

final rule also published on August 1, 2000 (65 FR 47054).

With respect to the TEFRA payment methodology, section 4414 of the BBA had provided for caps on target amounts for excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997. Section 121 of the BBRA amended section 1886(b)(3)(H) of the Act to provide for an appropriate wage adjustment to these caps on the target amounts for certain hospitals and units paid under the TEFRA provisions, effective for cost reporting periods beginning on or after October 1, 1999 through September 30, 2002.

4. BIPA Amendments to TEFRA

Section 306 of BIPA amended section 1886 of the Act by increasing the incentive payments for psychiatric hospitals and psychiatric units to 3 percent for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001.

II. Overview of the Proposed IPF Prospective Payment System

As required by statute, we are proposing a per diem prospective payment system for psychiatric hospitals and psychiatric units (hereinafter referred to as inpatient psychiatric facilities (IPFs)) that would replace the current reasonable cost-based payment system under the TEFRA provisions. In this rule, we are proposing to base the system on data from the 1999 Medicare Provider Analysis and Review (MedPAR) file, which includes patient characteristics (for example, patients' diagnoses and age), and data from the 1999 Hospital Cost Report Information System (HCRIS), which includes facility characteristics (for example, location and teaching status). We are using the 1999 MedPAR and HCRIS data because they are the best available data.

Based on our analysis, we are proposing the following methodology as the basis of the proposed IPF prospective payment system:

- Compute a Federal per diem base rate to be paid to all psychiatric hospitals and psychiatric units based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF adjusted for budget neutrality (see section III.C. of this proposed rule). In computing the Federal per diem base rate, our analysis showed that routine operating and capital represent approximately 88 percent of total costs and the remaining 12 percent of total costs are for ancillary services.
- Adjust the Federal per diem base rate to reflect certain patient and facility

characteristics that were found in the regression analysis to be associated with statistically significant cost differences (see section III.B. of this proposed rule). The variance explained by patient characteristics (19 percent) in the regression analysis is limited by the nature of the administrative data used to develop this system, which assigns average facility routine costs to individual patients. We are conducting research to better understand the relationship between individual patient characteristics and average facility routine costs that could be incorporated into the payment system in future updates. We note that ancillary costs are already identifiable at the individual patient level.

- Implement an April 1, 2004 effective date and a 3-year transition period. As explained in section IV of this proposed rule, it ultimately may be necessary to delay implementation beyond April 2004 as well as to increase the length of the transition period. However, the rate development, budget-neutrality adjustment, and impact analysis assume an April 1, 2004 effective date and a 3-year transition period.

- Include research information for future refinement of the proposed patient classification system. Part of this research could result in a new patient assessment instrument that could identify additional patient level characteristics.

In addition, we are proposing to make the following types of adjustments to appropriately make payments on a per-diem basis:

- Patient-level adjustments for age, specified diagnosis-related groups, and selected high cost comorbidity categories. These patient-level characteristics explain approximately 19 percent of the variance in the cost of psychiatric care in the administrative data, which establishes the empirical basis for this methodology.
- Facility adjustments that include a wage index adjustment, rural location adjustment, and an indirect teaching adjustment. These facility characteristics explain approximately 13 percent of the variance in the costs of psychiatric care in the administrative data.
- Variable per diem adjustments to recognize the higher costs incurred in the early days of a psychiatric stay.
- Outlier adjustments to target greater payment to the high cost cases.

We are also proposing the following policies:

- Interrupted stay policy for the purpose of applying the variable per diem adjustment and the outlier policy.

- Coding policy (see section II. A.) that would—(1) require IPFs to report patient diagnoses using the International Classification of Diseases-9th Revision, Clinical Modification (ICD-9-CM) code set to report the psychiatric diagnosis; and (2) select the diagnosis-related groups (DRGs) that would be used for payment adjustments in this proposed rule.

A. Use of Diagnostic Codes for Payment

The patient's principal diagnosis of his or her physical or mental condition is essential because it typically acts as a guide for treatment and validates payment. It is for these reasons that diagnostic information is routinely reported on hospital claims and is used in other prospective payment systems. In mental health treatment, the principal tool recognized and utilized by the psychiatric community for diagnostic assessment is the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM provides a broad and comprehensive description of patients through behavioral domains, or "axes." This multiaxial system is routinely used by clinical staff to diagnose patients and plan treatment. The DSM is currently in its fourth revision text revision (DSM-IV-TR). Although, the DSM is used for patient assessment by IPFs, the ICD-9-CM coding system is used currently for reporting diagnostic information for payment purposes.

1. ICD

The ICD coding system was designed for the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease. Chapter Five of the ICD-9-CM includes the codes for mental disorders.

In addition, the following definitions (as described in the 1984 Revision of the Uniform Hospital Discharge Data Set) are requirements of the ICD-9-CM coding system.

- Diagnoses include all diagnoses that affect the current hospital stay.
- Principal diagnosis is defined as the condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- Other diagnoses (also called secondary diagnoses or additional diagnoses) are defined as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded.