

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