

account for the training that occurred in February. Therefore, Hospital C could not count the resident's time in the nonhospital setting from February 1 through February 20 for direct GME and IME purposes.

We note that our proposal to require hospitals to pay for the nonhospital site training costs concurrently with the training that occurs in the nonhospital site is a departure from our current policy concerning the timeframe in which a hospital must make payment for the training costs. Currently, we apply the existing regulations at § 413.100(c)(2)(i), which state that a short-term liability (such as the hospital's obligation to pay the nonhospital site for the residency training costs) must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred. However, because we are proposing to no longer require that a written agreement between the hospital and the nonhospital site be in place prior to the time that the hospital begins to count the FTE residents training in the nonhospital site, we believe that a reasonable alternative to ensure that a hospital is facilitating the training at the nonhospital site through its ongoing commitment to incur all or substantially all of the costs is to require the hospital to make payments concurrently with the training that occurs in the nonhospital site in order to count the FTE residents for purposes of direct GME and IME payments.

We are aware that there are situations where, rather than providing direct financial compensation to the nonhospital site for supervisory teaching activities, the hospital is incurring all or substantially all of the teaching physician costs through nonmonetary, in-kind arrangements. We are proposing that, in order to be considered concurrent with the nonhospital site training, in-kind arrangements must be provided or made available to the teaching physician at least quarterly, to the extent that there are residents training in a nonhospital setting(s) in a quarter.

We are proposing to revise § 413.86(f) (proposed to be redesignated as § 413.78 in this proposed rule) to add a new paragraph (§ 413.78 (e)) to state that a hospital must incur all or substantially all of the costs of training in a nonhospital setting by the end of the month following a month in which the training in the nonhospital site occurred, to the extent that there are residents training in a nonhospital setting in a month. This proposed change would be effective for portions of cost reporting periods occurring on or after October 1, 2004. We would revise

paragraph (d) of the proposed redesignated § 413.78 to reflect the effective cost reporting periods of the provisions under the new paragraph (e).

P. Rural Community Hospital Demonstration Program

[If you choose to comment on issues in this section, please include the caption "Rural Community Hospital Demonstration" at the beginning of your comment.]

Section 410A(a) of Public Law 108-173 requires the Secretary to establish a demonstration to test the feasibility and advisability of establishing "rural community hospitals" for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that—

- Is located in a rural area (as defined in section 1886(d)(8)(E) of the Act) or treated as being so located under section 1886(d)(5)(F) of the Act;
- Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;
- Provides 24-hour emergency care services; and
- Is not designated or eligible for designation as a CAH.

Section 410A(a)(3) of Public Law 108-173 specifies that the Secretary is to select for participation not more than 15 rural community hospitals in rural areas of States that the Secretary identifies as having low population densities. Using 2003 data from the U.S. Census Bureau, we have identified 10 States with the lowest population density in which rural community hospitals must be located to participate in the demonstration: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming. (Source: U.S. Census Bureau Statistical Abstract of the United States: 2003)

Under the demonstration, participating hospitals will be paid the reasonable costs of providing covered inpatient hospital services (other than services furnished by a psychiatric or rehabilitation unit of a hospital that is a distinct part), applicable for discharges occurring in the first cost reporting period beginning on or after implementation of the demonstration program. For discharges occurring in subsequent cost reporting periods, payment is the lesser of reasonable cost or a target amount, which is the prior year's cost or, after the second cost reporting period, the prior year's target amount, adjusted by the inpatient prospective payment update factor.

Covered inpatient hospital services means inpatient hospital services (defined in section 1861(b) of the Act) and includes extended care services furnished under an agreement under section 1883 of the Act.

Sections 410A(a)(5) and (a)(6) require the demonstration to be implemented not later than January 1, 2005, but not before October 1, 2004. The demonstration is to operate for 5 years. We intend to implement the payment change for a participating hospital under this demonstration with the hospital's first cost reporting period beginning on or after October 1, 2004.

Section 410A of Public Law 108-173 requires that "in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented." Generally, when CMS implements a demonstration on a budget neutral basis, the demonstration is budget neutral in its own terms; in other words, aggregate payments to the participating providers do not exceed the amount that would be paid to those same providers in the absence of the demonstration. This form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration participants. These reduced expenditures offset increased payments elsewhere under the demonstration, thus ensuring that the demonstration as a whole is budget neutral or yields savings. However, the small scale of this demonstration, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration could be viable under the usual form of budget neutrality. Specifically, cost-based payments to 15 small rural hospitals is likely to increase Medicare outlays without producing any offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these providers.

In order to achieve budget neutrality, we are proposing to adjust national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are proposing to apply budget neutrality across the payment system as

a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. This is because the statutory language refers merely to ensuring that "aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented," and does not identify the range across which aggregate payments must be held equal. We invite public comment on this proposal. We discuss the payment rate adjustment that would be required to ensure the budget neutrality of this demonstration in the Addendum of this proposed rule.

To participate in this demonstration, a hospital must be located in one of the identified States and meet the criteria for a rural community hospital. Eligible hospitals that desire to participate in the demonstration must submit an application to CMS. Information about the demonstration and details on how to apply can be found on the CMS Web site: www.cms.hhs.gov/researchers/demos/rch.asp.

This demonstration has been approved by OMB under the title "Medicare Waiver Demonstration Application," under OMB approval number 0938-0880, with a current expiration date of July 30, 2006.

Q. Special Circumstances of Hospitals Facing High Malpractice Insurance Rate Increases

[If you choose to comment on issues in this section, please include the caption "Malpractice Insurance" at the beginning of your comment.]

We have received comments from several hospitals about the effects of rapidly escalating malpractice insurance premiums on hospital financial performance and continued access for Medicare beneficiaries to high quality inpatient hospital services. We are aware that malpractice insurance premiums have increased at a high rate in some areas of the country during the last few years. While we are not aware of any specific situations in which malpractice premiums have created issues of access to inpatient hospital services for Medicare beneficiaries, some hospitals have expressed concern that they may be compelled to curtail their current operations by the rate of increase in their malpractice premiums. Therefore, we are inviting comments on the effect of increases in malpractice insurance premiums on hospitals participating in the Medicare program, and whether increasing malpractice

costs may pose access problems for Medicare beneficiaries.

V. Proposed Changes to the PPS for Capital-Related Costs

[If you choose to comment on issues in this section, please include the caption "Capital PPS" at the beginning of your comment.]

A. Background

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services "in accordance with a PPS established by the Secretary." Under the statute, the Secretary has broad authority in establishing and implementing the PPS for capital-related costs. We initially implemented the PPS for capital-related costs in the August 30, 1991 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Federal fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital PPS payments are based solely on the Federal rate for the acute care hospitals (other than certain new hospitals and hospitals receiving certain exception payments). The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

$$\text{(Standard Federal Rate)} \times \text{(DRG Weight)} \times \text{(Geographic Adjustment Factor (GAF))} \times \text{(Large Urban Add-on, if applicable)} \times \text{(COLA Adjustment for hospitals located in Alaska and Hawaii)} \times \text{(1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable)}$$

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year as specified in § 412.312(c) of the existing regulations.

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of \$5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the August 1, 2002 IPPS final rule (67 FR 50102), we

revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)), but were available only during the transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital PPS transition period. Hospitals eligible for special exceptions payments were required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), refer to the August 1, 2001 IPPS final rule (66 FR 39911 through 39914) and the August 1, 2002 IPPS final rule (67 FR 50102).)

Under the PPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years (56 FR 43418, August 30, 1991). During the 10-year transition period, a new hospital was exempt from the capital PPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because we believe that special protection to new hospitals is also appropriate even after the transition period, as discussed in the August 1, 2002 IPPS final rule (67 FR 50101), we revised the regulations at § 412.304(c)(2)