

• DRG 467 includes a range of cases in which other factors influence health status. This DRG contains only one diagnosis code listed in Chapter Five of the ICD-9-CM, code 305.1 (tobacco use disorder). Patients with this diagnosis do not require inpatient treatment in an IPF unless there is a concomitant psychiatric disorder.

We are proposing not to recognize these 10 DRGs for payment adjustments (34, 35, 182, 183, 184, 352, 358, 359, 369, and 467) because they generally do not include a psychiatric diagnosis. We believe that failure to recognize these DRGs will not affect the care of Medicare beneficiaries because our analysis shows few, if any, of the patients with these diagnoses are admitted or treated in an IPF.

In addition, we believe that these cases would be classified into one of the selected DRGs and grouped with other beneficiaries with similar symptoms and requiring similar care. This approach would avoid creating case-mix groups based on small numbers of cases.

We believe there is value in selecting only those DRGs that contain a large enough number of psychiatric cases to ensure that individual variability can be averaged. We specifically invite public comments on this issue.

E. Applicability of the Proposed IPF Prospective Payment System

The following psychiatric hospitals and psychiatric units, currently paid under section 1886(b) of the Act, would be paid under the proposed IPF prospective payment system for cost reporting periods beginning on or after April 1, 2004. We are proposing that the IPF prospective payment system would apply to inpatient hospital services furnished by Medicare participating entities that are classified as psychiatric hospitals or psychiatric units as specified in § 412.22, § 412.23, § 412.25, and § 412.27. We note that psychiatric units that are currently paid under the hospital inpatient prospective payment system and do not meet the requirements of § 412.25 and § 412.27 would not be paid under the proposed IPF prospective payment system.

As specified in § 400.200, the United States means the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Therefore, IPFs located within the United States would be subject to the proposed IPF prospective payment system. However, the following hospitals are paid under special payment provisions specified in § 412.22(c) and, therefore, would not be

paid under the proposed IPF prospective payment system:

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR part 403.
- Hospitals that are reimbursed in accordance with demonstration projects specified in section 402(a) of Pub. L. 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Pub. L. 92-603 (42 U.S.C. 1395b-1(note)).
- Non-participating hospitals furnishing emergency services to Medicare beneficiaries.

This proposed rule would not change the basic criteria for a hospital or hospital unit to be classified as a psychiatric hospital or psychiatric unit that is excluded from the hospital prospective payment systems under sections 1886(d) and 1886(g) of the Act, nor would it revise the survey and certification procedures applicable to entities seeking this classification.

We note that we are proposing a technical change to § 412.27(a). We are proposing to replace the Third Edition with the Fourth Edition, Text Revision, of the DSM so that our rules reflect the most current edition of the DSM.

As noted previously, we are requesting public comments on continuing to require a DSM diagnosis for patients admitted to a psychiatric unit in light of the proposed requirement that IPFs use the ICD-9-CM code set in the proposed IPF prospective payment system.

III. Development of the Proposed IPF Per Diem Payment Amount

The primary goal in developing the proposed IPF prospective payment system is to pay each IPF an appropriate amount for the efficient delivery of care to Medicare beneficiaries. The system must be able to account adequately for each IPF's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those beneficiaries who require more costly care.

The proposed IPF prospective payment system would establish a standard per diem payment amount for inpatient psychiatric services provided to Medicare beneficiaries. The proposed per diem amount would reflect the average daily cost of inpatient psychiatric care in an IPF, including capital-related costs. This proposed per diem payment amount, after adjustment for budget neutrality, is then modified by factors for patient and facility characteristics that account for variation in patient resource use. The proposed IPF prospective payment system would also include an outlier policy and

account for interrupted stays. This section includes a discussion of how the proposed Federal per diem base rate was created, the factors that we considered to adjust the proposed Federal per diem base rate, and how the proposed per diem payment amount is calculated.

A. Proposed Market Basket

We are proposing to use a 1997-based excluded hospital with capital market basket. We periodically revise and rebase the market basket to reflect more current cost data. Rebasing means moving the base year for the structure of costs (in this case from 1992 to 1997), while revising means changing data sources, cost categories, or price proxies used. The proposed updated market basket would replace the 1992-based excluded hospital with capital market basket. This rebased (1997-base year) and revised market basket would be used to update FY 1999 IPF costs to the proposed 15-month period beginning April 1, 2004, the first year under the IPF prospective payment system.

The operating portion of the 1997-based excluded hospital with capital market basket is derived from the 1997-based excluded hospital market basket. The methodology used to develop the operating portion was described in the hospital inpatient prospective payment system final rule published in the **Federal Register** on August 1, 2002 (67 FR 50042 through 50044). In brief, the operating cost category weights in the 1997-based excluded hospital market basket were determined from the Medicare cost reports, the 1997 Business Expenditure Survey, and the 1997 Annual Input-Output data from the Bureau of the Census. As explained in that August 1, 2002 final rule, we revised the market basket by making two methodological revisions to the 1997-based excluded hospital market basket: (1) Changing the wage and benefit price proxies to use the Employment Cost Index (ECI) wage and benefit data for hospital workers; and (2) adding a cost category for blood and blood products.

When we add the weight for capital costs to the excluded hospital market basket, the sum of the operating and capital weights must still equal 100.0. Because capital costs account for 8.968 percent of total costs for excluded hospitals in 1997, it holds that operating costs must account for 91.032 percent. Each operating cost category weight in the 1997-based excluded hospital market basket was multiplied by 0.91032 to determine its weight in the 1997-based excluded hospital with capital market basket.