

2. Calculation of the Proposed Per Diem Amount

For routine services, the proposed per diem operating and capital costs would be used to develop the base for the psychiatric per diem amount. The per diem routine costs were obtained from each facility's Medicare cost report. To estimate the costs for routine services included in developing the proposed per diem amount, we summed the total routine costs (including costs for capital) submitted on the cost report for each provider and divided it by the total Medicare days. Some average routine costs per day were determined to be aberrant, that is, the costs were extraordinarily high or low and most likely contained data errors. The following method was used to trim extraordinarily high or low cost values in order to improve accuracy of our results. First, the average and standard deviations of the total per diem cost (routine and ancillary costs) were computed separately for cases from psychiatric hospitals and psychiatric units (separate statistics were computed for the groups of IPFs, because we did not want to systematically exclude a larger proportion of cases from the higher cost psychiatric units). Before calculating the means, we trimmed cases from the file when covered days were zero or routine costs were less than \$100 or greater than \$3,000. We selected these amounts because we believe this range captured the grossly aberrant cases. Elimination of the grossly aberrant cases would prevent the means from being distorted. Second, we trimmed cases when the provider's total cost per day was outside the standard and generally used statistical trim points of plus or minus 3 standard deviations from the respective means for each facility type (psychiatric hospitals and psychiatric units). If the total cost per day was outside the trim value, we would delete the data for that provider from the per diem rate development file. This method of trimming is consistent with the method used for the regression analysis. After trimming the data, the average routine cost per day would be \$495.

For the ancillary services, we would calculate the costs by converting charges from the 1999 Medicare claims into costs using facility-specific, cost-center specific cost-to-charge ratios obtained from each provider's applicable cost reports. We matched each provider's departmental cost-to-charge ratios from their Medicare cost report to each charge on their claims reported in the MedPAR file. Multiplying the total charges for each type of ancillary service

by the corresponding cost-to-charge ratio provided an estimate of the costs for all ancillary services received by the patient during the stay. For those departmental cost-to-charge ratios that we considered to be aberrant because they were outside the statistically valued trim points of plus or minus 3.00 standard deviations from the facility-type mean, we replaced the individual cost-to-charge ratios for each department with the median department cost-to-charge ratio by facility type (psychiatric hospital or psychiatric unit). Because the distribution of ratios of cost-to-charges is not normally distributed and because there is no limit to the upper ceiling of the ratio, the mean value tends to be overstated due to the higher values on the upper tail of the bell curve. Therefore, we chose the median by facility type as a better measure for the substitution value when the facility's actual cost-to-charge ratio was outside the trim values.

After computing the estimated costs by applying the cost-to-charge ratios to the total ancillary charges for each patient stay, we would determine the average ancillary amount per day by dividing the total ancillary costs for all stays by the total covered Medicare days. Using this methodology, the average ancillary cost per day would be \$67.

Adding the average ancillary costs per day (\$67) and the facility's average routine costs per day including capital costs (\$495) provides the base payment amount (\$562) for the estimated average per diem amount for each patient day of inpatient psychiatric care.

3. Determining the Update Factors for the Budget-Neutrality Calculation

Section 124(a)(1) of Pub. L. 106-113 requires that the proposed IPF prospective payment system be budget neutral. In other words, the amount of total payments under the proposed IPF prospective payment system, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the proposed prospective payment system were not implemented. Therefore, we are proposing to calculate the budget-neutrality factor for the implementation period by setting the total estimated prospective payment system payments equal to the total estimated payments that would have been made under the TEFRA methodology had the proposed prospective payment system not been implemented.

As discussed in section IV of this proposed rule, the implementation date of the proposed IPF prospective

payment system is cost reporting periods beginning on or after April 1, 2004. In order to create a more even and efficient process of updates for the various Medicare payment systems, we are recommending that the first Federal base rate update occur on July 1, 2005. Therefore, we calculated the proposed Federal base rate to be budget neutral for the 15-month period April 1, 2004 through June 30, 2005.

The data sources we used to calculate the budget-neutrality factor were the most complete data available for IPFs and included cost report data from FY 1999 and the 1999 Medicare claims data from the June 2001 update of the MedPAR files. We updated the cost report data for each IPF to the midpoint of that 15-month period (April 1, 2004 through June 30, 2005) and used the projected market basket update factors for each applicable year.

We note that the FY 1999 cost report file is not complete because of the lag in the filing of cost reports for some providers, therefore, a small number of IPFs do not have cost report data for the 1999 cost report period. To include as many IPFs in the payment calculation as possible, we filled in the missing data using data from the previous year for those IPFs. The prospective payment projections were based on case level data from the 1999 MedPAR files and the facility level characteristics from the 1999 cost reports. These data provide the input for the development of the appropriate update factors to be applied to the proposed prospective payment model.

a. Cost Report Data for April 1, 2004 Through June 30, 2005

In order to determine each provider's projected costs for the proposed implementation period, we are proposing to update each IPF's cost to the midpoint of the period April 1, 2004 through June 30, 2005. To calculate operating costs, we would use the applicable percentage increases to the TEFRA target amounts for FYs 1999 through 2002 (in accordance with § 413.40(c)(3)(vii)) and the full excluded hospital market-basket percentage increase for FY 2003 and later. For FYs 1999 through 2002, we would determine the appropriate update factor for each year by using the methodology described below:

- For IPFs with costs that equal or exceed their target amounts by 10 percent or more for the most recent cost reporting period for which information is available, the update factor would be the market-basket percentage increase.
- For IPFs that exceed their target amounts by less than 10 percent, the