

1999 cost report file (as explained in greater detail in section b. above). The proposed budget-neutrality adjustment was calculated by dividing total estimated payments under the TEFRA payment system by estimated payments under the proposed IPF prospective payment system without a budget-neutrality adjustment.

Since the proposed IPF prospective payment system amount for each provider would include applicable outlier amounts, we reduced the proposed budget neutral per diem base rate by 2 percent to account for the 2 percent of aggregate proposed prospective payments to be made for outlier payments. The appropriate proposed outlier amount was determined by comparing the adjusted prospective payment amount for the entire stay to the computed cost per case. If costs were above the prospective payment amount plus the adjusted fixed dollar loss threshold, an outlier payment was computed using the applicable risk-sharing percentages as explained in greater detail in section III.B.3 of this proposed rule. The outlier amount was computed for all stays and the total outlier amount was added to the final proposed prospective payment amount. If the total outlier amount for all providers was determined to be higher or lower than 2 percent of the total payments under the proposed prospective payment system, then the fixed dollar loss threshold was adjusted accordingly. The proposed fixed dollar loss threshold was determined to be \$4,200.

4. Proposed Behavioral Offset

We would calculate the proposed budget-neutral Federal per diem base rate by applying the budget-neutrality factor calculated above and the 2 percent adjustment for outlier payments to \$671 (the average cost per day for the 15-month period, April 1, 2004 through June 30, 2005). However, if the proposed IPF prospective payment system is implemented as proposed, we would expect that IPFs may experience usage patterns that are significantly different from their current usage patterns. Two examples are—(1) the proposed IPF prospective payment system is a per-diem system, therefore, IPFs might have an incentive to keep patients in the facility longer to maximize use of their beds or to receive the proposed outlier payments; and (2) the current TEFRA payment system does not rely on ICD-9-CM coding. Proper comorbidity coding, however, will have an impact on the proposed prospective payments under this proposed rule. Therefore, we expect that

IPFs will have an incentive to comprehensively code for the presence of comorbidities, thus, ultimately, the coding practice of IPFs should improve once the proposed IPF prospective payment system is implemented.

As a result, Medicare may incur higher payments than assumed in our calculation. These effects were taken into account when we calculated the proposed budget-neutral Federal per diem base rate. Accounting for these effects through an adjustment is commonly known as a behavioral offset. Based on accepted actuarial practices and consistent with the assumptions made under the inpatient rehabilitation facilities (IRF) prospective payment system, in determining this proposed behavioral offset, we assumed that the IPFs would regain 15 percent of potential “losses” and augment payment increases by 5 percent. We applied this actuarial assumption, which was based on consideration of our historical experience with new payment systems, to the estimated “losses” and “gains” among the IPFs. We intend to monitor the extent to which current practice in IPFs such as the average length of stay is affected by implementation of a per diem payment system and may propose adjustments to the behavioral assumptions accordingly. The above methodology made no behavioral assumptions for changes in the number of total psychiatric beds or the shift of utilization among types of psychiatric hospitals.

5. Proposed Federal Per Diem Base Rate

The proposed Federal per diem base rate with an outlier adjustment and budget neutrality with a behavioral offset would be \$530. This proposed dollar amount would include a 2-percent reduction to account for outlier payments, and a 19-percent reduction to account for budget neutrality and the behavioral offset to the proposed Federal per diem base rate otherwise calculated under the proposed methodology as described above.

6. Proposed Changes to Physician Recertification Requirements

In addition to the monitoring efforts mentioned above, we are proposing changes in the physician recertification requirements for inpatient psychiatric care as specified in § 424.14. This section states that Medicare Part A pays for inpatient psychiatric care only if a physician certifies and recertifies the need for services. Therefore, we are proposing to revise § 424.14(c), regarding the content of the physician recertification and § 424.14(d), regarding the timing of physician recertification to

ensure that a patient's continued stay in an IPF is medically necessary.

As specified in existing § 424.14(c), a physician must recertify that inpatient psychiatric services furnished since the previous certification were, and continue to be required: (1) For treatment that could reasonably be expected to improve the patient's condition or for diagnostic study; and (2) the hospital's records show that the services furnished were intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services. We are proposing to add a requirement that the physician recertify that the patient continues to need, on a daily basis, inpatient psychiatric care (furnished directly by or requiring the supervision of inpatient psychiatric facility personnel) or other professional services that, as a practical matter can only be provided on an inpatient basis.

Section 424.14(d)(2) requires the first recertification after admission to occur as of the 18th day of hospitalization. We are proposing to revise the timing of the first recertification to the 10th day of hospitalization in order to align the physician recertification of the need for continuation of the inpatient stay with the median length of stay. As noted previously, according to the 1999 MedPAR data, the median length of stay for Medicare beneficiaries was 9 days. These proposed changes are intended to ensure that a patient's continued stay in an IPF is medically necessary and more closely tied to the median length of stay.

We acknowledge that the additional protections afforded by the unique psychiatric hospital conditions of participation (COPs) in subpart E of part 482, which create administrative criteria and documentation requirements for psychiatric patients, are an additional protection in this regard. We believe these requirements provide adequate protection against the shift of lower cost nursing home patients with similar but less severe diagnoses into psychiatric hospitals. However, if we observe a shift of less severe cases into psychiatric hospitals, we may perform targeted reviews of admissions to assure that the COPs and physician certification requirements are being appropriately followed.

E. Proposed Area Wage Adjustment

Due to the variation in costs, because of the differences in geographic wage levels, we are proposing that payment rates under the proposed IPF prospective payment system be adjusted by a geographic index. In addition, we are proposing to use the inpatient acute care hospital wage data to compute the