



WISCONSIN HOSPITAL ASSOCIATION, INC.

**SUMMARY
OF THE
2004 MEDICARE PROPOSED RULE
FOR THE
INPATIENT PSYCHIATRIC FACILITY PROSPECTIVE
PAYMENT SYSTEM**

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SUMMARY OF THE 2004 MEDICARE PROPOSED RULE FOR THE INPATIENT PSYCHIATRIC FACILITY PROSPECTIVE PAYMENT SYSTEM

The Centers for Medicare and Medicaid Services (CMS) published proposed regulations for the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) in the November 28 *Federal Register*. Changes are scheduled to be effective for cost-reporting periods beginning on or after April 1, 2004. The rule proposes a prospective payment system for Medicare payment of inpatient services furnished in psychiatric hospitals and psychiatric units of acute care hospitals. The proposed rule provides for a 60-day comment period. CMS must receive comments by 5 p.m. on January 27, 2004. One original and two copies of comments may be delivered to:

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1213-P
P.O. Box 8012
Baltimore, MD 21244-8012

Alternatively, comments (an original and two copies) may be hand-delivered to CMS at:

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

This document summarizes the changes in the 2004 Inpatient Psychiatric Facility Prospective Payment System proposed rule. Where *Federal Register* page numbers are provided, they refer to the November 28, 2003 *Federal Register*. The proposed rule is available online at http://www.wha.org/financeAndData/pdf/2004ppsinppsyched_proprule.pdf.

INPATIENT PSYCHIATRIC FACILITY PROSPECTIVE PAYMENT SYSTEM

I. BACKGROUND

The IPF PPS will cover inpatient psychiatric services that are furnished in specialized hospitals, psychiatric distinct part or exempt units located in hospitals, and beds located in acute care hospitals that are in a separately certified exempt unit. Currently, psychiatric services in these hospitals and units are paid under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which is based on the reasonable costs of providing service to Medicare beneficiaries, subject to a limit on allowable costs.

The Balanced Budget Act of 1997 enacted several provisions to replace cost-based methods of reimbursement with prospective payment systems for excluded hospitals and units, including rehabilitation hospitals and units, long-term care hospitals, and psychiatric hospitals and units. The Balanced Budget Refinement Act of 1997 mandated the development of a per diem prospective payment system for Medicare inpatient psychiatric services provided in psychiatric hospitals or psychiatric distinct part units. The IPF PPS was to be implemented for cost-reporting periods beginning on or after October 1, 2002. However, according to CMS, proper analysis and administrative tasks delayed the release of the inpatient psychiatric payment rules.

The proposed IPF PPS would base payments on a national per diem rate with adjustments for wage index and teaching and an add-on for rural facilities. The payment for an individual patient would be further adjusted for factors such as the Diagnosis Related Group (DRG) classification, age, length of stay, and the presence of specified comorbidities. Additional payment would be provided for cost outlier cases.

The proposed IPF PPS would be effective for cost-reporting periods beginning on or after April 1, 2004. CMS is proposing that the annual rate year for the IPF PPS will be from July 1 to June 30, with the first update scheduled for July 1, 2005. Therefore, the first payment period of IPF PPS would be the 15-month period from April 1, 2004 through June 30, 2005. CMS has updated the base rate to the mid-point of this period. **CMS states that the implementation date may be delayed to allow time to review comments submitted on this proposal. In addition, CMS indicates that the transition period might be extended to allow time to refine the payment system before full implementation of the IPF PPS.**

CMS is proposing a three-year transition period for the implementation of the IPF PPS. During the transition period, IPFs would receive a blended payment of the PPS per diem payment amount and a hospital-specific amount based on the IPF's TEFRA payment. The table below outlines the transition period.

Proposed Three-Year Transition Period

April 1, 2004 - June 30, 2005	75%	Facility Specific
	25%	Per Diem
July 1, 2005 - June 30, 2006	50%	Facility Specific
	50%	Per Diem
July 1, 2006 - June 30, 2007	25%	Facility Specific
	75%	Per Diem
July 1, 2007	100%	Per Diem

When implementing the skilled nursing facility PPS and the rehabilitation PPS, CMS provided facilities the option of skipping the transition and receiving payment at 100% of the federal rate in the first year.

CMS rejected such an option for the IPF PPS. CMS holds that it is preferable to allow time to fine-tune the system and avoid major increases or decreases in revenue by gradually moving to full implementation.

II. PPS PAYMENT METHODOLOGY

The following example shows how PPS payment is calculated for a patient over the age of 65 with an 18-day psychiatric stay in a rural teaching hospital. Subsequent sections of this summary explain the calculation and provide details of the factors that are incorporated in the proposed IPF PPS.

Budget Neutral Base Rate Per Diem				\$530
Calculate Wage Adjusted Rate				
The labor portion of the base rate				\$386
Apply wage index factor of 0.8526 to the labor portion of \$386				\$329
The non-labor portion of the Federal base rate				\$144
The total wage-adjusted rate				\$473
Apply Facility Level Adjustments				
Teaching Adjustment				1.09
Rural Adjustment (if applicable)				1.16
Apply Patient Level Adjustments				
DRG 12: Degenerative Nervous System Disorders				1.07
Apply age adjustment				1.13
Apply comorbidity adjusters:				
Arteriosclerosis of the Extremity with Gangrene				1.17
Renal Failure, Chronic				1.14
Infectious Diseases				1.08
Total PPS Adjustment Factor (multiply all facility and patient level adjustments together)				2.2054
The wage-adjusted and pps-adjusted per diem amount is (2.2054 * \$473)				\$1,043
Apply variable per diem adjustment for 18 days:				
		Days	Payments	
Day 1 (adjustment factor=1.26):	\$1,043 * 1.26 = \$1,315	1	\$1,315	
Days 2-4 (adjustment factor=1.12):	\$1,043 * 1.12 = \$1,169	3	\$3,506	
Days 5-8 (adjustment factor=1.05):	\$1,043 * 1.05 = \$1,096	4	\$4,382	
Days over 8 (adjustment factor=1.00):	\$1,043 * 1.00 = \$1,043	10	\$10,434	
Total Psychiatric Hospital PPS Payment:				\$19,637

The above example is based on the IPF PPS Payment Calculator, which CMS has posted on its Web site at www.cms.gov/providers/ipfpps. The calculator is a Microsoft® Excel spreadsheet that will calculate the PPS payment for an individual psychiatric case.

NATIONAL PER DIEM BASE RATE

The IPF proposed rule establishes a per diem payment rate for inpatient psychiatric services. The rate is calculated to provide reimbursement for the average daily cost of inpatient psychiatric care, including capital-related costs. It is adjusted to make total payments under the IPF PPS budget neutral compared to the payments that would have been provided by the TEFRA methodology. **The proposed per diem base rate for the IPF PPS is \$530. CMS does not provide a breakdown of the adjustments to the rate but**

does specify that it incorporates a 2% reduction to account for outlier payments and a 19% reduction to account for budget neutrality and for a behavioral offset. CMS' calculation of the federal per diem base rate is discussed below.

Base Year Cost (*Federal Register* page 66936): CMS calculated the average cost per day for routine and ancillary services as reported in the 1999 cost reports filed by psychiatric hospitals and distinct part units. This resulted in an unadjusted national per diem cost of \$562 for each day of inpatient psychiatric care. To create an efficient process of updates for the various Medicare payment systems, CMS is recommending that the first federal base rate update occur on July 1, 2005. Therefore, CMS is proposing to calculate the federal per diem base rate for the 15-month period—April 1, 2004 through June 30, 2005.

Budget Neutrality Adjustment (*Federal Register* 66937): The IPF PPS is required to be budget-neutral compared to payment under the TEFRA methodology. CMS projected the TEFRA payments by updating the TEFRA data reported in the 1999 cost reports to the mid-point of the April 1, 2004 through June 30, 2005 rate period. The projected TEFRA payments were then compared to estimated PPS payments.

Outlier Adjustment (*Federal Register* 66939): CMS is proposing to provide cost outlier payments at a level that will result in 2% of total IPF PPS payments allocated to outliers. Therefore, CMS reduced the per diem base rate by 2%. A complete discussion of the IPF PPS outlier policy is included in the Outlier Payments section below.

Proposed Behavioral Offset (*Federal Register* 66939): CMS is proposing to further adjust the federal per diem base rate for “behavioral offsets” because CMS expects that, under the new payment system “IPFs may experience usage patterns that are significantly different from current usage patterns.” CMS notes in the proposed rule that because the proposed system is a per diem system, IPFs might have an incentive to keep patients in the facility longer. In addition, the current TEFRA payment system does not rely on International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM) coding. Proper comorbidity coding will have an impact on PPS payments and CMS expects that IPFs will improve their coding practices once the IPF PPS is implemented.

The calculation of the proposed budget-neutral per diem base rate accounts for these effects through an adjustment commonly known as a behavioral offset. According to CMS, the offset is based on accepted actuarial practices and experience with implementation of other prospective payment systems. CMS assumed that the IPFs would regain 15% of potential losses and augment payment increases by 5%. CMS applied this assumption to the estimated losses and gains among the IPFs and decreased the base per diem rate accordingly. HANYS has concerns with discounting the rate based on the assumption of significant behavioral changes.

WAGE ADJUSTMENT (*Federal Register* 66939)

The proposal would adjust the labor-related portion of the per diem base rate for differences in area wage levels. **CMS proposes to adjust for labor costs using the inpatient acute care hospital wage indices**, on the assumption that inpatient acute data reflect wage levels similar to psychiatric units as well as freestanding psychiatric hospitals. CMS believes the actual location of the IPF is most appropriate for determining the wage adjustment; hospitals that are geographically reclassified for inpatient acute payment will not use the reclassified wage index for IPF payment and there will be no provision for a rural floor. This is consistent with the wage adjustment in other post-acute settings.

CMS has established the labor-related share of the rate for IPF PPS at 72.828% and the non-labor related share at 27.172%.

FACILITY-LEVEL ADJUSTMENTS

Based on an analysis of cost differences across facility types, CMS is proposing to adjust the per diem base rate for rural location and for teaching status. CMS also considered, but rejected, a Disproportionate Share Hospital (DSH) adjustment and an adjustment for psychiatric units located in an acute care facility as opposed to psychiatric hospitals.

Teaching Status (*Federal Register* 66932): To account for the higher costs associated with psychiatric teaching facilities, CMS proposes providing an adjustment based on the ratio of the number of interns and residents assigned to the psychiatric unit to the average daily census (ADC) for the unit. **The IPF PPS teaching payment adjustment would be equal to the (1 + resident to ADC ratio) raised to the power of .5215.** An example of the calculation of the teaching adjustment is shown below.

$$\begin{aligned} \text{IPF ADC} &= 4,000 \text{ (total IPF patient days)} / 365 = 10.96 \\ \text{IPF Resident to ADC Ratio} &= 2.0 \text{ (residents)} / 10.96 \text{ (calculated ADC)} = .183 \\ \text{IPF Teaching Adjustment} &= \{1 + .183 \text{ (teaching status)}\} ^ .5215 \text{ (IPF teaching payment adj.)} = 1.09 \end{aligned}$$

CMS is concerned that hospitals may begin adding residents to psychiatric units unless there is a means of limiting growth. In the proposal, CMS indicates that it is considering extending the existing acute inpatient Indirect Medical Education resident caps to IPF teaching facilities.

Rural Location (*Federal Register* 66932): Based on a regression analysis, CMS found that smaller facilities are generally more costly on a per diem basis. Rural facilities are typically smaller and have average costs approximately 16% higher than facilities located in metropolitan areas. **Therefore, CMS is proposing a 16% adjustment to the per diem base rate for rural IPFs.**

Rejected Potential Adjustments (*Federal Register* 66932): CMS considered a DSH adjustment similar to that used in the inpatient acute PPS. However, CMS' analysis found that psychiatric facilities with higher DSH proportions actually had lower per diem costs. CMS did find that psychiatric units have higher costs than freestanding psychiatric hospitals. Even after controlling for size, occupancy, and patient comorbidities, psychiatric unit costs were 19% higher. CMS speculates that the higher costs may relate to admissions through the emergency room, to patients with medical conditions in addition to their psychiatric symptoms, to differences in patterns of care and staffing, and to accounting differences. However, CMS rejects a general adjustment for psychiatric units that would not take into account an individual unit's costs, efficiency, or case mix. Instead, CMS believes that refined adjustments for patient care needs will eventually address this issue.

PATIENT-LEVEL ADJUSTMENTS

CMS proposes adjusting the per diem base rate for patient characteristics based on each patient's DRG assignment, age, and for specified comorbid conditions. In the rule CMS discussed, but is not proposing, an adjustment for patient gender.

Patient Classification and Diagnosis Related Groups (*Federal Register* page 66923): Currently, the mental health community uses the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) for diagnostic patient assessment. The ICD-9-CM coding system is currently used for reporting diagnostic information for payment purposes under the Inpatient PPS. IPF PPS claims include ICD-9-CM codes and, although the TEFRA payment methodology does not use DRGs, the CMS administrative files include the DRG that would have been valid for payment purposes if the IPF was not exempt from the PPS. Currently, this DRG information is used only for statistical information purposes.

CMS proposes using the ICD-9-CM codes to classify IPF patients into DRGs and use the DRG assignment as part of the IPF PPS. This will require that IPFs use the psychiatric diagnosis codes in Chapter Five (“Mental Disorder”) of the ICD-9-CM to report diagnostic information for the proposed IPF PPS. CMS is also requesting comments on the need to continue to reference the DSM if ICD-9-CM codes are used to report diagnostic information for payment purposes.

Medicare regulations require that psychiatric units of acute care hospitals admit only those patients with a principal diagnosis listed in the DSM or in the ICD-9-CM. Therefore, if a patient is admitted to a general hospital for a medical condition such as pneumonia and presents psychiatric symptoms requiring an admission to the psychiatric unit, the principal diagnosis for the admission to the unit should be the psychiatric symptom. CMS analyzed the DRG assignment for psychiatric diagnoses included in the ICD-9-CM code set and the DSM and identified **15 DRGs that would be recognized for payment under the IPF PPS.** Below is a table of the DRGs recognized under the proposed IPF PPS and the proposed adjustment factor.

Proposed IPF PPS DRGs

DRG	Description	Adjustment Factor
12	Degenerative Nervous System Disorders	1.07
23	Nontraumatic Stupor and Cornea	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)

CMS found that a small number of psychiatric cases were assigned to other DRGs that CMS is proposing not to recognize under the IPF PPS. According to CMS, these DRGs were determined not to be clinically significant because the principal diagnoses did not result in enough admissions to IPFs to establish an accurate relative weight. Under the proposal, claims submitted with information that results in assignment to a DRG not recognized under the IPF PPS would be returned to the IPF for resubmission.

Patient Age (*Federal Register* 66931): CMS’ analysis determined that the per diem cost rises as a patient’s age increases. Therefore, CMS is proposing an adjustment of 13% to the per diem base rate for patients over the age of 65.

Comorbidities (*Federal Register* 66930): Psychiatric patients with comorbid conditions are generally more costly on a per diem basis. After review of ICD-9-CM codes, **CMS identified 17 comorbid conditions that would receive an adjustment to the per diem base rate.** The CMS proposal creates groups of ICD-9-CM codes to describe the similar comorbid conditions. Below is a table of the proposed comorbidity groups and the proposed adjustment factors.

Proposed Comorbidity Categories

Comorbidity Groupings	Adjustment Factor
Atherosclerosis of Extremity with Gangrene	1.17
Tracheotomy	1.14
Renal Failure, Chronic	1.14
Poisoning	1.14
Cardiac Conditions	1.13
Severe Protein Calorie Malnutrition	1.12
Chronic Obstructive Pulmonary Disease	1.12
Severe Musculoskeletal and Connective Tissue Diseases	1.12
Coagulation Factor Deficits	1.11
Malignant Neoplasms	1.10
Uncontrolled Diabetes Mellitus with or without Complications	1.10
Artificial Openings-Digestive and Urinary	1.09
Infectious Diseases	1.08
Renal Failure, Acute	1.08
Human Immunodeficiency Virus	1.06
Eating and Conduct Disorders	1.03
Drug and/or Alcohol Induced Mental	1.03

LENGTH OF STAY (*Federal Register 66931*)

CMS is proposing to apply a further adjustment to the per diem rate to account for the higher costs associated with the first days of an IPF stay. **The rule proposes to increase the rate for the first day of the stay by 26%. The rate for days two to four would be increased by 12% and the rate for days five through eight would be increased by 5%.** CMS notes that the higher payments for the earlier days of the stay are offset through the budget neutrality adjustment, lowering the overall payment rate.

III. OUTLIER PAYMENTS (*Federal Register 66933*)

To protect IPFs from significant “losses,” CMS is proposing to provide outlier payments for cases that require more costly care. Total outlier payments would be equal to 2% of the IPF PPS payments.

Outlier payments would be provided when the estimated cost of the patient’s entire stay exceeds the outlier threshold amount, defined as the total IPF PPS payment for the stay plus the fixed dollar loss amount. **CMS is proposing a fixed dollar loss amount of \$4,200,** which would be adjusted by the IPF’s facility adjustments (wage, rural location, and teaching status). The costs that exceed the outlier threshold would be further adjusted by the loss sharing ratio. CMS is proposing two separate loss sharing ratios. Since the per diem payment under the proposed IPF PPS is highest in the early days of the stay, **the proposed outlier payment adjustment for days one through eight of the stay is 80%. For days nine and thereafter, the adjustment would be 60%.**

CMS provides an example of the proposed outlier methodology on page 66936 of the *Federal Register*.

Calculation of the Proposed Outlier Payment

Calculate the Fixed Dollar Loss Threshold:		
Fixed Dollar Threshold		\$4,200
Wage adjusted labor share (.72828*4,200)*.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 Charges	\$20,000	
Cost to Charge Ratio	0.72	
Hospital Costs (\$20,000 * .72)	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	

The outlier calculation requires that the charges for a patient stay be converted to cost using the facility's cost-to-charge ratio (CCR). CMS is proposing to regulate the IPF PPS outlier policy in accordance with the provisions of the acute inpatient PPS outlier policy. Therefore, CMS is proposing to use the CCR from the latter of the most recently settled Medicare IPF cost report or the most recently tentative settled IPF Medicare cost report. In addition, CMS is proposing to enact a retroactive adjustment process with regard to the cost outlier adjustment. CMS will also apply a ceiling in determining a facility's CCR based on three times the standard deviation of the urban and rural IPF CCR.

IV. INTERRUPTED STAYS *(Federal Register 66936)*

Under the proposed IPF PPS, the per diem rate is increased for the first eight days of the IPF stay. CMS, "concerned that IPF could maximize payment by prematurely discharging patients after the eight days during which they receive higher payments (the variable per diem adjustments), and then readmitting the same patient," is proposing an interrupted stay policy. **CMS proposes to treat an IPF episode as a single stay if a patient is discharged from an IPF and returns to the same IPF within five consecutive calendar days.** Under the proposal, the costs of both stays would be combined for determining qualification for outlier payments.

V. RECERTIFICATION REQUIREMENTS *(Federal Register 66939)*

Currently, payment for inpatient psychiatric care is made only if a physician certifies and recertifies the need for a service. Current regulations specify that 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) if the hospital's records show that the services furnished were intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services. Current regulations require the first recertification after admission to occur as of the eighteenth day of hospitalization.

CMS proposes to revise the timing of the first recertification to the tenth day of hospitalization. In addition, CMS proposes requiring the physician to certify that the patient continues to need daily inpatient psychiatric care furnished directly by, or requiring the supervision of, inpatient psychiatric facility personnel or needs other professional services that as a practical matter can only be provided on an inpatient basis.

VI. NEW PROVIDERS (*Federal Register 66942*)

CMS is proposing to define a new IPF as a provider of inpatient psychiatric hospital services that meets the qualifying criteria, and whose first cost reporting period begins on or after April 1, 2004. New IPFs would be paid based on the national per diem rate without the three-year transition period.

VII. PERIODIC INTERIM PAYMENTS (PIPS) (*Federal Register 66942*)

Under TEFRA, IPFs may request interim payments approximating the actual costs of the provider. In addition, an IPF that is experiencing financial difficulties due to a delay by the fiscal intermediary in making payment, or a temporary delay in the IPF's preparation and submittal of bills because of an exceptional situation, may request accelerated payments. **CMS is proposing to continue both PIP and accelerated payments under the proposed IPF PPS.**

VIII. FUTURE UPDATES AND REFINEMENTS

Updates (*Federal Register 66942*): **CMS is proposing to delay updates to the adjustment factors described above and to delay recalculation of the per diem base rate until July 1, 2007.** This is the earliest that data from the first full year of IPF PPS will be available for analysis. Until that time, CMS is proposing to publish a notice each spring that would update the federal per diem base rate using the excluded hospital marketbasket, apply the most current hospital wage index, and update the outlier threshold to maintain payments at 2% of total IPF payments. Any revisions to ICD-9-CM codes or any DRG modifications effective October 1 under the Inpatient PPS would also affect the IPF PPS.

Future Refinements (*Federal Register 66943*): CMS believes that future refinement of the payment system may require additional patient information and the proposed rule discusses the development of a standard assessment tool. CMS, in conjunction with the University of Michigan's Public Health Institute, is attempting to develop a patient classification system based on a standard assessment tool called the Case Mix Assessment Tool (CMAT). CMS has attached a preliminary version of the CMAT to the proposed rule for review and comment. CMS believes that this automated tool could collect important information that is already available in the patient's medical record and treatment plans, requiring no additional data collection. CMS requests comments on a potential assessment instrument.

CMS has also 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. CMS anticipates that this may result in future refinements based on variations in treatment practices or patient characteristics.