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Medicare Inpatient Rehabilitation Facility Prospective Payment System for FY 2021
[CMS-1729-F]
Summary of Final Rule

On August 10, 2020, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* (85 FR 48424) a final rule on the Medicare inpatient rehabilitation facility prospective payment system (IRF PPS) for federal fiscal year (FY) 2021. In addition to provisions that update the IRF PPS payment rates and outlier threshold for FY 2021, the final rule adopts revised wage index areas with a transition year for IRFs that would experience a lower wage index; permanently removes the post-admission evaluation requirement; makes revisions to certain IRF coverage requirements; and allows non-physician practitioners to perform some of the required weekly visits in place of a rehabilitation physician. No changes are made to the IRF Quality Reporting Program (IRF QRP) or to the IRF PPS facility-level adjustment factors (i.e., for rural, low income percentage and teaching status).

Information available on the CMS website includes data files with the 2021 IRF wage index; the case mix groups, relative weights and average length of stay and standard deviation values; and a file containing estimated payments and other data for the 1,117 IRFs used to estimate the policy updates in this rule.

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I. Introduction and Background

The final rule provides an overview of the IRF PPS, including statutory provisions, a description of the IRF PPS for FYs 2002 through 2020, and an operational overview. In addition, CMS highlights efforts at promoting adoption of interoperable health information technology and health information exchange in post-acute settings. It cites the hospital discharge planning final rule (84 FR 51836) provisions promoting the exchange of patient information between health care settings, and the May 2020 rules from CMS and the HHS Office of the National Coordinator for Health Information Technology pertaining to patient access, interoperability and information blocking (85 FR 25642 and 85 FR 25510).

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

Under the IRF case-mix classification system, a patient's principal diagnosis or impairment is used to classify the patient into a Rehabilitation Impairment Category (RIC). The patient is then placed into a case-mix group (CMG) within the RIC based on the patient's functional status (motor and cognitive scores) and sometimes age. Other special circumstances (e.g., very short stay or patient death) are also considered in determining the appropriate CMG. CMGs are further divided into tiers based on the presence of certain comorbidities; the tiers reflect the differential cost of care compared with the average beneficiary in the CMG.

Updates to the CMG relative weights and average length of stay values are finalized for FY 2021, continuing the same methodologies used in past years, and now applied to FY 2019 IRF claims and FY 2018 IRF cost report data. CMS notes that the data used are updated from the proposed rule, reflecting additional claims and cost reports. Changes to the CMG weights are made in a budget neutral manner; the final budget neutrality factor is 0.9970.

Table 2 in the final rule displays the FY 2021 relative weights and length of stay values by CMG and comorbidity tier. Table 3 shows the distributional effects of changes in CMG weights across cases. It shows that 99.3 percent of IRF cases are in CMGs for which the FY 2021 weight differs from the FY 2020 weight by less than 5 percent (either increase or decrease).
CMS says that the changes in the average length of stay values from FY 2020 to FY 2021 are small and do not show any particular trends in IRF length of stay patterns.

Column 7 of Table 13 in the impact section of the final rule (section X below) shows the distributional effects of the changes in the CMGs by type of facility.

CMS responds to a commenter requesting that the relative weights be frozen for FY 2021. CMS disagrees with a freeze in the weights. It has confidence that the data are valid and reliable, and notes that updating the weights annually ensures that the payment system reflects the most recent possible data on IRF utilization and case mix.

III. FY 2021 IRF PPS Payment Update

For FY 2021 payment, CMS applies the annual market basket update and productivity adjustment; updates the labor-related share of payment; adopts revised wage index areas and provides a transition for resulting changes to the wage index.

A. Market Basket Update and Productivity Adjustment

An update factor of 2.4 percent is finalized for the IRF PPS payment rates for FY 2021, composed of the following elements.

Final FY 2021 IRF PPS Update Factor	
Market basket	2.4%
Multifactor productivity (MFP)	0.0%
Total	2.4%

The 2.4 percent FY 2021 market basket increase factor is based on IHS Global Insight's (IGI's) forecast from the second quarter of 2020, based on actual data through the first quarter. It is substantially below the 2.9 percent included in the proposed rule, which was based on IGI's first quarter 2020 forecast, with historical data through fourth quarter 2019. CMS notes the lower forecast is primarily the result of slower growth in compensation for both health-related and other occupations, as labor markets are expected to be significantly impacted by the recession that began in February 2020.

The final multifactor productivity (MFP) adjustment is 0.0, a notable change from the proposed rule, which included an adjustment of -0.4 percentage points. For the final rule, CMS uses the most recent available forecast for the 10-year moving average of changes in MFP for the period ending September 30, 2021. That forecast, from June 2020, is -0.1, which if subtracted from the market basket would result in a +0.1 percentage point addition to the IRF update factor. The statute does not allow for a positive MFP adjustment; the final rule therefore includes an adjustment of 0.0 percentage points. CMS notes that it is not using IGI's second quarter 2020 MFP forecast, which it usually would do for the final rule MFP. That forecast would have resulted in an MFP adjustment for FY 2021 of -0.7 percentage points. The large difference in the second quarter and June MFP forecasts is atypical and due to the unprecedented economic uncertainty associated with the COVID-19 pandemic. (The MFP forecasts are available monthly, whereas the market basket forecast is only updated quarterly. The most recent market basket forecast available for the final rule is the second quarter 2020 forecast.)

For IRFs that fail to meet the requirements of the IRF QRP, the FY 2021 update factor will be 0.4 percent (2.4 percent full update minus 2.0 percentage points). See section VIII.

B. Labor-Related Share

CMS finalizes a total labor-related share of 73.0 percent for FY 2021, a small change from the FY 2020 labor share of 72.7 percent. The 73.0 percent comes from the IGI second quarter 2020 estimate of 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 (46 percent) of the Capital-Related cost weight from the IRF market basket. The relative importance reflects the different rates of price change for these cost categories between the base year (2016) and FY 2021. Table 4 of the final rule compares the components of the FY 2020 and FY 2021 labor shares.

C. Wage Adjustment

Under previously adopted policy, for the IRF PPS wage index CMS uses the Core Based Statistical Areas (CBSA) labor market area definitions and the pre-floor, pre-reclassification Inpatient Prospective Payment System (IPPS) hospital wage index for the current fiscal year. For FY 2021, therefore, CMS will use the FY 2021 pre-floor, pre-reclassification IPPS wage index. The FY 2021 pre-reclassification and pre-floor hospital wage index is based on FY 2017 cost report data. Any changes made to the IRF PPS wage index from the previous fiscal year are made in a budget neutral manner.

The CBSAs are established by the Office of Management and Budget (OMB). They are generally subject to major revisions every 10 years to reflect information from the decennial census, but OMB also issues minor revisions in the intervening years through OMB Bulletins. CMS has previously adopted OMB changes to CBSA delineations for purposes of the IRF PPS labor market areas. The history of these changes to the IRF wage index is discussed in the final rule. For purposes of the IRF wage index, OMB-designated Micropolitan Statistical Areas[1] are considered to be rural areas. The OMB Bulletins are available at https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.

For FY 2021, CMS finalizes its proposal to modify the IRF wage index to reflect changes included in OMB Bulletin No. 18-04, issued on September 14, 2018, and to provide for a transition policy as detailed further below. CMS notes that on March 6, 2020, OMB issued OMB Bulletin 20-01, but it was not issued in time for development of this final rule. CMS does not believe that the minor updates included in that Bulletin would impact its updates to the labor market area delineations. If needed, CMS will propose any updates from that bulletin in the FY 2022 IRF PPS proposed rule.

Adopting the revised delineations included in OMB Bulletin No 18-04 changes 34 urban counties from urban to rural, another 47 counties from rural to urban, and shifts some urban counties between existing and new CBSAs. Tables 5, 6 and 8 in the final rule detail the areas affected by

[1] OMB defines a Micropolitan Statistical Area as an area 'associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000.

these substantive changes. Table 7 identifies areas where only the CBSA name or number would change, without affecting assignment of a wage index.

The transition policy caps the decrease in any IRF's wage index from FY 2020 to FY 2021 at 5 percent. No such cap will be applied in FY 2022. CMS believes this policy improves the accuracy of the IRF PPS wage index while giving negatively affected IRFs time to adapt.

CMS responds to comments on the transition policy. It does not agree with some commenters that the 5 percent cap should also limit increases in the wage index, because the policy is meant to mitigate negative effects of the changing wage areas, not curtail the positive impacts of making the wage index more accurate. It believes that using a 50/50 blend of wage indexes instead of the cap would unnecessarily affect all hospitals, while the final proposal is targeted at limiting the significant negative effects.

Changes to the IRF PPS wage index are made in a budget neutral manner; CMS calculates the budget neutrality adjustment for FY 2021 to be 1.0013. To make this calculation, CMS estimates aggregate IRF PPS payments using the FY 2020 labor-related share and wage index values and then estimates aggregate payments using the FY 2021 labor share and wage index values. The ratio of the amount based on the FY 2020 index to the amount estimated using the 2021 index is the budget neutrality adjustment to be applied to the federal per diem base rate for FY 2021.

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

Table 9 of the final rule (reproduced below) shows the calculations used to determine the final FY 2021 IRF standard payment amount. In addition, Table 10 lists the FY 2021 payment rates for each CMG, and Table 11 provides a detailed hypothetical example of how the IRF FY 2021 federal prospective payment would be calculated for CMG 0104 (without comorbidities) for two different IRF facilities (one urban, teaching and one rural, non-teaching), using the applicable wage index values and facility-level adjustment factors under the final rule.

Table 9: Calculations to Determine the FY 2021 Standard Payment Conversion Factor		
Explanation for Adjustment	**Calculations**	
Standard Payment Conversion Factor for FY 2020		$16,489
Market Basket Increase Factor for FY 2021 (2.4 percent), reduced by 0.0 percentage points for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act	X	1.024
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	X	1.0013
Budget Neutrality Factor for the Revisions to the CMGs and CMG Relative Weights	X	0.9970
FY 2021 Standard Payment Conversion Factor	=	$16,856

IV. Update to Payments for High-Cost Outliers under the IRF PPS

Under the IRF PPS, if the estimated cost of a case (based on application of an IRF's overall cost-to-charge ratio (CCR) to Medicare allowable covered charges) is higher than the adjusted outlier threshold, CMS makes an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold. From the beginning of the IRF

PPS, CMS' intent has been to set the outlier threshold so that the estimated outlier payments would equal 3 percent of total estimated payments, and this policy is continued for FY 2021. CMS believes this level reduces financial risk to IRFs of caring for high-cost patients while still providing adequate payments for all other cases.

To update the IRF outlier threshold amount for FY 2021, CMS uses FY 2019 claims data and the same methodology that has been used to set and update the outlier threshold since the FY 2002 IRF PPS final rule. CMS estimates that IRF outlier payments as a percentage of total estimated payments will be 2.6 percent of total IRF payments in FY 2020. To maintain estimated outlier payments at the 3 percent level, CMS updates the outlier threshold amount from $9,300 for FY 2020 to $7,906 for FY 2021.

Updates are finalized for the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2021, based on analysis of the most recent cost report data that are available (FY 2018). CCRs are used in converting an IRF's Medicare allowable covered charges for a case to costs for purposes of determining appropriate outlier payment amounts. The national urban and rural CCRs are applied in the following situations: new IRFs that have not yet submitted their first Medicare cost report; IRFs with an overall CCR that is more than the national CCR ceiling for FY 2019; and other IRFs for which accurate data to calculate an overall CCR are not available. The national CCR ceiling for FY 2021 continues to be set at 3 standard deviations above the mean CCR. If an individual IRF's CCR exceeds the ceiling, CMS replaces the IRF's CCR with the appropriate national average CCR (either urban or rural).

The final national average CCRs for FY 2021 are 0.398 for urban IRFs and 0.493 for rural IRFs, and the national CCR ceiling is 1.34. That is, if an individual IRF's CCR exceeds this ceiling of 1.33 for FY 2021, CMS replaces the IRF's CCR with the appropriate national average CCR (either rural or urban, depending on the geographic location of the IRF).

V. Removal of the Post-Admission Physician Evaluation Requirement

CMS permanently removes the post-admission physician evaluation requirement at §412.622(a)(4)(ii) that it has removed for the duration of the COVID-19 public health emergency.[2] This requirement provided that the patient's medical record at the IRF must contain a post-admission physician evaluation that meets all of the following requirements:

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

[2] See the interim final rule with comment "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency", published on April 6, 2020 (85 FR 19230).

Under this final rule the requirement is permanently removed for all IRF discharges beginning on or after October 1, 2020. Conforming changes are made to regulatory text at §412.622(a)(3)(iv), and CMS also rescinds the associated policy described in Chapter 1, Section 110.1.2, of the Medicare Benefit Policy Manual. Among other things the policy manual provides for up to three days of IRF payment in cases where the post-admission evaluation determines that the patient is not an appropriate candidate for IRF care in disagreement with the preadmission screening.

The rationale offered for permanent removal of this requirement is that CMS believes IRFs are more knowledgeable in determining prior to admission whether a patient meets the coverage criteria for IRF services than they were when the IRF coverage requirements were initially implemented. It believes that IRFs are doing due diligence while completing the pre-admission screening, and offers that over time, the number of cases for which the post admission evaluation determines the patient was not an appropriate candidate for IRF care has decreased to a total of 4 times across all IRFs in FY 2019. CMS reports that commenters were unanimously supportive of this policy change.

CMS notes that this does not preclude an IRF patient from being evaluated by a rehabilitation physician or by a non-physician practitioner (see section VII below) within the first 24 hours of admission if the IRF believes that the patient's condition warrants it. Further, CMS reminds readers that the requirements for rehabilitation physician visits within the first week of the patient's stay are retained. It believes that removing the post-admission physician evaluation will reduce administrative and paperwork burden for both IRF providers and Medicare Administrative Contractors (MACs).

VI. Revisions to Certain IRF Coverage Documentation Requirements

CMS finalizes its proposal to codify existing policies regarding preadmission screening documentation, with modifications from the proposed rule that eliminate some required elements.

A. Codification of Existing Preadmission Screening Documentation Instructions and Guidance

CMS codifies existing requirements for preadmission screening, some of which currently appear in regulatory text at §412.622(a)(4)(i), and further details which are set forth in the Medicare Benefit Policy Manual Chapter 1, Section 110.1.1. Because the latter represent longstanding guidance and instructions in place since the IRF coverage requirements were implemented in 2010, CMS believes codification will (1) improve clarity and reduce administrative burden on both IRF providers and MACs; (2) mitigate tasks that take away from time spent directly with the patient, and (3) locate all preadmission screening documentation requirements in the same place for ease of reference by providers and MACs.

Specifically, the following modifications to the regulatory text are finalized:

- At §412.622(a)(4)(i)(B), to provide that the comprehensive preadmission screening must include a detailed and comprehensive review of each patient's condition and medical history, including the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy, expected level of improvement, and the expected length of time necessary to achieve that level of improvement; an evaluation

of the patient's risk for clinical complications; the conditions that caused the need for rehabilitation; the treatments needed (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics); and anticipated discharge destination.

- In response to comments and in consultation with CMS medical officers, CMS removes from the Medicare Benefit Policy Manual three required elements of the preadmission screening that were also proposed for codification in the list above. It considers the removed elements as duplicative of information that will be captured in other medical documentation, such as the medical history and physical or the individualized plan of care, and ones that require the rehabilitation physician to predict what will happen during and after the IRF admission, which can change during the patient's stay. The three elements removed from preadmission screening requirements are anticipated post-discharge treatment, expected frequency and duration of treatment in the IRF, and other information relevant to the patient's care needs. CMS believes this change will reduce provider burden without reducing quality of care and is in keeping with the Patients over Paperwork initiative.
- At §412.622(a)(4)(i)(D), to provide that the comprehensive preadmission screening must be used to inform a rehabilitation physician who reviews and documents his or her concurrence with the findings and results of the preadmission screening prior to the IRF admission.

CMS responds to comments it received on this proposal and its solicitation of comments in the proposed rule regarding further changes to the preadmission screening documentation requirements. While CMS agrees with the commenters that IRF rehabilitation physicians should have the freedom to include in the preadmission screening document the information that best supports their decision to admit the patient, it believes it necessary to specify the basic minimum elements that should be included in a detailed and comprehensive preadmission screening to eliminate confusion and ambiguity in the requirement.

B. Definition of a "Week"

The regulation at §412.622(a)(3)(ii) states that current industry standards for an intensive rehabilitation therapy program generally consist of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF.

In this rule CMS clarifies that for purposes of the IRF coverage requirements "week" is defined as "7 consecutive calendar days beginning with the date of admission to the IRF." This change is made out of concern that the term might otherwise be construed to mean something different, such as Monday through Sunday. Specifically, the definition is added at §412.622(c) and the text at 412.622(a)(3)(ii) is modified to replace "7 consecutive day period, beginning with the date of admission to the IRF" with "week."

VII. Allowing Non-physician Practitioners to Perform Some of the Weekly Visits Currently Required of a Rehabilitation Physician

Currently, several of the IRF coverage requirements (§412.622(a)(3), (4), and (5)) must be performed by a rehabilitation physician, defined (at §412.622(c)) as a licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation. For example, a rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient and to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. More information and guidance are available in the Medicare Benefit Policy Manual, Chapter 1, Section 110.2.4.

In this rule CMS modifies these requirements to allow non-physician practitioners to perform certain IRF coverage requirements; only a portion of the proposed rule changes are adopted, however. The proposed rule would have broadly allowed a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation to perform any of the duties that are required to be performed by a rehabilitation physician, provided that the duties are within the non-physician practitioner's scope of practice under applicable state law.

While CMS continues to believe that non-physician practitioners have an important role in treating IRF patients, given the strong comments it received objecting to the proposed rule, CMS believes that taking a measured approach is appropriate to ensure that vulnerable IRF patients will receive the highest quality care. Those comments stated that the role and judgment of rehabilitation physicians in IRFs is central to the successful outcomes of complex IRF patients, and a key element in what separates IRFs from other lesser intensive post-acute care settings. They suggested that non-physician practitioners do not have adequate training and experience to conduct the preadmission screening, individualized plan of care, 3 weekly face-to-face visits, and interdisciplinary team requirements. Further, they suggested that substituting non-physician practitioners for rehabilitation physicians in the IRF would be likely to result in worse clinical outcomes for patients and an increase in medical complications, readmission, acute transfers, and emergency room utilization, thereby raising costs to the Medicare program.

As finalized, CMS provides (at §412.622(a)(3)(iv) to §412.29(e)) that non-physician practitioners may conduct one of the three required rehabilitation physician visits in every week of the IRF stay, with the exception of the first week, if permitted under state law. In the first week of the IRF stay, the rehabilitation physician would continue to be required to visit patients a minimum of three times to ensure that the patient's plan of care is fully established and optimized to the patient's care needs in the IRF.

CMS believes that the finalized approach takes full advantage of the extensive training and knowledge of rehabilitation physicians but also allows non-physician practitioners to take an expanded role in patient care once the rehabilitation physician has fully established the patient's plan of care in the first week. While CMS does not estimate significant savings from this provision, it disagrees with commenters that program costs will increase because rehabilitation physicians will still be directly involved in setting and implementing the patient's IRF plan of

care. CMS believes that non-physician practitioners can add significant expertise to the patient care team, including recognizing emergent issues that, if left unaddressed, could lead to unplanned readmissions to the acute care hospitals.

VIII. Update Factor Reduction for IRFs That Fail to Meet IRF QRP Requirements

An IRF that fails to meet the requirements of the IRF QRP for a year is subject to a 2-percentage point reduction in the applicable update factor for that year. Table 12 of the final rule (reproduced below) shows the calculation of the adjusted FY 2021 standard payment conversion factor for any IRF that fails to meet the IRF QRP reporting requirements.

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

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

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

CMS waives the requirement under the Congressional Review Act (CRA) that the final rule be published at least 60 days prior to the effective date. In light of the COVID-19 public health emergency and the resulting strain on its resources, CMS says it was impracticable for it to publish the IRF PPS final rule 60 days before the effective date. The IRF PPS final rule will take effect 55 days after issuance; CMS believes it would be contrary to the public interest for it to do otherwise. The authority for this waiver is provided in the CRA; if an agency finds good cause that notice and public comment procedure are impracticable, unnecessary, or contrary to the public interest, the rule shall take effect at such time as the agency determines.

X. Regulatory Impact Analysis

CMS estimates that the final rule will increase Medicare payments to IRFs by $260 million in FY 2021 compared with FY 2020. Of this total, $220 million results from the 2.4 percent increase from the update factor and $40 million from the change in the outlier threshold, which will increase aggregate payments to IRFs by an estimated 0.4 percent. Table 13 in the final rule, reproduced below, shows the effects of these and other policy changes by type of IRF. The other policy changes shown in Table 13 involving the wage index and labor market areas and changes to the CMG weights are all designed to be budget neutral and therefore have no effect on

aggregate payments to IRFs. The $260 million figure excludes the effects of payment reductions to IRFs that fail to meet the IRF QRP requirements.

Further, CMS estimates total annual cost savings from allowing non-physician practitioners to complete one of the three face-to-face visits required weekly for each IRF patient beginning with the patient's second week of admission. (See section VII above.) If all IRFs took full advantage of the flexibility to substitute non-physician practitioners for these requirements, CMS estimates $6 million in Medicare Part B savings based on Medicare Physician Fee Schedule (PFS) payment and billing policies. However, CMS assumes that IRFs will use this flexibility for half of services provided, for a total of $3 million. Of this amount, $2.4 million will accrue to the Medicare program and $600,000 to beneficiaries in reduced cost sharing. Medicare savings accrue from this proposal because non-physician practitioners are able to bill 80 percent of what physicians bill.

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

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 21 Wage Index and Labor Share	FY 21 Wage Index New CBSA and 5% Cap	CMG Weights	Total Percent Change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Total	1,118	410,883	0.4	0.0	0.0	0.0	2.8
Urban unit	684	161,642	0.7	0.1	0.0	0.0	3.2
Rural unit	132	20,758	0.7	0.0	0.1	0.0	3.2
Urban hospital	291	223,421	0.2	0.0	0.0	0.0	2.5
Rural hospital	11	5,062	0.0	0.0	-0.2	0.0	2.2
Urban For-Profit	361	218,350	0.2	0.0	0.0	0.0	2.5
Rural For-Profit	33	8,487	0.3	0.0	0.0	0.0	2.6
Urban Non-Profit	521	145,259	0.7	0.1	0.0	0.0	3.2
Rural Non-Profit	89	14,171	0.8	0.0	0.0	0.0	3.2
Urban Government	93	21,454	0.7	-0.1	0.2	0.0	3.2
Rural Government	21	3,162	0.4	0.0	0.0	0.1	3.0
Urban	975	385,063	0.4	0.0	0.0	0.0	2.8
Rural	143	25,820	0.6	0.0	0.0	0.0	3.0
Urban by region							
Urban New England	29	16,117	0.4	-0.6	0.0	-0.1	2.1
Urban Middle Atlantic	132	48,820	0.5	0.4	-0.3	0.1	3.0
Urban South Atlantic	153	78,375	0.3	0.1	0.0	0.0	2.8
Urban East North Central	159	50,217	0.5	0.2	0.0	0.0	3.1
Urban East South Central	56	28,428	0.2	0.1	0.0	0.0	2.6
Urban West North Central	73	21,136	0.5	-0.6	0.0	0.0	2.1
Urban West South Central	188	85,336	0.3	0.1	0.1	0.1	3.0
Urban Mountain	87	30,648	0.4	-0.4	0.0	-0.1	2.3
Urban Pacific	98	25,986	0.8	-0.3	0.3	-0.1	3.2
Rural by region							
Rural New England	5	1,347	0.5	0.6	0.0	-0.2	3.3
Rural Middle Atlantic	11	1,189	1.1	0.4	0.0	0.0	4.0
Rural South Atlantic	16	3,796	0.4	-0.3	-0.3	0.0	2.2
Rural East North Central	23	4,068	0.5	0.4	0.1	0.0	3.4
Rural East South Central	21	4,442	0.3	0.0	0.0	-0.1	2.6
Rural West North Central	20	3,047	0.8	-0.1	0.2	0.0	3.2
Rural West South Central	39	7,005	0.5	-0.2	0.1	0.2	3.0

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

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