

expenditures and IRF Medicare payments. If we were to implement option B, using the same assumptions described in option A, we estimate it would have cost the Medicare program approximately \$940 million dollars in the first year.

Another option (Option C) would be to retain the compliance percentage requirement at 75 percent, rather than lowering it to 65 percent, but recognize the comorbidities as proposed in section II.C. of this proposed rule. This option is similar to enforcement of the current policy and, thus, would further reduce Medicare payments to all IRFs over the policies proposed in this rule. Specifically, total estimated savings to Medicare from all IRFs would be increased from the range of \$42 to \$161 million (under the proposed policies) to the range of \$154 to \$357 million if we proposed 75 percent.

Another option (Option D) that we considered, similar to option C, was to allow a comorbidity to count only for hip and joint replacement patients as discussed previously in section II.C. of this proposed rule. If the compliance requirement were to be held at 75 percent along with this policy, the estimated reduction in Medicare payments for IRFs and savings to Medicare would be approximately the same as in option C.

We believe that the proposed changes to the clinical criteria are adequate to make the distinction of the intensive inpatient rehabilitation provided in IRFs from rehabilitation services provided in other settings, unlike the first alternative described above. In addition, while the proposed changes to the clinical criteria and the reduction in the compliance percentage to 65 percent do have a significant impact on Medicare payments to IRFs (\$42 to \$161 million), they are not as significant as the impact of the other alternatives described above. It is also important to note, as previously mentioned in section V.G., 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. Thus, a majority of hospital complexes (including rural hospitals) that maintain an IRF unit may experience an increase in Medicare payments from the proposed changes in this proposed rule in other settings within the complex.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget (OMB).

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV, part 412 as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

2. In § 412.23, paragraph (b)(2) is revised to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(b) * * *

(2) Except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, a hospital must show that during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the fiscal intermediary), it served an inpatient population that meets the criteria under paragraph (b)(2)(i) or (b)(2)(ii) of this section.

(i) For cost reporting periods beginning on or after January 1, 2004 and before January 1, 2007, the hospital has served an inpatient population of whom at least 65 percent required intensive rehabilitative services for treatment of one or more of the conditions specified at paragraph (b)(2)(iii) of this section. A patient with a comorbidity, as defined at § 412.602, may be included in the inpatient population that counts towards the required 65 percent if—

(A) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified at paragraph (b)(2)(iii) of this section;

(B) The patient has a comorbidity that falls in one of the conditions specified at paragraph (b)(2)(iii) of this section; and

(C) The comorbidity has caused significant functional ability decline in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and which cannot be appropriately performed in another care setting covered under this title.

(ii) For cost reporting periods beginning on or after January 1, 2007, the hospital has served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the conditions specified at paragraph (b)(2)(iii) of this section.

(iii) List of conditions.

(A) Stroke.

(B) Spinal cord injury.

(C) Congenital deformity.

(D) Amputation.

(E) Major multiple trauma.

(F) Fracture of femur (hip fracture).

(G) Brain injury.

(H) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(I) Burns.

(J) Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living, which have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or which result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(K) Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living, which have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or which result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(L) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving three or more major joints (elbow, shoulders, hips, or knees) with joint deformity and substantial loss of range of motion, atrophy, significant