

1886(j)(1)(A), which requires Medicare to make payments to IRFs under a PPS specifically designed for the services they furnish. Specifically, the 75 percent rule has the effect of limiting the type of patient that can be cared for in facilities identified as IRFs. This limitation serves to ensure that only patients requiring this type of specialized and more expensive care receive it. The medical conditions listed in the 75 percent rule are conditions in which patients require the services of rehabilitation professionals with specialized skills and experiences that may not be available in other settings.

The largest group of patients treated in rehabilitation hospitals but not considered in this analysis to meet the 75 percent rule is patients with major joint replacements, specifically knee and hip replacements. Joint replacement patients have been more commonly admitted to rehabilitation hospitals in some areas of the country, and nationally, less than one quarter of Medicare beneficiaries are admitted to IRFs after surgery. Although some joint replacement patients may have "polyarthritis," or another of the ten conditions specified in the 75 percent rule requiring intensive inpatient rehabilitation, these cases were generally not counted towards a facility's compliance with the 75 percent rule. Provider representatives also have requested that conditions classified into the cardiac and pulmonary RICs be added to the list of conditions in the 75 percent rule. These two RICs currently represent about 8 percent of beneficiaries serviced in IRFs using the 2002 patient assessment data. We note that many private insurers do not cover acute inpatient rehabilitation care (in IRFs) for many of these patients whose rehabilitation needs can be met in an alternative setting such as a skilled nursing facility. We request comments on any conditions that necessitate the intensive, multidisciplinary care that IRFs are required to provide.

As mentioned previously, we surveyed the FIs to determine the methods they were using to verify compliance with the 75 percent rule. Our analysis of that survey data led us to suspend enforcement of the 75 percent rule. The process for determining compliance with the 75 percent rule needs to be improved. However, we believe that currently there is no need to amend the regulation because it still appropriately functions to help distinguish an IRF from other types of inpatient treatment settings. We will instead be improving the method FIs use to verify compliance with the 75 percent rule, and ensuring that FIs are

consistent in how they verify compliance with the 75 percent rule.

When we suspended enforcement of the 75 percent rule we specified that the suspension of enforcement was not applicable to a facility that was first seeking classification as an IRF in accordance with § 412.23(b)(8) or § 412.30(b)(2). A facility first seeking classification as an IRF in accordance with § 412.23(b)(8) or § 412.30(b)(2) only has to self-attest that during its next full 12-month cost reporting period it will meet the 75 percent rule. Accordingly, a facility first seeking classification as an IRF in accordance with § 412.23(b)(8) or § 412.30(b)(2) has never had an FI verify that its patient population actually met the 75 percent rule. Until the medical conditions of this facility's patient population have been evaluated this facility has not proven that for at least one full 12-month cost reporting period it complied with the 75 percent rule and was appropriately classified as an IRF. Therefore, until a facility had proven that it qualified to be classified as an IRF because its patient population actually met the 75 percent rule it could not be eligible for suspension of enforcement of the 75 percent rule.

We will be instructing FIs to re-institute appropriate enforcement action if a FI determines that an IRF has not met the 75 percent rule. We realize that an IRF may need time to come into compliance with the 75 percent rule. An IRF's cost reporting period is the time period used to ascertain compliance with the 75 percent rule. Therefore, we will be instructing the FIs that the FI must use cost reporting periods that begin on or after October 1, 2003, as the time period to ascertain an IRF's compliance with the 75 percent rule.

While this proposed rule does not propose changes to the regulations related to the 75 percent rule, we expect that improved enforcement and compliance with the existing rule will have varying impacts on providers and beneficiaries.

Our analysis, detailed earlier in this section, indicates that approximately 50 percent of cases being cared for in IRFs fall outside of the ten conditions listed in the regulations. In addition, it estimates that potentially 86 percent of IRFs may currently be out of compliance. We again note that this analysis is based on Medicare administrative data (claims and patient assessments) rather than detailed medical record data and, thus, is limited in its ability to accurately classify all patients into one or more of the ten conditions cited in the regulations. Thus, we would expect our estimates of compliance to be higher if more detailed

information from the medical records were available to perform the analysis.

We also know from the data that cases observed in IRFs that do not fall in one of the ten conditions have, on the average, lower lengths of stay than those cases that fall into one of the ten conditions. Specifically, the cases that do not fall into one of the ten conditions (approximately 50 percent) account for approximately 40 percent of the Medicare covered days. Conversely, 60 percent of the Medicare covered days fall into one of the ten conditions.

While it is difficult to predict the aggregate impact of improved compliance on provider revenues, we expect that IRFs and/or their parent hospitals (80 percent of IRFs are units of acute care hospitals) will change their behavior in a variety of ways. IRFs may change admission practices to alter their case mix, either Medicare or total patient population, by admitting patients with more intensive rehabilitative needs that fall into the ten conditions. This could have the effect of elevating the facility's revenues because cases requiring more intensive rehabilitation care generally receive higher Medicare payments than less complex cases.

For example, in each of the three years of data examined, lower extremity joint replacements contained by far the largest number of cases not in the ten conditions (44 percent in 2002). Other conditions included cardiac (10.3 percent), pulmonary (4.8 percent) and pain (4.1 percent). IRFs specializing in or treating a significant number of such cases may have to alter their admissions practice to achieve compliance. Treating fewer joint replacement cases (that result in relatively low payments under the IRF PPS) with cases requiring more intensive treatment could actually increase a facility's revenues.

Conversely, some IRFs may not be able to find such cases and may be required to reduce capacity and serve fewer patients in order to achieve compliance, an action that may have the effect of lowering a facility's revenues. Since compliance with the 75 percent rule could be achieved with changes in admission practices for Medicare as well as non-Medicare patients, the impact on Medicare revenues may vary.

The current regulation reflects the fact that a significant number (up to 25 percent) of medically necessary admissions may fall outside of the ten conditions. These cases can continue to be admitted and treated under the regulation. Other cases may appropriately receive rehabilitative care in alternative settings. For certain medically complex cases, it may be