(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.

[69 FR 49254, Aug. 11, 2004, as amended at 70 FR 47489, Aug. 12, 2005; 71 FR 18666, Apr. 12, 2006; 71 FR 48141, Aug. 18, 2006; 72 FR 26995, May 11, 2007; 72 FR 47412, Aug. 22, 2007; 72 FR 66931, Nov. 27, 2007; 75 FR 50418, Aug. 16, 2010; 75 FR 72262, Nov. 24, 2010; 79 FR 50357, Aug. 22, 2014; 86 FR 73512, Dec. 27, 2021; 87 FR 49405, Aug. 10, 2022]

§ 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.

[69 FR 49254, Aug. 11, 2004]

§ 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