

We are proposing to revise § 412.4(d) to incorporate these additional 19 DRGs as qualifying DRGs for transfer payments and to make a conforming change to § 412.4(c).

We also examined whether any of these DRGs would qualify for the alternative payment methodology of 50 percent of the full DRG payment plus the per diem for the first day of the stay, and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment specified in existing regulations under § 412.4(f). To identify the DRGs that might qualify, the average charges for all cases with a length of stay of 1 day were compared to the average charges of all cases in a particular DRG. To qualify for the alternative methodology, the average charges of 1-day discharge cases must be at least 50 percent of the average charges for all cases in the DRG.

Based on this analysis, we determined that 5 out of the 19 DRGs would qualify for this payment method (DRGs 25, 122, 131, 297, and 321). However, the fact that the average charges of 1-day stays equal at least 50 percent of the average charges for all cases in these DRGs is due to the very short lengths of stay for these DRGs. Therefore, we do not believe that it is necessary to include them in the alternative payment methodology. For example, for a DRG with a 3-day geometric mean length of stay, full DRG payment will be met on the second day of the stay, regardless of which payment methodology is used. Therefore, we are proposing that none of the 19 additional DRGs that we are proposing to add to the postacute care transfer policy would be paid under the alternative payment methodology.

We also have analyzed the 10 DRGs that are currently subject to the postacute care transfer policy. Of the three DRGs that are receiving payments under the special payment (transfers after 1 day incur charges equal to at least 50 percent of the average charges for all cases). Unlike the five DRGs that would otherwise meet this criterion, the geometric mean lengths of stay of both DRG 209 and 211 are over 4 days. In addition, DRG 210 is currently paid under the special payment methodology, but our current analysis indicates average charges for one day stays are less than 50 percent of the average charges for all cases in the DRG. Nonetheless, DRG 210 is a paired with DRG 211, which meets the criteria. Therefore, we are proposing DRG 210 will continue to be paid under the special payment methodology. Similar to our rationale for including both paired DRGs when one qualifies for inclusion in the postacute care transfer

policy, we are including both DRGs in this pair under the special payment methodology. Accordingly, we are proposing that only DRGs 209, 210, and 211 that are currently paid under the alternative transfer payment methodology would continue to be paid under this methodology.

Finally, we note that the OIG has prepared several reports that examined hospitals' compliance with proper coding of patients' discharge status as transferred under our guidelines, and has found substantial noncompliance leading to excessive payments.<sup>4</sup> Specifically, the OIG found hospitals submitting claims indicating the patient had been discharged when, in fact, the patient was transferred to a postacute care setting. As we indicated in the May 8, 1998 **Federal Register** (63 FR 25593), hospitals found to be intentionally engaging in such practices may be investigated for fraudulent or abusive billing practices. We intend to work with the OIG to develop the most appropriate response to ensure all hospitals become compliant with our guidelines.

## B. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges beginning with that date, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Rural referral centers with a disproportionate share percentage of at least 30 percent are not subject to the 5.25 percent cap on DSH payments that is applicable to other rural hospitals (with the exception of rural hospitals with 500 or more beds). Rural referral centers are not subject to the proximity criteria when applying for geographic reclassification, and they do not have to meet the requirement that a hospital's average hourly wage must exceed 106 percent of the average hourly wage of the labor market area where the hospital is located.

<sup>4</sup> The OIG report identification numbers are: A-04-00-02162, A-04-00-01220 and A-04-01210. A fourth report is expected out soon.

As discussed in **Federal Register** documents at 62 FR 45999 and 63 FR 26325, under section 4202 of Public Law 105-33, a hospital that was classified as a rural referral center for FY 1991 is to be considered as a rural referral center for FY 1998 and later years so long as that hospital continues to be located in a rural area and does not voluntarily terminate its rural referral center status. Effective October 1, 2000, if a hospital located in what is now an urban area was ever a rural referral center, it is reinstated to rural referral center status (65 FR 47089). Otherwise, a hospital seeking rural referral center status must satisfy the applicable criteria.

One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5)). (See also the September 30, 1988 **Federal Register** (53 FR 38513).) With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if—

- The hospital's case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

### 1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national mean case-mix index value for FY 2004 includes all urban hospitals nationwide, and the proposed regional values for FY 2004 are the