policies, and activities on minority populations and low-income populations in the United States. The EPA determined that this rule will not have disproportionately high and adverse human health or environmental effects on minority or low-income populations because it does not affect the level of protection provided to human health or the environment. The EPA has assessed the overall protectiveness of modifying the existing Mobile ODMDS against the criteria established pursuant to the MPRSA to ensure that any adverse impact to the environment will be mitigated to the greatest extent practicable.

List of Subjects in 40 CFR Part 228

Environmental protection, Water pollution control.

Authority: This action is issued under the authority of Section 102 of the Marine Protection, Research, and Sanctuaries Act, as amended, 33 U.S.C. 1401, 1411, 1412.

Dated: July 17, 2020.

Mary Walker,

Regional Administrator, Region 4.

For the reasons set out in the preamble, the EPA amends chapter I, title 40 of the Code of **Federal Register** as follows:

PART 228—CRITERIA FOR THE MANAGEMENT OF DISPOSAL SITES FOR OCEAN DUMPING

■ 1. The authority citation for Part 228 continues to read as follows:

Authority: 33 U.S.C. 1412 and 1418.

■ 2. Section 228.15 is amended by revising paragraphs (h)(14)(i) through (iii) and (vi) to read as follows:

§ 228.15 Dumping sites designated on a final basis.

* * * * *

(h) * * *

(14) * * *

(i) *Location:* Corner Coordinates (NAD 1983) 30° 13.0′ N, 88° 08.8′ W; 30° 09.6′ N, 88° 04.8′ W; 30° 08.5′ N, 88° 05.8′ W; 30° 08.5′ N, 88° 12.8′ W; 30° 12.4′ N, 88° 12.8′ W.

(ii) *Size:* Approximately 23.8 square nautical miles in size.

(iii) *Depth:* Ranges from 34 to 57 feet (10.4 to 17.4 meters).

* * * * *

(vi) *Restrictions:* (A) Disposal shall be limited to dredged material from the Mobile, Alabama area;

(B) Disposal shall be limited to dredged material determined to be suitable for ocean disposal according to 40 CFR 220–228;

(C) Transportation and Disposal shall be managed by the restrictions and requirements contained in the Site Management and Monitoring Plan (SMMP).;

(D) Monitoring of the site also shall be governed by the currently approved SMMP.

* * * * *

[FR Doc. 2020–15963 Filed 8–3–20; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 482

[CMS–1731–F and CMS–1744–F]

RIN 0938–AU07 and 0938–AU31

Medicare Program; FY 2021 Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) and Special Requirements for Psychiatric Hospitals for Fiscal Year Beginning October 1, 2020 (FY 2021)

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

ACTION: Final rule.

SUMMARY: This final rule updates the prospective payment rates, the outlier threshold, and the wage index for Medicare inpatient hospital services provided by Inpatient Psychiatric Facilities (IPF), which include psychiatric hospitals and excluded psychiatric units of an Inpatient Prospective Payment System hospital or critical access hospital. In addition, we are adopting more recent Office of Management and Budget statistical area delineations, and applying a 2-year transition for all providers negatively impacted by wage index changes. We are also removing the term licensed independent practitioner(s) from the regulations for psychiatric hospitals. On April 6, 2020, we published an interim final rule with comment period to implement this statutorily mandated change. This final rule responds to comments on the interim final rule regarding changes to the term licensed independent practitioner, finalizes the implementing regulation, and explains how the new procedure will be put into practice. These changes will be effective for IPF discharges beginning with the 2021 Fiscal Year (FY), which runs from October 1, 2020 through September 30, 2021 (FY 2021).

DATES: These regulations are effective on October 1, 2020.

FOR FURTHER INFORMATION CONTACT: The IPF Payment Policy mailbox at *IPFPaymentPolicy@cms.hhs.gov* for general information.

Mollie Knight, (410) 786–7948 or Bridget Dickensheets, (410) 786–8670, for information regarding the market basket update, or the labor-related share.

Theresa Bean, (410) 786–2287 or James Hardesty, (410) 786–2629, for information regarding the regulatory impact analysis.

CAPT Scott Cooper, USPHS, (410) 786–9496, for issues related to special requirements for psychiatric hospitals.

SUPPLEMENTARY INFORMATION:

Availability of Certain Tables Exclusively Through the Internet on the CMS Website

Addendum A to this final rule summarizes the FY 2021 IPF PPS payment rates, outlier threshold, cost of living adjustment factors for Alaska and Hawaii, national and upper limit cost-to-charge ratios, and adjustment factors. In addition, the B Addenda to this final rule shows the complete listing of International Classification of Diseases (ICD–10) Clinical Modification (CM) and Procedure Coding System codes underlying the Code First table, the FY 2021 IPF PPS comorbidity adjustment, and electroconvulsive therapy (ECT) procedure codes. The A and B Addenda are available online at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

Tables setting forth the FY 2021 Wage Index for Urban Areas Based on Core-Based Statistical Area (CBSA) Labor Market Areas and the FY 2021 Wage Index Based on CBSA Labor Market Areas for Rural Areas are available exclusively through the internet, on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/IPFPPS/WageIndex.html.*

I. Executive Summary

A. Purpose

This final rule updates the prospective payment rates, the outlier threshold, and the wage index for Medicare inpatient hospital services provided by Inpatient Psychiatric Facilities (IPFs) for discharges occurring during the Fiscal Year (FY) beginning October 1, 2020 through September 30, 2021. In addition, this final rule updates the IPF wage index, adopts more recent Office of Management and Budget (OMB) statistical area delineations, and applies a 2-year transition for all providers negatively impacted by wage index changes.

B. Waiver of the 60-Day Delayed Effective Date for the Final Rule

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

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

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

Due to CMS prioritizing efforts in support of containing and combatting the COVID–19 PHE, and devoting significant resources to that end, the work needed on the IPF PPS final rule was not completed in accordance with our usual schedule for this rulemaking, which aims for a publication date of at least 60 days before the start of the fiscal year to which it applies. The IPF PPS final rule is necessary to annually review and update the payment system, and it is critical to ensure that the payment policies for this payment system are effective on the first day of the fiscal year to which they are intended to apply. Therefore, due to CMS prioritizing efforts in support of containing and combatting the COVID–19 PHE, and devoting significant resources to that end, we are hereby waiving the 60-day delay in the effective date of the IPF PPS final rule; it would be contrary to the public interest for CMS to do otherwise. However, we are providing a 30-day delay in the effective date of the final rule in accord with section 5 U.S.C. 553(d) of the Administrative Procedure Act, which ordinarily requires a 30-day delay in the effective date of a final rule from the date of its public availability in the **Federal Register**, and section 1871(e)(1)(B)(i) of the Act, which generally prohibits a substantive rule from taking effect before the end of the 30-day period beginning on the date of its public availability.

C. Summary of the Major Provisions

1. Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS)

In this final rule we:

- Adjust the 2016-based IPF market basket update (2.2 percent) for economy-wide productivity (0 percentage point) as required by section 1886(s)(2)(A)(i) of the Social Security Act (the Act), resulting in a final IPF payment rate update of 2.2 percent for FY 2021.
- Made technical rate setting changes: The IPF PPS payment rates will be adjusted annually for inflation, as well as statutory and other policy factors. This rule updates:

++ The IPF PPS federal per diem base rate from $798.55 to $815.22.

++ The IPF PPS federal per diem base rate for providers who failed to report quality data to $799.27.

++ The Electroconvulsive therapy (ECT) payment per treatment from $343.79 to $350.97.

++ The ECT payment per treatment for providers who failed to report quality data to $344.10.

++ The labor-related share from 76.9 percent to 77.3 percent.

++ The wage index budget-neutrality factor to 0.9989.

++ The fixed dollar loss threshold amount from $14,960 to $14,630 to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF PPS payments.

- Adopt more recent OMB core-based statistical area (CBSA) delineations and apply a 2-year transition for all providers negatively impacted by wage index changes.

2. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

We did not propose any changes to the IPFQR Program for FY 2021 or subsequent years; therefore, we are not finalizing any changes to the IPFQR Program. However, we received a comment requesting that CMS except IPFs from reporting IPFQR data during July 1, 2020 to December 31, 2020 under the IPFQR Program's Extraordinary Circumstances Exception (ECE) policy. We also received many comments requesting that we add a patient experience of care measure to the IPFQR Program. We appreciate these comments but note that they fall outside the scope of this rulemaking. We are evaluating options for potentially proposing to adopt a patient experience of care measure into the IPFQR Program in the future.

D. Summary of Impacts

Provision description	Total transfers & cost reductions
FY 2021 IPF PPS payment update	The overall economic impact of this final rule is an estimated $95 million in increased payments to IPFs during FY 2021.

II. Background

A. Overview of the Legislative Requirements of the IPF PPS

Section 124 of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) required the establishment and implementation of an IPF PPS. Specifically, section 124 of the BBRA mandated that the Secretary of the Department of Health and Human Services (the Secretary) develop a per diem Prospective Payment System (PPS) for inpatient hospital services furnished in psychiatric hospitals and excluded psychiatric units including an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and excluded psychiatric units. ''Excluded psychiatric unit'' means a psychiatric unit in an inpatient prospective payment system (IPPS) hospital that is excluded from the IPPS, or a psychiatric unit in a Critical Access Hospital (CAH) that is excluded from the CAH payment system. These excluded psychiatric units will be paid under the IPF PPS.

Section 405(g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) extended the IPF PPS to psychiatric distinct part units of CAHs.

Sections 3401(f) and 10322 of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by section 10319(e) of that Act and by section 1105(d) of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (hereafter referred to jointly as ''the Affordable Care Act'') added subsection (s) to section 1886 of the Act.

Section 1886(s)(1) of the Act titled ''Reference to Establishment and Implementation of System,'' refers to section 124 of the BBRA, which relates to the establishment of the IPF PPS.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the rate year (RY) beginning in 2012 (that is, a RY that coincides with a FY) and each subsequent RY.

Section 1886(s)(2)(A)(ii) of the Act required the application of an ''other adjustment'' that reduced any update to an IPF PPS base rate by a percentage point amount specified in section 1886(s)(3) of the Act for the RY beginning in 2010 through the RY beginning in 2019. As noted in the FY 2020 IPF PPS final rule, for the RY beginning in 2019, section 1886(s)(3)(E) of the Act required that the other adjustment reduction be equal to 0.75 percentage point. FY 2021 is the first year since the enactment of section 1886(s)(2)(A)(ii) that the ''other adjustment'' does not apply.

Sections 1886(s)(4)(A) through (D) of the Act require that for RY 2014 and each subsequent RY, IPFs that fail to report required quality data with respect to such a RY will have their annual update to a standard federal rate for discharges reduced by 2.0 percentage points. This may result in an annual update being less than 0.0 for a RY, and may result in payment rates for the upcoming RY being less than such payment rates for the preceding RY. Any reduction for failure to report required quality data will apply only to the RY involved, and the Secretary will not take into account such reduction in computing the payment amount for a subsequent RY. More information about the specifics of the current Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program is available in the FY 2020 IPF PPS final rule (84 FR 38459 through 38468).

To implement and periodically update these provisions, we have published various proposed rules, final rules and notices in the **Federal Register**. For more information regarding these documents, see the Center for Medicare & Medicaid (CMS) website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html?redirect=/InpatientPsychFacilPPS/.*

B. Overview of the IPF PPS

The November 2004 IPF PPS final rule (69 FR 66922) established the IPF PPS, as required by section 124 of the BBRA and codified at 42 CFR part 412, subpart N. The November 2004 IPF PPS final rule set forth the federal per diem base rate for the implementation year (the 18-month period from January 1, 2005 through June 30, 2006), and provided payment for the inpatient operating and capital costs to IPFs for covered psychiatric services they furnish (that is, routine, ancillary, and capital costs, but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IPF PPS). Covered psychiatric services include services for which benefits are provided under the fee-for-service Part A (Hospital Insurance Program) of the Medicare program.

The IPF PPS established the federal per diem base rate for each patient day in an IPF derived from the national average daily routine operating, ancillary, and capital costs in IPFs in FY 2002. The average per diem cost was updated to the midpoint of the first year under the IPF PPS, standardized to account for the overall positive effects of the IPF PPS payment adjustments, and adjusted for budget-neutrality.

The federal per diem payment under the IPF PPS is comprised of the federal per diem base rate described previously and certain patient-and facility-level payment adjustments for characteristics that were found in the regression analysis to be associated with statistically significant per diem cost differences with statistical significance defined as p less than 0.05. A complete discussion of the regression analysis that established the IPF PPS adjustment factors can be found in the November 2004 IPF PPS final rule (69 FR 66933 through 66936).

The patient-level adjustments include age, Diagnosis-Related Group (DRG) assignment, and comorbidities; additionally, there are adjustments to reflect higher per diem costs at the beginning of a patient's IPF stay and lower costs for later days of the stay. Facility-level adjustments include adjustments for the IPF's wage index, rural location, teaching status, a cost-of-living adjustment for IPFs located in Alaska and Hawaii, and an adjustment for the presence of a qualifying emergency department (ED).

The IPF PPS provides additional payment policies for outlier cases, interrupted stays, and a per treatment payment for patients who undergo electroconvulsive therapy (ECT). During the IPF PPS mandatory 3-year transition period, stop-loss payments were also provided; however, since the transition ended as of January 1, 2008, these payments are no longer available.

C. Annual Requirements for Updating the IPF PPS

Section 124 of the BBRA did not specify an annual rate update strategy for the IPF PPS and was broadly written to give the Secretary discretion in establishing an update methodology. Therefore, in the November 2004 IPF PPS final rule, we implemented the IPF PPS using the following update strategy:

- Calculate the final federal per diem base rate to be budget-neutral for the 18-month period of January 1, 2005 through June 30, 2006.
- Use a July 1 through June 30 annual update cycle.
- Allow the IPF PPS first update to be effective for discharges on or after July 1, 2006 through June 30, 2007.

In RY 2012, we proposed and finalized switching the IPF PPS payment rate update from a RY that begins on July 1 and ends on June 30, to one that coincides with the federal FY that begins October 1 and ends on September 30. In order to transition from one timeframe to another, the RY 2012 IPF PPS covered a 15-month period from July 1, 2011 through September 30, 2012. Therefore, the IPF RY has been equivalent to the October 1 through September 30 federal FY since RY 2013. For further discussion of the 15-month market basket update for RY 2012 and changing the payment rate update period to coincide with a FY period, we refer readers to the RY 2012 IPF PPS proposed rule (76 FR 4998) and the RY 2012 IPF PPS final rule (76 FR 26432).

In November 2004, we implemented the IPF PPS in a final rule that published on November 15, 2004 in the **Federal Register** (69 FR 66922). In developing the IPF PPS, and to ensure that the IPF PPS is able to account adequately for each IPF's case-mix, we performed an extensive regression analysis of the relationship between the per diem costs and certain patient and facility characteristics to determine those characteristics associated with statistically significant cost differences on a per diem basis. That regression analysis is described in detail in our November 28, 2003 IPF proposed rule (68 FR 66923; 66928 through 66933) and our November 15, 2004 IPF final rule

(69 FR 66933 through 66960). For characteristics with statistically significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments.

In the November 15, 2004 final rule, we explained the reasons for delaying an update to the adjustment factors, derived from the regression analysis, including waiting until we have IPF PPS data that yields as much information as possible regarding the patient-level characteristics of the population that each IPF serves. We indicated that we did not intend to update the regression analysis and the patient-level and facility-level adjustments until we complete that analysis. Until that analysis is complete, we stated our intention to publish a notice in the **Federal Register** each spring to update the IPF PPS (69 FR 66966).

On May 6, 2011, we published a final rule in the **Federal Register** titled, ''Inpatient Psychiatric Facilities Prospective Payment System—Update for Rate Year Beginning July 1, 2011 (RY 2012)'' (76 FR 26432), which changed the payment rate update period to a RY that coincides with a FY update. Therefore, final rules are now published in the **Federal Register** in the summer to be effective on October 1. When proposing changes in IPF payment policy, a proposed rule will be issued in the spring, and the final rule in the summer to be effective on October 1. For a detailed list of updates to the IPF PPS, we refer readers to our regulations at 42 CFR 412.428.

The most recent IPF PPS annual update was published in a final rule on August 6, 2019 in the **Federal Register** titled, ''Medicare Program; FY 2020 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2019 (FY 2020)'' (84 FR 38424), which updated the IPF PPS payment rates for FY 2020. That final rule updated the IPF PPS federal per diem base rates that were published in the FY 2019 IPF PPS final rule (83 FR 38576) in accordance with our established policies.

III. Provisions of the FY 2021 IPF PPS Final Rule and Responses to Comments

On April 14, 2020, we published the FY 2021 IPF PPS proposed rule (85 FR 20625). We received 462 comments on the FY 2021 IPF PPS proposed rule from various stakeholders, including patients, providers, national organizations, and the Medicare Payment Advisory Commission (MedPAC). We received 6 comments on payment policy issues, and 456 comments that were outside of the scope of the proposed rule or focused on quality reporting.

A. Update to the FY 2021 Market Basket for the IPF PPS

1. Background

Originally, the input price index that was used to develop the IPF PPS was the ''Excluded Hospital with Capital'' market basket. This market basket was based on 1997 Medicare cost reports for Medicare participating inpatient rehabilitation facilities (IRFs), IPFs, long-term care hospitals (LTCHs), cancer hospitals, and children's hospitals. Although ''market basket'' technically describes the mix of goods and services used in providing health care at a given point in time, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies) derived from that market basket. Accordingly, the term market basket as used in this document, refers to an input price index.

Since the IPF PPS inception, the market basket used to update IPF PPS payments has been rebased and revised to reflect more recent data on IPF cost structures. We last rebased and revised the IPF market basket in the FY 2020 IPF PPS rule, where we adopted a 2016-based IPF market basket, using Medicare cost report data for both Medicare participating freestanding psychiatric hospitals and psychiatric units. We refer readers to the FY 2020 IPF PPS final rule for a detailed discussion of the 2016-based IPF PPS market basket and its development (84 FR 38426 through 38447). References to the historical market baskets used to update IPF PPS payments are listed in the FY 2016 IPF PPS final rule (80 FR 46656).

2. FY 2021 IPF Market Basket Update

For FY 2021 (beginning October 1, 2020 and ending September 30, 2021), we are finalizing our proposal to use an estimate of the 2016-based IPF market basket increase factor to update the IPF PPS base payment rate. Consistent with historical practice, we are finalizing the market basket update for the IPF PPS based on the most recent IHS Global Inc.'s (IGI) forecast. IGI is a nationally recognized economic and financial forecasting firm that contracts with the CMS to forecast the components of the market baskets and multifactor productivity (MFP).

In the FY 2021 IPF PPS proposed rule (85 FR 20628), we proposed a FY 2021 IPF market basket percentage increase of 3.0 percent based on IGI's fourth quarter 2019 forecast of the 2016-based IPF market basket with historical data through third quarter 2019. We also proposed that if more recent data subsequently became available (for example, a more recent estimate of the market basket and/or the MFP), we would use such data, if appropriate, to determine the FY 2021 market basket update and the MFP adjustment in the final rule.

For this final rule, based on IGI's second quarter 2020 forecast with historical data through the first quarter of 2020, the 2016-based IPF market basket percentage increase for FY 2021 is 2.2 percent. Therefore, we are finalizing the 2016-based IPF market basket percentage increase for FY 2021 of 2.2 percent. We note that the fourth quarter 2019 forecast used for the proposed market basket update was developed prior to the economic impacts of the COVID–19 pandemic. This lower update (2.2 percent) for FY 2021 relative to the proposed rule (3.0 percent) is primarily driven by slower anticipated compensation growth for both health-related and other occupations as labor markets are expected to be significantly impacted during the recession that started in February 2020 and throughout the anticipated recovery.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (a RY that coincides with a FY) and each subsequent RY. In the FY 2021 IPF PPS proposed rule (85 FR 20628), we proposed a MFP adjustment of 0.4 percentage point based on IGI's fourth quarter 2019 forecast. Based on the more recent data available for this FY 2021 IPF PPS final rule, the current estimate of the 10-year moving average growth of MFP for FY 2021 is projected to be -0.1 percentage point. This MFP estimate is based on the most recent macroeconomic outlook from IGI at the time of rulemaking (released June 2020) in order to reflect more current historical economic data. IGI produces monthly macroeconomic forecasts, which include projections of all of the economic series used to derive MFP. In contrast, IGI only produces forecasts of the more detailed price proxies used in the 2016-based IPF market basket on a quarterly basis. Therefore, IGI's second quarter 2020 forecast is the most recent forecast of the 2016-based IPF market basket increase factor.

We note that it has typically been our practice to base the projection of the market basket price proxies and MFP in the final rule on the second quarter IGI forecast. For this FY 2021 IPF PPS final rule, we are using the IGI June

macroeconomic forecast for MFP because it is a more recent forecast, and it is important to use more recent data during this period when economic trends, particularly employment and labor productivity, are notably uncertain because of the COVID–19 pandemic. Historically, the MFP adjustment based on the second quarter IGI forecast has been very similar to the MFP adjustment derived with IGI's June macroeconomic forecast. Substantial changes in the macroeconomic indicators in between monthly forecasts is atypical.

Given the unprecedented economic uncertainty as a result of the COVID–19 pandemic, the changes in the IGI macroeconomic series used to derive MFP between the second quarter 2020 IGI forecast and the IGI June 2020 macroeconomic forecast is significant. Therefore, we believe it is technically appropriate to use IGI's more recent June 2020 macroeconomic forecast to determine the MFP adjustment for the final rule as it reflects more recent historical data. For comparison purposes, the 10-year moving average growth of MFP for FY 2021 is projected to be −0.1 percentage point based on IGI's June 2020 macroeconomic forecast compared to a FY 2021 projected 10-year moving average growth of MFP of 0.7 percentage point based on IGI's second quarter 2020 forecast. Mechanically subtracting the negative 10-year moving average growth of MFP from the IPF market basket percentage increase using the data from the IGI June 2020 macroeconomic forecast would have resulted in a 0.1 percentage point increase in the FY 2021 IPF payment update percentage. However, under section 1886(s)(2)(A) of the Act, the Secretary is required to reduce (not increase) the IPF market basket percentage by changes in economy-wide productivity. Accordingly, we will be applying a 0.0 percentage point MFP adjustment to the IPF market basket percentage. Therefore, the final FY 2021 IPF PPS payment rate update is 2.2 percent. For more information on the productivity adjustment, we refer readers to the discussion in the FY 2016 IPF PPS final rule (80 FR 46675).

3. FY 2021 IPF Labor-Related Share

Due to variations in geographic wage levels and other labor-related costs, payment rates under the IPF PPS will continue to be adjusted by a geographic wage index, which will apply to the labor-related portion of the federal per diem base rate (hereafter referred to as the labor-related share).

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 will 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 IPF market basket, we are finalizing our proposal to continue to include in the labor-related share the sum of the relative importance of Wages and Salaries; Employee Benefits; Professional Fees: Labor-Related; Administrative and Facilities Support Services; Installation, Maintenance, and Repair; All Other: Labor-related Services; and a portion of the Capital-Related cost weight (46 percent) from the 2016-based IPF market basket. The relative importance reflects the different rates of price change for these cost categories between the base year (FY 2016) and FY 2021. For more information on the labor-related share cost weights and its calculation, we refer readers to the FY 2020 IPF PPS final rule (84 FR 38445 through 38447). Based on IGI's fourth quarter 2019 forecast of the 2016-based IPF market basket, we proposed a total labor-related share for FY 2021 of 77.2 percent (the sum of 74.1 percent for the operating costs and 3.1 percent for the labor-related share of Capital). As stated in the FY 2021 IPF PPS proposed rule (85 FR 20629), we also proposed that if more recent data become available, we would use such data, if appropriate, to determine the FY 2021 labor-related share for the final rule.

Comment: One commenter opposed the increase in the labor-related share from 76.9 percent to 77.2 percent stating it would negatively impact any facility with a wage index below 1.0. This commenter was concerned that the growing disparity in wage index values places facilities in low wage areas at a significant disadvantage, and this proposal would further increase that disparity. The commenter encouraged CMS to maintain the FY 2020 labor-related share in FY 2021.

Response: We appreciate the commenter's concern over the increase in the labor-related share; however, we believe it is technically appropriate to use the sum of the FY 2021 relative importance values for the labor-related cost categories based on the most recent forecast of the 2016-based IPF market basket in order to determine the labor-related share for FY 2021, as it accounts for more recent data regarding price pressures and cost structure of IPFs. Our policy to use the most recent market basket to determine the labor-related share is a policy we have consistently applied for the IPF PPS (such as for the FY 2020 IPF PPS final rule (84 FR 38446)) as well as for other PPSs, including, but not limited to, the IRF PPS (84 FR 39089) and the LTCH PPS (84 FR 42642).

Final Decision: After careful consideration of the comment, we are finalizing the use of the sum of the FY 2021 relative importance for the labor-related cost categories based on the most recent forecast (IGI's second quarter 2020 forecast) of the 2016-based IPF market basket.

Based on IGI's second quarter 2020 forecast of the 2016-based IPF 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 74.2 percent. The portion of Capital costs that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage applied to the 2012-based IPF market basket. Since the relative importance for Capital is 6.8 percent of the 2016-based IPF market basket in FY 2021, we took 46 percent of 6.8 percent to determine the labor-related share of Capital for FY 2021 of 3.1 percent. Therefore, we are finalizing a total labor-related share for FY 2021 of 77.3 percent (the sum of 74.2 percent for the operating costs and 3.1 percent for the labor-related share of Capital). Table 1 shows the FY 2021 labor-related share and the FY 2020 labor-related share using the relative importance of the 2016-based IPF market basket.

Table 1: FY 2021 IPF Labor-Related Share and FY 2020 IPF Labor-Related Share based on the 2016-based IPF Market Basket

	Relative importance, labor-related share, FY 2021 20:2 forecast[1]	Relative importance, labor-related share, FY 2020 19:2 forecast[2]
Wages and Salaries	52.9	52.5
Employee Benefits	13.6	13.6
Professional Fees: Labor-related[3]	4.3	4.3
Administrative and Facilities Support Services	0.6	0.6
Installation, Maintenance and Repair	1.3	1.3
All Other Labor-related Services	1.5	1.5
Capital-related (.46)	3.1	3.1
Total	77.3	76.9

1 IHS Global Inc. 2nd quarter 2020 forecast.
2 Based on IHS Global Inc. 2nd quarter 2019 forecast as published in the Federal Register (84 FR 38447).
3 Includes all contract advertising and marketing costs and a portion of accounting, architectural, engineering, legal, management consulting, and home office contract labor costs.

B. Updates to the IPF PPS Rates for FY Beginning October 1, 2020

The IPF PPS is based on a standardized federal per diem base rate calculated from the IPF average per diem costs and adjusted for budget-neutrality in the implementation year. The federal per diem base rate is used as the standard payment per day under the IPF PPS and is adjusted by the patient-level and facility-level adjustments that are applicable to the IPF stay. A detailed explanation of how we calculated the average per diem cost appears in the November 2004 IPF PPS final rule (69 FR 66926).

1. Determining the Standardized Budget-Neutral Federal Per Diem Base Rate

Section 124(a)(1) of the BBRA required that we implement the IPF PPS in a budget-neutral manner. In other words, the amount of total payments under the IPF PPS, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the IPF PPS were not implemented. Therefore, we calculated the budget-neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) methodology had the IPF PPS not been implemented. A step-by-step description of the methodology used to estimate payments under the TEFRA payment system appears in the November 2004 IPF PPS final rule (69 FR 66926).

Under the IPF PPS methodology, we calculated the final federal per diem base rate to be budget-neutral during the IPF PPS implementation period (that is, the 18-month period from January 1, 2005 through June 30, 2006) using a July 1 update cycle. We updated the average cost per day to the midpoint of the IPF PPS implementation period (October 1, 2005), and this amount was used in the payment model to establish the budget-neutrality adjustment.

Next, we standardized the IPF PPS federal per diem base rate to account for the overall positive effects of the IPF PPS payment adjustment factors by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. Information concerning this standardization can be found in the November 2004 IPF PPS final rule (69 FR 66932) and the RY 2006 IPF PPS final rule (71 FR 27045). We then reduced the standardized federal per diem base rate to account for the outlier policy, the stop loss provision, and anticipated behavioral changes. A complete discussion of how we calculated each component of the budget-neutrality adjustment appears in the November 2004 IPF PPS final rule (69 FR 66932 through 66933) and in the RY 2007 IPF PPS final rule (71 FR 27044 through 27046). The final standardized budget-neutral federal per diem base rate established for cost reporting periods beginning on or after January 1, 2005 was calculated to be $575.95.

The federal per diem base rate has been updated in accordance with applicable statutory requirements and § 412.428 through publication of annual notices or proposed and final rules. A detailed discussion on the standardized budget-neutral federal per diem base rate and the electroconvulsive therapy (ECT) payment per treatment appears in the FY 2014 IPF PPS update notice (78 FR 46738 through 46740). These documents are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html.*

IPFs must include a valid procedure code for ECT services provided to IPF beneficiaries in order to bill for ECT services, as described in our Medicare Claims Processing Manual, Chapter 3, Section 190.7.3 (available at *https://*

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf.) There were no changes to the ECT procedure codes used on IPF claims as a result of the proposed update to the ICD–10–PCS code set for FY 2021. Addendum B to this final rule shows the ECT procedure codes for FY 2021 and is available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

2. Update of the Federal Per Diem Base Rate and Electroconvulsive Therapy Payment Per Treatment

The current (FY 2020) federal per diem base rate is $798.55 and the ECT payment per treatment is $343.79. For the final FY 2021 federal per diem base rate, we applied the payment rate update of 2.2 percent that is, the 2016-based IPF market basket increase for FY 2021 of 2.2 percent less the productivity adjustment of 0 percentage point and the wage index budget-neutrality factor of 0.9989 (as discussed in section III.D.1 of this final rule) to the FY 2020 federal per diem base rate of $798.55, yielding a final federal per diem base rate of $815.22 for FY 2021. Similarly, we applied the 2.2 percent payment rate update and the 0.9989 wage index budget-neutrality factor to the FY 2020 ECT payment per treatment of $343.79, yielding a final ECT payment per treatment of $350.97 for FY 2021.

Section 1886(s)(4)(A)(i) of the Act requires that for RY 2014 and each subsequent RY, in the case of an IPF that fails to report required quality data with respect to such RY, the Secretary will reduce any annual update to a standard federal rate for discharges during the RY by 2.0 percentage points. Therefore, we are applying a 2.0 percentage point reduction to the federal per diem base rate and the ECT payment per treatment as follows:

- For IPFs that fail to meet IPFQR Program requirements, we applied a 0.2 percent payment rate update (that is, the IPF market basket increase for FY 2021 of 2.2 percent less the productivity adjustment of 0 percentage point for an update of 2.2 percent, and further reduced by 2 percentage points in accordance with section 1886(s)(4)(A)(i) of the Act), and the wage index budget-neutrality factor of 0.9989 to the FY 2020 federal per diem base rate of $798.55, yielding a federal per diem base rate of $799.27 for FY 2021.
- For IPFs that fail to meet IPFQR Program requirements, we applied the 0.2 percent annual payment rate update and the 0.9989 wage index budget-neutrality factor to the FY 2020 ECT payment per treatment of $343.79, yielding an ECT payment per treatment of $344.10 for FY 2021.

C. Updates to the IPF PPS Patient-Level Adjustment Factors

1. Overview of the IPF PPS Adjustment Factors

The IPF PPS payment adjustments were derived from a regression analysis of 100 percent of the FY 2002 Medicare Provider and Analysis Review (MedPAR) data file, which contained 483,038 cases. For a more detailed description of the data file used for the regression analysis, see the November 2004 IPF PPS final rule (69 FR 66935 through 66936). We continue to use the existing regression-derived adjustment factors established in 2005 for FY 2021. However, we have used more recent claims data to simulate payments to finalize the outlier fixed dollar loss threshold amount and to assess the impact of the IPF PPS updates.

2. IPF PPS Patient-Level Adjustments

The IPF PPS includes payment adjustments for the following patient-level characteristics: Medicare Severity Diagnosis Related Groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments.

a. Update to MS–DRG Assignment

We believe it is important to maintain for IPFs the same diagnostic coding and Diagnosis Related Group (DRG) classification used under the (IPPS) for providing psychiatric care. For this reason, when the IPF PPS was implemented for cost reporting periods beginning on or after January 1, 2005, we adopted the same diagnostic code set (ICD–9–CM) and DRG patient classification system (MS–DRGs) that were utilized at the time under the IPPS. In the RY 2009 IPF PPS notice (73 FR 25709), we discussed CMS' effort to better recognize resource use and the severity of illness among patients. CMS adopted the new MS–DRGs for the IPPS in the FY 2008 IPPS final rule with comment period (72 FR 47130). In the RY 2009 IPF PPS notice (73 FR 25716), we provided a crosswalk to reflect changes that were made under the IPF PPS to adopt the new MS–DRGs. For a detailed description of the mapping changes from the original DRG adjustment categories to the current MS–DRG adjustment categories, we refer readers to the RY 2009 IPF PPS notice (73 FR 25714).

The IPF PPS includes payment adjustments for designated psychiatric DRGs assigned to the claim based on the patient's principal diagnosis. The DRG adjustment factors were expressed relative to the most frequently reported psychiatric DRG in FY 2002, that is, DRG 430 (psychoses). The coefficient values and adjustment factors were derived from the regression analysis discussed in detail in the November 28, 2003 IPF proposed rule (68 FR 66923; 66928 through 66933) and the November 15, 2004 IPF final rule (69 FR 66933 through 66960). Mapping the DRGs to the MS–DRGs resulted in the current 17 IPF MS–DRGs, instead of the original 15 DRGs, for which the IPF PPS provides an adjustment. For FY 2021, we did not propose any changes to the IPF MS–DRG adjustment factors.

In the FY 2015 IPF PPS final rule published August 6, 2014 in the **Federal Register** titled, ''Inpatient Psychiatric Facilities Prospective Payment System—Update for FY Beginning October 1, 2014 (FY 2015)'' (79 FR 45945 through 45947), we finalized conversions of the ICD–9–CM-based MS–DRGs to ICD–10–CM/PCS-based MS–DRGs, which were implemented on October 1, 2015. Further information on the ICD–10–CM/PCS MS–DRG conversion project can be found on the CMS ICD–10–CM website at *https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html.*

For FY 2021, we are finalizing our proposal to continue to make the existing payment adjustment for psychiatric diagnoses that group to one of the existing 17 IPF MS–DRGs listed in Addendum A. Addendum A is available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.* Psychiatric principal diagnoses that do not group to one of the 17 designated MS–DRGs will still receive the federal per diem base rate and all other applicable adjustments, but the payment will not include an MS–DRG adjustment.

The diagnoses for each IPF MS–DRG will be updated as of October 1, 2020, using the final IPPS FY 2021 ICD–10–CM/PCS code sets. The FY 2021 IPPS final rule includes tables of the changes to the ICD–10–CM/PCS code sets, which underlie the FY 2021 IPF MS–DRGs. Both the FY 2021 IPPS final rule and the tables of changes to the ICD–10–CM/PCS code sets, which underlie the FY 2021 MS–DRGs are available on the IPPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.*

Code First

As discussed in the ICD–10–CM Official Guidelines for Coding and Reporting, certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD–10–CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a ''use additional code'' note at the etiology code, and a ''code first'' note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes (etiology followed by manifestation). In accordance with the ICD–10–CM Official Guidelines for Coding and Reporting, when a primary (psychiatric) diagnosis code has a ''code first,'' the provider would follow the instructions in the ICD–10–CM text. The submitted claim goes through the CMS processing system, which will identify the primary diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign a DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment.

For more information on the code first policy, we refer readers to the November 2004 IPF PPS final rule (69 FR 66945) and sections I.A.13 and I.B.7 of the FY 2020 ICD–10–CM Coding Guidelines, which is available at *https://www.cdc.gov/nchs/icd/data/10cmguidelines-FY2019-final.pdf.* In the FY 2015 IPF PPS final rule, we provided a code first table for reference that highlights the same or similar manifestation codes where the code first instructions apply in ICD–10–CM that were present in ICD–9–CM (79 FR 46009). In FY 2018, FY 2019 and FY 2020, there were no changes to the final ICD–10–CM/PCS codes in the IPF Code First table. For FY 2021, there were 18 ICD–10–PCS codes deleted from the final IPF Code First table. The final FY 2021 Code First table is shown in Addendum B on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

b. Payment for Comorbid Conditions

The intent of the comorbidity adjustments is to recognize the increased costs associated with comorbid conditions by providing additional payments for certain existing medical or psychiatric conditions that are expensive to treat. In our RY 2012 IPF PPS final rule (76 FR 26451 through 26452), we explained that the IPF PPS includes 17 comorbidity categories and identified the new, revised, and deleted ICD–9–CM diagnosis codes that generate a comorbid condition payment adjustment under the IPF PPS for RY 2012 (76 FR 26451).

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, length of stay (LOS), or both treatment and LOS.

For each claim, an IPF may receive only one comorbidity adjustment within a comorbidity category, but it may receive an adjustment for more than one comorbidity category. Current billing instructions for discharge claims, on or after October 1, 2015, require IPFs to enter the complete ICD–10–CM codes for up to 24 additional diagnoses if they co-exist at the time of admission, or develop subsequently and impact the treatment provided.

The comorbidity adjustments were determined based on the regression analysis using the diagnoses reported by IPFs in FY 2002. The principal diagnoses were used to establish the DRG adjustments and were not accounted for in establishing the comorbidity category adjustments, except where ICD–9–CM code first instructions applied. In a code first situation, the submitted claim goes through the CMS processing system, which will identify the principal diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign an MS–DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment.

As noted previously, it is our policy to maintain the same diagnostic coding set for IPFs that is used under the IPPS for providing the same psychiatric care. The 17 comorbidity categories formerly defined using ICD–9–CM codes were converted to ICD–10–CM/PCS in our FY 2015 IPF PPS final rule (79 FR 45947 through 45955). The goal for converting the comorbidity categories is referred to as replication, meaning that the payment adjustment for a given patient encounter is the same after ICD–10–CM implementation as it would be if the same record had been coded in ICD–9–CM and submitted prior to ICD–10–CM/PCS implementation on October 1, 2015. All conversion efforts were made with the intent of achieving this goal. For FY 2021, we are finalizing our proposal to continue to use the same comorbidity adjustment factors in effect in FY 2020, which are found in Addendum A and available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

We have updated the ICD–10–CM/PCS codes which are associated with the existing IPF PPS comorbidity categories, based upon the final FY 2021 update to the ICD–10–CM/PCS code set. The final FY 2021 ICD–10–CM/PCS updates include 12 ICD10–CM diagnosis codes added to the Poisoning comorbidity category and 223 ICD–10–PCS codes added to the Oncology Procedures comorbidity category. In addition, 4 ICD10–PCS codes were deleted from the Poisoning comorbidity category. These updates are detailed in Addenda B–2 and B–3 of this final rule, which are available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/InpatientPsychFacilPPS/tools.html.*

In accordance with the policy established in the FY 2015 IPF PPS final rule (79 FR 45949 through 45952), we reviewed all new FY 2021 ICD–10–CM codes to remove codes that were site ''unspecified'' in terms of laterality from the FY 2020 ICD–10–CM/PCS codes in instances where more specific codes are available. As we stated in the FY 2015 IPF PPS final rule, we believe that specific diagnosis codes that narrowly identify anatomical sites where disease, injury, or a condition exists should be used when coding patients' diagnoses whenever these codes are available. We finalized in the FY 2015 IPF PPS rule, that we would remove site ''unspecified'' codes from the IPF PPS ICD–10–CM/PCS codes in instances when laterality codes (site specified codes) are available, as the clinician should be able to identify a more specific diagnosis based on clinical assessment at the medical encounter. We note that none of the final additions to the FY 2021 ICD–10–CM/PCS codes were site ''unspecified'' by laterality; therefore, we are not removing any of the new codes.

c. Patient Age Adjustments

As explained in the November 2004 IPF PPS final rule (69 FR 66922), we analyzed the impact of age on per diem cost by examining the age variable (range of ages) for payment adjustments. In general, we found that the cost per day increases with age. The older age groups are costlier than the under 45 age

group, the differences in per diem cost increase for each successive age group, and the differences are statistically significant. For FY 2021, we are finalizing our proposal to continue to use the patient age adjustments currently in effect in FY 2020, as shown in Addendum A of this rule (see *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html*).

d. Variable Per Diem Adjustments

We explained in the November 2004 IPF PPS final rule (69 FR 66946) that the regression analysis indicated that per diem cost declines as the LOS increases. The variable per diem adjustments to the federal per diem base rate account for ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF. As discussed in the November 2004 IPF PPS final rule, we used a regression analysis to estimate the average differences in per diem cost among stays of different lengths (69 FR 66947 through 66950). As a result of this analysis, we established variable per diem adjustments that begin on day 1 and decline gradually until day 21 of a patient's stay. For day 22 and thereafter, the variable per diem adjustment remains the same each day for the remainder of the stay. However, the adjustment applied to day 1 depends upon whether the IPF has a qualifying ED. If an IPF has a qualifying ED, it receives a 1.31 adjustment factor for day 1 of each stay. If an IPF does not have a qualifying ED, it receives a 1.19 adjustment factor for day 1 of the stay. The ED adjustment is explained in more detail in section III.D.4 of this rule.

For FY 2021, we are finalizing our proposal to continue to use the variable per diem adjustment factors currently in effect, as shown in Addendum A of this rule (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html*). A complete discussion of the variable per diem adjustments appears in the November 2004 IPF PPS final rule (69 FR 66946).

D. Updates to the IPF PPS Facility-Level Adjustments

The IPF PPS includes facility-level adjustments for the wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED.

1. Wage Index Adjustment

a. Background

As discussed in the RY 2007 IPF PPS final rule (71 FR 27061), RY 2009 IPF PPS (73 FR 25719) and the RY 2010 IPF PPS notices (74 FR 20373), in order to provide an adjustment for geographic wage levels, the labor-related portion of an IPF's payment is adjusted using an appropriate wage index. Currently, an IPF's geographic wage index value is determined based on the actual location of the IPF in an urban or rural area, as defined in § 412.64(b)(1)(ii)(A) and (C).

Due to the variation in costs and because of the differences in geographic wage levels, in the November 15, 2004 IPF PPS final rule, we required that payment rates under the IPF PPS be adjusted by a geographic wage index. We proposed and finalized a policy to use the unadjusted, pre-floor, pre-reclassified IPPS hospital wage index to account for geographic differences in IPF labor costs. We implemented use of the pre-floor, pre-reclassified IPPS hospital wage data to compute the IPF wage index since there was not an IPF-specific wage index available. We believe that IPFs generally compete in the same labor market as IPPS hospitals so the pre-floor, pre-reclassified IPPS hospital wage data should be reflective of labor costs of IPFs. We believe this pre-floor, pre-reclassified IPPS hospital wage index to be the best available data to use as proxy for an IPF specific wage index. As discussed in the RY 2007 IPF PPS final rule (71 FR 27061 through 27067), under the IPF PPS, the wage index is calculated using the IPPS wage index for the labor market area in which the IPF is located, without taking into account geographic reclassifications, floors, and other adjustments made to the wage index under the IPPS. For a complete description of these IPPS wage index adjustments, we refer readers to the FY 2019 IPPS/LTCH PPS final rule (83 FR 41362 through 41390). Our wage index policy at § 412.424(a)(2), requires us to use the best Medicare data available to estimate costs per day, including an appropriate wage index to adjust for wage differences.

When the IPF PPS was implemented in the November 15, 2004 IPF PPS final rule, with an effective date of January 1, 2005, the pre-floor, pre-reclassified IPPS hospital wage index that was available at the time was the FY 2005 pre-floor, pre-reclassified IPPS hospital wage index. Historically, the IPF wage index for a given RY has used the pre-floor, pre-reclassified IPPS hospital wage index from the prior FY as its basis. This has been due in part to the pre-floor, pre-reclassified IPPS hospital wage index data that were available during the IPF rulemaking cycle, where an annual IPF notice or IPF final rule was usually published in early May. This publication timeframe was relatively early compared to other Medicare payment rules because the IPF PPS follows a RY, which was defined in the implementation of the IPF PPS as the 12-month period from July 1 to June 30 (69 FR 66927). Therefore, the best available data at the time the IPF PPS was implemented was the pre-floor, pre-reclassified IPPS hospital wage index from the prior FY (for example, the RY 2006 IPF wage index was based on the FY 2005 pre-floor, pre-reclassified IPPS hospital wage index).

In the RY 2012 IPF PPS final rule, we changed the reporting year timeframe for IPFs from a RY to the FY, which begins October 1 and ends September 30 (76 FR 26434 through 26435). In that FY 2012 IPF PPS final rule, we continued our established policy of using the pre-floor, pre-reclassified IPPS hospital wage index from the prior year (that is, from FY 2011) as the basis for the FY 2012 IPF wage index. This policy of basing a wage index on the prior year's pre-floor, pre-reclassified IPPS hospital wage index has been followed by other Medicare payment systems, such as hospice and IRF. By continuing with our established policy, we remained consistent with other Medicare payment systems.

In FY 2020, we finalized the IPF wage index methodology to align the IPF PPS wage index with the same wage data timeframe used by the IPPS for FY 2020 and subsequent years. Specifically, we finalized to use the pre-floor, pre-reclassified IPPS hospital wage index from the FY concurrent with the IPF FY as the basis for the IPF wage index. For example, the FY 2020 IPF wage index would be based on the FY 2020 pre-floor, pre-reclassified IPPS hospital wage index rather than on the FY 2019 pre-floor, pre-reclassified IPPS hospital wage index.

We explained in the FY 2020 proposed rule (84 FR 16973), that using the concurrent pre-floor, pre-reclassified IPPS hospital wage index would result in the most up-to-date wage data being the basis for the IPF wage index. In addition, it would result in more consistency and parity in the wage index methodology used by other Medicare payment systems. The Medicare SNF PPS already used the concurrent IPPS hospital wage index data as the basis for the SNF PPS wage index. Thus, the wage adjusted Medicare payments of various provider types would be based upon wage index data from the same timeframe. CMS proposed similar policies to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index data in other Medicare payment systems, such as hospice facilities and IRFs. For FY 2021,

we proposed to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index.

Comment: We received two comments agreeing with our longstanding belief that IPFs generally compete in the same labor market as IPPS hospitals; however, the commenters recommend that CMS incorporate a frontier state floor for the IPF wage index. In addition, we received a comment encouraging CMS to consider developing, as an alternative to the current hospital wage index, a market-level wage index that would use wage data from all employers and industry-specific occupational weights, adjust for geographic differences in the ratio of benefits to wages, adjust at the county level and smooth large differences between counties, and include a transition period to mitigate large changes in wage index values.

Response: We appreciate these commenters' suggestions regarding opportunities to improve the accuracy of the IPF wage index. We did not propose the specific policies suggested by commenters, but we will take them into consideration to potentially inform future rulemaking.

Final Decision: For FY 2021, we are finalizing our proposal to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index.

We will apply the IPF wage index adjustment to the labor-related share of the national base rate and ECT payment per treatment. The labor-related share of the national rate and ECT payment per treatment will change from 76.9 percent in FY 2020 to 77.3 percent in FY 2021. This percentage reflects the labor-related share of the 2016-based IPF market basket for FY 2021 (see section III.A of this rule).

b. Office of Management and Budget (OMB) Bulletins

(i) Background

The wage index used for the IPF PPS is calculated using the unadjusted, pre-reclassified and pre-floor inpatient PPS (IPPS) wage index data and is assigned to the IPF on the basis of the labor market area in which the IPF is geographically located. IPF labor market areas are delineated based on the CBSAs established by the OMB.

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 through OMB Bulletins. These bulletins contain information regarding CBSA changes, including changes to CBSA numbers and titles. OMB bulletins may be accessed online at *https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.* In accordance with our established methodology, the IPF PPS has historically adopted any CBSA changes that are published in the OMB bulletin that corresponds with the IPPS hospital wage index used to determine the IPF wage index.

In the RY 2007 IPF PPS final rule (71 FR 27061 through 27067), we adopted the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for Metropolitan Statistical Areas and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. In adopting the OMB CBSA geographic designations in RY 2007, we did not provide a separate transition for the CBSA-based wage index since the IPF PPS was already in a transition period from TEFRA payments to PPS payments.

In the RY 2009 IPF PPS notice, we incorporated the CBSA nomenclature changes published in the most recent OMB bulletin that applied to the IPPS hospital wage index used to determine the current IPF wage index and stated that we expected to continue to do the same for all the OMB CBSA nomenclature changes in future IPF PPS rules and notices, as necessary (73 FR 25721).

On February 28, 2013, OMB issued OMB Bulletin No. 13–01, which established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas 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). These OMB Bulletin changes were reflected in the FY 2015 pre-floor, pre-reclassified IPPS hospital wage index, upon which the FY 2016 IPF wage index was based. We adopted these new OMB CBSA delineations in the FY 2016 IPF wage index and subsequent IPF wage indexes. We refer readers to the FY 2016 IPF PPS final rule (80 FR 46682 through 46689) for a full discussion of our implementation of the OMB labor market area delineations beginning with the FY 2016 wage index.

On July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provided updates to and superseded OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provided detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 were 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. The complete list of statistical areas incorporating these changes is provided in OMB Bulletin No. 15–01. A copy of this bulletin may be obtained at *https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.*

OMB Bulletin No. 15–01 established revised delineations for the Nation's Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas. The bulletin also provided delineations of Metropolitan Divisions as well as delineations of New England City and Town Areas. As discussed in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56913), the updated labor market area definitions from OMB Bulletin 15–01 were implemented under the IPPS beginning on October 1, 2016 (FY 2017). Therefore, we implemented these revisions for the IPF PPS beginning October 1, 2017 (FY 2018), consistent with our historical practice of modeling IPF PPS adoption of the labor market area delineations after IPPS adoption of these delineations (historically the IPF wage index has been based upon the pre-floor, pre-reclassified IPPS hospital wage index from the prior year).

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 IPF PPS final rule (84 FR 38453 through 38454), we adopted the updates set forth in OMB Bulletin No. 17–01 effective October 1, 2019, beginning with the FY 2020 IPF wage index. Given that the loss of the rural adjustment was mitigated in part by the increase in wage index value, and that only a single IPF was affected by this change, we did not believe it was necessary to transition this provider from its rural to newly urban status. We refer readers to the FY 2020 IPF PPS final rule (84 FR 38453 through 38454) for a more detailed discussion about the decision to forego a transition plan in FY 2020.

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 OMB Bulletin No. 18–04 may be obtained at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.* According to OMB, ''[t]his bulletin provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** [75 FR 37246], and Census Bureau data.'' (We note that, on March 6, 2020, OMB issued OMB Bulletin 20–01 (available on the web at *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*) but it was not issued in time for development of this final rule.)

While OMB Bulletin No. 18–04 is not based on new census data, it includes some material changes to the OMB statistical area delineations that are necessary to incorporate into the IPF PPS. These changes include some 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 the sections below.

(ii) Implementation of New Labor Market Area Delineations

We believe it is important for the IPF PPS to use, as soon as is reasonably possible, the latest available labor market area delineations in order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. We believe that using the most current delineations will increase the integrity of the IPF PPS wage index system by creating a more accurate representation of geographic variations in wage levels. We explained in the proposed rule (85 FR 20633) that we carefully analyzed the impacts of adopting the new OMB delineations, and found no compelling reason to further delay implementation. Therefore, we proposed (85 FR 20633 through 20639) to implement the new OMB delineations as described in the September 14, 2018 OMB Bulletin No. 18–04, effective beginning with the FY 2021 IPF PPS wage index. We proposed to adopt the updates to the OMB delineations announced in OMB Bulletin No. 18–04 effective for FY 2021 under the IPF PPS. As noted above, the March 6, 2020 OMB Bulletin 20–01 was not issued in time for development of this final rule. We also proposed to implement a wage index transition policy that would be applicable to all IPFs that may experience negative impacts due to the implementation of the revised OMB delineations. This transition is discussed in more detail below in section III.D.1.b.iii of this final rule.

(a.) Micropolitan Statistical Areas

OMB defines a ''Micropolitan Statistical Area'' as a CBSA associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000 (75 FR 37252). We refer to these as Micropolitan Areas. After extensive impact analysis, consistent with the treatment of these areas under the IPPS as discussed in the FY 2005 IPPS final rule (69 FR 49029 through 49032), we determined the best course of action would be to treat Micropolitan Areas as ''rural'' and include them in the calculation of each state's IPF PPS rural wage index. We refer the reader to the FY 2007 IPF PPS final rule (71 FR 27064 through 27065) for a complete discussion regarding treating Micropolitan Areas as rural.

(b.) Urban Counties That Would Become Rural Under the Revised OMB Delineations

As previously discussed, in the FY 2021 proposed rule (85 FR 20633 through 20639), we proposed to implement the new OMB labor market area delineations (based upon OMB Bulletin No. 18–04) beginning in FY 2021. Our analysis shows that a total of 34 counties (and county equivalents) and 5 providers are located in areas that were previously considered part of an urban CBSA but would be considered rural beginning in FY 2021 under these revised OMB delineations. Table 2 lists the 34 urban counties that would be rural if we finalize our proposal to implement the revised OMB delineations.

TABLE 2: Counties Previously Considered Part of an Urban CBSA that Would Become Rural Areas Under Revised OMB Delineations

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

We proposed that the wage data for all providers 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 IPF PPS. We recognize that rural areas typically have lower area wage index values than urban areas, and providers located in these counties may experience a negative impact in their IPF payment due to the proposed adoption of the revised OMB delineations. We refer readers to section iii of this final rule for a discussion of the finalized wage index transition policy, particularly, the discussion of the finalized wage index transition policy regarding the 5-percent cap for providers that may experience a decrease in their wage index from the prior FY.

(c.) Rural Counties That Would Become Urban Under the Revised OMB Delineations

As previously discussed, we proposed to implement the new OMB labor market area delineations (based upon OMB Bulletin No. 18–04) beginning in FY 2021. Analysis of these OMB labor market area delineations shows that a total of 47 counties (and county equivalents) and 4 providers are located in areas that were previously considered rural but would now be considered urban under the revised OMB delineations. Table 3 lists the 47 rural counties that would be urban if we finalize our proposal to implement the revised OMB delineations.

TABLE 3: Counties that Would Gain Urban Status Under Revised OMB Delineations

FIPS County Code	County/County Equivalent	State Name	New CBSA	Counties
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

FIPS County Code	County/County Equivalent	State Name	New CBSA	Counties
29053	Cooper	MO	17860	Columbia, MO
29089	Howard	MO	17860	Columbia, MO
30095	Stillwater	MT	13740	Billings, MT
37007	Anson	NC	16740	Charlotte-Concord-Gastonia, NC-SC
37029	Camden	NC	47260	Virginia Beach-Norfolk-Newport News, VA-NC
37077	Granville	NC	20500	Durham-Chapel Hill, NC
37085	Harnett	NC	22180	Fayetteville, NC
39123	Ottawa	OH	45780	Toledo, OH
45027	Clarendon	SC	44940	Sumter, SC
47053	Gibson	TN	27180	Jackson, TN
47161	Stewart	TN	17300	Clarksville, TN-KY
48203	Harrison	TX	30980	Longview, TX
48431	Sterling	TX	41660	San Angelo, TX
51097	King And Queen	VA	40060	Richmond, VA
51113	Madison	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV
51175	Southampton	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
51620	Franklin City	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC
54035	Jackson	WV	16620	Charleston, WV
54065	Morgan	WV	25180	Hagerstown-Martinsburg, MD-WV
55069	Lincoln	WI	48140	Wausau-Weston, WI
72001	Adjuntas	PR	38660	Ponce, PR
72083	Las Marias	PR	32420	Mayagüez, PR

When calculating the area wage index, beginning with FY 2021, the wage data for providers located in these counties would be included in their new respective urban CBSAs. Typically, providers located in an urban area receive a wage index value higher than or equal to providers located in their state's rural area. We refer readers to section iii of this final rule for a discussion of the finalized wage index transition policy.

(d.) 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 4 shows the current CBSA code and our proposed CBSA code where we have proposed to change either the name or CBSA number only. We are not discussing further in this section these changes because they are inconsequential changes with respect to the IPF PPS wage index.

TABLE 4: Current CBSAs and their New CBSA Codes and Titles

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

In some cases, 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 5 lists the urban counties that will move from one urban CBSA to another newly created or modified CBSA if we adopt the new OMB delineations.

TABLE 5: Urban Counties That Would Move to a Newly Proposed or Modified CBSA Under Revised OMB Delineations

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

We have identified 49 IPF providers located in the affected counties listed in Table 5. If providers located in these counties move from one CBSA to another under the revised OMB delineations, there may be impacts, both negative and positive, upon their specific wage index values.

We received mixed comments on the proposal to adopt the revised CBSA delineations. Several commenters recognized the impact of these delineation changes, and some commenters were supportive of this action, while others voiced concerns.

Comment: One commenter recommended that CMS delay changes to the labor market delineations until FY 2022 to ensure that providers stay focused on the COVID–19 Public Health Emergency (PHE).

Response: The methodology for determining Medicare payments to providers uses the most recent data available. We recognize the impact that the COVID–19 PHE is having on all providers, which is why we have issued waivers and flexibilities to ease burden and allow providers to respond effectively during the COVID–19 PHE. As we have previously stated, implementing the updated wage index values along with the revised OMB delineations would result in wage index values being more representative of the actual costs of labor in a given area. Delaying the implementation of these provisions would mean delaying substantial wage index increases for some facilities whose wage index values have not been representative of actual costs of labor in that area. For those providers whose wage index would decrease as a result of the proposed changes, we have stated our belief that it is appropriate to provide a transition period to mitigate the resulting short-term instability and negative impacts on these providers, providing time for them to adjust to their new labor market area delineations and wage index values. This approach is discussed in further detail below in section III.D.1.b.iii of this final rule.

Comment: One commenter suggested that the adoption of the New Brunswick-Lakewood, New Jersey CBSA would result in a reduction in reimbursement for the four New Jersey

counties that would make up the new CBSA and recommended that CMS delay finalizing the proposal to implement the new OMB delineations.

Response: We appreciate the detailed concerns sent in by the commenter regarding the impact of implementing the New Brunswick-Lakewood, NJ CBSA designation on their specific counties. We understand the commenter's concern regarding the potential financial impact; however, we believe that implementing the revised OMB delineations will create more accurate representations of labor market areas and result in IPF wage index values being more representative of the actual costs of labor in a given area. We note that there are many geographic locations and IPF providers that will experience positive impacts upon implementation of the revised CBSA designations. Therefore, we believe that the OMB standards for delineating Metropolitan and Micropolitan Statistical Areas are appropriate for determining wage area differences and that the values computed under the revised delineations will result in more appropriate payments to providers by more accurately accounting for and reflecting the differences in area wage levels.

We recognize that there are areas that will experience a decrease in their wage index. As such, it is our longstanding policy to provide a temporary transition to mitigate negative impacts from the adoption of new policies or procedures. In the FY 2021 IPF proposed rule, we proposed a two-year transition in order to mitigate the resulting short-term instability and negative impacts on certain providers and to provide time for providers to adjust to their new labor market delineations. We proposed that in the first year, FY 2021, a 5-percent cap on wage index decreases would be applied for all providers, and in the second year there would be no cap on decreases to a provider's wage index value. We continue to believe that the one-year 5-percent cap transitional policy provides an adequate safeguard against any significant payment reductions, allows for sufficient time to make operational changes for future FYs, and provides a reasonable balance between mitigating some short-term instability in IPF payments and improving the accuracy of the payment adjustment for differences in area wage levels. Therefore, we believe that it is appropriate to implement the new OMB delineations without delay.

Final Decision: For FY 2021, we are finalizing the proposal to adopt the revised CBSA delineations based on OMB Bulletin No. 18–04 in order to determine the wage index for all IPF providers.

(iii) Transition Policy for Providers Negatively Impacted by Wage Index Changes

Overall, we believe implementing updated wage index values along with the revised OMB delineations will result in wage index values being more representative of the actual costs of labor in a given area. However, we recognize that implementing these wage index changes will have distributional effects among IPF providers, and that some providers will experience decreases in wage index values as a result of our proposals. Therefore, we believe it would be appropriate to consider, as we have in the past, whether or not a transition period should be used to implement these finalized changes to the wage index.

We considered having no transition period and fully implementing the updated wage index values and new OMB delineations beginning in FY 2021. This would mean that we would adopt the updated wage index and revised OMB delineations for all providers on October 1, 2020. However, this would not provide any time for providers to adapt to the new OMB delineations or wage index values. As previously stated, some providers will experience a decrease in wage index due to implementation of the finalized new OMB delineations and wage index updates. Thus, we believe that it would be appropriate to provide for a transition period to mitigate the resulting short-term instability and negative impacts on these providers to provide time for them to adjust to their new labor market area delineations and wage index values. Furthermore, in light of the comments received during the RY 2007 and FY 2016 rulemaking cycles on our proposals to adopt revised CBSA definitions without a transition period, we believe that a transition period is appropriate for FY 2021.

We considered transitioning the finalized wage index changes over a number of years to minimize their impact in a given year. However, as discussed in the FY 2016 IPF PPS final rule (80 FR 46689), we continue to believe that a longer transition period would reduce the accuracy of the overall labor market area wage index system. The wage index is a relative measure of the value of labor in prescribed labor market areas; therefore, we believe it is important to implement the new delineations with as minimal a transition as is reasonably possible. As such, we believe that utilizing a 2-year (rather than a multiple year) transition period would strike the most appropriate balance between giving providers time to adapt to the new wage index changes while maintaining the accuracy of the overall labor market area wage index system.

We considered a transition methodology similar to that used to address past decreases in the wage index, as in FY 2016 (80 FR 46689) when major changes to CBSA delineations were introduced. Under that methodology, all IPF providers would receive a 1-year blended wage index using 50 percent of their FY 2021 wage index based on the proposed new OMB delineations and 50 percent of their FY 2021 wage index based on the OMB delineations used in FY 2020. However, if we were to propose a similar blended adjustment for FY 2021, we would have to calculate wage indexes for all providers using both old and new labor market definitions even though the blended wage index would only apply to providers that experienced a decrease in wage index values due to a change in labor market area definitions.

Because of the administrative complexity involved in implementing a blended adjustment, we decided to consider alternative transition methodologies that might provide greater transparency. Moreover, for FY 2021, we are not proposing the same transition policy we established in FY 2016 when we adopted new OMB delineations based on the decennial census data. However, consistent with our past practice of using transition policies to help mitigate negative impacts on hospitals of certain wage index proposals, we do believe it is appropriate to propose a transition policy for our proposed implementation of the revised OMB delineations.

In the proposed rule (85 FR 20638 through 20639) we stated that we believe adopting a transition of the 5-percent cap on a decrease in an IPFs wage index from the IPF's final wage index from the prior FY is an appropriate transition for FY 2021 for the revised OMB delineations as it provides greater transparency and consistency with other payment systems. We stated that this 2-year transition would allow the adoption of the revised CBSA delineations to be phased in over 2 years, where the estimated reduction in an IPF's wage index would be capped at 5 percent in FY 2021. We noted that this approach strikes an appropriate balance by providing for a transition period to mitigate the resulting short-term instability and negative impacts on these providers and provide time for

them to adjust to their new labor market area delineations and wage index values. We indicated that no cap would be applied to the reduction in the wage index for the second year, that is, FY 2022.

Comment: MedPAC suggested alternatives to the 5-percent cap transition policy. MedPAC recommended that the 5-percent cap limit should apply to both increases and decreases in the wage index because they believe that no provider should have its wage index value increase or decrease by more than 5 percent for FY 2021.

Response: We appreciate MedPAC's suggestion that the cap on wage index movements of more than 5 percent should also be applied to increases in the wage index. We do not believe it would be appropriate to apply the 5-percent cap on wage index increases as well. As we discussed in the FY 2021 IPF PPS proposed rule (85 FR 20638), the purpose of the proposed transition policy, as well as those we have implemented in the past, is to help mitigate the significant negative impacts of certain wage index changes, not to curtail the positive impacts of such changes.

Final Decision: For FY 2021, we are finalizing the proposal to implement a 2-year transition to mitigate any negative effects of wage index changes by applying a 5-percent cap on any decrease in an IPF's wage index from the IPF's final wage index from the prior FY.

Following the rationale outlined in the FY 2020 IPPS/LTCH PPS final rule (84 FR 42336), we continue to believe 5 percent is a reasonable level for the cap because it will effectively mitigate any significant decreases in the wage index for FY 2021. Therefore, for FY 2021, we are finalizing our proposal to provide for a transition of a 5-percent cap on any decrease in an IPF's wage index from the IPF's final wage index from the prior FY, which is FY 2020. Consistent with the application of the 5-percent cap transition provided in FY 2020 for the IPPS, this 5-percent cap on wage index decreases will be applied to all IPF providers that have any decrease in their wage indexes, regardless of the circumstance causing the decline, so that an IPF's final wage index for FY 2021 will not be less than 95 percent of its final wage index for FY 2020, regardless of whether the IPF is part of an updated CBSA.

e. Adjustment for Rural Location

In the November 2004 IPF PPS final rule, (69 FR 66954) we provided a 17 percent payment adjustment for IPFs located in a rural area. This adjustment was based on the regression analysis, which indicated that the per diem cost of rural facilities was 17 percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression. This 17 percent adjustment has been part of the IPF PPS each year since the inception of the IPF PPS. For FY 2021, we are finalizing our proposal to continue to apply a 17 percent payment adjustment for IPFs located in a rural area as defined at § 412.64(b)(1)(ii)(C) (see 69 FR 66954) for a complete discussion of the adjustment for rural locations.

f. Budget Neutrality Adjustment

Changes to the wage index are made in a budget-neutral manner so that updates do not increase expenditures. Therefore, for FY 2021, we are continuing to apply a budget-neutrality adjustment in accordance with our existing budget-neutrality policy. This policy requires us to update the wage index in such a way that total estimated payments to IPFs 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 IPF PPS rates. We use the following steps to ensure that the rates reflect the update to the wage indexes (based on the FY 2016 hospital cost report data) and the labor-related share in a budget-neutral manner:

Step 1. Simulate estimated IPF PPS payments, using the FY 2020 IPF wage index values (available on the CMS website) and labor-related share (as published in the FY 2020 IPF PPS final rule (84 FR 38424)).

Step 2. Simulate estimated IPF PPS payments using the finalized FY 2021 IPF wage index values (available on the CMS website) and final FY 2021 labor-related share (based on the latest available data as discussed previously).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the FY 2021 budget-neutral wage adjustment factor of 0.9989.

Step 4. Apply the FY 2021 budget-neutral wage adjustment factor from step 3 to the FY 2020 IPF PPS federal per diem base rate after the application of the market basket update described in section III.A of this rule, to determine the FY 2021 IPF PPS federal per diem base rate.

2. Teaching Adjustment

In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(1)(iii) to establish a facility-level adjustment for IPFs that are, or are part of, teaching hospitals. The teaching adjustment accounts for the higher indirect operating costs experienced by hospitals that participate in graduate medical education (GME) programs. The payment adjustments are made based on the ratio of the number of full-time equivalent (FTE) interns and residents training in the IPF and the IPF's average daily census (ADC).

Medicare makes direct GME payments (for direct costs such as resident and teaching physician salaries, and other direct teaching costs) to all teaching hospitals including those paid under a PPS, and those paid under the TEFRA rate-of-increase limits. These direct GME payments are made separately from payments for hospital operating costs and are not part of the IPF PPS. The direct GME payments do not address the estimated higher indirect operating costs teaching hospitals may face.

The results of the regression analysis of FY 2002 IPF data established the basis for the payment adjustments included in the November 2004 IPF PPS final rule. The results showed that the indirect teaching cost variable is significant in explaining the higher costs of IPFs that have teaching programs. We calculated the teaching adjustment based on the IPF's ''teaching variable,'' which is (1 + (the number of FTE residents training in the IPF/the IPF's ADC)). The teaching variable is then raised to 0.5150 power to result in the teaching adjustment. This formula is subject to the limitations on the number of FTE residents, which are described in this section of this rule.

We established the teaching adjustment in a manner that limited the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. We imposed a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. The cap limits the number of FTE residents that teaching IPFs may count for the purpose of calculating the IPF PPS teaching adjustment, not the number of residents teaching institutions can hire or train. We calculated the number of FTE residents that trained in the IPF during a ''base year'' and used that FTE resident number as the cap. An IPF's FTE resident cap is ultimately determined based on the final settlement of the IPF's most recent cost report filed before November 15, 2004 (publication date of the IPF PPS final rule). A complete discussion of the temporary adjustment to the FTE cap to reflect residents due to hospital closure or residency program closure appears in the RY 2012 IPF PPS proposed rule (76

FR 5018 through 5020) and the RY 2012 IPF PPS final rule (76 FR 26453 through 26456).

In the regression analysis, the logarithm of the teaching variable had a coefficient value of 0.5150. We converted this cost effect to a teaching payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value. We note that the coefficient value of 0.5150 was based on the regression analysis holding all other components of the payment system constant. A complete discussion of how the teaching adjustment was calculated appears in the November 2004 IPF PPS final rule (69 FR 66954 through 66957) and the RY 2009 IPF PPS notice (73 FR 25721). As with other adjustment factors derived through the regression analysis, we do not plan to rerun the teaching adjustment factors in the regression analysis until we more fully analyze IPF PPS data as part of the IPF PPS refinement we discuss in section IV of this rule. Therefore, in this FY 2021 final rule, we will continue to retain the coefficient value of 0.5150 for the teaching adjustment to the federal per diem base rate.

3. Cost of Living Adjustment for IPFs Located in Alaska and Hawaii

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the area in which the IPF is located. As we explained in the November 2004 IPF PPS final rule, the FY 2002 data demonstrated that IPFs in Alaska and Hawaii had per diem costs that were disproportionately higher than other IPFs. Other Medicare prospective payment systems (for example: The IPPS and LTCH PPS) adopted a COLA to account for the cost differential of care furnished in Alaska and Hawaii.

We analyzed the effect of applying a COLA to payments for IPFs located in Alaska and Hawaii. The results of our analysis demonstrated that a COLA for IPFs located in Alaska and Hawaii would improve payment equity for these facilities. As a result of this analysis, we provided a COLA in the November 2004 IPF PPS final rule.

A COLA for IPFs located in Alaska and Hawaii is made by multiplying the non-labor-related portion of the federal per diem base rate by the applicable COLA factor based on the COLA area in which the IPF is located.

The COLA factors through 2009 were published by the Office of Personnel Management (OPM), and the OPM memo showing the 2009 COLA factors is available at *https://www.chcoc.gov/content/nonforeign-area-retirement-equity-assurance-act.*

We note that the COLA areas for Alaska are not defined by county as are the COLA areas for Hawaii. In 5 CFR 591.207, the OPM established the following COLA areas:

- City of Anchorage, and 80-kilometer (50-mile) radius by road, as measured from the federal courthouse.
- City of Fairbanks, and 80-kilometer (50-mile) radius by road, as measured from the federal courthouse.
- City of Juneau, and 80-kilometer (50-mile) radius by road, as measured from the federal courthouse.
- Rest of the state of Alaska.

As stated in the November 2004 IPF PPS final rule, we update the COLA factors according to updates established by the OPM. However, sections 1911 through 1919 of the Nonforeign Area Retirement Equity Assurance Act, as contained in subtitle B of title XIX of the National Defense Authorization Act (NDAA) for FY 2010 (Pub. L. 111–84, October 28, 2009), transitions the Alaska and Hawaii COLAs to locality pay. Under section 1914 of NDAA, locality pay was phased in over a 3-year period beginning in January 2010, with COLA rates frozen as of the date of enactment, October 28, 2009, and then proportionately reduced to reflect the phase-in of locality pay.

When we published the proposed COLA factors in the RY 2012 IPF PPS proposed rule (76 FR 4998), we inadvertently selected the FY 2010 COLA rates, which had been reduced to account for the phase-in of locality pay. We did not intend to propose the reduced COLA rates because that would have understated the adjustment. Since the 2009 COLA rates did not reflect the phase-in of locality pay, we finalized the FY 2009 COLA rates for RY 2010 through RY 2014.

In the FY 2013 IPPS/LTCH final rule (77 FR 53700 through 53701), we established a new methodology to update the COLA factors for Alaska and Hawaii, and adopted this methodology for the IPF PPS in the FY 2015 IPF final rule (79 FR 45958 through 45960). We adopted this new COLA methodology for the IPF PPS because IPFs are hospitals with a similar mix of commodities and services. We think it is appropriate to have a consistent policy approach with that of other hospitals in Alaska and Hawaii. Therefore, the IPF COLAs for FY 2015 through FY 2017 were the same as those applied under the IPPS in those years. As finalized in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53700 and 53701), the COLA updates are determined every 4 years, when the IPPS market basket labor-related share is updated. Because the labor-related share of the IPPS market basket was updated for FY 2018, the COLA factors were updated in FY 2018 IPPS/LTCH rulemaking (82 FR 38529). As such, we also updated the IPF PPS COLA factors for FY 2018 (82 FR 36780 through 36782) to reflect the updated COLA factors finalized in the FY 2018 IPPS/LTCH rulemaking. We are continuing to apply the same COLA factors in FY 2021 that were used in FY 2018 through FY 2020.

TABLE 6: Comparison of IPF PPS Cost-of-Living Adjustment Factors: IPFs Located in Alaska and Hawaii

Area	FY 2015 through FY 2017	FY 2018 through FY 2020
Alaska:		
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23	1.25
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23	1.25
City of Juneau and 80-kilometer (50-mile) radius by road	1.23	1.25
Rest of Alaska	1.25	1.25
Hawaii:		
City and County of Honolulu	1.25	1.25
County of Hawaii	1.19	1.21
County of Kauai	1.25	1.25
County of Maui and County of Kalawao	1.25	1.25

The final IPF PPS COLA factors for FY 2021 are also shown in Addendum A to this final rule, and are available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

4. Adjustment for IPFs with a Qualifying Emergency Department (ED)

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs. We provide an adjustment to the federal per diem base rate to account for the costs associated with maintaining a full-service ED. The adjustment is intended to account for ED costs incurred by a psychiatric hospital with a qualifying ED or an excluded psychiatric unit of an IPPS hospital or a CAH, for preadmission services otherwise payable under the Medicare Hospital Outpatient Prospective Payment System (OPPS), furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the day immediately preceding the date of admission to the IPF (see § 413.40(c)(2)), and the overhead cost of maintaining the ED. This payment is a facility-level adjustment that applies to all IPF admissions (with one exception which we described), regardless of whether a particular patient receives preadmission services in the hospital's ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. Those IPFs with a qualifying ED receive an adjustment factor of 1.31 as the variable per diem adjustment for day 1 of each patient stay. If an IPF does not have a qualifying ED, it receives an adjustment factor of 1.19 as the variable per diem adjustment for day 1 of each patient stay.

The ED adjustment is made on every qualifying claim except as described in this section of the final rule. As specified in § 412.424(d)(1)(v)(B), the ED adjustment is not made when a patient is discharged from an IPPS hospital or CAH and admitted to the same IPPS hospital's or CAH's excluded psychiatric unit. We clarified in the November 2004 IPF PPS final rule (69 FR 66960) that an ED adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the IPPS hospital or through the reasonable cost payment made to the CAH.

Therefore, when patients are discharged from an IPPS hospital or CAH and admitted to the same hospital's or CAH's excluded psychiatric unit, the IPF receives the 1.19 adjustment factor as the variable per diem adjustment for the first day of the patient's stay in the IPF. For FY 2021, we are finalizing our proposal to continue to retain the 1.31 adjustment factor for IPFs with qualifying EDs. A complete discussion of the steps involved in the calculation of the ED adjustment factors are in the November 2004 IPF PPS final rule (69 FR 66959 through 66960) and the RY 2007 IPF PPS final rule (71 FR 27070 through 27072).

E. Other Payment Adjustments and Policies

1. Outlier Payment Overview

The IPF PPS includes an outlier adjustment to promote access to IPF care for those patients who require expensive care and to limit the financial risk of IPFs treating unusually costly patients. In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(3)(i) to provide a per-case payment for IPF stays that are extraordinarily costly. Providing additional payments to IPFs for extremely costly cases strongly improves the accuracy of the IPF PPS in determining resource costs at the patient and facility level. These additional payments reduce the financial losses that would otherwise be incurred in treating patients who require costlier care, and therefore, reduce the incentives for IPFs to under-serve these patients. We make outlier payments for discharges in which an IPF's estimated total cost for a case (which is calculated by multiplying the IPF's overall cost-to-charge ratio (CCR) by the Medicare allowable covered charge) exceeds a fixed dollar loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the federal per diem payment amount for the case.

In instances when the case qualifies for an outlier payment, we pay 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay (consistent with the median LOS for IPFs in FY 2002), and 60 percent of the difference for day 10 and thereafter. The adjusted threshold amount is equal to the outlier threshold amount adjusted for wage area, teaching status, rural area, and the COLA adjustment (if applicable), plus the amount of the Medicare IPF payment for the case. We established the 80 percent and 60 percent loss sharing ratios because we were concerned that a single ratio established at 80 percent (like other Medicare PPSs) might provide an incentive under the IPF per diem payment system to

increase LOS in order to receive additional payments.

After establishing the loss sharing ratios, we determined the current fixed dollar loss threshold amount through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target. Each year when we update the IPF PPS, we simulate payments using the latest available data to compute the fixed dollar loss threshold so that outlier payments represent 2 percent of total estimated IPF PPS payments.

2. Update to the Outlier Fixed Dollar Loss Threshold Amount

In accordance with the update methodology described in § 412.428(d), we are updating the fixed dollar loss threshold amount used under the IPF PPS outlier policy. Based on the regression analysis and payment simulations used to develop the IPF PPS, we established a 2 percent outlier policy, which strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the federal per diem base rate for all other cases that are not outlier cases.

Based on an analysis of the latest available data (the March 2020 update of FY 2019 IPF claims and most recent CCRs from the CY 2020 Provider Specific File) and rate increases, we believe it is necessary to update the fixed dollar loss threshold amount to maintain an outlier percentage that equals 2 percent of total estimated IPF PPS payments. We are updating the IPF outlier threshold amount for FY 2021 using FY 2019 claims data and the same methodology that we used to set the initial outlier threshold amount in the RY 2007 IPF PPS final rule (71 FR 27072 and 27073), which is also the same methodology that we used to update the outlier threshold amounts for years 2008 through 2020. In the proposed rule (85 FR 20642), based on an analysis of the December 2019 update of these data, we originally estimated that IPF outlier payments as a percentage of total estimated payments are approximately 2.2 percent in FY 2020. Therefore, we proposed to update the outlier threshold amount to $16,520 to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2021.

Comment: We received one comment that opposed increasing the fixed dollar threshold amount for 2 years in a row in order to maintain the 2 percent outlier policy. The commenter also acknowledged that an increase in the threshold is necessary, but stated that it should be limited to no more than 5 percent in any given year.

Response: The outlier fixed dollar threshold amount is calculated by simulating aggregate payments and using an iterative process to determine a threshold that results in outlier payments being equal to 2 percent of total payments under the simulation. To determine the IPF outlier threshold amount for FY 2021, we estimated the FY 2021 IPF PPS aggregate and outlier payments using the most recent claims available (March 2020 update of the FY 2019 MedPAR claims), the latest CCRs from the Provider Specific File, and the FY 2021 final payment rates. The outlier threshold was varied in this simulation until estimated outlier payments equaled 2 percent of estimated aggregate payments. Based on the regression analysis and payment simulations used to develop the IPF PPS, we established a 2 percent outlier policy in our November 2004 IPF PPS final rule (69 FR 66960 through 66962), which strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the federal per diem base rate for all other cases that are not outlier cases. This outlier fixed dollar loss threshold update methodology is based on longstanding IPF payment policy and is described in detail in the RY 2007 IPF PPS final rule (71 FR 27072 and 27073).

Based on an analysis of the latest updated data, we estimate that IPF outlier payments as a percentage of total estimated payments are approximately 1.9 percent in FY 2020. Therefore, we are finalizing to update the outlier threshold amount to $14,630 to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2021. This final rule update is a decrease from the FY 2020 threshold of $14,960. To maintain this established 2 percent outlier policy, we must raise or lower the IPF PPS outlier fixed dollar threshold amount as indicated by the latest updated data. If the fixed dollar threshold amount increase were limited to 5 percent for any year, as suggested by the commenter, we would not meet the established 2 percent outlier policy if the data indicated that a greater increase to the fixed dollar loss threshold were required.

Final Decision: We are finalizing the annual updates in accordance with existing policy.

3. Update to IPF Cost-to-Charge Ratio Ceilings

Under the IPF PPS, an outlier payment is made if an IPF's cost for a stay exceeds a fixed dollar loss threshold amount plus the IPF PPS amount. In order to establish an IPF's cost for a particular case, we multiply the IPF's reported charges on the discharge bill by its overall cost-to-charge ratio. This approach to determining an IPF's cost is consistent with the approach used under the IPPS and other PPSs. In the FY 2004 IPPS final rule (68 FR 34494), we implemented changes to the IPPS policy used to determine CCRs for IPPS hospitals, because we became aware that payment vulnerabilities resulted in inappropriate outlier payments. Under the IPPS, we established a statistical measure of accuracy for CCRs to ensure that aberrant CCR data did not result in inappropriate outlier payments.

As we indicated in the November 2004 IPF PPS final rule (69 FR 66961), we believe that the IPF outlier policy is susceptible to the same payment vulnerabilities as the IPPS; therefore, we adopted a method to ensure the statistical accuracy of CCRs under the IPF PPS. Specifically, we adopted the following procedure in the November 2004 IPF PPS final rule:

- Calculated two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas.
- Computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and rural IPFs using the most recent CCRs entered in the most recent Provider Specific File available.

For FY 2021, we are finalizing to continue to follow this methodology.

To determine the rural and urban ceilings, we multiplied each of the standard deviations by 3 and added the result to the appropriate national CCR average (either rural or urban). The upper threshold CCR for IPFs in FY 2021 is 2.0082 for rural IPFs, and 1.7131 for urban IPFs, based on CBSA-based geographic designations. If an IPF's CCR is above the applicable ceiling, the ratio is considered statistically inaccurate, and we assign the appropriate national (either rural or urban) median CCR to the IPF.

We apply the national median CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. We continue to use these national median CCRs until the facility's actual CCR can be computed using the first tentatively or final settled cost report.
- IPFs whose overall CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).

• Other IPFs for which the Medicare Administrative Contractor (MAC) obtains inaccurate or incomplete data with which to calculate a CCR.

We are continuing to update the FY 2021 national median and ceiling CCRs for urban and rural IPFs based on the CCRs entered in the latest available IPF PPS Provider Specific File. Specifically, for FY 2021, to be used in each of the three situations listed previously, using the most recent CCRs entered in the CY 2020 Provider Specific File, we provide an estimated national median CCR of 0.5720 for rural IPFs and a national median CCR of 0.4200 for urban IPFs. These calculations are based on the IPF's location (either urban or rural) using the CBSA-based geographic designations. A complete discussion regarding the national median CCRs appears in the November 2004 IPF PPS final rule (69 FR 66961 through 66964).

IV. Update on IPF PPS Refinements

For RY 2012, we identified several areas of concern for future refinement, and we invited comments on these issues in the RY 2012 IPF PPS proposed and final rules. For further discussion of these issues and to review the public comments, we refer readers to the RY 2012 IPF PPS proposed rule (76 FR 4998) and final rule (76 FR 26432).

We have delayed making refinements to the IPF PPS until we have completed a thorough analysis of IPF PPS data on which to base those refinements. Specifically, we would delay updating the adjustment factors derived from the regression analysis until we have IPF PPS data that include as much information as possible regarding the patient-level characteristics of the population that each IPF serves. We have begun and will continue the necessary analysis to better understand IPF industry practices so that we may refine the IPF PPS in the future, as appropriate. Our preliminary analysis has also revealed variation in cost and claim data, particularly related to labor costs, drugs costs, and laboratory services. Some providers have very low labor costs, or very low or missing drug or laboratory costs or charges, relative to other providers. As we noted in the FY 2016 IPF PPS final rule (80 FR 46693 through 46694), our preliminary analysis of 2012 to 2013 IPF data found that over 20 percent of IPF stays reported no ancillary costs, such as laboratory and drug costs, in their cost reports, or laboratory or drug charges on their claims. Because we expect that most patients requiring hospitalization for active psychiatric treatment would need drugs and laboratory services, we again remind providers that the IPF PPS federal per diem base rate includes the cost of all ancillary services, including drugs and laboratory services.

On November 17, 2017, we issued Transmittal 12, which made changes to the hospital cost report form CMS–2552–10 (OMB No. 0938–0050), and included the requirement that cost reports from psychiatric hospitals include certain ancillary costs, or the cost report will be rejected. On January 30, 2018, we issued Transmittal 13, which changed the implementation date for Transmittal 12 to be for cost reporting periods ending on or after September 30, 2017. For details, we refer readers to see these Transmittals, which are available on the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html.* CMS suspended the requirement that cost reports from psychiatric hospitals include certain ancillary costs effective April 27, 2018, in order to consider excluding all-inclusive rate providers from this requirement. CMS issued Transmittal 15 on October 19, 2018, reinstating the requirement that cost reports from psychiatric hospitals, except all-inclusive rate providers, include certain ancillary costs.

We only pay the IPF for services furnished to a Medicare beneficiary who is an inpatient of that IPF (except for certain professional services), and payments are considered to be payments in full for all inpatient hospital services provided directly or under arrangement (see 42 CFR 412.404(d)), as specified in 42 CFR 409.10.

V. Special Requirements for Psychiatric Hospitals (§ 482.61(d))

In the CMS interim final rule with comment period, ''Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency'' (85 FR 19230) (''IFC''), published on April 6, 2020, we revised the provision at § 482.61(d) in the ''Special Medical Record Requirements for Psychiatric Hospitals'' conditions of participation (CoP) by deleting an inappropriate reference to § 482.12(c), and deleting the modifier ''independent'' from the term ''licensed independent practitioner(s).''

This and other revisions in the April 6, 2020 IFC reflect our belief that advanced practice providers (APPs), including physician assistants (PAs), nurse practitioners (NPs), psychologists, and clinical nurse specialists (CNSs) (as well as other qualified, licensed practitioners to whom this revision may also be applicable), when acting in accordance with state law, their scope of practice, and hospital policy, should have the authority to practice more broadly and to the highest level of their education, training, and qualifications as allowed under their respective state requirements and laws in this area. Additionally, non-physician practitioners practicing in the psychiatric hospital setting should be able to record progress notes of psychiatric patients for whom they are responsible. Therefore, we now allow the use of non-physician practitioners, or APPs, to document progress notes of patients receiving services in psychiatric hospitals, in addition to medical doctors, doctors of osteopathy (MDs)/(DOs) as is currently allowed.

Given the changes made to the requirements under § 482.13 regarding the removal of the word ''independent'' from the phrase ''licensed independent practitioner'' when referencing non-physician practitioners that we previously discussed in the final rule published on September 30, 2019 **Federal Register** (the ''Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care'' final rule (84 FR 51775)), we have made the same change for this provision at § 482.61(d) in the April 6, 2020 IFC. We believe that the regulatory language should be as consistent as possible throughout the hospital CoPs and with the requirement under § 482.13. We also believe using the term ''licensed independent practitioner'' may inadvertently exacerbate workforce shortage concerns, and unnecessarily impose regulatory burden on hospitals by restricting a hospital's ability to allow APPs and other non-physician practitioners to operate within the scope of practice allowed by state law. In addition, we believe it does not recognize the benefits to patient care that might be derived from fully utilizing APPs and their clinical skills to the highest levels of their training, education, and experience, as allowed by hospital policy in accordance with state law.

In response to the April 6, 2020 IFC, we received several public comments from patient advocacy organizations as well as professional organizations and societies. The comments were generally supportive of the changes and are as follows:

Comment: Several commenters fully supported the changes made regarding APPs, expressed appreciation for CMS recognizing the changing dynamics of the healthcare system for both patients and for those practicing within it, and encouraged CMS to continue to evaluate other regulatory barriers limiting efficient practice by APPs. One

commenter expressed appreciation for the clarification that now allows non-physician practitioners to practice to the full extent of their licenses and certifications in the psychiatric hospital setting. The commenter referenced evidence of the safe practice of nurse practitioners and other practitioners in other settings, which the commenter stated confirms that this change is appropriate to make for psychiatric hospitals. Another commenter expressed appreciation for this increased flexibility and asked CMS to consider other Medicare regulations for future revisions, particularly those that might limit other types of advanced practice nurses from practicing to the full extent of their licenses, such as those practicing in oncology.

Response: We thank the commenters for their support of these changes and agree that evidence supports allowing these practitioners to practice to full extent of their training, education, and qualifications. Since the revisions discussed here are limited in scope to the psychiatric hospital CoP, we can only address the requirements for APPs, which we note currently allow APPs, regardless of area of practice, to practice to the full extent of their respective state laws and licenses and as allowed by their respective hospitals. However, we will continue to review the CoPs for other provider-types.

Comment: A few commenters, while supportive of these changes, emphasized that APPs, while practicing in accordance with state scope-of-practice laws, must also continue to practice as part of physician-led teams and that CMS should reinstate general supervision of APPs by physicians after the expiration of the current PHE declaration period. These commenters also stated that they believe the current revisions to allow for APPs to document progress notes for patients in psychiatric hospitals for whom they are responsible should only be temporary for the duration of the PHE.

Response: We appreciate the qualified support expressed by commenters and agree that APPs should practice in accordance with their respective state laws with regard to their roles on physician-led teams. However, we respectfully disagree that the changes made in the April 6, 2020 IFC should only be temporary in nature. Further, with regard to the revisions to the hospital CoPs discussed here, we defer to state law and hospital policy regarding the requirement of general supervision of APPs by physicians.

Final Decision: After consideration of the public comments, we are confirming as final the revisions to the provision at § 482.61(d) in the ''Special Medical Record Requirements for Psychiatric Hospitals'' CoP published in the April 6, 2020 IFC (85 FR 19230), without change.

VI. Collection of Information Requirements

This rule finalizes proposed updates to the prospective payment rates, outlier threshold, and wage index for Medicare inpatient hospital services provided by IPFs. It also finalizes our proposal to expand the IPPS wage index disparities policy and revise CBSA delineations. While discussed in section IV (Update on IPF PPS Refinements) of this preamble, the active requirements and burden associated with our hospital cost report form CMS–2552–10 (OMB control number 0938–0050) are unaffected by this rule. At § 482.61(d), this rule will allow licensed non-physician practitioners (specifically PAs, NPs, and CNSs) to document progress notes in accordance with state laws and scope-of-practice requirements. The recording of progress notes is not new as it is currently allowed by medical doctors and doctors of osteopathy. We believe that the recording of progress notes is a usual and customary practice that would be performed in the absence of federal regulation. In that regard it is not subject (see 5 CFR 1320.3(b)(2)) to the requirements of the Paperwork Reduction Act of 1995 (PRA; 44 U.S.C. 3501 *et seq.*).

Since this rule does not impose any new or revised collection of information requirements/burden, the rule is not subject to the requirements of the PRA. With respect to this section of the preamble, ''collection of information'' is defined under 5 CFR 1320.3(c) of OMB's implementing regulations.

VII. Regulatory Impact Analysis

A. Statement of Need

This rule finalizes updates to the prospective payment rates for Medicare inpatient hospital services provided by IPFs for discharges occurring during FY 2021 (October 1, 2020 through September 30, 2021). We are finalizing our proposal to apply the 2016-based IPF market basket increase of 2.2 percent, less the productivity adjustment of 0 percentage point as required by 1886(s)(2)(A)(i) of the Act resulting in a final FY 2021 IPF payment rate update of 2.2 percent. In this final rule, we are updating the IPF labor-related share and the IPF wage index to reflect the FY 2021 hospital inpatient wage index, and adopting more recent Office of Management and Budget (OMB) statistical area delineations.

B. Overall Impact

We have examined the impacts of this final 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 Social Security Act (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), 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 the Executive Order. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

We estimate that this rulemaking is not economically significant as measured by the $100 million threshold, and hence not a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

We estimate that the total impact of these changes for FY 2021 payments compared to FY 2020 payments will be

a net increase of approximately $95 million. This reflects a $90 million increase from the update to the payment rates ($90 million increase from the second quarter 2020 IGI forecast of the 2016-based IPF market basket of 2.2 percent, and a $0 reduction for the productivity adjustment of 0 percentage point), as well as a $5 million increase as a result of the update to the outlier threshold amount. Outlier payments are estimated to change from 1.9 percent in FY 2020 to 2.0 percent of total estimated IPF payments in FY 2021.

C. Detailed Economic Analysis

In this section, we discuss the historical background of the IPF PPS and the impact of this final rule on the Federal Medicare budget and on IPFs.

1. Budgetary Impact

As discussed in the November 2004 and RY 2007 IPF PPS final rules, we applied a budget neutrality factor to the federal per diem base rate and ECT payment per treatment to ensure that total estimated payments under the IPF PPS in the implementation period would equal the amount that would have been paid if the IPF PPS had not been implemented. The budget neutrality factor includes the following components: Outlier adjustment, stop-loss adjustment, and the behavioral offset. As discussed in the RY 2009 IPF PPS notice (73 FR 25711), the stop-loss adjustment is no longer applicable under the IPF PPS.

As discussed in section III.D.1 of this final rule, we are updating the wage index and labor-related share in a budget neutral manner by applying a wage index budget neutrality factor to the federal per diem base rate and ECT payment per treatment. Therefore, the budgetary impact to the Medicare program of this final rule will be due to the market basket update for FY 2021 of 2.2 percent (see section III.A.4 of this final rule) less the productivity adjustment of 0 percentage point required by section 1886(s)(2)(A)(i) of the Act and the update to the outlier fixed dollar loss threshold amount.

We estimate that the FY 2021 impact will be a net increase of $95 million in payments to IPF providers. This reflects an estimated $90 million increase from the update to the payment rates and a $5 million increase due to the update to the outlier threshold amount to set total estimated outlier payments at 2.0 percent of total estimated payments in FY 2021. This estimate does not include the implementation of the required 2.0 percentage point reduction of the market basket increase factor for any IPF that fails to meet the IPF quality reporting requirements (as discussed in section V.A. of this final rule).

2. Impact on Providers

To show the impact on providers of the changes to the IPF PPS discussed in this final rule, we compare estimated payments under the IPF PPS rates and factors for FY 2021 versus those under FY 2020. We determined the percent change in the estimated FY 2021 IPF PPS payments compared to the estimated FY 2020 IPF PPS payments for each category of IPFs. In addition, for each category of IPFs, we have included the estimated percent change in payments resulting from the update to the outlier fixed dollar loss threshold amount; the updated wage index data including the updated labor-related share; the adoption of the revised CBSA delineations based on the OMB Bulletin No. 18–04 published September 14, 2018; the implementation of the 2 year transition with a 5-percent cap on decreases to providers' wage index values; and the market basket update for FY 2021, as adjusted by the productivity adjustment according to section 1886(s)(2)(A)(i) of the Act.

To illustrate the impacts of the FY 2021 changes in this final rule, our analysis begins with FY 2019 IPF PPS claims (based on the 2019 MedPAR claims, March 2020 update). We estimate FY 2020 IPF PPS payments using these 2019 claims and the finalized FY 2020 IPF PPS federal per diem base rates and the finalized FY 2020 IPF PPS patient and facility level adjustment factors (as published in the FY 2020 IPF PPS final rule (84 FR 38424 through 38482)). We then estimate the FY 2020 outlier payments based on these simulated FY 2020 IPF PPS payments using the same methodology as finalized in the FY 2020 IPF PPS final rule (84 FR 38457) where total outlier payments are maintained at 2 percent of total estimated FY 2020 IPF PPS payments.

Each of the following changes is added incrementally to this baseline model in order for us to isolate the effects of each change:

- The update to the outlier fixed dollar loss threshold amount.
- The FY 2021 IPF wage index and the FY 2021 labor-related share.
- The adoption of the revised CBSAs based on OMB Bulletin No. 18–04 and the 5-percent cap on decreases to the wage index for providers whose wage index decreases from FY 2020.
- The market basket update for FY 2021 of 2.2 percent less the productivity adjustment of 0 percentage point in accordance with section 1886(s)(2)(A)(i) of the Act for a payment rate update of 2.2 percent.

Our final column comparison in Table 7 illustrates the percent change in payments from FY 2020 (that is, October 1, 2019, to September 30, 2020) to FY 2021 (that is, October 1, 2020, to September 30, 2021) including all the payment policy changes in this final rule.

TABLE 7: FY 2021 IPF PPS Final Payment Impacts
[Percent Change in Columns 3 through 6]

Facility by Type	Number of Facilities	Outlier	Wage Index FY21	Wage Index FY21 New CBSA and 5% Loss Cap	Total Percent Change[1]
(1)	(2)	(3)	(4)	(5)	(6)
All Facilities	1,550	0.1	0.0	0.0	2.3
Total Urban	1,241	0.1	0.0	0.0	2.3
Urban unit	755	0.1	0.0	0.1	2.4
Urban hospital	486	0.0	0.0	-0.1	2.2
Total Rural	309	0.0	-0.1	-0.1	2.0
Rural unit	248	0.0	-0.2	-0.2	1.9
Rural hospital	61	0.0	0.0	0.0	2.2
By Type of Ownership:					
Freestanding IPFs					
Urban Psychiatric Hospitals					
Government	118	0.1	0.3	0.1	2.7
Non-Profit	96	0.0	0.1	-0.1	2.2
For-Profit	272	0.0	0.0	-0.1	2.1
Rural Psychiatric Hospitals					
Government	31	0.0	0.0	0.0	2.2
Non-Profit	12	0.0	0.2	-0.1	2.4
For-Profit	18	0.0	0.0	0.0	2.2
IPF Units					
Urban					
Government	112	0.1	0.1	0.3	2.8
Non-Profit	492	0.1	0.0	0.1	2.4
For-Profit	151	0.0	-0.1	-0.1	2.1
Rural					
Government	63	0.0	-0.3	-0.1	1.8
Non-Profit	136	0.1	0.0	-0.2	2.1
For-Profit	49	0.0	-0.4	-0.2	1.7
By Teaching Status:					
Non-teaching	1,357	0.0	0.0	-0.1	2.1
Less than 10% interns and residents to beds	108	0.1	0.2	0.5	2.9
10% to 30% interns and residents to beds	65	0.1	0.1	0.2	2.7

More than 30% interns and residents to beds	20	0.2	0.4	0.0	2.7
By Region:					
New England	106	0.1	-0.9	-0.1	1.3
Mid-Atlantic	218	0.1	0.7	0.4	3.5
South Atlantic	243	0.0	0.0	0.0	2.2
East North Central	255	0.0	0.0	-0.1	2.2
East South Central	155	0.0	0.0	-0.1	2.1
West North Central	114	0.1	-0.6	0.0	1.6
West South Central	227	0.0	0.0	-0.1	2.1
Mountain	105	0.0	-0.6	-0.1	1.5
Pacific	127	0.1	0.3	-0.1	2.6
By Bed Size:					
Psychiatric Hospitals					
Beds: 0-24	87	0.0	0.1	0.0	2.3
Beds: 25-49	83	0.0	0.2	-0.1	2.3
Beds: 50-75	86	0.0	-0.3	-0.1	1.8
Beds: 76 +	291	0.0	0.1	-0.1	2.2
Psychiatric Units					
Beds: 0-24	561	0.1	-0.1	0.0	2.1
Beds: 25-49	260	0.1	-0.1	-0.1	2.1
Beds: 50-75	115	0.1	0.0	0.1	2.4
Beds: 76 +	67	0.1	0.4	0.6	3.3

[1] This column includes the impact of the updates in columns (3) through (5) above, and of the IPF market basket increase factor for FY 2021 (2.2 percent), reduced by 0 percentage point for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.

3. Impact Results

Table 7 displays the results of our analysis. The table groups IPFs into the categories listed here based on characteristics provided in the Provider of Services (POS) file, the IPF provider specific file, and cost report data from the Healthcare Cost Report Information System:

- Facility Type.
- Location.
- Teaching Status Adjustment.
- Census Region.
- Size.

The top row of the table shows the overall impact on the 1,550 IPFs included in this analysis. In column 3, we present the effects of the update to the outlier fixed dollar loss threshold amount. We estimate that IPF outlier payments as a percentage of total IPF payments are 1.9 percent in FY 2020. Thus, we are adjusting the outlier threshold amount in this final rule to set total estimated outlier payments equal to 2.0 percent of total payments in FY 2021. The estimated change in total IPF payments for FY 2021, therefore, includes an approximate 0.1 percent increase in payments because the outlier portion of total payments is expected to increase from approximately 1.9 percent to 2.0 percent.

The overall impact of this outlier adjustment update (as shown in column 3 of Table 7), across all hospital groups, is to increase total estimated payments to IPFs by 0.1 percent. The largest increase in payments due to this change is estimated to be 0.2 percent for teaching IPFs with more than 30 percent interns and residents to beds.

In column 4, we present the effects of the budget-neutral update to the IPF wage index and the Labor-Related Share (LRS). This represents the effect of using the concurrent hospital wage data without taking into account the updated OMB delineations, or the 5-percent cap on decreases to providers' wage index values for providers whose wage index decreases from FY 2020 as discussed in section III.D.1.b.iii of this final rule. That is, the impact represented in this column reflects the update from the FY 2020 IPF wage index to the final FY 2021 IPF wage index, which includes basing the FY 2021 IPF wage index on the FY 2021 pre-floor, pre-reclassified IPPS hospital wage index data and updating the LRS from 76.9 percent in FY 2020 to 77.3 percent in FY 2021. We note that there is no projected change in aggregate payments to IPFs, as indicated in the first row of column 4, however, there will be distributional effects among different categories of IPFs. For example, we estimate the largest increase in payments to be 0.7 percent for Mid-Atlantic IPFs, and the largest decrease in payments to be 0.9 percent for New England IPFs.

Next, column 5 shows the effect of the final update to the delineations used to identify providers as urban or rural providers and the CBSAs into which urban providers are classified. Additionally, column 5 shows the effect of the final five percent cap on wage index decreases in FY 2021 as discussed in section III.D.1.b.iii of this final rule. The new delineations will be based on the September 14, 2018 OMB Bulletin No. 18–04. In the aggregate, we do not estimate that these updates will affect overall estimated payments of IPFs since these changes will be implemented in a budget neutral manner. We observe that urban providers will experience no change in

payments and rural providers will see a 0.1 percent decrease in payments.

Finally, column 6 compares the total changes reflected in this final rule for FY 2021 to the estimates for FY 2020 (without these changes). The average estimated increase for all IPFs is approximately 2.3 percent. This estimated net increase includes the effects of the 2016-based IPF market basket update of 2.2 percent reduced by the productivity adjustment of 0 percentage point, as required by section 1886(s)(2)(A)(i) of the Act. It also includes the overall estimated 0.1 percent increase in estimated IPF outlier payments as a percent of total payments from the update to the outlier fixed dollar loss threshold amount. Column 6 also includes the distributional effects of the updates to the IPF wage index and the labor-related share whose impacts are displayed in columns 4 and 5.

IPF payments are estimated to increase by 2.3 percent in urban areas and 2.0 percent in rural areas. Overall, IPFs are estimated to experience a net increase in payments as a result of the updates in this final rule. The largest payment increase is estimated at 3.5 percent for IPFs in the Mid-Atlantic region.

4. Effect on Beneficiaries

Under the IPF PPS, IPFs will receive payment based on the average resources consumed by patients for each day. We do not expect changes in the quality of care or access to services for Medicare beneficiaries under the FY 2021 IPF PPS, but we continue to expect that paying prospectively for IPF services will enhance the efficiency of the Medicare program.

5. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will be directly impacted and will review this final rule, we assume that the total number of unique commenters on the most recent IPF proposed rule from FY 2021 (85 FR 20625) will be the number of reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this final rule. It is possible that not all commenters reviewed the FY 2021 IPF proposed rule in detail, and it is also possible that some reviewers chose not to comment on that proposed rule. For these reasons, we thought that the number of commenters would be a fair estimate of the number of reviewers who are directly impacted by this final rule. We did not receive any comments on this assumption.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this final rule; therefore, for the purposes of our estimate, we assume that each reviewer reads approximately 50 percent of this final rule.

Using the May, 2019 mean (average) wage information from the Bureau of Labor Statistics (BLS) for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this final rule is $110.74 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes119111.htm*). Assuming an average reading speed of 250 words per minute, we estimate that it would take approximately 49 minutes (0.82 hours) for the staff to review half of this final rule, given that there is a total of 24,480 words. For each IPF that reviews the final rule, the estimated cost is (0.82 hours × $110.74) or $90.36. Therefore, we estimate that the total cost of reviewing this final rule is $41,748.09 ($90.36 × 462 reviewers).

6. Special Requirements for Psychiatric Hospitals

In section V. of this final rule, we note that the existing requirements (prior to publication of the April 6, 2020 IFC) for psychiatric hospitals specified that progress notes must be recorded by the physicians(s), psychologists, or other ''licensed independent practitioner(s)'' responsible for the care of the patient. We believe that this provision required clarification and revision since the regulatory language was inconsistent with other recent changes finalized throughout the hospital CoPs as this provision applies to APPs, including PAs, NPs, clinical psychologists, and CNSs.

Continued use of this outdated term (''licensed independent practitioner(s)'') may inadvertently exacerbate workforce shortage concerns, and also might unnecessarily impose regulatory burden on hospitals, especially psychiatric hospitals, by restricting a hospital's ability to allow APPs to operate within the scope of practice allowed by state law. We believe that the previous regulation failed to recognize the benefits to patient care that might be derived from fully utilizing APPs and their clinical skills to the highest levels of their training, education, and experience as allowed by hospital policy in accordance with state law.

Therefore, we have removed the term ''licensed independent practitioner(s)'' (along with an inappropriate reference to § 482.12(c)) from the regulations. We believe that this revision is non-controversial, and that the public interest will be served by permitting a greater scope of practice for professionals in the psychiatric hospital context and further believe that these trained and qualified practitioners, when acting in accordance with state law, their scope of practice, and hospital policy, should have the authority to record progress notes of psychiatric patients for whose care they are responsible.

At § 482.61(d), we now allow non-physician practitioners, or APPs, to document progress notes in accordance with state laws and scope-of-practice requirements. We believe that clarification of the intent of the regulation is necessary and will result in non-physician practitioners (specifically PAs, NPs, and CNSs) documenting in the progress notes for patients receiving services in psychiatric hospitals.

We estimate that MDs/DOs currently spend approximately 30 minutes documenting progress notes in psychiatric hospitals, and that 33 percent of this time would be covered by non-physician practitioners. Of the 4,823 Medicare participating hospitals, approximately 620 (or 13 percent) are psychiatric hospitals. According to the American Hospital Association (AHA), there were 36,510,207 inpatient hospital stays in 2017, and therefore, an estimated 13 percent of these stays were at psychiatric hospitals.

Using May 2019 BLS data, we have obtained estimates of the national average hourly wage for Nurse Practitioners (29–1171), Physician Assistants (29–1071), Family Medicine Physicians (29–1215), General Internal Medicine Physicians (29–1216), and Psychiatrists (29–1223) in Psychiatric and Substance Abuse Hospitals (NAICS 622200). Using BLS employment numbers, we calculated a weighted average hourly wage for physicians/psychiatrists and for non-physician practitioners (NPs and PAs). We have adjusted these rates by adding 100 percent to the hourly wage to account for overhead costs and fringe benefit costs.

We estimate that this change in behavior will result in an annual savings of $176.8 million (4,746,327 psychiatric hospital stays × 2 progress notes per stay × 0.5 hours of physician/psychiatrist time × $112.88 per hourly wage difference between physicians/psychiatrists ($218.22) and non-physician practitioners ($105.34) × 33

percent of physician time spent writing progress notes covered by non-physician practitioners, or APPs), as shown in the Accounting Statement, Table 8, below. We note that there is some ambiguity in attributing these savings across the several rulemakings—Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (CoPs), (83 FR 47686); the April 6, 2020 IFC; and this final rule—that all address the progress note recording requirement.

D. Alternatives Considered

The statute does not specify an update strategy for the IPF PPS and is broadly written to give the Secretary discretion in establishing an update methodology. Therefore, we are updating the IPF PPS using the methodology published in the November 2004 IPF PPS final rule; applying the 2016-based IPF PPS market basket update for FY 2021 of 2.2 percent, reduced by the statutorily required multifactor productivity adjustment of 0 percentage point along with the wage index budget neutrality adjustment to update the payment rates; finalizing a FY 2021 IPF wage index which is fully based upon the OMB CBSA designations from Bulletin 18–04 and which uses the FY 2021 pre-floor, pre-reclassified IPPS hospital wage index as its basis.

E. Accounting Statement

As required by OMB Circular A–4 (available at *www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), in Table 8, we have prepared an accounting statement showing the classification of the expenditures associated with the updates to the IPF wage index and payment rates in this final rule. Table 8 provides our best estimates of the cost savings outlined in section VII.C.6 above, with high and low estimates generated at 25 percent above and below the primary estimate of $176.8 million as calculated in section VII.C.6. Table 8 also includes our best estimate of the increase in Medicare payments under the IPF PPS as a result of the changes presented in this final rule and based on the data for 1,550 IPFs in our database.

TABLE 8—Accounting Statement: Classification of Estimated Benefits, Savings, and Transfers
[$ millions]

Category	Primary estimate	Low estimate	High estimate	Units		
				Year dollars	Discount rate	Period covered
Annualized Monetized Costs (+) or Savings (-) ($million/ year) *	-176.8	-132.6	-221.0	2019	7%	2020–2030
	-176.8	-132.6	-221.0	2019	3%	2020–2030
Annualized Monetized Transfers from Federal Government to IPF Medicare Providers	95.0	-	-	2019	-	2020-2021

* We note that there is some ambiguity in attributing these savings across the several rulemakings—Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (CoPs), 83 FR 47686; the April 6, 2020, IFC, 85 FR 19230; and this final rule—that all address similar requirements.

F. Regulatory Flexibility Act

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 IPFs and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $8 million to $41.5 million or less in any 1 year. Individuals and states are not included in the definition of a small entity.

Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IPFs or the proportion of IPFs' revenue derived from Medicare payments. Therefore, we assume that all IPFs are considered small entities.

The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 7, we estimate that the overall revenue impact of this final rule on all IPFs is to increase estimated Medicare payments by approximately 2.3 percent. As a result, since the estimated impact of this final rule is a net increase in revenue across almost all categories of IPFs, the Secretary has determined that this final rule will have a positive revenue impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. As discussed in section V.C.1 of this final rule, the rates and policies set forth in this final rule will not have an adverse impact on the rural hospitals based on the data of the 248 rural excluded psychiatric units and 61 rural psychiatric hospitals in our database of 1,550 IPFs for which data were available. Therefore, the Secretary has determined that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandate Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2020, that threshold is approximately $156 million. This final rule does not mandate any requirements for state, local, or tribal governments, or for the private sector. This final rule would not impose a mandate that will result in the expenditure by state, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $156 million in any one year.

H. Federalism

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

proposed rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This final rule does not impose substantial direct costs on state or local governments or preempt state law.

I. Regulatory Reform Analysis Under Executive Order 13771

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.'' Though this final rule may contribute to the generation of $132.45 million in annualized cost savings (that is, $176.8 million as calculated in section VII.C.6 above, discounted at 7 percent relative to year 2016), this cost savings was accounted for in Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (CoPs) (83 FR 47686) and was associated with the special requirements for psychiatric hospitals in the April 6, 2020 IFC. As a result, it has been determined that this final rule is an action that primarily results in transfers and does not impose more than *de minimis* costs as described above and thus is not a regulatory or deregulatory action for the purposes of Executive Order 13771.

For the reasons set forth in the preamble, this rule is adopted as final and the amendment to § 482.61 (amendatory instruction number 48) in the interim final rule published on April 6, 2020 (85 FR 19292) is adopted as final without change.

Dated: July 23, 2020.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 29, 2020.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2020–16990 Filed 7–31–20; 4:15 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1733–F]

RIN 0938–AU09

Medicare Program; FY 2021 Hospice Wage Index and Payment Rate Update

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

ACTION: Final rule.

SUMMARY: This final rule updates the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2021. This rule also revises the hospice wage index to reflect the current Office of Management and Budget area delineations, with a 5 percent cap on wage index decreases. In addition, this rule responds to comments on the modified election statement and the addendum examples that were posted on the Hospice Center web page to assist hospices in understanding the content requirements finalized in the FY 2020 Hospice Wage Index and Payment Rate Update final rule, effective for hospice elections beginning on and after October 1, 2020.

DATES: These regulations are effective on October 1, 2020.

FOR FURTHER INFORMATION CONTACT:

For general questions about hospice payment policy, send your inquiry via email to: *hospicepolicy@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that recognizes the impending death of a terminally ill individual and warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define ''palliative care'' as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (42 CFR 418.3). Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit.

The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. Hospice is compassionate beneficiary and family/caregiver-centered care for those who are terminally ill.

As referenced in our regulations at § 418.22(b)(1), to be eligible for Medicare hospice services, the patient's attending physician (if any) and the hospice medical director must certify that the individual is ''terminally ill,'' as defined in section 1861(dd)(3)(A) of the Act and our regulations at § 418.3; that is, the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. The regulations at § 418.22(b)(3) require that the certification and recertification forms include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

Under the Medicare hospice benefit, the election of hospice care is a patient choice and once a terminally ill patient elects to receive hospice care, a hospice interdisciplinary group is essential in the seamless provision of services. These hospice services are provided primarily in the individual's home. The hospice interdisciplinary group works with the beneficiary, family, and caregivers to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families about changes in their condition. The beneficiary's care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

If, in the judgment of the hospice interdisciplinary team, which includes the hospice physician, the patient's symptoms cannot be effectively managed at home, then the patient is eligible for general inpatient care (GIP), a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital. GIP is provided to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to his or her home and continue to receive routine home care. Limited, short-term, intermittent, inpatient respite care (IRC) is also available