

day of the stay compared to costs for all cases across the DRG). However, DRGs 121 and 122 did not meet the 50 percent threshold.

*Comment:* Commenters again noted their objection to the expansion of the policy to all DRGs, even though we did not propose to expand the policy to all DRGs at this time. They refer to the language in section 1886(d)(J) of the Act that states that only those DRGs that have a "high volume of discharges" and "disproportionate use of post discharge services" could be included in an expanded postacute care transfer policy. Since this language would not apply to many DRGs, it makes this possibility "implausible."

Commenters also argue that, since we admit we need to do further analysis before expanding the policy to all DRGs, it is unclear why we do not need to conduct further analysis to make an incremental expansion.

*Response:* As noted previously, we did not propose to expand this policy to all DRGs because, for some DRGs, it may not be appropriate to reduce payment for these DRGs if the base payment already reflects a similar postacute care utilization rate. For the 29 DRGs included in the policy effective October 1, 2003, we have determined the data indicate there is substantial utilization of postacute care early in the stay, leading to decreasing lengths of stay.

*Comment:* Other commenters noted that, if we were focusing our efforts on analyzing lengths of stay in this manner, we should redirect our focus instead on a more thorough analysis of length of stay in particular regions to determine if changes are being adequately reflected in the yearly updates.

*Response:* We recognize that lengths of stay have tended to vary by region, and that regions with shorter lengths of stay tend to also have lower average costs due to the fewer number of days that patient spend in the hospitals. One of the reasons for the variation is the greater reliance on postacute care earlier in the stay in those areas with lower average lengths of stay.

We do not believe it would be appropriate to base the transfer payment methodology on regional average lengths of stay. The national standardized amounts, which apply across all regions, reflect costs and lengths of stay across all regions. To the extent hospitals in one area of the country are transferring patients early in the course of their treatment while hospitals in another part of the country are providing the entire treatment in the acute care hospital, adjusting payments for those hospitals transferring patients early in the stay and reflecting this in

the process of recalibration maintains full DRG payments for hospitals in areas of the country providing the full course of treatment in the acute care hospital.

#### *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.

As discussed in **Federal Register** documents at 62 FR 45999 and 63 FR 26325, under section 4202 of Pub. L. 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 in the May 19, 2003 proposed rule included all urban hospitals nationwide, and the proposed regional values for FY 2004 were the 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 were based on discharges occurring during FY 2002 (October 1, 2001 through September 30, 2002) and included bills posted to CMS' records through December 2002.

In the May 19, 2003 proposed rule, we proposed 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. (See the table set forth in the May 19, 2003 proposed rule at 68 FR 27201.)