

Based on the latest data available (FY 2002 bills received through March 2003), in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2003, must have a case-mix index value for FY 2003 that is at least—

- 1.3373; 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 final 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) .....	1.2245
2. Middle Atlantic (PA, NJ, NY) .....	1.2262
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV) ..	1.3146
4. East North Central (IL, IN, MI, OH, WI) .....	1.2489
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) .....	1.2705
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY) .....	1.3482
9. Pacific (AK, CA, HI, OR, WA) .....	1.2845

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

Based on the latest discharge data available for FY 2002, the final median number of discharges for urban hospitals by census region area are as follows:

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

We reiterate that if an osteopathic hospital is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2003, the hospital must have at least 3,000 discharges for its cost reporting period that began during FY 2002.

We did not receive any comments on the criteria for rural referral centers.

### *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 hospitals' ratios of residents to beds. The determination of the number of beds, based on available bed days, is specified at § 412.105(b). This determination of the number of available beds is also applicable for other purposes, including the level of the disproportionate share hospital (DSH) adjustment payments under § 412.106(a)(1)(i).

Section 1886(d)(5)(F) of the Act specifies two methods for a hospital to qualify for the Medicare DSH adjustment. The primary method, which is a subject of this final rule, is for a hospital to qualify based on a complex statutory formula under which payment adjustments are based on the level of the DSH patient percentage. The first computation includes the number of patient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits. This number is divided by the total number of patient days that are associated with patients entitled to benefits under Medicare Part A. The second computation includes hospital patient days that are furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A. This number is divided by the number of total hospital inpatient days in the same period.

Hospitals whose DSH patient percentage exceeds 15 percent are eligible for a DSH payment adjustment (prior to April 1, 2001, the qualifying DSH patient percentage varied, in part, by the number of beds (66 FR 39882)). The DSH payment adjustment may vary based on the DSH patient percentage and the type of hospital: the statute provides for different adjustments for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, hospitals that qualify as rural referral centers or SCHs, and other hospitals.

As described in the May 19, 2003 proposed rule, we are combining in this final rule our discussion of changes to the policies for counting beds and patient days, in relation to the calculations at §§ 412.105(b) and 412.106(a)(1) because the underlying concepts are similar, and we believe they should generally be interpreted in a consistent manner for both purposes. Specifically, we proposed to clarify that