

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