
0106	$ 48,081.74	$ 41,103.36	$ 38,141.76	$ 36,501.67

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0201	$ 19,375.97	$ 15,842.95	$ 14,231.52	$ 13,301.07
0202	$ 24,340.06	$ 19,901.88	$ 17,877.47	$ 16,709.35
0203	$ 29,347.98	$ 23,994.52	$ 21,553.77	$ 20,146.29
0204	$ 36,525.27	$ 29,865.46	$ 26,826.32	$ 25,074.99
0205	$ 46,133.19	$ 37,718.67	$ 33,882.25	$ 31,669.05
0301	$ 20,670.51	$ 16,756.55	$ 15,482.24	$ 14,351.20
0302	$ 26,482.46	$ 21,469.49	$ 19,836.14	$ 18,386.52
0303	$ 31,702.76	$ 25,700.34	$ 23,745.05	$ 22,010.56
0304	$ 35,567.85	$ 28,832.19	$ 26,640.91	$ 24,694.04
0305	$ 38,851.39	$ 31,495.44	$ 29,100.20	$ 26,972.97
0401	$ 23,065.75	$ 19,573.19	$ 17,631.38	$ 16,380.66
0402	$ 30,015.48	$ 25,469.42	$ 22,942.70	$ 21,316.10
0403	$ 36,022.96	$ 30,568.36	$ 27,535.96	$ 25,582.35
0404	$ 60,993.44	$ 51,758.03	$ 46,623.70	$ 43,316.55
0405	$ 46,259.61	$ 39,254.25	$ 35,360.52	$ 32,852.34
0406	$ 60,629.35	$ 51,447.88	$ 46,343.89	$ 43,056.97
0407	$ 69,227.59	$ 58,743.16	$ 52,917.73	$ 49,162.21
0501	$ 22,076.30	$ 17,156.04	$ 16,196.93	$ 14,959.70
0502	$ 27,429.77	$ 21,316.10	$ 20,124.38	$ 18,588.80
0503	$ 31,856.15	$ 24,756.41	$ 23,372.53	$ 21,587.48
0504	$ 37,936.11	$ 29,482.83	$ 27,834.31	$ 25,708.77
0505	$ 49,492.59	$ 38,463.71	$ 36,312.88	$ 33,541.75
0601	$ 23,047.21	$ 17,349.88	$ 16,264.35	$ 14,782.71
0602	$ 28,682.17	$ 21,590.85	$ 20,240.68	$ 18,398.32
0603	$ 34,072.72	$ 25,648.09	$ 24,043.40	$ 21,853.80
0604	$ 39,537.43	$ 29,762.64	$ 27,900.05	$ 25,359.85
0701	$ 21,024.49	$ 17,049.84	$ 16,156.48	$ 14,851.82
0702	$ 26,286.93	$ 21,317.78	$ 20,201.92	$ 18,568.57
0703	$ 31,952.23	$ 25,912.73	$ 24,555.82	$ 22,570.18
0704	$ 36,510.10	$ 29,609.25	$ 28,058.50	$ 25,789.68
0801	$ 18,993.34	$ 15,285.02	$ 13,688.76	$ 12,749.88
0802	$ 22,330.83	$ 17,970.18	$ 16,094.11	$ 14,990.04
0803	$ 24,945.19	$ 20,073.81	$ 17,978.61	$ 16,744.75
0804	$ 28,749.59	$ 23,136.55	$ 20,721.08	$ 19,298.43
0805	$ 33,499.61	$ 26,959.49	$ 24,144.53	$ 22,487.59
0901	$ 20,414.30	$ 16,267.73	$ 15,394.58	$ 13,944.97
0902	$ 25,415.48	$ 20,252.48	$ 19,166.96	$ 17,363.37
0903	$ 29,909.29	$ 23,832.70	$ 22,556.70	$ 20,432.84
0904	$ 34,340.73	$ 27,365.72	$ 25,899.24	$ 23,460.18
1001	$ 21,845.38	$ 18,310.67	$ 16,431.23	$ 15,177.14
1002	$ 26,986.46	$ 22,619.07	$ 20,298.00	$ 18,748.93
1003	$ 31,534.20	$ 26,431.89	$ 23,719.76	$ 21,907.74
1004	$ 37,165.79	$ 31,151.57	$ 27,955.68	$ 25,820.02
1101	$ 21,911.11	$ 19,524.30	$ 17,053.22	$ 16,535.74
1102	$ 29,273.82	$ 26,086.35	$ 22,784.26	$ 22,093.16
1103	$ 32,894.48	$ 29,312.58	$ 25,600.89	$ 24,825.52
1201	$ 24,021.49	$ 16,004.77	$ 16,004.77	$ 14,695.06
1202	$ 30,184.04	$ 20,109.21	$ 20,109.21	$ 18,464.06
1203	$ 35,085.76	$ 23,374.22	$ 23,374.22	$ 21,464.43
1204	$ 36,875.87	$ 24,567.62	$ 24,567.62	$ 22,558.38
1301	$ 19,008.51	$ 15,694.62	$ 14,899.02	$ 13,226.90

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1302	$ 26,007.12	$ 21,474.54	$ 20,385.65	$ 18,098.29
1303	$ 29,980.08	$ 24,754.72	$ 23,498.95	$ 20,862.67
1304	$ 34,752.02	$ 28,695.65	$ 27,240.98	$ 24,183.30
1305	$ 35,188.59	$ 29,054.69	$ 27,581.47	$ 24,486.71
1401	$ 19,310.23	$ 15,831.16	$ 14,288.83	$ 12,785.28
1402	$ 24,257.47	$ 19,888.39	$ 17,951.64	$ 16,062.08
1403	$ 29,454.17	$ 24,147.91	$ 21,796.49	$ 19,502.39
1404	$ 34,595.25	$ 28,363.59	$ 25,600.89	$ 22,907.30
1501	$ 21,752.67	$ 17,420.68	$ 16,274.47	$ 15,612.03
1502	$ 26,822.95	$ 21,481.29	$ 20,068.75	$ 19,251.24
1503	$ 31,143.15	$ 24,940.14	$ 23,300.05	$ 22,352.74
1504	$ 36,107.24	$ 28,914.78	$ 27,015.11	$ 25,916.10
1601	$ 16,668.90	$ 16,668.90	$ 15,033.87	$ 13,532.00
1602	$ 18,673.08	$ 18,673.08	$ 16,840.83	$ 15,156.92
1603	$ 22,819.65	$ 22,819.65	$ 20,579.49	$ 18,523.06
1604	$ 28,994.01	$ 28,994.01	$ 26,148.71	$ 23,536.03
1701	$ 23,446.70	$ 18,393.27	$ 16,719.47	$ 15,224.34
1702	$ 28,634.97	$ 22,465.68	$ 20,421.04	$ 18,593.85
1703	$ 33,947.98	$ 26,630.79	$ 24,208.59	$ 22,042.59
1704	$ 37,553.48	$ 29,460.92	$ 26,780.81	$ 24,383.89
1705	$ 41,207.86	$ 32,328.12	$ 29,386.75	$ 26,755.53
1801	$ 20,869.41	$ 16,554.28	$ 14,866.99	$ 13,788.21
1802	$ 26,576.86	$ 21,080.11	$ 18,932.66	$ 17,560.58
1803	$ 32,607.93	$ 25,863.85	$ 23,229.25	$ 21,545.34
1804	$ 37,391.66	$ 29,659.82	$ 26,637.54	$ 24,705.84
1805	$ 44,646.49	$ 35,414.46	$ 31,805.59	$ 29,499.69
1806	$ 57,510.99	$ 45,617.39	$ 40,968.51	$ 37,998.48
1901	$ 20,279.45	$ 15,770.47	$ 15,551.35	$ 14,728.77
1902	$ 27,461.80	$ 21,356.55	$ 21,058.20	$ 19,944.02
1903	$ 43,722.78	$ 34,001.92	$ 33,526.58	$ 31,753.33
1904	$ 64,371.38	$ 50,060.63	$ 49,361.11	$ 46,750.12
2001	$ 20,426.10	$ 16,574.50	$ 15,178.83	$ 13,960.14
2002	$ 25,113.75	$ 20,378.90	$ 18,662.96	$ 17,162.78
2003	$ 29,723.87	$ 24,119.25	$ 22,089.79	$ 20,314.85
2004	$ 33,454.10	$ 27,144.90	$ 24,860.91	$ 22,863.48
2005	$ 35,967.33	$ 29,186.16	$ 26,730.24	$ 24,581.10
2101	$ 30,396.42	$ 23,111.26	$ 19,000.08	$ 19,000.08
2102	$ 40,547.11	$ 30,827.94	$ 25,344.68	$ 25,344.68
5001	$ -	$ -	$ -	$ 2,769.44
5101	$ -	$ -	$ -	$ 12,240.83
5102	$ -	$ -	$ -	$ 30,366.08
5103	$ -	$ -	$ -	$ 14,250.06
5104	$ -	$ -	$ -	$ 35,222.30

F. Example of the Methodology for Adjusting the Prospective Payment Rates

Table 11 illustrates the methodology for adjusting the prospective payments (as described in section VI. of this final rule). The following examples are based on two hypothetical

Medicare beneficiaries, both classified into CMG 0104 (without comorbidities). The unadjusted prospective payment rate for CMG 0104 (without comorbidities) appears in Table 10.

Example: One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a rural non-teaching hospital has a Disproportionate Share Hospital (DSH) percentage of 5 percent (which would result in a LIP adjustment of 1.0156), a wage index of 0.8354, and a rural adjustment of 14.9 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0454 percent), a wage index of 0.8697, and a teaching status adjustment of 0.0784.

To calculate each IRF's labor and non-labor portion of the prospective payment, we begin by taking the unadjusted prospective payment rate for CMG 0104 (without comorbidities) from Table 10. Then, we multiply the labor-related share for FY 2021 (73.0 percent) described in section VI.C. of this final rule by the unadjusted prospective payment rate. To determine the non-labor portion of the prospective payment rate, we subtract the labor portion of the Federal payment from the unadjusted prospective payment.

To compute the wage-adjusted prospective payment, we multiply the labor portion of the Federal payment by the appropriate wage index located in the applicable wage index table. This table is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html.

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 of the Federal payment.

Adjusting the wage-adjusted Federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate

amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.0784, in this example) by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted prospective payment rates. Table 11 illustrates the components of the adjusted payment calculation.

TABLE 11: Example of Computing the FY 2021 IRF Prospective Payment

Steps		Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)	
1	Unadjusted Payment		$28,006.24		$28,006.24
2	Labor Share	X	0.730	X	0.730
3	Labor Portion of Payment	=	$20,444.56	=	$20,444.56
4	CBSA-Based Wage Index \	X	0.8354	X	0.8697
5	Wage-Adjusted Amount	=	$17,079.38	=	$ 17,780.63
6	Non-Labor Amount	+	$7,561.68	+	$7,561.68
7	Wage-Adjusted Payment	=	$24,641.06	=	$25,342.31
8	Rural Adjustment	X	1.149	X	1.000
9	Wage- and Rural-Adjusted Payment	=	$28,312.58	=	$25,342.31
10	LIP Adjustment	X	1.0156	X	1.0454
11	Wage-, Rural- and LIP-Adjusted Payment	=	$28,754.25	=	$26,492.85
12	Wage- and Rural-Adjusted Payment		$28,312.59		$25,342.31
13	Teaching Status Adjustment	X	0	X	0.0784
14	Teaching Status Adjustment Amount	=	$0.00	=	$1,986.84
15	Wage-, Rural-, and LIP-Adjusted Payment	+	$ 28,754.25	+	$26,492.85
16	Total Adjusted Payment	=	$28,754.25	=	$28,479.69

Thus, the adjusted payment for Facility A would be $28,754.25, and the adjusted payment for Facility B would be $28,479.69.

VII. Update to Payments for High-Cost Outliers under the IRF PPS for FY 2021

A. Update to the Outlier Threshold Amount for FY 2021

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 FY 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 2020 IRF PPS final rules and the FY 2011 and FY 2013 notices (70 FR 47880, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, 75 FR 42836, 76 FR 47836, 76 FR 59256, 77 FR 44618, 78 FR 47860, 79 FR 45872, 80 FR 47036, 81 FR 52056, 82 FR 36238, 83 FR 38514, and 84 FR 39054, 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 2021, we proposed to use FY 2019 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 2020. The outlier threshold is calculated by simulating aggregate payments and using an iterative

process to determine a threshold that results in outlier payments being equal to 3 percent of total payments under the simulation. To determine the outlier threshold for FY 2021, we estimate the amount of FY 2021 IRF PPS aggregate and outlier payments using the most recent claims available (FY 2019) and the proposed FY 2021 standard payment conversion factor, labor-related share, and wage indexes, incorporating any applicable budget-neutrality adjustment factors. The outlier threshold is adjusted either up or down in this simulation until the estimated outlier payments equal 3 percent of the estimated aggregate payments. Based on an analysis of the preliminary data used for the proposed rule, we estimated that IRF outlier payments as a percentage of total estimated payments would be approximately 2.6 percent in FY 2020. Therefore, we proposed to update the outlier threshold amount from $9,300 for FY 2020 to $8,102 for FY 2021 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2021.

We note that, as we typically do, we updated our data between the FY 2021 IRF PPS proposed and final rules to ensure that we use the most recent available data in calculating IRF PPS payments. This updated data includes a more complete set of claims for FY 2019. Based on our analysis using this updated data, we continue to estimate that IRF outlier payments as a percentage of total estimated payments are approximately 2.6 percent in FY 2020. Therefore, we will update the outlier threshold amount from $9,300 for FY 2020 to $7,906 for FY 2021 to account for the increases in IRF PPS payments and estimated costs and to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2021.

The comments we received on the update to the FY 2021 outlier threshold amount to maintain estimated outlier payments at approximately 3 percent of total estimated IRF payments are summarized below.

Comment: Commenters were generally supportive of the update to the outlier threshold. One commenter noted support for expanding the outlier pool from 3 percent to 5 percent of aggregate IRF payments, while other commenters stated that we should reduce the outlier pool below 3 percent and still others supported us maintaining the pool at 3 percent.

Response: We thank the commenters for their support of the update to the outlier threshold. We continue to believe that maintaining the outlier pool at 3 percent of aggregate IRF payments optimizes the extent to which we can reduce financial risk to IRFs of caring for high-cost patients, while still providing for adequate payments for all other non-high cost outlier cases. We refer readers to the FY 2002 IRF PPS final rule (66 FR 41316, 41362 through 41363) for more information regarding the rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments.

Comment: Commenters suggested that CMS pay the full 3 percent outlier pool each year and recommended that CMS include historical outlier reconciliation dollars in the calculation of the fixed loss threshold under the IRF PPS. Additionally, a commenter requested that CMS establish a new outlier threshold baseline to be updated by the market basket while other commenters suggested that CMS should cap the overall outlier payments an IRF can receive.

Response: We appreciate the commenters' suggestions regarding changes to the methodology used to establish an outlier threshold for IRF PPS payments. However, as we did not propose changes to this methodology, these comments are outside the scope of this final rule. We will continue to monitor our IRF outlier policies to ensure that they continue to compensate IRFs appropriately.

After consideration of the comments received and also taking into account the most recent available data, we are finalizing the outlier threshold amount of $7,906 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2021.

B. Update to the IRF Cost-to-Charge Ratio Ceiling and Urban/Rural Averages for FY 2021

Cost-to-charge ratios (CCRs) are used to adjust charges from Medicare claims to costs and are computed annually from facility-specific data obtained from MCRs. IRF specific CCRs are used in the development of the CMG relative weights and the calculation of outlier payments under the IRF PPS. In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR 45674, 45692 through 45694), we propose to apply a ceiling to IRFs' CCRs. Using the methodology described in that final rule, we proposed to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2021, 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 MCR.
- IRFs whose overall CCR is in excess of the national CCR ceiling for FY 2021, as discussed below in this section.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2021, we proposed to estimate a national average CCR of 0.490 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 proposed to estimate a national average CCR of 0.400 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 total costs factor more heavily into the averages than the CCRs of IRFs with lower total costs. For this final rule, we have used the most recent available cost report data (FY 2018). This includes all IRFs whose cost reporting periods begin on or after October 1, 2017, and before October 1, 2018. If, for any IRF, the FY 2018 cost report was missing or had an "as submitted" status, we used data from a previous FY's (that is, FY 2004 through FY 2017) settled cost report

for that IRF. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care. Using updated FY 2018 cost report data for this final rule, we estimate a national average CCR of 0.493 for rural IRFs, and a national average CCR of 0.398 for urban IRFs.

In accordance with past practice, we proposed to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, we proposed a national CCR ceiling of 1.33 for FY 2021. This means that, if an individual IRF's CCR were to exceed this ceiling of 1.33 for FY 2021, we will replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF). We calculated the proposed national CCR ceiling by:

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

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

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

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

Using the updated FY 2018 cost report data for this final rule, we estimate a national average CCR ceiling of 1.34, using the same methodology.

We did not receive any comments on the proposed update to the IRF CCR ceiling and urban/rural averages for FY 2021. Therefore, we are finalizing the national average urban CCR at 0.398, the national average rural CCR at 0.493, and the national average CCR ceiling at 1.34

for FY 2021.

VIII. Removal of the Post-Admission Physician Evaluation Requirement from the IRF Coverage Requirements

We are committed to transforming the health care delivery system, and the Medicare program, by putting an additional focus on patient-centered care and working with providers and clinicians to improve patient outcomes. We refer to this transformation as "Patients Over Paperwork." That is, CMS recognizes it is imperative that we develop and implement policies that allow providers and clinicians to focus the majority of their time treating patients rather than completing paperwork. Moreover, we believe it is essential for us to reexamine current regulations and administrative requirements to ensure that we are not placing unnecessary burden on providers.

In the FY 2018 IRF PPS proposed rule (82 FR 20743), we included a request for information (RFI) to solicit comments from stakeholders requesting information on CMS flexibilities and efficiencies. The purpose of the RFI was to receive feedback regarding ways in which we could reduce burden for hospitals and clinicians, improve quality of care, decrease costs and ensure that patients receive the best care. We received comments from IRF industry associations, state and national hospital associations, industry groups representing hospitals, and individual IRF providers in response to the solicitation. In the FY 2019 IRF PPS final rule (83 FR 38549 through 38553), we finalized several changes to the regulatory requirements that we believed were responsive to stakeholder feedback and helpful to providers in reducing administrative burden.

Patients over Paperwork has continued to be a priority for the agency, as we target ways in which we can reduce paperwork burden for hospitals and clinicians while improving quality of care for patients. Therefore, we are proposing to revise the current IRF coverage criteria. Specifically, we are focused on reducing medical record documentation requirements that we

believe are no longer necessary.

IRF care is only considered by Medicare to be reasonable and necessary under section 1862(a)(1) of the Act if the patient meets all of the IRF coverage requirements outlined in § 412.622(a)(3), (4), and (5). Failure to meet the IRF coverage criteria in a particular case will result in denial of the IRF claim. Under § 412.622(a)(4)(ii), to document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in § 412.622(a)(3) at the time of admission, the patient's medical record at the IRF must contain a post-admission physician evaluation that meets ALL of the following requirements:

- It is completed by the rehabilitation physician within 24 hours of the patient's admission to the IRF.
- It documents the patient's status on admission to the IRF, includes a comparison with the information noted in the preadmission screening documentation, and serves as the basis for the development of the overall individualized plan of care.
- It is retained in the patient's medical record at the IRF.

Before the current IRF coverage criteria were implemented in January 1, 2010, Medicare permitted "trial" IRF admissions (HCFAR 85-2-4 through 85-2-5). A "trial" IRF admission meant that patients were sometimes admitted to IRFs for 3 to 10 days to assess whether the patients would benefit significantly from treatment in the IRF or other settings. Therefore, if it was determined during a "trial" admission that a patient was not appropriate for IRF level services, their claims for items and services provided during the trial period could not be denied for failure to meet IRF coverage criteria. Over time, we concluded that IRFs had developed a better ability and were more capable of recognizing if a patient was appropriate for IRF services prior to being admitted. Therefore, the concept of a "trial" IRF admission was eliminated when we rescinded HCFA Ruling 85-2 through a **Federal Register** notice titled "Medicare Program; Criteria for Medicare Coverage of Inpatient Hospital Rehabilitation Services" (74 FR 54835),

effective January 1, 2010. We discussed our intent to rescind HCFA Ruling 85-2 in detail in the FY 2010 IRF PPS final rule (74 FR 39797 through 39798).

In addition, the Medicare Benefit Policy Manual, chapter 1, section 110.1.2 (Pub. 100-02), which can be downloaded from the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html), states, "In most cases, the clinical picture of the patient that emerges from the post-admission physician evaluation will closely resemble the information documented in the preadmission screening. However, for a variety of reasons, the patient's condition at the time of admission may occasionally not match the description of the patient's condition on the preadmission screening. If this occurs, the IRF must immediately begin the discharge process. It may take a day or more for the IRF to find placement for the patient in another setting of care. MACs will therefore allow the patient to continue receiving treatment in the IRF until placement in another setting can be found." It further states that in these particular cases, "Medicare authorizes its MACs to permit the IRF claim to be paid at the appropriate CMG for IRF patient stays of 3 days or less."

At this time, we believe that IRFs are more knowledgeable in determining prior to admission, whether a patient meets the coverage criteria for IRF services than they were when the IRF coverage requirements were initially implemented. Over time, we have analyzed the data regarding the number of above-mentioned cases described in chapter 1, section 110.1.2, of the Medicare Benefit Policy Manual, and it has trended downward since the IRF coverage requirements were initially implemented. In FY 2019, the payment was utilized 4 times across all 1,117 Medicare certified IRFs. Additionally, we believe that if IRFs are doing their due diligence while completing the pre-admission screening as required in § 412.622(a)(4)(i) by making sure each prospective IRF patient meets all of the requirements to be admitted to the IRF, then the post-admission physician evaluation is unnecessary.

Finally, we have removed the post-admission physician evaluation requirement during the public health emergency for the COVID-19 pandemic in the interim final rule with comment entitled, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency", published on April 6, 2020 (85 FR 19230) (hereinafter referred to as the April 6, 2020 IFC). We believe that this will provide us with experience to determine whether this requirement can be removed permanently to reduce paperwork burden for hospitals and clinicians while continuing to provide adequate quality of care for patients.

Therefore, we proposed to remove the post-admission physician evaluation documentation requirement at § 412.622(a)(4)(ii) beginning with FY 2021, that is, for all IRF discharges beginning on or after October 1, 2020. Accordingly, we proposed to amend § 412.622(a)(3)(iv) to remove the reference to § 412.622(a)(4)(ii). We would also rescind the above-mentioned policy described in chapter 1, section 110.1.2, of the Medicare Benefit Policy Manual.

We note that removal of the post-admission physician evaluation does not preclude an IRF patient from being evaluated within the first 24 hours of admission if the IRF believes that the patient's condition warrants such an evaluation. We merely proposed that a post-admission physician evaluation would no longer be an IRF documentation requirement for IRF discharges occurring on and after October 1, 2020. Moreover, removal of the post-admission physician evaluation does not remove one of the required rehabilitation physician visits in the first week of the patient's stay in the IRF as specified in § 412.622(a)(3)(iv). IRFs will need to continue to meet the requirements at § 412.622(a)(3)(iv) as they always have.

While removal of the post-admission physician evaluation does not attribute to any direct savings for Medicare Part-A or Part-B, we do believe that removing it will reduce administrative and paperwork burden for both IRF providers and MACs.

The comments we received on our proposal to remove the post-admission physician evaluation documentation requirement at § 412.622(a)(4)(ii) beginning with FY 2021, that is, for all IRF discharges beginning on or after October 1, 2020; our proposed conforming amendments to § 412.622(a)(3)(iv) to remove the reference to § 412.622(a)(4)(ii); and on rescinding the above-mentioned policy described in chapter 1, sections 110.1.2, of the Medicare Benefit Policy Manual are summarized below.

Comment: The commenters unanimously supported CMS' proposal. Many commenters agreed that the information contained in the post-admission physician evaluation is redundant, since the majority of the information required in the post-admission physician evaluation is already being captured in the IRF patient's history and physical. Many commenters stated that not only would the proposal to remove the post-admission physician evaluation remove redundant documentation requirements, but it would also remove the added burden of it being a time sensitive requirement.

Response: We appreciate the commenters' support for the proposal. We agree that finalizing this proposal will ease administrative and documentation burden in the IRF setting.

After consideration of the comments we received, we are finalizing our proposal to remove the post-admission physician evaluation documentation requirement at § 412.622(a)(4)(ii) beginning with FY 2021, that is, for all IRF discharges beginning on or after October 1, 2020; our proposed conforming amendments to § 412.622(a)(3)(iv) to remove the reference to § 412.622(a)(4)(ii); and on rescinding the above-mentioned policy described in chapter 1, sections 110.1.2, of the Medicare Benefit Policy Manual.

IX. Revisions to Certain IRF Coverage Documentation Requirements

A. Codification of Existing Preadmission Screening Documentation Instructions and Guidance

Another way in which CMS has continued to explore burden reduction for providers and clinicians, while keeping patient centered care a priority, is by reviewing subregulatory guidance

to identify any longstanding policies, instructions, or guidance that would be appropriate to codify through notice and comment rulemaking.

Specifically, in regards to the IRF PPS payment requirements, we conducted a detailed review of the Medicare Benefit Policy Manual, chapter 1, section 110.1.2 (Pub. 100-02), as well as the IRF PPS website (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index), to identify any such policies.

Currently, § 412.622(a)(4)(i) requires that a comprehensive preadmission screening must meet ALL of the following requirements:

- It is conducted by a licensed or certified clinician(s) designated by a rehabilitation physician described in § 412.622(a)(3)(iv) within the 48 hours immediately preceding the IRF admission.
- It includes a detailed and comprehensive review of each patient's condition and medical history.
- It serves as the basis for the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary in § 412.622(a)(3).
- It is used to inform a rehabilitation who reviews and comments his or her concurrence with the findings and results of the preadmission screening.
- It is retained in the patient's medical record at the IRF.

When the pre-admission screening documentation requirements were finalized (74 FR 39790 through 39792), we did not specify any individual elements as being required for the pre-admission screening documentation to be considered detailed and comprehensive in accordance with § 412.622(a)(4)(i)(B). In addition, we did not specify at § 412.622(a)(4)(i)(D) that the rehabilitation physician must review and concur with the preadmission screening prior to the IRF admission. The Medicare Benefit Policy Manual, chapter 1, section 110.1.1

(Pub. 100-02) provides a more detailed description of what elements the preadmission screening should include and clarifies that the rehabilitation physician should review and concur with the preadmission screening prior to the patient being admitted to the IRF.

In chapter 1, section 110.1.1 of the Medicare Benefit Policy Manual currently, we state, "The preadmission screening documentation must indicate the patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy), expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient." Additionally, we state, "All findings of the preadmission screening must be conveyed to a rehabilitation physician prior to the IRF admission. In addition, the rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the preadmission screening prior to the IRF admission." These have been our documentation instructions and guidance since the implementation of the IRF coverage requirements on January 1, 2010.

We believe that codifying these longstanding instructions and guidance would improve clarity and reduce administrative burden on both IRF providers and MACs. With patient centered care being such a high priority in today's healthcare climate, we want to mitigate, as much as possible, tasks that take away from time spent directly with the patient. Lastly, we believe IRF providers and MACs will appreciate all preadmission screening documentation requirements being located in the same place for ease of reference.

Thus, in the interest of reducing administrative burden and being able to locate all preadmission screening documentation requirements in the same place for ease of reference, we proposed to make the following regulatory amendments:

- At § 412.622(a)(4)(i)(B), to provide that the comprehensive preadmission screening must include a detailed and comprehensive review of each patient's condition and medical history, including the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy, expected level of improvement, and the expected length of time necessary to achieve that level of improvement; an evaluation of the patient's risk for clinical complications; the conditions that caused the need for rehabilitation; the treatments needed (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics); expected frequency and duration of treatment in the IRF; anticipated discharge destination; and anticipated post-discharge treatments; and

- At § 412.622(a)(4)(i)(D), to provide that the comprehensive preadmission screening must be used to inform a rehabilitation physician who must then review and document his or her concurrence with the findings and results of the preadmission screening prior to the IRF admission.

The comments we received on our proposal to amend § 412.622(a)(4)(i)(B) and (D) to codify our longstanding documentation instructions and guidance of the preadmission screening in regulation text, are summarized below.

Comment: The majority of commenters supported codifying the existing preadmission screening documentation requirements to the extent that it makes no substantive policy changes from the requirements described in the MDPM, chapter 1, section 110.1.1. Commenters stated that CMS' decision to codify these longstanding instructions and guidance would improve clarity and reduce administrative burden on both IRF providers and MACs. With patient-centered care being such a high priority in today's health care climate, commenters stated that they appreciated

CMS' efforts to reduce tasks that take away from time spend directly with the patient. Commenters also stated that they agree with CMS that IRF providers and MACs will benefit from all documentation requirements being located in the same place in the regulations for ease of reference.

Response: We appreciate the commenters' support for the proposal. We agree that finalizing this proposal will reduce administrative burden on both IRF providers and MACs and allow more time to be spent in direct patient care.

Comment: Some commenters did not support codifying the existing preadmission screening documentation requirements, stating that the proposal did not align with CMS' Patients over Paperwork initiative. These commenters suggested that instead of codifying the existing requirements, we should allow IRF rehabilitation physicians to rely on their training and experience to determine which information best supports the appropriateness of the IRF admission. These commenters stated that such an approach would reduce documentation burden, and facilitate timely patient admissions to IRFs.

Response: We appreciate the commenters' concerns. However, we respectfully disagree that it would be better not to specify basic elements to include in the pre-admission screening documentation, as we believe that this would lead to excessive ambiguity in the regulations and create unnecessary confusion. Codifying the current preadmission screening requirements into regulation text does not change the amount of documentation that is required. We did not propose any new required elements to be completed on the pre-admission screening. Therefore, the information being collected and the time it takes to collect the information remain the same. Additionally, we agree with the commenters that IRF rehabilitation physicians should have the freedom to document the information that best supports their decision to admit the patient in the preadmission screening documentation. For this reason, we require a detailed and comprehensive preadmission screening in which we allow rehabilitation physicians to include any additional

information they deem necessary to the preadmission screening, in addition to the required elements. However, we believe that it is necessary to specify the basic minimum elements that we expect to see in a detailed and comprehensive pre-admission screening to eliminate confusion and ambiguity in the requirement.

Comment: Several commenters suggested that if CMS finalizes the proposal to codify the pre-admission screening requirements into regulation text, CMS should also consider amending the timing of this requirement (which is currently required to be completed within the 48 hours immediately preceding the IRF admission). Additionally, several commenters suggested that CMS should allow rehabilitation physicians to give a verbal approval of the preadmission screening instead of requiring them to review and concur with the findings and results of the pre-admission screening prior to admission to the IRF.

Response: We appreciate the commenters' suggestions regarding other ways to reduce burden associated with the pre-admission screening. However, since we only solicited comments regarding the elements of the preadmission screening documentation in the proposed rule (85 FR 22065, 22088), any additional changes to the preadmission screening requirements are beyond the scope of this final rule. Therefore, we will take these suggestions into consideration for future rulemaking.

Comment: A few commenters were concerned that codifying the preadmission screening requirements into regulation text might increase the amount of technical denials of IRF claims whenever one or more of the elements is missing from the preadmission screening documentation.

Response: We respectfully disagree with the commenters suggesting that codifying the requirements into regulation text will increase the amount of technical denials of IRF claims. We did not propose to add any new requirements to the pre-admission screening. Therefore, we do not believe that merely codifying these existing requirements in regulation will increase

technical denials. We expect that IRFs will continue to complete the preadmission screening documentation as they always have.

Comment: Some commenters suggested that codifying the required elements of the pre-admission screening that are duplicative with other portions of the patient medical record does not alleviate documentation burden. These commenters suggested that CMS should consider removing some of the preadmission screening elements that duplicate data already included in other parts of the patient's IRF medical record (such as the history and physical and the individualized overall plan of care). A few commenters suggested that CMS should consider removing the preadmission screening documentation requirements altogether.

Response: We do not agree with the commenters who suggested that we remove the pre-admission screening requirement altogether, as we continue to believe that the pre-admission screening is an integral part of determining if a patient can tolerate and benefit from IRF level services. However, we do agree with commenters who suggested that we should not codify all of the current required elements of the pre-admission screening, as some of the elements duplicate data that is already included in other parts of the patients IRF medical record (such as the history and physical and the individualized overall plan of care). We are addressing the concerns of the current required elements of the preadmission screening in section IX. of this final rule.

Comment: Many commenters stated that removing some of the pre-admission screening elements that were duplicative of data collected in various other documents in the patient's IRF medical record (such as the history and physical and the individualized overall plan of care) would reduce burden. Several commenters suggested removing the pre-admission screening elements that require IRF clinicians to predict what will happen during the IRF stay, as this information frequently changes during the IRF stay and thereby becomes inaccurate and unnecessary.

Response: We appreciate the suggestions that commenters submitted in response to our solicitation of comments regarding what elements of the pre-admission screening should be removed in order to reduce burden on rehabilitation physicians. With the assistance of CMS medical officers, as well as the responses we received from the IRF industry, we are finalizing removal of the following elements from the pre-admission screening:

- Expected frequency and duration of treatment in the IRF
- Any anticipated post-discharge treatments
- Other information relevant to the patient's care needs

We believe that the elements noted above are duplicative requirements that will be captured in other medical documentation, such as the history and physical or the individualized overall plan of care, and require the rehabilitation physician to predict what will happen during and after the IRF admission, which often changes during the IRF stay. We believe that by removing the above mentioned elements, we are not only reducing provider burden, but we are continuing to align with the agency's Patients over Paperwork initiative without diminishing the quality of care patients receive.

We are, therefore, keeping the following key elements of the pre-admission screening documentation:

- Prior level of function
- Expected level of improvement
- Expected length of time to achieve that level of improvement
- Risk for clinical complications
- Conditions that caused the need for rehabilitation
- Combinations of treatments needed
- Anticipated discharge destination

We believe that the elements above demonstrate not only the anticipated functional progress of the patient and the therapeutic disciplines that will be utilized to reach those goals, but also the need for medical supervision by a physician and supports the need for an intensive inpatient rehabilitation program instead of a lower level of care. Since IRF patients are more medically complex than ever before, often suffering from chronic illnesses or disabilities, and/or recovering from devastating physical trauma, we believe that these elements are essential in determining if the patient can tolerate and benefit from IRF level care. They require a higher level of care and more intense therapy and physician supervision than patients in other post-acute care settings. Therefore, properly managing a patient's medical complexities while developing an informative and, to the extent possible, an all-inclusive pre-admission screening is of utmost importance. We continue to believe that having as much pertinent information about the patient as possible prior to the IRF admission improves the quality of care the patient receives in the IRF. Additionally, discharge planning in IRFs should begin on the day of admission, so while it may appear that some pre-admission screening elements are better discussed after the patient is admitted, we want to continue to encourage IRFs to begin planning for the patient's discharge upon admission. Discharge coordination often involves not only the patient, but family members, caregivers, etc. and it can sometimes take weeks for all of the discharge details to be sorted out. We want to ensure that upon discharge, patients are set up for continued success in their recovery.

Comment: One commenter suggested that we should specify the requirements for a "detailed and comprehensive review" of the patient's condition and medical history in the pre-admission screening.

Response: As noted above, we believe that it is appropriate for the rehabilitation physician to use his or her training and experience when determining what information best supports his or her decision to admit the patient to the IRF to include in the pre-admission

screening. For this reason, we require a detailed and comprehensive pre-admission screening in which we allow rehabilitation physicians to include any additional information, outside of the required elements, they deem necessary to the pre-admission screening.

After consideration of the comments we received, we are finalizing our proposal to amend § 412.622(a)(4)(i)(B) and (D) to codify certain elements of our longstanding documentation instructions and guidance of the preadmission screening in regulation text. Specifically, we are finalizing the following elements of the pre-admission screening requirements prior to codifying the pre-admission screening elements at § 412.622(a)(4)(i):

- Prior level of function
- Expected level of improvement
- Expected length of time to achieve that level of improvement
- Risk for clinical complications
- Conditions that caused the need for rehabilitation
- Combinations of treatments needed
- Anticipated discharge destination

These changes will become effective for all IRF discharges on or after Oct 1, 2020.

We are not finalizing the following elements of the pre-admission screening documentation:

- Expected frequency and duration of treatment in the IRF
- Any anticipated post-discharge treatments
- Other information relevant to the patient's care needs

These elements will be removed from chapter 1, section 110.1.1 of the Medicare Benefit Policy Manual.

B. Definition of a "Week"

In § 412.622(a)(3)(ii) we state that in certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF. This language is also used many times throughout the IRF Services section of the Medicare Benefit Policy Manual. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, section 110.1.2 (Pub. 100-02), which can be downloaded from the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

However, we understand there is some question as to whether the term "Week" may be construed as a different period (for example, Monday through Sunday). To provide clarity and reduce administrative burden for stakeholders regarding several of the IRF coverage requirements, we proposed to amend our regulation text to clarify that we define a "Week" as "a 7 consecutive calendar day period" for purposes of the IRF coverage requirements.

Therefore, we proposed to amend § 412.622(c) to clarify our definition of a "Week" as a period of "7 consecutive calendar days beginning with the date of admission to the IRF." We also proposed to make conforming amendments to § 412.622(a)(3)(ii) by replacing "7 consecutive day period, beginning with the date of admission to the IRF" with "Week".

The comments we received on our proposals to §§ 412.622(c) and 412.622(a)(3)(ii) are summarized below.

Comment: The majority of commenters support CMS' proposal to clarify the definition of "Week." Commenters stated that CMS' efforts to clarify this period of time and utilize consistent language throughout the regulatory text will improve clarity and reduce administrative burden on both IRF providers and MACs.

Response: We appreciate the commenters' support for the proposal. We agree that finalizing this proposal will reduce administrative burden on both IRF providers and MACs.

Comment: One commenter expressed concern that codifying the definition of a "Week" would cause greater provider burden, as IRF providers would need to independently track each patient's admission date to ensure that other requirements were being met timely.

Response: We appreciate the commenter's concern, but the proposed definition was always the definition that we used for the IRF requirements in § 412.622. We simply proposed to add the word "calendar" to help clarify the definition and eliminate any possible confusion.

Comment: One commenter suggested that CMS should instead define a "week" as a 7 consecutive calendar day period starting on the day *after* admission rather than on the day of admission. The commenter suggested that because some IRF patients are admitted late in the day, IRF therapists are unable to provide therapy services on the day of admission. Therefore, according to this commenter, therapists often only have 6 days to meet the minimum of 15 hours of intensive therapy requirement during the patient's first week of admission.

Response: We respectfully disagree with the commenter's suggested modification to the definition of "week." We believe that an IRF patient's stay should be tracked beginning with the day of admission as it always has. We believe that the suggested modification would create unnecessary confusion as to what the actual day of admission is for other documentation purposes in the IRF medical record. Additionally, IRFs have shown that they are able to meet the minimum of 15 hours of intensive therapy requirement, even if the patient is admitted late in the day.

After consideration of the comments we received, we are finalizing our proposal to amend § 412.622(c) to clarify the definition of a "Week" as a "7 consecutive calendar days beginning with the date of admission to the IRF." We are also finalizing our proposal to make conforming amendments to § 412.622(a)(3)(ii) by replacing "7 consecutive day period, beginning with the date of admission to the IRF" with "Week".

C. Solicitation of Comments Regarding Further Changes to the Preadmission Screening

Documentation Requirements

As noted in section VIII. of this final rule, we are considering ways in which we can continue to help reduce administrative burden on IRF providers. Specifically, we have been reviewing the pre-admission screening documentation requirements under § 412.622(a)(4)(i) and are considering whether we could remove some of the requirements, but still maintain an IRF patient's clinical history, as well as documentation of their medical and functional needs in sufficient detail to adequately describe and support the patient's need for IRF services.

To assist us in balancing the needs of the patient with the desire to reduce the regulatory burden on rehabilitation physicians, we solicited feedback from stakeholders in the proposed rule about potentially removing some of the preadmission screening documentation requirements. Specifically, we requested feedback regarding:

- What aspects of the preadmission screening do stakeholders believe are most or least critical and useful for supporting the appropriateness of an IRF admission, and why?

We appreciate the commenters' responses to this solicitation. We have summarized and responded to those comments in section IX.A. of this final rule.

X. Amendment to Allow Non-physician Practitioners To Perform Some of the Weekly Visits that are Currently Required to Be Performed by a Rehabilitation Physician

In October 2019, Executive Order 13890, entitled "Protecting and Improving Medicare for Our Nation's Seniors," available at https://www.whitehouse.gov/presidential-actions/executive-order-protecting-improving-medicare-nations-seniors/, was issued by the President of the United States instructing the Secretary to, among other things, propose a regulation under the Medicare program that would eliminate regulatory billing and other such requirements that are more stringent than applicable Federal or State laws and that limit professionals from practicing within their full scope of practice.

In responding to this executive order, CMS has begun to review any IRF coverage

requirements at §412.622(a) where we explicitly state the requirement must be completed by a rehabilitation physician to see if, when appropriate, some of these requirements could be fulfilled by non-physician practitioners (physician assistants, nurse practitioners, and licensed practical nurses).

Several of the IRF coverage requirements at § 412.622(a)(3), (4), and (5) explicitly state that a requirement must be completed by a rehabilitation physician, defined at § 412.622(c) as a licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation. For example, under § 412.622(a)(3)(iv), for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation at the time of the patient's admission to the IRF that the patient requires physician supervision by a rehabilitation physician. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. For more information, please refer to the Medicare Benefit Policy Manual, chapter 1, section 110.2.4 (Pub. 100-02), which can be downloaded from the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

In addition, under § 412.622(a)(4)(ii), to document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in § 412.622(a)(3) at the time of admission, the patient's medical record at the IRF must contain a post-admission physician evaluation that must, among other requirements, be completed by a rehabilitation physician within 24 hours of the patient's admission to the IRF. For more information, we refer readers to the Medicare Benefit Policy Manual, chapter 1, section 110.1.2 (Pub. 100-02), which can be downloaded from the CMS website at https://www.cms.gov/Regulations-and-

Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

In response to the RFI in the FY 2018 IRF PPS proposed rule (82 FR 20742 through 20743), we received comments suggesting that we consider amending the requirements in § 412.622(a)(3)(iv) and (a)(4)(ii) to allow non-physician practitioners to fulfill some of the requirements that rehabilitation physicians are currently required to complete. The commenters suggested that expanding the use of non-physician practitioners in meeting some of the IRF coverage requirements would ease the documentation burden on rehabilitation physicians.

We solicited additional comments in the FY 2019 proposed rule (83 FR 20998 through 20999) on potentially allowing non-physician practitioners to fulfill some of the requirements in § 412.622(a)(3), (4), and (5) that rehabilitation physicians are currently required to complete. Specifically, we sought feedback from the industry and asked:

- Does the IRF industry believe non-physician practitioners have the specialized training in rehabilitation that they need to have to appropriately assess IRF patients both medically and functionally?
- How would the non-physician practitioner's credentials be documented and monitored to ensure that IRF patients are receiving high quality care?
- Do stakeholders believe that utilizing non-physician practitioners to fulfill some of the requirements that are currently required to be completed by a rehabilitation physician would have an impact of the quality of care for IRF patients?

We received significant feedback in response to our solicitation of comments on allowing non-physician practitioners to fulfill the requirements at § 412.622(a)(3), (4) and (5). However, the comments from stakeholders were conflicting. Some commenters expressed concern with allowing non-physician practitioners to fulfill some or all of the requirements that rehabilitation physicians are currently required to meet. These commenters generally raised the following specific concerns:

- The first concern was that IRF patients would not continue receiving the hospital level and quality of care that is necessary to treat such complex conditions in an IRF if being treated only by a non-physician practitioner.

- The second concern was that non-physician practitioners have no specialized training in inpatient rehabilitation that would enable them to adequately assess the interaction between patients' medical and functional care needs in an IRF.

Conversely, we also received comments from industry stakeholders stating that non-physician practitioners do have the necessary education and are qualified to provide the same level of care currently being provided to IRF patients by rehabilitation physicians. These commenters stated that non-physician practitioners are capable of performing the same tasks that the rehabilitation physicians currently must perform in IRFs. These commenters stated that non-physician practitioners have a history of treating complex patients across all settings, and are already doing so in IRFs. They also stated that the types of patient assessments that they would be required to do in the IRFs are the same types of assessments they are currently authorized to provide in other settings, such as inpatient hospitals, skilled nursing facilities, hospice, and outpatient rehabilitation centers. Additionally, commenters stated that because non-physician practitioners practice in conjunction with rehabilitation physicians in IRFs already, time spent practicing with rehabilitation physicians has provided many non-physician practitioners with direct rehabilitation experience to provide quality of care and services to IRF patients. Lastly, several commenters stated that non-physician practitioner educational programs include didactic and clinical experiences to prepare graduates for advanced clinical practice. These commenters stated that current accreditation requirements and competency-based standards ensure that non-physician practitioners are equipped to provide safe, high level quality care.

Additionally, several commenters stated that allowing non-physician practitioners to practice to the full extent of their education, training, and scope of practice will increase the

number of available health care providers able to work in the post-acute care setting resulting in lower costs and improved quality of care. Allowing the use of non-physician practitioners, authorized to provide care to the full extent of their states scope of practice, would also help offset deficiencies in physician supply, especially in rural areas. Physician burnout is also something that commenters suggested can occur overtime, and they commented that allowing the use of non-physician practitioners could potentially help decrease the rate at which physicians move on from providing care in IRFs.

After carefully reviewing and taking all feedback that we received to our solicitation of comments into consideration, we proposed to allow the use of non-physician practitioners to perform the IRF services and documentation requirements currently required to be performed by the rehabilitation physician in § 412.622(a)(3), (4), and (5). In the FY 2021 IRF PPS proposed rule, we stated that we agreed with commenters that non-physician practitioners have the training and experience to perform the IRF requirements, and believe that allowing IRFs to utilize non-physician practitioners practicing to their full scope of practice under applicable state law will increase access to post-acute care services specifically in rural areas, where rehabilitation physicians are often in short supply. We stated that we believed that alleviating access barriers to post-acute care services will improve the quality of care and lead to better patient outcomes in rural areas. We also agreed with commenters that non-physician practitioners have the appropriate education and are capable of providing hospital level quality of care to complex IRF patients. Lastly, we stated that we believed that it continues to be the IRF's responsibility to exercise their best judgment regarding who has appropriate specialized training and experience, provided that these duties are within the practitioner's scope of practice under applicable state law.

We proposed to mirror our current definition of a rehabilitation physician with the proposed definition of a non-physician practitioner in that we expect the IRF to determine

whether the non-physician practitioner has specialized training and experience in inpatient rehabilitation and thus may perform any of the duties that are required to be performed by a rehabilitation physician, provided that the duties are within the non-physician practitioner's scope of practice under applicable state law.

Therefore, we proposed to add new § 412.622(d) providing that for purposes of § 412.622, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may perform any of the duties that are required to be performed by a rehabilitation physician, provided that the duties are within the non-physician practitioner's scope of practice under applicable state law.

Additionally, we noted that if an IRF believes in any given situation a rehabilitation physician should have sole responsibility, or shared responsibility with non-physician practitioners, for overseeing a patient's care, the IRF should make that decision. Furthermore, IRFs are required to meet the hospital Conditions of Participation in section 1861(e) of the Act and in the regulations in part 482. Under section 1861(e)(4) of the Act and § 482.12(c), every Medicare patient is generally required to be under the care of a physician.

Our proposal did not preclude IRFs from making decisions regarding the role of rehabilitation physicians or non-physician practitioners. We merely proposed to allow non-physician practitioners to perform the IRF coverage requirements at § 412.622(a)(3), (4), and (5) that are currently required to be performed by a rehabilitation physician, provided that these duties are within the practitioner's scope of practice under applicable state law.

We invited public comment on this proposal. In particular, we invited commenters to provide feedback on whether they believed that utilizing non-physician practitioners to fulfill some of the requirements that are currently required to be completed by a rehabilitation physician would have an impact on the quality of care for IRF patients. We also requested information from IRFs regarding whether or not their facilities would allow non-physician

practitioners to complete all of the requirements at § 412.622(a)(3), (4), and (5), some of these requirements at § 412.622(a)(3), (4), and (5), or none of the requirements at § 412.622(a)(3), (4), and (5). We stated that this information would assist us in refining our estimates of the changes in Medicare payment that may result from the proposal.

The comments we received on our proposal to allow non-physician practitioners to perform the IRF coverage requirements at § 412.622(a)(3), (4), and (5) that are currently required to be performed by a rehabilitation physician, provided that these duties are within the practitioner's scope of practice under applicable state law, are summarized below.

Comment: Some commenters expressed support for the proposal to allow non-physician practitioners to perform the IRF coverage requirements. Some commenters stated that non-physician practitioners are qualified, prepared, and experienced at performing and documenting mandatory assessments such as those of IRF patients, as well as providing the high quality of care these patients require. Additionally, the commenters suggested that authorizing non-physician practitioners, who have a long history of providing safe, high quality care to their patients, to treat patients would improve the care for IRF patients by reducing the burdens of the patient's clinical care team, thus enabling facilities to utilize their staff in the most efficient way possible. One of the commenters suggested that non-physician practitioners were an important part of the IRF team already assisting with many consults, admissions, and daily patient visits. Therefore, extending their ability to perform the proposed duties and sign documentation under the supervision and guidance of a board certified rehabilitation physician would provide additional assistance to IRF treatment teams. A few commenters that supported CMS' proposal stated that given ongoing staffing challenges that many providers face, including physician burnout, particularly in certain geographic areas, allowing non-physician practitioners to practice to the top of their license and use their full skill set would help lower health care costs and increase access to care. Lastly, a few commenters stated that it would be helpful if CMS would

clearly define the role of non-physician practitioners in IRFs as there are clinical differences between nurse practitioners and physician assistants, and state scope of practice laws differ.

Response: We appreciate the commenters' support for the proposal to allow non-physician practitioners to perform the IRF coverage requirements at § 412.622(a)(3), (4), and (5) that are currently required to be performed by a rehabilitation physician, provided that these duties are within the practitioner's scope of practice under applicable state law. We continue to believe that non-physician practitioners have an important role in treating IRF patients. We agree with commenters that non-physician practitioners have training and experience in caring for complex patient populations, and that they can provide much-needed help to rehabilitation physicians. However, given the overall nature of the comments that we received in response to this proposal, we believe it is prudent at this time to take a more measured approach to expanding the role of non-physician practitioners in the IRF setting to ensure that the vulnerable IRF populations will continue to receive the highest quality of care for their post-acute rehabilitation needs. Therefore, we are finalizing a portion of the proposed policy by amending § 412.622(a)(3)(iv) to allow non-physician practitioners to conduct one of the three required rehabilitation physician visits in every week of the IRF stay, with the exception of the first week, if permitted under state law. In the first week of the IRF stay, we continue to require the rehabilitation physician to visit patients a minimum of three times to ensure that the patient's plan of care is fully established and optimized to the patient's care needs in the IRF.

Comment: The majority of commenters urged CMS not to finalize this proposal, expressing concerns that the change would have negative impacts on the health, quality of care, and recovery success rate of IRF patients. These commenters stated that the role and judgment of rehabilitation physicians in IRFs is central to the successful outcomes of complex IRF patients, and a key element in what separates IRFs from other lesser intensive post-acute care settings. The commenters stated that rehabilitation physicians are specifically trained to handle

the distinctive needs of highly complex medical rehabilitation patients such as spinal cord injury patients, brain injury patients, and complex wound issues seen in mobility-impaired patients. Additionally, commenters suggested that rehabilitation physicians are better trained to manage the comorbidities and medication needs of IRF patients and evaluate and order durable medical equipment for patients with new onset of disabilities. Commenters suggested that substituting non-physician practitioners for rehabilitation physicians in the IRF is likely to result in worse clinical outcomes for patients and an increase in medical complications, readmission, acute transfers, and emergency room utilization. Commenters noted that the costs of these outcomes- both to the Medicare program and to individual patients- would more than offset any projected savings tied to the substitution of non-physician practitioners. Lastly, commenters stated that allowing non-physician practitioners to perform specific clinical and patient care functions that currently can only be satisfied by rehabilitation physicians is inconsistent with Medicare's benefit structure for rehabilitation hospitals and post-acute care benefits. These commenters indicated that the IRF benefit structure explicitly requires that each patient requires physician supervision by a rehabilitation physician, as specified at § 412.622(a)(3)(iv).

Response: We appreciate the commenters' feedback regarding the proposal to allow non-physician practitioners to perform the IRF coverage requirements at § 412.622(a)(3), (4), and (5) that are currently required to be performed by a rehabilitation physician, provided that these duties are within the practitioner's scope of practice under applicable state law. Given the strong concerns that many commenters noted over this proposed policy, we believe that the prudent approach at this time is to finalize only a portion of the proposed policy. Thus, we are finalizing a portion of the proposed policy by amending § 412.622(a)(3)(iv) to allow non-physician practitioners to conduct one of the three required rehabilitation physician visits in every week of the IRF stay, with the exception of the first week, if permitted under state law. We believe that this approach mitigates many of the concerns expressed by commenters, because it preserves the

existing benefit structure of the IRF setting, ensures the quality of care for IRF patients by continuing the rehabilitation physician's close involvement in the establishment of the patient's plan of care and the initial implementation of the plan of care, and allows non-physician practitioners to assist in implementing the plan of care once it has been fully established. We believe that this balanced approach maintains the central role and judgment of the rehabilitation physician in the patient's plan of care, while also allowing for the expanded role of non-physician practitioners. We believe this approach takes full advantage of the extensive training and knowledge that rehabilitation physicians bring to the care of IRF patients, but also allows patients to benefit from the training that non-physician practitioners have in caring for complex patients. We believe that this measured approach may result in improved outcomes for patients, as it takes full advantage of the skills of both non-physician practitioners and rehabilitation physicians. We do not estimate the savings from this expansion of the role of non-physician practitioners in IRFs to be significant, but we also do not anticipate that this measured approach will increase costs to the Medicare program, as suggested by commenters, because rehabilitation physicians will still be directly involved in establishing and implementing the patient's IRF plan of care. Non-physician practitioners can add significant expertise to the patient care team, including recognizing emergent issues that, if left unaddressed, could lead to unplanned readmissions to the acute care hospitals.

Comment: The majority of commenters suggested that non-physician practitioners do not have the adequate training and experience to fulfill the preadmission screening, individualized overall plan of care, 3 weekly face-to-face visits, and interdisciplinary team meeting requirements. Many of the commenters stated that physicians, by nature of their medical training and education, are the only types of health care providers that should make decisions tied to a patient's admission. Therefore, the majority of commenters stated that they did not believe that non-physician practitioners should be conducting the pre-admission

screening, as it is the initial evaluation and review of the patient's condition and need for rehabilitation therapy and medical treatment. Commenters also stated that having a rehabilitation physician make the admission decisions would significantly reduce erroneous claim reviews and denials.

Many commenters suggested that, while non-physician practitioners can play a vital role in supporting the rehabilitation physician in coordinating the patient's medical needs with his or her functional rehabilitation needs, they do not have the adequate training and experience to play a direct role in the execution of the individualized overall plan of care for IRF patients. Commenters noted that the complexity of patients in IRFs has been increasing, and it would be illogical, and particularly ill-timed in light of the COVID-19 public health emergency, to allow a non-physician practitioner to synthesize and approve all of the elements of the individualized overall plan of care for IRF patients.

Many commenters stated that CMS' proposal to allow non-physician practitioners to administer the three weekly face-to-face visits was particularly concerning because the physician visits with patients significantly inform the course of patients' treatment and overall plans of care. In these visits, physicians modify patients' course of treatment as needed, so that the patient's capacity to benefit is maximized. Commenters also suggested that a patient's ability to benefit from the IRF care is diminished if lesser trained clinicians are tasked with treating the patients. Additionally, commenters suggested that some states would not permit (under their current laws) non-physician practitioners to engage in these visits because such services are only intended to be performed by a licensed physician with the skillset that allows them to assess the patient or make modifications to treatment plans, both medically and functionally.

Lastly, commenters stated that all recommendations made by the interdisciplinary team are directly related to the prognosis and oversight of the patient's care and should be authorized only by a rehabilitation physician, as the complex nature of the patient in IRFs, combined with

the delivery of an intensive course of therapy, requires skills and expertise that far exceed those held by a non-physician practitioner.

Response: We appreciate the commenters' feedback. While we continue to believe that non-physician practitioners are well-trained to care for complex patient populations, the concerns that commenters brought to our attention on this proposal have led us to believe that we need to take a more measured approach to expanding the role of non-physician practitioners in the IRF setting without diminishing the quality of care. We understand that IRF beneficiaries are a vulnerable population that require the highest quality of care and we want to ensure that the policies we finalize provide just that. Thus, we are finalizing a portion of the proposed policy by amending § 412.622(a)(3)(iv) to allow non-physician practitioners to conduct one of the three required rehabilitation physician visits in every week of the IRF stay, with the exception of the first week, if permitted under state law. We believe that this measured approach responds to the concerns expressed by commenters by preserving the rehabilitation physician's training and judgment at the center of the patient's care plan in the IRF, while also allowing non-physician practitioners to take an expanded role in the care of patients We believe that this approach will allow non-physician practitioners to play a vital role in supporting the rehabilitation physician by coordinating the patient's medical needs with his or her functional rehabilitation needs once the rehabilitation physician has fully established the patient's plan of care in the first week. This approach also maintains the rehabilitation physician's direct involvement in other aspects of the patient's care.

After consideration of the comments we received, we are finalizing a portion of our proposed policy changes by amending § 412.622(a)(3)(iv) to allow, beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation to conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician

practitioner's scope of practice under applicable state law. To be clear, in the first week of the IRF stay, we continue to require the rehabilitation physician to visit patients a minimum of three times to ensure that the patient's plan of care is fully established and optimized to the patient's care needs in the IRF. In the second, third, fourth weeks of the stay, and beyond, we will continue to require Medicare fee-for-services beneficiaries in IRFs to receive a minimum of three rehabilitation physicians visits per week, but will amend § 412.622(a)(3)(iv) to allow non-physician practitioners to independently conduct one of these three minimum required visits per week. We believe that this measured approach to expanding the role of non-physician practitioners in IRFs balances the commenters' concerns about maintaining the rehabilitation physician at the core of the patient's plan of care in the IRF with the benefits of expanding the role of non-physician practitioners, who play an important role in the interdisciplinary team and the care of complex patients. We are also making conforming changes to § 412.29(e) to allow, beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation to conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law..

XI. Method for Applying the Reduction to the FY 2021 IRF Increase Factor for IRFs That Fail to Meet the Quality Reporting Requirements

As previously noted, section 1886(j)(7)(A)(i) of the Act requires the application of a 2-percentage point reduction of the applicable market basket increase factor for payments for discharges occurring during such FY for IRFs that fail to comply with the quality data submission requirements. In accordance with § 412.624(c)(4)(i), we apply a 2-percentage point reduction to the applicable FY 2021 market basket increase factor in calculating an adjusted FY 2021 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements. As previously noted, application of the

2-percentage point reduction may result in an update that is less than 0.0 for a FY and in payment rates for a FY being less than such payment rates for the preceding FY. Also, reporting-based reductions to the market basket increase factor are not cumulative; they only apply for the FY involved.

Table 12 shows the calculation of the proposed adjusted FY 2021 standard payment conversion factor that would be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the applicable reporting period.

TABLE 12: Calculations to Determine the Adjusted FY 2021 Standard Payment Conversion Factor for IRFs That Failed to Meet the Quality Reporting Requirement

Explanation for Adjustment	Calculations	
Standard Payment Conversion Factor for FY 2020		$ 16,489
Market Basket Increase Factor for FY 2021 (2.4 percent), reduced by 0.0 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act, and further reduced by 2 percentage points for IRFs that failed to meet the quality reporting requirement	X	1.004
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	X	1.0013
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	X	0.9970
Adjusted FY 2021 Standard Payment Conversion Factor	=	$ 16,527

XII. Miscellaneous Comments

Comment: Several commenters recommended that CMS evaluate how the public health emergency will impact future reimbursement under current practices and encouraged CMS to work with stakeholders to make adjustments to the case-mix system in the future.

Response: We recognize the impact that the public health emergency is having on all providers and we intend to examine the effects of this emergency in available Medicare data. We will propose any modifications to the existing methodologies used to update reimbursements in future rulemaking if and when appropriate. We value transparency in our processes and will continue to engage stakeholders in future development of payment policies.

Comment: We received several comments on the IRF QRP. Several commenters noted that the status of IRF-PAI 4.0 is unknown along with the adoption of additional standardized patient assessment data element items that are being added to IRF-PAI 4.0. Several commenters

thanked CMS for efforts taken to reduce data reporting burden, such as delaying the release of IRF-PAI 4.0, and granting an exception to the IRF QRP reporting requirements for Quarter 1 and Quarter 2 of 2020. One commenter requested that the exemption be extended for all affected quarters. One commenter requested that measure reliability analyses be performed and shared to ensure the accuracy of measure calculations in light of truncated, incomplete, or COVID-19 affected data.

Several commenters also provided recommendations for additions and modifications of IRF QRP measures. One commenter suggested CMS collect and stratify patient and caregiver data based on key variables of inequities in patient care within population segments and other communities of belonging, such as race and ethnicity, for all types of measures.

One commenter recommended that CMS exercise flexibility regarding the non-compliance payment penalty. Another commenter requested that CMS lower the IRF QRP APU minimum submission threshold from 95 percent to 80 percent, for consistency with the SNF QRP and LTCH QRP.

Response: We consider these comments to be outside the scope of the current rulemaking. We refer providers to the interim final rule with comment entitled, "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program" (85 FR 27595 through 27596) regarding the delay in the compliance date for the Transfer of Health Information quality measures and certain standardized patient assessment data elements (SPADEs). We also refer providers to our June 23, 2020 announcement at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Spotlights-Announcements that, effective July 1, 2020, IRFs must resume reporting their quality data.

We received several additional comments that were outside the scope of the FY 2021 IRF

PPS proposed rule. Specifically, we received comments regarding the facility-level adjustment factors, cognitive function and resource use in IRFs, the motor score, the reliability and validity of IRF data collection, modifications to the 60 percent rule, IRF regulatory burden reduction, the use of recreational therapy, IMPACT Act data availability, COVID-19 health pandemic, post-acute care payment reform, and the PAC PPS prototype among other topics. We thank the commenters for bringing these issues to our attention, and will take these comments into consideration for potential policy refinements.

XIII. Waiver of the 60-day Delayed Effective Date for the Final Rule

We ordinarily provide a 60-day delay in the effective date of final rules after the date they are issued in accord with the Congressional Review Act (CRA) (5 U.S.C. 801(a)(3)). However, section 808(2) of the CRA provides that, if an agency finds good cause that notice and public procedure are impracticable, unnecessary, or contrary to the public interest, the rule shall take effect at such time as the agency determines.

The United States is responding to an outbreak of respiratory disease caused by a novel (new) coronavirus that has now been detected in more than 190 locations internationally, including in all 50 States and the District of Columbia. The virus has been named "SARS-CoV-2" and the disease it causes has been named "coronavirus disease 2019" (abbreviated "COVID-19").

On January 30, 2020, the International Health Regulations Emergency Committee of the World Health Organization (WHO) declared the outbreak a "Public Health Emergency of international concern." On January 31, 2020, Health and Human Services Secretary, Alex M. Azar II, declared a public health emergency (PHE) for the United States to aid the nation's healthcare community in responding to COVID-19. On March 11, 2020, the WHO publicly characterized COVID-19 as a pandemic. On March 13, 2020, the President of the United States declared the COVID-19 outbreak a national emergency.

Due to CMS prioritizing efforts in support of containing and combatting the COVID-19 PHE, and devoting significant resources to that end, it was impracticable for CMS to complete the work needed on the IRF PPS final rule in accordance with our usual schedule for this rulemaking, which aims for a publication date providing for at least 60 days of public notice before the start of the fiscal year to which it applies. The IRF PPS final rule is necessary to annually review and update the payment system, and it is critical to ensure that the payment policies for this payment system are effective on the first day of the fiscal year to which they are intended to apply. Therefore, in light of the COVID-19 PHE and the resulting strain on CMS's resources, it was impracticable for CMS to publish the IRF PPS final rule 60 days before the effective date, and we are hereby waiving the 60-day requirement and determining that the IRF PPS final rule will take effect 55 days after issuance; it would be contrary to the public interest for CMS to do otherwise.

XIV. Provisions of the Final Regulations

In this final rule, we are adopting the provisions set forth in the FY 2021 IRF PPS proposed rule (85 FR 22065), specifically:

- We will update the CMG relative weights and average length of stay values for FY 2021, in a budget neutral manner, as discussed in section V. of this final rule.
- We will update the IRF PPS payment rates for FY 2021 by the market basket increase factor, based upon the most current data available, with a productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section VI. of this final rule.
- We will adopt the revised OMB delineations, the IRF wage index transition, and the update to the labor-related share for FY 2021 in a budget-neutral manner, as described in section VI. of this final rule.
- We will calculate the final IRF standard payment conversion factor for FY 2021, as discussed in section VI. of this final rule.

- We will update the outlier threshold amount for FY 2021, as discussed in section VII. of this final rule.

- We will update the CCR ceiling and urban/rural average CCRs for FY 2021, as discussed in section VII. of this final rule.

- We will amend the IRF coverage requirements to remove the post-admission physician evaluation requirement as discussed in section VIII. of this final rule.

- We will amend the IRF coverage requirements to codify existing documentation instructions and guidance as discussed in section IX. of this final rule.

- We will amend the IRF coverage requirements to allow non-physician practitioners to conduct one of the three minimum required rehabilitation physician visits every week of the IRF stay, except for the first week, if permitted under state law, as discussed in section X. of this final rule.

- We will apply the reduction to the FY 2021 IRF increase factor for IRFs that fail to meet the quality reporting requirements as discussed in section XI. of this final rule.

XV. Collection of Information Requirements

As discussed in section IX. of this final rule, we are amending § 412.622(a)(4)(i)(B) and (D) to codify our longstanding documentation instructions and guidance of the preadmission screening in regulation text. As per our discussion in the FY 2010 IRF PPS final rule (74 CR 39803), we do not believe that there is any burden associated with this requirement. The burden associated with this requirement is the time and effort put forth by the rehabilitation physician to document his or her concurrence with the pre-admission findings and the results of the pre-admission screening and retain the information in the patient's medical record. The burden associated with this requirement is in keeping with the "Conditions of Participation: Medical record services," that are already applicable to Medicare participating hospitals. Therefore, we believe that this requirement reflects customary and usual business and medical

practice. Thus, in accordance with section 1320.3(b)(2) of the Act, the burden is not subject to the PRA.

As discussed in section VIII. of this final rule, we are removing the post-admission physician evaluation requirement at § 412.622(a)(4)(ii) beginning with FY 2021, that is, for all IRF discharges beginning on or after October 1, 2020. Accordingly, we are amending § 412.622(a)(3)(iv) to remove the reference to § 412.622(a)(4)(ii). We discuss any potential cost savings from this revision in the Overall Impact section of this final rule.

XVI. Regulatory Impact Analysis

A. Statement of Need

This final rule updates the IRF prospective payment rates for FY 2021 as required under section 1886(j)(3)(C) of the Act and in accordance with section 1886(j)(5) of the Act, which requires the Secretary to publish in the **Federal Register** on or before the August 1 before each FY, the classification and weighting factors for CMGs used under the IRF PPS for such FY and a description of the methodology and data used in computing the prospective payment rates under the IRF PPS for that FY. This final rule also implements section 1886(j)(3)(C) of the Act, which requires the Secretary to apply a MFP adjustment to the market basket increase factor for FY 2012 and subsequent years.

Furthermore, this final rule adopts policy changes under the statutory discretion afforded to the Secretary under section 1886(j) of the Act. We are finalizing our proposal to adopt more recent OMB statistical area delineations and apply a 5 percent cap on any wage index decreases compared to FY 2020 in a budget neutral manner. We are also finalizing our proposal to amend the IRF coverage requirements to remove the post-admission physician evaluation requirement and codify existing documentation instructions and guidance.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on

Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

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). Section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule: (1) having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in Executive Order 12866.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate the total impact of the policy updates described in this final rule by comparing the estimated payments in FY 2021 with those in FY 2020. This analysis results in an estimated $260 million increase for FY 2021 IRF PPS payments. We estimate that this rulemaking is "economically significant" as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act.

Also, the rule has been reviewed by OMB. Accordingly, we have prepared an RIA that, to the best of our ability, presents the costs and benefits of the rulemaking.

C. Anticipated Effects

1. Effects on IRFs

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IRFs and most other providers and suppliers are small entities, either by having revenues of $8.0 million to $41.5 million or less in any 1 year depending on industry classification, or by being nonprofit organizations that are not dominant in their markets. (For details, see the Small Business Administration's final rule that set forth size standards for health care industries, at 65 FR 69432 at https://www.sba.gov/sites/default/files/2019-08/SBA%20Table%20of%20Size%20Standards_Effective%20Aug%2019%2C%202019_Rev.pdf, effective January 1, 2017 and updated on August 19, 2019.) 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 1,120 IRFs, of which approximately 55 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. HHS generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 13, we estimate that the net revenue impact of this final rule on all IRFs is to increase estimated payments by approximately 2.8 percent. However, we find that certain categories of IRF providers will be expected to experience revenue impacts in the 3 to 5 percent range. We estimate a 3.0 percent overall impact for rural IRFs. Additionally, we estimate a 3.1 percent overall impact for teaching IRFs with a resident to average daily census ratio of less than 10 percent, a 3.4 percent overall impact for teaching IRFs

with resident to average daily census ratio of 10 to 19 percent, and a 3.1 percent overall impact for teaching IRFs with a resident to average daily census ratio greater than 19 percent. Also, we estimate a 3.2 percent overall impact for IRFs with a DSH patient percentage of 0 percent and a 3.1 percent overall impact for IRFs with a DSH patient percentage greater than 20 percent. As a result, we anticipate this final rule will have a positive impact on a substantial number of small entities. MACs 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 an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 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 shown in Table 13, we estimate that the net revenue impact of this final rule on rural IRFs is to increase estimated payments by approximately 3.0 percent based on the data of the 132 rural units and 11 rural hospitals in our database of 1,118 IRFs for which data were available. We estimate an overall impact for rural IRFs in all areas except Rural South Atlantic and Rural East South Central of between 3.0 percent and 5.0 percent. As a result, we anticipate this final rule would have a positive impact on a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-04, enacted on March 22, 1995) (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2020, that threshold is approximately $156 million. This final rule does not mandate any requirements for State, local, or tribal governments, or for the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it

issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. As stated, this final rule will not have a substantial effect on state and local governments, preempt state law, or otherwise have a federalism implication.

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017 and requires that the costs associated with significant new regulations "shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations." It has been determined that this final rule is a transfer rule that does not impose more than de minimis costs and thus is not a regulatory action for the purposes of Executive Order 13771.

2. Detailed Economic Analysis

This final rule will update the IRF PPS rates contained in the FY 2020 IRF PPS final rule (84 FR 39054). Specifically, this final rule will update the CMG relative weights and average length of stay values, the wage index, and the outlier threshold for high-cost cases. This final rule will apply a MFP adjustment to the FY 2021 IRF market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. In addition, it adopts more recent OMB statistical area delineations and applies a transition wage index under the IRF PPS. We are also amending the IRF coverage requirements to remove the post-admission physician evaluation requirement and codify existing documentation instructions and guidance.

We estimate that the impact of the changes and updates described in this final rule will be a net estimated increase of $260 million in payments to IRF providers. This estimate does not include the implementation of the required 2 percentage point reduction of the market basket increase factor for any IRF that fails to meet the IRF quality reporting requirements (as discussed in section XI. of this final rule). The impact analysis in Table 13 of this final rule represents the projected effects of the updates to IRF PPS payments for FY 2021 compared with the estimated

IRF PPS payments in FY 2020. 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 2021, we are implementing standard annual revisions described in this final rule (for example, the update to the wage index and market basket increase factor used to adjust the Federal rates). We are also implementing a productivity adjustment to the FY 2021 IRF market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. We estimate the total increase in payments to IRFs in FY 2021, relative to FY 2020, would be approximately $260 million.

This estimate is derived from the application of the FY 2021 IRF market basket increase factor, as reduced by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act which yields an estimated increase in aggregate payments to IRFs of $220 million. Furthermore, there is an additional estimated $40 million increase in aggregate payments to IRFs due to the update to the outlier threshold amount. Therefore, summed together, we estimate that these updates will result in a net increase in estimated payments of $260 million from FY 2020 to FY 2021.

The effects of the updates that impact IRF PPS payment rates are shown in Table 13. 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 2.6 percent to 3.0 percent of total estimated payments for FY 2021, consistent with section 1886(j)(4) of the Act.
- The effects of the annual market basket update (using the IRF market basket) to IRF PPS payment rates, as required by sections 1886(j)(3)(A)(i) and (j)(3)(C) of the Act, including a productivity adjustment in accordance with section 1886(j)(3)(C)(i)(I) of the Act.
- The effects of applying the budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the budget neutral changes to the wage index due to the OMB delineation revisions and the transition wage index policy.
- The effects of the budget-neutral changes to the CMG relative weights and average LOS values under the authority of section 1886(j)(2)(C)(i) of the Act.
- The total change in estimated payments based on the FY 2021 payment changes relative to the estimated FY 2020 payments.

3. Description of Table 13

Table 13 shows the overall impact on the 1,118 IRFs included in the analysis.

The next 12 rows of Table 13 contain IRFs categorized according to their geographic location, designation as either a freestanding hospital or a unit of a hospital, and by type of ownership; all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and all rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 975 IRFs located in urban areas included in our analysis. Among these, there are 684 IRF units of hospitals located in urban areas and 291 freestanding IRF hospitals located in urban areas. There are 143 IRFs

located in rural areas included in our analysis. Among these, there are 132 IRF units of hospitals located in rural areas and 11 freestanding IRF hospitals located in rural areas. There are 394 for-profit IRFs. Among these, there are 361 IRFs in urban areas and 33 IRFs in rural areas. There are 610 non-profit IRFs. Among these, there are 521 urban IRFs and 89 rural IRFs. There are 114 government-owned IRFs. Among these, there are 93 urban IRFs and 21 rural IRFs.

The remaining four parts of Table 13 show IRFs grouped by their geographic location within a region, by teaching status, and by DSH patient percentage (PP). First, IRFs located in urban areas are categorized for their location within a particular one of the nine Census geographic regions. Second, IRFs located in rural areas are categorized for their location within a particular one of the nine Census geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. IRFs are then grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent. Finally, IRFs are grouped by DSH PP, including IRFs with zero DSH PP, IRFs with a DSH PP less than 5 percent, IRFs with a DSH PP between 5 and less than 10 percent, IRFs with a DSH PP between 10 and 20 percent, and IRFs with a DSH PP greater than 20 percent.

The estimated impacts of each policy described in this rule to the facility categories listed are shown in the columns of Table 13. The description of each column is as follows:

- Column (1) shows the facility classification categories.
- Column (2) shows the number of IRFs in each category in our FY 2021 analysis file.
- Column (3) shows the number of cases in each category in our FY 2021 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 labor-related share and wage index, in a budget-neutral manner.

- Column (6) shows the estimated effect of the revisions to the CBSA delineations and the transition wage index, in a budget-neutral manner.

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

- Column (8) compares our estimates of the payments per discharge, incorporating all of the policies reflected in this final rule for FY 2021 to our estimates of payments per discharge in FY 2020.

The average estimated increase for all IRFs is approximately 2.8 percent. This estimated net increase includes the effects of the IRF market basket increase factor for FY 2021 of 2.4 percent, reduced by a productivity adjustment of 0.0 percentage point in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. It also includes the approximate 0.4 percent overall 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, labor-related share and the CMG relative weights in a budget-neutral manner, they will not be expected to affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they will be expected to affect the estimated distribution of payments among providers.

TABLE 13: IRF Impact Table for FY 2021 (Columns 4 through 8 in percentage)

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 21 Wage Index and Labor Share	FY 21 Wage Index New CBSA and 5% Cap	CMG Weights	Total Percent Change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Total	1,118	410,883	0.4	0.0	0.0	0.0	2.8
Urban unit	684	161,642	0.7	0.1	0.0	0.0	3.2
Rural unit	132	20,758	0.7	0.0	0.1	0.0	3.2
Urban hospital	291	223,421	0.2	0.0	0.0	0.0	2.5
Rural hospital	11	5,062	0.0	0.0	-0.2	0.0	2.2
Urban For-Profit	361	218,350	0.2	0.0	0.0	0.0	2.5
Rural For-Profit	33	8,487	0.3	0.0	0.0	0.0	2.6
Urban Non-Profit	521	145,259	0.7	0.1	0.0	0.0	3.2
Rural Non-Profit	89	14,171	0.8	0.0	0.0	0.0	3.2
Urban Government	93	21,454	0.7	-0.1	0.2	0.0	3.2
Rural Government	21	3,162	0.4	0.0	0.0	0.1	3.0
Urban	975	385,063	0.4	0.0	0.0	0.0	2.8
Rural	143	25,820	0.6	0.0	0.0	0.0	3.0
Urban by region							
Urban New England	29	16,117	0.4	-0.6	0.0	-0.1	2.1
Urban Middle Atlantic	132	48,820	0.5	0.4	-0.3	0.1	3.0
Urban South Atlantic	153	78,375	0.3	0.1	0.0	0.0	2.8
Urban East North Central	159	50,217	0.5	0.2	0.0	0.0	3.1
Urban East South Central	56	28,428	0.2	0.1	0.0	0.0	2.6
Urban West North Central	73	21,136	0.5	-0.6	0.0	0.0	2.1
Urban West South Central	188	85,336	0.3	0.1	0.1	0.1	3.0
Urban Mountain	87	30,648	0.4	-0.4	0.0	-0.1	2.3
Urban Pacific	98	25,986	0.8	-0.3	0.3	-0.1	3.2
Rural by region							
Rural New England	5	1,347	0.5	0.6	0.0	-0.2	3.3
Rural Middle Atlantic	11	1,189	1.1	0.4	0.0	0.0	4.0
Rural South Atlantic			0.4	-0.3	-0.3	0.0	2.2

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 21 Wage Index and Labor Share	FY 21 Wage Index New CBSA and 5% Cap	CMG Weights	Total Percent Change [1]
	16	3,796					
Rural East North Central	23	4,068	0.5	0.4	0.1	0.0	3.4
Rural East South Central	21	4,442	0.3	0.0	0.0	-0.1	2.6
Rural West North Central	20	3,047	0.8	-0.1	0.2	0.0	3.2
Rural West South Central	39	7,005	0.5	-0.2	0.1	0.2	3.0
Rural Mountain	5	563	1.2	-0.2	0.0	0.1	3.5
Rural Pacific	3	363	1.8	0.7	0.0	0.0	5.0
Teaching status							
Non-teaching	1,012	363,781	0.4	0.0	0.0	0.0	2.8
Resident to ADC less than 10%	60	32,585	0.5	0.0	0.2	0.0	3.1
Resident to ADC 10%-19%	34	12,988	0.8	0.3	-0.1	0.1	3.4
Resident to ADC greater than 19%	12	1,529	0.4	0.1	0.2	0.1	3.1
Disproportionate share patient percentage (DSH PP)							
DSH PP = 0%	33	4,715	0.6	0.2	0.0	0.0	3.2
DSH PP <5%	142	60,645	0.3	0.1	-0.3	0.0	2.5
DSH PP 5%-10%	294	127,295	0.3	0.1	-0.1	0.0	2.8
DSH PP 10%-20%	393	147,404	0.4	-0.1	0.1	0.0	2.8
DSH PP greater than 20%	256	70,824	0.6	-0.1	0.1	0.0	3.1

[1]This column includes the impact of the updates in columns (4), (5), (6), and (7) above, and of the IRF market basket update for FY 2021 (2.4 percent), reduced by 0.0 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

4. Impact of the Update to the Outlier Threshold Amount

The estimated effects of the update to the outlier threshold adjustment are presented in column 4 of Table 13. In the FY 2020 IRF PPS final rule (84 FR 39095 through 39097), we used FY 2018 IRF claims data (the best, most complete data available at that time) to set the outlier threshold amount for FY 2020 so that estimated outlier payments will equal 3 percent of total estimated payments for FY 2020.

For the FY 2021 IRF PPS proposed rule, we used preliminary FY 2019 IRF claims data,

and, based on that preliminary analysis, we estimated that IRF outlier payments as a percentage of total estimated IRF payments would be 2.6 percent in FY 2020. As we typically do between the proposed and final rules each year, we updated our FY 2019 IRF claims data to ensure that we are using the most recent available data in setting IRF payments. Therefore, based on updated analysis of the most recent IRF claims data for this final rule, we continue to estimate that IRF outlier payments as a percentage of total estimated IRF payments are 2.6 percent in FY 2021. Thus, we are adjusting the outlier threshold amount in this final rule to maintain total estimated outlier payments equal to 3 percent of total estimated payments in FY 2021. The estimated change in total IRF payments for FY 2021, therefore, includes an approximate 0.4 percent increase in payments because the estimated outlier portion of total payments is estimated to increase from approximately 2.6 percent to 3 percent.

The impact of this outlier adjustment update (as shown in column 4 of Table 13) is to increase estimated overall payments to IRFs by 0.4 percent.

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

In column 5 of Table 13, we present the effects of the budget-neutral update of the wage index and labor-related share. The changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related share portion of payments, so the changes in the two have a combined effect on payments to providers. As discussed in section VI.C. of this final rule, we are updating the labor-related share from 72.7 percent in FY 2020 to 73.0 percent in FY 2021.

6. Impact of the Revisions to the OMB Delineations and the 5 percent Cap Transition Policy

In column 6 of Table 13, we present the effects of the budget-neutral update of the geographic labor-market area designations under the IRF PPS and the application of the 5 percent cap on any decrease in an IRF's wage index for FY 2021 from the prior FY. As discussed in section VI.D.2. of this final rule, we are implementing the new OMB delineations as

described in the September 14, 2018 OMB Bulletin No. 18–04, effective beginning with the FY 2021 IRF PPS wage index. Additionally, as discussed in section VI.D.3. of this final rule, we are applying a 5 percent cap on any decrease in an IRF's wage index from the prior FY to help mitigate any significant negative impacts that IRFs may experience due to our adoption of the revised OMB delineations under the IRF PPS.

7. Impact of the Update to the CMG Relative Weights and Average LOS Values.

In column 7 of Table 13, we present the effects of the budget-neutral update of the CMG relative weights and average LOS values. In the aggregate, we do not estimate that these updates will affect overall estimated payments of IRFs. However, we do expect these updates to have small distributional effects.

8. Effects of the Removal of the Post-Admission Physician Evaluation

As discussed in section VIII. of this final rule, we are removing § 412.622(a)(4)(ii) that requires an IRF to complete a post-admission physician evaluation for all patients admitted to the IRF, beginning with FY 2021, that is, for all IRF discharges beginning on or after October 1, 2020.

We do not estimate that there will be a cost savings associated with our removal of the post-admission physician evaluation, as discussed in section VIII. of this final rule. While we are removing the post-admission physician requirement at § 412.622(a)(4)(ii), we are not removing any of the required face-to-face visits in § 412.622(a)(3)(iv). Thus, the rehabilitation physician or non-physician practitioners, as described in section X. of this final rule, will still be required to conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF. Since this change does not decrease the amount of times the physician is required to visit and assess the patient, we do not estimate any cost savings to the IRF with this change.

9. Effects of the Amendment to Allow Non-physician Practitioners to Perform Some of the

Weekly Visits that are Currently Required to Be Performed by a Rehabilitation Physician

As discussed in section X. of this final rule, we are amending the regulations at § 412.622(a)(3)(iv) to allow, beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation to conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law. We believe this final rule represents a decrease in administrative burden to rehabilitation physicians and providers beginning in FY 2021, that is, for all IRF discharges on or after October 1, 2020. We estimate the cost savings associated with this change in the following way.

The requirement at § 412.622(a)(3)(iv) must currently be fulfilled by a rehabilitation physician; therefore, to estimate the burden reduction of these changes, we obtained the hourly wage rate for a physician (there was not a specific wage rate for a rehabilitation physician) from the Bureau of Labor Statistics (http://www.bls.gov/ooh/healthcare/home.htm), which is $100.00. The hourly wage rate including fringe benefits and overhead is $200.00. We also obtained the average hourly wage rate for a non-physician practitioner. As discussed in section X. of this final rule, we defer to each state's scope of practice in determining who is recognized as a non-physician practitioner; however, for the purposes of this burden reduction estimation, we used a combined average wage from the Bureau of Labor Statistics for a nurse practitioner and a physician's assistant, as E.O. 13890 specifically identifies both of these practitioners, which is $53.50. The hourly wage rate including fringe benefits and overhead is $107.00.

We estimate that the required face-to-face physician visits at § 412.622(a)(3)(iv) take, on average, 30 minutes each to complete. In FY 2019, we estimate that there were approximately 1,117 total IRFs and on average 366 discharges per IRF annually. A patient's average length of stay in an IRF is 13 days. Therefore, we can estimate that on average, each patient receives at

least six physician visits during their IRF admission. If each IRF has approximately 366 patients per year, and on average each patient receives at least six face-to-face visits with a rehabilitation physician that take an estimated 30 minutes each, annually the rehabilitation physician spends an estimated 1098 hours (366 patients x 6 visits x 0.5 hours) completing the required face-to-face physician visits. Allowing a non-physician practitioner to complete one of the required face-to-face visits for each patient beginning with the patient's second week of admission and estimating the patient's average length of stay is 13 days, we estimate a reduction of 183 hours for rehabilitation physicians per IRF annually (366 patients x 0.5 hours). We estimate a reduction of 204,411 hours for rehabilitation physicians across all IRFs annually (1,117 IRFs x 183 hours).

To estimate the total cost savings per IRF annually, assuming the IRF was able and willing to take full advantage of this regulatory provision, we multiply 183 hours by $200.00 (average physician's salary doubled to account for fringe and overhead costs) which equals $36,600. We then multiply 183 hours by $107.00 (average non-physician practitioners salary doubled to account for fringe and overhead costs) which equals $19,581. The total estimated cost savings per IRF is $17,019 ($36,600 - $19,581). Therefore, we can estimate the total cost savings across all IRFs annually for non-physician practitioners to conduct one of the 3 required face-to-face visits in a patient's average length of stay of 13 days would be $1.9 million ($17,019 x 1,117).

Please note that the $1.9 million in burden reduction described above will not solely be savings to the Medicare Trust Fund. We note that all of the cost savings reflected in this estimate will occur on the Medicare Part B side, in the form of reduced Part B payments to physicians under the Medicare Physician Fee Schedule (MPFS). Physician services provided in an IRF are billed directly to Part B; therefore, IRFs do not pay physicians for their services. Therefore, the Medicare Trust Fund will be saving 80 percent of the overall cost savings and 20 percent of the savings will be to beneficiaries due to the coinsurance requirement generally

applicable to Medicare Part B services. We estimate that if 100 percent of IRFs allowed non-physician practitioners to fulfill some of the requirement at § 412.622(a)(3)(iv) the overall savings to Medicare Part B would be $1.5 million. However, we are unsure if all IRFs will adopt this change. We are estimating that IRFs will adopt this change for about 50 percent of the services provided. Therefore, we estimate that the overall savings to the Medicare Trust Fund for allowing non-physician practitioners to fulfill some of the requirement at § 412.622(a)(3)(iv) would be $750,000.

We have also estimated the impacts of this change using the MPFS regarding what a physician would bill for these services versus what a non-physician practitioner would bill. The MPFS provides more than 10,000 physician services, the associated relative value units, a fee schedule state indicator and various payment policy indicators needed for payment adjustment. The MPFS pricing amounts are adjusted to reflect the variation in practice costs from area to area. For additional information regarding how to use the MPFS please visit the website at https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx.

The face-to-face physician visits are considered separately payable services for physicians. Therefore, we can use the active pricing paid in calendar year 2020 for a national base payment.

There are different evaluation and management codes depending on the complexity of the patient and the duration of the visit. The current evaluation and management codes for the face-to-face visit in a facility are 99231 ($40.06), 99232 ($73.62), or 99233 ($106.10). Therefore, we estimate that the average national pricing which is a standard reference payment amount for the physicians without geographic adjustment for one of the face-to-face visits in a facility is $73.26. During a patient's average length of stay of 13 days, the rehabilitation physician is currently required to see the patient a minimum of six times. The current estimated total that physicians are currently billing per IRF patient for 6 face-to-face visits is $439.56 ($73.26 x 6 visits). In FY

2019, we estimate that there were approximately 1,117 total IRFs and on average 366 discharges per IRF annually. Therefore, we estimate that on average each year physicians are billing $179 million for these services ($439.56 x 366 patients x 1117 IRFs). For the purposes of this estimation, if we allow non-physician practitioners to conduct one of the three face-to-face visits beginning with the second week during a patient's admission with an average length of stay of 13 days, the rehabilitation would complete only 5 face-to-face visits during the patient's IRF admission. Therefore, the estimated total that a physician would bill per IRF patient for 5 face-to-face visits is $366.30 ($73.26 x 5 visits). We estimate that on average each year physicians across all IRFs are billing $149 million for these services ($366.30 x 366 patients x 1,117 IRFs).

According to the Medicare Benefit Policy Manual, chapter 15, section 80 (Pub. 100-02), as well as, the IRF PPS website (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf), non-physician practitioners are able to bill 80 percent of what physicians bill. Therefore, we estimate that on average non-physician practitioners will bill $58.61 per face-to-face visit. Per IRF patient with an average length of stay of 13 days, the non-physician practitioner will bill an estimated $58.61. Therefore, we estimate that on average each year a non-physician practitioner will bill $24 million for these services ($58.61 x 366 x 1,117).

We estimate that if 100 percent of IRFs allowed non-physician practitioners to fulfill some of the requirement at § 412.622(a)(3)(iv) the overall savings to Medicare Part B would be $6 million. However, we are unsure that IRFs will adopt this change. Commenters suggested that states do not have scope of practice laws that are IRF specific and at least as focused on the clinical training as necessitated through CMS requirements for a physician to practice in an IRF. States have developed scope of practice laws around acute care hospitals, rather than IRFs specifically, to allow NPPs to perform visits to admitted patients. Also, since the average length of stay for an IRF patient is 13 days, there would be limited opportunities for the NPP visit to

occur. Considering the broad permissibility under scope of practice laws and average length of stays, we felt it was appropriate to pick a midpoint in formulating our estimation. Therefore, we are estimating that IRFs will adopt this change 50 percent of the time. To obtain more information on which to base our estimates, we solicited feedback from commenters to determine:

- How many IRFs would substitute non-physician practitioners for physicians; and
- Among the IRFs that do substitute non-physician practitioners for physicians, whether it will be for all requirements or only for specific requirements.

We did not receive any comments regarding this request for feedback. Therefore, we are finalizing our projected savings for the portion of the proposal that we are finalizing.

In the absence of specific information on which to base a specific estimate of how much IRFs would be expected to substitute non-physician practitioners for one of the required physician visits at § 412.622(a)(3)(iv) beginning the second week of the patient's admission, we are assuming that IRFs will adopt this change about 50 percent of the time. Thus, the estimated overall savings to Medicare Part B will be $3 million. We are estimating that 80 percent of that will remain in the Medicare Trust Fund and 20 percent will be a savings to beneficiaries. Therefore, we estimate $2.4 million in savings to the Medicare program and $600,000 in savings to beneficiaries.

D. Alternatives Considered

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

Section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services.

As noted previously in this final rule, section 1886(j)(3)(C)(ii)(I) of the Act requires the

Secretary to apply a productivity adjustment to the market basket increase factor for FY 2021. Thus, in accordance with section 1886(j)(3)(C) of the Act, we update the IRF prospective payments in this final rule by 2.4 percent (which equals the 2.4 percent estimated IRF market basket increase factor for FY 2021 reduced by a 0.0 percentage point productivity adjustment as determined under section 1886(b)(3)(B)(xi)(II) of the Act (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 2021. 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 not implementing the new OMB delineations for purposes of calculating the wage index under the IRF PPS; however, we believe implementing the new OMB delineations will result in wage index values being more representative of the actual costs of labor in a given area.

We considered having no transition period and fully implementing the revisions to the OMB delineations as described in section VI.D. of this final rule. However, this would not provide any time for IRF providers to adapt to their new wage index values. Thus, we believe that it is appropriate to provide for a transition period to mitigate any significant decreases in wage index values and to provide time for IRFs to adjust to their new labor market area delineations.

We considered using a blended wage index for all providers that would be computed using 50 percent of the FY 2021 IRF PPS wage index values under the FY 2020 CBSA delineations and 50 percent of the FY 2021 IRF PPS wage index values under the FY 2021 OMB

delineations as was utilized in FY 2016 when we adopted the new CBSA delineations based on the 2010 decennial census. However, the revisions to the CBSA delineations announced in the latest OMB bulletin are not based on new census data; they are updates of the CBSA delineations adopted in FY 2016 based on the 2010 census data. As such, we do not believe it is necessary to implement the multifaceted 50/50 blended wage index transition that we established for the adoption of the new OMB delineations based on the decennial census data in FY 2016.

We considered transitioning the wage index to the revised OMB delineations over a number of years to minimize the impact of the wage index changes in a given year. However, we also believe this must be balanced against the need to ensure the most accurate payments possible, which argues for a faster transition to the revised OMB delineations. As discussed above in section VI.D. of this final rule, we believe that using the most current OMB delineations will increase the integrity of the IRF PPS wage index by creating a more accurate representation of geographic variation in wage levels. As such, we believe it will be appropriate to utilize a 5 percent cap on any decrease in an IRF's wage index from the IRF's final wage index in FY 2020 to allow the effects of our policies to be phased in over 2 years.

We considered maintaining the existing outlier threshold amount for FY 2021. However, analysis of updated FY 2019 data indicates that estimated outlier payments would be less than 3 percent of total estimated payments for FY 2021, by approximately 0.4 percent, unless we updated the outlier threshold amount. Consequently, we are adjusting the outlier threshold amount in this final rule to reflect a 0.4 percent increase thereby setting the total outlier payments equal to 3 percent, instead of 2.6 percent, of aggregate estimated payments in FY 2021.

We considered not removing the post-admission physician evaluation requirement at § 412.622(a)(3)(iv). However, we believe that IRFs are more than capable of determining whether a patient meets the coverage criteria for IRF services prior to admission. Additionally, we believe that if IRFs are doing their due diligence while completing the pre-admission

screening by making sure each IRF candidate meets all of the requirements to be admitted to the IRF, then the post-admission physician evaluation is unnecessary.

We considered not amending § 412.622(a)(4)(i)(B) and (D) to codify our longstanding documentation instructions and guidance of the preadmission screening in regulation text. However, we believe for the ease of administrative burden and being able to locate the required elements of the preadmission screening documentation and the review and concurrence of a rehabilitation physician prior to the IRF admission needed for the basis of IRF payment in a timely fashion, we are should make the technical codifications in regulation text. Additionally, we considered codifying all of our longstanding required elements of the pre-admission screening documentation. However, as discussed in section IX. of this final rule, we believe that removing some of the pre-admission screening elements that were duplicative of data collected in various other documents in the patient's IRF medical record (such as the history and physical and the individualized overall plan of care) would reduce provider burden.

We considered not amending §§ 412.622(a)(3)(iv) and 412.29(e) to allow, beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation to conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law. However, we believe that it is critical, especially in light of the significant changes in health care that have occurred as a result of the PHE for the COVID-19 pandemic, for Medicare to recognize and expand the valuable role that non-physician practitioners play in assisting the rehabilitation physicians in implementing patients' plan of care in the IRF. We intend to monitor the quality of care in IRFs closely to ensure that the regulatory changes we are implementing improve care provided to vulnerable IRF patients.

In addition, we considered amending § 412.622(a)(3), (4), and (5) to allow non-physician

practitioners to perform all of the IRF coverage requirements that are currently required to be performed by rehabilitation physicians, provided that these duties are within the practitioner's scope of practice under applicable state law. However, as discussed in section X. of this final rule, we received many comments from stakeholders expressing significant concerns about the quality of care that the vulnerable IRF patients would receive if we no longer required the rehabilitation physician to lead the care of the patients. Thus, we determined that it would be prudent to finalize only a portion of the proposed policy at this time. Based on extensive clinical input by CMS's medical officers and after careful consideration of these issues, we believe that the measured approach that we are finalizing in this final rule balances the commenters' concerns about maintaining the rehabilitation physician at the core of the patient's plan of care in the IRF with the benefits of expanding the role of non-physician practitioners, who play an important role in the interdisciplinary team and the care of complex patients.

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on the FY 2021 IRF PPS proposed rule will be the number of reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this final rule. It is possible that not all commenters reviewed the FY 2021 IRF PPS proposed rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this final rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this final rule, and therefore, for the purposes of our estimate we assume

that each reviewer reads approximately 50 percent of the rule. We sought comments on this assumption.

Using the wage information from the BLS for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is $110.74 per hour, including overhead and fringe benefits (https://www.bls.gov/oes/current/oes_nat.htm). Assuming an average reading speed, we estimate that it would take approximately 2 hours for the staff to review half of this final rule. For each IRF that reviews the rule, the estimated cost is $221.48 (2 hours x $110.74). Therefore, we estimate that the total cost of reviewing this regulation is $590,908.64 ($221.48 x 2,668 reviewers).

F. Accounting Statement and Table

As required by OMB Circular A-4 (available at https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf), in Table 14, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table 14 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the updates presented in this final rule based on the data for 1,118 IRFs in our database.

TABLE 14: Accounting Statement: Classification of Estimated Expenditure

Change in Estimated Transfers from FY 2020 IRF PPS to FY 2021 IRF PPS	**Category**	**Transfers**
	Annualized Monetized Transfers	$260 million
	From Whom to Whom?	Federal Government to IRF Medicare Providers
Change in Estimated Costs		
Category		**Costs**
Annualized monetized cost in FY 2021 for IRFs due to the amendment of certain IRF coverage requirements		Reduction of ≤ $3 million

G. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2021 are projected to increase by 2.8 percent, compared with the estimated payments in FY 2020, as reflected in

column 8 of Table 13.

IRF payments per discharge are estimated to increase by 2.8 percent in urban areas and 3.0 percent in rural areas, compared with estimated FY 2020 payments. Payments per discharge to rehabilitation units are estimated to increase 3.2 percent in urban areas and 3.2 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 2.5 percent in urban areas and increase 2.2 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the proposed policies in this final rule. The largest payment increase is estimated to be a 5.0 percent increase for rural IRFs located in the Pacific region. The analysis above, together with the remainder of this preamble, provides an RIA.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by OMB.

List of Subjects in 42 CFR Part 412

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

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

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

Authority: 42 U.S.C. 1302 and 1395hh.

2. Section 412.29 is amended by revising paragraph (e) to read as follows:

§ 412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment system.

* * * * *

(e) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622, during the Public Health Emergency, as defined in § 400.200 of this chapter, have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process except that during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic such visits may be conducted using telehealth services (as defined in section 1834(m)(4)(F) of the Act). Beginning with the second week, as defined in § 412.622, of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner’s scope of practice under applicable state law.

* * * * *

3. Section 412.622 is amended—

a. By revising paragraphs (a)(3)(ii) and (iv) and (a)(4)(i)(B) and (D);

b. By removing paragraph (a)(4)(ii);

c. By redesignating paragraph (a)(4)(iii) as paragraph (a)(4)(ii); and

d. In paragraph (c) by adding the definition of "Week" in alphabetical order.

The revisions and addition read as follows:

§ 412.622 Basis of payment.

(a) * * *

(3) * * *

(ii) Except during the emergency period described in section 1135(g)(1)(B) of the Act, generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy per week. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF.

* * * * *

(iv) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in § 400.200 of this chapter, requires physician

supervision by a rehabilitation physician. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process, except that during a Public Health Emergency, as defined in § 400.200 of this chapter, such visits may be conducted using telehealth services (as defined in section 1834(m)(4)(F) of the Act). Beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.

(4) * * *

(i) * * *

(B) It includes a detailed and comprehensive review of each patient's condition and medical history, including the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy, expected level of improvement, and the expected length of time necessary to achieve that level of improvement; an evaluation of the patient's risk for clinical complications; the conditions that caused the need for rehabilitation; the treatments needed (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics); and anticipated discharge destination.

* * * * *

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

* * * * *

(c)* * *

Week means a period of 7 consecutive calendar days beginning with the date of admission to the IRF.

Dated: July 23, 2020.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: July 29, 2020.

Alex M. Azar II,

Secretary,

Department of Health and Human Services.

[FR Doc. 2020-17209 Filed: 8/4/2020 4:15 pm; Publication Date: 8/10/2020]