

CHART 1.—PROJECTED IMPACT OF THE PROPOSED CHANGES TO THE 75 PERCENT RULE ON THE MEDICARE PROGRAM—
Continued

Facility classification Column 1	Total number of IRF Column 2	Total Medi- care cases Column 3	Ratio of Medicare cases not admitted Column 4	Ratio of all set- ting cost/saving to IRF Medicare payments Column 5	In millions			
					All setting cost/saving Column 6	IRF Medi- care pay- ment impact Column 7	Current IRF Medicare payments Column 8	Projected IRF Medi- care pay- ments Column 9
Urban/Rural:								
Large Urban	493	209,489	4%	-2%	-48	-109	2,624	2,515
Missing	103	18,881	4%	-2%	-4	-10	236	227
Other Urban	404	188,494	4%	-2%	-42	-95	2,361	2,266
Rural	170	42,818	2%	-1%	-4	-9	536	527
Size:								
Large	201	172,951	5%	-2%	-43	-99	2,166	2,068
Medium	502	198,451	4%	-2%	-41	-93	2,486	2,393
Missing	158	31,400	3%	-1%	-5	-12	393	381
Small	309	56,880	3%	-1%	-9	-20	712	693
Size by Free Standing/Unit Facility:								
Free:								
Large	74	91,409	6%	-2%	-28	-64	1,145	1,081
Medium	71	53,640	6%	-3%	-17	-38	672	633
Missing	38	10,817	4%	-2%	-3	-6	135	130
Small	31	9,727	2%	-1%	-1	-2	122	120
Unit:								
Large	127	81,542	3%	-1%	-15	-34	1,021	987
Medium	431	144,811	3%	-1%	-24	-54	1,814	1,759
Missing	120	20,583	2%	-1%	-3	-6	258	252
Small	278	47,153	3%	-1%	-8	-18	591	573

Chart 1 breaks down the Medicare impacts into many categories that should serve to inform the public and interested parties of the different types of impacts of the changes in this proposed rule. As column seven in Chart 1 shows, IRFs are expected to experience a reduction in Medicare payments from the proposed rule of approximately \$223 million, with a net savings to Medicare of approximately \$98 million for all Medicare providers. Applying the different assumptions regarding qualifying joint replacement cases yields a Medicare impact range of \$42 million (60 percent qualifying) to \$161 million (20 percent qualifying).

For the purposes of the RFA analysis, the next few paragraphs discuss IRF impacts in more detail, and regulatory alternatives considered by CMS to explore the impact of different options on IRFs. There are distributional impacts among various IRFs due to existing levels of compliance. The expected Medicare savings is due to the percentage of patients admitted to IRFs that fall outside the identified conditions in relation to what IRFs would be paid in FY 2004 for all Medicare discharges assuming status quo (varying levels of compliance to the existing 75 percent rule). As we previously stated in this proposed rule, although the impacts of the proposed policy changes illustrate IRFs may experience a reduction in payments, we believe the impacts would show a greater reduction in payments to IRFs if

the existing policies were more effectively enforced. Further, we believe this reduction in Medicare payments is appropriate given the existing policy objectives described above.

Because this rule is likely to have a significant impact on all IRFs based on the RFA guidelines, we will discuss the alternative changes to the 75 percent rule that we considered.

One option (Option A) would have been to consider all cases in rehabilitation impairment categories (RICs) 1–19 and 21 as cases that could be counted towards the 75 percent rule. This would leave only miscellaneous cases (RIC 20) as cases that would not be considered to satisfy the requirements in proposed § 412.23(b)(2). The result would have been that all existing IRFs would not only meet the standard, but that they would have almost no restrictions on the type of cases that they would admit. The intent of the policy specified in proposed § 412.23(b)(2) is to ensure that IRFs are unique compared to other hospitals in that they provide intensive rehabilitative services in an inpatient setting. The uniqueness of these facilities justifies paying them under a separate payment system rather than paying them with the same payment system for acute care inpatient PPS. Thus, we believe it is crucial to Medicare to maintain criteria ensuring that only facilities providing intensive rehabilitation are identified as IRFs. In addition, we believe that 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 other settings.

We have estimated that the average occupancy rate of all IRFs is approximately 70 percent. If we were to implement option A, we believe that IRFs with available capacity would increase their occupancy rate because, as stated above, IRFs would have almost no restrictions on the type of cases that they would admit. The following estimated effects of implementing option A on the Medicare program assumes that IRFs would increase their Medicare cases using the present ratio of 70 percent Medicare beneficiaries to total patients. Thus, we estimate that in the first year of implementing option A it would cause an increase in IRF Medicare payments, and would cost the Medicare program, an additional \$2.7 billion dollars if occupancy increased to 100 percent, \$1.9 billion if occupancy increased to 90 percent, and \$1.2 billion if occupancy increased to 80 percent. This range of additional costs to the Medicare program represents up to 50 percent more than the current total IRF Medicare expenditures.

A variant of option A is option B which would add joint replacements, cardiac, pulmonary, pain, and cancer patients to the list of conditions, as discussed previously in this preamble in section II.A., which would also result in a significant impact on Medicare