DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 425, 455, and 495

[CMS–1752–F2 and CMS–1762–F2]

RIN 0938–AU44 and 0938–AU56

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Changes to Medicaid Provider Enrollment; and Changes to the Medicare Shared Savings Program; Corrections

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule; correction and correcting amendment.

SUMMARY: This document corrects technical and typographical errors in the final rule that appeared in the August 13, 2021, issue of the **Federal Register** titled ''Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Changes to Medicaid Provider Enrollment; and Changes to the Medicare Shared Savings Program.''

DATES:

Effective date: The final rule corrections and correcting amendment are effective on October 19, 2021.

Applicability date: The final rule corrections and correcting amendment are applicable to discharges occurring on or after October 1, 2021.

FOR FURTHER INFORMATION CONTACT: Donald Thompson, (410) 786–4487, and Michele Hudson, (410) 786–4487, Operating Prospective Payment, Wage Index, Hospital Geographic Reclassifications, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Graduate Medical Education, and Critical Access Hospital (CAH) Issues. Mady Hue, (410) 786–4510, and Andrea Hazeley, (410) 786–3543, MS–DRG Classification Issues.

Allison Pompey, (410) 786–2348, New Technology Add-On Payments Issues. Julia Venanzi, *julia.venanzi@cms.hhs.gov,* Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing Programs.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2021–16519 of August 13, 2021 (86 FR 44774), there were a number of technical and typographical errors that are identified and corrected in this final rule correction and correcting amendment. The final rule corrections and correcting amendment are applicable to discharges occurring on or after October 1, 2021, as if they had been included in the document that appeared in the August 13, 2021, **Federal Register**.

II. Summary of Errors

A. Summary of Errors in the Preamble

On page 44878, we are correcting an inadvertent error in the reference to the number of technologies for which we proposed to allow a one-time extension of new technology add-on payments for fiscal year (FY) 2022.

On page 44889, we are correcting an inadvertent typographical error in the International Classification of Disease, 10th Revision, Procedure Coding System (ICD–10–PCS) procedure code describing the percutaneous endoscopic repair of the esophagus.

On page 44960, in the table displaying the Medicare-Severity Diagnosis Related Groups (MS–DRGs) subject to the policy for replaced devices offered without cost or with a credit for FY 2022, we are correcting inadvertent typographical errors in the MS–DRGs describing Hip Replacement with Principal Diagnosis of Hip Fracture with and without MCC, respectively.

On pages 45047, 45048, and 45049, in our discussion of the new technology add-on payments for FY 2022, we are correcting typographical and technical errors in referencing sections of the final rule.

On page 45133, we are correcting an error in the maximum new technology add-on payment for a case involving the use of Aprevo™ Intervertebral Body Fusion Device.

On page 45150, we inadvertently omitted ICD–10–CM codes from the list of diagnosis codes used to identify cases involving the use of the INTERCEPT Fibrinogen Complex that would be eligible for new technology add-on payments.

On page 45157, we inadvertently omitted the ICD–10–CM diagnosis codes used to identify cases involving the use of FETROJA® for HABP/VABP.

On page 45158, we inadvertently omitted the ICD–10–CM diagnosis codes used to identify cases involving the use of RECARBRIO™ for HABP/VABP.

On pages 45291, 45293, and 45294, in three tables that display previously established, newly updated, and estimated performance standards for measures included in the Hospital Value-Based Purchasing Program, we are correcting errors in the numerical values for all measures in the Clinical Outcomes Domain that appear in the three tables.

On page 45312, in our discussion of payments for indirect and direct graduate medical education costs and Intern and Resident Information System (IRIS) data, we made a typographical error in our response to a comment.

On page 45386, we made an inadvertent typographical error in our discussion of the Hospital Inpatient Quality Reporting (IQR) Program Severe Hyperglycemia electronic clinical quality measure (eCQM).

On page 45400, in our discussion of the Hospital Inpatient Quality Reporting (IQR) Program measures for fiscal year (FY) 2024, we mislabeled the table title and inadvertently included a measure not pertaining to the FY 2024 payment determination along with its corresponding footnote.

On page 45404, in our discussion the Hospital Inpatient Quality Reporting (IQR) Program, we included a table with the measures for the FY 2025 payment determination. In the notes that immediately followed the table, we made a typographical error in the date associated with the voluntary reporting period for the Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) measure.

B. Summary of Errors in the Regulations Text

On page 45521, in the regulations text for § 413.24(f)(5)(i) introductory text and (f)(5)(i)(A) regarding cost reporting forms and teaching hospitals, we inadvertently omitted revisions that were discussed in the preamble.

C. Summary of Errors in the Addendum

In the FY 2022 Hospital Inpatient Prospective Payment Systems and Long-Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) final rule (85 FR 45166), we stated that we excluded the wage data for critical access hospitals (CAHs) as discussed in the FY 2004 IPPS final rule (68 FR 45397 through 45398); that is, any hospital that is designated as a CAH by 7 days prior to the publication of the preliminary wage index public use file (PUF) is excluded from the calculation

of the wage index. We inadvertently excluded a hospital that converted to CAH status after January 24, 2021, the cut-off date for CAH exclusion from the FY 2022 wage index. (CMS Certification Number (CCN) 230118) Therefore, we restored the wage data for this hospital and included it in our calculation of the wage index. This correction necessitated the recalculation of the FY 2022 wage index for rural Michigan (rural state code 23), as reflected in Table 3, and affected the final FY 2022 wage index for rural Michigan 23 as well as the rural floor for the State of Michigan. As discussed in this section, the final FY 2022 IPPS wage index is used when determining total payments for purposes of all budget neutrality factors (except for the MS–DRG reclassification and recalibration budget neutrality factor) and the final outlier threshold.

We note, in the final rule, we correctly listed the number of hospitals with CAH status removed from the FY 2022 wage index (86 FR 45166), the number of hospitals used for the FY 2022 wage index (86 FR 45166) and the number of hospital occupational mix surveys used for the FY 2022 wage index (86 FR 45173). Additionally, the FY 2022 national average hourly wage (unadjusted for occupational mix) (86 FR 45172), the FY 2022 occupational mix adjusted national average hourly wage (86 FR 45173), and the FY 2022 national average hourly wages for the occupational mix nursing subcategories (86 FR 45174) listed in the final rule remain unchanged. Because the numbers and values noted previously are correctly stated in the preamble of the final rule and remain unchanged, we do not include any corrections in section IV.A. of this final rule correction and correcting amendment.

We made an inadvertent error in the Medicare Geographic Classification Review Board (MGCRB) reclassification status of one hospital in the FY 2022 IPPS/LTCH PPS final rule. Specifically, CCN 360259 is incorrectly listed in Table 2 as reclassified to CBSA 19124. The correct reclassification area is to its geographic ''home'' of CBSA 45780. This correction necessitated the recalculation of the FY 2022 wage index for CBSA 19124 and affected the final FY 2022 wage index with reclassification. The final FY 2022 IPPS wage index with reclassification is used when determining total payments for purposes of all budget neutrality factors (except for the MS–DRG reclassification and recalibration budget neutrality factor and the wage index budget neutrality adjustment factor) and the final outlier threshold.

As discussed further in section II.E. of this final rule correction and correcting amendment, we made updates to the calculation of Factor 3 of the uncompensated care payment methodology to reflect updated information on hospital mergers received in response to the final rule and made corrections for report upload errors. Factor 3 determines the total amount of the uncompensated care payment a hospital is eligible to receive for a fiscal year. This hospital-specific payment amount is then used to calculate the amount of the interim uncompensated care payments a hospital receives per discharge. Per discharge uncompensated care payments are included when determining total payments for purposes of all of the budget neutrality factors and the final outlier threshold. As a result, the revisions made to the calculation of Factor 3 to address additional merger information and report upload errors directly affected the calculation of total payments and required the recalculation of all the budget neutrality factors and the final outlier threshold.

Due to the correction of the combination of errors that are discussed previously (correcting the number of hospitals with CAH status, the correction to the MGCRB reclassification status of one hospital, and the revisions to Factor 3 of the uncompensated care payment methodology), we recalculated all IPPS budget neutrality adjustment factors, the fixed-loss cost threshold, the final wage indexes (and geographic adjustment factors (GAFs)), the national operating standardized amounts and capital Federal rate. We note that the fixed-loss cost threshold was unchanged after these recalculations. Therefore, we made conforming changes to the following:

- On page 45532, the table titled ''Summary of FY 2022 Budget Neutrality Factors''.
- On page 45537, the estimated total Federal capital payments and the estimated capital outlier payments.
- On pages 45542 and 45543, the calculation of the outlier fixed-loss cost threshold, total operating Federal payments, total operating outlier payments, the outlier adjustment to the capital Federal rate and the related discussion of the percentage estimates of operating and capital outlier payments.
- On page 45545, the table titled ''Changes from FY 2021 Standardized Amounts to the FY 2022 Standardized Amounts''.

On pages 45553 through 45554, in our discussion of the determination of the Federal hospital inpatient capital related prospective payment rate update, due to the recalculation of the GAFs, we have made conforming corrections to the capital Federal rate. As a result of these changes, we also made conforming corrections in the table showing the comparison of factors and adjustments for the FY 2021 capital Federal rate and FY 2022 capital Federal rate. As we noted in the final rule, the capital Federal rate is calculated using unrounded budget neutrality and outlier adjustment factors. The unrounded GAF/DRG budget neutrality factor, the unrounded Quartile/Cap budget neutrality factor, and the unrounded outlier adjustment to the capital Federal rate were revised because of these errors. However, after rounding these factors to 4 decimal places as displayed in the final rule, the rounded factors were unchanged from the final rule.

On pages 45570 and 45571, we are making conforming corrections to the national adjusted operating standardized amounts and capital standard Federal payment rate (which also include the rates payable to hospitals located in Puerto Rico) in Tables 1A, 1B, 1C, and 1D as a result of the conforming corrections to certain budget neutrality factors, as previously described.

D. Summary of Errors in the Appendices

On pages 45576 through 45580, 45582 through 45583, and 45598 through 45600, in our regulatory impact analyses, we have made conforming corrections to the factors, values, and tables and accompanying discussion of the changes in operating and capital IPPS payments for FY 2022 and the effects of certain IPPS budget neutrality factors as a result of the technical errors that lead to changes in our calculation of the operating and capital IPPS budget neutrality factors, outlier threshold, final wage indexes, operating standardized amounts, and capital Federal rate (as described in section II.C. of this final rule correction and correcting amendment). These conforming corrections include changes to the following:

- On pages 45576 through 45578, the table titled ''Table I—Impact Analysis of Changes to the IPPS for Operating Costs for FY 2022''.
- On pages 45582 and 45583, the table titled ''Table II—Impact Analysis of Changes for FY 2022 Acute Care Hospital Operating Prospective Payment System (Payments per discharge)''.
- On pages 45599 and 45600, the table titled ''Table III—Comparison of

Total Payments per Case [FY 2021 Payments Compared to FY 2022 Payments]''.

On pages 45584 and 45585 we are correcting the maximum new-technology add-on payment for a case involving the use of Fetroja, Recarbrio, Tecartus, and Abecma and related information in the untitled tables as well as making conforming corrections to the total estimated FY 2022 payments in the accompanying discussion of applications approved or conditionally approved for new technology add-on payments.

On pages 45587 through 45589, we are correcting the discussion of the ''Effects of the Changes to Medicare DSH and Uncompensated Care Payments for FY 2022'' for purposes of the Regulatory Impact Analysis in Appendix A of the FY 2022 IPPS/LTCH PPS final rule, including the table titled ''Modeled Uncompensated Care Payments for Estimated FY 2022 DSHs by Hospital Type: Uncompensated Care Payments ($ in Millions)*—from FY 2021 to FY 2022'', in light of the corrections discussed in section II.E. of this final rule correction and correcting amendment.

On pages 45610 and 45611, we are making conforming corrections to the estimated expenditures under the IPPS as a result of the corrections to the maximum new technology add-on payment for a case involving the use of Aprevo™ Intervertebral Body Fusion Device, Fetroja, Recarbrio, Abecma, and Tecartus as described in this section and in section II.A. of this final rule correction and correcting amendment.

E. Summary of Errors in and Corrections to Files and Tables Posted on the CMS Website

We are correcting the errors in the following IPPS tables that are listed on pages 45569 and 45570 of the FY 2022 IPPS/LTCH PPS final rule and are available on the internet on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.* The tables that are available on the internet have been updated to reflect the revisions discussed in this final rule correction and correcting amendment.

Table 2—Case-Mix Index and Wage Index Table by CCN–FY 2022 Final Rule. As discussed in section II.C. of this final rule correction and correcting amendment, we inadvertently excluded a hospital that converted to CAH status after January 24, 2021, the cut-off date for CAH exclusion from the FY 2022 wage index. (CMS Certification Number (CCN) 230118). Therefore, we restored provider 230118 to the table. Also, as discussed in section II.C. of this final rule correction and correcting amendment, CCN 360259 is incorrectly listed as reclassified to CBSA 19124. The correct reclassification area is to its geographic ''home'' of CBSA 45780. In this table, we are correcting the columns titled ''Wage Index Payment CBSA'' and ''MGCRB Reclass'' to accurately reflect its reclassification to CBSA 45780. This correction necessitated the recalculation of the FY 2022 wage index for CBSA 19124. As also discussed later in this section, because the wage indexes are one of the inputs used to determine the out-migration adjustment, some of the out-migration adjustments changed. Therefore, we are making corresponding changes to the affected values.

Table 3.—Wage Index Table by CBSA—FY 2022 Final Rule. As discussed in section II.C. of this final rule correction and correcting amendment, we inadvertently excluded a hospital that converted to CAH status after January 24, 2021, the cut-off date for CAH exclusion from the FY 2022 wage index. (CMS Certification Number (CCN) 230118). Therefore, we recalculated the wage index for rural Michigan (rural state code 23), as reflected in Table 3, as well as the rural floor for the State of Michigan. Also, as discussed in section II.C. of this final rule correction and correcting amendment, CCN 360259 is incorrectly listed as reclassified to CBSA 19124. The correct reclassification area is to its geographic ''home'' of CBSA 45780. In this table, we are correcting the values that changed as a result of these corrections as well as any corresponding changes.

Table 4A.—List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act—FY 2022 Final Rule. As discussed in section II.C. of this final rule correction and correcting amendment, we inadvertently excluded a hospital that converted to CAH status after January 24, 2021, the cut-off date for CAH exclusion from the FY 2022 wage index. (CMS Certification Number (CCN) 230118). Also, as discussed in section II.C. of this final rule correction and correcting amendment, CCN 360259 is incorrectly listed as reclassified to CBSA 19124. The correct reclassification area is to its geographic ''home'' of CBSA 45780. As a result, as discussed previously, we are making changes to the FY 2022 wage indexes. Because the wage indexes are one of the inputs used to determine the out-migration adjustment, some of the out-migration adjustments changed. Therefore, we are making corresponding changes to some of the out-migration adjustments listed in Table 4A.

Table 6B.—New Procedure Codes—FY 2022. We are correcting this table to reflect the assignment of procedure codes XW033A7 (Introduction of ciltacabtagene autoleucel into peripheral vein, percutaneous approach, new technology group 7) and XW043A7 (Introduction of ciltacabtagene autoleucel into central vein, percutaneous approach, new technology group 7) to Pre-MDC MS–DRG 018 (Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies). Table 6B inadvertently omitted Pre-MDC MS–DRG 018 in Column E (MS–DRG) for assignment of these codes. Effective with discharges on and after April 1, 2022, conforming changes will be reflected in the Version 39.1 ICD–10 MS–DRG Definitions Manual and ICD–10 MS–DRG Grouper and Medicare Code Editor software.

Table 6P.—ICD–10–CM and ICD–10–PCS Codes for MS–DRG Changes—FY 2022. We are correcting Table 6P.1d associated with the final rule to reflect three procedure codes submitted by the requestor that were inadvertently omitted, resulting in 79 procedure codes listed instead of 82 procedure codes as indicated in the final rule (see pages 44808 and 44809).

Table 18.—Final FY 2022 Medicare DSH Uncompensated Care Payment Factor 3. For the FY 2022 IPPS/LTCH PPS final rule, we published a list of hospitals that we identified to be subsection (d) hospitals and subsection (d) Puerto Rico hospitals projected to be eligible to receive interim uncompensated care payments for FY 2022. As stated in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45249), we allowed the public an additional period after the issuance of the final rule to review and submit comments on the accuracy of the list of mergers that we identified in the final rule. Based on the comments received during this additional period, we are updating this table to reflect the merger information received in response to the final rule and to revise the Factor 3 calculations for purposes of determining uncompensated care payments for the FY 2022 IPPS/LTCH PPS final rule. We are revising Factor 3 for all hospitals to reflect the updated merger information received in response to the final rule. We are also revising the amount of the total uncompensated care payment calculated for each DSH eligible hospital. The total uncompensated care payment that a hospital receives is used to calculate the amount of the interim uncompensated care payments the hospital receives per discharge;

accordingly, we have also revised these amounts for all DSH eligible hospitals. These corrections will be reflected in Table 18 and the Medicare DSH Supplemental Data File. Per discharge uncompensated care payments are included when determining total payments for purposes of all of the budget neutrality factors and the final outlier threshold. As a result, these corrections to uncompensated care payments required the recalculation of all the budget neutrality factors as well as the outlier fixed-loss cost threshold. We note that the fixed-loss cost threshold was unchanged after these recalculations. In section IV.C. of this final rule correction and correcting amendment, we have made corresponding revisions to the discussion of the ''Effects of the Changes to Medicare DSH and Uncompensated Care Payments for FY 2022'' for purposes of the Regulatory Impact Analysis in Appendix A of the FY 2022 IPPS/LTCH PPS final rule to reflect the corrections discussed previously and to correct minor typographical errors. The files that are available on the internet have been updated to reflect the corrections discussed in this final rule correction and correcting amendment.

In addition, we are correcting the inadvertent omission of the following 32 ICD–10–PCS codes describing percutaneous cardiovascular procedures involving one, two, three or four arteries from the GROUPER logic for MS–DRG 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Arteries or Stents) and MS–DRG 248 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent with MCC or 4+ Arteries or Stents).

ICD-10-PCS code	Description
02703Z6	Dilation of coronary artery, one artery, bifurcation, percutaneous approach.
02703ZZ	Dilation of coronary artery, one artery, percutaneous approach.
02704Z6	Dilation of coronary artery, one artery, bifurcation, percutaneous endoscopic approach.
02704ZZ	Dilation of coronary artery, one artery, percutaneous endoscopic approach.
02C03Z6	Extirpation of matter from coronary artery, one artery, bifurcation, percutaneous approach.
02C03ZZ	Extirpation of matter from coronary artery, one artery, percutaneous approach.
02C04Z6	Extirpation of matter from coronary artery, one artery, bifurcation, percutaneous endoscopic approach.
02C04ZZ	Extirpation of matter from coronary artery, one artery, percutaneous endoscopic approach.
02713Z6	Dilation of coronary artery, two arteries, bifurcation, percutaneous approach.
02713ZZ	Dilation of coronary artery, two arteries, percutaneous approach.
02714Z6	Dilation of coronary artery, two arteries, bifurcation, percutaneous endoscopic approach.
02714ZZ	Dilation of coronary artery, two arteries, percutaneous endoscopic approach.
02C13Z6	Extirpation of matter from coronary artery, two arteries, bifurcation, percutaneous approach.
02C13ZZ	Extirpation of matter from coronary artery, two arteries, percutaneous approach.
02C14Z6	Extirpation of matter from coronary artery, two arteries, bifurcation, percutaneous endoscopic approach.
02C14ZZ	Extirpation of matter from coronary artery, two arteries, percutaneous endoscopic approach.
02723Z6	Dilation of coronary artery, three arteries, bifurcation, percutaneous approach.
02723ZZ	Dilation of coronary artery, three arteries, percutaneous approach.
02724Z6	Dilation of coronary artery, three arteries, bifurcation, percutaneous endoscopic approach.
02724ZZ	Dilation of coronary artery, three arteries, percutaneous endoscopic approach.
02C23Z6	Extirpation of matter from coronary artery, three arteries, bifurcation, percutaneous approach.
02C23ZZ	Extirpation of matter from coronary artery, three arteries, percutaneous approach.
02C24Z6	Extirpation of matter from coronary artery, three arteries, bifurcation, percutaneous endoscopic approach.
02C24ZZ	Extirpation of matter from coronary artery, three arteries, percutaneous endoscopic approach.
02733Z6	Dilation of coronary artery, four or more arteries, bifurcation, percutaneous approach.
02733ZZ	Dilation of coronary artery, four or more arteries, percutaneous approach.
02734Z6	Dilation of coronary artery, four or more arteries, bifurcation, percutaneous endoscopic approach.
02734ZZ	Dilation of coronary artery, four or more arteries, percutaneous endoscopic approach.
02C33Z6	Extirpation of matter from coronary artery, four or more arteries, bifurcation, percutaneous approach.
02C33ZZ	Extirpation of matter from coronary artery, four or more arteries, percutaneous approach.
02C34Z6	Extirpation of matter from coronary artery, four or more arteries, bifurcation, percutaneous endoscopic approach.
02C34ZZ	Extirpation of matter from coronary artery, four or more arteries, percutaneous endoscopic approach.

We have corrected the ICD–10 MS–DRG Definitions Manual Version 39 and the ICD–10 MS–DRG GROUPER and MCE Version 39 Software to correctly reflect the inclusion of these codes in the arterial logic lists for MS–DRGs 246 and 248 for FY 2022.

III. Waiver of Proposed Rulemaking and Delay in Effective Date

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (APA), the agency is required to publish a notice of the proposed rulemaking in the **Federal Register** before the provisions of a rule take effect. Similarly, section 1871(b)(1) of the Act requires the Secretary to provide for notice of the proposed rulemaking in the **Federal Register** and provide a period of not less than 60 days for public comment. In addition, section 553(d) of the APA, and section 1871(e)(1)(B)(i) of the Act mandate a 30-day delay in effective date after issuance or publication of a rule. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the notice and comment and delay in effective date APA requirements; in cases in which these exceptions apply, sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act provide exceptions from the notice and 60-day comment period and delay in effective date requirements of the Act as well. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act authorize an agency to dispense with normal rulemaking requirements for good cause if the agency makes a finding that the notice and comment process are impracticable, unnecessary, or contrary to the public interest. In addition, both section 553(d)(3) of the APA and section 1871(e)(1)(B)(ii) of the Act allow the agency to avoid the 30-day delay in effective date where such delay is contrary to the public interest and an agency includes a statement of support.

We believe that this final rule correction and correcting amendment does not constitute a rule that would be subject to the notice and comment or

delayed effective date requirements. This document corrects technical and typographical errors in the preamble, regulations text, addendum, payment rates, tables, and appendices included or referenced in the FY 2022 IPPS/LTCH PPS final rule, but does not make substantive changes to the policies or payment methodologies that were adopted in the final rule. As a result, this final rule correction and correcting amendment is intended to ensure that the information in the FY 2022 IPPS/LTCH PPS final rule accurately reflects the policies adopted in that document.

In addition, even if this were a rule to which the notice and comment procedures and delayed effective date requirements applied, we find that there is good cause to waive such requirements. Undertaking further notice and comment procedures to incorporate the corrections in this document into the final rule or delaying the effective date would be contrary to the public interest because it is in the public's interest for providers to receive appropriate payments in as timely a manner as possible, and to ensure that the FY 2022 IPPS/LTCH PPS final rule accurately reflects our policies. Furthermore, such procedures would be unnecessary, as we are not altering our payment methodologies or policies, but rather, we are simply implementing correctly the methodologies and policies that we previously proposed, requested comment on, and subsequently finalized. This final rule correction and correcting amendment is intended solely to ensure that the FY 2022 IPPS/LTCH PPS final rule accurately reflects these payment methodologies and policies. Therefore, we believe we have good cause to waive the notice and comment and effective date requirements. Moreover, even if these corrections were considered to be retroactive rulemaking, they would be authorized under section 1871(e)(1)(A)(ii) of the Act, which permits the Secretary to issue a rule for the Medicare program with retroactive effect if the failure to do so would be contrary to the public interest. As we have explained previously, we believe it would be contrary to the public interest not to implement the corrections in this final rule correction and correcting amendment because it is in the public's interest for providers to receive appropriate payments in as timely a manner as possible, and to ensure that the FY 2022 IPPS/LTCH PPS final rule accurately reflects our policies.

IV. Correction of Errors

In FR Doc. 2021–16519 of August 13, 2021 (86 FR 44774), we are making the following corrections:

A. Correction of Errors in the Preamble

1. On page 44878, second column, last paragraph, line 10, ''15 technologies'' is corrected to read ''technologies.''

2. On page 44889, lower two-thirds of the page, third column, partial paragraph, line 10, the procedure code ''0DQ540ZZ'' is corrected to read ''0DQ54ZZ.''

3. On page 44960, in the untitled table, last 2 lines are corrected to read as follows:

MDC	MS–DRG	MS–DRG title
*	*	* * * * * * *
08	521	Hip Replacement with Principal Diagnosis of Hip Fracture with MCC.
08	522	Hip Replacement with Principal Diagnosis of Hip Fracture without MCC.

4. On page 45047:

a. Second column, first full paragraph, lines 21 through 24, the sentence ''We summarize comments related to this comment solicitation and provide our responses as well as our finalized policy in section XXX of this final rule.'' is corrected to read ''We summarize comments related to this comment solicitation and provide our responses in section II.F.7. of the preamble of this final rule.''.

b. Third column, first full paragraph, line 28, the reference ''section XXX'' is corrected to read ''section II.F.8.''.

5. On page 45048, second column, second full paragraph, lines 20 through 24, the sentence ''We summarize comments related to this comment solicitation and provide our responses as well as our finalized policy in section XXX of this final rule.'' is corrected to read ''We summarize comments related to this comment solicitation and provide our responses in section II.F.7. of the preamble of this final rule.''.

6. On page 45049:

a. Second column:

(1) First full paragraph, line 12, the reference, ''section XXX of this final rule'' is corrected to read ''section II.F.8. of the preamble of this final rule''.

(2) Second full paragraph, lines 1 and 2, the reference, ''section XXX of this final rule'' is corrected to read ''section II.F.7. J95.851 (Ventilator associated pneumonia) and one of the following: B96.1 (Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified elsewhere), B96.20 (Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere), B96.21 (Shiga toxin-producing Escherichia coli [E. coli] [STEC] O157 as the cause of diseases classified elsewhere), B96.22 (Other specified Shiga toxin-producing Escherichia coli [E. coli] [STEC] as the cause of diseases classified elsewhere), B96.23 (Unspecified Shiga toxin-producing Escherichia coli [E. coli] [STEC] as the cause of diseases classified elsewhere, B96.29 (Other Escherichia coli [E. coli] as the cause of diseases classified elsewhere), B96.3 (Hemophilus influenzae [H. influenzae] as the cause of diseases classified elsewhere, B96.5 (Pseudomonas (aeruginosa) (mallei) (pseudomallei) as the cause of diseases classified elsewhere), or B96.89 (Other specified bacterial agents as the cause of diseases classified elsewhere) for VABP.''

10. On page 45158, third column, first partial paragraph, last line the phrase, ''technology group 5).'' is corrected to read ''technology group 5) in combination with the following ICD–10–CM codes: Y95 (Nosocomial condition) and one of the following: J14.0 (Pneumonia due to Hemophilus influenzae) J15.0 (Pneumonia due to Klebsiella pneumoniae), J15.1 (Pneumonia due to Pseudomonas), J15.5 (Pneumonia due to Escherichia coli), J15.6 (Pneumonia due to other Gram-negative bacteria), or J15.8 (Pneumonia due to other specified bacteria) for HABP and ICD10–PCS codes: XW033A6 (Introduction of cefiderocol antinfective into peripheral vein, percutaneous approach, new technology group 6) or XW043A6 (Introduction of cefiderocol anti-infective into central vein, percutaneous approach, new technology group 6) in combination with the following ICD–10–CM codes: J95.851 (Ventilator associated pneumonia) and one of the following: B96.1 (Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified elsewhere), B96.20 (Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere), B96.21 (Shiga toxin-producing Escherichia coli [E. coli]

[STEC] O157 as the cause of diseases classified elsewhere), B96.22 (Other specified Shiga toxin-producing Escherichia coli [E. coli] [STEC] as the cause of diseases classified elsewhere), B96.23 (Unspecified Shiga toxin-producing Escherichia coli [E. coli] [STEC] as the cause of diseases classified elsewhere, B96.29 (Other Escherichia coli [E. coli] as the cause of diseases classified elsewhere), B96.3 (Hemophilus influenzae [H. influenzae] as the cause of diseases classified elsewhere, B96.5 (Pseudomonas (aeruginosa) (mallei)(pseudomallei) as the cause of diseases classified elsewhere), or B96.89 (Other specified bacterial agents as the cause of diseases classified elsewhere) for VABP.''

11. On page 45291, middle of the page, the table titled ''Table V.H–11: Previously Established and Newly Updated Performance Standards for the FY 2024 Program Year'' is corrected to read as follows:

TABLE V.H–11—PREVIOUSLY ESTABLISHED AND ESTIMATED PERFORMANCE STANDARDS FOR THE FY 2024 PROGRAM YEAR

Measure short name	Achievement threshold	Benchmark
Clinical Outcomes Domain		
MORT–30–AMI #	0.869247	0.887868
MORT–30–HF #	0.882308	0.907773
MORT–30–PN (updated cohort) #	0.840281	0.872976
MORT–30–COPD #	0.916491	0.934002
MORT–30–CABG #	0.969499	0.980319
COMP–HIP–KNEE * #	0.025396	0.018159

♦ As discussed in section V.H.4.b. of this final rule, we are finalizing the updates to the FY 2024 baseline periods for measures included in the Person and Community Engagement, Safety, and Efficiency and Cost Reduction domains to use CY 2019. Therefore, the performance standards displayed in this table for the Safety domain measures were calculated using CY 2019 data.

* Lower values represent better performance.

Previously established performance standards.

12. On page 45293, top of the page, the table titled ''V.H–13 Previously Established and Estimated Performance Standards for the FY 2025 Program Year'' is corrected to read as follows:

TABLE V.H–13—PREVIOUSLY ESTABLISHED AND ESTIMATED PERFORMANCE STANDARDS FOR THE FY 2025 PROGRAM YEAR

Measure short name	Achievement threshold	Benchmark
Clinical Outcomes Domain		
MORT–30–AMI #	0.872624	0.889994
MORT–30–HF #	0.883990	0.910344
MORT–30–PN (updated cohort) #	0.841475	0.874425
MORT–30–COPD #	0.915127	0.932236
MORT–30–CABG #	0.970100	0.979775
COMP–HIP–KNEE * #	0.025332	0.017946

* Lower values represent better performance.

Previously established performance standards.

13. On page 45294, top of page, the table titled ''V.H–14 Previously Established and Estimated Performance Standards for the FY 2026 Program Year'' is corrected to read as follows:

TABLE V.H–14—PREVIOUSLY ESTABLISHED AND ESTIMATED PERFORMANCE STANDARDS FOR THE FY 2026 PROGRAM YEAR

Measure short name	Achievement threshold	Benchmark
Clinical Outcomes Domain		
MORT–30–AMI #	0.874426	0.890687
MORT–30–HF #	0.885949	0.912874
MORT–30–PN (updated cohort) #	0.843369	0.877097
MORT–30–COPD #	0.914691	0.932157
MORT–30–CABG #	0.970568	0.980473
COMP–HIP–KNEE * #	0.024019	0.016873

* Lower values represent better performance.

Previously established performance standards.

14. On page 45312, second column, first full paragraph, lines 7 through 9, the phrase ''rejection of the cost report if the submitted IRIS GME and IME FTEs do match'' is corrected to read ''rejection of the cost report if the submitted IRIS GME and IME FTEs do not match''.

15. On page 45386, third column, first full paragraph, line 12, the phrase ''mellitus and who either'' is corrected to read ''mellitus, who''.

16. On page 45400, top of the page, the table titled ''Measures for the FY 2024 Payment Determination and Subsequent Years'', is corrected by—

a. Correcting the title to read ''Measures for the FY 2023 Payment Determination and Subsequent Years''.

b. Removing the heading ''Claims and Electronic Data Measures'' and the entry ''Hybrid HWR**'' (rows 20 and 21).

c. Following the table, lines 3 through 8, removing the second table note.

17. On page 45404, bottom of the page, after the table titled ''Measures for the FY 2025 Payment Determination and Subsequent Years'', in the third note to the table, line 10, the parenthetical phrase ''(July 1, 2023–June 30, 2023)'' is corrected to read ''(July 1, 2022–June 30, 2023)''.

B. Correction of Errors in the Addendum

1. On page 45532, bottom of the page, the table titled ''Summary of FY 2022 Budget Neutrality Factors'' is corrected to read as follows:

SUMMARY OF FY 2022 BUDGET NEUTRALITY FACTORS

MS-DRG Reclassification and Recalibration Budget Neutrality Factor	1.000107
Wage Index Budget Neutrality Factor	1.000715
Reclassification Budget Neutrality Factor	0.986741
*Rural Floor Budget Neutrality Factor	0.992868
Rural Demonstration Budget Neutrality Factor	0.999361
Low Wage Index Hospital Policy Budget Neutrality Factor	0.998029
Transition Budget Neutrality Factor	0.999859

* The rural floor budget neutrality factor is applied to the national wage indexes while the rest of the budget neutrality adjustments are applied to the standardized amounts.

2. On page 45537, first column, first full paragraph, lines 4 through 10, the parenthetical phrase ''(estimated capital outlier payments of $ 430,689,396 divided by (estimated capital outlier payments of $430,689,396 plus the estimated total capital Federal payment of $7,676,990,253)).'' is corrected to read ''(estimated capital outlier payments of $430,698,533 divided by (estimated capital outlier payments of $430,698,533 plus the estimated total capital Federal payment of $7,676,964,386)).''.

3. On page 45542, third column, last paragraph, lines 23 and 24, the figure ''$5,326,356,951'' is corrected to read ''$5,326,379,560''.

4. On page 45543:

a. Top of the page, first column, first partial paragraph:

(1) Line 1, the figure ''$100,164,666,975'' is corrected to read ''$100,165,281,272''.

(2) Line 17, the figure ''$31,108'' is corrected to read ''$31,109''.

b. Middle of the page, the untitled table is corrected to read as follows:

	Operating standardized amounts	Capital Federal rate *
National	0.949	0.947078

* The adjustment factor for the capital Federal rate includes an adjustment to the estimated percentage of FY 2022 capital outlier payments for capital outlier reconciliation, as discussed previously and in section III. A. 2 in the Addendum of this final rule.

5. On page 45545, the table titled ''CHANGES FROM FY 2021 STANDARDIZED AMOUNTS TO THE FY 2022 STANDARDIZED AMOUNTS'' is corrected to read as follows:

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CHANGES FROM FY 2021 STANDARDIZED AMOUNTS TO THE FY 2022 STANDARDIZED AMOUNTS

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2022 Base Rate after removing: 1. FY 2021 Geographic Reclassification Budget Neutrality (0.986616) 2. FY 2021 Operating Outlier Offset (0.949)	If Wage Index is Greater Than 1.0000: Labor (67.6%): $ 4,319.35 Nonlabor (32.4%): $ 2,070.22	If Wage Index is Greater Than 1.0000: Labor (67.6%): $ 4,319.35 Nonlabor (32.4%): $ 2,070.22	If Wage Index is Greater Than 1.0000: Labor (67.6%): $ 4,319.35 Nonlabor (32.4%): $ 2,070.22	If Wage Index is Greater Than 1.0000: Labor (67.6%): $ 4,319.35 Nonlabor (32.4%): $ 2,070.22
3. FY 2021 Rural Demonstration Budget Neutrality Factor (0.999626) 4. FY 2021 Lowest Quartile Budget Neutrality Factor (0.99797) 5. FY 2021 Transition Budget Neutrality Factor (0.998851)	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $ 3,961.53 Nonlabor (38%): $ 2,428.04	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $ 3,961.53 Nonlabor (38%): $ 2,428.04	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $ 3,961.53 Nonlabor (38%): $ 2,428.04	If Wage Index is less Than or Equal to 1.0000: Labor (62%): $ 3,961.53 Nonlabor (38%): $ 2,428.04
FY 2022 Update Factor	1.02	0.99975	1.01325	0.993
FY 2022 MS-DRG Reclassification and Recalibration Budget Neutrality Factor	1.000107	1.000107	1.000107	1.000107
FY 2022 Wage Index Budget Neutrality Factor	1.000715	1.000715	1.000715	1.000715
FY 2022 Reclassification Budget Neutrality Factor	0.986741	0.986741	0.986741	0.986741
FY 2022 Rural Demonstration Budget Neutrality Factor	0.999361	0.999361	0.999361	0.999361
FY 2022 Lowest Quartile Budget Neutrality Factor	0.998029	0.998029	0.998029	0.998029
FY 2022 Transition Budget Neutrality Factor	0.999859	0.999859	0.999859	0.999859
FY 2022 Operating Outlier Factor	0.949	0.949	0.949	0.949
Adjustment for FY 2022 Required under Section 414 of Pub. L. 114-10 (MACRA)	1.005	1.005	1.005	1.005
National Standardized Amount for FY 2022 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (67.6/32.4)	**Labor: $4,138.24 Nonlabor $1,983.41**	**Labor: $4,056.08 Nonlabor: $1,944.03**	**Labor: $4,110.85 Nonlabor: $1,970.28**	**Labor: $4,028.70 Nonlabor: $1,930.91**
National Standardized Amount for FY 2022 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)	**Labor: $3,795.42 Nonlabor: $2,326.23**	**Labor: $3,720.07 Nonlabor: $2,280.04**	**Labor: $3,770.30 Nonlabor: $2,310.83**	**Labor: $3,694.96 Nonlabor: $2,264.65**

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6. On page 45553, second column, last paragraph, line 9, the figure ''$472.60'' is corrected to read ''$472.59''.

7. On page 45554, top of the page, in the table titled ''COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2021 CAPITAL FEDERAL RATE AND THE FY 2022 CAPITAL FEDERAL RATE'', the list entry (row 5) is corrected to read as follows:

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2021 CAPITAL FEDERAL RATE AND THE FY 2022 CAPITAL FEDERAL RATE

	FY 2021	FY 2022	Change	Percent change
* * * * * * * *				
Capital Federal Rate	$466.21	$472.59	1.0137	[4] 1.37

8. On page 45570:

a. The table titled ''TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)—FY 2022'' is corrected to read as follows:

TABLE 1A—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)—FY 2022

Hospital submitted quality data and is a meaningful EHR user (update = 2.0 percent)		Hospital submitted quality data and is not a meaningful EHR user (update = −0.025 percent)		Hospital did not submit quality data and is a meaningful EHR user (update = 1.325 percent)		Hospital did not submit quality data and is not a meaningful EHR user (update = −0.7 percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,138.24	$1,983.41	$4,056.08	$1,944.03	$4,110.85	$1,970.28	$4,028.70	$1,930.91

b. The table titled ''TABLE 1B.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2022'' is corrected to read as follows:

TABLE 1B—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2022

Hospital submitted quality data and is a meaningful EHR user (update = 2.0 percent)		Hospital submitted quality data and is not a meaningful EHR user (update = −0.025 percent)		Hospital did not submit quality data and is a meaningful EHR user (update = 1.325 percent)		Hospital did not submit quality data and is not a meaningful EHR user (update = −0.7 percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$3,795.42	$2,326.23	$3,720.07	$2,280.04	$3,770.30	$2,310.83	$3,694.96	$2,264.65

9. On page 45571, the top of page:

a. The table titled ''Table 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR HOSPITALS IN PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSE WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2022'' is corrected to read as follows:

TABLE 1C—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR HOSPITALS IN PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSE WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2022

	Rates if wage index greater than 1		Hospital is a meaningful EHR user and wage index less than or equal to 1 (update = 2.0)		Hospital is NOT a meaningful EHR user and wage index less than or equal to 1 (update = 1.325)	
	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
[1] National	Not Applicable	Not Applicable	$3,795.42	$2,326.23	$3,770.30	$2,310.83

[1] For FY 2022, there are no CBSAs in Puerto Rico with a national wage index greater than 1.

b. The table titled ''TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE—FY 2022'' is corrected to read as follows:

TABLE 1D—CAPITAL STANDARD FEDERAL PAYMENT RATE—FY 2022

	Rate
National	$472.59

C. Correction of Errors in the Appendices

1. On pages 45576 through 45578, the table titled ''Table I.—Impact Analysis of Changes to the IPPS for Operating Costs for FY 2022'' is corrected to read as follows:

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Table I.—Impact Analysis of Changes to the IPPS for Operating Costs for FY 2022

	Number of Hospitals[1]	Hospital Rate Update and Adjustment under MACRA (1)[2]	FY 2022 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2)[3]	FY 2022 Wage Data with Application of Wage Budget Neutrality (3)[4]	FY 2022 MGCRB Reclassifications (4)[5]	Rural Floor with Application of National Rural Floor Budget Neutrality (5)[6]	Imputed Floor Wage Index (6)[7]	Application of the Frontier State Wage Index and Outmigration Adjustment (7)[8]	All FY 2022 Changes (8)[9]
All Hospitals	3,195	2.5	0.0	0.0	0.0	0.0	0.2	0.1	2.6
By Geographic Location:									
Urban hospitals	2,459	2.5	0.0	0.0	-0.1	0.0	0.2	0.1	2.6
Rural hospitals	736	2.2	0.1	0.2	1.3	-0.2	0.0	0.1	2.8
Bed Size (Urban):									
0-99 beds	634	2.4	0.0	0.1	-0.6	0.1	0.2	0.3	2.7
100-199 beds	754	2.5	0.0	0.0	-0.2	0.2	0.2	0.2	2.6
200-299 beds	427	2.5	0.0	0.1	0.2	0.0	0.2	0.1	2.4
300-499 beds	421	2.5	0.0	0.0	0.1	0.0	0.1	0.1	2.6
500 or more beds	223	2.5	0.0	-0.1	-0.3	0.0	0.2	0.0	2.6
Bed Size (Rural):									
0-49 beds	311	2.1	0.1	0.3	0.7	-0.1	0.0	0.2	4.3
50-99 beds	253	2.1	0.1	0.2	0.8	-0.1	0.0	0.2	2.4
100-149 beds	94	2.1	0.1	0.2	1.3	-0.2	0.0	0.0	2.5
150-199 beds	39	2.3	0.0	0.2	1.6	-0.2	0.0	0.1	2.6
200 or more beds	39	2.3	0.0	0.3	2.0	-0.3	0.0	0.0	2.8
Urban by Region:									
New England	112	2.5	0.0	-1.0	0.8	3.7	0.6	0.1	2.7
Middle Atlantic	304	2.5	0.0	-0.2	0.3	-0.4	0.5	0.2	2.5
East North Central	381	2.5	0.0	-0.2	-0.2	-0.4	0.0	0.0	2.4
West North Central	160	2.4	-0.1	0.2	-0.6	-0.3	0.0	0.6	2.7
South Atlantic	402	2.5	0.0	0.3	-0.5	-0.3	0.2	0.0	2.9
East South Central	144	2.5	0.0	0.1	-0.3	-0.3	0.0	0.0	2.5
West South Central	364	2.5	0.0	-0.3	-0.5	-0.3	0.0	0.0	2.3
Mountain	172	2.4	0.0	0.2	0.1	-0.1	0.0	0.2	2.6
Pacific	370	2.4	-0.1	0.5	0.2	0.4	0.0	0.1	2.5
Puerto Rico	50	2.5	-0.5	-0.3	-1.0	0.2	0.0	0.1	1.7
Rural by Region:									
New England	19	2.3	0.0	-0.4	1.3	-0.3	0.2	0.0	3.4
Middle Atlantic	50	2.2	0.1	0.3	1.0	-0.2	0.0	0.0	2.6
East North Central	113	2.2	0.1	0.1	0.9	-0.1	0.0	0.0	2.2
West North Central	89	2.1	0.0	0.1	0.3	-0.1	0.0	0.2	2.8
South Atlantic	114	2.2	0.1	1.1	1.6	-0.2	0.0	0.0	3.0
East South Central	144	2.3	0.1	-0.1	1.8	-0.3	0.0	0.1	2.6
West South Central	135	2.2	0.1	0.0	2.8	-0.3	0.0	0.0	3.0

	Number of Hospitals[1]	Hospital Rate Update and Adjustment under MACRA (1)[2]	FY 2022 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2)[3]	FY 2022 Wage Data with Application of Wage Budget Neutrality (3)[4]	FY 2022 MGCRB Reclassifications (4)[5]	Rural Floor with Application of National Rural Floor Budget Neutrality (5)[6]	Imputed Floor Wage Index (6)[7]	Application of the Frontier State Wage Index and Outmigration Adjustment (7)[8]	All FY 2022 Changes (8)[9]
Mountain	48	1.9	0.0	0.6	-0.1	-0.1	0.0	0.8	1.9
Pacific	24	2.1	0.0	-0.1	1.1	-0.1	0.0	0.0	5.2
By Payment Classification:									
Urban hospitals	1,983	2.5	0.0	0.0	-0.6	0.2	0.2	0.1	2.6
Rural areas	1,212	2.4	0.0	0.0	0.9	-0.3	0.1	0.1	2.6
Teaching Status:									
Nonteaching	2,031	2.4	0.0	0.2	0.1	0.1	0.1	0.1	2.7
Fewer than 100 residents	907	2.5	0.0	0.0	0.1	-0.1	0.2	0.2	2.5
100 or more residents	257	2.4	0.0	-0.1	-0.2	0.0	0.2	0.0	2.6
Urban DSH:									
Non-DSH	502	2.5	0.0	0.0	-0.6	0.0	0.3	0.2	2.6
100 or more beds	1,227	2.5	0.0	0.0	-0.6	0.2	0.2	0.1	2.6
Less than 100 beds	348	2.5	0.0	0.1	-0.5	0.2	0.1	0.2	2.7
Rural DSH:									
SCH	265	2.0	0.0	0.1	0.2	0.0	0.0	0.1	2.5
RRC	608	2.4	0.0	0.0	1.0	-0.3	0.1	0.1	2.6
100 or more beds	30	2.4	0.1	-0.1	0.1	-0.4	0.0	0.0	1.5
Less than 100 beds	215	2.3	0.1	0.3	1.0	-0.3	0.0	0.2	3.2
Urban teaching and DSH:									
Both teaching and DSH	679	2.5	0.0	-0.1	-0.6	0.1	0.3	0.1	2.6
Teaching and no DSH	74	2.5	0.0	-0.1	-0.9	0.6	0.4	0.2	2.4
No teaching and DSH	896	2.5	0.0	0.2	-0.5	0.4	0.1	0.1	2.6
No teaching and no DSH	334	2.5	0.0	0.1	-0.6	-0.2	0.3	0.3	2.6
Special Hospital Types:									
RRC	523	2.5	0.0	0.0	1.0	-0.4	0.1	0.1	2.6
SCH	305	2.0	0.0	0.1	0.1	0.0	0.0	0.0	2.5
MDH	153	2.1	0.1	0.0	0.0	-0.2	0.1	0.1	2.6
SCH and RRC	154	2.1	0.0	0.1	0.5	-0.1	0.0	0.0	2.2
MDH and RRC	27	2.2	0.0	0.0	0.7	-0.2	0.1	0.0	2.2
Type of Ownership:									
Voluntary	1,881	2.5	0.0	-0.1	0.1	0.0	0.2	0.1	2.6
Proprietary	828	2.5	0.0	0.1	-0.1	0.1	0.1	0.1	2.6
Government	486	2.4	0.0	0.2	-0.3	-0.1	0.0	0.0	2.5
Medicare Utilization as a Percent of Inpatient Days:									
0-25	643	2.5	0.0	0.1	-0.6	-0.2	0.0	0.0	2.5
25-50	2,110	2.5	0.0	0.0	0.1	0.0	0.2	0.1	2.6
50-65	367	2.4	0.0	-0.1	0.2	0.3	0.3	0.2	2.2
Over 65	50	2.3	0.1	0.3	-0.7	-0.3	0.3	0.1	3.7

	Number of Hospitals[1]	Hospital Rate Update and Adjustment under MACRA (1)[2]	FY 2022 Weights and DRG Changes with Application of Recalibration Budget Neutrality (2)[3]	FY 2022 Wage Data with Application of Wage Budget Neutrality (3)[4]	FY 2022 MGCRB Reclassifications (4)[5]	Rural Floor with Application of National Rural Floor Budget Neutrality (5)[6]	Imputed Floor Wage Index (6)[7]	Application of the Frontier State Wage Index and Outmigration Adjustment (7)[8]	All FY 2022 Changes (8)[9]
FY 2022 Reclassifications:									
All Reclassified Hospitals	934	2.4	0.0	0.0	1.2	-0.3	0.1	0.1	2.6
Non-Reclassified Hospitals	2,261	2.5	0.0	0.0	-0.9	0.2	0.2	0.2	2.6
Urban Hospitals Reclassified	749	2.4	0.0	0.0	1.1	-0.3	0.1	0.1	2.5
Urban Non-Reclassified Hospitals	1,723	2.5	0.0	0.0	-1.1	0.3	0.3	0.1	2.6
Rural Hospitals Reclassified Full Year	300	2.2	0.1	0.2	2.0	-0.2	0.0	0.0	2.5
Rural Non-Reclassified Hospitals Full Year	423	2.2	0.1	0.2	0.0	-0.2	0.0	0.2	3.3
All Section 401 Reclassified Hospitals	532	2.4	0.0	0.0	0.8	-0.3	0.1	0.1	2.5
Other Reclassified Hospitals (Section 1886(d)(8)(B))	56	2.3	0.1	0.0	2.4	-0.3	0.2	0.0	3.1

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2019, and hospital cost report data are from reporting periods beginning in FY 2018 and FY 2017.

[2] This column displays the payment impact of the hospital rate update and other adjustments, including the 2.0 percent update to the national standardized amount and the hospital-specific rate (the estimated 2.7 percent market basket update reduced by 0.7 percentage point for the productivity adjustment), and the 0.5 percentage point adjustment to the national standardized amount required under section 414 of the MACRA.

[3] This column displays the payment impact of the changes to the Version 39 GROUPER, the changes to the relative weights and the recalibration of the MS-DRG weights based on FY 2019 MedPAR data as the best available data in accordance with section 1886(d)(4)(C)(iii) of the Act. This column displays the application of the recalibration budget neutrality factor of 1.000107 in accordance with section 1886(d)(4)(C)(iii) of the Act.

[4] This column displays the payment impact of the update to wage index data using FY 2018 cost report data and the OMB labor market area delineations based on 2010 Decennial Census data. This column displays the payment impact of the application of the wage budget neutrality factor, which is calculated separately from the recalibration budget neutrality factor, and is calculated in accordance with section 1886(d)(3)(E)(i) of the Act. The wage budget neutrality factor is 1.000715.

[5] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2022 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2022. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.986741.

[6] This column displays the effects of the rural floor. The Affordable Care Act requires the rural floor budget neutrality adjustment to be a 100 percent national level adjustment. The rural floor budget neutrality factor applied to the wage index is 0.992868.

[6] This column displays the effects of the imputed rural floor for all-urban states provided for under section 1886(d)(3)(E)(iv) of the Act. This is not a budget neutral policy.

[8] This column shows the combined impact of the policy required under section 10324 of the Affordable Care Act that hospitals located in frontier States have a wage index no less than 1.0 and of section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if a threshold percentage of residents of the county where the hospital is located commute to work at hospitals in counties with higher wage indexes. These are not budget neutral policies.

[9] This column shows the estimated change in payments from FY 2021 to FY 2022. This column includes the effects of the continued policy of increasing the wage index for hospitals with a wage index value below the 25th percentile wage index (that is, the lowest quartile wage index adjustment), the extended transition policy to place a 5-percent cap on any decrease in a hospital's wage index from its final wage index in FY 2021 (that is, the 5-percent cap), and the associated budget neutrality factors. This column reflects the budget neutrality factor of 0.998029 for the lowest quartile wage index adjustment and the budget neutrality factor of 0.999859 for the 5-percent cap for FY 2022.

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2. On page 45579, third column, first paragraph, line 23, the figure "1.000712" is corrected to read "1.000715".

3. On page 45580, lower three-fourths of the page, first column, third full paragraph, line 6, the figure ''0.986737'' is corrected to read ''0.986741''.

4. On pages 45582 and 45583, the table titled ''Table II.—Impact Analysis of Changes for FY 2022 Acute Care Hospital Operating Prospective Payment System (Payments Per Discharge)'' is corrected to read as follows:

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2022 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per discharge]

	Number of hospitals	Estimated average FY 2021 payment per discharge	Estimated average FY 2022 payment per discharge	FY 2022 changes
	(1)	(2)	(3)	(4)
All Hospitals	3,195	13,109	13,448	2.6
By Geographic Location:				
Urban hospitals	2,459	13,454	13,800	2.6
Rural hospitals	736	9,901	10,178	2.8
Bed Size (Urban):				
0–99 beds	634	10,723	11,011	2.7
100–199 beds	754	11,015	11,305	2.6
200–299 beds	427	12,251	12,551	2.4
300–499 beds	421	13,496	13,847	2.6
500 or more beds	223	16,568	16,992	2.6
Bed Size (Rural):				
0–49 beds	311	8,556	8,921	4.3
50–99 beds	253	9,419	9,644	2.4
100–149 beds	94	9,789	10,033	2.5
150–199 beds	39	10,519	10,788	2.6
200 or more beds	39	11,465	11,784	2.8
Urban by Region:				
New England	112	14,858	15,253	2.7
Middle Atlantic	304	15,432	15,814	2.5
East North Central	381	12,838	13,150	2.4
West North Central	160	13,121	13,475	2.7
South Atlantic	402	11,710	12,049	2.9
East South Central	144	11,290	11,576	2.5
West South Central	364	11,806	12,072	2.3
Mountain	172	13,698	14,054	2.6
Pacific	370	17,230	17,664	2.5
Puerto Rico	50	8,491	8,637	1.7
Rural by Region:				
New England	19	13,990	14,463	3.4
Middle Atlantic	50	9,736	9,988	2.6
East North Central	113	10,361	10,592	2.2
West North Central	89	10,638	10,932	2.8
South Atlantic	114	9,032	9,302	3
East South Central	144	8,732	8,955	2.6
West South Central	135	8,292	8,540	3
Mountain	48	12,134	12,359	1.9
Pacific	24	13,865	14,588	5.2
By Payment Classification:				
Urban hospitals	1,983	12,673	13,003	2.6
Rural areas	1,212	13,796	14,148	2.6
Teaching Status:				
Nonteaching	2,031	10,677	10,963	2.7
Fewer than 100 residents	907	12,388	12,694	2.5
100 or more residents	257	18,938	19,437	2.6
Urban DSH:				
Non-DSH	502	11,749	12,054	2.6
100 or more beds	1,227	13,015	13,355	2.6
Less than 100 beds	348	9,559	9,820	2.7
Rural DSH:				
SCH	265	11,906	12,203	2.5
RRC	608	14,380	14,747	2.6
100 or more beds	30	12,115	12,298	1.5
Less than 100 beds	215	7,778	8,025	3.2
Urban teaching and DSH:				
Both teaching and DSH	679	14,116	14,483	2.6
Teaching and no DSH	74	12,825	13,127	2.4
No teaching and DSH	896	10,850	11,137	2.6
No teaching and no DSH	334	10,824	11,110	2.6
Special Hospital Types:				

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2022 ACUTE CARE HOSPITAL OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per discharge]

	Number of hospitals (1)	Estimated average FY 2021 payment per discharge (2)	Estimated average FY 2022 payment per discharge (3)	FY 2022 changes (4)
RRC	523	14,478	14,859	2.6
SCH	305	12,053	12,356	2.5
MDH	153	9,169	9,404	2.6
SCH and RRC	154	12,475	12,746	2.2
MDH and RRC	27	10,622	10,853	2.2
Type of Ownership:				
Voluntary	1,881	13,321	13,667	2.6
Proprietary	828	11,473	11,769	2.6
Government	486	14,109	14,466	2.5
Medicare Utilization as a Percent of Inpatient Days:				
0–25	643	15,158	15,535	2.5
25–50	2,110	12,926	13,268	2.6
50–65	367	10,773	11,010	2.2
Over 65	50	8,132	8,431	3.7
FY 2022 Reclassifications by the Medicare Geographic Classification Review Board:				
All Reclassified Hospitals	934	13,592	13,944	2.6
Non-Reclassified Hospitals	2,261	12,772	13,102	2.6
Urban Hospitals Reclassified	749	14,261	14,619	2.5
Urban Nonreclassified Hospitals	1,723	12,851	13,187	2.6
Rural Hospitals Reclassified Full Year	300	10,087	10,341	2.5
Rural Nonreclassified Hospitals Full Year	423	9,610	9,929	3.3
All Section 401 Reclassified Hospitals	532	14,968	15,343	2.5
Other Reclassified Hospitals (Section 1886(d)(8)(B))	56	9,149	9,429	3.1

5. On page 45584, bottom third of the page, third column, partial paragraph:

a. Line 7, the figure ''$151 million'' is corrected to read ''$158 million''.

b. Line 10, the figure ''$50 million'' is corrected to read ''$57 million''.

c. Lines 15 and 16, the phrase ''for which we are approving new technology add-on payments'' is corrected to read ''for which we are approving or conditionally approving new technology add-on payments''.

6. On page 45585:

a. Top third of the page:

(1) In the untitled table, the third and fourth column headings and the entries at rows 6 and 9 are corrected to read as follows:

Technology name	Estimated cases	FY 2022 NTAP amount	Estimated FY 2022 total impact	Pathway (QIDP, LPAD, or breakthrough device)
* * * * * * *				
Fetroja (HABP/VABP)	379	$8,579.84	$3,251,759.36	QIDP.
* * * * * * *				
Recarbrio (HABP/VABP)	928	9,576.51	8,887,001.28	QIDP.
* * * * * * *				

(2) Following the first untitled table, second column, partial paragraph, last line, the figure ''$498 million'' is corrected to read ''$514 million''.

b. Middle third of the page, in the untitled table, the third and fourth column headings and the entries at rows 2 and 4 are corrected to read as follows:

Technology name	Estimated cases	FY 2022 NTAP amount	Estimated FY 2022 total impact
* * * * * * *			
Abecma	484	$272,675.00	$131,974,700.00

Technology name	Estimated cases	FY 2022 NTAP amount	Estimated FY 2022 total impact
* * * * *	*	*	*
Tecartus	15	259,350.00	3,890,250.00
* * * * *	*	*	*

7. On pages 45587 and 45588, the table titled ''Modeled Uncompensated Care Payments for Estimated FY 2022 DSHs by Hospital Type: Model Uncompensated Care Payments ($ in Millions)—from FY 2021 to FY 2022'' is corrected to read as follows:

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Modeled Uncompensated Care Payments for Estimated FY 2022 DSHs by Hospital Type: Model Uncompensated Care Payments ($ in Millions)* - from FY 2021 to FY 2022					
	Number of Estimated DSHs (1)	FY 2021 Final Rule Estimated Uncompensated Care Payments ($ in millions) (2)	FY 2022 Final Rule Estimated Uncompensated Care Payments ($ in millions) (3)	Dollar Difference: FY 2021 - FY 2022 ($ in millions) (4)	Percent Change** (5)
Total	**2,365**	**8,290**	**7,192**	**-1098**	**-13.24%**
By Geographic Location					
Urban Hospitals	1,900	7,803	6,789	-1014	-12.99
Large Urban Areas	989	4,829	4,146	-683	-14.15
Other Urban Areas	911	2,974	2,643	-331	-11.12
Rural Hospitals	465	487	403	-84	-17.28
Bed Size (Urban)					
0 to 99 Beds	325	290	245	-45	-15.49
100 to 249 Beds	818	1,898	1,603	-294	-15.50
250+ Beds	757	5,615	4,940	-675	-12.02
Bed Size (Rural)					
0 to 99 Beds	352	269	218	-51	-18.97
100 to 249 Beds	100	166	141	-26	-15.53
250+ Beds	13	52	45	-7	-14.16
Urban by Region					
New England	92	227	186	-40	-17.79
Middle Atlantic	230	983	819	-163	-16.62
South Atlantic	313	864	800	-64	-7.44
East North Central	98	405	354	-51	-12.58
East South Central	312	2,027	1,759	-268	-13.2
West North Central	126	498	439	-59	-11.92
West South Central	241	1,637	1,434	-204	-12.44
Mountain	132	333	299	-34	-10.32
Pacific	315	723	607	-116	-15.99
Puerto Rico	41	107	93	-14	-13.01
Rural by Region					
New England	8	15	15	0	-1.27
Middle Atlantic	21	15	12	-3	-17.92
South Atlantic	65	58	43	-15	-25.28
East North Central	28	31	23	-8	-25.87
East South Central	83	135	117	-18	-13.01
West North Central	124	102	85	-18	-17.22
West South Central	107	105	88	-17	-15.92
Mountain	24	19	14	-5	-25.92
Pacific	5	7	5	-2	-25.68
By Payment Classification					
Urban Hospitals	1,506	5,470	4,773	-697	-12.74
Large Urban Areas	850	3,614	3,125	-489	-13.52
Other Urban Areas	656	1,855	1,648	-208	-11.21
Rural Hospitals	859	2,820	2,419	-401	-14.23
Teaching Status					
Nonteaching	1,370	2,444	2,116	-328	-13.4
Fewer than 100 residents	742	2,865	2,494	-371	-12.94
100 or more residents	253	2,980	2,581	-399	-13.39
Type of Ownership					
Voluntary	1,422	4,556	3,981	-574	-12.61
Proprietary	575	1,217	1,076	-141	-11.56

Modeled Uncompensated Care Payments for Estimated FY 2022 DSHs by Hospital Type: Model Uncompensated Care Payments ($ in Millions)* - from FY 2021 to FY 2022					
	Number of Estimated DSHs (1)	FY 2021 Final Rule Estimated Uncompensated Care Payments ($ in millions) (2)	FY 2022 Final Rule Estimated Uncompensated Care Payments ($ in millions) (3)	Dollar Difference: FY 2021 - FY 2022 ($ in millions) (4)	Percent Change** (5)
Government	368	2,517	2,134	-383	-15.21
Medicare Utilization Percent* **					
0 to 25	554	3,388	2,940	-448	-13.22
25 to 50	1,602	4,707	4,098	-609	-12.94
50 to 65	187	189	150	-39	-20.85
Greater than 65	22	6	4	-2	-32.86

Source: Dobson | DaVanzo analysis of 2013 and 2018 Hospital Cost Reports.

*Dollar uncompensated care payments calculated by [0.75 * estimated section 1886(d)(5)(F) payments * Factor 2 * Factor 3]. When summed across all hospitals projected to receive DSH payments, uncompensated care payments are estimated to be $8,290 million in FY 2021 and $7,192 million in FY 2022.

** Percentage change is determined as the difference between Medicare uncompensated care payments modeled for this FY 2022 IPPS/LTCH PPS final rule (column 3) and Medicare uncompensated care payments modeled for the FY 2021 IPPS/LTCH PPS final rule correction notice (column 2) divided by Medicare uncompensated care payments modeled for the FY 2021 IPPS/LTCH PPS final rule correction notice (column 2) times 100 percent.

***Hospitals with missing or unknown Medicare utilization are not shown in table.

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8. On page 45588, lower half of the page, beginning with the second column, first full paragraph, line 1 with the phrase ''Rural hospitals, in general, are projected to experience'' and ending in the third column last paragraph with the phrase ''15.22 percent. All'' the paragraphs are corrected to read as follows:

''Rural hospitals, in general, are projected to experience larger decreases in uncompensated care payments than their urban counterparts. Overall, rural hospitals are projected to receive a 17.28 percent decrease in uncompensated care payments, which is a greater decrease than the overall hospital average, while urban hospitals are projected to receive a 12.99 percent decrease in uncompensated care payments, similar to the overall hospital average.

By bed size, smaller rural hospitals are projected to receive the largest decreases in uncompensated care payments. Rural hospitals with 0–99 beds are projected to receive an 18.97 percent payment decrease, and rural hospitals with 100–249 beds are projected to receive a 15.53 percent decrease. In contrast, larger rural hospitals with 250+ beds are projected to receive a 14.16 percent payment decrease. Among urban hospitals, the smallest urban hospitals, those with 0–99 and 100–249 beds, are projected to receive a decrease in uncompensated care payments that is greater than the overall hospital average, at 15.49 and 15.50 percent, respectively. In contrast, the largest urban hospitals with 250+ beds are projected to receive a 12.02 percent decrease in uncompensated care payments, which is a smaller decrease than the overall hospital average.

By region, rural hospitals are expected to receive larger than average decreases in uncompensated care payments in all Regions, except for rural hospitals in New England, which are projected to receive a decrease of 1.27 percent in uncompensated care payments, and rural hospitals in the East South Central Region, which are projected to receive a smaller than average decrease of 13.01 percent. Regionally, urban hospitals are projected to receive a more varied range of payment changes. Urban hospitals in the New England, Middle Atlantic, and Pacific Regions are projected to receive larger than average decreases in uncompensated care payments. Urban hospitals in the South Atlantic, East North Central, West North Central, West South Central, and Mountain Regions, as well as hospitals in Puerto Rico are projected to receive smaller than average decreases in uncompensated care payments. Urban hospitals in the East South Central Region are projected to receive an average decrease in uncompensated care payments.

By payment classification, although hospitals in urban areas overall are expected to receive a 12.74 percent decrease in uncompensated care payments, hospitals in large urban areas are expected to see a decrease in uncompensated care payments of 13.52 percent, while hospitals in other urban areas are expected to receive a decrease in uncompensated care payments of 11.21 percent. Rural hospitals are projected to receive the largest decrease of 14.23 percent.

Nonteaching hospitals are projected to receive a payment decrease of 13.4 percent, teaching hospitals with fewer than 100 residents are projected to receive a payment decrease of 12.94 percent, and teaching hospitals with 100+ residents have a projected payment decrease of 13.39 percent. All of these decreases closely approximate the overall hospital average. Proprietary and voluntary hospitals are projected to receive smaller than average decreases of 11.56 and 12.61 percent respectively, while government hospitals are expected to receive a larger payment decrease of 15.21 percent. All''.

9. On page 45589, first column, first partial paragraph, the phrase ''hospitals with less than 50 percent Medicare utilization are projected to receive decreases in uncompensated care payments consistent with the overall hospital average percent change, while hospitals with 50–65 percent and greater than 65 percent Medicare utilization are projected to receive larger decreases of 20.79 and 32.81 percent, respectively.'' is corrected to read as follows: ''hospitals with less than 50 percent Medicare utilization are projected to receive decreases in uncompensated care payments consistent with the overall hospital average percent change, while hospitals with 50–65 percent and greater than 65 percent Medicare utilization are projected to receive larger decreases of 20.85 and 32.86 percent, respectively.''

10. On page 45598, third column, last paragraph, lines 21 through 23, the sentence ''The estimated percentage increase for both rural reclassified and nonreclassified hospitals is 1.4 percent.'' is corrected to read ''The estimated percentage increase for rural reclassified hospitals is 1.3 percent, while the estimated percentage increase for rural nonreclassified hospitals is 1.4 percent.''

11. On pages 45599 and 45600, the table titled ''TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE [FY 2021 PAYMENTS COMPARED TO FY 2022 PAYMENTS]'' is corrected to read as follows:

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TABLE III.--COMPARISON OF TOTAL PAYMENTS PER CASE [FY 2021 PAYMENTS COMPARED TO FY 2022 PAYMENTS]				
	Number of Hospitals	Average FY 2021 Payments/ Case	Average FY 2022 Payments/ Case	Change
All hospitals	3,195	981	990	0.9
By Geographic Location:				
Urban Hospitals	2,459	1,014	1,023	0.9
Rural areas	736	673	683	1.5
Bed Size (Urban)				
0-99 beds	634	803	813	1.2
100-199 beds	754	860	871	1.3
200-299 beds	427	939	949	1.1
300-499 beds	421	1,020	1,029	0.9
500 or more beds	223	1,215	1,221	0.5
Bed Size (Rural)				
0-49 beds	311	568	577	1.6
50-99 beds	253	626	634	1.3
100-149 beds	94	666	675	1.4
150-199 beds	39	737	750	1.8
200 or more beds	39	797	810	1.6
By Region:				
Urban by Region				
New England	112	1,104	1,121	1.5
Middle Atlantic	304	1,129	1,134	0.4
South Atlantic	402	889	902	1.5
East North Central	381	966	975	0.9
East South Central	144	863	869	0.7
West North Central	160	989	994	0.5
West South Central	364	927	929	0.2
Mountain	172	1,023	1,032	0.9
Pacific	370	1,304	1,314	0.8
Rural by Region				
New England	19	937	953	1.7
Middle Atlantic	50	651	662	1.7
South Atlantic	114	623	637	2.2
East North Central	113	681	687	0.9
East South Central	144	630	636	1.0
West North Central	89	701	709	1.1
West South Central	135	602	616	2.3
Mountain	48	765	773	1.0
Pacific	24	869	876	0.8
By Payment Classification:				
Urban hospitals	1,983	982	995	1.3
Rural areas	1,212	980	981	0.1
Teaching Status:				
Non-teaching	2,031	817	828	1.3
Fewer than 100 Residents	907	941	949	0.9

TABLE III.--COMPARISON OF TOTAL PAYMENTS PER CASE [FY 2021 PAYMENTS COMPARED TO FY 2022 PAYMENTS]				
	Number of Hospitals	Average FY 2021 Payments/ Case	Average FY 2022 Payments/ Case	Change
100 or more Residents	257	1,358	1,365	0.5
Urban DSH:				
Non-DSH	502	904	915	1.2
100 or more beds	1,227	1,008	1,022	1.4
Less than 100 beds	348	728	737	1.2
Rural DSH:				
Sole Community (SCH/EACH)	265	751	750	-0.1
Referral Center (RRC/EACH)	608	1,030	1,031	0.1
100 or more beds	30	895	875	-2.2
Less than 100 beds	215	559	567	1.4
Urban teaching and DSH:				
Both teaching and DSH	679	1,075	1,090	1.4
Teaching and no DSH	74	981	993	1.2
No teaching and DSH	896	866	878	1.4
No teaching and no DSH	334	859	870	1.3
Special Hospital Types:				
Non special status hospitals	152	781	775	-0.8
RRC/EACH	523	1,061	1,063	0.2
SCH/EACH	305	758	758	0.0
Medicare-dependent hospitals (MDH)	153	610	615	0.8
SCH, RRC and EACH	154	807	815	1.0
MDH, RRC and EACH	27	687	694	1.0
Type of Ownership:				
Voluntary	1,881	993	1,002	0.9
Proprietary	828	896	905	1.0
Government	486	1,031	1,035	0.4
Medicare Utilization as a Percent of Inpatient Days:				
0-25	643	1,119	1,125	0.5
25-50	2,110	972	981	0.9
50-65	367	797	804	0.9
Over 65	50	586	596	1.7
2022 Reclassifications by the Medicare Classification Review Board:				
All Reclassified Hospitals	934	987	993	0.6
All Nonreclassified Hospitals	2,261	977	988	1.1
Urban Hospitals Reclassified	749	1,039	1,042	0.3
Urban Nonreclassified Hospitals	1,723	995	1,008	1.3
Rural Hospitals Reclassified Full Year	300	695	704	1.3
Rural Nonreclassified Hospitals Full Year	423	641	650	1.4
All Section 401 Reclassified Hospitals	532	1,073	1,072	-0.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	56	662	672	1.5

12. On page 45610:

a. Second column, first partial paragraph:

(1) Line 1, the figure ''$2.293'' is corrected to read ''$2.316''.

(2) Line 11, the figure ''$0.65'' is corrected to read ''$0.68''.

b. Third column, last full paragraph, last line, the figure ''$2.293'' is corrected to read ''$2.316''.

13. On page 45611, the table titled ''Table V—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM FY 2021 TO FY 2022'' is corrected to read as follows:

Category	Transfers
Annualized Monetized Transfers.	$2.316 billion.
From Whom to Whom.	Federal Government to IPPS Medicare Providers.

List of Subjects in 42 CFR Part 413

Diseases, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

As noted in section II.B. of the preamble, the Centers for Medicare & Medicaid Services is making the following correcting amendments to 42 CFR part 413:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

■ 1. The authority citation for part 413 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww.

■ 2. Amend § 413.24 by:
■ a. In paragraph (f)(5)(i) introductory text, removing the phrase ''except as provided in paragraph (f)(5)(i)(E) of this section:'' and adding in its place the phrase ''except as provided in paragraphs (f)(5)(i)(A)(*2*)(*ii*) and (f)(5)(i)(E) of this section:''; and
■ b. Revising paragraph (f)(5)(i)(A).

The revision reads as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(f) * * *

(5) * * *

(i) * * *

(A) *Teaching hospitals.* For teaching hospitals, the Intern and Resident Information System (IRIS) data.

(*1*) *Data format.* For cost reporting periods beginning on or after October 1, 2021, the IRIS data must be in the new XML IRIS format.

(*2*) *Resident counts.* (*i*) Effective for cost reporting periods beginning on or after October 1, 2021, the IRIS data must contain the same total counts of direct GME FTE residents (unweighted and weighted) and IME FTE residents as the total counts of direct GME FTE and IME FTE residents reported in the provider's cost report.

(*ii*) For cost reporting periods beginning on or after October 1, 2021, and before October 1, 2022, the cost report is not rejected if the requirement in paragraph (f)(5)(i)(A)(*2*)(*i*) of this section is not met.

* * * * *

Karuna Seshasai,

Executive Secretary to the Department, Department of Health and Human Services.

[FR Doc. 2021–22724 Filed 10–19–21; 8:45 am]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 64

[WC Docket No. 17–97; FCC 20–136; FRS 52215]

Call Authentication Trust Anchor

AGENCY: Federal Communications Commission.

ACTION: Final rule; announcement of effective date.

SUMMARY: In this document, the Commission announces the effective date of an information collection associated with a rule contained in the Commission's *Call Authentication Trust Anchor,* Second Report and Order (Order). This document is consistent with the Commission's *Call Authentication Trust Anchor,* Second Report and Order (Order) which stated that the Commission would publish a document in the **Federal Register** announcing the effective date of that rule.

DATES: The amendment to 47 CFR 64.6306(e) (instruction 11), published November 17, 2020 (85 FR 73360), and delayed indefinitely, is effective October 20, 2021. This final rule is effective October 20, 2021.

FOR FURTHER INFORMATION CONTACT: For further information, please contact Alexander Hobbs, Competition Policy Division, Wireline Competition Bureau at (202) 418–7433 or by email at *Alexander.Hobbs@fcc.gov.*

SUPPLEMENTARY INFORMATION: On June 4, 2021, the Commission announced OMB approval of § 64.6306(e) in a **Federal Register** publication, at 86 FR 29952. This document now announces the effective date of § 64.6306(e). In the Order and the text of § 64.6306(e), the Commission directed the Wireline Competition Bureau to set the compliance date for this rule. On September 3, 2021, the Bureau released a Public Notice, DA 21–1103, setting the date by which voice service providers granted an exemption from the Commission's caller ID authentication rule must file implementation verification certifications and associated supporting statements. Voice service providers must file all certifications and associated supporting statements electronically in WC Docket No. 20–68, Exemption from Caller ID Authentication Requirements, in ECFS, no later than October 4, 2021. We therefore modify the text of § 64.6306(e), previously published at 85 FR 73360, to incorporate this compliance date announced by the Bureau.

If you have any comments on the burden estimates listed below, or how the Commission can improve the collections and reduce any burdens caused thereby, please contact Nicole Ongele, Federal Communications Commission, Room 3.310, 45 L Street NE, Washington, DC 20002. Please include the OMB Control Number, 3060–1285, in your correspondence. The Commission will also accept your comments via email at *PRA@fcc.gov.*

To request materials in accessible formats for people with disabilities (*e.g.,* Braille, large print, electronic files, audio format, etc.), send an email to *fcc504@fcc.gov* or call the Consumer & Governmental Affairs Bureau at (202) 418–0530 (voice), or (202) 418–0432 (TTY).

Synopsis

As required by the Paperwork Reduction Act of 1995 (44 U.S.C. 3507), the FCC is notifying the public that it received final OMB approval on May 13, 2021, for the information collection requirements contained in the modifications to the Commission's rules in 47 CFR part 64 and modifying the language of § 64.6306(e) to conform to the compliance date adopted by the Wireline Competition Bureau in DA 21–1103.

Under 5 CFR part 1320, an agency may not conduct or sponsor a collection of information unless it displays a current, valid OMB Control Number.

No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act that does not display a current, valid OMB Control Number. The OMB Control Number is 3060–1285.

The foregoing is required by the Paperwork Reduction Act of 1995, Public Law 104–13, October 1, 1995, and 44 U.S.C. 3507.

The total annual reporting burdens and costs for the respondents are as follows:

OMB Control Number: 3060–1285.
OMB Approval Date: May 13, 2021.
OMB Expiration Date: May 31, 2024.