ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[EPA–HQ–OPP–2015–0230; FRL–10007–81]

RIN 2070–ZA16

Banda de Lupinus Albus Doce (BLAD); Proposal To Revoke Exemption and Establish Pesticide Tolerances; Reopening of Comment Period

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule; reopening of comment period.

SUMMARY: EPA issued a proposed rule in the **Federal Register** of February 11, 2020, concerning the revocation of an existing tolerance exemption and establishment of pesticide tolerances for residues of the fungicide BLAD. This document reopens and extends the comment period to July 12, 2020. Consumo Em Verde S.A., Biotecnologia De Plantas, Parque Technologico de Cantanhede (CEV) formally requested a 90-day extension of the public comment period to permit it reasonable time to respond to the proposed rule.

DATES: Comments, identified by docket identification number EPA–HQ–OPP–2015–0230, must be received on or before July 12, 2020.

ADDRESSES: Follow the detailed instructions provided under **ADDRESSES** in the **Federal Register** document of February 11, 2020 (85 FR 7698) (FRL–9998–74).

FOR FURTHER INFORMATION CONTACT: Anne Overstreet, Deputy Director, Biopesticides and Pollution Prevention Division (7511P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001; main telephone number: (703) 305–7090; email address: *BPPDFRNotices@epa.gov.*

SUPPLEMENTARY INFORMATION: This document reopens the public comment period established in the **Federal Register** document of February 11, 2020 (85 FR 7698) (FRL–9998–74). In that document, EPA is proposing to revoke the existing exemption from the requirement of a tolerance for residues of the fungicide BLAD in or on all food commodities that was established in the **Federal Register** of March 22, 2013 (78 FR 17600) (FRL–9380–6). In place of the exemption, EPA is proposing to establish tolerances for residues of the fungicide BLAD at the level of quantitation, *i.e.,* 0.02 parts per million (ppm), in or on the following commodities: Almond; almond, hulls; fruit, pome, group 11–10; fruit, stone, group 12–12; grape; hops, dried cones; strawberry; vegetable, cucurbit, group 9; and vegetable, fruiting, group 8–10. In order to provide additional time for comments, EPA is hereby reopening the comment period that ended on April 13, 2020, such that it now ends on July 12, 2020.

To submit comments, or access the docket, please follow the detailed instructions provided under **ADDRESSES** in the **Federal Register** document of February 11, 2020. If you have questions, consult the person listed under **FOR FURTHER INFORMATION CONTACT**.

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: April 14, 2020.

Richard Keigwin,

Director, Office of Pesticide Programs.

[FR Doc. 2020–08192 Filed 4–20–20; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1729–P]

RIN 0938–AU05

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2021. As required by statute, this proposed rule includes the classification and weighting factors for the IRF prospective payment system's case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2021. We are proposing to adopt the most recent Office of Management and Budget 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 proposing to amend the IRF coverage requirements to remove the post-admission physician evaluation requirement and codify existing documentation instructions and guidance. Additionally, we are proposing to amend the IRF coverage requirements to allow non-physician practitioners to perform certain requirements that are currently required to be performed by a rehabilitation physician.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 15, 2020.

ADDRESSES: In commenting, please refer to file code CMS–1729–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

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

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1729–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1729–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT: Gwendolyn Johnson, (410) 786–6954, for general information.

Catie Cooksey, (410) 786–0179, for information about the IRF payment policies and payment rates.

Kadie Derby, (410) 786–0468, for information about the IRF coverage policies.

SUPPLEMENTARY INFORMATION:

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

Availability of Certain Information Through the Internet on the CMS website

The IRF PPS Addenda along with other supporting documents and tables referenced in this proposed rule are available through the internet on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.*

We note that in previous years, each rule or notice issued under the IRF PPS has included a detailed reiteration of the various regulatory provisions that have affected the IRF PPS over the years. That discussion, along with detailed background information for various other aspects of the IRF PPS, is now available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.*

I. Executive Summary

A. Purpose

This proposed rule would update the prospective payment rates for IRFs for FY 2021 (that is, for discharges occurring on or after October 1, 2020, and on or before September 30, 2021) as required under section 1886(j)(3)(C) of the Social Security Act (the Act). As required by section 1886(j)(5) of the Act, this proposed rule includes the classification and weighting factors for the IRF PPS's case-mix groups (CMGs) and a description of the methodologies and data used in computing the prospective payment rates for FY 2021. We are proposing to adopt the most recent Office of Management and Budget (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 proposing to amend the IRF coverage requirements to remove the post-admission physician evaluation requirement and codify existing documentation instructions and guidance. Additionally, we are proposing to amend the IRF coverage requirements to allow non-physician practitioners to perform certain requirements that are currently required be performed by a rehabilitation physician. There are no proposals or updates in this proposed rule to the IRF Quality Reporting Program (QRP).

B. Summary of Major Provisions

In this proposed rule, we use the methods described in the FY 2020 IRF PPS final rule (84 FR 39054) to update the prospective payment rates for FY 2021 using updated FY 2019 IRF claims and the most recent available IRF cost report data, which is FY 2018 IRF cost report data. We are proposing to adopt the most 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 proposing to amend the IRF coverage requirements to remove the post-admission physician evaluation requirement and codify existing documentation instructions and guidance. Additionally, we are proposing to amend the IRF coverage requirements to allow non-physician practitioners to perform certain requirements that are currently required to be performed by a rehabilitation physician.

C. Summary of Impact

TABLE 1—COST AND BENEFIT

Provision description	Transfers
FY 2021 IRF PPS payment rate update.	The overall economic impact of this proposed rule is an estimated $270 million in increased payments from the Federal Government to IRFs during FY 2021.

II. Background

A. Statutory Basis and Scope

Section 1886(j) of the Act provides for the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (collectively, hereinafter referred to as IRFs). Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs), but not direct graduate medical education costs, costs of approved nursing and allied health education activities, bad debts, and other services or items outside the scope of the IRF PPS. A complete discussion of the IRF PPS provisions appears in the original FY 2002 IRF PPS final rule (66 FR 41316) and the FY 2006 IRF PPS final rule (70 FR 47880), and we provided a general description of the IRF PPS for FYs 2007 through 2019 in the FY 2020 IRF PPS final rule (84 FR 39055 through 39057).

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

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

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

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

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

allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the Federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs now consist of 100 percent of the Federal IRF PPS rate.

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

The regulatory history previously included in each rule or notice issued under the IRF PPS is available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index?redirect=/InpatientRehabFacPPS/.*

B. Provisions of the PPACA Affecting the IRF PPS in FY 2012 and Beyond

The Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the PPACA, was enacted on March 30, 2010. In this proposed rule, we refer to the two statutes collectively as the ''Patient Protection and Affordable Care Act'' or ''PPACA''.

The PPACA included several provisions that affect the IRF PPS in FYs 2012 and beyond. In addition to what was previously discussed, section 3401(d) of the PPACA also added section 1886(j)(3)(C)(ii)(I) of the Act (providing for a ''productivity adjustment'' for fiscal year (FY) 2012 and each subsequent FY). The productivity adjustment for FY 2021 is discussed in section V.B. of this proposed rule. Section 1886(j)(3)(C)(ii)(II) of the Act provides that the application of the productivity adjustment to the market basket update 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.

Sections 3004(b) of the PPACA and section 411(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114–10, enacted April 16, 2015) (MACRA) also addressed the IRF PPS. Section 3004(b) of PPACA reassigned the previously designated section 1886(j)(7) of the Act to section 1886(j)(8) of the Act and inserted a new section 1886(j)(7) of the Act, which contains requirements for the Secretary to establish a quality reporting program (QRP) for IRFs. Under that program, data must be submitted in a form and manner and at a time specified by the Secretary. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Act requires the application of a 2 percentage point reduction to the market basket increase factor otherwise applicable to an IRF (after application of paragraphs (C)(iii) and (D) of section 1886(j)(3) of the Act) for a FY if the IRF does not comply with the requirements of the IRF QRP for that FY. 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. Reporting-based reductions to the market basket increase factor are not cumulative; they only apply for the FY involved. Section 411(b) of the MACRA amended section 1886(j)(3)(C) of the Act by adding paragraph (iii), which required us to apply for FY 2018, after the application of section 1886(j)(3)(C)(ii) of the Act, an increase factor of 1.0 percent to update the IRF prospective payment rates.

C. Operational Overview of the Current IRF PPS

As described in the FY 2002 IRF PPS final rule (66 FR 41316), upon the admission and discharge of a Medicare Part A fee-for-service (FFS) patient, the IRF is required to complete the appropriate sections of a Patient Assessment Instrument (PAI), designated as the IRF–PAI. In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each Medicare Advantage (MA) patient, as described in the FY 2010 IRF PPS final rule (74 FR 39762 and 74 FR 50712). All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the Grouper software. The Grouper software uses specific IRF–PAI data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The Grouper software produces a five-character CMG number. The first character is an alphabetic character that indicates the comorbidity tier. The last four characters are numeric characters that represent the distinct CMG number. A free download of the Grouper software is available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html.* The Grouper software is also embedded in the iQIES User tool available in iQIES at *https://www.cms.gov/medicare/quality-safety-oversight-general-information/iqies.*

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

Section 3 of the ASCA amended section 1862(a) of the Act by adding

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

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

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

D. Advancing Health Information Exchange

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care and patient access to their health information. The Office of the National Coordinator for Health Information Technology (ONC) and CMS work collaboratively to advance interoperability across settings of care, including post-acute care.

To further interoperability in post-acute care settings, CMS continues to explore opportunities to advance electronic exchange of patient information across payers, providers and with patients, including developing systems that use nationally recognized health IT standards such as the Logical Observation Identifiers Names and Codes (LOINC), the Systematized Nomenclature of Medicine (SNOMED), and the Fast Healthcare Interoperability Resources (FHIR). In addition, CMS and ONC established the Post-Acute Care Interoperability Workgroup (PACIO) to facilitate collaboration with industry stakeholders to develop FHIR standards that could support the exchange and reuse of patient assessment data derived from the minimum data set (MDS), inpatient rehabilitation facility patient assessment instrument (IRF–PAI), long term care hospital continuity assessment record and evaluation (LCDS), outcome and assessment information set (OASIS) and other sources.

The Data Element Library (DEL) continues to be updated and serves as the authoritative resource for PAC assessment data elements and their associated mappings to health IT standards. The DEL furthers CMS' goal of data standardization and interoperability. These interoperable data elements can reduce provider burden by allowing the use and exchange of healthcare data, support provider exchange of electronic health information for care coordination, person-centered care, and support real-time, data driven, clinical decision making. Standards in the Data Element Library (*https://del.cms.gov/DELWeb/pubHome*) can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA). The 2020 ISA is available at *https://www.healthit.gov/isa.*

In the September 30, 2019 **Federal Register**, CMS published a final rule, ''Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning'' (84 FR 51836) (''Discharge Planning final rule''), that revises the discharge planning requirements that hospitals (including psychiatric hospitals, long-term care hospitals, and inpatient rehabilitation facilities), critical access hospitals (CAHs), and home health agencies, must meet to participate in Medicare and Medicaid programs. The rule supports CMS' interoperability efforts by promoting the exchange of patient information between health care settings, and by ensuring that a patient's necessary medical information is transferred with the patient after discharge from a hospital, CAH, or post-acute care services provider. For more information on the Discharge planning requirements, please visit the final rule at *https://www.federalregister.gov/documents/2019/09/30/2019-20732/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals.*

III. Summary of Provisions of the Proposed Rule

The proposed policy changes and updates to the IRF prospective payment rates for FY 2021 are as follows:

- Update the CMG relative weights and average length of stay values for FY 2021, in a budget neutral manner, as discussed in section IV. of this proposed rule.
- Update the IRF PPS payment rates for FY 2021 by the proposed market basket increase factor, based upon the most current data available, with a proposed productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section V. of this proposed rule.
- Describe the proposed adoption of the revised OMB delineations, the proposed IRF wage index transition, and the proposed update to the labor-related share for FY 2021 in a budget-neutral manner, as described in section V. of this proposed rule.
- Describe the calculation of the IRF standard payment conversion factor for FY 2021, as discussed in section V. of this proposed rule.
- Update the outlier threshold amount for FY 2021, as discussed in section VI. of this proposed rule.
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2021, as discussed in section VI. of this proposed rule.
- Amend the IRF coverage requirements to remove the post-admission physician evaluation requirement as discussed in section VII. of this proposed rule.
- Amend the IRF coverage requirements to codify existing documentation instructions and guidance as discussed in section VIII. of this proposed rule.
- Amend the IRF coverage requirements to allow non-physician

practitioners to perform certain requirements that are currently required to be performed by a rehabilitation physician as discussed in section IX. of this proposed rule.

- Describe the method for applying the reduction to the FY 2021 IRF increase factor for IRFs that fail to meet the quality reporting requirements as discussed in section X. of this proposed rule.

IV. Proposed Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay Values for FY 2021

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

In this proposed rule, we propose to update the CMG relative weights and average length of stay values for FY 2021. As required by statute, we always use the most recent available data to update the CMG relative weights and average lengths of stay. For FY 2021, we propose to use the FY 2019 IRF claims and FY 2018 IRF cost report data. These data are the most current and complete data available at this time. Currently, only a small portion of the FY 2019 IRF cost report data are available for analysis, but the majority of the FY 2019 IRF claims data are available for analysis. We are also proposing that if more recent data become available after the publication of this proposed rule and before the publication of the final rule, we would use such data to determine the FY 2021 CMG relative weights and average length of stay values in the final rule.

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

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

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

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

Step 4. We normalize the FY 2021 CMG relative weights to the same average CMG relative weight from the CMG relative weights implemented in the FY 2020 IRF PPS final rule (84 FR 39054).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we propose to update the CMG relative weights for FY 2021 in such a way that total estimated aggregate payments to IRFs for FY 2021 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget neutrality factor to the standard payment amount. To calculate the appropriate budget neutrality factor for use in updating the FY 2021 CMG relative weights, we use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2021 (with no changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2021 by applying the proposed changes to the CMG relative weights (as discussed in this proposed rule).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the budget neutrality factor of 0.9969 that would maintain the same total estimated aggregate payments in FY 2021 with and without the proposed changes to the CMG relative weights.

Step 4. Apply the budget neutrality factor from step 3 to the FY 2021 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section V.D. of this proposed rule, we discuss the proposed use of the existing methodology to calculate the proposed standard payment conversion factor for FY 2021.

In Table 2, ''Proposed Relative Weights and Average Length of Stay Values for Case-Mix Groups,'' we present the CMGs, the comorbidity tiers, the corresponding relative weights, and the average length of stay values for each CMG and tier for FY 2021. The average length of stay for each CMG is used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment.

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TABLE 2: Relative Weights And Average Length Of Stay Values For The Revised Case-Mix Groups

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
0101	Stroke M >=72.50	1.0380	0.8853	0.8196	0.7842	10	10	10	9
0102	Stroke M >=63.50 and M <72.50	1.3254	1.1305	1.0466	1.0014	13	13	12	11
0103	Stroke M >=50.50 and M <63.50	1.6934	1.4442	1.3371	1.2794	15	16	15	14
0104	Stroke M >=41.50 and M <50.50	2.1990	1.8755	1.7363	1.6614	19	19	18	18
0105	Stroke M <41.50 and A >=84.50	2.4967	2.1294	1.9714	1.8863	23	23	21	20
0106	Stroke M <41.50 and A <84.50	2.8614	2.4405	2.2593	2.1618	26	24	23	23
0201	Traumatic brain injury M >=73.50	1.1733	0.9427	0.8472	0.7923	10	11	10	10
0202	Traumatic brain injury M >=61.50 and M <73.50	1.4690	1.1803	1.0607	0.9920	13	13	12	12
0203	Traumatic brain injury M >=49.50 and M <61.50	1.7700	1.4221	1.2781	1.1953	15	15	14	14
0204	Traumatic brain injury M >=35.50 and M <49.50	2.1993	1.7670	1.5880	1.4851	20	19	17	16
0205	Traumatic brain injury M <35.50	2.7551	2.2136	1.9894	1.8605	31	23	21	18
0301	Non-traumatic brain injury M >=65.50	1.2295	0.9957	0.9188	0.8518	11	11	10	10
0302	Non-traumatic brain injury M >=52.50 and M <65.50	1.5763	1.2766	1.1780	1.0920	14	14	13	12
0303	Non-traumatic brain injury M >=42.50 and M <52.50	1.8862	1.5276	1.4096	1.3068	16	16	15	14
0304	Non-traumatic brain injury M <42.50 and A >=78.50	2.1149	1.7128	1.5805	1.4652	19	18	16	16
0305	Non-traumatic brain injury M <42.50 and A <78.50	2.3053	1.8670	1.7228	1.5971	21	20	17	17
0401	Traumatic spinal cord injury M >=56.50	1.3703	1.1649	1.0453	0.9724	12	12	12	11
0402	Traumatic spinal cord injury M >=47.50 and M <56.50	1.7842	1.5168	1.3611	1.2662	17	16	14	15
0403	Traumatic spinal cord injury M >=41.50 and M <47.50	2.1436	1.8224	1.6352	1.5213	20	20	18	17
0404	Traumatic spinal cord injury M <31.50 and A <61.50	3.5461	3.0147	2.7051	2.5166	27	35	32	25
0405	Traumatic spinal cord injury M >=31.50 and M <41.50	2.7520	2.3395	2.0993	1.9530	25	26	22	21
0406	Traumatic spinal cord injury M >=24.50 and M <31.50 and A >=61.50	3.5946	3.0558	2.7420	2.5510	34	31	28	28
0407	Traumatic spinal cord injury M <24.50 and A >=61.50	4.1177	3.5006	3.1411	2.9223	46	36	32	32
0501	Non-traumatic spinal cord injury M >=60.50	1.3210	1.0176	0.9622	0.8877	13	12	11	10
0502	Non-traumatic spinal cord injury M >=53.50 and M <60.50	1.6394	1.2629	1.1941	1.1017	15	14	13	12
0503	Non-traumatic spinal cord injury M >=48.50 and M <53.50	1.8988	1.4627	1.3830	1.2760	16	16	15	14
0504	Non-traumatic spinal cord injury M >=39.50 and M <48.50	2.2679	1.7470	1.6519	1.5240	21	19	18	17
0505	Non-traumatic spinal cord injury M <39.50	2.9524	2.2743	2.1505	1.9840	28	24	22	21
0601	Neurological M >=64.50	1.3775	1.0296	0.9651	0.8771	12	11	10	10
0602	Neurological M >=52.50 and M	1.7131	1.2803	1.2002	1.0907	14	13	12	12

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
	<64.50								
0603	Neurological M >=43.50 and M <52.50	2.0340	1.5202	1.4251	1.2951	16	15	15	14
0604	Neurological M <43.50	2.3598	1.7637	1.6533	1.5025	20	18	17	16
0701	Fracture of lower extremity M >=61.50	1.2537	1.0123	0.9586	0.8812	11	12	11	10
0702	Fracture of lower extremity M >=52.50 and M <61.50	1.5680	1.2660	1.1990	1.1021	14	14	13	12
0703	Fracture of lower extremity M >=41.50 and M <52.50	1.9049	1.5380	1.4566	1.3389	17	16	15	15
0704	Fracture of lower extremity M <41.50	2.1759	1.7569	1.6638	1.5295	19	18	17	17
0801	Replacement of lower-extremity joint M >=63.50	1.1346	0.9128	0.8117	0.7566	10	10	9	9
0802	Replacement of lower-extremity joint M >=57.50 and M <63.50	1.3335	1.0729	0.9540	0.8893	12	11	11	10
0803	Replacement of lower-extremity joint M >=51.50 and M <57.50	1.4900	1.1988	1.0659	0.9937	12	13	12	11
0804	Replacement of lower-extremity joint M >=42.50 and M <51.50	1.7165	1.3810	1.2279	1.1447	14	15	13	13
0805	Replacement of lower-extremity joint M <42.50	1.9985	1.6080	1.4297	1.3328	17	17	15	14
0901	Other orthopedic M >=63.50	1.2185	0.9646	0.9131	0.8270	11	11	10	10
0902	Other orthopedic M >=51.50 and M <63.50	1.5163	1.2004	1.1363	1.0291	13	13	12	12
0903	Other orthopedic M >=44.50 and M <51.50	1.7843	1.4125	1.3370	1.2109	15	15	14	14
0904	Other orthopedic M <44.5	2.0484	1.6216	1.5349	1.3901	17	17	16	15
1001	Amputation lower extremity M >=64.50	1.2985	1.0813	0.9716	0.8979	12	13	11	11
1002	Amputation lower extremity M >=55.50 and M <64.50	1.6123	1.3426	1.2064	1.1149	14	15	13	13
1003	Amputation lower extremity M >=47.50 and M <55.50	1.8837	1.5685	1.4094	1.3026	16	17	15	14
1004	Amputation lower extremity M <47.50	2.2178	1.8468	1.6594	1.5336	18	19	17	16
1101	Amputation non-lower extremity M >=58.50	1.3042	1.1630	1.0187	0.9860	12	10	11	13
1102	Amputation non-lower extremity M >=52.50 and M <58.50	1.7339	1.5462	1.3544	1.3109	14	12	14	14
1103	Amputation non-lower extremity M <52.50	1.9502	1.7390	1.5233	1.4744	17	13	16	14
1201	Osteoarthritis M >=61.50	1.4424	0.9550	0.9550	0.8764	11	10	10	11
1202	Osteoarthritis M >=49.50 and M <61.50	1.8004	1.1921	1.1921	1.0940	13	14	13	12
1203	Osteoarthritis M <49.50 and A >=74.50	2.0937	1.3863	1.3863	1.2722	15	14	16	14
1204	Osteoarthritis M <49.50 and A <74.50	2.1990	1.4560	1.4560	1.3362	15	15	15	15
1301	Rheumatoid other arthritis M >=62.50	1.1318	0.9310	0.8820	0.7831	9	11	10	9
1302	Rheumatoid other arthritis M >=51.50 and M <62.50	1.5523	1.2769	1.2096	1.0740	12	13	13	12
1303	Rheumatoid other arthritis M >=44.50 and M <51.50 and A >=64.50	1.7844	1.4679	1.3905	1.2346	14	15	14	14

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
1304	Rheumatoid other arthritis M <44.50 and A >=64.50	2.0734	1.7056	1.6157	1.4345	14	17	16	16
1305	Rheumatoid other arthritis M <51.50 and A <64.50	2.0944	1.7229	1.6321	1.4491	15	16	16	16
1401	Cardiac M >=68.50	1.1571	0.9424	0.8493	0.7600	11	10	10	9
1402	Cardiac M >=55.50 and M <68.50	1.4500	1.1810	1.0643	0.9523	13	13	11	11
1403	Cardiac M >=45.50 and M <55.50	1.7623	1.4353	1.2935	1.1574	15	15	13	13
1404	Cardiac M <45.50	2.0649	1.6818	1.5156	1.3561	18	17	16	14
1501	Pulmonary M >=68.50	1.2965	1.0348	0.9661	0.9281	11	10	10	10
1502	Pulmonary M >=56.50 and M <68.50	1.5970	1.2746	1.1901	1.1433	13	13	12	12
1503	Pulmonary M >=45.50 and M <56.50	1.8540	1.4797	1.3816	1.3272	16	14	13	13
1504	Pulmonary M <45.50	2.1395	1.7076	1.5943	1.5316	21	16	15	14
1601	Pain syndrome M >=65.50	0.9934	0.9934	0.8962	0.8051	9	10	11	9
1602	Pain syndrome M >=58.50 and M <65.50	1.1097	1.1097	1.0011	0.8994	10	11	11	11
1603	Pain syndrome M >=43.50 and M <58.50	1.3534	1.3534	1.2210	1.0969	12	14	13	13
1604	Pain syndrome M <43.50	1.7185	1.7185	1.5503	1.3928	13	15	17	15
1701	Major multiple trauma without brain or spinal cord injury M >=57.50	1.3861	1.0888	0.9928	0.9032	12	13	11	11
1702	Major multiple trauma without brain or spinal cord injury M >=50.50 and M <57.50	1.6923	1.3293	1.2121	1.1026	15	14	13	13
1703	Major multiple trauma without brain or spinal cord injury M >=41.50 and M <50.50	2.0051	1.5749	1.4361	1.3064	18	15	16	15
1704	Major multiple trauma without brain or spinal cord injury M >=36.50 and M <41.50	2.2215	1.7450	1.5912	1.4475	17	19	17	16
1705	Major multiple trauma without brain or spinal cord injury M <36.50	2.4273	1.9066	1.7385	1.5815	22	20	18	17
1801	Major multiple trauma with brain or spinal cord injury M >=67.50	1.2438	0.9770	0.8778	0.8157	14	13	10	10
1802	Major multiple trauma with brain or spinal cord injury M >=55.50 and M <67.50	1.5968	1.2544	1.1270	1.0473	13	15	12	12
1803	Major multiple trauma with brain or spinal cord injury M >=45.50 and M <55.50	1.9458	1.5285	1.3733	1.2761	17	16	15	14
1804	Major multiple trauma with brain or spinal cord injury M >=40.50 and M <45.50	2.2380	1.7581	1.5795	1.4678	21	19	17	16
1805	Major multiple trauma with brain or spinal cord injury M >=30.50 and M <40.50	2.6613	2.0906	1.8783	1.7454	28	22	20	19
1806	Major multiple trauma with brain or spinal cord injury M <30.50	3.3710	2.6481	2.3792	2.2108	35	29	22	24
1901	Guillain-Barré M >=66.50	1.1854	0.9355	0.9258	0.8741	14	12	13	10
1902	Guillain-Barré M >=51.50 and M <66.50	1.6098	1.2705	1.2573	1.1871	17	14	14	14
1903	Guillain-Barré M >=38.50 and M	2.5682	2.0268	2.0058	1.8938	23	21	21	21

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
	<51.50								
1904	Guillain-Barré M <38.50	3.6734	2.8991	2.8689	2.7087	42	30	27	29
2001	Miscellaneous M >=66.50	1.2176	0.9846	0.9006	0.8283	11	11	10	9
2002	Miscellaneous M >=55.50 and M <66.50	1.4972	1.2106	1.1073	1.0184	13	13	12	11
2003	Miscellaneous M >=46.50 and M <55.50	1.7706	1.4317	1.3095	1.2044	15	15	14	13
2004	Miscellaneous M <46.50 and A >=77.50	1.9940	1.6124	1.4748	1.3564	18	17	15	15
2005	Miscellaneous M <46.50 and A <77.50	2.1432	1.7330	1.5851	1.4578	19	18	16	15
2101	Burns M >=52.50	1.8160	1.3699	1.1285	1.1285	17	13	13	14
2102	Burns M <52.50	2.4202	1.8256	1.5040	1.5040	20	21	15	15
5001	Short-stay cases, length of stay is 3 days or fewer				0.1646				2
5101	Expired, orthopedic, length of stay is 13 days or fewer				0.7315				8
5102	Expired, orthopedic, length of stay is 14 days or more				1.8082				19
5103	Expired, not orthopedic, length of stay is 15 days or fewer				0.8414				8
5104	Expired, not orthopedic, length of stay is 16 days or more				2.0739				20

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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 proposed 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 propose to implement the CMG relative weight revisions in a budget-neutral manner (as previously described), total estimated aggregate payments to IRFs for FY 2021 would not be affected as a result of the proposed CMG relative weight revisions. However, the proposed revisions would affect the distribution of payments within CMGs and tiers.

TABLE 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%	1,678	0.4
Changed by less than 5%	401,521	99.3
Decreased by between 5% and 15%	936	0.2
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 proposed revisions for FY 2021. The proposed 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.

We invite public comment on our proposed updates to the CMG relative weights and average length of stay values for FY 2021.

V. Proposed 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, we propose 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. Proposed FY 2021 Market Basket Update and Productivity Adjustment

For FY 2021 (that is, beginning October 1, 2020 and ending September 30, 2021), we propose 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 propose 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 are proposing 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 is projected to be 2.9 percent. Therefore, we are proposing that the 2016-based IRF market basket increase factor for FY 2021 would be 2.9 percent. We are also proposing that if more recent data become available after the publication of this proposed rule and before the publication of the 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 the 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 MFP adjustment for FY 2021 (the 10-year moving average of MFP for the period ending FY 2021) is projected to be 0.4 percent. Thus, in accordance with section 1886(j)(3)(C) of the Act, we are proposing to base the FY 2021 market basket update, which is used to determine the applicable percentage increase for the IRF payments, on the 2016-based IRF market basket. We are proposing to then reduce this percentage increase by the estimated MFP adjustment for FY 2021 of 0.4 percentage point (the 10-year moving average of MFP for the period ending FY 2021 based on IGI's fourth quarter 2019 forecast). Therefore, the proposed FY 2021 IRF update would be 2.5 percent (2.9 percent market basket update, less 0.4 percentage point MFP adjustment). Furthermore, we are proposing that if more recent data become available after the publication of this proposed rule and before the publication of the final rule (for example, a more recent estimate of the market basket and MFP adjustment), we would use such data to determine the FY 2021 market basket update and MFP adjustment in the final rule.

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 proposing to update the IRF PPS payment rates for FY 2021 by an adjusted market basket increase factor of 2.5 percent, as section 1886(j)(3)(C) of the Act does not provide the Secretary with the authority to apply a different update factor to IRF PPS payment rates for FY 2021.

We invite public comment on the proposed market basket update and productivity adjustment.

C. Proposed 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 propose 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 propose 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 is 69.0 percent. We propose 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 propose 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 are proposing 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 propose that if more recent data become available after publication of this proposed rule and before the publication of the final rule (for example, a more recent estimate of the labor-related share), we will use such data to determine the FY 2021 IRF labor-related share in the final rule. Table 4 shows the FY 2021 proposed 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 PROPOSED LABOR-RELATED SHARE AND FY 2020 IRF LABOR-RELATED SHARE

	FY 2021 proposed labor-related share [1]	FY 2020 final labor-related share [2]
Wages and Salaries	48.4	48.1
Employee Benefits	11.4	11.4
Professional Fees: Labor-Related [3]	5.0	5.0
Administrative and Facilities Support Services	0.8	0.8
Installation, Maintenance, and Repair Services	1.6	1.6
All Other: Labor-Related Services	1.8	1.8
Subtotal	69.0	68.7
Labor-Related portion of Capital-Related (46%)	3.9	4.0
Total Labor-Related Share	72.9	72.7

[1] Based on the 2016-based IRF market basket relative importance, IHS Global, Inc. 4th quarter 2019 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.

We invite public comment on the proposed labor-related share for FY 2021.

D. Proposed 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 propose 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 propose 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 propose to continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation for the FY 2021 IRF PPS 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 minor updates and revisions to statistical areas in the years between the decennial censuses. 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 the most recent 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*), which, as discussed later in the proposed rule, was not issued in time for development of this proposed 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 V.D.2.b. of this proposed rule. We are proposing 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 in this proposed rule, the March 6, 2020 OMB Bulletin 20–01 was not issued in time for development of this proposed rule. While we do not believe that the minor updates included in OMB Bulletin 20–01 would impact our proposed updates to the CBSA-based labor market area delineations, if appropriate, we would propose any updates from this bulletin in the FY 2022 IRF PPS proposed rule.

b. Proposed 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 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 are proposing 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 are proposing 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 are proposing 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 proposed transition is discussed in more detail in section V.D.3. of this proposed 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 are proposing to continue to treat Micropolitan Areas as ''rural'' and to include Micropolitan Areas in the calculation of the state's rural wage index.

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

As previously discussed, we are proposing 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 would be rural if we finalize our proposal to implement the new OMB delineations.

TABLE 5—COUNTIES THAT WOULD 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.

TABLE 5—COUNTIES THAT WOULD TRANSITION FROM URBAN TO RURAL STATUS—Continued

FIPS county code	County/county equivalent	State	Current CBSA	Current CBSA name
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 are proposing 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 V.D.3. of this proposed rule for a discussion of the proposed wage index transition policy due to these proposed changes.

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

As previously discussed, we are proposing to implement 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 would be considered located in urban areas under the new OMB delineations. Table 6 lists the 47 rural counties that would be urban if we finalize our proposal to implement the new OMB delineations.

TABLE 6—COUNTIES THAT WOULD 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.

TABLE 6—COUNTIES THAT WOULD TRANSITION FROM RURAL TO URBAN STATUS—Continued

FIPS county code	County/county equivalent	State	Proposed CBSA code	Proposed CBSA name
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 are proposing 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 V.D.3. of this proposed rule for a discussion of the proposed wage index transition policy.

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

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

TABLE 7—CURRENT CBSAS THAT WOULD 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.

TABLE 7—CURRENT CBSAS THAT WOULD CHANGE CBSA CODE OR TITLE—Continued

Proposed CBSA code	Proposed CBSA title	Current CBSA code	Current CBSA title
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, if we adopt the new OMB delineations, counties would 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 would move from one urban CBSA to another a newly proposed or modified CBSA if we adopted the new OMB delineations.

TABLE 8—URBAN COUNTIES THAT WOULD 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 V.D.3. of this proposed rule for a discussion of the proposed wage index transition policy due to these proposed changes.

We believe these 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 are proposing 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 are proposing to adopt these revisions to the CSBA based labor market area delineations in a budget neutral manner. Our proposed methodology for calculating the proposed budget neutrality factor is discussed in section V.D.4. of this proposed rule.

We invite public comment on the proposal to adopt the new OMB delineations, effective beginning with the FY 2021 IRF PPS wage index.

3. Proposed 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 believed that using the new OMB delineations would create a more accurate payment adjustment for differences in area wage levels, we also recognized 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 are proposing 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 are proposing 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 are proposing that this proposed 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 proposed budget neutrality factor is discussed below in section V.D.4. of this proposed rule.

We invite comments on our proposed implementation of the new OMB delineations and our proposed transition methodology.

4. Proposed Wage Adjustment

To calculate the wage-adjusted facility payment for the proposed payment rates set forth in this proposed rule, we would multiply the proposed unadjusted Federal payment rate for IRFs by the FY 2021 labor-related share based on the 2016-based IRF market basket relative importance (72.9 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 V.C. of this proposed rule. We would 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 propose 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 propose to use the listed steps to ensure that the FY 2021 IRF standard payment conversion factor reflects the proposed update to the wage indexes (based on the FY 2017 hospital cost report data and taking into account the proposed revisions to the OMB delineations and the transition policy) and the proposed 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 proposed FY 2021 wage index values (based on updated hospital wage data and taking into account the proposed changes to geographic labor market area delineations and the transition policy) and the proposed FY 2021 labor-related share of 72.9 percent.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the proposed FY 2021 budget-neutral wage adjustment factor of 0.9999.

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 proposed FY 2021 standard payment conversion factor.

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

We invite public comment on the proposed IRF wage adjustment for FY 2021.

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

To calculate the proposed standard payment conversion factor for FY 2021, as illustrated in Table 5, we begin by applying the proposed 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 proposed 2.5 percent increase factor for FY 2021 to the standard payment conversion factor for FY 2020 of $16,489 yields a standard payment amount of $16,901. Then, we apply the proposed budget neutrality factor for the FY 2021 wage index (taking into account the proposed revisions to the CBSA delineations and the transition policy), and labor-related share of 0.9999, which results in a proposed standard payment amount of $16,900. We next apply the proposed budget neutrality factor for the revised CMGs and CMG relative weights of 0.9969, which results in the standard payment conversion factor of $16,847 for FY 2021.

We invite public comment on the proposed FY 2021 standard payment conversion factor.

TABLE 9—CALCULATIONS TO DETERMINE THE PROPOSED FY 2021 STANDARD PAYMENT CONVERSION FACTOR

Explanation for adjustment	Calculations
Standard Payment Conversion Factor for FY 2020	$16,489

TABLE 9—CALCULATIONS TO DETERMINE THE PROPOSED FY 2021 STANDARD PAYMENT CONVERSION FACTOR—Continued

Explanation for adjustment	Calculations
Market Basket Increase Factor for FY 2021 (2.9 percent), reduced by 0.4 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.	× 1.025
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	× 0.9999
Budget Neutrality Factor for the Revisions to the CMGs and CMG Relative Weights	× 0.9969
Proposed FY 2020 Standard Payment Conversion Factor	= $16,847

After the application of the proposed CMG relative weights described in section IV. of this proposed rule to the proposed FY 2021 standard payment conversion factor ($16,847), the resulting unadjusted IRF prospective payment rates for FY 2021 are shown in Table 10.

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TABLE 10: FY 2021 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	$ 17,487.19	$ 14,914.65	$ 13,807.80	$ 13,211.42
0102	$ 22,329.01	$ 19,045.53	$ 17,632.07	$ 16,870.59
0103	$ 28,528.71	$ 24,330.44	$ 22,526.12	$ 21,554.05
0104	$ 37,046.55	$ 31,596.55	$ 29,251.45	$ 27,989.61
0105	$ 42,061.90	$ 35,874.00	$ 33,212.18	$ 31,778.50
0106	$ 48,206.01	$ 41,115.10	$ 38,062.43	$ 36,419.84
0201	$ 19,766.59	$ 15,881.67	$ 14,272.78	$ 13,347.88
0202	$ 24,748.24	$ 19,884.51	$ 17,869.61	$ 16,712.22
0203	$ 29,819.19	$ 23,958.12	$ 21,532.15	$ 20,137.22
0204	$ 37,051.61	$ 29,768.65	$ 26,753.04	$ 25,019.48
0205	$ 46,415.17	$ 37,292.52	$ 33,515.42	$ 31,343.84
0301	$ 20,713.39	$ 16,774.56	$ 15,479.02	$ 14,350.27
0302	$ 26,555.93	$ 21,506.88	$ 19,845.77	$ 18,396.92
0303	$ 31,776.81	$ 25,735.48	$ 23,747.53	$ 22,015.66
0304	$ 35,629.72	$ 28,855.54	$ 26,626.68	$ 24,684.22
0305	$ 38,837.39	$ 31,453.35	$ 29,024.01	$ 26,906.34
0401	$ 23,085.44	$ 19,625.07	$ 17,610.17	$ 16,382.02
0402	$ 30,058.42	$ 25,553.53	$ 22,930.45	$ 21,331.67
0403	$ 36,113.23	$ 30,701.97	$ 27,548.21	$ 25,629.34
0404	$ 59,741.15	$ 50,788.65	$ 45,572.82	$ 42,397.16
0405	$ 46,362.94	$ 39,413.56	$ 35,366.91	$ 32,902.19
0406	$ 60,558.23	$ 51,481.06	$ 46,194.47	$ 42,976.70
0407	$ 69,370.89	$ 58,974.61	$ 52,918.11	$ 49,231.99
0501	$ 22,254.89	$ 17,143.51	$ 16,210.18	$ 14,955.08
0502	$ 27,618.97	$ 21,276.08	$ 20,117.00	$ 18,560.34
0503	$ 31,989.08	$ 24,642.11	$ 23,299.40	$ 21,496.77
0504	$ 38,207.31	$ 29,431.71	$ 27,829.56	$ 25,674.83
0505	$ 49,739.08	$ 38,315.13	$ 36,229.47	$ 33,424.45
0601	$ 23,206.74	$ 17,345.67	$ 16,259.04	$ 14,776.50
0602	$ 28,860.60	$ 21,569.21	$ 20,219.77	$ 18,375.02
0603	$ 34,266.80	$ 25,610.81	$ 24,008.66	$ 21,818.55
0604	$ 39,755.55	$ 29,713.05	$ 27,853.15	$ 25,312.62
0701	$ 21,121.08	$ 17,054.22	$ 16,149.53	$ 14,845.58
0702	$ 26,416.10	$ 21,328.30	$ 20,199.55	$ 18,567.08
0703	$ 32,091.85	$ 25,910.69	$ 24,539.34	$ 22,556.45
0704	$ 36,657.39	$ 29,598.49	$ 28,030.04	$ 25,767.49
0801	$ 19,114.61	$ 15,377.94	$ 13,674.71	$ 12,746.44
0802	$ 22,465.47	$ 18,075.15	$ 16,072.04	$ 14,982.04
0803	$ 25,102.03	$ 20,196.18	$ 17,957.22	$ 16,740.86
0804	$ 28,917.88	$ 23,265.71	$ 20,686.43	$ 19,284.76
0805	$ 33,668.73	$ 27,089.98	$ 24,086.16	$ 22,453.68
0901	$ 20,528.07	$ 16,250.62	$ 15,383.00	$ 13,932.47
0902	$ 25,545.11	$ 20,223.14	$ 19,143.25	$ 17,337.25
0903	$ 30,060.10	$ 23,796.39	$ 22,524.44	$ 20,400.03
0904	$ 34,509.39	$ 27,319.10	$ 25,858.46	$ 23,419.01
1001	$ 21,875.83	$ 18,216.66	$ 16,368.55	$ 15,126.92
1002	$ 27,162.42	$ 22,618.78	$ 20,324.22	$ 18,782.72

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1003	$ 31,734.69	$ 26,424.52	$ 23,744.16	$ 21,944.90
1004	$ 37,363.28	$ 31,113.04	$ 27,955.91	$ 25,836.56
1101	$ 21,971.86	$ 19,593.06	$ 17,162.04	$ 16,611.14
1102	$ 29,211.01	$ 26,048.83	$ 22,817.58	$ 22,084.73
1103	$ 32,855.02	$ 29,296.93	$ 25,663.04	$ 24,839.22
1201	$ 24,300.11	$ 16,088.89	$ 16,088.89	$ 14,764.71
1202	$ 30,331.34	$ 20,083.31	$ 20,083.31	$ 18,430.62
1203	$ 35,272.56	$ 23,355.00	$ 23,355.00	$ 21,432.75
1204	$ 37,046.55	$ 24,529.23	$ 24,529.23	$ 22,510.96
1301	$ 19,067.43	$ 15,684.56	$ 14,859.05	$ 13,192.89
1302	$ 26,151.60	$ 21,511.93	$ 20,378.13	$ 18,093.68
1303	$ 30,061.79	$ 24,729.71	$ 23,425.75	$ 20,799.31
1304	$ 34,930.57	$ 28,734.24	$ 27,219.70	$ 24,167.02
1305	$ 35,284.36	$ 29,025.70	$ 27,495.99	$ 24,412.99
1401	$ 19,493.66	$ 15,876.61	$ 14,308.16	$ 12,803.72
1402	$ 24,428.15	$ 19,896.31	$ 17,930.26	$ 16,043.40
1403	$ 29,689.47	$ 24,180.50	$ 21,791.59	$ 19,498.72
1404	$ 34,787.37	$ 28,333.28	$ 25,533.31	$ 22,846.22
1501	$ 21,842.14	$ 17,433.28	$ 16,275.89	$ 15,635.70
1502	$ 26,904.66	$ 21,473.19	$ 20,049.61	$ 19,261.18
1503	$ 31,234.34	$ 24,928.51	$ 23,275.82	$ 22,359.34
1504	$ 36,044.16	$ 28,767.94	$ 26,859.17	$ 25,802.87
1601	$ 16,735.81	$ 16,735.81	$ 15,098.28	$ 13,563.52
1602	$ 18,695.12	$ 18,695.12	$ 16,865.53	$ 15,152.19
1603	$ 22,800.73	$ 22,800.73	$ 20,570.19	$ 18,479.47
1604	$ 28,951.57	$ 28,951.57	$ 26,117.90	$ 23,464.50
1701	$ 23,351.63	$ 18,343.01	$ 16,725.70	$ 15,216.21
1702	$ 28,510.18	$ 22,394.72	$ 20,420.25	$ 18,575.50
1703	$ 33,779.92	$ 26,532.34	$ 24,193.98	$ 22,008.92
1704	$ 37,425.61	$ 29,398.02	$ 26,806.95	$ 24,386.03
1705	$ 40,892.72	$ 32,120.49	$ 29,288.51	$ 26,643.53
1801	$ 20,954.30	$ 16,459.52	$ 14,788.30	$ 13,742.10
1802	$ 26,901.29	$ 21,132.88	$ 18,986.57	$ 17,643.86
1803	$ 32,780.89	$ 25,750.64	$ 23,135.99	$ 21,498.46
1804	$ 37,703.59	$ 29,618.71	$ 26,609.84	$ 24,728.03
1805	$ 44,834.92	$ 35,220.34	$ 31,643.72	$ 29,404.75
1806	$ 56,791.24	$ 44,612.54	$ 40,082.38	$ 37,245.35
1901	$ 19,970.43	$ 15,760.37	$ 15,596.95	$ 14,725.96
1902	$ 27,120.30	$ 21,404.11	$ 21,181.73	$ 19,999.07
1903	$ 43,266.47	$ 34,145.50	$ 33,791.71	$ 31,904.85
1904	$ 61,885.77	$ 48,841.14	$ 48,332.36	$ 45,633.47
2001	$ 20,512.91	$ 16,587.56	$ 15,172.41	$ 13,954.37
2002	$ 25,223.33	$ 20,394.98	$ 18,654.68	$ 17,156.98
2003	$ 29,829.30	$ 24,119.85	$ 22,061.15	$ 20,290.53
2004	$ 33,592.92	$ 27,164.10	$ 24,845.96	$ 22,851.27
2005	$ 36,106.49	$ 29,195.85	$ 26,704.18	$ 24,559.56
2101	$ 30,594.15	$ 23,078.71	$ 19,011.84	$ 19,011.84
2102	$ 40,773.11	$ 30,755.88	$ 25,337.89	$ 25,337.89
5001	$ -	$ -	$ -	$ 2,773.02
5101	$ -	$ -	$ -	$ 12,323.58

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
5102	$ -	$ -	$ -	$ 30,462.75
5103	$ -	$ -	$ -	$ 14,175.07
5104	$ -	$ -	$ -	$ 34,938.99

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

Table 11 illustrates the methodology for adjusting the proposed prospective payments (as described in section V. of this proposed rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified into CMG 0104 (without comorbidities). The proposed 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 0.8382, 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 0.8683, and a teaching status adjustment of 0.0784.

To calculate each IRF's labor and non-labor portion of the proposed prospective payment, we begin by taking the unadjusted prospective payment rate for CMG 0104 (without comorbidities) from Table 10. Then, we multiply the proposed labor-related share for FY 2021 (72.9 percent) described in section V.C. of this proposed rule by the proposed unadjusted prospective payment rate. To determine the non-labor portion of the proposed prospective payment rate, we subtract the labor portion of the Federal payment from the proposed unadjusted prospective payment.

To compute the proposed wage-adjusted prospective payment, we multiply the labor portion of the proposed Federal payment by the appropriate wage index located in Tables A and B. These 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.*

The resulting figure is the wage-adjusted labor amount. Next, we compute the proposed wage-adjusted Federal payment by adding the wage-adjusted labor amount to the non-labor portion of the proposed Federal payment.

Adjusting the proposed 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	$27,989.61	$27,989.61
2	Labor Share	× 0.729	× 0.729
3	Labor Portion of Payment	= $20,404.43	= $20,404.43
4	CBSA-Based Wage Index (shown in the Addendum, Tables A and B)	× 0.8382	× 0.8683
5	Wage-Adjusted Amount	= $17,102.99	= $17,717.16
6	Non-Labor Amount	+ $7,585.18	+ $7,585.18
7	Wage-Adjusted Payment	= $24,688.17	= $25,302.35
8	Rural Adjustment	× 1.149	× 1.000
9	Wage- and Rural-Adjusted Payment	= $28,366.71	= $25,302.35
10	LIP Adjustment	× 1.0156	× 1.0454
11	Wage-, Rural- and LIP-Adjusted Payment	= $28,809.23	= $26,451.07
12	Wage-and Rural-Adjusted Payment	$28,366.71	$25,302.35
13	Teaching Status Adjustment	× 0	× 0.0784
14	Teaching Status Adjustment Amount	= $0.00	= $1,983.70
15	Wage-, Rural-, and LIP-Adjusted Payment	+ $28,809.23	+ $26,451.07
16	Total Adjusted Payment	= $28,809.23	= $28,434.78

Thus, the proposed adjusted payment for Facility A would be $28,809.23, and the adjusted payment for Facility B would be $28,434.78.

VI. Proposed Update to Payments for High-Cost Outliers Under the IRF PPS for FY 2021

A. Proposed 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 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 propose 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 propose 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 invite public comment on the proposed update to the FY 2021 outlier threshold amount to maintain estimated outlier payments at approximately 3 percent of total estimated IRF payments.

B. Proposed Update to the IRF Cost-to-Charge Ratio Ceiling and Urban/Rural Averages 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 proposed to apply a ceiling to IRFs' CCRs. Using the methodology described in that final rule, we propose to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 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 propose 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 propose 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 proposed 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 proposed rule, we estimate a national average CCR of 0.490 for rural IRFs, and a national average CCR of 0.400 for urban IRFs.

In accordance with past practice, we propose to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, we propose 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 would replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF). We calculated the proposed national CCR ceiling by:

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

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

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

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

We are also proposing that if more recent data become available after the publication of this proposed rule and before the publication of the final rule, we would use such data to determine the FY 2021 national average rural and urban CCRs and the national CCR ceiling in the final rule.

We invite public comment on the proposed update to the IRF CCR ceiling

and the urban/rural averages for FY 2021.

VII. Proposed 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. [Medicare Administrative Contractors (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 improving quality of care for patients.

Therefore, we are proposing 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 are proposing 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.

In the April 6, 2020 IFC, to address the public health emergency for the COVID–19 pandemic, we finalized removal of the post-admission physician evaluation requirement at § 412.622(a)(4)(ii) only for the duration of the public health emergency for the COVID–19 pandemic. In this proposed rule, we are proposing to remove the requirement at § 412.622(a)(4)(ii) permanently, beginning in FY 2021.

We note that our proposal would not preclude an IRF patient from being evaluated by a rehabilitation physician or, if the proposed policy changes in section XI. of this proposed rule are finalized, non-physician practitioners within the first 24 hours of admission if the IRF believes that the patient's condition warrants such an evaluation. We are simply proposing that a post-admission physician evaluation would no longer be an IRF documentation requirement. Nor would our proposal 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 this proposal does not attribute to any direct savings for Medicare Part-A or Part-B, we do believe that removing the post-admission physician evaluation would reduce administrative and paperwork burden for both IRF providers and MACs.

We invite public comment 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, and our proposed conforming amendments to § 412.622(a)(3)(iv) to remove the reference to § 412.622(a)(4)(ii). We anticipate that stakeholders' experience with the removal of this requirement during the public health emergency for the COVID–19 pandemic will help to inform whether removing this requirement permanently can reduce the paperwork burden for IRFs while maintaining quality of care for beneficiaries. We also invite public comment on rescinding the above-mentioned policy described in chapter 1, sections 110.1.2, of the Medicare Benefit Policy Manual.

VIII. Proposed 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 are proposing 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. We refer readers to section IX. of this proposed rule for a discussion of our proposal to amend the IRF coverage requirements to allow non-physician practitioners to perform certain requirements that are currently required to be performed by a rehabilitation physician.

We invite public comment 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.

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 are proposing 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 are proposing 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 are also proposing 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''.

We invite public comment on these proposals.

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

As noted in section VII. of this proposed 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 are seeking feedback from stakeholders about potentially removing some of the preadmission screening documentation requirements. Specifically, we would appreciate 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?

IX. Proposal To Allow Non-Physician Practitioners To Perform Certain IRF Coverage Requirements That Are Currently Required To Be Performed by a Rehabilitation Physician

Several of the IRF coverage requirements at § 412.622(a)(3), (4), and (5) expressly 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 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, as section 5(c) of the October 3, 2019, Executive Order 13890 on Protecting and Improving Medicare for Our Nation's Seniors (84 FR 53573) instructed that we do, we have decided to propose 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). We agree 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 believe 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 agree 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 believe 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 are proposing 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 are proposing 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 note 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.

This proposal does not preclude IRFs from making decisions regarding the role of rehabilitation physicians or non-physician practitioners. We are merely proposing 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 invite public comment on this proposal. Specifically, we invite commenters to comment on our analysis of this issue, and whether they have any other evidence to inform this analysis. We encourage commenters to share with us whether they believe that quality of care in IRFs will be impacted by this proposal, including any specific evidence that may help to inform this issue. We also request 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). This information will assist us in refining our estimates of the changes in Medicare payment that may result from this proposal.

X. 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 PROPOSED 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 (2.9 percent), reduced by 0.4 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	× 1.005
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	× 0.9999
Budget Neutrality Factor for the Revisions to the CMGs and CMG Relative Weights	× 0.9969
Adjusted FY 2021 Standard Payment Conversion Factor	= $16,518

XI. Collection of Information Requirements

As discussed in section VIII. of this proposed rule, we are proposing 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. 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 proposed rule, we are proposing to remove 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 proposing to amend § 412.622(a)(3)(iv) to remove the reference to § 412.622(a)(4)(ii). Additionally, we are making revisions to the requirements to allow non-physician practitioners to complete any of the IRF coverage requirements in § 412.622(a)(3), (4), and (5) that we currently require a rehabilitation physician to fulfill, provided that these duties are within the practitioner's scope of practice under applicable state law. We discuss any potential cost savings from this proposal in the Overall Impact section of this proposed rule.

XII. Response to Comments

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

XIII. Regulatory Impact Analysis

A. Statement of Need

This proposed rule would update 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 proposed rule would also implement 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 proposed rule would adopt policy changes under the statutory discretion afforded to the Secretary under section 1886(j) of the Act. We are proposing to adopt the most 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 proposing to amend the IRF coverage requirements to remove the post-admission physician evaluation requirement and codify existing documentation instructions and guidance. Additionally, consistent with section 5(c) of Executive Order 13890, we are proposing to amend the IRF coverage requirements to allow non-physician practitioners to perform certain requirements that are currently

required to be performed by a rehabilitation physician.

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.

We estimate the total impact of the policy updates described in this proposed rule by comparing the estimated payments in FY 2021 with those in FY 2020. This analysis results in an estimated $270 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 proposed rule on all IRFs is to increase estimated payments by approximately 2.9 percent. However, we find that certain categories of IRF providers would be expected to experience revenue impacts in the 3 to 5 percent range. We estimate a 3.2 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 3.6 percent overall impact for teaching IRFs with resident to average daily census ratio of 10 to 19 percent, and a 3.3 percent overall impact for teaching IRFs with a resident to average daily census ratio greater than 19 percent. Also, we estimate a 3.4 percent overall impact for IRFs with a DSH patient percentage of 0 percent and a 3.2 percent overall impact for IRFs with a DSH patient percentage greater than 20 percent. As a result, we anticipate this proposed rule would 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 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table 13, we estimate that the net revenue impact of this proposed rule on rural IRFs is to increase estimated payments by approximately 3.2 percent based on the data of the 132 rural units and 11 rural hospitals in our database of 1,117 IRFs for which data were available. We estimate an overall impact for rural IRFs in all areas except Rural New England, Rural South Atlantic, and Rural East South Central of between 3.2 percent and 4.8 percent. As a result, we anticipate this proposed 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 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 proposed 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 proposed 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.''

This proposed rule, if finalized as proposed, is expected to be a deregulatory action for the purposes of Executive Order 13771.

2. Detailed Economic Analysis

This proposed rule would update the IRF PPS rates contained in the FY 2020 IRF PPS final rule (84 FR 39054). Specifically, this proposed rule would update the CMG relative weights and average length of stay values, the wage index, and the outlier threshold for high-cost cases. This proposed rule would 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 includes proposals to adopt the most recent OMB statistical area delineations and apply a transition wage index under the IRF PPS. We are also proposing to amend the IRF coverage requirements to remove the post-admission physician evaluation requirement and codify existing documentation instructions and guidance. Additionally, consistent with section 5(c) of Executive Order 13890, we are proposing to amend the IRF coverage requirements to allow non-physician practitioners to perform certain requirements that are currently required to be performed by a rehabilitation physician.

We estimate that the impact of the changes and updates described in this proposed rule would be a net estimated increase of $270 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 X. of this proposed rule). The impact analysis in Table 13 of this proposed 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 proposing standard annual revisions described in this proposed 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 $270 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 $230 million. Furthermore, there is an additional estimated $40 million increase in aggregate payments to IRFs due to the proposed updated to the outlier threshold amount. Therefore, summed together, we estimate that these updates will result in a net increase in estimated payments of $270 million from FY 2020 to FY 2021.

The effects of the proposed updates that impact IRF PPS payment rates are shown in Table 13. The following proposed updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the proposed update to the outlier threshold amount, from approximately 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 proposed 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 proposed budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act.
- The effects of the proposed budget neutral changes to the wage index due to the OMB delineation revisions and the transition wage index policy.
- The effects of the proposed 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 1,117 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 974 IRFs located in urban areas included in our analysis. Among these, there are 683 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 113 government-owned IRFs. Among these, there are 92 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 proposed adjustment to the outlier threshold amount.
- Column (5) shows the estimated effect of the proposed update to the IRF labor-related share and wage index, in a budget-neutral manner.
- Column (6) shows the estimated effect of the proposed revisions to the CBSA delineations and the transition wage index, in a budget-neutral manner.
- Column (7) shows the estimated effect of the proposed 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 proposed rule for FY 2021 to our estimates of payments per discharge in FY 2020.

The average estimated increase for all IRFs is approximately 2.9 percent. This estimated net increase includes the effects of the proposed IRF market basket increase factor for FY 2021 of 2.9 percent, reduced by a productivity adjustment of 0.4 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 proposed 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 would be expected to affect the estimated distribution of payments among providers.

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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	1,117	409,232	0.4	0.0	0.0	0.0	2.9
Urban unit	683	160,590	0.7	0.0	0.0	0.0	3.3
Rural unit	132	20,608	0.7	0.1	0.0	0.0	3.4
Urban hospital	291	222,986	0.2	0.0	0.0	0.0	2.6
Rural hospital	11	5,048	0.0	0.2	-0.1	-0.1	2.5
Urban For-Profit	361	218,830	0.2	0.0	0.0	0.0	2.6
Rural For-Profit	33	8,454	0.3	0.2	0.0	0.0	2.9
Urban Non-Profit	521	143,397	0.7	0.0	0.0	0.0	3.2
Rural Non-Profit	89	14,078	0.7	0.1	0.0	0.0	3.4
Urban Government	92	21,349	0.7	-0.1	0.2	0.0	3.4
Rural Government	21	3,124	0.4	0.2	0.0	0.1	3.3
Urban	974	383,576	0.4	0.0	0.0	0.0	2.9
Rural	143	25,656	0.6	0.1	0.0	0.0	3.2
Urban by region							
Urban New England	29	16,062	0.4	-0.8	0.0	-0.1	2.0
Urban Middle Atlantic	132	48,621	0.5	0.2	-0.2	0.1	3.1
Urban South Atlantic	152	78,107	0.3	0.2	0.0	0.0	3.0
Urban East North Central	159	49,969	0.5	0.0	0.0	0.0	3.0
Urban East South Central	56	28,340	0.2	0.1	0.0	0.0	2.8
Urban West North Central	73	21,045	0.5	-0.5	0.0	0.0	2.3
Urban West South Central	188	85,097	0.3	0.2	0.1	0.1	3.1
Urban Mountain	87	30,531	0.4	-0.3	0.0	-0.1	2.5
Urban Pacific	98	25,804	0.8	-0.3	0.3	-0.1	3.3
Rural by region							
Rural New England	5	1,345	0.5	-0.4	0.0	-0.2	2.3
Rural Middle Atlantic	11	1,185	1.2	0.5	0.0	0.0	4.3
Rural South Atlantic	16	3,778	0.3	0.3	-0.2	0.0	2.9
Rural East North Central	23	4,034	0.6	0.5	0.1	0.0	3.6
Rural East South Central	21	4,404	0.4	0.0	0.0	-0.1	2.8
Rural West North Central	20	3,024	0.7	0.0	0.2	-0.1	3.3
Rural West South Central	39	6,965	0.4	0.0	0.1	0.1	3.2
Rural Mountain	5	559	1.2	-0.2	0.0	0.1	3.7
Rural Pacific	3	362	1.5	0.8	0.0	0.0	4.8
Teaching status							
Non-teaching	1,014	363,349	0.4	0.0	0.0	0.0	2.9
Resident to ADC less than 10%	59	32,695	0.5	-0.1	0.2	0.0	3.1
Resident to ADC 10%-19%	31	11,643	0.8	0.2	-0.1	0.1	3.6
Resident to ADC greater than 19%	13	1,545	0.4	0.0	0.2	0.1	3.3
Disproportionate share patient percentage (DSH PP)							
DSH PP = 0%	35	7,558	0.5	0.5	-0.1	0.0	3.4
DSH PP <5%	144	58,952	0.4	0.3	-0.3	0.0	2.8
DSH PP 5%-10%	294	129,346	0.4	0.1	-0.1	0.0	2.9
DSH PP 10%-20%	395	144,151	0.4	-0.1	0.1	0.0	2.8
DSH PP greater than 20%	249	69,225	0.6	-0.1	0.1	0.0	3.2

[1]This column includes the impact of the updates in columns (4), (5), (6), and (7) above, and of the IRF market basket increase factor for FY 2021 (2.9 percent), reduced by 0.4 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

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

The estimated effects of the proposed update to the outlier threshold adjustment are presented in column 4 of Table 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 would equal 3 percent of total estimated payments for FY 2020.

For this proposed rule, we are using 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. Thus, we propose to adjust the outlier threshold amount in this proposed 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 proposed 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 Proposed Wage Index and Labor-Related Share

In column 5 of Table 13, we present the effects of the proposed budget-neutral update of the wage index and labor-related share. The proposed changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related share portion of payments, so the proposed changes in the two have a combined effect on payments to providers. As discussed in section V.C. of this proposed rule, we are proposing to update the labor-related share from 72.7 percent in FY 2020 to 72.9 percent in FY 2021.

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

In column 6 of Table 13, we present the effects of the proposed budget-neutral update of the geographic labor-market area designations under the IRF PPS and the proposed 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 V.D.2. of this proposed rule, we are proposing to implement 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 V.D.3. of this proposed rule, we are proposing to apply 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 proposal to adopt the revised OMB delineations under the IRF PPS.

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

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

8. Effects of the Proposal To Remove the Post-Admission Physician Evaluation

As discussed in section VII. of this proposed rule, we are proposing to remove § 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 proposal to remove the post-admission physician evaluation, as discussed in section VII. of this proposed rule. While we are proposing to remove the post-admission physician requirement at § 412.622(a)(4)(ii), we are not proposing to remove any of the required rehabilitation physician face-to-face visits in § 412.622(a)(3)(iv). Thus, the rehabilitation physician or, if the proposed policy changes in section XI. of this proposed rule are finalized, non-physician practitioners would 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 the proposal 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 proposal.

9. Effects of the Proposal To Allow Non-Physician Practitioners To Perform Certain IRF Coverage Requirements That Are Currently Required To Be Performed by a Rehabilitation Physician

As discussed in section IX. of this proposed rule, we are proposing to allow non-physician practitioners to perform any of 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. While we do not know how many states will allow for this flexibility, we would appreciate information from commenters that would help us analyze the impact of this provision for the final rule. We believe this proposal represents a significant decrease in administrative burden to rehabilitation physicians and providers beginning in FY 2021, that is, all IRF discharges on or after October 1, 2020. We estimate the cost savings associated with this proposed change in the following way.

These requirements must currently be fulfilled by a rehabilitation physician; therefore, to estimate the burden reduction of these proposed 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*) to be $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 IX. of this proposed 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 the Executive Order 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 pre-admission screening documentation review and compliance requirement at § 412.622(a)(3) takes approximately 10 minutes to complete. In FY 2019, we estimate that there were approximately 1,117 total IRFs and on average 366 discharges per IRF annually. Therefore, there were an estimated seven patients (366 discharges/52 weeks) at the IRF per week. Per IRF, the rehabilitation physician spends 61 hours (10 minutes × 366 discharges/60 minutes) annually reviewing and concurring with the pre-admission screening. Allowing a non-physician practitioner to complete the review and concurrence of the pre-admission screening, we estimate a reduction of 68,137 hours for rehabilitation physicians across all IRFs annually (1,117 IRFs × 61 hours).

To estimate the total cost savings per IRF annually, assuming the IRF was able and wanted to take maximum use of this regulatory provision, we multiply 61 hours by $200.00 (average physician's salary doubled to account for fringe and overhead costs) which equals $12,200. We then multiply 61 hours by $107.00 (average non-physician practitioners salary doubled to account for fringe and overhead costs) which equals $6,527. We then subtract the non-physician practitioners total cost from the rehabilitation physicians total cost to get an estimated total cost savings per IRF of $5,673 annually. Therefore, we can estimate the total cost savings across all IRFs annually for non-physician practitioners to complete the pre-admission screening would be $6 million ($5,673 × 1,117).

Next we estimate that the development of the patient's plan of care requirement at § 412.622(a)(4)(iii) takes approximately 1 hour to complete. The rehabilitation physician spends 366 hours (1 hour × 366 discharges)

annually per IRF developing plans of care. Allowing a non-physician practitioner to complete the plan of care for each patient, we estimate a reduction of 408,822 hours for rehabilitation physicians across all IRFs annually (1,117 IRFs × 366 hours).

To estimate the total cost savings per IRF annually, assuming the IRF was able and wanted to take maximum use of this regulatory provision, we multiply 366 hours by $200.00 (average physician's salary doubled to account for fringe and overhead costs) which equals $73,200. We then multiply 366 hours by $107.00 (average non-physician practitioners salary doubled to account for fringe and overhead costs) which equals $39,162. The total estimated cost savings per IRF is $34,038 ($73,200 − $39,162). Therefore, we can estimate the total cost savings across all IRFs annually for non-physician practitioners to develop each patient's plan of care would be $38 million ($34,038 × 1,117).

Lastly, we estimate that during the interdisciplinary team meeting requirement at § 412.622(a)(5) that is led by the rehabilitation physician weekly, each patient is discussed for an estimated 15 minutes. The average length of stay of an IRF patient is 14 days; therefore, each patient will be discussed at the interdisciplinary teaming meeting for an estimated total of 30 minutes. The rehabilitation physician spends 183 hours (30 minutes × 366 discharges/60 minutes) annually discussing IRF patients at the interdisciplinary team meeting. Allowing a non-physician practitioner to lead the interdisciplinary team meeting, we estimate a reduction of 204,441 hours for rehabilitation physicians across all IRFs annually (1,117 IRFs × 183 hours).

To estimate the total cost savings per IRF annually, assuming the IRF was able and wanted to take maximum use 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 lead the interdisciplinary team meeting would be $19 million ($17,019 × 1,117).

We estimate that the overall cost savings per IRF annually assuming the IRF was able and wanted to take maximum use of this regulatory provision, for a non-physician practitioner to fulfill the requirements of the rehabilitation physician to be $56,730 ($5,673 + $34,038 + 17,019). Therefore, the estimated total cost savings across all IRFs annually for allowing non-physician practitioners to fulfill the requirements of the rehabilitation physician in an IRF setting is $63 million.

Please note that the $63 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 the requirements at § 412.622(a)(3), (4), and (5) the overall savings to Medicare Part B would be $51 million. However, we do not believe that IRFs will adopt this proposed change for all of the services they provide. We are estimating that IRFs will adopt this proposed change for about 50 percent of the services provided (and request comment that would allow for refinement of this estimate). Therefore, we estimate that the overall savings to the Medicare Trust Fund for allowing non-physician practitioners to fulfill the rehabilitation requirements at § 412.622(a)(3), (4), and (5) would be $25.5 million.

We have also estimated the impacts of this proposed 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 post-admission physician evaluation and 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. The interdisciplinary team meeting is not payable separately which means that the payments to physicians for their time spent conducting the interdisciplinary team meeting are already bundled and included with an existing service.

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 and national pricing for the post-admission physician evaluation in a facility are 99221 ($103.94), 99222 ($140.39), or 99223 ($206.07). For the sake of this estimation, we have used an average of these 3 codes. Therefore, we estimate that the average national pricing which is a standard reference payment amount for physicians without geographic adjustment for the post-admission physician evaluation in a facility is $150.13. Similarly, 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. Since the physician is required to conduct at a minimum of 3 face-to-face visits per the requirement at § 412.622(a)(3)(iv) the estimated total for 3 face-to-face visits is $219.78.

Therefore, we estimate that physicians are currently billing $369.91 per IRF patient for the post-admission physician evaluation and the minimum of 3 face-to-face visits currently required to be fulfilled by a physician. 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 $151 million for these services.

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 would bill $120.10 for the post-admission physician evaluation and an estimated $58.61 per face-to-face visit (a minimum of 3 visits would be $175.82). Per IRF patient the non-physician practitioner would bill an estimated $295.92. Therefore, we estimate that on average each year a non-physician practitioner

would bill $121 million for these services.

We estimate that if 100 percent of IRFs allowed non-physician practitioners to fulfill the requirements at § 412.622(a)(3), (4), and (5) the overall savings to Medicare Part B would be $31 million. However, we do not believe that IRFs will adopt this proposed change for all of the services they provide. We are estimating that IRFs will adopt this proposed change for about 50 percent of the services provided. To obtain more information on which to base our estimates, we are soliciting 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.

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 physicians under this proposed policy, we are assuming that IRFs would adopt this proposal for about 50 percent of the requirements. Thus, the estimated overall savings to Medicare Part B would be $15.5 million. We are estimating that 80 percent of that would remain in the Medicare Trust Fund and 20 percent would be a savings to beneficiaries. Therefore, we estimate $12.4 million in savings to the Medicare program and $3.1 million in savings to beneficiaries.

D. Alternatives Considered

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

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

As noted previously in this proposed rule, section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a productivity adjustment to the market basket increase factor for FY 2021. Thus, in accordance with section 1886(j)(3)(C) of the Act, we propose to update the IRF prospective payments in this proposed rule by 2.5 percent (which equals the 2.9 percent estimated IRF market basket increase factor for FY 2021 reduced by a 0.4 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 propose to update the CMG relative weights and average length of stay values at this time to ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs.

We considered 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 would 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 proposed revisions to the OMB delineations as described in section V.D. of this proposed rule. However, this would not provide any time for IRF providers to adapt to their new wage index values. Thus, we believe that it would be 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 proposed 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 V.D. of this proposed rule, we believe that using the most current OMB delineations would increase the integrity of the IRF PPS wage index by creating a more accurate representation of geographic variation in wage levels. As such, we believe it would 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 proposed 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 propose adjusting the outlier threshold amount in this proposed 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.

We considered not amending § 412.622(a)(3), (4), and (5) to allow non-physician practitioners to complete any of the IRF coverage requirements that we currently require a rehabilitation physician to fulfill. However, the non-physician practitioner groups stated that

they have the necessary education and are qualified to provide the same level of care currently being provided to IRF patients by rehabilitation physicians. They also 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, they also stated that they have direct rehabilitation experience to provide quality of care and services to IRF patients, that non-physician practitioner educational programs include didactic and clinical experiences to prepare graduates for advanced clinical practice, and that current accreditation requirements and competency-based standards ensure that non-physician practitioners are equipped to provide safe, high level quality care.

Furthermore, we believe that allowing non-physician practitioners to practice to the full extent of their education, training, and scope of practice would 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. In addition, we believe that allowing the use of non-physician practitioners could reduce the rates of rehabilitation physician burn-out. We reviewed this information, as we were instructed to do by section 5(c) of Executive Order 13890, and we believe it is appropriate at this time to propose to allow non-physician practitioners to complete any of the IRF coverage requirements that we currently require a rehabilitation physician to fulfill.

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed 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 2020 IRF PPS proposed rule would be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule. It is possible that not all commenters reviewed the FY 2020 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 proposed rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed 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 $109.36 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 proposed rule. For each IRF that reviews the rule, the estimated cost is $218.72 (2 hours × $109.36). Therefore, we estimate that the total cost of reviewing this regulation is $274,931.04 ($218.72 × 1,257 reviewers).

F. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a004/a-4.pdf*), in Table 14, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 14 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the proposed updates presented in this proposed rule based on the data for 1,117 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	$270 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 removal of certain IRF coverage requirements.	Reduction of $15.5 million.

G. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2021 are projected to increase by 2.9 percent, compared with the estimated payments in FY 2020, as reflected in column 9 of Table 13.

IRF payments per discharge are estimated to increase by 2.9 percent in urban areas and 3.2 percent in rural areas, compared with estimated FY 2020 payments. Payments per discharge to rehabilitation units are estimated to increase 3.3 percent in urban areas and 3.4 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 2.6 percent in urban areas and increase 2.5 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the proposed policies in this proposed rule. The largest payment increase is estimated to be a 4.8 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 proposes to amend 42 CFR chapter IV as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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

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

■ 2. 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; and
■ e. By adding paragraph (d).

The revisions and addition read as follows:

§ 412.622 Basis of payment.

(a) * * *

(3) * * *

(ii) Generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy 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) 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).

(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); expected frequency and duration of treatment in the IRF; anticipated discharge destination; and anticipated post-discharge treatments.

* * * * *

(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.

(d) *Non-physician practitioners.* For purposes of this section, 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.

Dated: March 24, 2020.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 9, 2020.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2020–08359 Filed 4–16–20; 4:15 pm]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 64

[WC Docket Nos. 17–97, 20–67; FCC 20–42; FRS 16632]

Call Authentication Trust Anchor; Implementation of TRACED Act—Knowledge of Customers by Entities with Access to Numbering Resources

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, the Commission seeks comment on proposals to further efforts to promote caller ID authentication and implement Section 4 of the Pallone-Thune Telephone Robocall Abuse Criminal Enforcement and Deterrence (TRACED) Act. In addition, the Commission also seeks comment in this document on implementing section 6(a) of the TRACED Act, which concerns access to numbering resources. The Commission concurrently adopted a Report and Order mandating that all originating and terminating voice service providers implement the STIR/SHAKEN caller ID authentication framework in the internet Protocol (IP) portions of their networks by June 30, 2021.

DATES: Comments are due on or before May 15, 2020. Reply Comments are due on or before May 29, 2020.

ADDRESSES: Comments and reply comments may be filed using the Commission's Electronic Comment Filing System (ECFS). See Electronic Filing of Documents in Rulemaking Proceedings, 63 FR 24121 (1998). Interested parties may file comments or reply comments, identified by WC Docket Nos. 17–97, 20–67, by any of the following methods:

- *Electronic Filers:* Comments may be filed electronically using the internet by accessing the ECFS: *https://www.fcc.gov/ecfs/*
- *Paper Filers:* Parties who choose to file by paper must file an original and one copy of each filing.

Filings can be sent by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9050 Junction Drive, Annapolis Junction, MD 20701.
- U.S. Postal Service first-class, Express, and Priority mail must be