

as opposed to under another payment system, such as the acute care IPPS, which may not adequately compensate these facilities for the intensive rehabilitative services they are to provide. We believe it is crucial to ensure that IRFs are indeed providing intensive rehabilitation so that we pay for these services appropriately under the IRF PPS. In addition, we believe it is imperative to identify conditions that would “typically require intensive inpatient rehabilitation” in IRFs because rehabilitation in general can be delivered in a variety of settings such as acute care hospitals, skilled nursing facilities, outpatient or home health.

This policy objective is not new. However, the manner in which the existing regulations have been implemented and enforced may not have enabled CMS to accomplish these objectives to the extent we hoped. The policies set forth in this proposed rule are intended to accomplish these same policy objectives, clarify interpretational issues that have led to inconsistent implementation, and improve the extent to which IRFs can admit patients that would need and benefit from intensive inpatient rehabilitative services. Therefore, although the impacts of the proposed policy changes shown below illustrate that IRFs may experience reduced Medicare payments from these proposed policies, we believe the impacts would show a greater reduction in Medicare payments to IRFs if the existing policies were more effectively enforced.

We discuss below the Medicare impact of this proposed rule on IRFs. We used the following data and assumptions to estimate the impacts of the proposed policies set forth in this preamble.

- As stated in section I.D. of this proposed rule, we used patient assessment data from January to August 2002 to estimate compliance with the 75 percent rule in the May 16, 2003 proposed rule. We are using the same patient assessment data to construct the impact analysis set forth in this proposed rule.

- We used data described in the report titled Case Mix Certification Rule for Inpatient Rehabilitation Facilities”, published in May 2003, developed by the Rand Corporation. This report states, on page XIV, that 70 percent of all cases treated in IRFs are those of Medicare beneficiaries.

- In addition to Medicare patients, this proposed rule may have an effect on the 30 percent, or approximately 200,000, of the cases in IRFs that are non-Medicare. While there are numerous approaches a facility might

take, and it is impossible to predict either the specific course of treatment or the financial impact, the facility could change both its Medicare and non-Medicare case mix in order to remain an IRF.

- We used regression results from page 25 of the Rand report to estimate that the percentage of total cases that meet the specified conditions for each IRF will be approximately 5 percent more than the percentage of Medicare cases that meet the specified conditions. However, other than an estimate of the size of the non-Medicare population in this proposed rule may affect, CMS does not have enough information to quantitatively estimate the impact to non-Medicare IRF cases, and encourages comments on this issue.

- 10 percent of the cases that did not meet the proposed criteria would meet the proposed criteria due to more accurate coding and removing the moratorium of the classification rule.

- 10 percent of the cases that did not meet the proposed criteria with the limited Medicare administrative data used in our analysis would meet the proposed criteria using more extensive medical record data.

- The diagnosis listed in Appendix A in the “Case Mix Certification Rule for Inpatient Rehabilitation Facilities” report, published in May 2003, developed by Rand identified cases that would meet the 75 percent rule. The report showed that a large number of cases with possible arthritis-related joint replacements did not meet the 75 percent rule. We believe that the proposed changes to the conditions related to arthritis in this proposed rule may increase the number of these cases that would count towards meeting the proposed 75 percent rule over those cases shown in the RAND report. However, it is difficult to determine the exact number of joint replacement cases that would meet the proposed criteria without extensive medical record data. Therefore, to estimate the impacts on the various classifications of IRFs shown in Chart 1, we chose the assumption that 35 percent of the joint replacement cases would meet the proposed clinical criteria as set forth in this proposed rule.

- We assume that a percentage of Medicare cases being admitted under the current practices would not be admitted to an IRF under the proposed criteria. We believe that these cases would be admitted or treated in extended hospital inpatient stays, outpatient departments, or other post acute care settings. We estimated that it would be equally possible that the cases not admitted to IRFs may be treated in

inpatient hospitals, outpatient departments, or home health care settings. We found that approximately 80 percent of IRFs are units within a hospital complex and that approximately 60 percent of these hospital complexes include a skilled nursing facility. Accordingly, we estimated that skilled nursing facilities will have a higher possibility than other settings to absorb the cases not admitted to IRFs. Since long term care hospitals need to meet the average 25-day length of stay requirement and the average IRF length of stay is 14 Days, we estimated that long term care hospitals will absorb a smaller portion of the cases not admitted to IRFs.

Based on the above assumptions and the average payments for their respective settings, we have estimated that the average payment for these hospital inpatient, outpatient, and other post acute care settings to be approximately \$7,000 per case. Thus, for Medicare patients, the difference between the IRF standardized payment per case (\$12,525) and the estimated average per case amount for hospital inpatient, outpatient, and other post acute care settings (\$7,000) results in a net savings to the Medicare program of approximately \$5,525 per case.

Note that this result also depends on the assumption that all IRFs will continue to want to be classified as an IRF and admit those patients that will allow them to meet the proposed changes set forth in this proposed rule.

1. Impact Summary

Dependent on the range of assumptions related to joint replacement cases described above, we project a proposed net savings to the Medicare program between \$42 million and \$161 million. Specifically, the estimated net savings would be \$161 million if we assume that 20 percent of joint replacement cases meet the proposed criteria, \$98 million if 35 percent of joint replacement cases meet the proposed criteria, and \$42 million if 60 percent of joint replacement cases meet the proposed criteria. This net savings to Medicare would be a net loss of Medicare payments to IRFs or facilities that contain both an IRF and an alternative treatment facility. Some alternative treatment facilities, however, would experience an increase in Medicare payments if they experience a net increase in cases.

2. Calculation of Impacts

To determine the estimated effects of implementing the policies in this proposed rule, we have developed Chart 1 to show the estimated impact on the