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## Acronyms

Because of the many terms to which we refer by acronym in this proposed rule, we are listing the acronyms used and their corresponding terms in alphabetical order below:

- BBA Balanced Budget Act of 1997, (Pub. L. 105–33)
- BBRA Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, (Pub. L. 106–113)
- BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, (Pub. L. 106–554)
- CMS Centers for Medicare & Medicaid Services DSM–IV–TR Diagnostic and Statistical Manual of Mental Disorders Fourth Edition—Text Revision
- DRGs Diagnosis-related groups
- FY Federal fiscal year
- HCRIS Hospital Cost Report Information System
- ICD–9-CM International Classification of Diseases, 9th Revision, Clinical Modification

- IPFs Inpatient psychiatric facilities
- IRFs Inpatient rehabilitation facilities
- LTCHs Long-term care hospitals
- MedPAR Medicare provider analysis and review file
- PIP Periodic interim payments
- TEFRA Tax Equity and Fiscal Responsibility Act of 1982, (Pub. L. 97–248)

## I. Background

### A. General and Legislative History

When the Medicare statute was originally enacted in 1965, Medicare payment for hospital inpatient services was based on the reasonable costs incurred in furnishing services to Medicare beneficiaries. Section 223 of the Social Security Act Amendments of 1972 (Pub. L. 92–603) amended section 1861(v)(1) of the Social Security Act (the Act) to set forth limits on reasonable costs for hospital inpatient services. The statute was later amended by section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) to limit payment by placing a limit on allowable costs per discharge.

The Congress directed implementation of a prospective payment system for acute care hospitals in 1983, with the enactment of Pub. L. 98–21. Section 601 of the Social Security Amendments of 1983 (Pub. L. 98–21) added a new section 1886(d) to the Act that replaced the reasonable cost-based payment system for most hospital inpatient services with a prospective payment system.

Although most hospital inpatient services became subject to the prospective payment system, certain specialty hospitals were excluded from the prospective payment system and continued to be paid reasonable costs subject to limits imposed by TEFRA. These hospitals included psychiatric hospitals and psychiatric units in acute care hospitals, long-term care hospitals (LTCHs), children's hospitals, and rehabilitation hospitals and units. Cancer hospitals were added to the list of excluded hospitals by section 6004(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239).

The Congress enacted various provisions in the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act (BBRA) (Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) (Pub. L. 106–554) to replace the cost-based methods of reimbursement with a prospective

payment system for the following excluded hospitals:

- Rehabilitation hospitals (including units in acute care hospitals).
- Psychiatric hospitals (including units in acute care hospitals).
- LTCHs.

The BBA also imposed national limits (or caps) on hospital-specific target amounts (that is, annual per discharge limits) for these hospitals until cost reporting periods beginning on or after October 1, 2002. A detailed description of the TEFRA payment methodology is provided in section I.B.1. of this proposed rule.

Section 124 of the BBRA mandated that the Secretary—(1) develop a per diem prospective payment system for inpatient hospital services furnished in psychiatric hospitals and psychiatric units; (2) include in the prospective payment system an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units; (3) maintain budget neutrality; (4) permit the Secretary to require psychiatric hospitals and psychiatric units to submit information necessary for the development of the prospective payment system; and (5) submit a report to the Congress describing the development of the prospective payment system.

Section 124 also required that the payment system for inpatient psychiatric services be implemented for cost reporting periods beginning on or after October 1, 2002. The creation of each new payment system requires an extraordinary amount of lead-time to develop and implement the necessary changes to our existing computerize claims processing systems. In order to meet the BBRA requirement to develop an adequate patient classification system, we undertook two research projects. It became apparent that the two research projects could not be completed in time for us to implement an inpatient psychiatric facility prospective payment system by October 1, 2002. It was impossible for us to analyze our existing administrative data in a sufficient amount of time to go through notice and comment rulemaking and implementation of the inpatient psychiatric facility prospective payment system by the statutory deadline. This delay enabled us to analyze our existing administrative data to determine the feasibility and validity of using these data to develop the proposed inpatient psychiatric facility prospective payment system. We are using a combination of available facility and patient specific data for this proposed rule. Our research efforts will