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Subpart F—Specific Categories of Costs

§413.75 Direct GME payments: General requirements.

(a) *Statutory basis and scope*— (1) Basis. This section and §§413.76 through 413.83 implement section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section and §§413.76 through 413.83 apply to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions.* For purposes of this section and §§413.76 through 413.83, the following definitions apply:

"*All or substantially all of the costs for the training program in the nonhospital setting*" means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education (GME).

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in §415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

Approved medical residency program means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in §415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, Suite 805, Evanston, Illinois 60201.

(3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

Base period means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.

Community support means funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. Community support does not include grants, gifts, and endowments of the kind that are not to be offset in accordance with section 1134 of the Act.

CPI–U stands for the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics.

Foreign medical graduate means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:

(1) The Liaison Committee on Medical Education of the American Medical Association.

(2) The American Osteopathic Association.

(3) The Commission on Dental Accreditation.

(4) The Council on Podiatric Medical Education.

FMGEMS stands for the Foreign Medical Graduate Examination in the Medical Sciences (Part I and Part II).

FTE stands for full-time equivalent.

GME stands for graduate medical education.

Medicare GME affiliated group means—

(1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in § 412.62(f) of this subchapter) or in a contiguous area and meet the rotation requirements in § 413.79(g)(2).

(2) Two or more hospitals that are not located in the same or in a contiguous urban or rural area, but meet the rotation requirement in § 413.79(g)(2), and are jointly listed—

(i) As the sponsor, primary clinical site, or major participating institution for one or more programs as these terms are used in the most current publication of the *Graduate Medical Education Directory;* or

(ii) As the sponsor or is listed under "affiliations and outside rotations" for one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs.*

(3) Two or more hospitals that are under common ownership and, effective for all Medicare GME affiliation agreements beginning July 1, 2003, meet the rotation requirement in § 413.79(g)(2).

Medicare GME affiliation agreement means a written, signed, and dated agreement by responsible representatives of each respective hospital in a Medicare GME affiliated group, as defined in this section, that specifies—

(1) The term of the Medicare GME affiliation agreement (which, at a minimum is 1 year), beginning on July 1 of a year;

(2) Each participating hospital's direct and indirect GME FTE caps in effect prior to the Medicare GME affiliation;

(3) The total adjustment to each hospital's FTE caps in each year that the Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;

(4) The adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in a shared rotational arrangement at each hospital participating in the Medicare GME affiliated group for each year the Medicare GME affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and

(5) The names of the participating hospitals and their Medicare provider numbers.

Medicare patient load means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

Primary care resident is a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice.

Redistribution of costs occurs when a hospital counts FTE residents in medical residency programs and the costs of the program had previously been incurred by an educational institution.

Resident means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.

Rural track FTE limitation means the maximum number of residents (as specified in § 413.79(l)) training in a rural track residency program that an urban hospital may include in its FTE count and that is in addition to the number of FTE residents already included in the hospital's FTE cap.

Rural track or integrated rural track means an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or a rural nonhospital site(s).

Shared rotational arrangement means a residency training program under which a resident(s) participates in

training at two or more hospitals in that program.

(c) *Payment for GME costs—General rule.* Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved GME programs as described in §§413.76 through 413.83.

(d) *Documentation requirements.* To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(1) The name and social security number of the resident.

(2) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(3) The dates the resident is assigned to the hospital and any hospital-based providers.

(4) The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any.

(5) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

(6) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of this section.

(7) The name of the employer paying the resident's salary.

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§413.76 Direct GME payments: Calculation of payments for GME costs.

A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

(a) *Step one.* The hospital's updated per resident amount (as determined under §413.77) is multiplied by the actual number of FTE residents (as determined under §413.79). This result is the aggregate approved amount for the cost reporting period.

(b) *Step two.* The product derived in step one is multiplied by the hospital's Medicare patient load.

(c) *Step three.* For portions of cost reporting periods occurring on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage equal to—

(1) 20 percent for 1998;

(2) 40 percent for 1999;

(3) 60 percent in 2000;

(4) 80 percent in 2001; and

(5) 100 percent in 2002 and subsequent years.

(d) *Step four.* Effective for portions of cost reporting periods occurring on or after January 1, 2000, the product derived from step three is reduced by a percentage equal to the ratio of the Medicare+Choice nursing and allied health payment "pool" for the current calendar year as described at §413.87(f), to the projected total Medicare+Choice direct GME payments made to all hospitals for the current calendar year.

(e) *Step five.* (1) For portions of cost reporting periods beginning on or after January 1, 1998 and before January 1, 2000, add the results of steps two and three.

(2) Effective for portions of cost reporting periods beginning on or after January 1, 2000, add the results of steps two and four.

(f) *Step six.* The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding GME costs attributable to each part as determined through the Medicare cost report.

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§413.77 Direct GME payments: Determination of per resident amounts.

(a) *Per resident amount for the base period*—(1) Except as provided in paragraph (d) of this section, the intermediary determines a base-period per