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. Effective for cost reporting periods beginning on or after October 1, 2010, resident means an intern, resident, or fellow who is formally accepted, enrolled, and participating 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(k)) 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 free-standing 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.

§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;
§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 contractor determines a base-period per resident amount for each hospital as follows:

(i) Determine the allowable GME costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, GME costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and GME costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(ii) Divide the costs calculated in paragraph (a)(1)(i) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (a)(1)(i) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(2) In determining the base-period per resident amount under paragraph (a)(1) of this section, the contractor—

(i) Verifies the hospital’s base-period GME costs and the hospital’s average number of FTE residents;

(ii) Excludes from the base-period GME costs any nonallowable or misclassified costs, including those previously allowed under §412.113(b)(3) of this chapter; and

(iii) Upon a hospital’s request, includes GME costs that were misclassified as operating costs during the hospital’s prospective payment base year and were not allowable under §412.113(b)(3) of this chapter during the GME base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in §413.82(a) of this chapter.

(3) If the hospital’s cost report for its GME base period is no longer subject to reopening under §405.1885 of this chapter, the contractor may modify the hospital’s base-period costs solely for purposes of computing the per resident amount.

(4) If the contractor modifies a hospital’s base-period GME costs as described in paragraph (a)(2)(ii) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in §413.82(a) of this chapter.

(5) The contractor notifies each hospital that either had direct GME costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1983, and before October 1, 1984, of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(b) Per resident amount for cost reporting periods beginning on or after July 1, 1985, and before July 1, 1986. For cost reporting periods beginning on or after July 1, 1985, and before July 1, 1986, a hospital’s base-period per resident amount is adjusted as follows:

(1) If a hospital’s base period began on or after October 1, 1983, and before