

median values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). These proposed values are based on discharges occurring during FY 2002 (October 1, 2001 through September 30,

2002) and include bills posted to CMS' records through December 2002.

We are proposing that, in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2003, rural hospitals with fewer than 275 beds must have a case-mix index value for FY 2002 that is at least—

- 1.3374; or

- The median case-mix index value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located.

The proposed median case-mix index values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2252
2. Middle Atlantic (PA, NJ, NY)	1.2270
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3157
4. East North Central (IL, IN, MI, OH, WI)	1.2485
5. East South Central (AL, KY, MS, TN)	1.2511
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1841
7. West South Central (AR, LA, OK, TX)	1.2733
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3511
9. Pacific (AK, CA, HI, OR, WA)	1.2834

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 2002 MedPAR file, which will contain data from additional bills received through March 31, 2002.

Hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria should obtain hospital-specific case-mix index values (not transfer-adjusted) from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these case-mix index values are computed based on all

Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY

2002 (that is, October 1, 2001 through September 30, 2002).

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2003, must have as the number of discharges for its cost reporting period that began during FY 2002 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,476
2. Middle Atlantic (PA, NJ, NY)	8,906
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	9,497
4. East North Central (IL, IN, MI, OH, WI)	8,439
5. East South Central (AL, KY, MS, TN)	6,894
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	3,991
7. West South Central (AR, LA, OK, TX)	7,629
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,908
9. Pacific (AK, CA, HI, OR, WA)	7,021

These numbers will be revised in the final rule based on the latest available cost report data.

C. Indirect Medical Education (IME) Adjustment (§ 412.105) and Disproportionate Share Hospital (DSH) Adjustment (§ 412.105)

1. Available Beds and Patient Days: Background (§ 412.105(b) and § 412.106(a)(1)(ii))

Section 1886(d)(5)(B) of the Act provides that subsection (d) hospitals that have residents in approved graduate medical education (GME)

programs receive an additional payment for each discharge of Medicare beneficiaries to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The existing regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The additional payment is based on the IME adjustment factor, calculated using