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Medicare Program; Prospective Payment System for Inpatient Psychiatric Facilities; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, and 424

[CMS–1213–P]

RIN 0938–AL50

Medicare Program; Prospective Payment System for Inpatient Psychiatric Facilities

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This rule proposes a prospective payment system for Medicare payment of inpatient hospital services furnished in psychiatric hospitals and psychiatric units of acute care hospitals. This rule proposes to implement section 124 of the Medicare, Medicaid, andSCHIP Balanced Budget Refinement Act of 1999 (BBRA), which requires the implementation of a per diem prospective payment system for hospital services of psychiatric hospitals and psychiatric units. The prospective payment system described in this proposed rule would replace the reasonable cost-based payment system currently in effect.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 27, 2004.

ADDRESSES: In commenting, please refer to file code CMS–1213–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1213–P, P.O. Box 8012, Baltimore, MD 21244–8012. Please allow sufficient time for mailed comments to be received timely in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850. (Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.) Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Janet Samen, (410) 786–4533. Philip Cotterill, (410) 786–6598, for information regarding the regression analysis.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 4 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–9994.

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Acronyms

Because of the many terms to which we refer by acronym in this proposed rule, we are listing the acronyms used and their corresponding terms in alphabetical order below:

BBA Balanced Budget Act of 1997, (Pub. L. 105–33)
BBRA Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, (Pub. L. 106–113)
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, (Pub. L. 106–554)
CMS Centers for Medicare & Medicaid Services DSM–IV–TR Diagnostic and Statistical Manual of Mental Disorders Fourth Edition—Text Revision
DRGs Diagnosis-related groups
FY Federal fiscal year
HCRIS Hospital Cost Report Information System
ICD–9-CM International Classification of Diseases, 9th Revision, Clinical Modification
IPFs Inpatient psychiatric facilities
IRFs Inpatient rehabilitation facilities
LTCHs Long-term care hospitals
MedPAR Medicare provider analysis and review file
PIP Periodic interim payments
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, (Pub. L. 97–248)

I. Background

A. General and Legislative History

When the Medicare statute was originally enacted in 1965, Medicare payment for hospital inpatient services was based on the reasonable costs incurred in furnishing services to Medicare beneficiaries. Section 223 of the Social Security Act Amendments of 1972 (Pub. L. 92–603) amended section 1861(v)(1) of the Social Security Act (the Act) to set forth limits on reasonable costs for hospital inpatient services. The statute was later amended by section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) to limit payment by placing a limit on allowable costs per discharge.

The Congress directed implementation of a prospective payment system for acute care hospitals in 1983, with the enactment of Pub. L. 98–21. Section 601 of the Social Security Amendments of 1983 (Pub. L. 98–21) added a new section 1886(d) to the Act that replaced the reasonable cost-based payment system for most hospital inpatient services with a prospective payment system.

Although most hospital inpatient services became subject to the prospective payment system, certain specialty hospitals were excluded from the prospective payment system and continued to be paid reasonable costs subject to limits imposed by TEFRA. These hospitals included psychiatric hospitals and psychiatric units in acute care hospitals, long-term care hospitals (LTCHs), children's hospitals, and rehabilitation hospitals and units. Cancer hospitals were added to the list of excluded hospitals by section 6004(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239).

The Congress enacted various provisions in the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement ACT (BBRA) (Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) (Pub. L. 106–554) to replace the cost-based methods of reimbursement with a prospective payment system for the following excluded hospitals:

- Rehabilitation hospitals (including units in acute care hospitals).
- Psychiatric hospitals (including units in acute care hospitals.
- LTCHs.

The BBA also imposed national limits (or caps) on hospital-specific target amounts (that is, annual per discharge limits) for these hospitals until cost reporting periods beginning on or after October 1, 2002. A detailed description of the TEFRA payment methodology is provided in section I.B.1. of this proposed rule.

Section 124 of the BBRA mandated that the Secretary—(1) develop a per diem prospective payment system for inpatient hospital services furnished in psychiatric hospitals and psychiatric units; (2) include in the prospective payment system an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units; (3) maintain budget neutrality; (4) permit the Secretary to require psychiatric hospitals and psychiatric units to submit information necessary for the development of the prospective payment system; and (5) submit a report to the Congress describing the development of the prospective payment system.

Section 124 also required that the payment system for inpatient psychiatric services be implemented for cost reporting periods beginning on or after October 1, 2002. The creation of each new payment system requires an extraordinary amount of lead-time to develop and implement the necessary changes to our existing computerize claims processing systems. In order to meet the BBRA requirement to develop an adequate patient classification system, we undertook two research projects. It became apparent that the two research projects could not be completed in time for us to implement an inpatient psychiatric facility prospective payment system by October 1, 2002. It was impossible for us to analyze our existing administrative data in a sufficient amount of time to go through notice and comment rulemaking and implementation of the inpatient psychiatric facility prospective payment system by the statutory deadline. This delay enabled us to analyze our existing administrative data to determine the feasibility and validity of using these data to develop the proposed inpatient psychiatric facility prospective payment system. We are using a combination of available facility and patient specific data for this proposed rule. Our research efforts will

continue and will be used to refine the proposed system.

In this proposed rule, as required under section 124 of the BBRA, we set forth the proposed Medicare prospective payment system for psychiatric hospitals and psychiatric units of acute care hospitals. We note that many hospitals have ''psychiatric units,'' however; only those units that are separately certified from the hospital and meet the requirements of § 412.23, § 412.25, and § 412.27 are excluded from the hospital inpatient prospective payment system and would be subject to this proposed prospective payment system. Psychiatric units that are currently paid under the hospital inpatient prospective payment system and do not meet the requirements of § 412.22, § 412.25 and § 412.27 would not be paid under the proposed IPF prospective payment system. The proposed system includes an adequate patient classification system that would result in higher prospective payments to providers treating more costly, resource intensive patients using statistically objective criteria.

We are proposing to establish a base payment rate that would be paid to inpatient psychiatric facilities for each day of inpatient psychiatric care (the Federal per diem base rate). The proposed base rate would be adjusted by certain proposed patient-level and facility-level characteristics.

B. Overview of the Payment System for Psychiatric Hospitals and Psychiatric Units Before the BBA

1. Description of the TEFRA Payment Methodology

Hospitals and units that are excluded from the hospital inpatient prospective payment system under section 1886(d)(1)(B) of the Act are paid for their inpatient operating costs under the provisions of Pub. L. 97–248 (TEFRA). The TEFRA provisions are found in section 1886(b) of the Act and implemented in regulations at 42 CFR Part 413. TEFRA established payments based on hospital-specific limits for inpatient operating costs. As specified in § 413.40, TEFRA established a ceiling on payments for hospitals excluded from the acute care hospital inpatient prospective payment system. A ceiling on payments is determined by calculating the product of a facility's base year costs (the year in which its target reimbursement limit is based) per discharge, updated to the current year by a rate-of-increase percentage, and multiplied by the number of total current year discharges. A detailed discussion of target amount payment limits under TEFRA can be found in the final rule concerning the hospital inpatient prospective payment system published in the **Federal Register** on September 1, 1983 (48 FR 39746).

The base year for a facility varied, depending on when the facility was initially determined to be a prospective payment system-excluded provider. The base year for facilities that were established before the implementation of the TEFRA provision was 1982. For facilities established after the implementation of the TEFRA provision, facilities were allowed to choose which of their first 3 cost-reporting years would be used in the future to determine their target limit. In 1992, the ''new provider'' period was shortened to 2 full years of cost-reporting periods (§ 413.40(f)(1)).

Excluded facilities whose costs were below their target amounts would receive bonus payments equal to the lesser of half of the difference between costs and the target amount, up to a maximum of 5 percent of the target amount, or the hospital's costs. For excluded hospitals whose costs exceeded their target amounts, Medicare provided relief payments equal to half of the amount by which the hospital's costs exceeded the target amount up to 10 percent of the target amount. Excluded facilities that experienced a more significant increase in patient acuity could also apply for an additional amount as specified in § 413.40(d) for Medicare exception payments.

2. BBA Amendments to TEFRA

The BBA amendments to section 1886 of the Act significantly altered the payment provisions for hospitals and units paid under the TEFRA provisions and added other qualifying criteria for certain hospitals excluded from the hospital inpatient prospective payment system. A complete explanation of these amendments can be found in the final rule concerning the hospital inpatient prospective payment system we published in the **Federal Register** on August 29, 1997 (62 FR 45966).

The BBA made the following changes to section 1886 of the Act for TEFRA hospitals:

- Section 4411 of the BBA amended section 1886(b)(3)(B) of the Act and restricted the rate-of-increase percentages that are applied to each provider's target amount so that excluded hospitals and units experiencing lower inpatient operating costs relative to their target amounts receive lower rates of increase.
- Section 4412 of the BBA amended section 1886(g) of the Act to establish a 15-percent reduction in capital payments for excluded psychiatric and rehabilitation hospitals and units and LTCHs, for portions of cost reporting periods occurring during the period of October 1, 1997, through September 30, 2002.
- Section 4414 of the BBA amended section 1886(b)(3) of the Act to establish caps on the target amounts for excluded hospitals and units at the 75th percentile of target amounts for similar facilities for cost reporting periods beginning on or after October 1, 1997, through September 30, 2002. The caps on these target amounts apply only to psychiatric and rehabilitation hospitals and units and LTCHs. Payments for these excluded hospitals and units are based on the lesser of a provider's cost per discharge or its hospital-specific cost per discharge, subject to this cap.
- Section 4415 of the BBA amended section 1886(b)(1) of the Act by revising the percentage factors used to determine the amount of bonus and relief payments and establishing continuous improvement bonus payments for excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997. If a hospital is eligible for the continuous improvement bonus, the bonus payment is equal to the lesser of: (1) 50 percent of the amount by which operating costs are less than expected costs; or (2) 1 percent of the target amount.
- Sections 4416 and 4419 of the BBA amended sections 1886(b) of the Act to establish a new framework for payments for new excluded providers. Section 4416 added a new section 1886(b)(7) to the Act that established a new statutory methodology for new psychiatric and rehabilitation hospitals and units, and LTCHs. Under section 4416, payment to these providers for their first two cost reporting periods is limited to the lesser of the operating costs per case, or 110 percent of the national median of target amounts, as adjusted for differences in wage levels, for the same class of hospital for cost reporting periods ending during FY 1996, updated to the applicable period.

3. BBRA Amendments to TEFRA

The BBRA of 1999 refined some of the policies mandated by the BBA for hospitals and units paid under the TEFRA provisions. The provisions of the BBRA, which amended section 1886(b)(3)(H) of the Act, were explained in detail and implemented in the hospital inpatient prospective payment system interim final rule published in the **Federal Register** on August 1, 2000 (65 FR 47026) and in the hospital inpatient prospective payment system

final rule also published on August 1, 2000 (65 FR 47054).

With respect to the TEFRA payment methodology, section 4414 of the BBA had provided for caps on target amounts for excluded hospitals and units for cost reporting periods beginning on or after October 1, 1997. Section 121 of the BBRA amended section 1886(b)(3)(H) of the Act to provide for an appropriate wage adjustment to these caps on the target amounts for certain hospitals and units paid under the TEFRA provisions, effective for cost reporting periods beginning on or after October 1, 1999 through September 30, 2002.

4. BIPA Amendments to TEFRA

Section 306 of BIPA amended section 1886 of the Act by increasing the incentive payments for psychiatric hospitals and psychiatric units to 3 percent for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001.

II. Overview of the Proposed IPF Prospective Payment System

As required by statute, we are proposing a per diem prospective payment system for psychiatric hospitals and psychiatric units (hereinafter referred to as inpatient psychiatric facilities (IPFs)) that would replace the current reasonable cost-based payment system under the TEFRA provisions. In this rule, we are proposing to base the system on data from the 1999 Medicare Provider Analysis and Review (MedPAR) file, which includes patient characteristics (for example, patients' diagnoses and age), and data from the 1999 Hospital Cost Report Information System (HCRIS), which includes facility characteristics (for example, location and teaching status). We are using the 1999 MedPAR and HCRIS data because they are the best available data.

Based on our analysis, we are proposing the following methodology as the basis of the proposed IPF prospective payment system:

- Compute a Federal per diem base rate to be paid to all psychiatric hospitals and psychiatric units based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF adjusted for budget neutrality (see section III.C. of this proposed rule). In computing the Federal per diem base rate, our analysis showed that routine operating and capital represent approximately 88 percent of total costs and the remaining 12 percent of total costs are for ancillary services.
- Adjust the Federal per diem base rate to reflect certain patient and facility characteristics that were found in the regression analysis to be associated with statistically significant cost differences (see section III.B. of this proposed rule). The variance explained by patient characteristics (19 percent) in the regression analysis is limited by the nature of the administrative data used to develop this system, which assigns average facility routine costs to individual patients. We are conducting research to better understand the relationship between individual patient characteristics and average facility routine costs that could be incorporated into the payment system in future updates. We note that ancillary costs are already identifiable at the individual patient level.
- Implement an April 1, 2004 effective date and a 3-year transition period. As explained in section IV of this proposed rule, it ultimately may be necessary to delay implementation beyond April 2004 as well as to increase the length of the transition period. However, the rate development, budget-neutrality adjustment, and impact analysis assume an April 1, 2004 effective date and a 3-year transition period.
- Include research information for future refinement of the proposed patient classification system. Part of this research could result in a new patient assessment instrument that could identify additional patient level characteristics.

In addition, we are proposing to make the following types of adjustments to appropriately make payments on a per-diem basis:

- Patient-level adjustments for age, specified diagnosis-related groups, and selected high cost comorbidity categories. These patient-level characteristics explain approximately 19 percent of the variance in the cost of psychiatric care in the administrative data, which establishes the empirical basis for this methodology.
- Facility adjustments that include a wage index adjustment, rural location adjustment, and an indirect teaching adjustment. These facility characteristics explain approximately 13 percent of the variance in the costs of psychiatric care in the administrative data.
- Variable per diem adjustments to recognize the higher costs incurred in the early days of a psychiatric stay.
- Outlier adjustments to target greater payment to the high cost cases.

We are also proposing the following policies:

- Interrupted stay policy for the purpose of applying the variable per diem adjustment and the outlier policy.
- Coding policy (see section II. A.) that would—(1) require IPFs to report patient diagnoses using the International Classification of Diseases-9th Revision, Clinical Modification (ICD–9–CM) code set to report the psychiatric diagnosis; and (2) select the diagnosis-related groups (DRGs) that would be used for payment adjustments in this proposed rule.

A. Use of Diagnostic Codes for Payment

The patient's principal diagnosis of his or her physical or mental condition is essential because it typically acts as a guide for treatment and validates payment. It is for these reasons that diagnostic information is routinely reported on hospital claims and is used in other prospective payment systems. In mental health treatment, the principal tool recognized and utilized by the psychiatric community for diagnostic assessment is the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM provides a broad and comprehensive description of patients through behavioral domains, or ''axes.'' This multiaxial system is routinely used by clinical staff to diagnose patients and plan treatment. The DSM is currently in its fourth revision text revision (DSM–IV–TR). Although, the DSM is used for patient assessment by IPFs, the ICD–9–CM coding system is used currently for reporting diagnostic information for payment purposes.

1. ICD

The ICD coding system was designed for the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease. Chapter Five of the ICD–9–CM includes the codes for mental disorders.

In addition, the following definitions (as described in the 1984 Revision of the Uniform Hospital Discharge Data Set) are requirements of the ICD–9–CM coding system.

- Diagnoses include all diagnoses that affect the current hospital stay.
- Principal diagnosis is defined as the condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- Other diagnoses (also called secondary diagnoses or additional diagnoses) are defined as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded.

We are proposing to require IPFs to use the psychiatric diagnosis codes in Chapter Five (''Mental Disorder'') of the ICD–9–CM to report diagnostic information for the proposed IPF prospective payment system. All changes to the ICD coding system that would affect the proposed IPF prospective payment system would be addressed annually in the hospital inpatient prospective payment system rules. The updated codes are effective October 1 of each year and must be used to report diagnostic or procedure information. (Additional information regarding updates to the ICD–9–CM and DRGs is included in section V.B. of this proposed rule). The official version of the ICD–9–CM is available on CD–ROM from the U.S. Government Printing Office. The FY 2004 version can be ordered by contacting the Superintendent of Documents, U.S. Government Printing Office, Department 50, Washington, D.C. 20402–9329, telephone: (202) 512–1800. The stock number is 017–022–01544–7, and the price is $25.00. In addition, private vendors publish the ICD–9–CM.

Questions and comments concerning the codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Purchasing Policy Group, Division of Acute Care, Mailstop C4–08–06, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Comments may be sent via e-mail to: *pbrooks@cms.hhs.gov.*

2. DRGs

DRGs constitute the patient classification system used in the hospital inpatient prospective payment system. DRGs provide a means of relating the types of patients treated by a hospital to the costs incurred by the hospital. While each patient is unique, groups of patients have demographic, diagnostic, and therapeutic attributes in common that determine their level of resource intensity.

Currently, IPF claims include ICD–9–CM diagnosis coding information. The TEFRA payment methodology does not use the DRG classification of IPF cases. Nonetheless, when IPF claims are submitted to us, the DRG associated with the patient's principal ICD–9–CM diagnosis code is assigned to the claim by the GROUPER software program. As a result, our administrative data includes the DRG assignments for all IPF cases.

We are proposing to require IPFs to use the psychiatric diagnosis codes in Chapter Five (''Mental Disorders'') of the ICD–9–CM. This decision is consistent with the Standards for Electronic Transaction final rule published in the **Federal Register** on August 17, 2000 (65 FR 50312). The ICD–9–CM coding system is currently designated as the standard medical data code set for capturing cause and manifestation of injury, disease, impairments, or other health problems. These guidelines are available through a number of sources, including the following Web site: *http://www.cdc.gov/nch/data/icdguide.pdf.*

Current regulations at § 412.27 require that a psychiatric unit admit only those patients who have a principal diagnosis that is listed in the DSM or classified in Chapter Five (''Mental Disorders'') of the ICD–9–CM. The hospital must maintain records that substantiate the psychiatric diagnoses of its patients. We specifically request public comments on continuing to reference the DSM in light of the proposed requirement that IPFs use the ICD–9–CM code set in the proposed IPF prospective payment system.

B. Limitations of the DRG System for Psychiatric Patients

Adopting a patient classification system for IPFs based on diagnosis alone may not explain the wide variation in resource use among patients in IPFs for several reasons. For instance, the diagnosis may not fully capture the reasons for hospitalization. A patient with a chronic disorder, like schizophrenia, may be admitted for a variety of acute problems (suicide attempt, catatonic withdrawal, or psychotic episode) that require very different treatments (Goldman, H.H., Pincus, H.A., Taube, C.A., and Reiger, D.A. (1984). Hospital and Community Psychiatry, 35(5): 460–464).

Further, treatment patterns are more variable in psychiatry, with multiple clinically accepted methods of care. As a result, resource use varies substantially between acute care and chronic care patients, and between the facilities that treat predominately one type of patient. For example, public psychiatric hospitals tend to treat the chronically mentally ill, with substantially longer lengths of stay, compared to the patients generally treated in psychiatric units and private psychiatric hospitals.

Predicated on the analysis of the administrative data and pending refinements from the research, we believe the DRG is an appropriate method to account for certain, although not all, clinical characteristics and associated resources. Therefore, under this prospective payment system, we are proposing to assign a DRG to each case based on the principal diagnosis (ICD–9–CM code) reported by the IPF as one adjustment to the Federal per diem base rate.

In making this decision, we analyzed past research as well as a recent study supported by the American Psychiatric Association (APA). In the study, APA partnered with the Health Economics and Outcomes Research Institute (THEORI), a division of the Greater New York Hospital Association, to assess whether our existing administrative data could be used to develop a prospective payment system for IPFs. This study found that a prospective payment system for IPFs could be developed based on existing CMS administrative data, be clinically relevant, and limit the administrative burden on providers. The system they proposed included an adjustment for DRG assignment.

In summary, we acknowledge that the psychiatric community uses the DSM as a tool to diagnose a patient's mental illness and to aid in treatment planning. However, we are proposing to require IPFs to report diagnoses in Chapter Five of the ICD–9–CM as required by the Administrative Simplification Provisions found in 45 CFR subchapter C. In addition, we are proposing to identify specific DRGs for payment adjustment under the proposed IPF prospective payment system. The rationale for the selection of the proposed DRGs for use in the proposed IPF prospective payment system is described below.

C. Proposed DRG Adjustments Under the Proposed IPF Prospective Payment System

As noted above, the principal diagnosis is defined as the condition, after study (clinical evaluation), to be chiefly responsible for admitting the patient to the hospital for care. Despite this longstanding definition, our review of hospital claims data that were used to develop the proposed IPF prospective payment system indicates that a substantial number of claims have non-psychiatric diagnoses identified as the principal diagnosis.

Medicare regulations as specified in § 412.27(a) require psychiatric units of acute care hospitals to admit only those patients with a principal diagnosis in the DSM or Chapter Five (''Mental Disorders'') in the ICD–9–CM. Therefore, if a patient is admitted to a general hospital for a medical condition such as pneumonia, and also presents psychiatric symptoms, which necessitates an admission to the psychiatric unit, the principal diagnosis for the admission to the psychiatric unit should be the psychiatric symptoms

exhibited by the patient in accordance with § 412.27(a). We note that current regulations applicable to psychiatric hospitals (§ 412.23(a)) do not include these requirements, however, historically, psychiatric hospitals have limited admissions to psychiatric patients. Section 412.27(a) also requires that patients be admitted to the psychiatric units for active treatment that is of an intensity that can be furnished appropriately only in an inpatient hospital setting. For this reason, in order to be paid under the proposed IPF prospective payment system, patients must be capable of participating in an active treatment program.

In selecting the proposed DRGs for payment adjustment, we analyzed the DRG assignments for ICD–9–CM diagnosis codes in Chapter Five. In addition, as noted previously, IPFs use the DSM–IV–TR to establish diagnoses and current regulations at § 412.27(a) refer to DSM diagnoses. However, most, but not all, DSM codes crosswalk to the codes in Chapter Five of the ICD–9–CM. Although, all the DSM codes are psychiatric, some of the corresponding ICD–9–CM codes are located in other chapters of the ICD–9–CM coding system and are linked to the body system affected. For example, the DSM diagnosis, Male Erectile Disorder, crosswalks to ICD–9–CM code 607.84, Impotence of Organic Nature which is found in Chapter 10, Diseases of the Genitourinary Systems. Accordingly, we also analyzed the DRG assignments for certain ICD–9–CM codes that are based on DSM diagnoses but are not in Chapter Five of the ICD–9–CM. These codes are discussed in the next section of this proposed rule.

As a result of this analysis, we identified 25 DRGs with one or more psychiatric diagnoses that are included in Chapter Five of the ICD–9–CM as well as those diagnoses that are in other chapters of the ICD–9–CM. We are proposing payment adjustments for 15 out of the 25 DRGs we analyzed. The remaining 10 DRGs include codes for a specific range of diseases other than psychiatric, but have a few codes for DSM diagnoses that are included in Chapter Five or other body system chapters of the ICD–9–CM. The rationale for our decisions regarding these 10 codes is provided in section II.D. below.

Table 1 below lists the DRGs that we are proposing to recognize under the proposed IPF prospective payment system and the proposed adjustment factors. This information also is presented in Addendum A.

TABLE 1.—PROPOSED IPF PROSPECTIVE PAYMENT SYSTEM DRGS

DRG	Description	Adjustment Factor
12	Degenerative Nervous System Disorders	1.07
23	Nontraumatic Stupor and Coma	1.10
424*	O.R. Procedure with Principal Diagnosis of Mental Illness	1.22
425	Acute Adjustment Reaction and Psychosocial Dysfunction	1.08
426	Depressive Neurosis	1.00
427	Neurosis Except Depressive	1.01
428	Disorders of Personality and Impulse Control	1.03
429	Organic Disturbances and Mental Retardation	1.02
430	Psychosis	1.00
431	Childhood Mental Disorders	1.02
432	Other Mental Disorder Diagnoses	0.96
433**	Alcohol/Drug Abuse or Dependence, Left Against Medical Advice	0.88
521	Alcohol/Drug Abuse or Dependence with Complication or Comorbidity	1.02
522	Alcohol/Drug Abuse or Dependence with Rehabilitation Therapy without Complication or Comorbidity	0.97
523	Alcohol/Drug Abuse or Dependence without Rehabilitation Therapy without Complication or Comorbidity	0.88

*DRG 424—is an O.R. procedure code that must be billed with a principal diagnosis of mental disorder.
**DRG 433—is used when providers indicate a patient left against medical advice (discharge status code 07).

D. DRGs Not Recognized in the Proposed IPF Prospective Payment System

We are proposing not to recognize the following 10 DRGs in the proposed IPF prospective payment system. They were determined not to be clinically significant because the principal diagnoses did not result in enough admissions to IPFs in order to establish an adjustment to the payment rate:

- DRGs 34 and 35 include a range of cases for disorders of the nervous system. The diagnoses in these DRGs also include five ICD–9–CM codes for DSM diagnoses: Codes 333.1 (Tremor not elsewhere classified), code 333.82 (Orofacial Dyskinesia), code 333.92 (Neuroleptic Malignant Syndrome), code 347 (Cataplexy and Narcolepsy), and code 307.23 (Gilles de La Tourette's Disorder). In the 1999 MedPAR records for admissions to IPFs, only one patient was grouped in these DRGs. In addition, patients with these diagnoses generally do not require management in an IPF unless there is a concomitant psychiatric disorder.
- DRGs 182, 183, and 184 include a range of gastrointestinal conditions, including esophagitis, gastroenteritis, and other digestive system diseases. The diagnoses in these DRGs include one that is listed in Chapter Five of the ICD–9–CM, code 306.4 (Psychogenic GI Disease). In the 1999 MedPAR records for admissions to IPFs, we found that only a few patients with this ICD–9–CM diagnosis were grouped in these DRGs.
- DRG 352 includes a range of diagnoses affecting the testes, prostate, and male external genitalia. This DRG includes DSM diagnoses that are not in Chapter Five of the ICD–9–CM: code 607.84 (Impotence of an Organic Origin), and code 608.89 (Male Genital Diseases, not elsewhere classified). In the 1999 MedPAR records for admissions to IPFs, we were able to identify only one patient grouped in DRG 352.
- DRGs 358, 359, and 369 include a range of cases in which procedures have been performed on the uterus and fallopian tubes (Adnexa). These DRGs include two diagnoses that are in Chapter Five of the ICD–9–CM: code 306.51 (Psychogenic Vaginismus), and code 306.52 (Psychogenic Dysmenorrhea). In the 1999 MedPAR records for admissions to IPFs, we were able to identify only 11 patients grouped into DRGs 358, 359, and 369, and there were no patients diagnosed with codes 306.51 or 306.52.

• 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.

The aggregate capital component of the 1997-based excluded hospital market basket (8.968 percent) was determined from the same set of Medicare cost reports used to derive the operating component. The detailed capital cost categories of depreciation, interest, and other capital expenses were also determined using the Medicare cost reports. Two sets of weights for the capital portion of the revised and rebased market basket needed to be determined. The first set of weights identifies the proportion of capital expenditures attributable to each capital cost category, while the second set represents relative vintage weights for depreciation and interest. The vintage weights identify the proportion of capital expenditures that is attributable to each year over the useful life of capital assets within a cost category (see the hospital inpatient prospective payment final rule published in the **Federal Register** on August 1, 2002 (67 FR 50045 through 50047), for a discussion of how vintage weights are determined).

The cost categories, price proxies, and base-year FY 1992 and proposed FY 1997 weights for the excluded hospital with capital market basket are presented in Table 2 below. The vintage weights for the proposed 1997-based excluded hospital with capital market basket is presented in Table 2(A) below.

TABLE 2.—PROPOSED EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1992 AND PROPOSED FY 1997) STRUCTURE AND WEIGHTS

Cost category	Price wage variable	Weights (%) base-year 1992	Proposed weights (%) base-year 1997
TOTAL		100.000	100.000
Compensation		57.935	57.579
Wages and Salaries	ECI—Wages and Salaries, Civilian Hospital Workers	47.417	47.355
Employee Benefits	ECI—Benefits, Civilian Hospital Workers to capture total costs (operating and capital), In order to capture total costs (operating and capital), HCFA Occupational Benefit Proxy.	10.519	10.244
Professional fees: Non-Medical	ECI—Compensation: Prof. & Technical	1.908	4.423
Utilities		1.524	1.180
Electricity	WPI—Commercial Electric Power	0.916	0.726
Fuel Oil, Coal, etc.	WPI—Commercial Natural Gas	0.365	0.248
Water and Sewerage	CPI–U—Water & Sewage	0.243	0.206
Professional Liability Insurance	HCFA—Professional Liability Premiums	0.983	0.733
All Other Products and Services		28.571	27.117
All Other Products		22.027	17.914
Pharmaceuticals	WPI—Prescription Drugs	2.791	6.318
Food: Direct Purchase	WPI—Processed Foods	2.155	1.122
Food: Contract Service	CPI–U—Food Away from Home	0.998	1.043
Chemicals	WPI—Industrial Chemicals	3.413	2.133
Blood and Blood Products	WPI—Blood and Derivatives		0.748
Medical Instruments	WPI—Med. Inst. & Equipment	2.868	1.795
Photographic Supplies	WPI—Photo Supplies	0.364	0.167
Rubber and Plastics	WPI—Rubber & Plastic Products	4.423	1.366
Paper Products	WPI—Convert. Paper and Paperboard	1.984	1.110
Apparel	WPI—Apparel	0.809	0.478
Machinery and Equipment	WPI—Machinery & Equipment	0.193	0.852
Miscellaneous Products	WPI—Finished Goods excluding Food and Energy	2.029	0.783
All Other Services		6.544	9.203
Telephone	CPI–U—Telephone Services	0.574	0.348
Postage	CPI–U—Postage	0.268	0.702
All Other: Labor	ECI—Compensation: Service Workers	4.945	4.453
All Other: Non-Labor Intensive	CPI–U—All Items (Urban)	0.757	3.700
Capital-Related Costs		9.080	8.968
Depreciation		5.611	5.586
Fixed Assets	Boeckh-Institutional Construction: 23 Year Useful Life	3.570	3.503
	Life Y_y_YYF e.		
Movable Equipment	WPI—Machinery & Equipment: 11 Year Useful life	2.041	2.083
Interest Costs		3.212	2.682
Non-profit	Avg. Yield Municipal Bonds: 23 Year Useful Life	2.730	2.280
For-profit	Avg. Yield AAA Bonds: 23 Year Useful Life	0.482	0.402
Other Capital Related Costs	CPI–U—Residential Rent	0.257	0.699

Note: The operating cost category weights in the proposed excluded hospital market basket add to 100.0. When we add an additional set of cost category weights (total capital weight = 8.968 percent) to this original group, the sum of the weights in the new index must still add to 100.0. Because capital costs account for 8.968 percent of the market basket, then operating costs account for 91.032 percent. Each weight in the proposed 1997-based excluded hospital market basket was multiplied by 0.91032 to determine its weight in the proposed 1997-based excluded hospital with capital market basket.

Note: Weights may not sum to 100.0 due to rounding.

TABLE 2(A).—PROPOSED EXCLUDED HOSPITAL WITH CAPITAL INPUT PRICE INDEX (FY 1997) VINTAGE WEIGHTS

Year from farthest to most recent	Fixed assets (23-year weights)	Movable assets (11-year weights)	Interest: capital-related (23-year weights)
1	0.018	0.063	0.007
2	0.021	0.068	0.009
3	0.023	0.074	0.011
4	0.025	0.080	0.012
5	0.026	0.085	0.014
6	0.028	0.091	0.016
7	0.030	0.096	0.019
8	0.032	0.101	0.022
9	0.035	0.108	0.026
10	0.039	0.114	0.030
11	0.042	0.119	0.035
12	0.044	.....	0.039
13	0.047	.....	0.045
14	0.049	.....	0.049
15	0.051	.....	0.053
16	0.053	.....	0.059
17	0.057	.....	0.065
18	0.060	.....	0.072
19	0.062	.....	0.077
20	0.063	.....	0.081
21	0.065	.....	0.085
22	0.064	.....	0.087
23	0.065	.....	0.090
Total	1.0000	1.0000	1.0000

NOTE: Weights may not sum to 1.000 due to rounding.

Table 2(B) below compares the 1992-based excluded hospital with capital market basket to the proposed 1997-based excluded hospital with capital market basket. As shown below, the rebased and revised market basket grows slightly faster over the 1999 through 2001 period than the 1992-based market basket. The main reason for this growth is the switching of the wage and benefit proxy to the ECI for hospital workers from the previous occupational blend. This revision had a similar impact on the hospital inpatient prospective payment system and excluded hospital market baskets, as described in the final rule published in the **Federal Register** on August 1, 2002 (67 FR 50032 through 50041).

TABLE 2(B).—PERCENT CHANGES IN THE 1992-BASED AND PROPOSED 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKETS, FYS 1999 THROUGH 2004

Fiscal year	Percent change, 1992-based market basket	Percent change, proposed 1997-based market basket
1999	2.3	2.7
2000	3.4	3.1
2001	3.9	4.0
Average historical:	3.2	3.3
2002	2.7	3.6
2003	3.0	3.5
2004	3.0	3.3
Average forecast:	2.9	3.5

Source: Global Insights, Inc, 4th Qtr 2002,*@USMARCO.MODTREND@CISSIM/TL1102.SIM. Historical data through 3rd Qtr 2002.*

Based upon the analysis mentioned below, we believe the excluded hospital with capital market basket provides a reasonable measure of the price changes facing IPFs. However, we have also been researching the feasibility of developing a market basket specific to IPF services. This research includes analyzing data sources for cost category weights, specifically the Medicare cost reports, and investigating other data sources on cost, expenditure, and price information specific to IPFs.

Our analysis of the Medicare cost reports indicates that the distribution of costs among major cost report categories (wages, pharmaceuticals, and capital) for IPFs is not substantially different from the 1997-based excluded hospital with capital market basket we propose to use. In addition, the only data available to us for these cost categories (wages, pharmaceuticals, and capital) presented a potential problem since no other major cost category weights would be based on IPF data. Based on the research discussed below, at this time, we are not proposing to develop a market basket specific to IPF services.

We conducted an analysis of annual percent changes in the market basket when the weights for wages, pharmaceuticals, and capital in IPFs were substituted into the excluded hospital with capital market basket. Other cost categories were recalibrated using ratios available from the hospital inpatient prospective payment system hospital market basket. On average, between 1995 and 2002, the excluded hospital with capital market basket increased at nearly the same average annual rate (3.4 percent) as the market basket with IPF weights for wages, pharmaceuticals, and capital (3.5 percent). This difference is less than the 0.25 percentage point criterion that determines whether a forecast error adjustment is warranted under the hospital inpatient prospective payment system update framework.

Based upon this analysis, we believe that the excluded hospital with capital market basket is doing an adequate job of reflecting the price changes facing IPFs. We will continue to solicit comments about issues particular to IPFs that should be considered in our development of the proposed 1997-based excluded hospital with capital market basket, as well as encourage suggestions for additional data sources that may be available. Our hope is that the additional cost data being collected under the proposed IPF prospective payment system will eventually allow for the development of a market basket based primarily on IPF data. We welcome comments on issues particular to IPFs that should be considered in our use of the proposed 1997-based excluded hospital with capital market basket, as well as on suggestions for additional data sources that may be readily available on the cost structure of IPFs.

As discussed more fully in section IV of this proposed rule, we are proposing to implement the proposed IPF prospective payment system for IPF cost reporting periods that begin on or after April 1, 2004. The first update, however, would not be until July 1, 2005. This extends the first year for 3 additional months in order to adjust the update cycle for this proposed payment system. As a result, the effective period for this proposed rule is April 1, 2004 through June 30, 2005. To update payments between FY 2003 and the effective period, the update must reflect the market basket increase over this period, which is currently estimated at 5.3 percent. This would represent the proposed increase in the excluded hospital with capital market basket for FY 2004 and the first 9 months of FY 2005.

B. Development of the Proposed Case-Mix Adjustment Regression

In order to ensure that the proposed IPF prospective payment system would be able to account adequately for each IPF's case-mix, we performed an extensive regression analysis of the relationship between the per diem costs and both patient and facility characteristics to determine those characteristics associated with statistically significant cost differences. For characteristics with statistically

significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments. Based on the regression analysis, we are proposing to adjust the per diem payment for differences in the patient's DRG, age, comorbidities, and the day of the stay. Also, we are proposing adjustments for area wage levels, rural IPFs, and teaching IPFs.

We computed a per diem cost for each Medicare inpatient psychiatric stay, including routine operating, ancillary, and capital components using information from the 1999 MedPAR file and data from the 1999 Medicare cost reports. The method described below that was used to construct the proposed per diem cost for IPFs is a standard method that has been used to construct a Medicare cost per discharge for inpatient acute care (Newhouse, J.P., S. Cretin, and C. Witsberger. Predicting Hospital Accounting Costs, *Health Care Financing Review,* V.11, No. 1. Fall 1989). We believe that this method provides a full account of IPF's per diem costs.

To calculate the cost per day for each inpatient psychiatric stay, routine costs were estimated by multiplying the routine cost per day from the IPF's 1999 Medicare cost report by the number of Medicare covered days on the 1999 MedPAR stay record. Ancillary costs were estimated by multiplying each departmental cost-to-charge ratio by the corresponding ancillary charges on the MedPAR stay record. The total cost per day was calculated by summing routine and ancillary costs for the stay and dividing it by the number of Medicare covered days for each day of the stay. We used the best available data and methods for this proposed IPF prospective payment system. However, the data are potentially limited for the purpose of determining the extent to which differences in patient characteristics influence the per diem cost of inpatient psychiatric care.

This potential limitation results from Medicare cost accounting practices in which routine per diem costs are calculated as an average and, therefore, do not vary among patients within a facility (that is, a patient requiring intensive staff attention is assigned the same routine cost as a patient requiring little staff attention). This potential limitation assumes heightened importance for IPFs because routine costs represent about 88 percent of total costs. As a result, our cost measure may not capture the degree of variation in routine cost attributable to differences in patient characteristics. Patient differences are reflected in our measure of routine cost only to the extent that facilities tend on average to treat different proportions of patients with differing routine resource needs. For example, one IPF may have higher routine per diem costs because it treats a higher proportion of older patients (or patients who require continuous monitoring) than another IPF. However, our cost variable will not measure the extent to which older patients within the same IPF are more costly than younger patients. We are currently conducting a research study with the RTI International® (trade name of Research Triangle Institute) that will provide information as to the effects of this data limitation. As a result, we expect to have more information about the extent to which routine costs vary by certain patient characteristics. We solicit suggestions on other data sets or studies that could provide additional information on the relationship between individual patients and average facility routine costs.

This routine cost limitation does not apply to ancillary costs because they can be measured at the patient level using Medicare claims as reported in the MedPAR file. However, there are differences in charging practices between psychiatric hospitals and psychiatric units that affect our measurement of ancillary costs. For example, there are approximately 100 hospitals in our MedPAR data file that do not bill ancillary charges; the majority of these providers are State psychiatric hospitals who bill a single average per diem rate that includes routine, ancillary, and other costs.

The proposed payment adjustors were derived from regression analysis of 100 percent of the 1999 MedPAR data file. The MedPAR data file used for the final regression contains 467,372 cases although the complete file contains 476,541 cases. We deleted 5,822 cases (1.24 percent) from this file because routine cost data for certain IPFs was not available. In order to include as many IPFs as possible in the regression, we substituted the 1998 Medicare cost report data for routine cost and ancillary cost to charge ratios (using the 1998 Medicare cost report data).

For the remaining 470,719 cases, we used the following method to trim extraordinarily high or low cost values that most likely contained data errors, in order to improve the accuracy of our results. The means and standard deviations of the logged per diem total cost 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 of the logged per diem total cost, we trimmed cases from the file when covered days were zero, or routine costs were less than $100 or greater than $3,000, (because we believe this range captured the grossly aberrant cases), so that the means would not be distorted. We trimmed cases when the logged per diem cost was outside the standard and generally used statistical trim points of plus or minus 3 standard deviations from the respective means for hospitals and psychiatric units. These criteria eliminated another 3,347 cases, leaving 467,372 cases that were used in the final regression.

The log of per diem cost, like most health care cost measures, appears to be normally distributed. Therefore, the natural logarithm of the per diem cost was the dependent variable in the regression analysis. To control for psychiatric hospitals that do not bill ancillary costs, we included a categorical variable that identified them.

The proposed per diem cost was adjusted for differences in labor cost across geographic areas using the FY 1999 hospital wage index unadjusted for geographic reclassifications, in order to be consistent with our use of the market basket labor share in applying the wage index adjustment.

We computed a proposed wage adjustment factor for each case by multiplying the Medicare hospital wage index for each facility by the proposed labor-related share (.72828) and adding the proposed non-labor share (.27172). We used the proposed excluded hospital with capital market basket to determine the labor-related share (see section III.A. of this proposed rule). The per diem cost for each case was divided by this factor before taking the natural logarithm (that is, a standard mathematical practice accepted by the scientific community). The payment adjustment for the wage index was computed consistently with the wage adjustment factor, which is equivalent to separating the per diem cost into a labor portion and a non-labor portion and adjusting the labor portion by the wage index.

With the exception of the proposed payment adjustment for teaching facilities, the independent variables were specified as one or more categorical variables. Once the regression model was finalized based on the log normal variables, the regression coefficients for these variables were converted to payment adjustment factors by treating each coefficient as an exponent of the base e for natural

logarithms, which is approximately equal to 2.718. The proposed payment adjustment factors represent the proportional effect of each variable relative to a reference variable.

1. Proposed Patient-Level Characteristics

Subject to the limitations of the proposed cost variable described above and the availability of patient characteristic information contained in the administrative data, we attempted to use patient characteristics to explain the cost variation amongst IPFs. By adjusting for DRGs, comorbidities, age, and day of the stay, we were able to explain approximately 19 percent of the variation in the per diem cost. This result is comparable to that obtained by THEORI in the analysis they conducted for the APA. The study is described in section II.B. of this proposed rule.

a. DRGs

The principal diagnosis ICD code listed on the claim is used to assign each case to one of the 15 DRGs that we are proposing to recognize in this IPF prospective payment system (see section II.C of this proposed rule). The coefficients of these DRGs from the cost regression analysis were used to determine the magnitude of the payment adjustment for each of the proposed 15 DRGs. The payment adjustments are expressed relative to the most frequently assigned DRG (DRG 430, Psychoses). That is, the proposed adjustment factor for DRG 430 would be 1.00, and the proposed adjustment factors for the other 14 DRGs would vary above and below 1.00. For 8 DRGs, the proposed adjustments would be relatively small (between .96 and 1.04, that is, between 4 percent lower to 4 percent higher). The following 4 DRGs would receive relatively large payment adjustments:

- DRG 424 (Surgical procedure with Principal Diagnosis of Mental Illness) would have the largest payment adjustment of approximately 1.22.
- DRG 023 (Non-traumatic stupor and coma) would receive an adjustment of approximately 1.10.
- DRG 425 (Acute Adjustment Reaction and Psychosocial Dysfunction) would receive an adjustment of approximately 1.08.
- DRG 12 (Degenerative Nervous System Disorders) would receive an adjustment of approximately 1.07.

Both of the following two DRGs would be paid substantially less than DRG 430 with payment adjustments of approximately 0.88:

- DRG 433 (Alcohol/Drug Abuse or Dependence, left against medical advice).
- DRG 523 (Alcohol/Drug Abuse or Dependence, without Complications and/or Comorbidity and without Rehabilitation Therapy).

Cases in our MedPAR data file whose principal diagnosis classified them in DRGs other than one of the 15 DRGs that we are proposing to recognize in this proposed IPF prospective payment system were grouped into a single ''other'' category.

b. Comorbidities

Our analysis of the data indicates that patients who have certain comorbid conditions in addition to their psychiatric condition generally require more expensive care while they are hospitalized. After a thorough review of the ICD–9–CM codes, some comorbid conditions were identified as being more costly on a per diem basis. Groups of similar diagnosis codes were created to describe these conditions, which tend to be chronic illnesses that require additional medications, supplies, laboratory, or diagnostic testing in addition to the care provided for their psychiatric condition. Conditions in which the patient is acutely ill requiring care in a general hospital, for example, myocardial infarction, were not included in our analysis.

Based upon this analysis, we are proposing payment adjustments for 17 comorbidity categories that we would recognize for payment adjustments under the proposed IPF prospective payment system. Table 3 below provides a listing of the proposed comorbidity categories, the ICD–9–CM diagnostic codes comprising each category, and the payment adjustment factors. The adjustment factors are also in Addendum A.

As in the case of the DRGs, the cost regression analysis was used to determine the magnitude of the proposed payment adjustments for the comorbidity groups. Of the 17 comorbidity categories, the following 4 groups would have proposed payment adjustment factors ranging from 1.11 to 1.17 more than a case that did not have any of the 17 comorbid conditions: (1) Coagulation factor deficits; (2) renal failure, chronic; (3) chronic cardiac conditions; and (4) atherosclerosis of extremity with gangrene. Seven categories would be paid payment adjustments from 1.08 to 1.14: (1) Tracheotomy; (2) renal failure, acute; (3) malignant neoplasms; (4) severe protein calorie malnutrition; (5) chronic obstructive pulmonary disease; (6) poisoning; and (7) severe musculoskeletal and connective tissue diseases. The remaining 6 comorbidity categories would receive payment adjustments ranging from 1.03 to 1.10: (1) HIV; (2) infectious diseases; (3) uncontrolled type I diabetes mellitus; (4) artificial openings digestive and urinary; (5) drug and/or alcohol induced mental disorders; and (6) eating and conduct disorders.

Other potential conditions were considered as potentially more expensive, but the small number of cases in the MedPAR data file made it impossible to propose an appropriate adjustment for those conditions. We solicit comments suggesting other conditions that may be expected to increase the per diem cost of care in IPFs. In addition, we expect that as facilities become aware of the importance of providing accurate information on the diagnoses of patients, we will have more data to use as a basis for refinements to the list of proposed comorbid conditions affecting the per diem cost of care.

TABLE 3.—DIAGNOSIS CODES FOR PROPOSED COMORBIDITY CATEGORIES

Description of proposed comorbidity	ICD–9–CM code	Proposed adjustment factor
HIV	042	1.06
Coagulation Factor Deficits	2860 through 2864	1.11
Tracheotomy	51900 and V440	1.14
Renal Failure, Acute	5846 through 5849; 7885; 9585; V451; V560, V561; and V562	1.08
Renal Failure, Chronic	40301; 40311; 40391; 40402; 40412; 40492, 585; and 586	1.14
Malignant Neoplasms	1400 through 1720; 1740 through 1840; and 1850 through 2080.	1.10

TABLE 3.—DIAGNOSIS CODES FOR PROPOSED COMORBIDITY CATEGORIES—Continued

Description of proposed comorbidity	ICD–9–CM code	Proposed adjustment factor
Uncontrolled Type I Diabetes-Mellitus, with or without complications.	25003; 25083; 25013; 25023; 25033; 25093; 25043; 25053; 25063; and 25073.	1.10
Severe Protein Calorie Malnutrition	260 through 262	1.12
Eating and Conduct Disorders	3071; 30750; 31203; 31233; and 31234	1.03
Infectious Diseases	01000 through 04110; 04500 through 05319, 05440 through 05449; 0550 through 0770; 0782 through 0789; and 07950 through 07595.	1.08
Drug and/or Alcohol Induced Mental Disorders	2920; 2922; 2910; 29212; 30300; and 30400	1.03
Cardiac Conditions	3910; 3911; 3912; 40201; 41403; 4160; and 4210	1.13
Atherosclerosis of Extremity with Gangrene	44024	1.17
Chronic Obstructive Pulmonary Disease	5100; 51883; 51884; 4920; 494; 49120 through 49122, and V461.	1.12
Artificial Openings-Digestive and Urinary	56960; V441 through V443; and V4450	1.09
Severe Musculoskeletal and Connective Tissue Diseases	6960; 7100; 73000 through73009; 73010 through 73019; 73020 through 73029; and 7854.	1.12
Poisoning	96500 through 96509; and 9654; 9670 through 9700; 9800 through 9809; 9830 through 9839; 986; 9890 through 9897.	1.14

c. Patient Age and Gender

The cost regressions explored several alternative configurations of age and gender variables. The results indicate that the per diem cost rises as a patient's age increases, and the per diem cost are higher for female patients.

We examined the variation in the per diem cost for 5-year age intervals ranging from age 40 to 80 with open-ended categories ranging above age 80 and below 40 and determined that the effect of age was statistically significant. We initially ran the regression for three age groups consistent with the natural breaks in the distribution of age (under 55, 55 to 64, and 65 and over). The distribution showed that most Medicare psychiatric patients are under age 55 and over age 65. In addition, the distribution showed that the age group between 55 and 65 years of age increased the predictive power of the model only by a factor of .002 percent because there were few patients in that age category. For this reason, we are not proposing adjustments reflecting the three age groups. Rather, we are proposing to make a single adjustment of 13 percent for patients 65 years and over. We are proposing two age groups (under 65 and over 65) to correspond with the major populations within Medicare: the disabled and the elderly, which we believe are largely responsible for the age-related cost differences that we observed. In addition, preliminary results from the RTI International® research that used estimates of patient-specific routine cost per day (from a sample of 40 IPFs) found that splitting age into two groups (under 65 and over 65) has greater explanatory power than alternative age group configurations. The research study is described in more detail in section V.C.1. of this proposed rule.

The cost regression implies that female patients are approximately 3 percent more costly than male patients. However, the explanatory power of the equation increases by less than .002 percentage points. There is also a small reduction in the age effect for the 65 and over age group (less than one percentage point). We also examined the alternative of including gender along with the three age groups (under 55, 55 to 64, and 65 and over) and compared the results to the regression without gender and with two age groups (under 65 and 65 and over). The fuller specification of age and gender only increased the explanatory power by .003 points and had little effect on the size of the age effects.

We know that the elderly and women are more frequently treated in psychiatric units than in freestanding psychiatric hospitals. When an indicator variable for psychiatric units is included in the cost regression, the age and gender effects decrease (the 65 and over age effect declines from approximately 13 percent to approximately 9 percent, and the gender effect decreases from approximately 3 percent to 2 percent). We are unable to determine the extent to which this interaction of psychiatric unit status with age and gender indicates higher direct costs of treating the elderly and women, as opposed to other reasons for the higher costs of psychiatric units. However, RTI International's® preliminary results, which used a better patient-specific cost variable for a sample of 40 hospitals found a much stronger effect for age than for gender. This is because the evidence currently available to us is limited and we believe we cannot identify a direct link between the costs of psychiatric care in psychiatric units and treatment of female IPF patients. We are not proposing to adjust the per diem payment rate to account for gender. We invite comments on the appropriateness of including a gender variable as a payment adjustment as well as comments on the age categories used to identify variations in costs. We will continue to assess the effects of gender and age as we analyze more current data in the development of the final rule.

d. Length of Stay

Cost regressions indicate that the per diem cost declines as the length of stay increases. We are proposing adjustments to account for ancillary and certain administrative costs that occur disproportionately in the first days after being admitted to an IPF (the variable per diem adjustments). We examined the per diem cost over a range of 1 to 14 days. According to the 1999 MedPAR data file, the per diem costs were highest on day 1 and declined for days 2 through 8 as indicated below. Per diem costs for days 9 and thereafter remained relatively consistent with the median length of stay in an IPF for Medicare beneficiaries. The cost regression analysis was used to determine the following proposed payment adjustments. Relative to a stay of 9 or more days, the resulting adjustments for the first 8 days of a stay that we are proposing to use in this IPF prospective payment system are as follows:

- The variable per diem adjustment for day 1 would be an increase of approximately 26 percent.

- The variable per diem adjustment for days 2 to 4 would be an increase of approximately 12 percent.
- The variable per diem adjustment for days 5 to 8 would be an increase of approximately 5 percent.
- No variable per diem adjustment would be paid after the 8th day.

The higher payments for earlier days are offset through the budget neutrality adjustment, which has the effect of lowering the average payment to account for the increased payments.

2. Proposed Facility-Level Characteristics

As noted earlier, we were able to explain 19 percent of the variation in wage-adjusted per diem cost using patient characteristics. We explored a variety of ways to incorporate facility characteristics into the cost regressions in order to raise the explanatory power and refine the proposed payment system to better align payments with cost differences across facility types.

Per diem costs are strongly related to facility occupancy, because occupancy (as measured by the ratio of actual days to available days) measures the extent to which the facility is efficiently utilizing its capacity. When occupancy is low, fixed costs must be spread across relatively few days of care and the per diem costs are high. Because we do not want to pay for inefficiency, we are not proposing that occupancy be used as a payment adjuster. However, this variable is included in the cost regression to improve the estimates of the effects of other factors that may more appropriately be used to adjust payments.

An analysis of the facility-level characteristics we considered follows. To summarize the analysis, we are proposing that payments be adjusted based on the IPF's wage index, rural location, and teaching status. We considered, and explain below, the reasons why we are proposing not to provide adjustments for psychiatric units, disproportionate share intensity, or IPFs in Alaska or Hawaii.

a. Rural Location

We found that, controlling for the patient characteristics and other facility variables included in our cost regression, facilities located in non-metropolitan area counties had per diem costs about 16 percent higher than facilities located in metropolitan area counties. Most of the higher cost of rural IPFs is related to the fact that the vast majority are psychiatric units within small general acute care hospitals. Small-scale facilities are more costly on a per diem basis because there are minimum levels of fixed costs that cannot be avoided. Based on this analysis, we are proposing to make an adjustment of 16 percent for IPFs located in rural areas.

b. Teaching Status

One option for paying psychiatric teaching facilities for their higher costs relies on past experience with the teaching adjustment for other Medicare prospective payment systems. As in other inpatient prospective payment systems, we measured teaching status as one plus the ratio of the number of interns and residents assigned to the facility divided by the IPF's average daily census (ADC). Similarly for psychiatric units, we used the number of interns and residents assigned to the psychiatric unit.

The advantages of using the ADC rather than the number of beds for the denominator of the ratio noted above was discussed in the final rule we published in the **Federal Register** on August 30, 1991 (56 FR 43380) for putting inpatient hospital capital payments under a prospective payment. As described in that rule, the two key advantages of the ADC are that it is—(1) easier to define more precisely than number of beds; and (2) less subject to understatement in an effort to increase the size of the teaching variable. We believe that these advantages apply equally to IPFs.

The teaching variable in our cost regressions, that is, the logarithm of one plus the ratio of interns and residents to ADC, has a coefficient value of .5215. This cost effect is converted to a payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to the .5215 power. Applying this method for a facility with a teaching variable of 1.10 would yield a 5.1 percent increase in the per diem payment; for a facility with a teaching variable of 1.25, there would be a 12.3 percent higher payment.

Our impact tables are based on the assumption that we would pay a proposed IPF teaching adjustment in this manner and our proposed regulatory text is also based on this approach. However, we are considering alternatives because we are concerned that this method creates incentives for teaching hospitals to add residents and to increase their payments under an open-ended formula that pays higher teaching payments as teaching intensity, as measured by resident to ADC ratios, increases.

The BBA, sections 4621 and 4623, limited the incentives to add residents in hospitals paid under the hospital inpatient prospective payment system by adopting caps for both direct and indirect teaching payments. The number of residents was capped for the purpose of computing both the direct and indirect teaching adjustments and the resident to ADC was capped for purposes of computing the indirect teaching adjustment. Because IPFs would now be paid on a prospective basis similar to acute care hospitals, we are considering extending the indirect teaching caps to IPF teaching hospitals. Regulations, as specified at § 413.86, already apply the BBA caps to direct medical education payments for all teaching hospitals.

We are also exploring whether there are other alternatives for paying IPF teaching hospitals their higher teaching costs. We are interested in developing methodologies for estimating these higher costs and then, based on the newly available estimates and current data, distributing those costs fairly to individual teaching hospitals. We invite comments on obtaining the estimates and current data and on other approaches to paying psychiatric teaching hospitals for their higher medical-education costs based on that data.

c. Disproportionate Share Hospital Status

We measured the extent to which a facility provides care to low income patients using the disproportionate share hospital (DSH) variable used in other Medicare prospective payment systems (that is, the sum of the proportion of Medicare days of care provided to recipients of Supplemental Security Income and the proportion of the total days of care provided to Medicaid beneficiaries). For psychiatric units, both proportions are specific to the unit and not the entire hospital. A limitation of the Medicaid proportion as applied to psychiatric hospitals is that Medicaid does not pay for services provided to individuals under the age of 65 in an institution for mental diseases (IMD), as specified in section 1905(h) of the Act. As a result, low-income beneficiaries in IMDs cannot be identified as Medicaid beneficiaries, and the Medicaid proportion will be biased downwards.

The DSH variable was highly significant in our cost regressions; however, we found that facilities with higher DSH had lower per diem costs. We note that the previously cited study for the APA also found the same results. The relationship of high DSH with lower costs cannot be attributed to downward bias in the Medicaid proportion due to the IMD exclusion. This is because public psychiatric

hospitals already have lower costs on average than other types of IPFs. Therefore, if we propose a DSH adjustment based on the regression analysis, IPFs with high DSH shares would be paid lower per diem rates.

We tried a variety of supplemental analyses in an attempt to better understand the observed relationship, but did not find a positive relationship between the per diem cost and the DSH ratio. Therefore, we are not proposing a payment adjustment for DSH intensity but will monitor the effect of DSH for possible future adjustments.

d. Psychiatric Units in General Acute Care Hospitals

On average, psychiatric units have higher per diem costs than psychiatric hospitals. According to the 1999 MedPAR file, the average per diem cost for psychiatric units was $615, compared to $444 for psychiatric hospitals.

Some of the patient characteristics and facility variables that we included in our cost regressions explain part, but not all, of the cost difference between hospitals and psychiatric units. Controlling for facility size, occupancy, and selected comorbidities reduces the magnitude of the estimated cost difference from approximately 37 percent to 19 percent. Several factors may account for the remaining 19 percent difference: (1) A large proportion of psychiatric admissions to these units enter the hospital through the emergency room (ER), and ER charges are included on the inpatient claims used in our analysis (this issue will not be relevant to IPF payment in the future because ER services have been paid under the outpatient hospital prospective payment system since August 2000); (2) some of these admissions have medical conditions in addition to psychiatric symptoms and require more treatments resulting in higher costs due to more services and equipment; (3) psychiatric hospitals and psychiatric units may utilize different patterns of care and staffing; and (4) accounting differences may account for some of the cost difference.

We have decided not to propose a specific adjustment for psychiatric units. We are concerned about applying such an adjustment to all psychiatric units regardless of an individual unit's costs, efficiency, or case mix.

We hope that with further research, we will be able to gain a better understanding of the cost differences that would enable us to propose even more refined payment adjustments to directly measure the differences in patient care needs in psychiatric units.

e. Adjustment for Alaska and Hawaii IPFs

Some of the prospective payment systems that have been developed include a cost-of-living adjustment for the unique circumstances of Medicare providers located in Alaska and Hawaii. Therefore, we analyzed our data to determine the existence of IPFs located in Alaska and Hawaii. Currently, in Alaska, there are only two psychiatric hospitals and no psychiatric units. In Hawaii, there is one psychiatric hospital and one psychiatric unit. In the absence of a cost-of-living adjustment, our analyses indicates that some facilities in Alaska and Hawaii would ''profit'' and other facilities would experience a ''loss.'' Due to the limited number of cases, the results of our analysis are inconclusive regarding whether a cost-of-living adjustment would improve payment equity for these facilities. Therefore, we are not proposing an adjustment for IPFs located in Alaska and Hawaii. We will continue to assess the impact of the proposed IPF prospective payment system on IPFs located in Alaska and Hawaii as we obtain more current data.

3. Proposed Payment Adjustments

a. Proposed Outlier Adjustment

While we are not statutorily required to provide outlier payments, we believe that it is appropriate to propose an outlier payment policy in connection with this prospective payment system in order to both ensure that IPFs treating unusually costly cases do not incur substantial ''losses'' and promote access to IPFs for patients requiring expensive care. Providing additional payments for costs that are beyond the IPF's control can strongly improve the accuracy of the proposed IPF prospective payment system in determining resource costs at the patient and facility level.

Notwithstanding the factors that we are proposing to recognize in the IPF prospective payment system as proposed adjustments to the per diem payment rate, the cost of care for some psychiatric patients may still substantially exceed the otherwise applicable payments during the course of a stay. This may occur because of multiple comorbid conditions and complications that require a high utilization of ancillary services. Since this is a per diem payment system, the extent to which length of stay is a factor would be mitigated because payment is made for each day of the stay.

We have determined that it is important to provide some protection from financial risk caused by treating patients who require more costly care and to reduce the incentives to under serve these patients.

Therefore, in order to protect IPFs from significant ''losses'' on very costly cases, we are proposing to provide outlier payments and set outlier numerical criteria prospectively so that outlier payments are projected to equal 2 percent of total payments under the proposed IPF prospective payment system. Based on the regression analysis and payment simulations, we believe that using a 2 percent threshold optimizes our ability to protect vulnerable IPFs while providing adequate payment for all other cases that are not outlier cases.

We are proposing, in § 412.424(c), to make an outlier payment for any case in which the estimated total cost exceeds an outlier threshold amount equal to the total IPF prospective payment system payment amount plus a fixed dollar loss amount. The fixed dollar loss amount is the amount used to limit the loss that an IPF would incur under the proposed outlier policy (see section III.C.3. of this proposed rule for an explanation of how the fixed dollar loss amount is calculated). Once the cost of a case exceeds the outlier threshold amount, an outlier payment would be made. A basic principle of an outlier policy is that outlier payments should cover less than the full amount of the additional costs above the outlier threshold in order to preserve the incentive to contain costs once a case qualifies for outlier payments (see Emmett B. Keeler, Grace M. Carter, and Sally Trude, ''Insurance Aspects of DRG Outlier Payments,'' The Rand Corporation, N–2762–HHS, October 1988). This results in Medicare and the IPF sharing financial risk in the treatment of extraordinarily costly cases.

b. Methodology for Proposed Outlier Payments

We are proposing to make outlier payments on a per case basis rather than on a per diem basis. Outlier payments would be made for IPF cases when the estimated cost of the entire stay exceeds the outlier threshold amount. We believe it is appropriate to determine outlier status on a per case basis in order to accurately assess the ''losses'' associated with the care of a patient for the entire stay. If we propose to establish a per diem fixed dollar loss threshold, outlier payments could occur for part of an inpatient stay when no ''losses'' actually occur. If we review the stay in terms of the resources expended each day, the facility may incur a ''loss'' on some days of the stay and may experience ''gains'' on other days of the stay. Thus, assessing the resources

expanded over the course of the entire stay provides a fuller picture of the actual resources needed to provide care for the complete episode of care. After assessing the entire stay, one can determine if a ''loss'' was actually incurred by the IPF.

Therefore, we are proposing to define the outlier threshold amount as the total IPF prospective payment for an IPF stay, plus a fixed dollar loss amount. As explained below, the fixed dollar amount is determined to be the dollar amount per stay that achieves a total outlier percentage of 2 percent of the proposed prospective payments. The proposed outlier payment would be defined as a proportion of the estimated cost beyond the outlier threshold. The proportion of additional costs paid as outlier payments is referred to as the loss-sharing ratio. We chose to propose the fixed dollar loss amount and the loss-sharing ratios to allow the estimated total outlier payments to be 2 percent of the total estimated proposed IPF prospective payments.

In order to determine the most appropriate outlier policy, our goal was to analyze the extent to which the various outlier percentages reduce financial risk, reduce incentives to under serve costly beneficiaries, and improve the overall fairness of the payment system. Our analysis showed that the higher the outlier percentage, the more cases qualified for outlier payments, and the less payment was made per case. Conversely, a low outlier percentage resulted in a higher fixed dollar loss threshold and although fewer cases exceeded the threshold, the amount paid was more substantial.

We began our analysis by determining that if approximately 10 percent of IPF cases received an outlier payment, we would be maintaining the basic premise behind establishing an outlier policy, that is, to compensate IPFs for their truly high cost cases. Also, this percentage of cases, that is 10 percent, is not inconsistent with the percentage of total outlier cases paid in other prospective payment systems.

Initially, we believed that a 5 percent outlier policy would result in outlier payments for approximately 10 percent of total IPF cases. However, our analysis showed that a 5 percent outlier policy resulted in outlier payments for approximately 20 percent of IPF cases, paying an average of $1,975 per case. Since 20 percent of IPF cases would receive an outlier payment, we do not believe that a 5 percent outlier policy limits outlier payments to only the truly high cost cases. We then reduced the outlier policy to 3 percent and found that 12 percent of IPF cases received outlier payments, with an average payment of $2,125 per case. Although a 3 percent outlier policy reduced the number of cases that would qualify for outlier payments, 12 percent of cases still exceeded our target of 10 percent of total IPF cases.

However, we have determined that an outlier policy of 2 percent of the total proposed IPF payments would allow us to achieve a balance of the above stated goals. A 2 percent outlier policy would appropriately compensate for the truly high cost cases with a much more appropriate level of payment and reduced financial risk without causing a significant reduction in the per diem base rate. Under a 2 percent outlier policy, approximately 7 percent of IPF cases qualify for outlier payments with an average payment of $2,350 per case. Providing outlier payments to 7 percent of cases meets the 10 percent target and would provide outlier payment for only the high cost IPF cases. Accordingly, we are proposing the outlier policy to be 2 percent of the total proposed IPF payments. The amount of outlier payments would be funded by prospectively reducing the non-outlier payment rates in a budget-neutral manner.

Under our proposed outlier policy, we would make outlier payments for discharges in which estimated costs exceed an adjusted threshold amount ($4,200 multiplied by the IPF's facility adjustments, that is wages, rural location, and teaching status) plus the total IPF prospective payment system adjusted payment amount for the discharge. The estimated cost for a case would be calculated by multiplying the overall facility-specific cost-to-charge ratio by the total charges for the inpatient stay.

In establishing the loss-sharing ratio, we considered establishing a single ratio consistent with the hospital inpatient prospective payment system, which is set at a marginal cost of 80 percent of the difference between the cost for the discharge and the adjusted threshold amount. However, the proposed IPF prospective payment system unlike the hospital inpatient prospective payment system is a per diem payment system, we are concerned that a single loss-sharing ratio at 80 percent might provide an incentive to increase length of stay in order to receive additional outlier payments. Therefore, we are proposing to reduce the loss-sharing ratio when the length of the stay increases beyond the median length of stay. We believe that a reduction to the outlier loss-sharing ratio should occur in a similar manner to the declining per diem payment. The per diem payment amount under the proposed IPF prospective payment system is highest on days 1 through 4, declines on days 5 through 8, and declines further for all days beyond 8. Similarly, we are proposing to establish an 80-percent loss-sharing ratio for days 1 through 8 in order to reflect higher costs early in an IPF stay and reduce the ratio by 20 percent for days 9 and thereafter. This is consistent with the median length of stay for IPFs. Reducing the amount Medicare would share in the loss of high cost cases would provide an incentive for an IPF to contain costs once a case qualifies for outlier payments. We solicit comments on this approach.

c. Proposed Implementation of the Outlier Policy

The intent of proposing an outlier policy is to adequately pay for truly high-cost cases. However, we have become aware that under the hospital inpatient prospective payment system, some hospitals have taken advantage of two system features in the outlier policy to maximize their outlier payments. The first is the time lag between the current charges on a submitted claim and the cost-to-charge ratio taken from the most recent settled cost report. Second, statewide average cost-to-charge ratios are used in those instances in which an acute care hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. We set forth these parameters and the statewide cost-to-charge ratios for acute care hospitals in the annual publication of prospective payment rates that are published by August 1 of each year in accordance with § 412.8(b)(2). Currently, these parameters represent 3.0 standard deviations (plus or minus) from the geometric mean of cost-to-charge ratios for all hospitals. Hospitals could arbitrarily increase their charges so far above costs that their cost-to-charge ratios would fall below 3 standard deviations from the geometric mean of the cost-to-charge ratio. Thus, a higher statewide average cost-to-charge ratio would be applied to determine if the hospital should receive an outlier payment. This disparity results in their cost-to-charge ratios being set too high, which in turn results in an overestimation of their current costs per case.

The intention of the outlier policy under both the hospital inpatient prospective payment system and the proposed IPF prospective payment system is to make payments only when the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. We

believe that if hospitals' charges are not sufficiently comparable in magnitude to their costs, the legislative purpose underlying payment for outliers is thwarted. Thus, on June 9, 2003, we published a final rule in the **Federal Register** (68 FR 34494) to ensure that outlier payments are paid for truly high-cost cases under the hospital inpatient prospective payment system.

We believe the use of parameters is appropriate for determining cost-to-charge ratios to ensure these values are reasonable and that outlier payments can be made in the most equitable manner possible. Further, we believe the proposed methodology of computing IPF outlier payments is susceptible to the same payment enhancement practices identified under the hospital inpatient prospective payment system because it depends on the cost-to-charge ratio to determine the IPF's cost. Accordingly, as discussed below, we are proposing provisions for implementing the outlier policy to ensure the statistical accuracy of cost-to-charge ratios and appropriate adjustment of IPF outlier payments.

1. Statistical Accuracy of Cost-to-Charge Ratios

We believe that there is a need to ensure that the cost-to-charge ratio used to compute an IPF's estimated costs should be subject to a statistical measure of accuracy. Removing aberrant data from the calculation of outlier payments will allow us to enhance the extent to which outlier payments are equitably distributed and continue to reduce incentives for IPFs to under serve patients who require more costly care. Further, using a statistical measure of accuracy to address aberrant cost-to-charge ratios would also allow us to be consistent with the outlier policy under the hospital inpatient prospective payment system. Therefore, we are making the following two proposals:

- We will calculate two national ceilings, one for IPFs located in rural areas and one for facilities located in urban areas. We propose to compute this ceiling by first calculating the national average and the standard deviation of the cost-to-charge ratios for both urban and rural IPFs.

To determine the rural and urban ceilings, we propose to multiply each of the standard deviations by 3 and add the result to the appropriate national cost-to-charge ratio average (either rural or urban). We believe that the method explained above results in statistically valid ceilings. If an IPF's cost-to-charge ratio is above the applicable ceiling, the ratio is considered to be statistically inaccurate. Therefore, we are proposing to assign the national (either rural or urban) median cost-to-charge ratio to the IPF. Due to the small number of IPFs compared to the number of acute care hospitals, we believe that statewide averages used in the hospital inpatient prospective payment system, would not be statistically valid in the IPF context.

In addition, the distribution of cost-to-charge ratios for IPFs is not normally distributed and there is no limit to the upper ceiling of the ratio. For these reasons, the average value tends to be overstated due to the higher values on the upper tail of the distribution of cost-to-charge ratios. Therefore, we are proposing to use the national median by urban and rural type as the substitution value when the facility's actual cost-to-charge ratio is outside the trim values. Cost-to-charge ratios above this ceiling are probably due to faulty data reporting or entry, and, therefore, should not be used to identify and make payments for outlier cases because these data are clearly erroneous and should not be relied upon. In addition, we propose to update and announce the ceiling and averages using this methodology every year.

- We will not apply the applicable national median cost-to-charge ratio when an IPF's cost-to-charge ratio falls below a floor. We are proposing this policy because we believe IPFs could arbitrarily increase their charges in order to maximize outlier payments.

Even though this arbitrary increase in charges should result in a lower cost-to-charge ratio in the future (due to the lag time in cost report settlement), if we propose a floor on cost-to-charge ratios, we would apply the applicable national median for the IPFs actual cost-to-charge ratio. Using the national median cost-to-charge ratio in place of the provider's actual cost-to-charge ratio would estimate the IPF's costs higher than they actually are and may allow the IPF to inappropriately qualify for outlier payments.

Accordingly, we are proposing to apply the IPF's actual cost-to-charge ratio to determine the cost of the case rather than creating and applying a floor. In such cases as described above, applying an IPF's actual cost-to-charge ratio to charges in the future to determine the cost of the case will result in more appropriate outlier payments.

Consistent with the policy change under the hospital inpatient prospective payment system, we are proposing that IPFs would receive their actual cost-to-charge ratios no matter how low their ratios fall. We are still assessing the procedural changes that would be necessary to implement this change.

2. Adjustment of IPF Outlier Payments

As discussed in the hospital inpatient prospective payment system final rule for outliers, we have implemented changes to the outlier policy used to determine cost-to-charge ratios for acute care hospitals, because we became aware that payment vulnerabilities exist in the current outlier policy. Because we believe the IPF outlier payment methodology is likewise susceptible to the same payment vulnerabilities, we are proposing the following:

- Include in proposed § 412.424(c)(2)(v) a cross-reference to § 412.84(i) that was included in the final rule published in the **Federal Register** on June 9, 2003 (68 FR 34515). Through this cross-reference, we are proposing that fiscal intermediaries would use more recent data when determining an IPF's cost-to-charge ratio. Specifically, as provided in § 412.84(i), we are proposing that fiscal intermediaries would use either the most recent settled IPF cost report or the most recent tentatively settled IPF cost report, whichever is later to obtain the applicable IPF cost-to-charge ratio. In addition, as provided under § 412.84(i), any reconciliation of outlier payments will be based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

- Include in proposed § 412.424(c)(2)(v) a cross reference to § 412.84(m) (that was included in the final rule published in the **Federal Register** on June 9, 2003 (68 FR 34415) to revise the outlier policy under the hospital inpatient prospective payment system). Through this cross-reference, we are proposing that IPF outlier payments may be adjusted to account for the time value of money during the time period it was inappropriately held by the IPF as an ''overpayment.'' We also may adjust outlier payments for the time value of money for cases that are ''underpaid'' to the IPF. In these cases, the adjustment will result in additional payments to the IPF. We are proposing that any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation. We are still assessing the procedural changes that would be necessary to implement this change.

d. Computation of Proposed Outlier Payments

In order to illustrate the proposed outlier payment mechanism, we present

the following example of how we would calculate the outlier payment.

Example: John Smith was hospitalized at a non-teaching IPF facility in Richmond, Virginia for 14 days. His total allowable billed charges for the 14 days was $20,000. The prospective payment amount (per diem payments plus adjustments) was $8,000.

To determine whether this case qualifies for outlier payments, it would be necessary to compute the cost of the case by multiplying the facility's overall cost-to-charge ratio of .72 by the allowable charge of $20,000. In this case, the total allowable costs for Mr. Smith's case is $14,400 ($20,000 × .72). Because the IPF is a non-teaching urban facility, the fixed dollar threshold is adjusted by the wage index 0.9477.

TABLE 4.—COMPUTATION EXAMPLE OF THE PROPOSED OUTLIER PAYMENT

Steps to Calculate the Proposed Outlier Payment		
Calculate the Fixed Dollar Loss Threshold:		
Fixed Dollar Threshold		$4,200
Wage adjusted labor share (.72828×4,200)*0.9477	$2,899	
Non Labor Share (0.27172 × $4.200)	1,141	
Adjusted Fixed Dollar Threshold ($2,899+$1,141)	4.040	
Calculate Eligible Outlier Costs:		
Hospital Costs	14,400	
Adjusted Fixed Dollar Threshold	4,040	
Prospective Payment System Adjusted Payment	8,000	
Eligible for Outlier Costs ($14,400 − $4,040 − $8,000)	2,360	
Calculate the Loss Sharing Ratio Amount:		
Per Diem Outlier Costs ($2,360/14 days)		169
Loss-sharing Ratio Days 1 through 8 ($169×.80×8 days)	1,079	
Loss-sharing Ratio Days 9 through 14 $169×.60 ×6 days)	607	
The Total Outlier Payment Amount $1,079+$607)	1,686	

e. Interrupted Stays

Since per diem payments under the proposed IPF prospective payment system would be higher for the first 8 days of a stay (the variable per diem adjustment discussed earlier in this section), we are proposing to adopt an interrupted stay policy. The policy is intended to reduce incentives to move patients among Medicare-covered sites of care in order to maximize Medicare payment. We are concerned that IPFs could maximize payment by prematurely discharging patients after the 8 days during which they receive higher payments (the variable per diem adjustments), and then readmitting the same patient. In some cases a discharge and subsequent readmission within a short period of time may be appropriate. For example, we are concerned, in particular, that when there is a psychiatric unit within an acute care hospital, a patient could be transferred from the unit after only a few days of care to another part of the hospital and then be readmitted to the psychiatric unit. In this scenario, the hospital could receive the per diem adjustments for both stays in the psychiatric unit as well as receive the DRG payment associated with the acute hospital stay.

In proposed § 412.402, we define an interrupted stay as one in which the patient is discharged from an IPF and returns to the same IPF within 5 consecutive calendar days. Specifically, we are proposing in § 412.424(d) that if a patient is discharged from an IPF and returns to the same IPF within 5 consecutive calendar days, we would treat both stays as a single stay. Therefore, we would not apply the variable per diem adjustment for the second admission and would combine the costs of both stays for the purpose of determining whether the case qualifies for outlier payments.

We considered defining an interrupted stay as a readmission within 8 days of discharge since the variable per diem adjustments are not applied after the 8th day of the stay. We are not proposing this definition for an interrupted stay because we believe that after an 8-day absence from the IPF, many of the services that account for increased costs early in an inpatient psychiatric stay would need to be repeated, for example, assessments and laboratory testing. After a shorter absence from the IPF of 1 through 4 days, however, many of those admission-related services such as psychiatric evaluations and the patient's medical history would not need to be repeated. Therefore, we believe the lower end of the last range of payment adjustment, that is, 5 days, would provide for appropriate per diem payment adjustment as well as provide a disincentive to inappropriately shift patients between Medicare-covered sites of care. In addition, we intend to monitor the extent and timing of readmissions to IPFs and plan to account for changes in practice patterns as we refine the proposed IPF prospective payment system. Public comments are welcome on the proposed definition of an interrupted stay.

For the purposes of counting the 5-calendar day time period to determine the length of the interrupted stay, the day of discharge would be counted as ''day 1'', with midnight of that day serving as the end of that calendar day. The 4 calendar days that immediately follow day 1 would be days 2 through 5.

C. Development of the Proposed Budget-Neutral Federal Per Diem Base Rate

1. Data Used To Develop the Proposed Federal Per Diem Base Rate

Based on the regression analysis, we are proposing a prospective payment system for IPFs based on a per diem payment amount calculated from average costs adjusted for budget neutrality. The per diem amount would be adjusted by a budget-neutrality factor to arrive at the Federal per diem base rate used as the standard payment per day for the proposed IPF prospective payment system. The proposed Federal per diem base payment would be adjusted by the proposed wage index and the proposed patient-level and facility-level characteristics identified in the regression analysis. To calculate the proposed per diem amount, we would estimate the average cost per day for—(1) routine services from the most recent available cost report data (cost reports beginning in FY 1999 supplemented with 1998 cost reports if the 1999 cost report is missing); and (2) ancillary costs per day using data from the 1999 Medicare bills and corresponding data from facility cost reports.

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

update factor would be equal to the market basket minus 0.25 percentage points for each percentage point in which operating costs are less than 10 percent over the target (but in no case less than 0 percent).

- For IPFs that are at or below their target amounts but exceed 66.7 percent of the target amounts, the update factor would be the market basket minus 2.5 percentage points (but in no case less than 0 percent).
- For IPFs that do not exceed 66.7 percent of their target amounts, the update factor would be 0 percent.
- For FYs 2003 and later, we use the most recent estimate of the percentage increase projected by the excluded hospital market-basket index.

In addition, since the proposed prospective payment system would include both the operating and capital-related costs, we needed to project the capital-related cost under the TEFRA system as well. We used the excluded capital market basket to project the capital-related costs under the TEFRA system. Table 5 below, summarizes the excluded hospital market basket and the excluded capital market basket indexes.

TABLE 5.—PROPOSED EXCLUDED HOSPITAL MARKET BASKET AND EXCLUDED CAPITAL MARKET BASKET

Fiscal year	Excluded hospital market basket percent	Excluded capital market basket percent
FY 1999	2.9	0.9
FY 2000	3.3	1.2
FY 2001	4.3	1.0
FY 2002	3.9	0.9
FY 2003* ...	3.7	0.8
FY 2004* ...	3.5	1.1
FY 2005* ...	3.2	1.1

*NOTE: Projected Percentage.

b. Estimate of Total Payments Under the TEFRA Payment System

We estimated payments for inpatient operating and capital services under the current TEFRA system using the following methodology:

Step 1: IPF's Facility-Specific Target Amount.

The facility-specific target amount for an IPF would be calculated based on the IPF's allowable inpatient operating cost per discharge for the base period, excluding capital-related, nonphysician anesthetist, and medical education costs. We would update this target amount using a rate-of-increase percentage as specified in § 413.40(c)(3)(viii).

From FYs 1998 through 2002, there were two national caps on the payment amounts for IPFs. As specified in § 413.40(c)(4)(iii), an IPF's facility-specific target is the lower of its net allowable base-year costs per discharge increased by the applicable update factors or the cap for the applicable cost reporting period. In determining each IPF's facility-specific target amount, we would use the labor-related and non-labor related shares of the national cap amounts for FY 2002 that appeared in the hospital inpatient prospective payment system final rule published in the **Federal Register** on August 1, 2001 (66 FR 39916). For existing IPFs (that is, IPFs paid under TEFRA before October 1, 1997), we adjusted the labor-related share ($8,429) by the applicable geographic wage index and added that amount to the non-labor related share ($3,351). For new IPFs (that is, IPFs first paid under TEFRA after October 1, 1997), we adjusted the labor-related share ($6,815) and added that amount to the non-labor related share ($2,709).

Step 2: IPF's Payment Amount for Inpatient Operating Services

Under the TEFRA system, an IPF's payment amount for inpatient operating services is the lower of—

- The hospital-specific target amount (subject to application of the cap as determined in Step (1) multiplied by the number of Medicare discharges (the ceiling); or
- The hospital's average inpatient operating cost per case multiplied by the number of Medicare discharges.

In addition, under the TEFRA system, payments may include a bonus or relief payment, as follows:

- IPFs whose net inpatient operating costs are lower than or equal to the ceiling, would receive the lower payment of either the net inpatient operating costs plus 15 percent of the difference between the inpatient operating costs and the ceiling; or the net inpatient operating costs plus 2 percent of the ceiling.
- IPFs whose net inpatient operating costs are greater than the ceiling, but less than 110 percent of the ceiling, would receive the ceiling payment.
- IPFs whose net inpatient operating costs are greater than 110 percent of the ceiling would receive the ceiling payment plus the lower of 50 percent of the difference between the 110 percent of the ceiling and the net inpatient operating costs or 10 percent of the ceiling payment.

Step 3: IPF's Payment for Capital-Related Costs

Under the TEFRA system, in accordance with section 1886(g) of the Act, Medicare allowable capital-related costs are paid on a reasonable cost basis. Each IPF's payment for capital-related costs would be taken directly from the cost report and updated for inflation using the excluded capital market basket.

Step 4: IPF's Total (Operating and Capital-Related Costs) Payment Under the TEFRA Payment System

Once estimated payments for inpatient operating costs are determined (including bonus and relief payments, as appropriate), we would add the TEFRA adjusted operating payments and capital-related cost payments together to determine each IPF's total payments under the TEFRA payment system.

c. Payments Under the Proposed Prospective Payment System Without a Budget-Neutrality Adjustment

Payments under the proposed prospective payment system would be estimated without a budget-neutrality adjustment. We used $562 (the average cost per day consistent with the average cost per day used in the regression model) as the starting point for the Federal per diem base rate. By applying the aggregate cost increase factor using the applicable market basket increase factors, we updated the base rate to the April 1, 2004 through June 30, 2005 period. The updated cost per day of $671 was then used in the payment model to project future payments under the proposed IPF prospective payment system. The next step was to apply the associated proposed wage index and all applicable proposed patient-level and facility-level adjustments to determine the appropriate proposed prospective payment amount for each stay in the final payment model file.

We note that no separate wage or standardization factors were applied to the per diem amount used to derive the total proposed prospective payment system payments as these factors would be accounted for through the budget-neutrality computation described below. Thus, when the total proposed prospective payment system payments are compared to projected TEFRA payments, the resulting factor applied to the per diem amount would implicitly account for the effects of wage and standardization adjustments to the per diem costs.

d. Calculation of the Proposed Budget-Neutral Adjustment

In determining the proposed budget-neutrality factor, we compared the proposed prospective payment system amounts calculated from the psychiatric stays in the 1999 MedPAR file to the projected TEFRA payments from the

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

IPF wage indices, because there is not an IPF-specific wage index available. We believe that the inpatient acute care hospital wage data reflects wage levels similar to psychiatric units as well as free-standing psychiatric hospitals. We also believe that IPFs generally compete in the same labor market as inpatient acute care hospitals.

Furthermore, we are proposing to adjust the labor-related portion of the proposed prospective payment rates for area differences in wage levels by a factor reflecting the relative facility wage level in the geographic area of the IPF compared to the national average wage level for these hospitals. We believe that the actual location of the IPF as opposed to the location of affiliated providers is most appropriate for determining the wage adjustment because the data support the premise that the prevailing wages in the area in which the IPF is located influence the cost of a case. Thus, we are using the inpatient acute care hospital wage data without regard to any approved geographic reclassification as specified in section 1886(d)(8) or 1886(d)(10) of the Act. We note this policy is consistent with the area wage adjustments used in other non-acute care facility prospective payment systems.

To account for wage differences, we first identified the proportion of labor and non-labor components of costs. We used our proposed 1997-based excluded hospital market basket with capital to determine the labor-related share. We calculated the proposed labor-related share as the sum of the weights for those cost categories contained in the proposed 1997-based excluded hospital with capital market basket that are influenced by local labor markets. These cost categories include wages and salaries, employee benefits, professional fees, labor-intensive services, and a 46 percent share of capital-related expenses. The labor-related share for the base period of the proposed prospective payment system (April 1, 2004 through June 30, 2005) is the sum of the relative importance of each labor-related cost category for this period, and reflects the different rates of price change for these cost categories between the base year (FY 1997) and this period. The sum of the relative importance for operating costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) is 69.348 percent, as shown below in Table 6. The portion of capital that is influenced by local labor markets is estimated to be 46 percent. Because the relative importance of capital is 7.566 percent of the proposed 1997-based excluded hospital with capital market basket for the period April 1, 2004 through June 30, 2005, we would take 46 percent of 7.566 percent to determine the proposed labor-related share of capital. The result, 3.48 percent, is then added to the proposed 69.348 percent calculated for operating costs to determine the total proposed labor-related relative importance. The resulting labor-related share that we propose to use for the proposed IPF prospective payment system is 72.828 percent. The table below shows that the proposed labor-related share would have been 73.570 percent if we had not rebased the excluded hospital with capital market basket using more recent 1997 data rather than using 1992 data. As shown in Table 6, rebasing results in a lowering of the labor-related share by .742 percent.

TABLE 6.—PROPOSED LABOR-RELATED SHARE RELATIVE IMPORTANCE

Cost Category	Relative Importance 1992-based Market Basket (April 2004 to June 2005)	Relative Importance 1997-based Market Basket (April 2004 to June 2005)
Wages and salaries	50.714	49.158
Employee benefits	11.930	11.077
Professional fees	2.060	4.540
Postage	0.252	.....
All other labor intensive services	5.252	4.572
Subtotal	70.209	69.348
Labor-related share of capital costs	3.360	3.480
Total	73.570	72.828

A precedent exists for using this method to determine the proportion of payments adjusted for geographic differences in labor costs. Specifically, the labor-related share for acute care hospitals is determined from the prospective payment system hospital operating market basket using a similar method.

We believe that a wage index based on acute care hospital wage data is the best and most appropriate wage index to use in adjusting payments for IPFs, since both the acute care hospitals and IPFs compete in the same labor markets. This wage data includes the following categories of data: (1) Salaries and hours from short-term acute care hospitals; (2) home office costs and hours; (3) certain contract labor costs and hours; and (4) wage-related costs. The wage data excludes wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare Part B, because we would not cover these services under the proposed IPF prospective payment system.

Consistent with the wage index methodologies in other prospective payment systems, we are proposing to divide IPFs into labor market areas. For the purpose of defining labor market areas, we are proposing to define an urban area as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Office of Management and Budget (OMB). In addition, we are proposing to define a rural area as any area outside an urban area. The proposed IPFs wage indices would be computed as follows:

- Compute an average hourly wage for each urban and rural area.
- Compute a national average hourly wage.
- Divide the average hourly wage for each urban and rural area by the national average hourly wage.

The result is a proposed wage index for each urban and rural area (see Addendum B1 for the proposed wage index for urban areas and Addendum B2 for the proposed wage index for rural areas).

To calculate the wage-adjusted facility payments, we are proposing the following method: (1) Multiply the prospectively determined Federal base rate by the labor-related percentage to determine the labor-related portion; (2) multiply this labor-related portion by the applicable IPF wage index; and (3) add the resulting wage-adjusted labor-related portion to the nonlabor-related portion, resulting in a wage-adjusted base rate.

F. Effect of the Proposed Transition on Budget Neutrality

Section 124(a)(1) of Pub. L. 106–113 requires that the proposed IPF prospective payment system maintain budget neutrality. As discussed in further detail in section IV of this proposed rule, we are proposing a 3-year transition period from the cost-based TEFRA reimbursement to payment based on 100-percent prospective payment. During the transition period, we are proposing that an IPF would be paid a blend of an increasing percentage of the IPF Federal per diem payment amount and a decreasing percentage of its TEFRA rate for each discharge. Since the estimated prospective payments were calculated in a budget-neutral manner, this proposed transition methodology would result in the same total estimated payments that are expected under the current rules.

G. Calculation of the Proposed Payment

Payments under the proposed IPF prospective payment system would be determined by adjusting the per diem base amount by the appropriate wage index and applicable IPF prospective payment system payment adjustments and adding any applicable outlier amounts. An example of how to calculate payment under the proposed IPF prospective payment system follows.

Example: Jane Doe, a 78-year-old female, is admitted to a psychiatric unit within the Get Well General Hospital located in Richmond, Virginia. Ms. Doe presents with signs and symptoms indicating a primary diagnosis of Major Depressive Disorder (ICD–296.33, DRG–430). Her medical history includes Uncontrolled Type 1 Diabetes with Ophthalmic manifestations (ICD–250.53) and Chronic Renal Failure (ICD–585). Ms. Doe remains in the hospital for 5 days.

TABLE 7.—EXAMPLE OF PROPOSED PAYMENT

Steps To Determine the Proposed Per Diem Payment		
Federal Base Prospective Payment Rate:		
Calculate Wage Adjusted Federal Base Rate	.....	$530
Calculate the labor portion of the Federal base rate (.72828 × $530)	.....	386
Apply wage index factor from Addendum B1 for Richmond Virginia (0.9477 × $386)	$366	.....
Calculate the non-labor of the Federal base rate: (0.27172 × $530)	$144	.....
Calculate total wage-adjusted Federal base rate: ($366 + $144)	$510	.....
Apply Facility Level Adjusters:		
Teaching adjustment (not applicable)	.....	.....
Rural adjustment (not applicable)	.....	.....
Apply Patient Level Adjusters:		
DRG adjustment for DRG 430	1.00	.....
Age adjustment (over 65)	1.13	.....
Comorbidity adjusters:		
Diabetes	1.11	.....
Chronic renal failure	1.12	.....
Total prospective payment adjustment factor: (1.00 × 1.13 × 1.11 × 1.12):	1.405	.....
Calculate Wage Adjustment and Prospective Payment System Adjusted Federal Per Diem: ($510 × 1.405)	.....	716
Apply Variable Per Diem Adjustments:		
Day 1: (1.26 × $716)	$902	.....
Days 2 to 4: (1.12 × $716 x 3)	$2,406	.....
Day 5: (1.05 × $716)	$752	.....
The Total Proposed Prospective Payment System Payment for Jane Doe's IPF Stay	$4,060	.....

IV. Implementation of the Proposed IPF Prospective Payment System

We are proposing that payment to an IPF would convert to the IPF prospective payment system at the beginning of its first cost reporting period beginning on or after April 1, 2004.

A. Proposed Transition

We are proposing a 3-year transition to fully implement the IPF prospective payment system. During that time, we propose to use two payment percentages to determine an IPF's total payment under the proposed IPF prospective payment system. In addition, during the proposed transition, IPFs would receive a blended payment of the Federal per diem payment amount and a hospital-specific amount based on the IPF's TEFRA payment. As noted above, we are proposing that the system would become effective for cost reporting periods beginning on or after April 1, 2004.

As discussed in section V. of this proposed rule, we are proposing that the first year of the transition would continue for 15 months, thereby, moving the IPF prospective payment system to a July 1 update cycle. As a result, the first year of the transition period would be for cost reporting periods beginning on or after April 1, 2004 and before July 1, 2005. The total payment for this period would consist of 75 percent based on the TEFRA payment system and 25 percent based on the proposed IPF prospective payment amount. We are also proposing that for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2006, the total payment would consist of 50 percent based on the TEFRA payment system, and 50 percent based on the proposed IPF prospective payment amount. In addition, we are also proposing that for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007, the total payment would consist of 25 percent based on the TEFRA payment system and 75 percent based on the proposed IPF prospective payment amount. Thus, we are proposing that payments to IPFs would be at 100 percent of the proposed IPF prospective payment amount for cost reporting periods beginning on or after July 1, 2007. Given the complex and redistributive nature of the

proposed prospective payment system and in order to thoroughly review the anticipated volume of comments we expect to receive on this proposed rule, it may ultimately be necessary to delay implementation beyond April 2004. In addition, it may be helpful to increase the transition period because a longer transition period would allow us to adjust the payment system if necessary before the full implementation of the IPF prospective payment system. Also, a longer transition period may be appropriate if the research designed to refine the payment system takes longer than we currently anticipate. We specifically request public comments on these implementation issues.

In order to mitigate the impacts of the prospective payment system, we are not proposing to allow an IPF to elect to be paid based on 100 percent of the Federal per diem payment amount in lieu of the blended methodology. In this way, the transition will allow IPFs time to become familiar with the prospective payment system and gradually move to the full Federal per diem amount over a 3-year period.

B. New Providers

We believe that we need to propose a definition of a new IPF because new IPFs will not participate in the 3-year transition from cost-based reimbursement to a prospective payment system (section IV.A. of this proposed rule). The transition period described is intended to provide currently existing IPFs time to adjust to payment under the new system. A new IPF would not have received payment under TEFRA for the delivery of IPF services before the effective date of the IPF prospective payment system. We do not believe that new IPFs require a transition period in order to make adjustments to their operating and capital financing, as will IPFs that have been paid under TEFRA, or need to otherwise integrate the effects of changing from one payment system to another payment system.

For purposes of Medicare payment under the proposed IPF prospective payment system, we are defining a new IPF as a provider of inpatient psychiatric hospital services that otherwise meets the qualifying criteria for IPFs, set forth in § 412.22, § 412.23, § 412.25, and § 412.27 under present or previous ownership (or both), and its first cost reporting period as an IPF begins on or after April 1, 2004, the proposed implementation date of the IPF prospective payment system.

C. Claims Processing

With respect to the proposed IPF prospective payment system, we are proposing to continue processing claims in a manner similar to the current claims processing system. Hospitals would continue to report diagnostic information on the claim form and the Medicare fiscal intermediaries would continue to enter clinical and demographic information in their claims processing systems for review by the Medicare Code Editor (MCE). The MCE reviews claims to determine if they are improperly coded (for example, diagnosis inappropriate to sex of the patient) or require more information (imprecise coding) in order to be processed. After screening, each claim would be classified into the appropriate DRG by a software program called the ''GROUPER.'' If the ''GROUPER'' assigns a DRG that is not recognized under the proposed IPF prospective payment system, the claim would be returned to the IPF. If the ''GROUPER'' assigns a DRG recognized by the system, a ''PRICER'' program would calculate the Federal per diem payment amount, including the DRG adjustment and other patient-level and facility-level adjustments appropriate to the claim.

D. Periodic Interim Payments (PIP)

Under the TEFRA payment system—(1) a psychiatric hospital may be paid using the PIP method as specified in § 413.64(h); (2) psychiatric units are paid under the PIP method if the hospital of which they are a part is paid as specified in § 412.116(b); and (3) an IPF may be eligible to receive accelerated payments as specified in § 413.64(g) or for psychiatric units specified in § 412.116(f). We are proposing in § 412.432 to continue to allow for PIP and accelerated payment methods under the proposed IPF prospective payment system.

In addition, we are proposing that an IPF receiving prospective payments, whether or not it received a PIP under cost reimbursement, may receive a PIP if it meets the requirements specified in proposed § 412.432(b)(1) and receives approval by its intermediary. If an intermediary determines that an IPF, which received a PIP under cost reimbursement, is no longer entitled to receive a PIP, it will remove the IPF from the PIP method. As specified in proposed § 412.432(b)(1), intermediary approval of a PIP is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

Excluded from PIP amounts are outlier payments that are paid upon the submission of a discharge bill. Also, Part A costs that are not paid under the proposed IPF prospective payment system, including Medicare bad debts and costs of an approved education program, and other costs paid outside the IPF prospective payment system, will be subject to the interim payment provisions as specified in § 413.64.

Under the proposed prospective payment system, if an IPF is not paid under the PIP method it may qualify to receive an accelerated payment. As specified in proposed § 412.432(e), the IPF must be experiencing financial difficulties due to a delay by the intermediary in making payment to the IPF, or there is a temporary delay in the IPFs preparation and submittal of bills to the intermediary beyond its normal billing cycle, because of an exceptional situation. A request for an accelerated payment must be made by the IPF and approved by the intermediary and us. The amount of an accelerated payment would be computed as a percentage of the net payment for unbilled or unpaid covered services. Recoupment of an accelerated payment would be made as bills are processed or by direct payment by the IPF.

E. Limitation on Beneficiaries Charges

In accordance with § 409.82 and § 409.83 and consistent with other established prospective payment systems policies, we are proposing in § 412.404(c) that an IPF may not charge a beneficiary for any service for which payment is made by Medicare. This policy will apply, even if the IPF's costs of furnishing services to that beneficiary are greater than the amount the IPF would be paid under the proposed IPF prospective payment system. In addition, we are proposing that an IPF receiving a prospective payment for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts as specified in § 409.82, § 409.83, § 409.87, and § 489.20.

V. Future Updates

A. Proposed Annual Update Strategy

Section 124 of Pub. L. 106–113 does not specify an update strategy for the proposed IPF prospective payment system and is broadly written to give the Secretary a tremendous amount of discretion in proposing an update methodology. Therefore, we reviewed the update approach used in other hospital prospective payment systems

(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 used 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).

However, other variables are not collected on claims (Global Assessment of Functioning scores and functional deficits, such as, activities of daily living). This limited set of candidate variables was selected with input from RTI International's® technical evaluation panel. We will continue to investigate the functional status, and we are soliciting comments specifically on this issue.

c. Analysis

Using a cluster analysis technique, RTI International® will attempt to develop an index that could be highly predictive of resource use among the resulting psychiatric patient classification categories.

The RTI International® is also investigating whether a more refined payment model is possible. Such a model might reduce the need for a sophisticated psychiatric patient classification system. Currently, data are being collected for a 7-day period to analyze the change in resources over time. This study will allow a test of a hypothesis advocated by Frank, R.G., and Lave, HR. (1986). Journal of Human Resources, 21(3): (321–337). They suggested that when using a per diem rate that declines with the length of stay, the rate would be higher at the beginning of the stay to cover the higher costs associated with admission, and decline over time as treatment achieved stabilization of the patient's condition.

2. University of Michigan Research

We are also currently contracting with the University of Michigan's Public Health Institute to conduct research to assist us in developing a patient classification system based on a standard assessment tool. We believe that additional patient level information such as patient functioning and patient resource use is necessary to augment our administrative data and would result in a more equitable and accurate payment system. We are in the early stages of developing a preliminary tool, the Case Mix Assessment Tool (CMAT) instrument. We have attached a draft copy to this proposed rule for review and comment (*see* Addendum C.).

We believe that this assessment tool would collect minimal but necessary information. The draft instrument contains 36 questions. Each item in the draft assessment tool resulted from the University of Michigan's evaluation of existing instruments and clinical scales. It reflects the input and feedback to the contractor of both the technical evaluation panel and mental health associations as well as related psychological and psychiatric industry groups. This input included mental health professionals with experience in both payment methodology and assessment instruments. The tool would collect information on the patient characteristics, clinical characteristics, functional status, services, and treatments.

The information that would be collected in the CMAT is available in the patient's medical record and treatment plans. We do not believe that completing the assessment tool would require additional data collection on the part of the clinical staff. We have assumed that in addition to the medical record, a team of clinical staff provides services and treatment to these patients, including but not limited to nurses, psychiatric nurses, physicians, clinical psychologists, social workers, psychiatrists, and rehabilitation, physical, and speech therapists. To reduce both the complexity of the information collection process and the burden, the instrument would be completed at discharge. We are requesting comments on the availability of the information to complete this instrument.

In order to collect information in the most efficient manner possible, the CMAT would be automated. This approach would shorten the time to complete the instrument and simplify the input process. Upon completion, the instrument would be transmitted to us. We would develop and provide the software to perform the transmission to IPFs at no cost. In addition, we would provide training and manuals to facilitate both the transmission process and the completion of the assessment tool.

Finally, once the instrument has been pilot-tested and the instrument reflects changes resulting from this testing, we would pursue clearance by the Office of Management and Budget (OMB). A detailed OMB information collection package will be prepared and available for public comment. The package will include delineation of the technical evaluation panel membership, comments on specific items in the instrument, justifications for including selected questions (for example, activities of daily living), and the scaling for individual items. In addition, the OMB package will contain manuals and training material that support the instrument. Any comments on this preliminary draft instrument will assist us in developing a potential instrument.

3. Case-Mix Tool

The Ashcraft study used a patient assessment instrument to develop additional variables beyond psychiatric diagnosis to predict differences in the length of stay. The study led to a further effort (Fries, *et al.*, 1990), which resulted in the development of a classification system for long stay Veterans Administration's psychiatric patients (length of stay greater than 100 days). This research was the first to consider which characteristics could explain measured resource use for chronic psychiatric residents. Those characteristics included a broad assessment of patients' medical conditions, functional status, mental deficits, treatments, as well as the direct measurement of daily staff time spent with each patient. Using only six patient categories developed from these variables, the resulting long-stay classification system (PPCs) explained 11.4 percent of the variability in per diem resource use. While this number seems low, the Ashcraft and Fries Veterans Administration's studies were the first to offer a patient assessment instrument approach for the construction of case mix measures potentially useful in an IPF prospective payment system.

VI. Provisions of the Proposed Rule

We are proposing to make a number of revisions to the regulations in order to implement the proposed prospective payment system for IPFs. Specifically, we are proposing to make conforming changes in 42 CFR parts 412 and 413. We would establish a new subpart N in part 412, ''Prospective Payment System for Hospital Inpatient Services of Psychiatric Facilities.'' This subpart would implement section 124 of the BBRA, which requires the implementation of a per diem prospective payment system for IPFs. This subpart would set forth the framework for the proposed IPF prospective payment system, including the methodology used for the development of the payment rates and related rules. These proposed revisions and others are discussed in detail below.

Section 412.1 Scope of Part

We propose to revise § 412.1 by redesignating paragraphs (a)(2) and (a)(3) as paragraphs (a)(3) and (a)(4).

We propose to add a new paragraph (a)(2) that would specify that this part implements section 124 of Pub. L. 106–113 by establishing a per diem based prospective payment system for inpatient operating and capital costs of hospital inpatient services furnished to Medicare beneficiaries by a psychiatric facility that meets the conditions of subpart N.

We propose to revise § 412.1 by redesignating paragraphs (b)(12) and (b)(13) as paragraphs (b)(13) and (b)(14).

We propose to add a new paragraph (b)(12) that would summarize the content of the new subpart N which sets forth the general methodology for paying operating and capital costs for inpatient psychiatric facilities effective with cost reporting periods beginning on or after April 1, 2004.

Section 412.20 Hospital Services Subject to the Prospective Payment Systems

We propose to amend § 412.20(a) by adding a reference to IPFs.

We propose to revise § 412.20 by redesignating paragraphs (b), (c), and (d), as paragraphs (c), (d), and (e).

We propose to add a new paragraph (b) that would indicate that effective for cost reporting periods beginning on or after April 1, 2004, covered hospital inpatient services furnished by a psychiatric facility as specified in § 412.404 of subpart N are paid under the prospective payment system.

Section 412.22 Excluded Hospitals and Hospital Units: General Rules

We propose to amend § 412.22(b) by revising paragraph (b) to state that except for those hospitals specified in paragraph (c) of this section, and § 412.20(b), (c), and (d), all excluded hospitals (and excluded hospital units, as described in § 412.23 through § 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this chapter, and are subject to the ceiling on the rate of hospital cost increases as specified in § 413.40.

Section 412.23 Excluded Hospitals: Classifications

We propose to revise § 412.23 by redesignating paragraphs (a)(1) and (a)(2) as paragraphs (a)(2) and (a)(3).

We propose to add a new paragraph (a)(1) that would specify the requirements a psychiatric hospital must meet in order to be excluded from reimbursement under the prospective payment system as specified in § 412.1(a)(1) and to be paid under the IPF prospective payment system as specified in § 412.1(a)(2).

Section 412.25 Excluded Hospital Units: Common Requirements

We propose to amend § 412.25(a) by adding a reference to § 412.1(a)(2).

Section 412.27 Excluded Psychiatric Units: Additional Requirements

We propose to amend the introductory text of § 412.27 by adding the reference to § 412.1(a)(1) and (a)(2).

We propose to amend § 412.27(a) by removing the words the ''Third Edition,'' and adding in its place, ''Fourth Edition, Text Revision.''

Section 412.116 Method of Payment

We propose to revise § 412.116 by redesignating paragraphs (a)(3) and (a)(4) as paragraphs (a)(4) and (a)(5).

We propose to add a new paragraph (a)(3) that would specify the cost reporting period to which the proposed IPF prospective payment system applies and how payments for inpatient psychiatric services are made to a qualified IPF.

Subpart N—Prospective Payment System for Hospital Inpatient Services of Psychiatric Facilities

We propose to add a new subpart N as follows:

Section 412.400 Basis and Scope of Subpart

We are proposing to add a new section § 412.400. In § 412.400(a), we would provide the requirements for the implementation of a prospective payment system for IPFs.

In proposed § 412.400(b), we would specify that this subpart sets forth the framework for the prospective payment system, including the methodology used for the development of payment rates and associated adjustments, the application of a transition period, and the related rules for IPFs for cost reporting periods beginning on or after April 1, 2004.

Section 412.402 Definitions

In § 412.402, we are proposing to define the following terms for purposes of this new subpart:

- *Comorbidity.*
- *Fixed dollar loss threshold.*
- *Inpatient psychiatric facilities.*
- *Interrupted stay.*
- *Outlier payment.*
- *Per diem payment amount.*
- *Principal diagnosis.*
- *Rural area.*
- *Urban area.*

Section 412.404 Conditions for Payment Under the Prospective Payment System for Hospital Inpatient Services of Psychiatric Facilities

In proposed § 412.404(a), we would specify that IPFs must meet the following general requirements to receive payment under the IPF prospective payment system:

- The IPF must meet the conditions as specified in this subpart.
- If the IPF fails to comply fully with the provisions of this part then the following are applicable—

++ Withhold (in full or in part) or reduce payment to the IPF until the facility provides adequate assurances of compliance; or

++ Classify the IPF as an hospital subject to the hospital inpatient prospective payment system.

In proposed paragraph (b), we would specify that, subject to the special payment provisions of § 412.22(c), an inpatient psychiatric facility must meet the general criteria set forth in § 412.22. For exclusion from the hospital inpatient prospective payment system as specified in § 412.1(a)(1), a psychiatric hospital must meet the criteria set forth in § 412.23(a) and psychiatric units must meet the criteria set forth in § 412.25 and § 412.27.

In proposed paragraph (c), we would specify the prohibited and permitted charges that may be imposed on Medicare beneficiaries.

In proposed paragraph (c)(1), we would specify that an IPF may not charge the beneficiary for any services which payment is made by Medicare, even if the IPFs costs are greater than the amount the facility is paid under the IPF prospective payment system.

In proposed paragraph (c)(2), we would specify that an IPF receiving payment for a covered stay may charge the Medicare beneficiary or other person for only the applicable deductible and coinsurance amounts under § 409.82, § 409.83, and § 409.87.

In proposed paragraph (d), we would specify the following provisions for furnishing IPF services directly or under arrangement:

- Applicable payments made under the IPF prospective payment system are considered payment in full for all hospital inpatient services (as defined in § 409.10) other than physicians' services to individual patients (as specified in § 415.102(a)) that are reimbursed on a fee schedule basis.
- Hospital inpatient services do not include physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwives, qualified psychologist, and certified registered nurse anesthetist services.
- Payment is not made to a provider or supplier other than the IPF, except for services provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwives, qualified psychologist, and certified registered nurse anesthetist.
- The IPF must furnish all necessary covered services to the Medicare beneficiary directly or under arrangement (as defined in § 409.3).

In proposed paragraph (e), we would specify that IPFs must meet the recordkeeping and cost reporting

requirements of § 412.27(c), § 413.20, and § 413.24.

Section 412.422 Basis of Payment

In proposed § 412.422(a), we would specify that under the prospective payment system, IPFs would receive a predetermined per diem amount, adjusted for patient characteristics and facility characteristics, for inpatient services furnished to Medicare beneficiaries. In addition, we would specify that during the transition period, payment would be based on a blend of the Federal per diem payment amount and the facility-specific payment rate.

In proposed § 412.422(b), we would specify that payments made under the prospective payment system represent payment in full for inpatient operating and capital-related costs associated with services furnished in an IPF but not for the cost of an approved medical education program described in § 413.85 and § 413.86 and for bad debts of Medicare beneficiaries as specified in § 413.80.

Section 412.424 Methodology for Calculating the Federal Per Diem Payment Rate

In proposed § 412.424, we would specify the methodology for calculating the Federal per diem payment rate for IPFs.

In proposed paragraph (a), we would specify the data sources used to calculate the prospective payment rate.

In proposed paragraph (b), we would specify that the methodology used for determining the Federal per diem base rate would include the following:

- The updated average per diem amount.
- The budget-neutrality adjustment factor.

In proposed paragraph (c), we would specify that the Federal per diem payment amount for IPFs would be the product of the Federal per diem base rate, the facility-level adjustments, and the patient-level adjustments applicable to the case as described below:

- Facility-level adjustments include:
- Adjustment for wages
- Location in rural areas
- Teaching status
- Patient-level adjustments include:
- Age
- Principal diagnosis
- Comorbodities
- Variable per diem adjustments
- Adjustment for high-cost outlier cases

In proposed paragraph (d), we would specify the special payment provisions for interrupted stays.

Section 412.426 Transition Period

In proposed § 412.426(a), we would specify the duration of the transition period to the IPF prospective payment system. In addition, we would specify that IPFs would receive a payment that is a blend of the Federal per diem payment amount and the facility-specific payment amount the IPF would receive under the TEFRA payment methodology.

In proposed paragraph (b), we would specify how the facility-specific payment amount is calculated.

In proposed paragraph (c), we would specify that new IPFs, that is, facilities that under present or previous ownership, or both, have its first cost reporting period as an IPF beginning on or after April 1, 2004, are paid the full Federal per diem rate.

Section 412.428 Publication of the Federal Per Diem Payment Rates

In proposed § 412.428, we would specify how we plan to publish information each year in the **Federal Register** to update the IPF prospective payment system.

Section 412.432 Method of Payment Under the Inpatient Psychiatric Facility Prospective Payment System

In proposed § 412.432, we would specify the following method of payment used under the IPF prospective payment system:

- General rules for receiving payment.
- Periodic interim payments including—
  - Criteria for receiving periodic interim payments
  - Frequency of payments
  - Termination of periodic interim payments
- Interim payment for Medicare bad debts and for costs not paid under the prospective payment system and other costs paid outside the prospective payment system.
- Outlier payments.
- Accelerated payments including—
  - General rule for requesting accelerated payments
  - Approval of accelerated payments
  - Amount of the accelerated payment
  - Recovery of the accelerated payment

Section 413.1 Introduction

We propose to amend § 413.1(d)(2)(ii) by removing the words ''psychiatric hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals).''

We propose to revise § 413.1 by redesignating paragraphs (d)(2)(iv), (d)(2)(v), (d)(2)(vi), and (d)(2)(vii) as paragraphs (d)(2)(vi), (d)(2)(vii), (d)(2)(viii), and (d)(2)(ix).

We propose to add a new paragraph (iv) that would specify that for cost reporting periods beginning before April 1, 2004, payment to psychiatric hospitals (as well as separate psychiatric units of short-term general hospitals) that are excluded under subpart B of part 412 of this chapter from the prospective payment system is on a reasonable cost basis, subject to the provisions of § 413.40.

We propose to add a new paragraph (v) that would specify that for cost reporting periods beginning on or after April 1, 2004, payment to psychiatric hospitals (as well as separate psychiatric units of short-term general hospitals) that meet the conditions of § 412.404 of this chapter is based on prospectively determined rates under subpart N of part 412.

Section 413.40 Ceiling on the Rate of Increase in Hospital Costs

Section 413.40(a)(2)(i) specifies the types of facilities to which the ceiling on the rate of increase in hospital inpatient costs is not applicable.

We propose to revise § 413.40(a)(2)(i) by redesignating paragraphs (a)(2)(i)(C) and (a)(2)(i)(D) as paragraphs (a)(2)(i)(D) and (a)(2)(i)(E).

We propose to add a new paragraph (C) to § 413.40 to clarify that § 413.40 is not applicable to psychiatric hospitals and psychiatric units under subpart N of part 412 of this chapter for cost reporting periods beginning on or after April 1, 2004.

We propose to revise paragraph (a)(2)(ii)(B) to specify the facilities to which the ceiling applies for cost reporting periods beginning on or after October 1, 1983 through March 31, 2004.

We propose to revise paragraph (a)(2)(iii) by redesignating paragraphs (a)(2)(iii) and (a)(2)(iv) as paragraphs (a)(2)(iv) and (a)(2)(v).

We propose to add a new paragraph (a)(2)(iii) that would specify psychiatric facilities are excluded from the prospective payment system as specified in § 412.1(a)(1) and paid under § 412.1(a)(2) for cost reporting periods beginning on or after April 1, 2004.

Section 413.64 Payment to Providers: Special Rules

We propose to amend § 413.64(h)(2)(i) by adding a reference to hospitals paid under the IPF prospective payment system.

Section 424.14 Requirements for Inpatient Services of Psychiatric Hospitals

We propose to amend § 424.14 by adding a new paragraph (c)(3) to state that for recertification a physician must indicate 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 be provided only on a inpatient basis.

We propose to amend § 424.14(d)(2) by removing the word ''18th day of hospitalization'' and replacing it with ''10th day of hospitalization.''

VII. Collection of Information Requirements

These regulations do not impose any new information collection requirements. The burden of the requirements in § 412.404(e), reporting and recordkeeping requirements, are captured in the burden for the cross-referenced § 412.27(c), § 413.20, and § 413.24 under OMB approval numbers 0938–0301, 0938–0500, 0938–0358, and 0938–0600.

VIII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this proposed rule, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

IX. Regulatory Impact Statement

A. Overall Impact

We have examined the impact of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of the Act, the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4), and Executive Order 13132).

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). Based on analysis of the aggregate dollar impacts for each of the different facility types, we have determined that the re-distributive impact among facility types is $78 million. In addition, our analysis showed that a payment reduction of $40 million would occur for psychiatric units and a payment increase of $10 million would occur for-profit hospitals, $26 million for government hospitals, and $2 million for non-profit hospitals. Therefore, we have determined that this proposed rule would not be a major rule within the meaning of Executive Order 12866 because the redistributive effects do not constitute a shift of $100 million in any 1 year. In addition, because the proposed IPF prospective payment system must be budget neutral in accordance with section 124(a)(1) of Pub. L. 106–113, we estimate that there will be no budgetary impact for the Medicare program (section IX.B.6. of this proposed rule).

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $29 million or less in any 1 year. Medicare fiscal intermediaries are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

HHS considers that a substantial number of entities are affected if the rule impacts more than 5 percent of the total number of small entities as it does in this rule. We included all freestanding psychiatric hospitals (88 are nonprofit hospitals) in the analysis since their total revenues do not exceed the $29 million threshold. We also included small psychiatric units as well as psychiatric units of small hospitals, that is, fewer than 100 beds. We did not include psychiatric units within larger hospitals in the analysis because we believe this proposed rule would not significantly impact total revenues of the entire hospital that supports the unit. We have provided the following RFA analysis in section B, to emphasize that although the proposed rule would impact a substantial number of IPFs that were identified as small entities, we do not believe it would have a significant economic impact. Based on the analysis of the 917 psychiatric facilities that were classified as small entities by the definitions described above, we estimate the combined impact of the proposed rule would be a 1-percent increase in payments relative to their payments under TEFRA. This estimated impact does not meet the threshold established by HHS to be considered a significant impact. Nonetheless, we have prepared the following analysis to describe the impact of the proposed rule.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an MSA and has fewer than 100 beds. We have determined that this proposed rule would have a substantial impact on hospitals classified as located in rural areas. As discussed earlier in this preamble, we are proposing to adjust payments by 16 percent for IPFs located in rural areas. In addition, we are proposing a 3-year transition to the new system to allow IPFs an opportunity to adjust to the new system. Therefore, the impacts shown in Table 8 below reflect the adjustments that are designed to minimize or eliminate the negative impact that the proposed IPF prospective payment may otherwise have on small rural IPFs.

Section 202 of the UMRA also requires that agencies assess anticipated costs and benefits before issuing any proposed rule that may result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million or more. This proposed rule does not mandate any requirements for State, local, or tribal governments nor would it result in expenditures by the private sector of $110 million or more in any 1 year.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this proposed rule under the criteria set forth in Executive Order 13132 and have determined that this proposed rule will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments or preempt State law.

B. Anticipated Effects

Below, we discuss the impact of this proposed rule on the Federal Medicare budget and on IPFs.

1. Budgetary Impact

Section 124(a)(1) of Pub. L. 106–113 requires us to set the payment rates contained in this proposed rule to ensure that total payments under the IPF prospective payment system are projected to equal the amount that would have been paid if this proposed prospective payment system had not been implemented. As a result of this analysis, which is discussed in section III of this proposed rule, we are proposing a budget-neutrality adjustment to the Federal per diem base rate. Thus, there will be no budgetary impact to the Medicare program by implementation of the proposed IPF prospective payment system.

2. Impacts on Providers

To understand the impact of the proposed IPF prospective payment system on providers, it is necessary to estimate payments that would be made under the current TEFRA payment methodology (current payments) and payments under the proposed IPF prospective payment system. The IPFs were grouped into the categories listed below based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the 1999 cost report data from HCRIS:

- Facility Type
- Location
- Teaching Status
- Census Region
- Size

To estimate the impacts among the various categories of IPFs, we had to compare estimated future payments that would have been made under the TEFRA payment methodology to estimated payments under the proposed IPF prospective payment system. We estimated the impacts using the same set of providers (1,975 IPFs) that was used for the regression analysis to calculate the budget-neutral Federal per diem base rate, and to determine the appropriateness of various adjustments to the Federal per diem base rate. A detailed explanation of the methods we used to simulate TEFRA payments and estimated payments under the proposed IPF prospective payment system is provided in section III.C. of this proposed rule.

The impacts reflect the estimated ''losses'' or ''gains'' among the various classifications of IPF providers for the first year of the proposed IPF prospective payment system. Proposed prospective payments were based on the proposed budget-neutral Federal per diem base rate of $530 adjusted by the IPFs' estimated patient-level, facility-level adjustments, and simulated outlier amounts. This payment was compared to the IPF's payments based on its cost from the cost report inflated to the midpoint of the effective period (April 1, 2004 through June 30, 2005) and subject to the updated per discharge target amount.

Table 8 below illustrates the aggregate impact of the proposed IPF prospective payment system on various classifications of IPFs. The first column identifies the type of IPF, the second column indicates the number of IPFs for each type of IPF, and the third column indicates the ratio of the proposed IPF prospective payment system payments to the current TEFRA payments in the first year of the transition.

TABLE 8.—AGGREGATE IMPACT

Facility by type	Number of facilities	Ratio of proposed prospective payment amount to TEFRA payment with transition
All Facilities	1975	1.00
By Type of Ownership:		
Psychiatric Hospitals		
Government	181	1.14
Non-profit	88	1.01
For-profit	236	1.02
Psychiatric Units	1470	0.99
All Facilities	1975	1.00
Rural	445	0.99
Urban	1530	1.00
By Urban or Rural Classification:		
Urban by Facility Type		
Psychiatric Hospitals:		
Government	138	1.14
Non-profit	80	1.01
For-profit	221	1.02
Psychiatric Units	1091	0.99
Rural by Facility Type:		
Psychiatric Hospitals:		
Government	43	1.14
Non-profit	8	0.99
For-profit	15	1.02
Psychiatric Units	379	0.98
By Teaching Status:		
Non-teaching	1676	0.99
Less than 10% interns and residents to beds	163	1.02
10% to 30% interns and residents to beds	80	1.02
More than 30% interns and residents to beds	56	1.03
By Region:		
New England	128	0.99
Mid-Atlantic	316	1.04

TABLE 8.—AGGREGATE IMPACT—Continued

Facility by type	Number of facilities	Ratio of proposed prospective payment amount to TEFRA payment with transition
South Atlantic	283	1.00
East North Central	369	0.98
East South Central	161	0.99
West North Central	174	0.99
West South Central	270	0.97
Mountain	88	1.00
Pacific	181	1.00
By Bed Size:		
Psychiatric Hospitals:		
Under 10 beds	2	0.99
10 to 25 beds	36	0.99
25 to 50 beds	71	1.01
50 to 100 beds	199	1.02
100 to 200 beds	127	1.05
200 to 400 beds	49	1.10
Over 400 beds	21	1.19
Psychiatric Units		
Under 10 beds	55	0.96
10 to 25 beds	749	0.97
25 to 50 beds	443	0.98
50 to 100 beds	184	1.00
100 to 200 beds	32	1.02
200 to beds 400	6	1.07
Over 400 beds	1	1.12

3. Results

We measured the impact of the proposed IPF prospective payment system by comparing proposed payments under the IPF prospective payment system relative to current TEFRA payments. This was computed as a ratio of the proposed prospective payment to the current TEFRA payment for each classification of IPF. We have prepared the following summary of the impact of the proposed IPF prospective payment system set forth in this proposed rule.

a. Facility type

We grouped the IPFs into the following four categories: (1) Psychiatric units; (2) government hospitals; (3) for-profit hospitals; and (4) non-profit hospitals. Roughly 75 percent of all IPFs are psychiatric units. The impact analysis in Table 8 indicates that under the proposed IPF prospective payment system, freestanding psychiatric hospitals would receive an increase relative to the current payment. The psychiatric units would have a proposed prospective payment to the current TEFRA payment ratio of 0.99, the government hospitals would have a proposed prospective payment to the current TEFRA payment ratio of 1.14, and the non-profit and for-profit hospitals would have a proposed prospective payment to the current TEFRA payment ratio of 1.01 and 1.02, respectively.

b. Location

Approximately 23 percent of all IPFs are located in rural areas. The impact analysis in Table 8 indicates that under the proposed IPF prospective payment system, the proposed prospective payment to the current TEFRA payment ratio would be approximately 0.99 for rural IPFs and 1.00 for urban IPFs. If we grouped all of the IPFs by facility type within urban and rural locations, the impact analysis would indicate that the estimated proposed prospective payment to current TEFRA payment ratios would be between approximately 0.98 and 1.02 for all IPFs except government hospitals. Under the proposed IPF prospective payment system, the payment ratios for rural and urban government hospitals are both estimated to be approximately 1.14.

c. Teaching Status

Using the ratio of interns and residents to the average daily census for each facility as a measure of the magnitude of the teaching status, we grouped facilities into the following four major categories: (1) non teaching; (2) less than 10 percent ratio of interns and residents to average daily census; (3) 10 to 30 percent ratio of interns and residents to average daily census; and (4) more than 30 percent of interns and residents to average daily census. Facilities that are classified with a teaching ratio greater than 0 percent would benefit under the proposed IPF prospective payment system.

d. Census Region

Under the proposed IPF prospective payment system, IPFs in the Mid-Atlantic region would receive a higher payment ratio of approximately 1.04. IPFs in other regions would receive payment ratios between approximately 0.97 and 1.00. Specifically, the South Atlantic States, the Mountain States, and the Pacific States would receive payment ratios of 1.00. The New England States, East South Central States, and the West North Central States, would receive payment ratios of approximately 0.99. The proposed IPF prospective payments would be slightly lower than 0.99 for IPFs in the West South Central and East North Central States.

e. Size

We grouped the IPFs into 7 categories for each group of psychiatric facilities based on bed size: (1) Under 10 beds; (2) 10 to 25 beds; (3) 25 to 50 beds; (4) 50 to 100 beds; (5) 100 to 200 beds; (6) 200 to 400 beds; and (7) over 400 beds. Under the proposed IPF prospective

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

system, we believe that the proposed payment system appropriately accommodates the higher costs of those psychiatric units with a more complex case-mix. The proposed DRG and comorbidity payment adjustments, the proposed 3-year transition period that would allow a gradual phase-in of the proposed IPF prospective payment system, and the proposed outlier payment policy would ensure that those psychiatric units with more costly, resource-intensive cases are not unfairly disadvantaged.

Although the use of a psychiatric unit adjustment in connection with the proposed IPF prospective payment system was described in our August 21, 2002 Report to the Congress as a potential payment option, as discussed in section III.B.2. of this proposed rule, we have not adopted this approach.

• Another option we considered was a facility model based on the IPF's historical payment and patient mix.

In order to address the limitation of routine cost data that is discussed in section III.B. of this proposed rule, we considered a model based on facility-level routine costs and patient-level ancillary costs separately. Under this model, the variables in the facility routine cost regression are defined differently than in the ancillary cost and proposed rule regressions. For example, in the ancillary cost regression, length of stay is each patient's length of stay, but in the routine cost regression it is the facility's average length of stay. Similarly, in the ancillary cost regression, the age variable indicates whether an individual patient is over 65 years of age, but in the routine cost regression it indicates the percentage of the facility's patients who are over 65 years of age. This difference in the routine and ancillary cost regressions also applies to the comorbidity and DRG variables. These differences in measurement mean that the coefficient values of these variables are not directly comparable between the facility-level routine cost regression and the patient-level regression for ancillary cost or total cost. In addition, operationalizing this model would present claims processing and systems issues to keep the facility-level data up to date. Therefore, we rejected this approach.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT PSYCHIATRIC SERVICES

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provisions

2. Section 412.1 is amended as follows:

a. Redesignating paragraphs (a)(2) and (a)(3) as paragraphs (a)(3) and (a)(4).

b. Adding a new paragraph (a)(2).

c. Redesignating paragraphs (b)(12) and (b)(13) as paragraphs (b)(13) and (b)(14).

d. Adding a new paragraph (b)(12).

The additions read as follows:

§ 412.1 Scope of part.

(a) * * *

(2) This part implements section 124 of Public Law 106–113 by establishing a per diem prospective payment system for the inpatient operating and capital costs of hospital inpatient services furnished to Medicare beneficiaries by a psychiatric facility that meets the conditions of subpart N of this part.

* * * * *

(b) * * *

(12) Subpart N describes the prospective payment system specified in paragraph (a)(2) of this section for inpatient psychiatric facilities and sets forth the general methodology for paying the operating and capital-related costs of hospital inpatient services furnished by inpatient psychiatric facilities effective with cost reporting periods beginning on or after April 1, 2004.

* * * * *

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital Related Costs

3. Section 412.20 is amended as follows:

a. Revising paragraph (a).

b. Redesignating paragraphs (b), (c), and (d) as paragraphs (c), (d), and (e).

c. Adding a new paragraph (b).

The revision and addition read as follows:

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b), (c), (d), and (e) of this section, all covered hospital inpatient services furnished to beneficiaries during the subject cost reporting periods are paid under the prospective payment system as specified in § 412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after April 1, 2004, covered hospital inpatient services furnished to Medicare beneficiaries by an inpatient psychiatric facility that meets the conditions of § 412.404 are paid under the prospective payment system described in subpart N of this part.

* * * * *

4. Section 412.22 is amended by revising paragraph (b).

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section, and § 412.20(b), (c), and (d), all excluded hospitals (and excluded hospital units, as described in § 412.23 through § 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this chapter, and are subject to the ceiling on the rate of hospital cost increases as specified in § 413.40 of this chapter.

* * * * *

5. Section 412.23 is amended as follows:

a. Republishing paragraph (a) introductory text.

b. Redesignating paragraphs (a)(1) and (a)(2) as paragraphs (a)(2) and (a)(3).

c. Adding a new paragraph (a)(1).

The republication and addition read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(a) *Psychiatric hospitals.* A psychiatric hospital must—

(1) Meet the following requirements to be excluded from the prospective

payment system as specified in § 412.1(a)(1) and to be paid under the prospective payment system as specified in § 412.1(a)(2) and in subpart N of this part;

* * * * *

6. Section 412.25 is amended by revising the paragraph (a) introductory text to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment systems as specified in § 412.1(a)(1) and to be paid under the inpatient prospective payment system as specified in 412.1(a)(2), a psychiatric unit must meet the following requirements.

* * * * *

§ 412.27 [Amended]

7. Section 412.27 is amended as follows:

a. Revising the introductory text.

b. Amending paragraph (a) by removing the words ''Third Edition'', and adding in its place, ''Fourth Edition, Text Revision''.

The revision reads as follows:

§ 412.27 Excluded psychiatric units: Additional requirements.

In order to be excluded from the prospective payment system as specified in § 412.1(a)(1), and paid under the inpatient psychiatric prospective payment system as specified in § 412.1(a)(2), a psychiatric unit must meet the following requirements:

* * * * *

8. Section 412.116 is amended as follows:

a. Redesignating paragraphs (a)(3) and (a)(4) as paragraphs (a)(4) and (a)(5).

b. Adding a new paragraph (a)(3).

The addition reads as follows:

§ 412.116 Method of payment.

(a) * * *

(3) For cost reporting periods beginning on or after April 1, 2004, payments for hospital inpatient services furnished by a psychiatric hospital and psychiatric unit that meet the conditions of § 412.404 are made as described in § 412.432.

* * * * *

9. A new subpart N is added to read as follows:

Subpart N—Prospective Payment System for Hospital Inpatient Services of Psychiatric Facilities.

Sec.

412.400 Basis and scope of subpart.
412.402 Definitions.
412.404 Conditions for payment under the prospective payment system for hospital inpatient services of psychiatric facilities.
412.422 Basis of payment.
412.424 Methodology for calculating the Federal per diem payment rates.
412.426 Transition period.
412.428 Publication of the Federal per diem payment rates.
412.432 Method of payment under the inpatient psychiatric facility prospective payment system.

Subpart N—Prospective Payment System for Hospital Inpatient Services of Psychiatric Facilities.

§ 412.400 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 124 of Public Law 106–113, which provides for the implementation of a per diem based prospective payment system for inpatient psychiatric hospitals and psychiatric units (inpatient psychiatric facilities).

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for inpatient psychiatric facilities, including the methodology used for the development of the per diem rate and associated adjustments, the application of a transition period, and the related rules. Under this system, for cost reporting periods beginning on or after April 1, 2004, payment for the operating and capital-related costs of hospital inpatient services furnished by inpatient psychiatric facilities is made on the basis of prospectively determined rates and applied on a per diem basis.

§ 412.402 Definitions.

As used in this subpart—

Comorbidity means all specific patient conditions that are secondary to the patient's primary diagnosis and that coexists at the time of admission, develop subsequently, or that affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.

Fixed dollar loss threshold means a dollar amount by which the costs of a case exceed payment in order to qualify for an outlier payment.

Inpatient psychiatric facilities means hospitals that meet the requirements as specified in § 412.22, § 412.23(a) and units that meet the requirements as specified in § 412.22, § 412.25, and § 412.27.

Interrupted stay means a Medicare inpatient is discharged from the inpatient psychiatric facility and returns to the same inpatient psychiatric facility within 5 consecutive calendar days. The 5 consecutive calendar days begin with the day of discharge.

Outlier payment means an additional payment beyond the Federal prospective payment amount for cases with unusually high costs.

Per diem payment amount means payment based on the average cost of 1 day of inpatient psychiatric services.

Principal diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the inpatient psychiatric facility.

Rural area means an area as defined in § 412.62(f)(1)(iii).

Urban area means an area as defined in § 412.62(f)(1)(ii).

§ 412.404 Conditions for payment under the prospective payment system for hospital inpatient services of psychiatric facilities.

(a) *General requirements.* (1) Effective for cost reporting periods beginning on or after April 1, 2004, an inpatient psychiatric facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for hospital inpatient services furnished in psychiatric facilities to Medicare beneficiaries.

(2) If an inpatient psychiatric facility fails to comply fully with these conditions, CMS may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient psychiatric facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient psychiatric facility as a hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment system as specified in § 412.1(a)(1).

(b) *Inpatient psychiatric facilities subject to the prospective payment system.* Subject to the special payment provisions of § 412.22(c), an inpatient psychiatric facility must meet the general criteria set forth in § 412.22. For exclusion from the hospital inpatient prospective payment system as specified in § 412.1(a)(1), a psychiatric hospital must meet the criteria set forth in § 412.23(a) and psychiatric units must meet the criteria set forth in § 412.25 and § 412.27.

(c) *Limitations on charges to beneficiaries*—(1) *Prohibited charges.* Except as permitted in paragraph (c)(2) of this section, an inpatient psychiatric facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's cost of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient psychiatric facility receiving payment

under this subpart for a covered hospital stay (that is, a stay that included at least one covered day) may charge the Medicare beneficiary or other person only the applicable deductible and coinsurance amounts under § 409.82, § 409.83, and § 409.87 of this chapter and for items or services as specified under § 489.20(a) of this chapter.

(d) *Furnishing of hospital inpatient services directly or under arrangement.* (1) Subject to the provisions of § 412.422, the applicable payments made under this subpart are payment in full for all hospital inpatient services, as specified in § 409.10 of this chapter. Hospital inpatient services do not include the following:

(i) Physicians' services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(ii) Physician assistant services, as specified in section 1861(s)(2)(K)(i) of the Act.

(iii) Nurse practitioners and clinical nurse specialist services, as specified in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse midwife services, as specified in section 1861(gg) of the Act.

(v) Qualified psychologist services, as specified in section 1861(ii) of the Act.

(vi) Services of a certified registered nurse anesthetist, as specified in section 1861(bb) of the Act.

(2) CMS does not pay providers or suppliers other than inpatient psychiatric facilities for services furnished to a Medicare beneficiary who is an inpatient of the inpatient psychiatric facility, except for services described in paragraphs (d)(1)(i) through (d)(1)(vi) of this section.

(3) The inpatient psychiatric facility must furnish all necessary covered services to the Medicare beneficiary who is an inpatient of the inpatient psychiatric facility, either directly or under arrangements (as specified in § 409.3 of this chapter).

(e) *Reporting and recordkeeping requirements.* All inpatient psychiatric facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements as specified in § 412.27(c), § 413.20, and § 413.24 of this chapter.

§ 412.422 Basis of payment.

(a) *Method of Payment.* (1) Under the prospective payment system, inpatient psychiatric facilities receive a predetermined per diem payment amount for inpatient services furnished to Medicare Part A fee-for-service beneficiaries.

(2) Payment under the prospective payment system is based on the Federal per diem payment rate that includes adjustments as specified in § 412.424.

(3) During the transition period, payment is based on a blend of the Federal per diem payment amount and the facility-specific payment rate as specified in § 412.426.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as specified in subpart G of part 409 of this chapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient psychiatric facility, but not the cost of an approved medical education program as specified in § 413.85 and § 413.86 of this chapter.

(2) In addition to the payments based on the prospective payment rates, inpatient psychiatric facilities receive payment for bad debts of Medicare beneficiaries, as specified in § 413.80 of this chapter.

§ 412.424 Methodology for calculating the Federal per diem payment rates.

(a) *Data sources.* To calculate the Federal per diem payment rate for inpatient psychiatric facilities, CMS uses the following data sources:

(1) The best Medicare data available to estimate the average per diem payment amount for inpatient operating and capital-related costs made as specified in part 413 of this chapter.

(2) Patient and facility cost report data capturing routine and ancillary costs.

(3) An appropriate wage index to adjust for wage differences.

(4) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services provided by inpatient psychiatric facilities.

(b) *Determining the Federal per diem base amount.* The Federal per diem base rate is the product of the updated average per diem rate and the budget-neutrality adjustment factor as described in paragraphs (b)(1) and (b)(2) of this section.

(1) *Determining the average per diem rate.* CMS determines the average inpatient operating and capital per diem cost for inpatient psychiatric facilities by using the best available data as specified in paragraph (a) of this section. CMS applies the increase factor described in paragraph (a)(4) of this section to update the rate to the midpoint of the first 15 months under the system.

(2) *Budget-neutrality factor.* (i) CMS adjusts the average per diem amount to ensure that the aggregate payments under the prospective payment system are estimated to equal the amount that would have been made to inpatient psychiatric facilities if the prospective payment system described in this subpart was not implemented.

(ii) CMS evaluates the accuracy of the budget-neutrality adjustment within the first 5 years after implementation of the inpatient prospective payment system. CMS may make a one-time prospective adjustment to the Federal per diem base rate to account for significant differences between the historical data on cost-based TEFRA payments (the basis of the budget-neutrality adjustment at the time of implementation) and estimates of TEFRA payments based on actual data from the first year of the prospective payment system.

(c) *Determining the Federal per diem amount.* The Federal per diem payment amount is the product of the Federal per diem base rate, the facility-level adjustments applicable to the inpatient psychiatric facility, and the patient-level characteristics applicable to the case as described in paragraphs (c)(1) and (c)(2) of this section.

(1) *Facility-level adjustments.* (i) *Adjustment for wages.* The labor portion of the Federal per diem base rate is adjusted to account for geographic differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the inpatient psychiatric facility in an urban or rural area as specified in § 412.402.

(ii) *Location in rural areas.* CMS adjusts the Federal per diem base rate by a factor for facilities located in rural areas as specified in § 412.62(f)(1)(iii).

(iii) *Teaching status.* CMS adjusts the Federal per diem base rate by a factor to account for a facility's teaching status based on the ratio of the number of interns and residents assigned to the facility divided by the facility's average daily census.

(2) *Patient-level adjustments.* (i) *Age.* CMS adjusts the Federal per diem base rate by a factor for patients age 65 and older.

(ii) *Principal diagnosis.* The inpatient psychiatric facility must identify a psychiatric diagnosis for each patient. CMS adjusts the wage-adjusted Federal per diem base rate by a factor to account for the diagnosis-related group assignment associated with the principal diagnosis, as specified by CMS.

(iii) *Comorbidities.* CMS adjusts the Federal per diem base rate by a factor to account for certain comorbidities as specified by CMS.

(iv) *Variable per diem adjustments.* CMS adjusts the Federal per diem base rate by declining factors for day 1, days 2 through 4, and days 5 through 8 of the inpatient stay. The variable per diem adjustment does not apply after day 8.

(v) *Adjustment for high-cost cases.* CMS provides for an additional payment if the estimated total cost for a case exceeds a fixed dollar loss threshold plus the total per diem payment amount for the case.

(A) The fixed dollar loss threshold is adjusted for area wage levels, teaching status, and rural location.

(B) The additional payment equals 80 percent of the difference between the estimated cost of the case and the per diem payment amount for days 1 through 8, 60 percent for days 9 and beyond.

(C) Additional payments made under this section would be subject to the adjustments at § 412.84(i), except that the national urban and rural medians would be used instead of statewide averages, and at § 412.84(m) of this part.

(d) *Special payment provision for interrupted stays.* If a patient is discharged from an inpatient psychiatric facility and returns to the same facility before midnight of the 5th consecutive day, the case is considered to be continuous for purposes:

(1) Determining the appropriate variable per diem adjustment, as specified in paragraph (c)(2)(iv) of this section, applicable to the case.

(2) Determining whether the total cost for a case exceeds the fixed dollar loss threshold and qualifies for outlier payments as specified in paragraph (c)(2)(v) of this section.

§ 412.426 Transition period.

(a) *Duration of transition period and proportion of the blended transition rate.* Except as provided in paragraph (c) of this section, for cost reporting periods beginning on or after April 1, 2004 through June 30, 2007, an inpatient psychiatric facility receives a payment comprised of a blend of the Federal per diem payment amount, as specified in § 412.424(c) and a facility-specific payment as specified under paragraph (b) of this section.

(1) For cost reporting periods beginning on or after April 1, 2004 and before June 30, 2005, payment is based on 75 percent of the facility-specific payment and 25 percent of the Federal per diem payment amount.

(2) For cost reporting periods beginning on or after July 1, 2005 and before June 30, 2006, payment is based on 50 percent of the facility-specific payment and 50 percent of the Federal per diem payment amount.

(3) For cost reporting periods beginning on or after July 1, 2006 and before June 30, 2007, payment is based on 25 percent of the facility-specific payment and 75 percent of the Federal per diem payment amount.

(4) For cost reporting periods beginning on or after July 1, 2007, payment is based entirely on the Federal per diem payment amount.

(b) *Calculation of the facility-specific payment.* The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital costs in accordance with part 413 of this chapter.

(c) *Treatment of new inpatient psychiatric facilities.*

New inpatient psychiatric facilities, that is, facilities that under present or previous ownership or both have their first cost reporting period as an IPF beginning on or after April 1, 2004, are paid based entirely on the Federal per diem payment system.

§ 412.428 Publication of the Federal per diem payment rates.

CMS will publish annually in the **Federal Register** information pertaining to the inpatient psychiatric facility prospective payment system. This information includes the Federal per diem payment rates, the area wage index, and a description of the methodology and data used to calculate the payment rates.

§ 412.432 Method of payment under the inpatient psychiatric facility prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient psychiatric facility receives payment under this subpart for inpatient operating cost and capital-related costs for each inpatient stay following submission of a bill.

(b) *Periodic interim payments (PIP).* (1) Criteria for receiving PIP.

(i) An inpatient psychiatric facility receiving payment under this subpart may receive PIP for Part A services under the PIP method subject to the provisions of § 413.64(h) of this chapter.

(ii) To be approved for PIP, the inpatient psychiatric facility must meet the qualifying requirements in § 413.64(h)(3) of this chapter.

(iii) Payments to a psychiatric unit are made under the same method of payment as the hospital of which it is a part as specified in § 412.116.

(iv) As provided in § 413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the annual inpatient psychiatric facility's Federal per diem prospective payments, net of estimated beneficiary deductibles and coinsurance, and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient psychiatric facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as specified in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient psychiatric facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the inpatient psychiatric facility.* Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient psychiatric facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient psychiatric facility no longer meets the requirements of § 413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system.* The intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of the biweekly period of service as specified in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient psychiatric facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) *Accelerated payments.* (1) *General rule.* Upon request, an accelerated payment may be made to an inpatient psychiatric facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient psychiatric facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient psychiatric facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient psychiatric facility's preparation and submittal of bills to the intermediary beyond the normal billing cycle.

(2) *Approval of payment.* An inpatient psychiatric facility's request for an accelerated payment must be approved by the intermediary and CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percent of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as inpatient psychiatric facility bills are processed or by direct payment by the inpatient psychiatric facility.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERICES; PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861 (v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

2. Section 413.1 is amended as follows:

a. Revising paragraph (d)(2)(ii).

b. Redesignating paragraphs (d)(2)(iv),(d)(2)(v), (d)(2)(vi), and (d)(2)(vii) as paragraphs (d)(2)(vi), (d)(2)(vii), (d)(2)(viii), and (d)(2)(ix).

(c) Adding new paragraphs (d)(2)(iv) and (d)(2)(v).

The revision and additions read as follows:

§ 413.1 Introduction.

* * * * *

(d) * * *

(2) * * *

(ii) Payment to children's hospitals that are excluded from the prospective payment systems under subpart B of part 412 of this chapter, and hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of § 413.40.

* * * * *

(iv) For cost reporting periods beginning before April 1, 2004, payment to psychiatric hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals) that are excluded under subpart B of part 412 of this chapter from the prospective payment system is on a reasonable cost basis, subject to the provisions of § 413.40.

(v) For cost reporting periods beginning on or after April 1, 2004, payment to psychiatric hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals) that meet the conditions of § 412.404 of this chapter is based on prospectively determined rates under subpart N of part 412 of this chapter.

* * * * *

3. Section 413.40 is amended as follows:

a. Redesignating paragraphs (a)(2)(i)(C) and (a)(2)(i)(D) as paragraphs (a)(2)(i)(D) and (a)(2)(i)(E).

b. Adding a new paragraph (a)(2)(i)(C).

c. Republishing paragraphs (a)(2)(ii) introductory text.

d. Revising paragraph (a)(2)(ii)(B).

e. Redesignating paragraphs (a)(2)(iii) and (a)(2)(iv) as paragraphs (a)(2)(iv) and (a)(2)(v).

f. Adding a new paragraph (a)(2)(iii).

The revision and additions read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) * * *

(2) * * *

(i) * * *

(C) Psychiatric hospitals and psychiatric units that are paid under the prospective payment system for hospital inpatient services under subpart N of part 412 of this chapter for cost reporting periods beginning on or after April 1, 2004.

* * * * *

(ii) For cost reporting periods beginning on or after October 1, 1983 through March 31, 2004, this section applies to—

* * * * *

(B) Psychiatric and rehabilitation units excluded from the prospective payment systems, as specified in § 412.1(a)(1) of this chapter and in accordance with § 412.25 through § 412.30 of this chapter, except as limited by paragraphs (a)(2)(iii) and (a)(2)(iv) of this section with respect to psychiatric and rehabilitation hospitals and psychiatric and rehabilitation units as specified in § 412.22, § 412.23, § 412.25, § 412.27, § 412.29 and § 412.30 of this chapter.

* * * * *

(iii) For cost reporting periods beginning on or after April 1, 2004 this section applies to psychiatric hospitals and psychiatric units that are excluded from the prospective payment systems as specified in § 412.1(a)(1) of this chapter and paid under the prospective payment system as specified in § 412.1(a)(2) of this chapter.

* * * * *

4. Section 413.64 is amended by revising paragraph (h)(2)(i) to read as follows:

§ 413.64 Payment to providers: Specific rules.

* * * * *

(h) * * *

(2) * * *

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, as specified in § 412.1(a)(1) of this chapter, and are paid under the prospective payment system as specified in subpart N of part 412 of this chapter.

* * * * *

PART 424—CONDITIONS OF MEDICARE PAYMENT

1. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 424.14 is amended as follows:

a. Adding paragraph (c)(3).

b. Revising paragraph (d)(2).

The addition and revision read as follows:

§ 424.14 Requirements for inpatient services of psychiatric hospitals.

* * * * *

(c) * * *

(3) 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.

(d) * * *

(2) The first recertification is required as of the 10th day of hospitalization. Subsequent recertifications are required

at intervals established by the UR committee (on a case-by-case basis if it so chooses), but no less frequently than every 30 days.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: April 17, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: April 29, 2003.

Tommy G. Thompson,

Secretary.

Editorial Note: This document was received at the Office of the Federal Register on November 18, 2003.

[The following addenda will not appear in the Code of Federal Regulations.]

Addendum A—Proposed Psychiatric Prospective Payment Adjustment

Rate and Adjustment Factors

PROPOSED RATE AND ADJUSTMENT FACTORS

Proposed Per Diem Rate	
Proposed Per Diem Rate	$530

PROPOSED RATE AND ADJUSTMENT FACTORS—Continued

Labor-Share	$386
Non-Labor-Share	$144
Proposed Facility Adjustments	
Rural Location	1.16
Wage Area Adjustment	(1)
Teaching Adjustment	(2)
Proposed Variable Per Diem Adjustments	
Day 1	1.26
Days 2 through 4	1.12
Days 5 through 8	1.05
Proposed Age Adjustments	
65 Years of Age and Over	1.13
Proposed DRG Adjustments	
DRG 12	1.07
DRG 23	1.10
DRG 424	1.22
DRG 425	1.08
DRG 426	1.00
DRG 427	1.01
DRG 428	1.03
DRG 429	1.02
DRG 430	1.00
DRG 431	1.02
DRG 432	0.96
DRG 433	0.88
DRG 521	1.02
DRG 522	0.97

PROPOSED RATE AND ADJUSTMENT FACTORS—Continued

DRG 523	0.88
Proposed Comorbidity Adjustments	
HIV	1.06
Coagulation Factor Deficits	1.11
Tracheotomy	1.14
Eating and Conduct Disorders	1.03
Infectious Diseases	1.08
Renal Failure, Acute	1.08
Rental Failure, Chronic	1.14
Malignant Neoplasm's	1.10
Uncontrolled Diabetes Mellitus with or without complications	1.10
Sever Protein Calorie Malnutrition	1.12
Drug and Alcohol Induce Mental Disorders	1.03
Cardiac Conditions	1.13
Arteriosclerosis of the Extremity with Gangrene	1.17
Chronic Obstructed Pulmonary Disease	1.12
Artificial Openings-Digestive and Urinary	1.09
Severe Musculoskeletal and Connective Tissue Diseases	1.12
Poisoning	1.14

[1] See Addendum B.
[2] See section III.B.2.b.

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS

MSA	Urban area (constituent counties or county equivalents)	Wage index
0040	Abilene, TX	0.7792
	Taylor, TX	
0060	Aguadilla, PR	0.4587
	Aguada, PR	
	Aguadilla, PR	
	Moca, PR	
0080	Akron, OH	0.9600
	Portage, OH	
	Summit, OH	
0120	Albany, GA	1.0594
	Dougherty, GA	
	Lee, GA	
0160	Albany-Schenectady-Troy, NY	0.8384
	Albany, NY	
	Montgomery, NY	
	Rensselaer, NY	
	Saratoga, NY	
	Schenectady, NY	
	Schoharie, NY	
0200	Albuquerque, NM	0.9315
	Bernalillo, NM	
	Sandoval, NM	
	Valencia, NM	
0220	Alexandria, LA	0.7859
	Rapides, LA	
0240	Allentown-Bethlehem-Easton, PA	0.9735
	Carbon, PA	
	Lehigh, PA	
	Northampton, PA	
0280	Altoona, PA	0.9225
	Blair, PA	
0320	Amarillo, TX	0.9034
	Potter, TX	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Randall, TX	
0380	Anchorage, AK	1.2358
	Anchorage, AK	
0440	Ann Arbor, MI	1.1103
	Lenawee, MI	
	Livingston, MI	
	Washtenaw, MI	
0450	Anniston,AL	0.8044
	Calhoun, AL	
0460	Appleton-Oshkosh-Neenah, WI	0.8997
	Calumet, WI	
	Outagamie, WI	
	Winnebago, WI	
0470	Arecibo, PR	0.4337
	Arecibo, PR	
	Camuy, PR	
	Hatillo, PR	
0480	Asheville, NC	0.9876
	Buncombe, NC	
	Madison, NC	
0500	Athens, GA	1.0211
	Clarke, GA	
	Madison, GA	
	Oconee, GA	
0520	Atlanta, GA	0.9991
	Barrow, GA	
	Bartow, GA	
	Carroll, GA	
	Cherokee, GA	
	Clayton, GA	
	Cobb, GA	
	Coweta, GA	
	De Kalb, GA	
	Douglas, GA	
	Fayette, GA	
	Forsyth, GA	
	Fulton, GA	
	Gwinnett, GA	
	Henry, GA	
	Newton, GA	
	Paulding, GA	
	Pickens, GA	
	Rockdale, GA	
	Spalding, GA	
	Walton, GA	
0560	Atlantic City-Cape May, NJ	1.1017
	Atlantic City, NJ	
	Cape May, NJ	
0580	Auburn-Opelika, AL	0.8325
	Lee, AL	
0600	Augusta-Aiken, GA–SC	1.0264
	Columbia, GA	
	McDuffie, GA	
	Richmond, GA	
	Aiken, SC	
	Edgefield, SC	
0640	Austin-San Marcos, TX	0.9637
	Bastrop, TX	
	Caldwell, TX	
	Hays, TX	
	Travis, TX	
	Williamson, TX	
0680	Bakersfield, CA	0.9899
	Kern, CA	
0720	Baltimore, MD	0.9929
	Anne Arundel, MD	
	Baltimore, MD	
	Baltimore City, MD	
	Carroll, MD	
	Harford, MD	
	Howard, MD	
	Queen Annes, MD	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
0733	Bangor, ME Penobscot, ME	0.9664
0743	Barnstable-Yarmouth, MA Barnstable, MA	1.3202
0760	Baton Rouge, LA Ascension, LA East Baton Rouge Livingston, LA West Baton Rouge, LA	0.8294
0840	Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	0.8324
0860	Bellingham, WA Whatcom, WA	1.2282
0870	Benton Harbor, MI Berrien, MI	0.9042
0875	Bergen-Passaic, NJ Bergen, NJ Passaic, NJ	1.2150
0880	Billings, MT Yellowstone, MT	0.9022
0920	Biloxi-Gulfport-Pascagoula, MS Hancock, MS Harrison, MS Jackson, MS	0.8757
0960	Binghamton, NY Broome, NY Tioga, NY	0.8341
1000	Birmingham, AL Blount, AL Jefferson, AL St. Clair, AL Shelby, AL	0.9222
1010	Bismarck, ND Burleigh, ND Morton, ND	0.7972
1020	Bloomington, IN Monroe, IN	0.8907
1040	Bloomington-Normal, IL McLean, IL	0.9109
1080	Boise City, ID Ada, ID Canyon, ID	0.9310
1123	Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH Bristol, MA Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA Worcester, MA Hillsborough, NH Merrimack, NH Rockingham, NH Strafford, NH	1.1235
1125	Boulder-Longmont, CO Boulder, CO	0.9689
1145	Brazoria, TX Brazoria, TX	0.8535
1150	Bremerton, WA Kitsap, WA	1.0944
1240	Brownsville-Harlingen-San Benito, TX Cameron, TX	0.8880
1260	Bryan-College Station, TX Brazos, TX	0.8821
1280	Buffalo-Niagara Falls, NY Erie, NY Niagara, NY	0.9365
1303	Burlington, VT Chittenden, VT Franklin, VT	1.0052

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Grand Isle, VT	
1310	Caguas, PR	0.4371
	Caguas, PR	
	Cayey, PR	
	Cidra, PR	
	Gurabo, PR	
	San Lorenzo, PR	
1320	Canton-Massillon, OH	0.8932
	Carroll, OH	
	Stark, OH	
1350	Casper, WY	0.9690
	Natrona, WY	
1360	Cedar Rapids, IA	0.9056
	Linn, IA	
1400	Champaign-Urbana, IL	1.0635
	Champaign, IL	
1440	Charleston-North Charleston, SC	0.9235
	Berkeley, SC	
	Charleston, SC	
	Dorchester, SC	
1480	Charleston, WV	0.8898
	Kanawha, WV	
	Putnam, WV	
1520	Charlotte-Gastonia-Rock Hill, NC–SC	0.9850
	Cabarrus, NC	
	Gaston, NC	
	Lincoln, NC	
	Mecklenburg, NC	
	Rowan, NC	
	Stanly, NC	
	Union, NC	
	York, SC	
1540	Charlottesville, VA	1.0438
	Albemarle, VA	
	Charlottesville City, VA	
	Fluvanna, VA	
	Greene, VA	
1560	Chattanooga, TN–GA	0.8976
	Catoosa, GA	
	Dade, GA	
	Walker, GA	
	Hamilton, TN	
	Marion, TN	
1580	Cheyenne, WY	0.8628
	Laramie, WY	
1600	Chicago, IL	1.1044
	Cook, IL	
	De Kalb, IL	
	Du Page, IL	
	Grundy, IL	
	Kane, IL	
	Kendall, IL	
	Lake, IL	
	McHenry, IL	
	Will, IL	
1620	Chico-Paradise, CA	0.9745
	Butte, CA	
1640	Cincinnati, OH–KY–IN	0.9381
	Dearborn, IN	
	Ohio, IN	
	Boone, KY	
	Campbell, KY	
	Gallatin, KY	
	Grant, KY	
	Kenton, KY	
	Pendleton, KY	
	Brown, OH	
	Clermont, OH	
	Hamilton, OH	
	Warren, OH	
1660	Clarksville-Hopkinsville, TN–KY	0.8406
	Christian, KY	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Montgomery, TN	
1680	Cleveland-Lorain-Elyria, OH	0.9670
	Ashtabula, OH	
	Geauga, OH	
	Cuyahoga, OH	
	Lake, OH	
	Lorain, OH	
	Medina, OH	
1720	Colorado Springs, CO	0.9916
	El Paso, CO	
1740	Columbia MO	0.8496
	Boone, MO	
1760	Columbia, SC	0.9307
	Lexington, SC	
	Richland, SC	
1800	Columbus, GA–AL	0.8374
	Russell, AL	
	Chattahoochee, GA	
	Harris, GA	
	Muscogee, GA	
1840	Columbus, OH	0.9751
	Delaware, OH	
	Fairfield, OH	
	Franklin, OH	
	Licking, OH	
	Madison, OH	
	Pickaway, OH	
1880	Corpus Christi, TX	0.8729
	Nueces, TX	
	San Patricio, TX	
1890	Corvallis, OR	1.1453
	Benton, OR	
1900	Cumberland, MD–WV	0.7847
	Allegany, MD	
	Mineral, WV	
1920	Dallas, TX	0.9998
	Collin, TX	
	Dallas, TX	
	Denton, TX	
	Ellis, TX	
	Henderson, TX	
	Hunt, TX	
	Kaufman, TX	
	Rockwall, TX	
1950	Danville, VA	0.8859
	Danville City, VA	
	Pittsylvania, VA	
1960	Davenport-Moline-Rock Island, IA–IL	0.8835
	Scott, IA	
	Henry, IL	
	Rock Island, IL	
2000	Dayton-Springfield, OH	0.9282
	Clark, OH	
	Greene, OH	
	Miami, OH	
	Montgomery, OH	
2020	Daytona Beach, FL	0.9062
	Flagler, FL	
	Volusia, FL	
2030	Decatur, AL	0.8973
	Lawrence, AL	
	Morgan, AL	
2040	Decatur, IL	0.8055
	Macon, IL	
2080	Denver, CO	1.0601
	Adams, CO	
	Arapahoe, CO	
	Broomfield, CO	
	Denver, CO	
	Douglas, CO	
	Jefferson, CO	
2120	Des Moines, IA	0.8791

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Dallas, IA	
	Polk, IA	
	Warren, IA	
2160	Detroit, MI	1.0448
	Lapeer, MI	
	Macomb, MI	
	Monroe, MI	
	Oakland, MI	
	St. Clair, MI	
	Wayne, MI	
2180	Dothan, AL	0.8137
	Dale, AL	
	Houston, AL	
2190	Dover, DE	0.9356
	Kent, DE	
2200	Dubuque, IA	0.8795
	Dubuque, IA	
2240	Duluth-Superior, MN–WI	1.0368
	St. Louis, MN	
	Douglas, WI	
2281	Dutchess County, NY	1.0684
	Dutchess, NY	
2290	Eau Claire, WI	0.8952
	Chippewa, WI	
	Eau Clair, WI	
2320	El Paso, TX	0.9265
	El Paso, TX	
2330	Elkhart-Goshen, IN	0.9722
	Elkhart, IN	
2335	Elmira, NY	0.8416
	Chemung, NY	
2340	Enid, OK	0.8376
	Garfield, OK	
2360	Erie, PA	0.8925
	Erie, PA	
2400	Eugene-Springfield, OR	1.0944
	Lane, OR	
2440	Evansville-Henderson, IN–KY	0.8177
	Posey, IN	
	Vanderburgh, IN	
	Warrick, IN	
	Henderson, KY	
2520	Fargo-Moorhead, ND–MN	0.9684
	Clay, MN	
	Cass, ND	
2560	Fayetteville, NC	0.8889
	Cumberland, NC	
2580	Fayettevile-Springdale-Rogers, AR	0.8100
	Benton, AR	
	Washington, AR	
2620	Flagstaff, AZ–UT	1.0682
	Coconino, AZ	
	Kane, UT	
2640	Flint, MI	1.1135
	Genesee, MI	
2650	Florence, AL	0.7792
	Colbert, AL	
	Lauderdale, AL	
2655	Florence, SC	0.8780
	Florence, SC	
2670	Fort Collins-Loveland, CO	1.0066
	Larimer, CO	
2680	Ft. Lauderdale, FL	1.0297
	Broward, FL	
2700	Fort Myers-Cape Coral, FL	0.9680
	Lee, FL	
2710	Fort Pierce-Port St. Lucie, FL	0.9823
	Martin, FL	
	St. Lucie, FL	
2720	Fort Smith, AR–OK	0.7895
	Crawford, AR	
	Sebastian, AR	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Sequoyah, OK	
2750	Fort Walton Beach, FL	0.9693
	Okaloosa, FL	
2760	Fort Wayne, IN	0.9457
	Adams, IN	
	Allen, IN	
	De Kalb, IN	
	Huntington, IN	
	Wells, IN	
	Whitley, IN	
2800	Fort Worth-Arlington, TX	0.9446
	Hood, TX	
	Johnson, TX	
	Parker, TX	
	Tarrant, TX	
2840	Fresno, CA	1.0216
	Fresno, CA	
	Madera, CA	
2880	Gadsden AL	0.8505
	Etowah, AL	
2900	Gainesville, FL	0.9871
	Alachua, FL	
2920	Galveston-Texas City, TX	0.9465
	Galveston, TX	
2960	Gary, IN	0.9584
	Lake, IN	
	Porter, IN	
2975	Glens Falls, NY	0.8281
	Warren, NY	
	Washington, NY	
2980	Goldsboro, NC	0.8892
	Wayne, NC	
2985	Grand Forks, ND–MN	0.8897
	Polk, MN	
	Grand Forks, ND	
2995	Grand Junction, CO	0.9456
	Mesa, CO	
3000	Grand Rapids-Muskegon-Holland, MI	0.9525
	Allegan, MI	
	Kent, MI	
	Muskegon, MI	
	Ottawa, MI	
3040	Great Falls, MT	0.8950
	Cascade, MT	
3060	Greeley, CO	0.9237
	Weld, CO	
3080	Green Bay, WI	0.9502
	Brown, WI	
3120	Greensboro-Winston-Salem-High Point, NC	0.9282
	Alamance, NC	
	Davidson, NC	
	Davie, NC	
	Forsyth, NC	
	Guilford, NC	
	Randolph, NC	
	Stokes, NC	
	Yadkin, NC	
3150	Greenville, NC	0.9100
	Pitt, NC	
3160	Greenville-Spartanburg-Anderson, SC	0.9122
	Anderson, SC	
	Cherokee, SC	
	Greenville, SC	
	Pickens, SC	
	Spartanburg, SC	
3180	Hagerstown, MD	0.9268
	Washington, MD	
3200	Hamilton-Middletown, OH	0.9418
	Butler, OH	
3240	Harrisburg-Lebanon-Carlisle, PA	0.9223
	Cumberland, PA	
	Dauphin, PA	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Lebanon, PA	
	Perry, PA	
3283	Hartford, CT	1.1549
	Hartford, CT	
	Litchfield, CT	
	Middlesex, CT	
	Tolland, CT	
3285	Hattiesburg, MS	0.7659
	Forrest, MS	
	Lamar, MS	
3290	Hickory-Morganton-Lenoir, NC	0.9028
	Alexander, NC	
	Burke, NC	
	Caldwell, NC	
	Catawba, NC	
3320	Honolulu, HI	1.1457
	Honolulu, HI	
3350	Houma, LA	0.8385
	Lafourche, LA	
	Terrebonne, LA	
3360	Houston, TX	0.9892
	Chambers, TX	
	Fort Bend, TX	
	Harris, TX	
	Liberty, TX	
	Montgomery, TX	
	Waller, TX	
3400	Huntington-Ashland, WV–KY–OH	0.9636
	Boyd, KY	
	Carter, KY	
	Greenup, KY	
	Lawrence, OH	
	Cabell, WV	
	Wayne, WV	
3440	Huntsville, AL	0.8903
	Limestone, AL	
	Madison, AL	
3480	Indianapolis, IN	0.9717
	Boone, IN	
	Hamilton, IN	
	Hancock, IN	
	Hendricks, IN	
	Johnson, IN	
	Madison, IN	
	Marion, IN	
	Morgan, IN	
	Shelby, IN	
3500	Iowa City, IA	0.9587
	Johnson, IA	
3520	Jackson, MI	0.9532
	Jackson, MI	
3560	Jackson, MS	0.8607
	Hinds, MS	
	Madison, MS	
	Rankin, MS	
3580	Jackson, TN	0.9275
	Chester, TN	
	Madison, TN	
3600	Jacksonville, FL	0.9281
	Clay, FL	
	Duval, FL	
	Nassau, FL	
	St. Johns, FL	
3605	Jacksonville, NC	0.8239
	Onslow, NC	
3610	Jamestown, NY	0.7976
	Chautaqua, NY	
3620	Janesville-Beloit, WI	0.9849
	Rock, WI	
3640	Jersey City, NJ	1.1190
	Hudson, NJ	
3660	Johnson City-Kingsport-Bristol, TN–VA	0.8268

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Carter, TN	
	Hawkins, TN	
	Sullivan, TN	
	Unicoi, TN	
	Washington, TN	
	Bristol City, VA	
	Scott, VA	
	Washington, VA	
3680	Johnstown, PA	0.8329
	Cambria, PA	
	Somerset, PA	
3700	Jonesboro, AR	0.7749
	Craighead, AR	
3710	Joplin, MO	0.8613
	Jasper, MO	
	Newton, MO	
3720	Kalamazoo-Battlecreek, MI	1.0595
	Calhoun, MI	
	Kalamazoo, MI	
	Van Buren, MI	
3740	Kankakee, IL	1.0790
	Kankakee, IL	
3760	Kansas City, KS–MO	0.9736
	Johnson, KS	
	Leavenworth, KS	
	Miami, KS	
	Wyandotte, KS	
	Cass, MO	
	Clay, MO	
	Clinton, MO	
	Jackson, MO	
	Lafayette, MO	
	Platte, MO	
	Ray, MO	
3800	Kenosha, WI	0.9686
	Kenosha, WI	
3810	Killeen-Temple, TX	1.0399
	Bell, TX	
	Coryell, TX	
3840	Knoxville, TN	0.8970
	Anderson, TN	
	Blount, TN	
	Knox, TN	
	Loudon, TN	
	Sevier, TN	
	Union, TN	
3850	Kokomo, IN	0.8971
	Howard, IN	
	Tipton, IN	
3870	La Crosse, WI–MN	0.9400
	Houston, MN	
	La Crosse, WI	
3880	Lafayette, LA	0.8475
	Acadia, LA	
	Lafayette, LA	
	St. Landry, LA	
	St. Martin, LA	
3920	Lafayette, IN	0.9278
	Clinton, IN	
	Tippecanoe, IN	
3960	Lake Charles, LA	0.7965
	Calcasieu, LA	
3980	Lakeland-Winter Haven, FL	0.9357
	Polk, FL	
4000	Lancaster, PA	0.9078
	Lancaster, PA	
4040	Lansing-East Lansing, MI	0.9726
	Clinton, MI	
	Eaton, MI	
	Ingham, MI	
4080	Laredo, TX	0.8472
	Webb, TX	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
4100	Las Cruces, NM	0.8745
	Dona Ana, NM	
4120	Las Vegas, NV–AZ	1.1521
	Mohave, AZ	
	Clark, NV	
	Nye, NV	
4150	Lawrence, KS	0.7923
	Douglas, KS	
4200	Lawton, OK	0.8315
	Comanche, OK	
4243	Lewiston-Auburn, ME	0.9179
	Androscoggin, ME	
4280	Lexington, KY	0.8581
	Bourbon, KY	
	Clark, KY	
	Fayette, KY	
	Jessamine, KY	
	Madison, KY	
	Scott, KY	
	Woodford, KY	
4320	Lima, OH	0.9483
	Allen, OH	
	Auglaize, OH	
4360	Lincoln, NE	0.9892
	Lancaster, NE	
4400	Little Rock-North Little, AR	0.9097
	Faulkner, AR	
	Lonoke, AR	
	Pulaski, AR	
	Saline, AR	
4420	Longview-Marshall, TX	0.8629
	Gregg, TX	
	Harrison, TX	
	Upshur, TX	
4480	Los Angeles-Long Beach, CA	1.2001
	Los Angeles, CA	
4520	Louisville, KY–IN	0.9276
	Clark, IN	
	Floyd, IN	
	Harrison, IN	
	Scott, IN	
	Bullitt, KY	
	Jefferson, KY	
	Oldham, KY	
4600	Lubbock, TX	0.9646
	Lubbock, TX	
4640	Lynchburg, VA	0.9219
	Amherst, VA	
	Bedford City, VA	
	Bedford, VA	
	Campbell, VA	
	Lynchburg City, VA	
4680	Macon, GA	0.9204
	Bibb, GA	
	Houston, GA	
	Jones, GA	
	Peach, GA	
	Twiggs, GA	
4720	Madison, WI	1.0467
	Dane, WI	
4800	Mansfield, OH	0.8900
	Crawford, OH	
	Richland, OH	
4840	Mayaguez, PR	0.4914
	Anasco, PR	
	Cabo Rojo, PR	
	Hormigueros, PR	
	Mayaguez, PR	
	Sabana Grande, PR	
	San German, PR	
4880	McAllen-Edinburg-Mission, TX	0.8428
	Hidalgo, TX	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
4890	Medford-Ashland, OR	1.0498
	Jackson, OR	
4900	Melbourne-Titusville-Palm Bay, FL	1.0253
	Brevard, FL	
4920	Memphis, TN–AR–MS	0.8920
	Crittenden, AR	
	De Soto, MS	
	Fayette, TN	
	Shelby, TN	
	Tipton, TN	
4940	Merced, CA	0.9837
	Merced, CA	
5000	Miami, FL	0.9802
	Dade, FL	
5015	Middlesex-Somerset-Hunterdon, NJ	1.2313
	Hunterdon, NJ	
	Middlesex, NJ	
	Somerset, NJ	
5080	Milwaukee-Waukesha, WI	0.9893
	Milwaukee, WI	
	Ozaukee, WI	
	Washington, WI	
	Waukesha, WI	
5120	Minneapolis-St. Paul, MN-WI	1.0903
	Anoka, MN	
	Carver, MN	
	Chisago, MN	
	Dakota, MN	
	Hennepin, MN	
	Isanti, MN	
	Ramsey, MN	
	Scott, MN	
	Sherburne, MN	
	Washington, MN	
	Wright, MN	
	Pierce, WI	
	St. Croix, WI	
5140	Missoula, MT	0.9157
	Missoula, MT	
5160	Mobile, AL	0.8108
	Baldwin, AL	
	Mobile, AL	
5170	Modesto, CA	1.0498
	Stanislaus, CA	
5190	Monmouth-Ocean, NJ	1.0674
	Monmouth, NJ	
	Ocean, NJ	
5200	Monroe, LA	0.8137
	Ouachita, LA	
5240	Montgomery, AL	0.7734
	Autauga, AL	
	Elmore, AL	
	Montgomery, AL	
5280	Muncie, IN	0.9284
	Delaware, IN	
5330	Myrtle Beach, SC	0.8976
	Horry, SC	
5345	Naples, FL	0.9754
	Collier, FL	
5360	Nashville, TN	0.9578
	Cheatham, TN	
	Davidson, TN	
	Dickson, TN	
	Robertson, TN	
	Rutherford, TN	
	Sumner, TN	
	Williamson, TN	
	Wilson, TN	
5380	Nassau-Suffolk, NY	1.3357
	Nassau, NY	
	Suffolk, NY	
5483	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2408

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Fairfield, CT	
	New Haven, CT	
5523	New London-Norwich, CT	1.1767
	New London, CT	
5560	New Orleans, LA	0.9046
	Jefferson, LA	
	Orleans, LA	
	Plaquemines, LA	
	St. Bernard, LA	
	St. Charles, LA	
	St. James, LA	
	St. John The Baptist, LA	
	St. Tammany, LA	
5600	New York, NY	1.4414
	Bronx, NY	
	Kings, NY	
	New York, NY	
	Putnam, NY	
	Queens, NY	
	Richmond, NY	
	Rockland, NY	
	Westchester, NY	
5640	Newark, NJ	1.1381
	Essex, NJ	
	Morris, NJ	
	Sussex, NJ	
	Union, NJ	
	Warren, NJ	
5660	Newburgh, NY–PA	1.1387
	Orange, NY	
	Pike, PA	
5720	Norfolk-Virginia Beach-Newport News, VA–NC	0.8574
	Currituck, NC	
	Chesapeake City, VA	
	Gloucester, VA	
	Hampton City, VA	
	Isle of Wight, VA	
	James City, VA	
	Mathews, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
	York, VA	
5775	Oakland, CA	1.5072
	Alameda, CA	
	Contra Costa, CA	
5790	Ocala, FL	0.9402
	Marion, FL	
5800	Odessa-Midland, TX	0.9397
	Ector, TX	
	Midland, TX	
5800	Oklahoma City, OK	0.8900
	Canadian, OK	
	Cleveland, OK	
	Logan, OK	
	McClain, OK	
	Oklahoma, OK	
	Pottawatomie, OK	
5910	Olympia, WA	1.0960
	Thurston, WA	
5920	Omaha, NE–IA	0.9978
	Pottawattamie, IA	
	Cass, NE	
	Douglas, NE	
	Sarpy, NE	
	Washington, NE	
5945	Orange County, CA	1.1474
	Orange, CA	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
5960	Orlando, FL	0.9640
	Lake, FL	
	Orange, FL	
	Osceola, FL	
	Seminole, FL	
5990	Owensboro, KY	0.8344
	Daviess, KY	
6015	Panama City, FL	0.8865
	Bay, FL	
6020	Parkersburg-Marietta, WV–OH	0.8127
	Washington, OH	
	Wood, WV	
6080	Pensacola, FL	0.8645
	Escambia, FL	
	Santa Rosa, FL	
6120	Peoria-Pekin, IL	0.8739
	Peoria, IL	
	Tazewell, IL	
	Woodford, IL	
6160	Philadelphia, PA–NJ	1.0713
	Burlington, NJ	
	Camden, NJ	
	Gloucester, NJ	
	Salem, NJ	
	Bucks, PA	
	Chester, PA	
	Delaware, PA	
	Montgomery, PA	
	Philadelphia, PA	
6200	Phoenix-Mesa, AZ	0.9820
	Maricopa, AZ	
	Pinal, AZ	
6240	Pine Bluff, AR	0.7962
	Jefferson, AR	
6280	Pittsburgh, PA	0.9365
	Allegheny, PA	
	Beaver, PA	
	Butler, PA	
	Fayette, PA	
	Washington, PA	
	Westmoreland, PA	
6323	Pittsfield, MA	1.0235
	Berkshire, MA	
6340	Pocatello, ID	0.9372
	Bannock, ID	
6360	Ponce, PR	0.5169
	Guayanilla, PR	
	Juana Diaz, PR	
	Penuelas, PR	
	Ponce, PR	
	Villalba, PR	
	Yauco, PR	
6403	Portland, ME	0.9794
	Cumberland, ME	
	Sagadahoc, ME	
	York, ME	
6440	Portland-Vancouver, OR–WA	1.0667
	Clackamas, OR	
	Columbia, OR	
	Multnomah, OR	
	Washington, OR	
	Yamhill, OR	
	Clark, WA	
6483	Providence-Warwick-Pawtucket, RI	1.0854
	Bristol, RI	
	Kent, RI	
	Newport, RI	
	Providence, RI	
	Washington, RI	
6520	Provo-Orem, UT	0.9984
	Utah, UT	
6560	Pueblo, CO	0.8820

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Pueblo, CO	
6580	Punta Gorda, FL	0.9218
	Charlotte, FL	
6600	Racine, WI	0.9334
	Racine, WI	
6640	Raleigh-Durham-Chapel Hill, NC	0.9990
	Chatham, NC	
	Durham, NC	
	Franklin, NC	
	Johnston, NC	
	Orange, NC	
	Wake, NC	
6660	Rapid City, SD	0.8846
	Pennington, SD	
6680	Reading, PA	0.9295
	Berks, PA	
6690	Redding, CA	1.1135
	Shasta, CA	
6720	Reno, NV	1.0648
	Washoe. NV	
6740	Richland-Kennewick-Pasco, WA	1.1491
	Benton, WA	
	Franklin, WA	
6760	Richmond-Petersburg, VA	0.9477
	Charles City County, VA	
	Chesterfield, VA	
	Colonial Heights City, VA	
	Dinwiddie, VA	
	Goochland, VA	
	Hanover, VA	
	Henrico, VA	
	Hopewell City, VA	
	New Kent, VA	
	Petersburg City, VA	
	Powhatan, VA	
	Prince George, VA	
	Richmond City, VA	
6780	Riverside-San Bernardino, CA	1.1365
	Riverside, CA	
	San Bernardino, CA	
6800	Roanoke, VA	0.8614
	Botetourt, VA	
	Roanoke, VA	
	Roanoke City, VA	
	Salem City, VA	
6820	Rochester, MN	1.2139
	Olmsted, MN	
6840	Rochester, NY	0.9194
	Genesee, NY	
	Livingston, NY	
	Monroe, NY	
	Ontario, NY	
	Orleans, NY	
	Wayne, NY	
6880	Rockford, IL	0.9625
	Boone, IL	
	Ogle, IL	
	Winnebago, IL	
6895	Rocky Mount, NC	0.9228
	Edgecombe, NC	
	Nash, NC	
6920	Sacramento, CA	1.1500
	El Dorado, CA	
	Placer, CA	
	Sacramento, CA	
6960	Saginaw-Bay City-Midland, MI	0.9650
	Bay, MI	
	Midland, MI	
	Saginaw, MI	
6980	St. Cloud, MN	0.9700
	Benton, MN	
	Stearns, MN	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
7000	St. Joseph, MO	0.8021
	Andrews, MO	
	Buchanan, MO	
7040	St. Louis, MO–IL	0.8855
	Clinton, IL	
	Jersey, IL	
	Madison, IL	
	Monroe, IL	
	St. Clair, IL	
	Franklin, MO	
	Jefferson, MO	
	Lincoln, MO	
	St. Charles, MO	
	St. Louis, MO	
	St. Louis City, MO	
	Warren, MO	
	Sullivan City, MO	
7080	Salem, OR	1.0367
	Marion, OR	
	Polk, OR	
7120	Salinas, CA	1.4623
	Monterey, CA	
7160	Salt Lake City-Ogden, UT	0.9945
	Davis, UT	
	Salt Lake, UT	
	Weber, UT	
7200	San Angelo, TX	0.8374
	Tom Green, TX	
7240	San Antonio, TX	0.8753
	Bexar, TX	
	Comal, TX	
	Guadalupe, TX	
	Wilson, TX	
7320	San Diego, CA	1.1131
	San Diego, CA	
7360	San Francisco, CA	1.4142
	Marin, CA	
	San Francisco, CA	
	San Mateo, CA	
7400	San Jose, CA	1.4145
	Santa Clara, CA	
7440	San Juan-Bayamon, PR	0.4741
	Aguas Buenas, PR	
	Barceloneta, PR	
	Bayamon, PR	
	Canovanas, PR	
	Carolina, PR	
	Catano, PR	
	Ceiba, PR	
	Comerio, PR	
	Corozal, PR	
	Dorado, PR	
	Fajardo, PR	
	Florida, PR	
	Guaynabo, PR	
	Humacao, PR	
	Juncos, PR	
	Los Piedras, PR	
	Loiza, PR	
	Luguillo, PR	
	Manati, PR	
	Morovis, PR	
	Naguabo, PR	
	Naranjito, PR	
	Rio Grande, PR	
	San Juan, PR	
	Toa Alta, PR	
	Toa Baja, PR	
	Trujillo Alto, PR	
	Vega Alta, PR	
	Vega Baja, PR	
	Yabucoa, PR	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
7460	San Luis Obispo-Atascadero-Paso Robles, CA	1.1271
	San Luis Obispo, CA	
7480	Santa Barbara-Santa Maria-Lompoc, CA	1.0481
	Santa Barbara, CA	
7485	Santa Cruz-Watsonville, CA	1.3646
	Santa Cruz, CA	
7490	Santa Fe, NM	1.0712
	Los Alamos, NM	
	Santa Fe, NM	
7500	Santa Rosa, CA	1.3046
	Sonoma, CA	
7510	Sarasota-Bradenton, FL	0.9425
	Manatee, FL	
	Sarasota, FL	
7520	Savannah, GA	0.9376
	Bryan, GA	
	Chatham, GA	
	Effingham, GA	
7560	Scranton-Wilkes-Barre-Hazleton, PA	0.8599
	Columbia, PA	
	Lackawanna, PA	
	Luzerne, PA	
	Wyoming, PA	
7600	Seattle-Bellevue-Everett, WA	1.1474
	Island, WA	
	King, WA	
	Snohomish, WA	
7610	Sharon, PA	0.7869
	Mercer, PA	
7620	Sheboygan, WI	0.8697
	Sheboygan, WI	
7640	Sherman-Denison, TX	0.9255
	Grayson, TX	
7680	Shreveport-Bossier City, LA	0.8987
	Bossier, LA	
	Caddo, LA	
	Webster, LA	
7720	Sioux City, IA-NE	0.9046
	Woodbury, IA	
	Dakota, NE	
7760	Sioux Falls, SD	0.9257
	Lincoln, SD	
	Minnehaha, SD	
7800	South Bend, IN	0.9802
	St. Joseph, IN	
7840	Spokane, WA	1.0852
	Spokane, WA	
7880	Springfield, IL	0.8659
	Menard, IL	
	Sangamon, IL	
7920	Springfield, MO	0.8424
	Christian, MO	
	Greene, MO	
	Webster, MO	
8003	Springfield, MA	1.0927
	Hampden, MA	
	Hampshire, MA	
8050	State College, PA	0.8941
	Centre, PA	
8080	Steubenville-Weirton, OH-WV	0.8804
	Jefferson, OH	
	Brooke, WV	
	Hancock, WV	
8120	Stockton-Lodi, CA	1.0506
	San Joaquin, CA	
8140	Sumter, SC	0.8273
	Sumter, SC	
8160	Syracuse, NY	0.9714
	Cayuga, NY	
	Madison, NY	
	Onondaga, NY	
	Oswego, NY	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
8200	Tacoma, WA	1.0940
	Pierce, WA	
8240	Tallahassee, FL	0.8504
	Gadsden, FL	
	Leon, FL	
8280	Tampa-St. Petersburg-Clearwater, FL	0.9065
	Hernando, FL	
	Hillsborough, FL	
	Pasco, FL	
	Pinellas, FL	
8320	Terre Haute, IN	0.8599
	Clay, IN	
	Vermillion, IN	
	Vigo, IN	
8360	Texarkana, AR-Texarkana, TX	0.8088
	Miller, AR	
	Bowie, TX	
8400	Toledo, OH	0.9810
	Fulton, OH	
	Lucas, OH	
	Wood, OH	
8440	Topeka, KS	0.9199
	Shawnee, KS	
8480	Trenton, NJ	1.0432
	Mercer, NJ	
8520	Tucson, AZ	.8911
	Pima, AZ	
8560	Tulsa, OK	0.8332
	Creek, OK	
	Osage, OK	
	Rogers, OK	
	Tulsa, OK	
	Wagoner, OK	
8600	Tuscaloosa, AL	0.8130
	Tuscaloosa, AL	
8640	Tyler, TX	0.9521
	Smith, TX	
8680	Utica-Rome, NY	0.8465
	Herkimer, NY	
	Oneida, NY	
8720	Vallejo-Fairfield-Napa, CA	1.3354
	Napa, CA	
	Solano, CA	
8735	Ventura, CA	1.1096
	Ventura, CA	
8750	Victoria, TX	0.8756
	Victoria, TX	
8760	Vineland-Millville-Bridgeton, NJ	1.0031
	Cumberland, NJ	
8780	Visalia-Tulare-Porterville, CA	0.9429
	Tulare, CA	
8800	Waco, TX	0.8073
	McLennan, TX	
8840	Washington, DC–MD–VA–WV	1.0851
	District of Columbia, DC	
	Calvert, MD	
	Charles, MD	
	Frederick, MD	
	Montgomery, MD	
	Prince Georges, MD	
	Alexandria City, VA	
	Arlington, VA	
	Clarke, VA	
	Culpepper, VA	
	Fairfax, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fauquier, VA	
	Fredericksburg City, VA	
	King George, VA	
	Loudoun, VA	
	Manassas City, VA	

ADDENDUM B1.—PROPOSED PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

MSA	Urban area (constituent counties or county equivalents)	Wage index
	Manassas Park City, VA	
	Prince William, VA	
	Spotsylvania, VA	
	Stafford, VA	
	Warren, VA	
	Berkeley, WV	
	Jefferson, WV	
8920	Waterloo-Cedar Falls, IA	0.8069
	Black Hawk, IA	
8940	Wausau, WI	0.9782
	Marathon, WI	
8960	West Palm Beach-Boca Raton, FL	0.9939
	Palm Beach, FL	
9000	Wheeling, OH–WV	0.7670
	Belmont, OH	
	Marshall, WV	
	Ohio, WV	
9040	Wichita, KS	0.9520
	Butler, KS	
	Harvey, KS	
	Sedgwick, KS	
9080	Wichita Falls, TX	0.8498
	Archer, TX	
	Wichita, TX	
9140	Williamsport, PA	0.8544
	Lycoming, PA	
9160	Wilmington-Newark, DE–MD	1.1173
	New Castle, DE	
	Cecil, MD	
9200	Wilmington, NC	0.9640
	New Hanover, NC	
	Brunswick, NC	
9260	Yakima, WA	1.0569
	Yakima, WA	
9270	Yolo, CA	0.9434
	Yolo, CA	
9280	York, PA	0.9026
	York, PA	
9320	Youngstown-Warren, OH	0.9358
	Columbiana, OH	
	Mahoning, OH	
	Trumbull, OH	
9340	Yuba City, CA	1.0276
	Sutter, CA	
	Yuba, CA	
9360	Yuma, AZ	0.8589
	Yuma, AZ	

ADDENDUM B2.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7660
Alaska	1.2293
Arizona	0.8493
Arkansas	0.7666
California	0.9840
Colorado	0.9015
Connecticut	1.2394
Delaware	0.9128
Florida	0.8814
Georgia	0.8230
Guam	0.9611
Hawaii	1.0255
Idaho	0.8747
Illinois	0.8204
Indiana	0.8755
Iowa	0.8315
Kansas	0.7923
Kentucky	0.8079

ADDENDUM B2.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Louisiana	0.7567
Maine	0.8874
Maryland	0.8946
Massachusetts	1.1288
Michigan	0.9000
Minnesota	0.9151
Mississippi	0.7680
Missouri	0.8021
Montana	0.8481
Nebraska	0.8204
Nevada	0.9577
New Hampshire	0.9796
New Jersey [1]	
New Mexico	0.8872
New York	0.8542
North Carolina	0.8666
North Dakota	0.7788

ADDENDUM B2.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Ohio	0.8613
Oklahoma	0.7590
Oregon	1.0303
Pennsylvania	0.8462
Puerto Rico	0.4356
Rhode Island [1]	
South Carolina	0.8607
South Dakota	0.7815
Tennessee	0.7877
Texas	0.7821
Utah	0.9312
Vermont	0.9345
Virginia	0.8504
Virgin Islands	0.7845
Washington	1.0179
West Virginia	0.7975
Wisconsin	0.9162

ADDENDUM B2.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Wyoming	0.9007

[1] All counties within the State are classified urban.

BILLING CODE 4120–01–P

ADDENDUM C-- CASE MIX ASSESSMENT TOOL (CMAT) DRAFT 7.0 version 1.0

For research purposes only - Final operational instrument will retain only items useful for case mix. Paper version of automated CMAT.

DEMOGRAPHICS

1. Name of Patient (last, first, MI, suffix)

2. Medicare Number

3. Medical Record Number

4. Medicare Facility Identification Number

5. Gender 1. Male 2. Female

6. Date of Birth (MM-DD-YYYY)

7. Education (Highest Level Completed)
1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's Degree
8. Graduate Degree

SERVICE HISTORY

8. Number of Psychiatric Admissions Record the number of lifetime psychiatric admissions, not including this one.
0. None 1. 1-3
2. 4-10 3. 11 or more

9. Number of Medications Record the number of different medications administered in last 7 days, including OTCs

STAY PARAMETERS

10. Legal Status
1. Voluntary
2. Involuntary (e.g., civil court hold, admitted by guardian)
3. Criminal court hold (e.g., forensic)

11. Admission Date (MM-DD-YYYY)

12. Assessment Date (MM-DD-YYYY)

13. Type of Hospital
1. Freestanding psychiatric hospital
2. Exempt unit in a general hospital
3. State psychiatric hospital
4. Federal psychiatric hospital
5. Other _____

14. Housing Status: Availability of housing at discharge
0. No 1. Yes 2. Discharge not expected

PSYCHIATRIC and COMORBID CONDITIONS

15. Psychiatric Diagnoses During Stay
ICD-9 codes at **admission** ICD-9 codes **current**

16. Medical Diagnoses/ Complexities During Stay
ICD-9 codes Condition is unstable or out of control 0.No 1.Yes

17. Depressed (Code for indicators observed in the last 3 days)
0. Not exhibited
1. Not exhibited in last three days but is reported to be present
2. Exhibited 1-2 of last 3 days
3. Exhibited daily, not persistent
4. Exhibited daily, persistent

a. Facial Expression: sad, pained, worried facial expression (e.g., furrowed brow)
b. Tearfulness: crying, tearfulness
c. Negative or Depressive Statements: patient made negative statements (e.g., "Nothing matters; I would rather be dead; What's the use; Let me die"; regrets having lived so long)
d. Anxious Complaints: repetitive anxious complaints (non-health related) (e.g., persistently seeks attention/reassurance)
e. Fears/Phobias: expression (including non-verbal) of what appear to be unrealistic fears (e.g., fear of being abandoned, of being left alone, of being with others) or intense fear of specific objects or situations
f. Health Complaints: repetitive health complaints (e.g., persistently seeks medical attention; excessive concerns with bodily functions)
g. Anger: persistent anger with self or others (e.g., easily annoyed; anger at care received)

CASE MIX ASSESSMENT TOOL (CMAT) DRAFT 7.0 version 1.0

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PSYCHIATRIC and COMORBID CONDITIONS (cont)

18. Psychotic Symptoms (Code for indicators observed in the last 3 days)

0. Not exhibited
1. Not exhibited in last three days but is reported to be present
2. Exhibited 1-2 of last 3 days
3. Exhibited daily, not persistent
4. Exhibited daily, persistent

a. Hallucinations: Erroneous/false perception involving any of the senses (hearing, vision, smell, taste, touch) ☐
b. Delusions: Fixed false beliefs or thoughts ☐
c. Disorganized Thinking/Speech: Loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality, etc. ☐

19. Mania - grandiosity, talkativeness, racing thoughts/flight of ideas, distractibility, agitation, irritability. Indicate if exhibited in last 3 days. ☐

0. Not exhibited 1. Exhibited 1-2 of last 3 days 2. Exhibited daily

20. Danger to Others (Code for most recent incidence)

0. Never exhibited
1. Instance prior to the last year
2. Instance in the last year
3. Instance in the last 30 days
4. Instance in the last 3 days

a. Violence toward Others ☐
b. Violent Ideation ☐

21. Aggression (Code for frequency within the last 3 days)

0. Not exhibited
1. Not exhibited in last three days but is reported to be present
2. Exhibited 1-2 of last 3 days
3. Exhibited daily, not persistent
4. Exhibited daily, persistent

a. Verbal Aggression ☐
b. Physical Aggression (e.g., attack or assault) ☐

22. Self-injury and Suicidality

a. Considered performing a self-injurious act in the last 30 days ☐
0. No 1. Yes

b. Self-Injurious attempt (Code for most recent instance) ☐
0. Never
1. Attempt more than 1 year ago
2. Attempt in the last year
3. Attempt in the last 30 days
4. Attempt in the last 3 days

c. Intent of any self-injurious attempt was to kill him/herself ☐
0. No/No attempt 1. Yes

d. Suicide plan - Patient has a current suicide plan ☐
0. No 1. Yes

23. Cognitive Function / Communication

a. Short-term memory OK - seems/appears to recall after 5 minutes ☐
0. Memory OK 1. Memory Problem

b. Long-term memory OK - seems/appears to recall distant past ☐
0. Memory OK 1. Memory Problem

c. Procedural memory OK - Can perform all or almost all steps in a multi-task sequence without cues for initiation ☐
0. Memory OK 1. Memory Problem

d. Situational memory OK - Both recognizes staff names/faces frequently encountered **AND** knows location of places regularly visited (bedroom, dining room, activity room, therapy room) ☐
0. Memory OK 1. Memory Problem

e. Daily decision making: How well patient makes decisions about organizing the day (e.g., when to get up or have meals, which clothes to wear or activities to do) ☐

0. Independent - decisions consistent/reasonable
1. Modified Independence - some difficulty in new situations only
2. Minimally Impaired - in specific situations, decisions become poor and cues/supervision necessary at those times
3. Moderately Impaired - decision is consistantly poor, cues/supervision required at all times
4. Severely Impaired - never/rarely makes decisions

f. Insight into mental health problems - Degree of patient insight ☐
0. Full 1. Limited 2. None

g. Making self understood (Expression) - Expressing information content -- however able ☐

0. Understood—Expresses ideas without difficulty
1. Usually understood—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
2. Often understood -- Difficulty finding words or finishing thoughts, prompting usually required
3. Sometimes understood -- Ability is limited to concrete requests
4. Rarely/never understood

CASE MIX ASSESSMENT TOOL (CMAT) DRAFT 7.0 version 1.0

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PSYCHIATRIC and COMORBID CONDITIONS (cont)

24. Signs and Symptoms (Code for indicators observed in last 3 days)
0. No 1. Yes

- **a. Dry mouth** ☐
- **b. Nausea** ☐
- **c. Constipation** ☐
- **d. Impaired Balance/ataxia** ☐
- **e. Edema** ☐

25. Health Problems:

a. Pain - Frequently complains or shows evidence of pain in last 3 days ☐
0. None 1. Less than daily 2. Daily

b. Sleep Problems - Any sleep problems present on 2 or more of the last 3 days, including awakening earlier than desired, difficulty falling asleep, restless or nonrestful sleep, too much sleep, interrupted sleep. ☐
0. No 1. Yes

26. Substance Abuse/Dependence

a. An increase in either amount or frequency of substance use within the past 30 days ☐
0. No 1. Yes

b. Unable to control substance use within the past 30 days ☐
0. No 1. Yes

c. Substance Abuse Withdrawal: Severity of signs or symptoms possibly indicative of withdrawal from alcohol or drugs. Code for most severe level in last 3 days. ☐

- **0. None**
- **1. Mild** - symptoms typical of early stages of withdrawal (e.g., agitation, "jitters", craving, hostility, gastrointestinal upset, anxiety, vivid dreaming)
- **2. Moderate** - increased severity of early indicators, weakness, sweating, hot flashes, fainting, muscle twitching
- **3. Severe** - symptoms typical of late stages of withdrawal (e.g., exhaustion, seizures, tremors, tachycardia, disorientation, hyperventilation)

d. Intentional Misuse of Medication - Misuse of prescription or over-the-counter medications in the **past 30 days** (e.g., uses medication for purpose other than intended) ☐
0. No 1. Yes

27. History of Abuse Towards Patient
0. No 1. Yes

- **a. Any history of physical abuse or assault** ☐
- **b. Any history of sexual abuse or assault** ☐
- **c. Any history of emotional abuse** ☐

FUNCTIONING

28. Activities of Daily Living: Code for self-performance, last 3 days

- **0. Independent** - no help, setup, or supervision - or help, setup or supervision provided only 1 or 2 times
- **1. Setup help only** - article or device provided or placed within reach of patient 3 or more times
- **2. Supervision** - oversight, encouragement or cueing provided 3 or more times – OR – supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)
- **3. Limited Assistance** – patient highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times –OR– combination of non-weight bearing help with more help provided only 1 or 2 times (for a total of 3 or more episodes of physical help)
- **4. Extensive Assistance** – patient performed part of activity on own (50% or more of subtasks) BUT help of the following type(s) was provided 3 or more times:
  – Weight-bearing support (e.g., holding weight of limb, trunk)
  – Full performance by another of a task (some of the time) or discrete subtask
- **5. Maximal Assistance** – patient was involved and completed less than 50% of subtasks on own, received weight bearing help or full performance of certain subtasks 3 or more times. Includes two person assists where the patient completes less than 50% of subtasks on own
- **6. Total Dependence** – full performance of activity by other(s)
- **8. Activity did not occur**

a. Personal Hygiene: how patient maintains personal hygiene. Includes combing hair, brushing teeth, shaving, applying makeup, controlling body odor, washing/drying face, hands, and perineum (exclude baths & showers) ☐

b. Locomotion: how patient moves between locations in his or her room and adjacent corridor on same floor. If in wheelchair, self sufficiency once in wheelchair ☐

c. Toilet Use: How patient uses the toilet room (or commode, bedpan, urinal) ☐

d. Eating: How patient eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) ☐

CASE MIX ASSESSMENT TOOL (CMAT) DRAFT 7.0 version 1.0

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FUNCTIONING (cont)

29. Capacity to Perform Instrumental Activities of Daily Living

If patient *had been required* to carry out the activity over the **last 24 hours**, *speculate* and code for what you consider the patient's capacity (ability) would have been to perform the activity at that time

0. **Independent**– would have required no help, setup, or supervision
1. **Setup Help Only** – would have required help that would have been limited to providing or placing article/device within reach of patient; could have performed all other tasks on own
2. **Supervision** – would have required oversight, encouragement, or cueing
3. **Limited Assistance** – on some occasion(s) could have done on own, other times would have required help
4. **Moderate Assistance** – while patient could have been involved, would have required presence of helper at all times, and would have performed 50% or more of subtasks on own
5. **Maximal Assistance**– while patient could have been involved, would have required presence of helper at all times, and would have performed less than 50% of subtasks on own
6. **Total Dependence**– full performance by other(s) of activity would have been required at all times (no residual capacity exists)

a. Meal Preparation: How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils) ☐

b. Managing Medications: How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments) ☐

c. Transportation: How patient travels by vehicle (e.g., gets to places beyond walking distance) ☐

30. Bladder Continence: In the last 3 days, control of urinary bladder function (includes dribbling)

0. **Continent** - Complete control - DOES NOT USE any type of catheter or other urinary collection device
1. **Continent With Catheter** - Complete control with use of catheter or urinary collection device that doesn't leak urine
2. **Infrequent Incontinence** - Not incontinent over last 3 days, but patient does have incontinent episodes ☐
3. **Episode of Incontinence** - On one day
4. **Occasionally Incontinent** - On two days
5. **Frequently Incontinent** - Tended to be incontinent daily, but some control present (e.g., during day)
6. **Incontinent** - Inadequate control of bladder
8. **Did Not Occur** - No urine output from bladder.

31. Number of Falls in last 30 days ☐

0. None 1. One 2. Two or more

SERVICE / TREATMENTS

32. Past ECT: Time since last ECT ☐

0. Never received
1. Instance prior to the last year
2. Instance in the last year
3. Instance in the last 30 days
4. Instance in the last 3 days

33. Control Interventions (Code for use of each device in the **last 3 days**)

0. Not used
1. Less than daily use
2. Daily use - night only
3. Daily use - day only
4. Night and day, but not constant
5. Constant use for full 24 hours (with periodic release)

a. Mechanical restraint, no ambulation ☐
b. Mechanical restraint, ambulation possible ☐
c. Chair prevents rising ☐
d. Physical/manual restraint by staff ☐
e. Seclusion room ☐

DIAGNOSTIC STUDIES/LAB RESULTS

In the last 3 days, or since admission, code for the most recent test. For each test use the following codes:

0. Not evaluated
1. Evaluated, met criteria
2. Evaluated, did not meet criteria

34. White Blood Count, WBC: criteria - range 3.8 - 10.8 ☐

35. Head CT or MRI: criteria - No hemorrhages, infarcts, masses, or white matter hyperdensity. ☐

36. Lithium Toxicity: criteria - 1.2 or lower ☐

37. Completed by:

_____

(last, first, MI, suffix, degree)

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