

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, H.R. (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.