

(specifically, the IRF and LTCH prospective payment system methodologies). As a result of this analysis, we are proposing the following strategy for updating the IPF prospective payment system: (1) Use the FY 2000 bills and cost report data, and the most current ICD-9-CM codes and DRGs, when we issue the IPF prospective payment system final rule; (2) implement the system effective for cost reporting periods beginning on or after April 1, 2004; and (3) update the Federal per diem base rate on July 1, 2005, since a July 1 update coincides with more hospital cost reporting cycles and would be administratively easier to manage. This means that the first year of the proposed Federal per diem base rate would be the 15-month period April 1, 2004 to June 30, 2005.

We believe it is important to delay updating the adjustment factors until the IPF data includes as much information as possible regarding the patient-level characteristics of the population that each IPF serves. For this reason, we do not intend to update the regression and recalculate the proposed Federal per diem base rate until we have analyzed 1 complete year of data under the IPF prospective payment system, that is, no earlier than July 1, 2007. We note that the ability of a regression analysis to appropriately identify variation in costs is dependent upon continued submission of claims and cost reports that are as accurate and complete as possible. Until that analysis is complete, we are proposing to publish a notice each spring that would do the following:

- Update the Federal per diem base rate using the excluded hospital with capital market basket increase in order to reflect the price of goods and services used by IPFs.
- Apply the most current hospital wage index with an adjustment factor to the Federal per diem base rate to ensure that aggregate payments to IPFs are not affected by an updated wage index.
- Update the fixed dollar loss threshold to maintain an outlier percentage that is 2 percent of total estimated IPF payments.
- Describe the impact of the ICD-9-CM coding changes discussed in the hospital inpatient prospective payment system proposed rule that would effect the proposed IPF prospective payment system.

In the future, we may propose an update methodology for the IPF prospective payment system that would be based on the excluded hospital with capital market basket index along with other appropriate adjustment factors relevant to psychiatric service delivery

such as productivity, intensity, new technology, and changes in practice patterns.

B. Update of the ICD Codes and DRGs

In the health care industry, annual changes to the ICD-9-CM codes and the DRGs used in the hospital inpatient prospective payment system are effective for discharges occurring on or after October 1 of each year. Changes in ICD-9-CM codes and composition of the DRGs are presented in the hospital inpatient prospective payment system proposed rule published in the **Federal Register** in the spring of each year. We are proposing that through the hospital inpatient prospective payment system proposed rule, we would notify IPFs of any revised ICD-9-CM codes or proposed DRG modifications that would become effective on October 1 of that year if finalized. As noted earlier, all health care providers are required to use the updated ICD-9-CM codes on or after October 1 of each year.

Under the IPF prospective payment system, we are proposing to establish a base rate and provide for adjustments to the rate, including adjustments to reflect the DRG assigned to the patient's principal diagnosis and the comorbidity category for certain secondary or tertiary diagnoses. These adjustments would be driven by the ICD-9-CM codes provided on the IPF's claims.

For this reason, we urge IPFs to review the hospital inpatient prospective payment proposed rule to determine if any changes have been made to the ICD-9-CM codes or are being proposed in the composition of the 15 DRGs we are proposing to recognize under the IPF prospective payment system. In the event that occurs, we would explain in the hospital inpatient prospective payment system rules how the change would be handled under the IPF prospective payment system for claims on or after October 1 of each year.

C. Future Refinements

1. RTI International®

We have contracted with RTI International® to examine the extent to which modes of practice and staffing patterns explain the per diem cost differences among the various types of IPF facilities (private psychiatric hospitals, psychiatric units, and government hospitals). In addition, RTI International® will analyze the extent to which the different types of facilities treat different types of patients. We anticipate that this study may assist us in proposing refinements to the

prospective payment system in the future.

Approximately two-thirds of the direct expense for providing inpatient psychiatric services is captured in the routine cost category of the Medicare cost report. After the allocation of overhead, this category represents 88 percent of the cost presently being reimbursed. The RTI International® project will collect patient-level and facility-level data from a small sample of psychiatric hospitals and psychiatric units nationwide. These data will provide information on the extent to which variation in the per diem cost across facilities can be explained by the differences in the mix of services and staffing that characterize their modes of practice. RTI International® will also analyze the links among costs, practice mode, and patient characteristics.

a. Mode of Practice

The mode of practice can be defined by treatment modality (services delivered) and by staffing levels. To analyze the mode of practice, RTI International® first developed a typology of therapeutic services (activities) provided in inpatient settings. The services range from labor-intensive activities (one-on-one intake assessments and evaluations), to less labor-intensive activities (therapies). In addition, RTI International® developed a classification of psychiatric labor resources that could be used to depict different staffing models. The RTI International® used these typologies to organize the collection of service and staffing data within the sampled psychiatric facilities. The RTI International® study hypothesized that lower cost facilities use lower cost practice modalities that can result from either the use of lower cost labor or lower cost treatment methods.

b. Patient Characteristics

To link the mode of practice with patient characteristics, modality must be collected at the patient level. Resource usage can be defined by estimating the type and cost of staff involved with providing patient care. This can be accomplished by linking each patient's activity with the time spent by each staffing type for an activity with the average wage rate for that staff. Adding the cost of each activity over a 24-hour period determines the per diem resource cost for a patient. These per diem costs can then be compared and linked with patient characteristics in order to explain resource use.

The RTI International® used patient characteristics that were available from claims data (age and diagnoses).