

first two 12-month cost reporting periods, as specified at § 413.40(f)(2)(ii)(A) and (B), could not exceed 110 percent of the national median of target amounts of IRFs for cost reporting periods ending during FY 1996, updated by the hospital market basket increase percentage to the first cost reporting period in which the IRF receives payment.

Because we were concerned that a number of pre-1997 excluded hospitals (including IRFs), governed by § 413.40(c)(4)(iii), would seek to create satellite arrangements in order to avoid the effect of the lower payment caps that would apply to new hospitals under § 413.40(f)(2)(ii), we established rules regarding the exclusion of and payments to satellites of existing facilities. If the number of beds in the hospital or unit (including both the base hospital or unit and the satellite location) exceeds the number of State-licensed and Medicare-certified beds in the hospital or unit on the last day of the hospital's or unit's last cost reporting period beginning before October 1, 1997, the facility would be paid under the acute care hospital inpatient DRG system. Therefore, while an excluded hospital or unit could "transfer" bed capacity from a base facility to a satellite, if it increased total bed capacity beyond the level it had in the most recent cost reporting period before October 1, 1997 (see 64 FR 41532–41533, July 30, 1999), the hospital will not be paid as a hospital excluded from the acute care hospital inpatient PPS. However, no similar limitation was imposed with respect to the number of total beds in excluded hospitals and units and satellite facilities of those excluded hospitals and units established after October 1, 1997, since those excluded hospitals and units were subject to the lower payment limits of section 4416 of Pub. L. 105–33, and would, therefore, not benefit from the higher payment cap on target amounts under § 413.40(c)(4) by creating a satellite facility.

On March 22, 2002, we published a proposed rule in the **Federal Register** (67 FR 13416) that set forth the proposed Medicare PPS for long-term care hospitals (LTCHs). Discussion of the comments received on that LTCH proposed rule and our responses were published in a final rule on August 30, 2002 **Federal Register** (67 FR 55954). Specific comments received were discussed on page 56013 of the LTCH final rule that urged us to eliminate the bed-number criteria in § 412.22(h)(2)(i) for pre-1997 IRFs since the applicable PPS is fully phased in. The rationale for the bed-number criteria provision at § 412.22(h)(2)(i) was the potential for

circumventing the PPS by creating a satellite location that could have their payment based on a higher TEFRA target amount cap. However, once an IRF's payment under the IRF PPS does not include a TEFRA-based payment (referred to as the facility-specific payment under the transition period described in § 412.626) and is based on 100 percent of the Federal prospective payment rate, we believe that the need for the bed-number criteria does not exist because IRF prospective payments will be the same regardless of when the IRF was established. Because all IRFs will be paid 100 percent of the proposed FY 2004 Federal prospective payment rates, we are proposing to eliminate the bed-number criteria by amending § 412.22(h) for freestanding satellite IRFs. We are also proposing to eliminate the bed-number criteria for IRF satellite units of a hospital by amending § 412.25(e) to conform with the proposed change in § 412.22(h).

#### *Section 412.23 Excluded Hospitals: Classifications*

Classification as an IRF—"The 75 Percent Rule"

Under the § 412.23(b)(2) of the regulations, a facility may be classified as an IRF if it can show that during its most recent 12-month cost reporting period it served an inpatient population of whom at least 75 percent required intensive rehabilitation services for the treatment of one or more of the following conditions:

1. Stroke.
2. Spinal cord injury.
3. Congenital deformity.
4. Amputation.
5. Major multiple trauma.
6. Fracture of femur (hip fracture).
7. Brain injury.
8. Polyarthritis, including rheumatoid arthritis.
9. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.
10. Burns.

Under § 412.604(b), the requirement at § 412.23(b)(2) must be met as one of the conditions for payment under the IRF PPS. However, even before the implementation of the IRF PPS, the rehabilitation industry expressed an interest in having CMS re-examine the regulatory criteria used to determine the classification of a unit or hospital as an IRF. Recently this interest has focused on the regulatory requirement at § 412.23(b)(2) commonly known as the "75 Percent Rule."

#### *B. Regulatory Background of the 75 Percent Rule*

We initially stipulated the "75 percent" requirement in the September 1, 1983, interim final rule with comment period entitled "Medicare Program; Prospective Payments for Medicare Inpatient Hospital Services" (48 FR 39752). That rule implemented the Social Security Amendments of 1983 (Pub. L. 98–21), changing the method of payment for inpatient hospital services from a cost-based, retrospective reimbursement system to a diagnosis specific PPS. However, the rule stipulated that in accordance with sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act both a rehabilitation unit, which is a distinct part of a hospital, and a rehabilitation hospital were excluded from the inpatient hospital PPS. We noted that sections 1886(d)(1)(B) and 1886(d)(1)(B)(ii) of the Act also gave the Secretary discretion in defining what is a "rehabilitation unit" and a "rehabilitation hospital."

In order to define a rehabilitation hospital we consulted with the Joint Commission on Accreditation of Hospitals (JCAH), and other accrediting organizations. (JCAH is currently known as the Joint Commission on Accreditation of Hospital Organizations.) The criteria we included in our definition of a rehabilitation hospital incorporated some of the accreditation requirements of these organizations. The definition also included other criteria, which we believed distinguished a rehabilitation hospital from a hospital that furnished general medical and surgical services as well as some rehabilitation services. One criterion was that "The hospital must be primarily engaged in furnishing intensive rehabilitation services as demonstrated by patient medical records showing that, during the hospital's most recently completed 12-month cost reporting period, at least 75 percent of the hospital's inpatients were treated for one or more conditions specified in these regulations that typically require intensive inpatient rehabilitation." (48 FR 39756) This requirement was originally specified in § 405.471(c)(2)(ii) of the regulations. We included this requirement, as a defining feature of a rehabilitation hospital, because we believed "that examining the types of conditions for which a hospital's inpatients are treated, and the proportion of patients treated for conditions that typically require intensive inpatient rehabilitation, will help distinguish those hospitals in which the provisions of rehabilitation