

payment system, the payment ratios for all bed size categories would be greater than 0.96. The majority of IPFs' bed sizes were categories in which the payment ratio would be greater than 0.98. Under the proposed IPF prospective payment system, large IPFs with over 400 beds would receive the highest payment ratio (1.19 percent for psychiatric hospitals and 1.12 for psychiatric units), while psychiatric units with less than 10 beds would receive the lowest payment ratio of 0.96.

4. Effect on the Medicare Program

Based on actuarial projections resulting from our experience with other prospective payment systems, we estimate that Medicare spending (total Medicare program payments) for IPF services over the next 5 years would be as follows:

TABLE 9.—ESTIMATED PAYMENTS

Fiscal time periods	Dollars in millions
April 1, 2004 to June 30, 2005	5,311
July 1, 2005 to June 30, 2006	4,531
July 1, 2006 to June 30, 2007	4,788
July 1, 2007 to June 30, 2008	5,053
July 1, 2008 to June 30, 2009	5,328

These estimates are based on the current estimate of increases in the proposed excluded hospitals with capital market basket as follows:

- 3.3 percent for FY 2004;
- 3.1 percent for FY 2005;
- 3.0 percent for FY 2006;
- 2.9 percent for FY 2007;
- 3.0 percent for FY 2008; and
- 3.0 percent for FY 2009.

We estimate that there would be an increase in fee-for-service Medicare beneficiary enrollment as follows:

- 1.8 percent in FY 2004;
- 1.5 percent in FY 2005;
- 1.5 percent in FY 2006;
- 1.9 percent in FY 2007;
- 2.0 percent in FY 2008; and
- 1.9 percent in FY 2009.

Consistent with the statutory requirement for budget neutrality in the initial year of implementation, we intend for estimated aggregate payments under the proposed IPF prospective payment system to equal the estimated aggregate payments that would be made if the IPF prospective payment system were not implemented. Our methodology for estimating payments for purposes of the budget-neutrality calculations uses the best available data. After the proposed IPF prospective payment system is implemented, we will evaluate the accuracy of the assumptions used to compute the budget-neutrality calculation. We intend

to analyze claims and cost report data from the first year of the prospective payment system to determine whether the factors used to develop the Federal per diem base rate are not significantly different from the actual results experienced in that year. We are planning to compare payments under the final Federal per diem rate (which relies on an estimate of cost-base TEFRA payments using historical data from a base year and assumptions that trend the data to the initial year of implementation) to estimated cost-based TEFRA payments based on actual data from the first year of the IPF prospective payment system. The percent difference (either positive or negative) would be applied prospectively to the established prospective payment rates to ensure the rates accurately reflect the payment levels intended by the statute. We intend to perform this analysis within the first 5 years of the implementation of the prospective payment system.

Section 124 of Pub. L. 106–113 provides the Secretary broad authority in developing the proposed IPF prospective payment system, including the authority for appropriate adjustments. In accordance with this authority, we may make a one-time prospective adjustment to the Federal per diem base rate in an effort to ensure that the best historical data available forms the foundation of the prospective payment rates in future years.

5. Effect on Beneficiaries

Under the proposed IPF prospective payment system, IPFs would receive payment based on the average resources consumed by patients for each day. We do not expect changes in the quality of care or access to services for Medicare beneficiaries under the proposed IPF prospective payment system. In fact, we believe that access to IPF services would be enhanced due to the proposed adjustment factors for comorbid conditions and the proposed outlier policy, which are intended to adequately reimburse IPFs for expensive cases. In addition, we expect that paying prospectively for IPF services will enhance the efficiency of the Medicare program.

6. Computer Hardware and Software

We do not anticipate that IPFs will incur additional systems operating costs in order to effectively participate in the proposed IPF prospective payment system. We believe that IPFs possess the computer hardware capability to handle the billing requirements under the proposed IPF prospective payment system. Our belief is based on indications that approximately 99

percent of hospital inpatient claims are submitted electronically. In addition, we are not proposing any significant changes in claims processing (see section IVC. of this proposed rule).

C. Alternatives Considered

We considered the following alternatives in developing the proposed IPF prospective payment system:

- One option we considered incorporated not only the patient-level and facility-level variables described previously, but also a site-of-service distinction. Under this approach, psychiatric units would have received a higher per diem payment, all other factors being equal, based on the assumption that psychiatric units on average treat a more complex and costly case-mix. A psychiatric unit adjustment to the otherwise applicable per diem payment rate would reflect the absence of a more sophisticated patient classification system specifically linked to resource use. Our analysis of the 1999 cost report and billing data used to develop this proposed rule reveals that an adjustment would have increased the otherwise applicable per diem payment to psychiatric units by approximately 33 percent.

The average 1999 inpatient psychiatric per diem cost were \$615 for psychiatric units, \$534 for non-profit hospitals, \$448 for proprietary providers, and \$378 for governmental facilities. While some of the higher than average per diem cost in psychiatric units may be due to a greater medical and surgical acuity among patients treated in psychiatric units, part of the difference is undoubtedly attributable to economy of scale inefficiencies associated with operating small units, including higher overhead expenses, and generally lower occupancy rates. A psychiatric unit site-of-service distinction in payment rates would represent a proxy adjuster in lieu of a more refined classification system. Therefore, we are concerned about applying such an adjustment to all psychiatric units regardless of cost, efficiency, or case-mix. In addition, no other Medicare prospective payment system has a distinction in payments solely based on the site of service.

We strongly believe that payments on behalf of Medicare beneficiaries should reflect the resource needs of patients, not simply where patients are treated. A higher per diem payment to psychiatric units compared to psychiatric hospitals may create powerful incentives to increase the number of psychiatric units without regard to patient need or acuity. Pending the development of a more refined facility-specific case-mix