

- 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