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§ 413.74 Payment to a foreign hospital.

(a) *Principle.* Section 1814(f) of the Act provides for the payment of emergency and nonemergency inpatient hospital services furnished by foreign hospitals to Medicare beneficiaries. Subpart H of part 424 of this chapter, together with this section, specifies the conditions for payment.

(b) *Amount of payment.* Effective with admissions on or after January 1, 1980, the reasonable cost for services covered under the Medicare program furnished to beneficiaries by a foreign hospital will be equal to 100 percent of the hospital's customary charges (as defined in § 413.13(b)) for the services.

(c) *Submittal of claims.* The hospital must establish its customary charges for the services by submitting an itemized bill with each claim it files in accordance with its election under § 424.104 of this chapter.

(d) *Exchange rate.* Payment to the hospital will be subject to the official exchange rate on the date the patient is discharged and to the applicable deductible and coinsurance amounts described in §§ 409.80 through 409.83.

[51 FR 34793, Sept. 30, 1986, as amended at 51 FR 41351, Nov. 14, 1986; 53 FR 6648, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 71 FR 48141, Aug. 18, 2006]

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—

(1) Effective on or after January 1, 1999 and for cost reporting periods beginning before July 1, 2007, 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); and

(2) Effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to nonpatient care direct GME activities.

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.

Emergency Medicare GME affiliated group means at least one home hospital and one or more host hospitals, as those terms are defined below, that meet the requirements at § 413.79(f)(7). For purposes of an emergency Medicare GME affiliated group, the following definitions apply:

(1) *Home hospital* means a hospital that—

(i) Is located in section 1135 emergency area;

(ii) Had its inpatient bed occupancy decreased by 20 percent or more as the result of a section 1135 emergency period so that it is unable to train the number of residents it originally intended to train in that academic year; and

(iii) Needs to send the displaced residents to train at a host hospital.

(2) *Host hospital* means a hospital training residents displaced from a home hospital.

(i) *In-State host hospital* means a host hospital located in the same State as a home hospital.

(ii) *Out-of-State host hospital* means a host hospital located in a different State from the home hospital.

(3) *Section 1135 emergency area or section 1135 emergency period* mean, respec-

tively, a geographic area in which, or a period during which, there exists—

(i) An emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and

(ii) A public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.

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 subpart D of Part 412 of this subchapter) or in a contiguous area and meet the rotation requirements in § 413.79(f)(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(f)(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(f)(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.

Nonprovider setting that is primarily engaged in furnishing patient care means a nonprovider setting in which the pri-

mary activity is the care and treatment of patients.

Orientation activities means activities that are principally designed to prepare an individual for employment as a resident in a particular setting, or for participation in a particular specialty program and patient care activities associated with that particular specialty program.

Patient care activities means the care and treatment of particular patients, including services for which a physician or other practitioner may bill, and orientation activities as defined in this section.

Primary care resident is a resident who is enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice. Effective for cost reporting periods beginning on or after October 1, 2010, *primary care resident* is a resident who is formally accepted, enrolled, and participating 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. 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 or rural 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, for programs started in cost reporting periods prior to October 1, 2022, 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).

Rural track Medicare GME affiliated group means an urban hospital and a rural hospital that—

- (i) Participate in a rural track program defined in this paragraph (b);
- (ii) Have rural track FTE limitations in effect prior to October 1, 2022; and
- (iii) Comply with the regulations at § 413.79(f)(1) through (6) for Medicare GME affiliated groups.

Rural track Medicare GME affiliation agreement means a written, signed, and dated agreement by responsible representatives of each respective hospital in a rural track Medicare GME affiliated group, as defined in this paragraph (b), that specifies all of the following:

- (i) A statement attesting that each participating hospital's FTE counts and rural track FTE limitations in the agreement do not reflect FTE residents nor FTE caps associated with programs other than the rural track program.
- (ii) The term of the rural track Medicare GME affiliation agreement (which, at a minimum is 1 year), beginning on July 1 of a year.
- (iii) Each participating hospital's direct and indirect GME rural track FTE limitations in effect prior to the rural track Medicare GME affiliation.
- (iv) The total adjustment to each hospital's rural track FTE limitations in each year that the rural track Medicare GME affiliation agreement is in effect, for both direct GME and indirect medical education (IME), that reflects a positive adjustment to one hospital's direct and indirect rural track FTE limitations that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect rural track FTE limitations of at least the same amount.
- (v) 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 rural track 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 rural track FTE limitations (in accordance with paragraph (iii) of this definition).

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

Rural Track Program means, effective for cost reporting periods beginning on or after October 1, 2022, an ACGME-accredited program in which residents/fellows gain both urban and rural experience with more than half of the education and training for a resident/fellow taking place in a rural area as defined at 42 CFR 412.62(f)(iii).

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.

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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.

[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

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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, 1984, and before October 1, 1985, 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 July 1, 1984, the amount is adjusted by

the percentage change in the CPI-U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this section apply. The adjusted amount is then increased by one percent.

(2) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

(c) *Per resident amount for cost reporting periods beginning on or after July 1, 1986.* Subject to the provisions of paragraph (d) of this section, for cost reporting periods beginning on or after July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(1) Except as provided in paragraph (c)(2) of this section, each hospital's per resident amount for the previous cost reporting is adjusted by the projected change in the CPI-U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI-U that occurred during the cost reporting period.

(2) For cost reporting periods beginning on or after October 1, 1993 through September 30, 1995, each hospital's per resident amount for the previous cost reporting period will not be adjusted for any resident FTEs who are not either a primary care resident or an obstetrics and gynecology resident.

(d) *Per resident amount for cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2013.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2013, a hospital's per resident amount for each fiscal year is adjusted in accordance with the following provisions:

(1) *General provisions.* For purposes of this § 413.77—

(i) *Weighted average per resident amount.* The weighted average per resident amount is established as follows:

(A) Using data from hospitals' cost reporting periods ending during FY 1997, CMS calculates each hospital's single per resident amount by adding each hospital's primary care and non-primary care per resident amounts, weighted by its respective FTEs, and dividing by the sum of the FTEs for

primary care and nonprimary care residents.

(B) Each hospital's single per resident amount calculated under paragraph (d)(1)(i)(A) of this section is standardized by the 1999 geographic adjustment factor for the physician fee schedule area (as determined under § 414.26 of this chapter) in which the hospital is located.

(C) CMS calculates an average of all hospitals' standardized per resident amounts that are determined under paragraph (d)(1)(i)(B) of this section. The resulting amount is the weighted average per resident amount.

(ii) *Primary care/obstetrics and gynecology and nonprimary care per resident amounts.* A hospital's per resident amount is an amount inclusive of any CPI-U adjustments that the hospital may have received since the hospital's base year, including any CPI-U adjustments the hospital may have received because the hospital trains primary care/obstetrics and gynecology residents and nonprimary care residents as specified under paragraph (c)(2) of this section.

(2) *Adjustment beginning in FY 2001 and ending in FY 2013.* For cost reporting periods beginning on or after October 1, 2000, and ending on or before September 30, 2013, a hospital's per resident amount is adjusted in accordance with paragraphs (d)(2)(i) through (d)(2)(iv) of this section, in that order:

(i) *Updating the weighted average per resident amount for inflation.* The weighted average per resident amount (as determined under paragraph (d)(1)(i) of this section) is updated by the estimated percentage increase in the CPI-U during the period beginning with the month that represents the midpoint of the cost reporting periods ending during FY 1997 (that is, October 1, 1996) and ending with the midpoint of the hospital's cost reporting period that begins in FY 2001.

(ii) *Adjusting for locality.* The updated weighted average per resident amount determined under paragraph (d)(2)(i) of this section (the national average per resident amount) is adjusted for the locality of each hospital by multiplying the national average per resident amount by the 1999 geographic adjustment factor for the physician fee

schedule area in which each hospital is located, established in accordance with § 414.26 of this chapter.

(iii) *Determining necessary revisions to the per resident amount.* The locality-adjusted national average per resident amount, as calculated in accordance with paragraph (d)(2)(ii) of this section, is compared to the hospital's per resident amount and is revised, if appropriate, according to the following three categories:

(A) *Floor.* (1) For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, if the hospital's per resident amount would otherwise be less than 70 percent of the locality-adjusted national average per resident amount for FY 2001 (as determined under paragraph (d)(2)(ii) of this section), the per resident amount is equal to 70 percent of the locality-adjusted national average per resident amount for FY 2001.

(2) For cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, if the hospital's per resident amount would otherwise be less than 85 percent of the locality-adjusted national average per resident amount for FY 2002 (as determined under paragraph (d)(2)(ii) of this section), the per resident amount is equal to 85 percent of the locality-adjusted national average per resident amount for FY 2002.

(3) For subsequent cost reporting periods beginning on or after October 1, 2002, the hospital's per resident amount is updated using the methodology specified under paragraph (c)(1) of this section.

(B) *Ceiling.* If the hospital's per resident amount is greater than 140 percent of the locality-adjusted national average per resident amount, the per resident amount is adjusted as follows for FY 2001 through FY 2013:

(1) *FY 2001.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's FY 2000 per resident amount exceeds 140 percent of the FY 2001 locality-adjusted national average per resident amount (as calculated under paragraph (d)(2)(ii) of this section), subject to the provision stated in paragraph (d)(2)(iii)(B)(5) of this section, the hospital's per resident

amount is frozen at the FY 2000 per resident amount and is not updated for FY 2001 by the CPI-U factor.

(2) *FY 2002.* For cost reporting periods beginning on or after October 1, 2001, and on or before September 30, 2002, if the hospital's FY 2001 per resident amount exceeds 140 percent of the FY 2002 locality-adjusted national average per resident amount, subject to the provision stated in paragraph (d)(2)(iii)(B)(5) of this section, the hospital's per resident amount is frozen at the FY 2001 per resident amount and is not updated for FY 2002 by the CPI-U factor.

(3) *FY 2003.* For cost reporting periods beginning on or after October 1, 2002, and on or before September 30, 2003, if the hospital's per resident amount for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average per resident amount for that same previous cost reporting period (for example, for cost reporting periods beginning in FY 2003, compare the hospital's per resident amount from the FY 2002 cost report to the hospital's locality-adjusted national average per resident amount from FY 2002), subject to the provision stated in paragraph (d)(2)(iii)(B)(5) of this section, the hospital's per resident amount is adjusted using the methodology specified in paragraph (c)(1) of this section, except that the CPI-U applied for a 12-month period is reduced (but not below zero) by 2 percentage points.

(4) *FY 2004 through FY 2013.* For cost reporting periods beginning on or after October 1, 2003, and on or before September 30, 2013, if the hospital's preceding year per resident amount exceeds 140 percent of the current year's locality-adjusted national average per resident amount (as calculated under paragraph (d)(2)(ii) of this section), subject to the provision stated in paragraph (d)(2)(iii)(B)(5) of this section, the hospital-specific per resident amount is frozen for the current year at the preceding year's hospital-specific per resident amount and is not updated by the CPI-U factor.

(5) *General rule for hospitals that exceed the ceiling.* For cost reporting periods beginning on or after October 1, 2000, and on or before September 30,

2013, if a hospital's per resident amount exceeds 140 percent of the hospital's locality-adjusted national average per resident amount and it is adjusted under any of the criteria under paragraphs (d)(2)(iii)(B)(1) through (d)(2)(iii)(B)(3) of this section, the current year per resident amount cannot be reduced below 140 percent of the locality-adjusted national average per resident amount.

(C) *Per resident amounts greater than or equal to the floor and less than or equal to the ceiling.* For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2013, if a hospital's per resident amount is greater than or equal to 70 percent and less than or equal to 140 percent of the hospital's locality-adjusted national average per resident amount for each respective fiscal year, the hospital's per resident amount is updated using the methodology specified in paragraph (c)(1) of this section.

(e) *Exceptions—(1) Base period for certain hospitals.* If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the contractor establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Effective for cost reporting periods beginning on or after October 1, 2006, if a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after October 1, 2006, and the residents are not on duty during the first month of that period, the contractor establishes a per resident amount for the hospital using the information from the first cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital. The per resident amount is based on the lower of the amount specified in paragraph (e)(1)(i) or paragraph (e)(1)(ii) of this

section, subject to the provisions of paragraph (e)(1)(iii) of this section. Any GME costs incurred by the hospital during the cost reporting period prior to the base period used for calculating the PRA are reimbursed on a reasonable cost basis.

(i) The hospital's actual cost per resident incurred in connection with the GME program(s) based on the cost and resident data from the hospital's base year cost reporting period as established in paragraph (e)(1) of this section.

(ii) Except as specified in paragraph (e)(1)(iii) of this section—

(A) For base periods that begin before October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under Part 412 of this chapter.

(B) For base periods beginning on or after October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.

(iii) If, under paragraph (e)(1)(ii)(A) or (B) or (e)(1)(iv)(B) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in subpart D of part 412 of this subchapter.

(iv) A hospital that, as of December 27, 2020, has a per resident amount based on less than 1.0 FTE in any cost reporting period beginning before October 1, 1997, may choose to receive a recalculated per resident amount either when it trains at least 1.0 FTE in the earliest cost reporting period beginning on or after December 27, 2020, and before December 26, 2025, or when it trains at least 1.0 FTE in the first cost

reporting period beginning after December 27, 2021. A hospital that, as of December 27, 2020, has a per resident amount based on no more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997, and before December 27, 2020, may choose to receive a recalculated per resident amount either when it trains more than 3.0 FTEs in the earliest cost reporting period beginning on or after December 27, 2020 and before December 26, 2025, or when it trains more than 3.0 FTE in the first cost reporting period beginning after December 27, 2021. In either case, residents need not be on duty during the first month of the cost reporting period. The recalculated per resident amount is based on the lower of—

(A) The hospital's actual cost per resident incurred in connection with the GME program(s) based on the cost and resident data from the hospital's base year cost reporting period, which is, for hospitals with a per resident amount previously based on less than 1.0 FTE, either when it trains at least 1.0 FTE in the earliest cost reporting period beginning on or after December 27, 2020, and before December 26, 2025, or when it trains at least 1.0 FTE in the first cost reporting period beginning after December 27, 2021; and for hospitals with a per resident amount previously based on not more than 3.0 FTEs, either when it trains more than 3.0 FTEs in the earliest cost reporting period beginning on or after December 27, 2020 and before December 26, 2025, or when it trains more than 3.0 FTE in the first cost reporting period beginning on or after December 27, 2021; or

(B) The updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.

(v) Effective for a cost reporting periods beginning on or after December 27, 2020, a per resident amount must be established if a hospital trains less than 1.0 FTE resident and this training results from the hospital's participation

in a Medicare GME affiliation agreement under § 413.79(f). Effective for a cost reporting period beginning on or after December 27, 2020, a per resident amount must only be established when the hospital trains at least 1.0 FTE and does not participate in a Medicare GME affiliation agreement under § 413.79(f) for that training. Residents need not be on duty during the first month of the cost reporting period from which the per resident amount is established.

(2) *Short or long base-period cost reporting periods.* If a hospital's base-period cost reporting period reflects GME costs for a period that is shorter than 50 weeks or longer than 54 weeks, the contractor converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or 366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(3) *Short or long cost reporting periods beginning on or after July 1, 1985.* If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's contractor should contact CMS Central Office to receive a special CPI-U adjustment factor.

(f) *Residency match.* Effective for portions of cost reporting periods beginning on or after October 1, 2004, with respect to a resident who matches simultaneously for a first year of training in a primary care specialty, and for an additional year(s) of training in a nonprimary care specialty, the per resident amount that is used to determine direct GME payment with respect to that resident is the nonprimary care per resident amount for the first year of training in the primary care specialty and for the duration of the resident's training in the nonprimary care specialty.

(g) *Special use of locality-adjusted national average per resident amount.* Effective for portions of cost reporting periods beginning on or after July 1, 2005, for a hospital that counts additional residents as a result of an increase in its FTE resident cap under § 413.79(c)(4) direct GME payments attributable to

those additional FTE residents are calculated using the locality-adjusted national average per resident amount, as determined under paragraph (d)(2)(ii) of this section. The hospital will receive direct GME payments based on the sum of the following two direct GME calculations:

(1) A calculation using the per resident amount(s) as determined under paragraph (d) of this section and the hospital's number of FTE residents that is not attributable to an FTE resident cap increase under § 413.79(c)(4); and

(2) A calculation using the locality-adjusted national average per resident amount, as determined under paragraph (d)(2)(ii) of this section, inflated to the hospital's current cost reporting period, and the hospital's number of FTE residents that is attributable to the increase in the hospital's FTE resident cap under § 413.79(c)(4).

(h) *Hospital mergers.* Effective for cost reporting periods beginning on or after October 1, 2006, when multiple hospitals merge, a primary care and obstetrics and gynecology weighted average per resident amount and a nonprimary care weighted average per resident amount is calculated, if applicable, for the surviving hospital, using FTE resident data and per resident amount data from the most recently settled cost reports of the respective hospitals prior to the merger.

[69 FR 49254, Aug. 11, 2004, as amended at 69 FR 60252, Oct. 7, 2004; 70 FR 47489, Aug. 12, 2005; 71 FR 48142, Aug. 18, 2006; 86 FR 73512, Dec. 27, 2021; 87 FR 4167, Jan. 27, 2022]

§ 413.78 Direct GME payments: Determination of the total number of FTE residents.

Subject to the weighting factors in §§ 413.79 and 413.80, and subject to the provisions of § 413.81, the count of FTE residents is determined as follows:

(a) Residents in an approved program working in all areas of the hospital complex may be counted.

(b) (1) No individual resident may be counted as more than one FTE based on the total time spent in training at all sites. A hospital cannot claim the time spent by residents training at another hospital, except as provided in paragraph (i) of this section. Except as

provided in paragraphs (c), (d), and (e) of this section, if a resident spends time in more than one hospital or in a non-provider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(2) Effective for a cost reporting period beginning on or after December 27, 2020, a hospital must report FTE residents on its Medicare cost report for a cost reporting period if it does not participate in a Medicare GME affiliation agreement (as defined under § 413.75(b)), and the hospital trains at least 1.0 FTE in an approved program or programs, or, if the hospital trains less than 1.0 FTE residents in an approved program or programs and this training results from the hospital's participation in a Medicare GME affiliation agreement (as defined under § 413.75(b)).

(c) On or after July 1, 1987, and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities, as defined in § 413.75(b).

(2) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

(d) For portions of cost reporting periods occurring on or after January 1, 1999, and before October 1, 2004, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities, as defined in § 413.75(b).

(2) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(3) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in § 413.75(b).

(4) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

(e) For portions of cost reporting periods occurring on or after October 1, 2004, and for cost reporting periods beginning before July 1, 2007, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:

(1) The resident spends his or her time in patient care activities, as defined in § 413.75(b).

(2) The hospital must incur all or substantially all of the costs of the training program in a nonhospital setting(s) (in accordance with the definition under § 413.75(b)).

(3) The hospital must comply with one of the following:

(i) The hospital must pay all or substantially all of the costs of the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred.

(ii) There is a written agreement between the hospital and the nonhospital site that states that the hospital will incur the cost of the resident's salary

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and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(iii) If the hospital has in place an emergency Medicare GME affiliation agreement in accordance with § 413.79(f)(7), during the period covered by the emergency Medicare GME affiliation agreement—

(A) The hospital must pay all or substantially all of the costs of the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the sixth month following the month in which the training in the nonhospital site occurred. For the costs that would otherwise be required to be paid by the hospital during the period of August 29, 2005 through November 1, 2007, the participating hospital must pay the costs by April 29, 2008; or

(B) There is a written agreement that specifies that the hospital is incurring the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities. The written agreement must be submitted to the contractor by 180 days after the training at the nonhospital site begins. For written agreements that would otherwise be required to be submitted prior to the date the resident(s) begin training at the nonhospital site during the period of August 29, 2005 through November 1, 2007, the written agreement must be submitted to the CMS contractor by April 29, 2008.

(4) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

(f) For cost reporting periods beginning on or after July 1, 2007, and before July 1, 2010, the time residents spend in nonprovider settings such as free-

standing clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities as defined at § 413.75(b), except that for cost reporting periods beginning on or after July 1, 2009, the time spent training in nonpatient care activities, such as didactic conferences and seminars, but excluding research not associated with the treatment or diagnosis of a particular patient, in a nonprovider setting that is primarily engaged in furnishing patient care activities, as defined at § 413.75(b), also may be counted.

(2) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting(s) (in accordance with the definition under § 413.75(b)).

(3) The hospital must comply with one of the following:

(i) The hospital must pay for all or substantially all of the costs for the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred.

(ii) There is a written agreement in place between the hospital and the nonhospital site before the training begins that states that the hospital will incur at least 90 percent of the total of the costs of the resident's salary and fringe benefits (and travel and lodging where applicable) while the resident is training in the nonhospital site and the portion of the cost of the teaching physician's salary attributable to nonpatient care direct GME activities. The written agreement must specify the total cost of the training program at the nonhospital site, and the amount the hospital will incur (at least 90 percent of the total), and must indicate the portion of the amount the hospital will incur that reflects residents' salaries and fringe benefits (and travel and lodging where applicable), and the portion of this amount that reflects teaching physician compensation. Hospitals

may modify the amounts specified in the written agreement by the end of the academic year (that is, June 30) to reflect that at least 90 percent of the costs of the training program in the nonhospital site has been incurred.

(iii) If the hospital has in place an emergency Medicare GME affiliation agreement in accordance with § 413.79(f)(7), during the period covered by the emergency Medicare GME affiliation agreement—

(A) The hospital must pay all or substantially all of the costs of the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the sixth month after the month in which the training in the nonhospital site occurs. For the costs that would otherwise be required to be incurred by the hospital during the period of August 29, 2005 through November 1, 2007, the participating hospital must incur the costs by April 29, 2008; or

(B) There is a written agreement that specifies that the hospital will incur at least 90 percent of the total of the costs of the resident's salary and fringe benefits (and travel and lodging where applicable) while the resident is training in the nonhospital site and the portion of the cost of the teaching physician's salary attributable to nonpatient care direct GME activities. The written agreement must specify the total cost of the training program at the nonhospital site, and the amount the hospital will incur (at least 90 percent of the total), and must indicate the portion of the amount the hospital will incur that reflects residents' salaries and fringe benefits (and travel and lodging where applicable), and the portion of this amount that reflects teaching physician compensation. The written agreement must be submitted to the contractor by 180 days after the training at the nonhospital site begins. Hospitals may modify the amounts specified in the written agreement by the end of the academic year (that is, June 30) to reflect that at least 90 percent of the costs of the training program in the nonhospital site has been incurred. For written agreements that would otherwise be required to be submitted prior to the date the training begins in the nonhospital site during the period

of August 29, 2005 through November 1, 2007, the hospital must submit the written agreement to its contractor by April 29, 2008.

(4) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

(g) For cost reporting periods beginning on or after July 1, 2010, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time—

(i) In patient care activities as defined at § 413.75(b); or

(ii) In nonpatient care activities, such as didactic conferences and seminars, but excluding research not associated with the treatment or diagnosis of a particular patient, in a nonprovider setting that is primarily engaged in furnishing patient care activities, as defined at § 413.75(b).

(2) The hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting. If more than one hospital incurs these costs, either directly or through a third party, the hospitals must count a proportional share of the time that residents train at the nonprovider setting(s) as recorded in a written agreement between the hospitals.

(i) Hospitals must have a reasonable basis for establishing that proportion of the cost and the FTE time that each will incur and count.

(ii) If hospitals already arrange payment to the nonprovider site via a written agreement as described in paragraph (g)(3)(ii) of this section, the proportion may be recorded in that agreement.

(iii) If hospitals choose to pay the nonprovider site concurrently as described in paragraph (g)(3)(i) of this section, the hospitals must record the proportion of cost and FTE time they are incurring and counting in a written agreement between the hospitals.

(3) The hospital or hospitals must comply with one of the following:

(i) The hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting by the end of the third month following the month in which the training in the nonprovider site occurred.

(ii) There is a written agreement between the hospital or hospitals and the outside entity that states that the residents' salaries and fringe benefits (including travel and lodging where applicable) during the time the resident spends in the nonprovider setting is to be paid by the hospital(s). Hospitals may modify the amounts specified in the written agreement by the end of the academic year (that is, June 30) to reflect that the costs of the training program in the nonprovider site have been incurred.

(4) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

(5) For cost reporting periods beginning on or after July 1, 2010, a hospital must maintain and make available records of the FTE count determined for direct GME purposes under this section that its residents spend in nonprovider sites, in order to compare that time to the time spent by its residents in nonprovider sites in the base year of cost reporting periods beginning on or after July 1, 2009, and before June 30, 2010. The hospital must supply the CMS contractor with the data for each of its primary care programs on a program-specific basis, and with data for its nonprimary care programs on an overall basis.

(6) The provisions of paragraphs (g)(1)(ii), (g)(2), (g)(3), and (g)(5) of this section shall not be applied in a manner that requires reopening of any settled cost reports as to which there is not a jurisdictionally proper appeal pending as of March 23, 2010, on direct GME or IME payments. Cost reporting periods beginning before July 1, 2010 are not governed by paragraph (g) of this section.

(h) Effective for cost reporting periods beginning on or after January 1, 1983, the time spent by a resident in an

approved medical residency program on vacation, sick leave, or other approved leave that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program is countable. This provision cannot be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.

(i) For the time frame that the Public Health Emergency (as defined in § 400.200 of this chapter) associated with COVID-19 was in effect, a sending hospital can include FTE residents training at another hospital in its FTE count if all of the following conditions are met.

(1) The sending hospital sends the resident to the other hospital in response to the COVID-19 pandemic.

(2) The time spent by the resident training at the other hospital is in lieu of time that would have been spent in approved training at the sending hospital.

(3) The time that the resident spent training immediately prior to and/or subsequent to the time frame that the Public Health Emergency (as defined in § 400.200 of this chapter) associated with COVID-19 was in effect is included in the FTE count for the sending hospital.

[69 FR 49254, Aug. 11, 2004, as amended at 71 FR 48142, Aug. 18, 2006; 72 FR 26995, May 11, 2007; 72 FR 66931, Nov. 27, 2007; 75 FR 72262, Nov. 24, 2010; 78 FR 50968, Aug. 19, 2013; 79 FR 50357, Aug. 22, 2014; 85 FR 27623, May 8, 2020; 86 FR 73513, Dec. 27, 2021; 89 FR 69912, Aug. 28, 2024]

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

Subject to the provisions in § 413.80, CMS determines a hospital's number of FTE residents by applying a weighting factor to each resident and then summing the resulting numbers that represent each resident. The weighting factor is determined as follows:

(a) *Initial residency period.* Generally, for purposes of this section, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility.

(1) Prior to July 1, 1995, the initial residency period equals the minimum number of years required for board eligibility in a specialty or subspecialty plus 1 year. An initial residency period may not exceed 5 years in order to be counted toward determining FTE status except in the case of a resident in an approved geriatric program whose initial residency period may last up to 2 additional years.

(2) Effective October 1, 2003, for a resident who trains in an approved geriatric program that requires the residents to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatrics program are treated as part of the resident's initial residency period.

(3) Effective July 1, 2000, for residency programs that began before, on, or after November 29, 1999, the period of board eligibility and the initial residency period for a resident in an approved child neurology program is the period of board eligibility for pediatrics plus 2 years.

(4) Effective August 10, 1993, residents or fellows in an approved preventive medicine residency or fellowship program also may be counted as a full FTE resident for up to 2 additional years beyond the initial residency period limitations.

(5) For combined residency programs, an initial residency period is defined as the time required for individual certification in the longer of the programs. If the resident is enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training primary care residents (as defined in §413.75(b)) or obstetrics and gynecology residents, the initial residency period is the time required for individual certification in the longer of the programs plus 1 year.

(6) For residency programs other than those specified in paragraphs (a)(2) through (a)(4) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the

most recently published edition of the Graduate Medical Education Directory.

(7) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in §415.152 of this chapter.

(8) For residency programs in geriatric medicine, accredited by the appropriate approving body listed in §415.152 of this chapter, these programs are considered approved programs on the later of—

(i) The starting date of the program within a hospital; or

(ii) The hospital's cost reporting periods beginning on or after July 1, 1985.

(9) The time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs, as described in §413.75(b), is counted toward the initial residency period limitation.

(10) Effective for portions of cost reporting periods beginning on or after October 1, 2004, if a hospital can document that a resident simultaneously matched for one year of training in a particular specialty program, and for a subsequent year(s) of training in a different specialty program, the resident's initial residency period will be determined based on the period of board eligibility for the specialty associated with the program for which the resident matched for the subsequent year(s) of training. Effective for portions of cost reporting periods beginning on or after October 1, 2005, if a hospital can document that a particular resident, prior to beginning the first year of residency training, matched in a specialty program for which training would begin at the conclusion of the first year of training, that resident's initial residency period will be determined in the resident's first year of training based on the period of board eligibility associated with the specialty program for which the resident matched for subsequent training year(s).

(b) *Weighting factor.* (1) If the resident is in an initial residency period, the weighting factor is one.

(2) If the resident is not in an initial residency period, the weighting factor is 1.00 during the period beginning on or after July 1, 1985 and before July 1, 1986, .75 during the period beginning on or after July 1, 1986 and before July 1, 1987, and .50 thereafter without regard to the hospital's cost reporting period.

(c) *Unweighted FTE counts*—(1) *Definitions*. As used in this paragraph (c):

(i) *Otherwise applicable resident cap* refers to a hospital's FTE resident cap that is determined for a particular cost reporting period under paragraph (c)(2) of this section.

(ii)(A) For purposes of paragraph (c)(3) of this section, *reference resident level* refers to a hospital's resident level in the applicable reference period specified under paragraph (c)(3) of this section.

(B) For purposes of paragraph (m) of this section, *reference resident level* means with respect to a hospital, the highest resident level for any of the three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010.

(iii) *Resident level* refers to the number of unweighted allopathic and osteopathic FTE residents who are training in a hospital in a particular cost reporting period.

(2) *Determination of the FTE resident cap*. Subject to the provisions of paragraphs (c)(3) through (6) and (m) through (p) of this section and § 413.81, for purposes of determining direct GME payment—

(i) For cost reporting periods beginning on or after October 1, 1997, a hospital's resident level may not exceed the hospital's unweighted FTE count (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996.

(ii) If a hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, and before October 1, 2001, exceeds the limit described in this section, the hospital's total weighted FTE count (before ap-

plication of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iii) Effective for cost reporting periods beginning on or after October 1, 2001, if the hospital's unweighted number of FTE residents exceeds the limit described in this section, and the number of weighted FTE residents in accordance with paragraph (b) of this section also exceeds that limit, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the limit. If the number of FTE residents weighted in accordance with paragraph (b) of this section does not exceed that limit, then the allowable weighted FTE count is the actual weighted FTE count.

(iv) Hospitals that are part of the same Medicare GME affiliated group or the same emergency Medicare GME affiliated group (as described under § 413.75(b)) may elect to apply the limit on an aggregate basis as described under paragraph (f) of this section.

(v) The contractor may make appropriate modifications to apply the provisions of this paragraph (c) of this section based on the equivalent of a 12-month cost reporting period.

(3) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots under section 422 of Public Law 108–173*. If a hospital's reference resident level is less than its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section or paragraph (e) of this section in the reference cost reporting period (as described under paragraph (c)(3)(ii) of this section), for portions of cost reporting periods beginning on or after July 1, 2005, the hospital's otherwise applicable FTE resident cap is reduced by 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level. Under this provision—

(i) *Exemption for certain rural hospitals*. A rural hospital, as defined at

subpart D of part 412 of this subchapter, with less than 250 beds (as determined at § 412.105(b)) in its most recent cost reporting period ending on or before September 30, 2002, is exempt from any reduction to the otherwise applicable FTE resident cap limit under paragraph (c)(3) of this section.

(ii) *Reference cost reporting periods.*

(A) To determine a hospital's reference resident level, CMS uses one of the following periods:

(1) A hospital's most recent cost reporting period ending on or before September 30, 2002, for which a cost report has been settled or if the cost report has not been settled, the as-submitted cost report (subject to audit); or

(2) A hospital's cost reporting period that includes July 1, 2003 if the hospital submits a timely request to CMS to increase its resident level due to an expansion of an existing program and that expansion is not reflected on the hospital's most recent settled cost report. An expansion of an existing program means that, except for expansions due to newly approved programs under paragraph (c)(3)(ii)(A)(3) of this section, the number of unweighted allopathic and osteopathic FTE residents in any cost reporting period after the hospital's most recent settled cost report, up to and including the hospital's cost report that includes July 1, 2003, is greater than the number of unweighted allopathic and osteopathic FTE residents in programs that were existing at that hospital during the hospital's most recent settled cost report.

(3) A hospital may submit a timely request that CMS adjust the resident level for purposes of determining any reduction under paragraph (c)(3) of this section for the following purposes:

(i) In the hospital's reference cost reporting period under paragraph (c)(3)(ii)(A)(1) of this section, to include the number of FTE residents for which a new program was accredited by the appropriate allopathic or osteopathic accrediting body (listed under § 415.152 of this chapter) before January 1, 2002, if the program was not in operation during the reference cost reporting period under paragraph (c)(3)(ii)(A)(1); or

(ii) In the hospital's reference cost reporting period under paragraph

(c)(3)(ii)(A)(2) of this section, to include the number of FTE residents for which a new program was accredited by the appropriate allopathic or osteopathic accrediting body (listed under § 415.152 of this chapter) before January 1, 2002, if the program was not in operation during the cost reporting period that includes July 1, 2003, and if the hospital also qualifies to use its cost report under paragraph (c)(3)(ii)(A)(2) of this section due to an expansion of an existing program.

(B) If the cost report that is used to determine a hospital's otherwise applicable FTE resident cap in the reference period is not equal to 12 months, the contractor may make appropriate modifications to apply the provisions of paragraph (c)(3)(i)(A) of this section based on the equivalent of a 12-month cost reporting period.

(iii) If the new program described in paragraph (c)(3)(ii)(A)(3)(i) or paragraph (c)(3)(ii)(A)(ii) was accredited for a range of residents, the hospital may request that its reference resident level in its applicable reference cost reporting period under paragraph (c)(3)(ii)(A)(1) or (c)(3)(ii)(A)(2) of this section be adjusted to reflect the maximum number of accredited slots applicable to that hospital.

(iv) *Consideration of Medicare GME affiliated group agreements.* For hospitals that are members of the same affiliated group for the program year July 1, 2003 through June 30, 2004, in determining whether a hospital's otherwise applicable resident FTE resident cap is reduced under paragraph (c)(3) of this section, CMS treats these hospitals as a group. Using information from the hospitals' cost reports that include July 1, 2003, if the hospitals' aggregate FTE resident counts are equal to or greater than the aggregate otherwise applicable FTE resident cap for the affiliated group, then no reductions are made under paragraph (c)(3) of this section to the hospitals' otherwise applicable FTE resident caps. If the hospitals' aggregate FTE resident count is below the aggregate otherwise applicable FTE resident cap, then CMS determines on a hospital-specific basis whether the individual hospital's FTE

resident count is less than its otherwise applicable resident cap (as adjusted by affiliation agreement(s)) in the hospital's cost report that includes July 1, 2003. If the hospital's FTE resident count is in excess of its otherwise applicable FTE resident cap, the hospital will not have its otherwise applicable FTE resident cap reduced under paragraph (c)(3) of this section. Hospitals in the affiliated group that have FTE resident counts below their individual otherwise applicable FTE resident caps are subject to a pro rata reduction in their otherwise applicable FTE resident caps that is equal, in total, to 75 percent of the difference between the aggregate FTE cap and the aggregate FTE count for the affiliated group. The pro rata reduction to the individual hospital's otherwise applicable resident cap is calculated by dividing the difference between the hospital's individual otherwise applicable FTE resident cap and the hospital's FTE resident count by the total amount by which all of the hospitals' individual FTE resident counts are below their otherwise affiliated FTE resident caps, multiplying the quotient by the difference between the aggregate FTE resident cap and the aggregate FTE resident counts for the affiliated group, and multiplying that result by 75 percent.

(4) *Determination of an increase in the otherwise applicable resident cap under section 422 of Public Law 108–173.* For portions of cost reporting periods beginning on or after July 1, 2005, a hospital may receive an increase in its otherwise applicable FTE resident cap up to an additional 25 FTEs (as determined by CMS) if the hospital meets the requirements and qualifying criteria of section 1886(h)(7) of the Act and implementing instructions issued by CMS and if the hospital submits an application to CMS within the timeframe specified by CMS.

(5) *Special rules for hospitals that participate in demonstration projects or voluntary resident reduction plans for purposes of section 422 of Public Law 108–173.*

(i) If a hospital was participating in a demonstration project under section 402 of Public Law 90–248 or the voluntary reduction plan under § 413.88 for a greater period of time than the time

period that elapsed since it withdrew from participation (or if it completed its participation) in the demonstration program or the voluntary reduction plan, for purposes of determining a possible reduction to the FTE resident caps under paragraph (c)(3) of this section, CMS compares the higher of the hospital's base number of residents (after subtracting any dental and podiatric FTE residents) or the hospital's reference resident level to the hospital's otherwise applicable resident cap determined under paragraph (c)(2) of this section.

(ii) If a hospital participated in the demonstration project or the voluntary resident reduction plan for a period of time that is less than the time that elapsed since it withdrew from participation in the demonstration project or the voluntary reduction plan, the special rules in paragraph (c)(5)(i) do not apply, and the hospital is subject to the procedures applicable to all other hospitals for determining possible reductions to the FTE resident caps under paragraph (c)(3) of this section.

(iii) CMS will not redistribute residency positions that are attributable to a hospital's participation in a demonstration project or a voluntary resident reduction plan to other hospitals that seek to increase their FTE resident caps under paragraph (c)(4) of this section.

(6) *FTE resident caps for rural hospitals that are redesignated as urban.* A rural hospital redesignated as urban after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003, may retain the increases to its FTE resident cap that it received under paragraphs (c)(2)(i), (e)(1)(iii), and (e)(3) of this section while it was located in a rural area. Effective October 1, 2014, if a rural hospital is redesignated as urban due to the most recent OMB standards for delineating statistical areas adopted by CMS, the redesignated urban hospital may retain any existing increases to its FTE resident cap that it had received prior to when the redesignation became effective. Effective October 1, 2014, if a rural hospital is redesignated as urban due to the most recent OMB standards for delineating statistical

areas adopted by CMS, the redesignated urban hospital may receive an increase to its FTE resident cap for a new program, in accordance with paragraph (e) of this section, if it received a letter of accreditation for the new program and/or started training residents in the new program prior to the redesignation becoming effective.

(d) *Weighted FTE counts.* Subject to the provisions of §413.81, for purposes of determining direct GME payment—

(1) For the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period.

(2) For cost reporting periods beginning on or after October 1, 1998, and before October 1, 2001, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods.

(3) For cost reporting periods beginning on or after October 1, 2001, the hospital's weighted FTE count for primary care and obstetrics and gynecology residents is equal to the average of the weighted primary care and obstetrics and gynecology counts for the payment year cost reporting period and the preceding two cost reporting periods, and the hospital's weighted FTE count for nonprimary care residents is equal to the average of the weighted nonprimary care FTE counts for the payment year cost reporting period and the preceding two cost reporting periods. For cost reporting periods beginning on or after October 1, 2001, the hospital's weighted FTE counts for the preceding two cost reporting periods are calculated in accordance with the payment formula in paragraph (c)(2)(iii) of this section.

(4) The contractor may make appropriate modifications to apply the provisions of this paragraph (d) based on the equivalent of 12-month cost reporting periods.

(5) (i) For new programs started prior to October 1, 2012, if a hospital qualifies for an adjustment to the limit established under paragraph (c)(2) of this section for new medical residency pro-

grams created under paragraph (e) of this section, the count of the residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (d), for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph (d), for each new program started, the period of years equals the minimum accredited length for each new program. The period of years begins when the first resident begins training in each new program.

(ii) For new programs started on or after October 1, 2012, for hospitals for which the FTE cap may be adjusted in accordance with §413.79(e), FTE residents participating in new medical residency training programs are excluded from the hospital's FTE count before applying the averaging rules during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, for hospitals for which the FTE may be adjusted in accordance with §413.79(e)(1), and prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of the each individual new program started, for hospitals for which the FTE cap may be adjusted in accordance with §413.79(e)(3). Beginning with the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started for hospitals for which the FTE cap may be adjusted in accordance with §413.79(e)(1), and beginning with the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of the each individual new program started for hospitals for which the FTE cap may be adjusted in accordance with §413.79(e)(3), FTE residents participating in new medical

residency training programs are included in the hospital's FTE count before applying the averaging rules.

(6) Subject to the provisions of paragraph (h) of this section, FTE residents who are displaced by the closure of either another hospital or another hospital's program are added to the FTE count after applying the averaging rules in this paragraph (d), for the receiving hospital for the duration of the time that the displaced residents are training at the receiving hospital.

(7) (i) Subject to the provisions under paragraph (k) of this section, effective for cost reporting periods beginning on or after April 1, 2000 and before cost reporting periods beginning on or after October 1, 2022, FTE residents in a rural track program at an urban hospital are included in the urban hospital's rolling average calculation described in this paragraph (d).

(ii) Subject to the provisions under paragraph (k) of this section, effective for rural track programs started in a cost reporting period beginning on or after October 1, 2022, FTE residents in a rural track program at an urban hospital or rural hospital are excluded from rolling average calculation described in this paragraph (d) during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of each rural track.

(e) *New medical residency training programs.* If a hospital establishes a new medical residency training program as defined in paragraph (l) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (c) of this section may be adjusted as follows:

(1) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted for new residency training programs based on the sum of the products of the highest number of FTE residents in any program year during the

third year of the first new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program. If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins training residents in a new medical residency training program(s) for the first time on or after October 1, 2012, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted for new residency training programs based on the sum of the products of the highest number of FTE residents in any program year during the fifth year of the first new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(i) If a hospital begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012, and if the residents are spending portions of a program year (or years) at one hospital and the remainder of the program at another hospital(s), the adjustment to each qualifying hospital's cap for a new medical residency training program(s) is equal to the sum of the products of the highest number of FTE residents in any program year during the third year of the first new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program and the number of years the residents are training at each respective hospital. If a hospital begins training residents in a new medical residency training program(s) for the first time on or after October 1, 2012, and if the residents are spending portions of a program (or

years) at one hospital and the remainder of the program at another hospital(s), the adjustment to each qualifying hospital's cap for new residency training program (s) is equal to the sum of the products of three factors (limited to the number of accredited slots for each program):

(A) The highest total number of FTE residents trained in any program year during the fifth year of the first new program's existence at all of the hospitals to which the residents in the program rotate;

(B) The number of years in which residents are expected to complete the program, based on the minimum accredited length for each type of program.

(C) The ratio of the number of FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents that trained at all hospitals over the entire 5-year period.

(ii) If a hospital begins training residents in a new medical residency training program(s) for the first time on or after January 1, 1995, but before October 1, 2012, prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's first new residency program(s), the hospital's cap may be temporarily adjusted during each of the first 3 years of the hospital's first new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year. If a hospital begins training residents in a new medical residency training program(s) for the first time on or after October 1, 2012, prior to the implementation of the hospital's adjustment to its FTE cap beginning with the sixth year of the hospital's first new residency program(s), the hospital's cap may be adjusted temporarily during each of the first 5 years of the hospital's first new residency program using the actual number of FTE residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(iii) If a hospital begins training residents in a new medical residency training program for the first time on or after January 1, 1995, but before October 1, 2012, the cap will not be adjusted for new programs established more than 3 years after residents begin training in the first new program, or if a hospital begins training residents in a new medical residency training program for the first time on or after October 1, 2012, the cap will not be adjusted for new programs established more than 5 years after residents begin training in the first new program.

(iv)(A) Effective for Medicare GME affiliation agreements entered into on or after October 1, 2005, except as provided in paragraph (e)(1)(iv)(B) of this section, an urban hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap only if the adjustment that results from the affiliation is an increase to the urban hospital's FTE cap.

(B) Effective for Medicare GME affiliation agreements entered into on or after July 1, 2019, an urban hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap and receive an adjustment that is a decrease to the urban hospital's FTE cap, provided the Medicare GME affiliated group meets one of the following conditions:

(1) The Medicare GME affiliated group consists solely of two or more urban hospitals that qualify for adjustments to their FTE caps under paragraph (e)(1) of this section.

(2) The Medicare GME affiliated group includes an urban hospital(s) that received FTE cap(s) under paragraph (c)(2)(i) of this section or §412.105(f)(1)(iv)(A) of this subchapter, or both. This Medicare GME affiliated group must be established effective with a July 1 date (the residency training year) that is at least 5 years after the start of the cost reporting period that coincides with or follows the start of the sixth program year of the first new program for which the hospital's

FTE cap was adjusted in accordance with paragraph (e)(1) of this section or § 412.105(f)(1)(v)(C) or (D) of this subchapter, or both.

(v) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(vi) In the case of a hospital that, as of December 27, 2020, has a FTE cap based on the training of less than 1.0 FTE in any cost reporting period beginning before October 1, 1997; or based on the training of no more than 3.0 FTEs in on a cost reporting period beginning on or after October 1, 1997, and before December 27, 2020, if such a hospital begins training residents in a new approved program (as defined under § 413.79(l)) in a program year beginning on or after December 27, 2020 and before December 26, 2025, the hospital with a previous FTE cap of less than 1.0 FTE may receive an adjusted FTE cap when it begins to train at least 1.0 FTE in a new program(s); and the hospital with a previous FTE cap of no more than 3.0 FTEs may receive an adjusted FTE cap when it begins to train more than 3.0 FTEs in a new program(s). The adjusted FTE cap is equal to the sum of the original FTE cap and the products of the following three factors (limited to the number of accredited slots for each program):

(A) The highest total number of FTE residents trained in any program year during the fifth year of the first new program's existence started in a program year beginning on or after December 27, 2020 and before December 26, 2025, at all of the hospitals to which the residents in the program rotate;

(B) The number of years in which residents are expected to complete the program, based on the minimum accredited length for each type of program.

(C) The ratio of the number of FTE residents in the new program that trained at the hospital over the entire 5-year period to the total number of FTE residents that trained at all hospitals over the entire 5-year period.

(2) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or be-

fore December 31, 1996, the hospital's unweighted FTE cap may be adjusted for a new medical residency training program(s) established on or after January 1, 1995, and on or before August 5, 1997. The adjustment to the hospital's FTE resident cap for new residency training programs is based on the sum of the product of the highest number of FTE residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

(i) If the residents are spending portions of a program year (or years) at one hospital and the remainder of the program at another hospital(s), the adjustment to each respective hospital's cap for each program is equal to the product of the highest number of FTE residents in any program year during the third year of each program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program and the number of years the residents are training at each respective hospital.

(ii) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program, the hospital's cap may be temporarily adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of FTE residents in the new programs. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(3) If a rural hospital participates in new medical residency training programs, regardless of whether the rural hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted in the same manner described in paragraph (e)(2) of this section to reflect the increase for residents training in a new medical residency training program(s) established after August 5, 1997 and before October 1, 2012. If a rural hospital participates in new medical

residency training programs on or after October 1, 2012, the hospital's unweighted FTE cap is adjusted in accordance with paragraph (e)(1) of this section, except that the adjustment is based on the sum of the products of the highest number of FTE residents in any program year during the fifth year of each new program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for each type of program.

(4) A hospital seeking an adjustment to its FTE cap must provide documentation to its fiscal contractor justifying the adjustment.

(5) The cap will not be adjusted for expansion of existing or previously existing programs.

(6) Effective for a cost reporting period beginning on or after December 27, 2020, FTE resident caps must be established when the hospital trains 1.0 or more FTE residents in a new medical residency program (as defined under paragraph (1) of this section).

(f) *Medicare GME affiliated group.* A hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules under paragraph (d) of this section, to reflect residents added or subtracted because the hospital is participating in a Medicare GME affiliated group (as defined under § 413.75(b)). Under this provision—

(1) Except as provided in paragraph (f)(6) of this section, each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under § 413.75(b) of this section, to the CMS contractor or MAC servicing the hospital and send a copy to the CMS Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

(2) Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement, as defined in § 413.75(b), with at least one other hospital within the Medicare GME affiliated group, and all of the hospitals within the Medicare GME affiliated group must be connected by a series of such shared rotational arrangements.

(3) During the shared rotational arrangements under a Medicare GME affiliation agreement, as defined in § 413.75(b), more than one of the hospitals in the Medicare GME affiliated group must count the proportionate amount of the time spent by the resident(s) in its FTE resident counts. No resident may be counted in the aggregate as more than one FTE.

(4) The net effect of the adjustments (positive or negative) on the Medicare GME affiliated hospitals' aggregate FTE cap for each Medicare GME affiliation agreement must not exceed zero.

(5) If the Medicare GME affiliation agreement terminates for any reason, the FTE cap of each hospital in the Medicare GME affiliated group will revert to the individual hospital's pre-affiliation FTE cap that is determined under the provisions of paragraph (c) of this section.

(6) Effective October 1, 2009, a hospital that is new after July 1 and begins training residents for the first time after the July 1 start date of an academic year may receive a temporary adjustment to its FTE resident cap to reflect its participation in an existing Medicare GME affiliated group by submitting the Medicare GME affiliation agreement, as defined under § 413.75(b), to the CMS contractor or MAC servicing the hospital and sending a copy to the CMS Central Office by the earlier of June 30 of the residency program year during which the Medicare GME affiliation agreement will be in effect or the end of the first cost reporting period during which the hospital begins training residents. The Medicare GME affiliation agreement must specify the effective period for the agreement, which may begin no earlier than the date the affiliation agreement is submitted to CMS. Each of the other hospitals participating in the Medicare GME affiliated group must submit an amended Medicare GME affiliation agreement that reflects the participation of the new hospital to the CMS contractor or MAC servicing the hospital and send a copy to the CMS Central Office no later than June 30 of the residency program year during which the Medicare GME affiliation agreement will be in effect. For

purposes of this paragraph, a new hospital is one for which a new Medicare provider agreement takes effect in accordance with § 489.13 of this chapter.

(7) *Emergency Medicare GME affiliated group.* Effective on or after August 29, 2005, home and host hospitals as defined in § 413.75(b) may form an emergency Medicare GME affiliated group by meeting the requirements provided in this section. The emergency Medicare GME affiliation agreements may be made effective beginning on or after the first day of a section 1135 emergency period, and must terminate no later than at the conclusion of 4 academic years following the academic year during which the section 1135 emergency period began.

(i) *Requirements for submission of emergency Medicare GME affiliation agreements.* Each hospital in the emergency Medicare GME affiliated group must submit an emergency Medicare GME affiliation agreement that is written, signed, and dated by responsible representatives of each participating hospital in the manner specified in paragraph (ii) and includes the following information:

(A) List each participating hospital and its provider number; and indicate whether each hospital is a home or host hospital.

(B) Specify the effective period of the emergency Medicare GME affiliation agreement (which must, in any event, terminate at the conclusion of four academic years following the academic year in which the section 1135 emergency period began).

(C) List each participating hospital's IME and direct GME FTE caps in effect before the emergency Medicare GME affiliation agreement (including any adjustments to those caps in effect as a result of other Medicare GME affiliation agreements but not including any slots gained under § 413.79(c)(4)).

(D) Specify the total adjustment to each participating hospital's FTE caps in each academic year that the emergency Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to the host hospital's direct and indirect FTE caps that is offset by a negative adjustment to the home hospital's (or hospitals') direct and in-

direct FTE caps of at least the same amount subject to the following—

(1) The sum total of adjustments to all the participating hospitals' FTE caps under the emergency Medicare GME affiliation agreement may not exceed the aggregate adjusted FTE caps of the hospitals participating in the emergency Medicare GME affiliated group.

(2) A home hospital's IME and direct GME FTE cap reductions in an emergency Medicare GME affiliation agreement are limited to the home hospital's IME and direct GME FTE resident caps at § 413.79(c) or § 413.79(f)(1) through (f)(5), that is, as adjusted by any and all existing affiliation agreements as applicable.

(3) For emergency Medicare GME affiliation agreements for the third or fourth academic years subsequent to the year in which the section 1135 emergency period began and involving an out-of-State host hospital, the positive adjustment to the out-of-State host hospital's direct and indirect FTE caps pursuant to the agreement shall reflect only FTE residents that were actually displaced from a home hospital immediately following the emergency.

(E) Attach copies of all existing Medicare GME affiliation agreements and emergency Medicare GME affiliation agreements in which the hospital is participating at the time the emergency Medicare GME affiliation agreement is executed.

(ii) *Deadline for submission of the emergency Medicare GME affiliation agreement.* Each participating home and host hospital must submit an emergency Medicare GME affiliation agreement to CMS and submit a copy to the CMS contractor/MAC by the applicable due date.

(A) For emergency Medicare GME affiliation agreements that would otherwise be required to be submitted by June 30, 2006, or July 1, 2006, each participating host and home hospital must submit an emergency Medicare GME affiliation agreement to CMS and submit a copy to its CMS contractor/MAC on or before October 9, 2006.

(B) Except for emergency Medicare GME affiliation agreements specified in paragraph (f)(6)(ii)(A) of this section,

for emergency Medicare GME affiliation agreements that would otherwise be required to be submitted prior to October 1, 2008, the following due dates are applicable:

(1) *First year.* The later of 180 days after the section 1135 emergency period begins or by June 30 of the academic year in which the section 1135 emergency was declared; or

(2) *Subsequent academic years.* The later of 180 days after the section 1135 emergency period begins, or by July 1 of each academic year.

(C) For emergency Medicare GME affiliation agreements that would otherwise be required to be submitted after October 1, 2008, the following due dates are applicable:

(1) *First year.* By 180 days after the end of the academic year in which the section 1135 emergency was declared;

(2) *Second academic year.* By 180 days after the end of the next academic year following the academic year in which the section 1135 emergency was declared; or

(3) *Subsequent academic years.* By July 1 of each academic year.

(iii) *Exemption from the Shared Rotational Arrangement Requirement.* During the effective period of the emergency Medicare GME affiliation agreement, hospitals in the emergency Medicare GME affiliated group are not required to participate in a shared rotational arrangement as defined at §413.75(b).

(iv) *Host Hospital Exception from the Rolling Average for the Period from August 29, 2005 to June 30, 2006.* To determine the FTE resident count for a host hospital that is training residents in excess of its cap, a two step process will be applied. First, subject to the limit at paragraph (f)(6)(i)(D) of this section, a host hospital is to exclude the displaced FTE residents that are counted by a host hospital in excess of the hospital's cap pursuant to an emergency Medicare GME affiliation agreement from August 29, 2005, to June 30, 2006, from the current year's FTE resident count before applying the three-year rolling averaging rules under paragraph (d) of this section to calculate the average FTE resident count. Second, the displaced FTE residents that are counted by the host hospital in excess of the host hospital's cap pur-

suant to an emergency Medicare GME affiliation agreement from August 29, 2005, to June 30, 2006, are added to the hospital's 3-year rolling average FTE resident count to determine the host hospital's FTE resident count for payment purposes.

(8) FTE resident cap slots added under section 126 of Public Law 116-260 and section 4122 of Public Law 117-328 may be used in a Medicare GME affiliation agreement beginning in the fifth year after the effective date of those FTE resident cap slots.

(g) *Newly constructed hospitals.* A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995, and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.

(1) The newly constructed hospital's FTE cap is equal to the lesser of—

(i) The product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

(ii) The number of accredited slots available to the hospital for each year of the programs.

(2) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training in the third year of the programs begun at the temporary training site.

(3) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents

training at the newly constructed hospital in the third year of the programs (including the years at the temporary training site).

(4) A hospital that qualifies for an adjustment to its FTE cap under this paragraph (g) may be part of an affiliated group for purposes of establishing an aggregate FTE cap.

(5) The provisions of this paragraph (g) are applicable during portions of cost reporting periods occurring on or after October 1, 1999.

(h) *Closure of hospital or hospital residency program*—(1) *Definitions*. For purposes of this section—

(i) *Closure of a hospital* means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter.

(ii) *Closure of a hospital residency training program* means the hospital ceases to offer training for residents in a particular approved medical residency training program.

(iii) *Displaced resident* means a resident who—

(A) Leaves a program after the hospital or program closure is publicly announced, but before the actual hospital or program closure;

(B) Is assigned to and training at planned rotations at another hospital who will be unable to return to his/her rotation at the closing hospital or program;

(C) Is accepted into a GME program at the closing hospital or program but has not yet started training at the closing hospital or program;

(D) Is physically training in the hospital on the day prior to or day of program or hospital closure; or

(E) Is on approved leave at the time of the announcement of closure or actual closure, and therefore, cannot return to his/her rotation at the closing hospital or program.

(2) *Closure of a hospital*. A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:

(i) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

(ii) No later than 60 days after the hospital begins to train the residents,

the hospital submits a request to its contractor for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

(3) *Closure of a hospital's residency training program*. If a hospital that closes its residency training program voluntarily agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (h)(3)(ii) of this section, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in paragraph (h)(3)(i) of this section are met.

(i) *Receiving hospital(s)*. A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another hospital's residency training program if—

(A) The hospital is training additional residents from the residency training program of a hospital that closed a program; and

(B) No later than 60 days after the hospital begins to train the residents, the hospital submits to its contractor a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from another hospital's closed program and have caused the hospital to exceed its cap, specifies the length of time the adjustment is needed, and submits to its contractor a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (h)(3)(ii)(B) of this section.

(ii) *Hospital that closed its program(s)*. A hospital that agrees to train residents who have been displaced by the closure of another hospital's program may receive a temporary FTE cap adjustment only if the hospital with the closed program—

(A) Temporarily reduces its FTE cap based on the FTE residents in each program year training in the program at

the time of the program's closure. This yearly reduction in the FTE cap will be determined based on the number of those residents who would have been training in the program during that year had the program not closed; and

(B) No later than 60 days after the residents who were in the closed program begin training at another hospital, submit to its contractor a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the hospital training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were in training at the time of the program's closure; identifies the hospitals to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

(i) *Additional FTEs for residents on maternity or disability leave or other approved leave of absence.* Effective for cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional resident FTEs, if the hospital meets the following criteria:

(1) The additional residents are residents of a primary care program that would have been counted by the hospital as residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on maternity or disability leave or a similar approved leave of absence during the hospital's most recent cost reporting period ending on or before December 31, 1996;

(2) The leave of absence was approved by the residency program director to allow the residents to be absent from the program and return to the program after the leave of absence; and

(3) No later than 6 months after August 1, 2000, the hospital submits to the contractor a request for an adjustment to its FTE cap, and provides contemporaneous documentation of the approval of the leave of absence by the residency director, specific to each additional resident that is to be counted for purposes of the adjustment.

(j) *Residents previously trained at VA hospitals.* For cost reporting periods beginning on or after October 1, 1997, a

non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who had previously trained at a VA hospital and were subsequently transferred to the non-VA hospital, if that hospital meets the following criteria:

(1) The transferred residents had been training previously at a VA hospital in a program that would have lost its accreditation by the ACGME if the residents continued to train at the VA hospital;

(2) The residents were transferred to the hospital from the VA hospital on or after January 1, 1997, and before July 31, 1998; and

(3) The hospital submits a request to its contractor for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from the VA hospital, and specifies the length of time those residents will be trained at the hospital.

(k) *Residents training in rural track programs.* Subject to the provisions of §413.81, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may add the rotations of the residents in those rural tracks to its FTE cap specified under paragraph (c) of this section. An urban hospital (or, effective for a cost reporting period beginning on or after October 1, 2022, a rural hospital) with a Rural Track Program (as defined at section 413.75(b) of this subchapter) may count residents in those Rural Track Programs up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (k)(2) through (7) of this section.

(1) If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, and before October 1, 2022, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital, not

to exceed its rural track FTE limitation. For cost reporting periods beginning on or after October 1, 2022, if an urban hospital rotates residents to a Rural Track Program (as defined at section 413.75(b) of this subchapter) at a rural hospital(s) for more than one-half of the duration of the program, both the urban and the rural hospital may include those residents in their FTE counts for the time the rural track residents spend at the urban and rural hospital, respectively, not to exceed their rural track FTE limitations. The rural track FTE limitation is determined as follows:

(i) For rural track programs started prior to October 1, 2012, for the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average at paragraph (d)(7) of this section, training in the rural track at the urban hospital. For rural track programs started on or after October 1, 2012, and before October 1, 2022, prior to the start of the urban hospital's cost reporting period that coincides with or follows the start of the sixth program year of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average at paragraph (d)(7) of this section, training in the rural track at the urban hospital. For cost reporting periods beginning on or after October 1, 2022, before the start of the urban or rural hospital's cost reporting period that coincides with or follows the start of the sixth program year of the Rural Track Program's existence, the rural track FTE limitation for each hospital will be the actual number of FTE residents training in the Rural Track Program at the urban or rural hospital.

(ii) For rural track programs started prior to October 1, 2012, beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of the highest number of residents, in any program year, who during the third year of the rural track's existence are training in the rural track at the urban hospital and are designated at the beginning of their training to be rotated to the

rural hospital(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, and the number of years those residents are training at the urban hospital. For rural track programs started on or after October 1, 2012 and before October 1, 2022, beginning with the start of the urban hospital's cost reporting period that coincides with or follows the start of the sixth program year of the rural track's existence, the rural track FTE limitation is calculated in accordance with paragraph (e)(1) of this section. For Rural Track Programs started on or after October 1, 2022, beginning with the start of the urban or rural hospital's cost reporting period that coincides with or follows the start of the sixth program year of the rural track's existence, the rural track FTE limitation is calculated in accordance with paragraph (e)(1) of this section.

(2) If an urban hospital rotates residents to a separately accredited rural track program at a rural nonprovider site(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.78(d) through (g). For cost reporting periods beginning on or after October 1, 2022, if an urban or rural hospital rotates residents to a Rural Track Program (as defined at section 413.75(b) of this subchapter) at a rural nonprovider site for more than one-half of the duration of the program, the urban or rural hospital may include those residents in its FTE count, subject to which hospital meets the requirements under § 413.78(g), not to exceed their rural track FTE limitations. The rural track FTE limitation is determined as follows:

(i)(A) For rural track programs started before October 1, 2012, for the first 3 years of the rural track's existence, the rural track FTE limitation for each

urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (d)(7) of this section, training in the rural track at the urban hospital and the rural nonprovider site(s).

(B) For rural track programs started on or after October 1, 2012, and before October 1, 2022, prior to the start of the urban hospital's cost reporting period that coincides with or follows the start of the sixth program year of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (d)(7) of this section, training in the rural track at the urban hospital and the rural nonprovider site(s).

(C) For cost reporting periods beginning on or after October 1, 2022, before the start of the urban or rural hospital's cost reporting period that coincides with or follows the start of the sixth program year of the Rural Track Program's existence, the rural track FTE limitation for each hospital will be the actual number of FTE residents training in the Rural Track Program at the urban or rural hospital and subject to the requirements under §413.78(g), at the rural nonprovider site(s).

(ii)(A) For rural track programs started prior to October 1, 2012, beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(I) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at—

(i) The urban hospital and are designated at the beginning of their training to be rotated to a rural nonprovider site(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

(ii) The rural nonprovider site(s); and

(2) The number of years in which the residents are expected to complete each program based on the minimum

accredited length for the type of program.

(B) For rural track programs started on or after October 1, 2012, beginning with the start of the urban hospital's cost reporting period that coincides with or follows the start of the sixth program year of the rural track's existence, the rural track FTE limitation is calculated in accordance with paragraph (e)(1) of this section.

(3) For rural track programs started prior to October 1, 2012, if an urban hospital rotates residents in the rural track program to a rural hospital(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the rural hospital may not include those residents in its FTE count (unless the rural track is a new program under paragraph (e)(3) of this section, or the rural hospital's FTE count does not exceed that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation. For rural track programs started on or after October 1, 2012, if an urban hospital rotates residents in the rural track program to a rural hospital(s) for one-half or less than one-half of the duration of the program, the rural hospital may not include those residents in its FTE count (unless the rural track is a new program under paragraph (e)(3) of this section, or the rural hospital's FTE count does not exceed that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation. For cost reporting periods beginning on or after October 1, 2022, if less than or equal to 50 percent of the duration of the training program occurs in a rural area, neither the urban or rural hospital may receive a rural track FTE limitation.

(4)(i) For rural track programs started prior to October 1, 2012, if an urban hospital rotates residents in the rural track program to a rural nonprovider site(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after

April 1, 2000 and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.78(d) through (g), as applicable. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (d)(7) of this section, training in the rural track at the rural nonprovider site(s).

(B) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(1) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the rural nonprovider site(s) or are designated at the beginning of their training to be rotated to the rural nonprovider site(s) for a period that is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

(2) The length of time in which the residents are training at the rural nonprovider site(s) only.

(C) For programs started in a cost reporting period beginning on or after October 1, 2022, if less than or equal to 50 percent of the duration of the training program occurs in a rural area, neither the urban or rural hospital may receive a rural track FTE limitation.

(ii) For rural track programs started on or after October 1, 2012 and prior to October 1, 2022, if an urban hospital rotates residents in the rural track program to a rural nonprovider site(s) for one-half or less than one-half of the duration of the program, the urban hospital may include those residents in its

FTE count, subject to the requirements under § 413.78(g). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track limitation, determined as follows:

(A) Prior to the start of the urban hospital's cost reporting period that coincides with or follows the start of the sixth program year of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (d)(7) of this section, training in the rural track at the rural nonprovider site(s).

(B) Beginning with the start of the urban hospital's cost reporting period that coincides with or follows the start of the sixth program year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(1) The highest number of residents in any program year who, during the fifth year of the rural track's existence, are training in the rural track at the rural nonprovider site(s) or are designated at the beginning of their training to be rotated to the rural nonprovider site(s) for a period that is for one-half or less than one-half of the duration of the program; and

(2) The ratio of the length of time in which the residents are training at the rural nonprovider site(s) only to the total duration of the program.

(C) For cost reporting periods beginning on or after October 1, 2022, if less than or equal to 50 percent of the duration of the training program occurs in a rural area, neither the urban or rural hospital may receive a rural track FTE limitation.

(5) All urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitation, must also comply with all of the following conditions:

(i) A hospital may not include in its rural track FTE limitation or (assuming the hospital's FTE count exceeds its FTE cap) FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap.

(ii) Each hospital must base its count of residents in a rural track on written contemporaneous documentation that

each resident enrolled in a rural track program at the hospital intends to rotate for a portion of the residency program to a rural area.

(iii) All residents that are included by the hospital as part of its rural track FTE count (not to exceed its rural track FTE limitation) must train in the rural area. However, where a resident begins to train in the rural track program at the urban hospital but leaves the program before completing the total required portion of training in the rural area, the urban hospital may count the time the resident trained in the urban hospital if another resident fills the vacated FTE slot and completes the training in the rural portion of the rural track program. An urban hospital may not receive GME payment for the time the resident trained at the urban hospital if another resident fills the vacated FTE slot and first begins to train at the urban hospital.

(iv) Effective for cost reporting periods beginning on or after October 1, 2022, in order for an urban or rural hospital to receive a rural track FTE limitation, greater than 50 percent of the program must occur in a rural area.

(6) If CMS finds that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, CMS will reopen the urban hospital's cost report within the 3-year reopening period as specified in §405.1885 of this chapter and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

(7)(i) Effective prior to October 1, 2014, if an urban hospital had established a rural track training program under the provisions of this paragraph (k) with a hospital located in a rural area and that rural area subsequently becomes an urban area due to the most recent census data and implementation of the new labor market area definitions announced by OMB on June 6, 2003, the urban hospital may continue to adjust its FTE resident limit in accordance with this paragraph (k) for the rural track programs established prior to the adoption of such new labor market area definitions. In order to receive an adjustment to its FTE resi-

dent cap for a new rural track residency program, the urban hospital must establish a rural track program with hospitals that are designated rural based on the most recent geographical location delineations adopted by CMS.

(ii)(A) For rural track programs started prior to October 1, 2012, effective October 1, 2014, if an urban hospital started a rural track training program under the provisions of this paragraph (k) with a hospital located in a rural area and, during the 3-year period that is used to calculate the urban hospital's rural track FTE limit, that rural area subsequently becomes an urban area due to the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, the urban hospital may continue to adjust its FTE resident limit in accordance with this paragraph (k) and subject to paragraph (k)(7)(iii) of this section for the rural track programs started prior to the adoption of such new OMB standards for delineating statistical areas.

(B) For rural track programs started on or after October 1, 2012, effective October 1, 2014, if an urban hospital started a rural track training program under the provisions of this paragraph (k) with a hospital located in a rural area and, during the 5-year period that is used to calculate the urban hospital's rural track FTE limit, that rural area subsequently becomes an urban area due to the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, the urban hospital may continue to adjust its FTE resident limit in accordance with this paragraph (k) and subject to paragraph (k)(7)(iii) of this section for the rural track programs started prior to the adoption of such new OMB standards for delineating statistical areas.

(iii)(A) For rural track programs started prior to October 1, 2012, effective October 1, 2014, if an urban hospital started a rural track training program under the provisions of this paragraph (k) with a hospital located in a rural area and that rural area subsequently becomes an urban area due to the most recent OMB standards for delineating statistical areas adopted by

CMS and the most recent Census Bureau data, regardless of whether the redesignation of the rural hospital occurs during the 3-year period that is used to calculate the urban hospital's rural track FTE limit, or after the 3-year period used to calculate the urban hospital's rural track FTE limit, the urban hospital may continue to adjust its FTE resident limit in accordance with this paragraph (k) based on the rural track programs started prior to the change in the hospital's geographic designation. In order for the urban hospital to receive or use the adjustment to its FTE resident cap for training FTE residents in the rural track residency program that was started prior to the most recent OMB standards for delineating statistical areas adopted by CMS, one of the following two conditions must be met by the end of a period that begins when the most recent OMB standards for delineating statistical areas are adopted by CMS and continues through the end of the second residency training year following the date the most recent OMB delineations are adopted by CMS: The hospital that has been redesignated from rural to urban must reclassify as rural under § 412.103 of this chapter, for purposes of IME only; or the urban hospital must find a new site that is geographically rural consistent with the most recent geographical location delineations adopted by CMS. In order to receive an adjustment to its FTE resident cap for an additional new rural track residency program, the urban hospital must participate in a rural track program with sites that are geographically rural based on the most recent geographical location delineations adopted by CMS.

(B) For rural track programs started on or after October 1, 2012, effective October 1, 2014, if an urban hospital started a rural track training program under the provisions of this paragraph (k) with a hospital located in a rural area and that rural area subsequently becomes an urban area due to the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, regardless of whether the redesignation of the rural hospital occurs during the 5-year period that is used to calculate

the urban hospital's rural track FTE limit, or after the 5-year period used to calculate the urban hospital's rural track FTE limit, the urban hospital may continue to adjust its FTE resident limit in accordance with this paragraph (k) based on the rural track programs started prior to the change in the hospital's geographic designation. In order for the urban hospital to receive or use the adjustment to its FTE resident cap for training FTE residents in the rural track residency program that was started prior to the most recent OMB standards for delineating statistical areas adopted by CMS, one of the following two conditions must be met by the end of a period that begins when the most recent OMB standards for delineating statistical areas are adopted by CMS and continues through the end of the second residency training year following the date the most recent OMB delineations are adopted by CMS: The hospital that has been redesignated from rural to urban must reclassify as rural under § 412.103 of this chapter, for purposes of IME only; or the urban hospital must find a new site that is geographically rural consistent with the most recent geographical location delineations adopted by CMS. In order to receive an adjustment to its FTE resident cap for an additional new rural track residency program, the urban hospital must participate in a rural track program with sites that are geographically rural based on the most recent geographical location delineations adopted by CMS.

(l) For purposes of this section, a new medical residency training program means a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.

(m) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots under section 5503 of Public Law 111–148.* If a hospital's reference resident level, as defined under paragraph (c)(1)(ii)(B) of this section is less than its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section or paragraph (e) of this section in the reference cost reporting period (as described under paragraph (m)(6) of this section), for

portions of cost reporting periods beginning on or after July 1, 2011, the hospital's otherwise applicable FTE resident cap is reduced by 65 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level. The reduction shall take into account the hospital's FTE resident cap as reduced under paragraph (c)(3) of this section. Under this provision—

(1) *Exemption for certain rural hospitals.* A rural hospital, as defined at subpart D of part 412 of this subchapter, with fewer than 250 beds (as determined at §412.105(b)) in its most recent cost reporting period ending on or before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(2) *Exemption for certain hospitals that participate in demonstration projects or voluntary residency reduction plans.* A hospital that was participating in a demonstration project under section 402 of Public Law 90-248 or the voluntary reduction plan under §413.88, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section if, by January 21, 2011, it submits a plan to CMS for filling all of its unused FTE resident slots by not later than March 23, 2012.

(3) *Exemption for a hospital described at section 1886(h)(4)(H)(v) of the Act.* A hospital described at section 1886(h)(4)(H)(v) of the Act, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(4) *Exemptions for certain other hospitals.* A hospital training at or above its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section for all three most recent cost reporting periods ending prior to March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(5) *New teaching hospital.* A new teaching hospital that does not have an otherwise applicable FTE resident cap as determined under paragraph (e)(1) of this section for all three most recent cost reporting periods ending prior to March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(6) *Reference cost reporting period.* (i) To determine a hospital's reference resident level, CMS determines, for a hospital's three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010, the cost reporting period with the highest resident level.

(ii) If the cost report that is used to determine a hospital's otherwise applicable FTE resident cap in the reference period is not equal to 12 months, the Medicare contractor may make appropriate modifications to apply the provisions of paragraph (m) of this section based on the equivalent of a 12-month cost reporting period.

(7) *Consideration for members of Medicare GME affiliated groups.* For a hospital that is a member of a Medicare GME affiliated group at any point during any of the hospital's three most recent cost reporting periods ending before March 23, 2010 for which a cost report has been settled or has been submitted to Medicare contractor by March 23, 2010, in determining whether a hospital's otherwise applicable resident FTE resident cap is reduced under paragraph (m) of this section, the Medicare contractor determines a hospital's reference cost reporting period by finding the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit.

(i) If the reference resident level is less than the otherwise applicable resident limit in that reference cost reporting period, the Medicare contractor must then determine if the hospital was a member of a Medicare GME affiliated group as of the July 1 that

occurs during that reference cost reporting period.

(ii) If the hospital was a member of a Medicare GME affiliated group as of the July 1 that occurs during that reference cost report, the Medicare contractor does all of the following:

(A) Treat the members of the Medicare GME affiliated group as a group for that reference cost reporting period, for the purpose of determining a reduction to the particular hospital's FTE resident cap.

(B) Determine for each hospital in the Medicare GME affiliated group respectively the FTE resident cap and FTE resident count (IME and direct GME separately).

(C) Add each hospital's FTE resident caps (IME and direct GME separately) to determine the aggregate FTE resident cap.

(D) Add each hospital's FTE resident count (IME and direct GME separately) to determine the aggregate FTE resident count.

(iii) If the aggregate FTE resident count is equal to or exceeds the aggregate FTE resident cap, then the Medicare contractor would make no reduction to the particular hospital's otherwise applicable FTE resident cap under paragraph (m) of this section, and no further steps are necessary for that hospital.

(iv) If the hospitals' aggregate FTE resident count is less than the aggregate FTE resident cap, then the Medicare contractor would determine on a hospital-specific basis whether the particular hospital's FTE resident count is less than its otherwise applicable FTE resident cap (as adjusted by affiliation agreement(s)) in the hospital's reference cost report.

(v) If the hospital's FTE resident count exceeds its otherwise applicable FTE resident cap, the hospital will not have its otherwise applicable FTE resident cap reduced under paragraph (m) of this section.

(vi) If the particular hospital's FTE resident count is less than its otherwise applicable FTE resident cap, the Medicare contractor determines a pro rata cap reduction amount that is equal, in total, to 65 percent of the difference between the aggregate FTE resident cap and the aggregate FTE

resident count for the Medicare GME affiliated group.

(A) The pro rata cap reduction to the particular hospital's otherwise applicable FTE resident cap is calculated by dividing the difference between the hospital's otherwise applicable FTE resident cap and the hospital's FTE resident count, by the total amount by which all of the hospitals' individual FTE resident counts are below their affiliated FTE resident caps, multiplying the quotient by the difference between the aggregate FTE resident cap and the aggregate FTE resident counts for the Medicare GME affiliated group, and multiplying that result by 65 percent.

(B) The final reduction takes into account the hospital's FTE resident cap as reduced under the provisions of paragraph (c)(3) of this section.

(n) *Determination of an increase in the otherwise applicable resident cap under section 5503 of Public Law 111–148.* (1) For portions of cost reporting periods beginning on or after July 1, 2011, a hospital may receive an increase in its otherwise applicable FTE resident cap (as determined by CMS) of not more than 75 additional FTEs if the hospital meets the requirements and qualifying criteria of section 1886(h)(8) of the Act and implementing instructions issued by CMS and if the hospital submits an application to CMS within the time-frame specified by CMS.

(2) A hospital that receives an increase in the otherwise applicable FTE resident cap under paragraph (n)(1) of this section must ensure, during the 5-year period beginning on July 1, 2011 and ending on June 30, 2016, that—

(i) The number of FTE primary care residents, as defined in § 413.75(b), excluding any additional positions under this paragraph, is not less than the average number of FTE primary care residents (as so determined) during the three most recent cost reporting periods ending prior to March 23, 2010 (and submitted to the Medicare contractor by March 23, 2010); and not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency programs.

(ii) If a hospital receives an increase in the otherwise applicable FTE resident cap under paragraph (n)(1) of this

section, and does not use all of that increase in its final (12-month or partial) cost report of the 5-year period beginning July 1, 2011 and ending June 30, 2016, the Medicare contractor will remove the applicable unused slots, and the hospital's increase in the otherwise applicable FTE resident cap received under paragraph (n)(1) of this section will be reduced for portions of cost reporting periods on or after July 1, 2016. The number of applicable unused slots is equal to the difference between the increase in the otherwise applicable FTE resident cap and the applicable slots used. In determining the applicable slots used, the following amounts are added, as relevant:

(A) If a hospital uses the increase in the otherwise applicable FTE resident cap under paragraph (n)(1) of this section to expand an existing program(s), the used slots are equal to the lesser of the number of slots used for an expansion(s) in the fourth 12-month cost report or the final cost report.

(B) If a hospital uses the increase in the otherwise applicable FTE resident cap under paragraph (n)(1) of this section to start a new program(s), the used slots are equal to the number of slots used for a new program(s) in the final cost report.

(C) The portion, if any, of the increase in the otherwise applicable FTE resident cap under paragraph (n)(1) of this section used for cap relief, subject to the requirements in paragraph (n)(2)(i) of this section.

(iii) CMS may determine whether a hospital has met the requirements under paragraphs (n)(2)(i) and (n)(2)(ii) of this section during the 5-year period of July 1, 2011, through June 30, 2016, in such manner and at such time as CMS determines appropriate, including at the end of such 5-year period.

(iv) In a case where the Medicare contractor determines that a hospital did not meet the requirements under paragraphs (n)(2)(i), (n)(2)(ii), and (n)(2)(iii) of this section in a cost reporting period within the 5-year time period, the Medicare contractor will reduce the otherwise applicable FTE resident cap of the hospital by the amount by which such limit was increased under paragraph (n)(1) of this section from the earliest cost reporting

period that is reopenable in which it would be determined that the hospital did not meet the requirements.

(o) *Determination of an increase in the FTE resident cap due to slots redistributed from a closed hospital.* (1) Except in the case of the closure of the hospital with Medicare Provider Number 05-0578, in the instance of a hospital closure, as defined at paragraph (h)(1)(i) of this section, the FTE resident cap of the closed hospital would be redistributed, and a hospital that meets the requirements and qualifying criteria of section 1886(h)(4)(H)(vi) of the Act and implementing instructions issued by CMS, including submission of a timely application to CMS, may receive an increase in its FTE resident cap, as determined by CMS.

(2)(i) Except in the case of the closure of the hospital with Medicare Provider Number 05-0578, in redistributing the FTE resident cap of a closed hospital, consideration shall be given to ensure that there is no duplication of FTE slots between FTE slots redistributed under this paragraph and temporary adjustments to FTE resident caps provided under paragraph (h)(2) of this section.

(ii) The provisions of this paragraph (o) will not be applied in a manner that will require the reopening of settled cost reports, except where the provider has a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.

(p) *Determination of an increase in the otherwise applicable resident cap under section 126 of the Consolidated Appropriations Act (Pub. L. 116-260).* For portions of cost reporting periods beginning on or after July 1, 2023, a hospital may receive an increase in its otherwise applicable FTE resident cap (as determined by CMS) if the hospital meets the requirements and qualifying criteria under section 1886(h)(9) of the Act and if the hospital submits an application to CMS within the timeframe specified by CMS.

(q) *Determination of an increase in the otherwise applicable resident cap under section 4122 of the Consolidated Appropriations Act (Pub. L. 117-328).* For portions of cost reporting periods beginning on or after July 1, 2026, a hospital

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may receive an increase in its otherwise applicable FTE resident cap (as determined by CMS) if the hospital meets the requirements and qualifying criteria under section 1886(h)(10) of the Act and if the hospital submits an application to CMS within the timeframe specified by CMS.

[69 FR 49254, Aug. 11, 2004]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 413.79, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

§ 413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.

(a) The weighting factor for a foreign medical graduate is determined under the provisions of § 413.79 if the foreign medical graduate—

(1) Has passed FMGEMS; or

(2) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(b) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight determined under the provisions of § 413.79. On or after July 1, 1986, and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (a) of this section is .50 times the weight determined under the provisions of § 413.79.

(c) On or after July 1, 1987, these foreign medical graduates are not counted in determining the number of FTE residents.

(d) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of § 413.79 for the part of the cost reporting period beginning with the month the resident passes the test.

(e) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section.

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(f) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section. On or after July 1, 1993, only the results of steps I and II of the United States Medical Licensing Examination will be accepted for purposes of making this determination.

[69 FR 49254, Aug. 11, 2004]

§ 413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.

(a) For purposes of determining direct GME payments, the following principles apply:

(1) *Community support.* If the community has undertaken to bear the costs of medical education through community support, the costs are not considered GME costs to the hospital for purposes of Medicare payment.

(2) *Redistribution of costs.* The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered GME costs to the hospital for purposes of Medicare payment.

(b) *Application.* A hospital must continuously incur costs of direct GME of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents in accordance with the provisions of §§ 413.78, 413.79 (c) through (e), and 413.79(k). This rule also applies to providers that are paid for direct GME in accordance with § 405.2468 of this chapter, § 422.270 of this subchapter, and § 413.70.

(c)(1) *Effective date.* Subject to the provisions of paragraph (c)(2) of this section, payments made in accordance with determinations made under the provisions of paragraphs (a) and (b) of this section will be effective for portions of cost reporting periods occurring on or after October 1, 2003.

(2) *Applicability for certain hospitals.* With respect to an FTE resident who begins training in a residency program on or before October 1, 2003, and with

respect to whom there has been a redistribution of costs or community support determined under the provisions of paragraphs (a) and (b) of this section, the hospital may continue to count the FTE resident until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first.

[69 FR 49254, Aug. 11, 2004]

§ 413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicare reimbursement principles.

(a) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1 or section 222(a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b-1 (note)) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(b) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(c) Per resident amounts are determined for the base period and updated as described in § 413.77. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in § 413.76.

[69 FR 49254, Aug. 11, 2004]

§ 413.83 Direct GME payments: Adjustment of a hospital's target amount or prospective payment hospital-specific rate.

(a) *Misclassified operating costs*—(1) *General rule.* If a hospital has its base-period GME costs reduced under § 413.77(a) of this section because those costs included misclassified operating costs, the hospital may request that the contractor review the classifica-

tion of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) *Request for review.* The hospital must request review of the classification of its rate-of-increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the contractor of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the contractor that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) *Effect of contractor's review.* If the contractor, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(b) *Misclassification of GME costs*—(1) *General rule.* If costs that should have been classified as GME costs were treated as operating costs during both the GME base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as GME costs in the GME base period, the hospital must request that the contractor review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the contractor's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the contractor that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) *Effect of contractor's review.* If the contractor, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

[69 FR 49254, Aug. 11, 2004]

§ 413.85 Cost of approved nursing and allied health education activities.

(a) *Statutory basis.* This section implements section 1861(v)(1)(A) of the Act and section 4004(b) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) by establishing the methodology for Medicare payment of the costs of approved nursing and allied health education activities.

(b) *Scope.* (1) This section sets forth the rules for determining Medicare payments to hospitals for the costs of nursing and allied health education activities.

(2) This section does not address Medicare payments for the direct and indirect costs of graduate medical education (that is, approved residency programs in medicine, osteopathy, dentistry, and podiatry). Medicare payment for these costs is determined as provided in § 412.105 of this subchapter and §§ 413.75 through 413.83.

(3) The rules under this section do not apply to activities that are specified in paragraph (h) of this section and identified as normal operating costs.

(c) *Definitions.* For purposes of this section, the following definitions apply:

Approved educational activities means formally organized or planned programs of study of the type that:

(1) Are operated by providers as specified in paragraph (f) of this section;

(2) Enhance the quality of health care at the provider; and

(3) Meet the requirements of paragraph (e) of this section for State licensure or accreditation.

Classroom instruction costs are those costs associated with formal, didactic instruction on a specific topic or subject in a class that meets at regular, scheduled intervals over a specific time period (for example, semester or quarter), and for which a student receives a grade.

Clinical training costs means costs of training for the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. Clinical training may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques; it involves no classroom instruction.

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.

Redistribution of costs means an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the provider and were considered costs of an educational institution. For example, costs for a school of nursing or allied health education or a medical school that were incurred by an educational institution and were not allowable to the provider in its prospective payment or rate-of-increase limit base year cost report, or graduate medical education per resident amount calculated under §§ 413.75 through 413.83, are not allowable costs in subsequent fiscal years.

(d) *General payment rules.* (1) Payment for a provider's net cost of nursing and allied health education activities is determined on a reasonable cost basis, subject to the following conditions and limitations:

(i) An approved educational activity—

(A) Is recognized by a national approving body or State licensing authority as specified in paragraph (e) of this section;

(B) Meets the criteria specified in paragraph (f) of this section for identification as an operator of an approved education program.

(C) Enhance the quality of health care at the provider.

(ii) The cost for certain nonprovider-operated programs are reimbursable on a reasonable cost basis if the programs meet the criteria specified in paragraph (g)(2) of this section.

(iii) The costs of certain nonprovider-operated programs at wholly owned subsidiary educational institutions are reimbursable on a reasonable cost basis if the provisions of paragraph (g)(3) of this section are met.

(2) *Determination of net cost.* (i) Subject to the provisions of paragraph (d)(2)(iii) of this section, the net cost of approved educational activities is determined by deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable educational costs that are directly related to approved educational activities.

(ii) A provider's total allowable educational costs are those costs incurred by the provider for trainee stipends, compensation of teachers, and other costs of the activities as determined under the Medicare cost-finding principles in § 413.24. These costs do not include patient care costs, costs incurred by a related organization, or costs that constitute a redistribution of costs from an educational institution to a provider or costs that have been or are currently being provided through community support.

(iii) The net costs of approved certified registered nurse anesthetist (CRNA) education programs that are determined on a reasonable cost basis are subject to the additional condition that allowable compensation costs for

faculty members who are CRNAs are limited to the compensation costs for administrative activities related to the educational program, the compensation costs directly related to hours spent in classroom instruction, and the costs related to the clinical training of students for which the CRNA may not receive payment under the CRNA fee schedule. No pass-through compensation costs are allowable for the time a CRNA spends in the clinical training of a student anesthetist during a surgical procedure in the operating room for which the CRNA may receive payment under the CRNA fee schedule. As specified at § 414.46 of this chapter, if the CRNA continuously supervises the services of a single student nurse anesthetist, or where the medical direction rules allow a CRNA to bill for the service, payment can be made under the CRNA fee schedule.

(iv) Net costs are subject to apportionment for Medicare utilization as described in § 413.50.

(e) *Approved nursing and allied health education programs.* CMS will consider an activity an approved nursing and allied health education program if the program is a planned program of study that is licensed by State law, or if licensing is not required, is accredited by the recognized national professional organization for the particular activity. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs, the National League of Nursing Accrediting Commission, the Association for Clinical Pastoral Education Inc., and the American Dietetic Association.

(f) *Criteria for identifying programs operated by a provider.* (1) Except as provided in paragraph (f)(2) of this section, for cost reporting periods beginning on or after October 1, 1983, in order to be considered the operator of an approved nursing or allied health education program, a provider must meet all of the following requirements:

(i) Directly incur the training costs.

(ii) Have direct control of the program curriculum. (A provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider

must provide all of the courses relating to the theory and practice of the nursing or allied health profession involved that are required for the degree, diploma, or certificate awarded at the completion of the program.)

(iii) Control the administration of the program, including collection of tuition (where applicable), control the maintenance of payroll records of teaching staff or students, or both (where applicable), and be responsible for day-to-day program operation. (A provider may contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions.)

(iv) Employ the teaching staff.

(v) Provide and control both classroom instruction and clinical training (where classroom instruction is a requirement for program completion), subject to the parenthetical sentence in paragraph (f)(1)(ii) of this section.

(2) Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) of this section and to be the operator of the program.

(g) *Payment for certain nonprovider-operated programs*—(1) *Payment rule.* Costs incurred by a provider, or by an educational institution that is related to the provider by common ownership or control (that is, a related organization as defined in § 413.17(b)), for the clinical training of students enrolled in an approved nursing or allied health education program that is not operated by the provider, are paid on a reasonable cost basis if the conditions specified in paragraph (g)(2) of this section are met.

(2) *Criteria for identification of nonprovider-operated education programs.* Payment for the incurred costs of educational activities identified in paragraph (g)(1) of this section will be made if the following conditions are met:

(i) The clinical training must occur on the premises of the provider, that is, in the hospital itself or in the physical area immediately adjacent to the provider's main buildings, or in other areas and structures that are not strictly contiguous to the main build-

ings but are located within 250 yards of the main buildings.

(ii) The provider must have claimed and been paid for clinical training costs on a reasonable cost basis during the most recent cost reporting period that ended on or before October 1, 1989. This condition is met if a notice of program reimbursement (NPR) was issued for that cost reporting period by November 5, 1990, and the clinical training costs were included as pass-through costs. If an NPR was not issued by that date, or an NPR was issued but did not treat the clinical training costs as pass-through costs, the condition is met if—

(A) The contractor included the clinical training costs in the allowable costs used to determine the interim rate for the most recent cost reporting period ending on or before October 1, 1989; or

(B) The provider claimed the clinical training costs as pass-through costs when the cost report for the most recent cost reporting period ending on or before October 1, 1989, was initially submitted.

(iii) In any cost reporting period, the percentage of total allowable provider cost attributable to allowable clinical training cost does not exceed the percentage of total cost for clinical training in the provider's most recent cost reporting period ending on or before October 1, 1989.

(iv) The students in the educational program must provide a benefit to the provider through the provision of clinical services to patients of the provider.

(v) The clinical training costs must be incurred by the provider or by an educational institution related to the provider by common control or ownership as defined in § 413.17(b) (“*Cost to related organizations.*”) Costs incurred by a third-party, regardless of its relationship to either the provider or the educational institution, are not allowed.

(vi) The costs incurred by a provider does not exceed the costs the provider would have incurred if it was the sole operator of the program.

(3) *Special rule: Payment for certain nonprovider-operated programs at wholly owned subsidiary educational institutions.* (i) Effective for portions of cost

reporting periods occurring on or after October 1, 2003, a provider that incurs costs for a nursing or allied health education program(s) where those program(s) had originally been provider-operated according to the criteria at paragraph (f) of this section, and then operation of the program(s) was transferred to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the provider has continuously incurred the costs of both the classroom and clinical training portions of the program(s) at the educational institution, may receive reasonable cost payment for such a program(s) according to the specifications under paragraphs (g)(3)(ii) and (g)(3)(iii) of this section.

(ii) Payment for the incurred costs of educational activities identified in paragraph (g)(3)(i) of this section will be made on a reasonable cost basis if a provider, as described in paragraph (g)(3)(i) of this section, received Medicare reasonable cost payment for those nursing and allied health education program(s) both prior and subsequent to the date the provider transferred operation of the program(s) to its wholly owned subsidiary educational institution (and ceased to be a provider-operated program(s) according to the criteria under paragraph (f) of this section).

(iii) The provider that meets the requirements in paragraphs (g)(3)(i) and (g)(3)(ii) of this section will be eligible to receive payment under this paragraph for: (A) the clinical training costs incurred for the program(s) as described in paragraph (g)(3)(i) of this section; and (B) classroom costs, but only those costs incurred by the provider for the courses that were included in the programs.

(h) *Cost of educational activities treated as normal operating costs.* The costs of the following educational activities incurred by a provider but not operated by that provider are recognized only as normal operating costs and paid in accordance with the reimbursement principles specified in Part 412 of this subchapter. They include:

(1) Orientation and on-the-job training.

(2) Part-time education for bona fide full-time employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work.

(3) Educational seminars, workshops, and continuing education programs in which the employees or trainees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.

(4) Maintenance of a medical library.

(5) Training of a patient or patient's family in the use of medical appliances or other treatments.

(6) Except as provided in paragraph (g) of this section, clinical training and classroom instruction of students enrolled in an educational program that is not operated by the provider. The following are clinical training and classroom instruction costs that are allowable as normal operating costs:

(i) Costs incurred in the clinical training of students, including the clinical training or clerkship of undergraduate medical school students that takes place in a provider.

(ii) Classroom instruction costs incurred by a provider that meet the following criteria:

(A) The provider's support does not constitute a redistribution of nonprovider costs to the provider. The support must be in addition to the costs already being incurred by the nonprovider-operated program. If the nonprovider entity reduces its costs due to receiving provider support, this reduction constitutes a redistribution of costs from an educational institution to a patient care institution and is a nonallowable provider cost.

(B) The provider receives a benefit for the support it furnishes.

(C) The cost of the provider's support is less than the cost the provider would incur were it to operate the program.

(7) Other activities that do not involve the actual operation of an approved educational program.

[66 FR 3374, Jan. 12, 2001, as amended at 66 FR 14342, Mar. 12, 2001; 68 FR 45471, Aug. 1, 2003; 69 FR 49254, Aug. 11, 2004; 71 FR 48142, Aug. 18, 2006; 75 FR 50418, Aug. 16, 2010]

§ 413.87 Payments for Medicare + Choice nursing and allied health education programs.

(a) *Statutory basis.* This section implements section 1886(l) of the Act, which provides for additional payments to hospitals that operate and receive Medicare reasonable cost reimbursement for approved nursing and allied health education programs and the methodology for determining the additional payments.

(b) *Scope.* This section sets forth the rules for determining an additional payment amount to hospitals that receive payments for the costs of operating approved nursing or allied health education programs under § 413.85.

(c) *Qualifying conditions for payment.*

(1) For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, a hospital that operates and receives payment for a nursing or allied health education program under § 413.85 may receive an additional payment amount associated with Medicare + Choice utilization. The hospital may receive the additional payment amount, which is calculated in accordance with the provisions of paragraph (d) of this section, if both of the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section are met.

(i) The hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. (For example, if the current year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998.) For a hospital that first establishes a nursing or allied health education program after FY 1998 and receives reasonable cost payment for the program as specified under § 413.85 after FY 1998, the hospital is eligible to receive an additional payment amount in a calendar year that is 2 years after the respective fiscal year so long as the hospital also meets the condition under paragraph (c)(1)(ii) of this section.

(ii) The hospital must be receiving reasonable cost payment for an approved nursing or allied health edu-

cation program under § 413.85 in the current calendar year.

(2) For portions of cost reporting periods occurring on or after January 1, 2001, in addition to meeting the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, the hospital must have had a Medicare + Choice utilization greater than zero in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

(d) *Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001.* For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, subject to the provisions of § 413.76(d)(4) relating to calculating a proportional reduction in Medicare + Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:

(1) *Step one.* Each calendar year, determine the hospital's total nursing and allied health education program payments from its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

(2) *Step two.* Determine the ratio of the hospital's payments from step one to the total of all nursing and allied health education program payments across all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.

(3) *Step three.* Multiply the ratio calculated in step two by the Medicare + Choice nursing and allied health payment "pool" determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

(e) *Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2001.* For portions of cost reporting periods occurring on or after January 1, 2001, subject to the provisions of § 413.76(d) relating to calculating a proportional reduction in Medicare + Choice direct GME payments, the additional payment amount specified in paragraph (c)

of this section is calculated according to the following steps:

(1) *Step one.* Each calendar year, determine for each eligible hospital the total—

(i) Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year; and

(ii) Inpatient days for that same cost reporting period.

(iii) Medicare + Choice inpatient days for that same cost reporting period.

(2) *Step two.* Using the data from step one, determine the ratio of the individual hospital's total nursing or allied health payments, to its total inpatient days. Multiply this ratio by the hospital's total Medicare + Choice inpatient days.

(3) *Step three.* CMS will determine, using the best available data, for all eligible hospitals the total of all—

(i) Nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year;

(ii) Inpatient days from those same cost reporting periods; and

(iii) Medicare + Choice inpatient days for those same cost reporting periods.

(4) *Step four.* Using the data from step three, CMS will determine the ratio of the total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year, to the total of all inpatient days from those same cost reporting periods. CMS will multiply this ratio by the total of all Medicare + Choice inpatient days for those same cost reporting periods.

(5) *Step 5.* Calculate the ratio of the product determined in step two to the product determined in step four.

(6) *Step 6.* Multiply the ratio calculated in step five by the amount determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

(f) *Calculation of the payment "pool."*

(1) Subject to paragraph (f)(3) of this section, each calendar year, CMS will calculate a Medicare + Choice nursing and allied health payment "pool" according to the following steps:

(i) Determine the ratio of projected total Medicare + Choice direct GME payments made in accordance with the provisions of § 413.76(c) across all hospitals in the current calendar year to projected total direct GME payments made across all hospitals in the current calendar year.

(ii) Multiply the ratio calculated in paragraph (f)(1)(i) of this section by projected total Medicare nursing and allied health education reasonable cost payments made to all hospitals in the current calendar year.

(2) The resulting product of the steps under paragraphs (f)(1)(i) and (f)(1)(ii) of this section is the Medicare + Choice nursing and allied health payment "pool" for the current calendar year.

(3) The payment pool may not exceed \$60 million in any calendar year.

[65 FR 47051, Aug. 1, 2000, as amended at 66 FR 32195, June 13, 2001; 69 FR 49265, Aug. 11, 2004; 70 FR 47489, Aug. 12, 2005]

§ 413.88 Incentive payments under plans for voluntary reduction in number of medical residents.

(a) *Statutory basis.* This section implements section 1886(h)(6) of the Act, which establishes a program under which incentive payments may be made to qualifying entities that develop and implement approved plans to voluntarily reduce the number of residents in medical residency training.

(b) *Qualifying entity defined.* "Qualifying entity" means:

(1) An individual hospital that is operating one or more approved medical residency training programs as defined in § 413.75(b) of this chapter; or

(2) Two or more hospitals that are operating approved medical residency training programs as defined in § 413.75(b) of this chapter and that submit a residency reduction application as a single entity.

(c) *Conditions for payments.* (1) A qualifying entity must submit an application for a voluntary residency reduction plan that meets the requirements and conditions of this section in

order to receive incentive payments for reducing the number of residents in its medical residency training programs.

(2) The incentive payments will be determined as specified under paragraph (g) of this section.

(d) *Requirements for voluntary plans.* In order for a qualifying entity to receive incentive payments under a voluntary residency reduction plan, the qualifying entity must submit an application that contains the following information, documents, and agreements—

(1) A description of the operation of a plan for reducing the full-time equivalent (FTE) residents in its approved medical residency training programs, consistent with the percentage reduction requirements specified in paragraphs (g)(2) and (g)(3) of this section;

(2) An election of the period of residency training years during which the reductions will occur. The reductions must be fully implemented by not later than the fifth residency training year in which the plan is effective;

(3) FTE counts for the base number of residents, as defined in paragraph (g)(1) of this section, with a breakdown of the number of primary care residents compared to the total number of residents; and the direct and indirect FTE counts of the entity on June 30, 1997. For joint applicants, these counts must be provided individually and collectively;

(4) Data on the annual and cumulative targets for reducing the number of FTE residents and the ratios of the number of primary care residents to the total number of residents for the base year and for each year in the 5-year reduction period. For joint applicants, these data must be provided individually and collectively;

(5) An agreement to not reduce the proportion of its primary care residents to its total number of residents below the proportion that exists in the base year, as specified in paragraph (g)(1) of this section;

(6) An agreement to comply with data submission requirements deemed necessary by CMS to make annual incentive payments during the 5-year residency reduction plan, and to fully cooperate with additional audit and

monitoring activities deemed necessary by CMS;

(7) For a qualifying entity that is a member of an affiliated group as defined in § 413.75(b), a statement that all members of the group agree to an aggregate FTE cap that reflects—

(i) The reduction in the qualifying entity's FTE count as specified in the plan during each year of the plan; and

(ii) The 1996 FTE count of the other hospital(s) in the affiliated group.

(8) A statement indicating voluntary participation in the plan under the terms of this section, signed by each hospital that is part of the applying entity.

(e) *Deadline for applications.* A qualifying entity must submit an application that meets the requirements of paragraph (d) of this section at least one day prior to the first day of the period to which the plan would be effective but no later than November 1, 1999. The application must be submitted to the contractor, with a copy to CMS.

(f) *Effective dates of plans.* Residency reduction plans that are submitted to the contractor on or after September 17, 1999 but on or before November 1, 1999, may be effective for portions of cost reporting periods beginning no earlier than the day after the date of the application.

(g) *Residency reduction requirements—*

(1) *Base number of residents defined.* (i) “Base number of residents” means the lesser of—

(A) The number of FTE residents in all approved medical residency training programs of the qualifying entity (before application of weighting factors under § 413.79) for the most recent residency training year ending June 30, 1996; or

(B) The number of FTE residents in all approved medical residency training programs of the qualifying entity (before application of weighting factors under § 413.79) for any subsequent residency training year that ends before the date the entity submits its plan to the contractor and CMS.

(ii) The residency training year used to determine the base number of residents is the “base year” for determining reduction requirements.

(iii) The qualifying entity's base number of residents may not be adjusted to reflect adjustments that may otherwise be made to the entity's FTE caps for new medical residency training programs.

(2) *Qualifying entity consisting of individual hospital.* The base number of FTE residents in all the approved medical residency training programs operated by or through a qualifying entity consisting of an individual hospital must be reduced as follows:

(i) If the base number of residents exceeds 750, residents, by at least 20 percent of the base number.

(ii) If the base number of residents exceeds 600 but is less than or equal to 750 residents—

(A) By 150 residents; or

(B) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number by at least 20 percent.

(iii) If the base number of residents is 600 or less residents—

(A) By 25 percent; or

(B) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number of residents by at least 20 percent.

(3) *Qualifying entity consisting of two or more hospitals.* The base number of FTE residents in the aggregate for all the approved medical residency training programs operated by or through a qualifying entity consisting of two or more hospitals must be reduced—

(i) By 25 percent; or

(ii) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number of residents by at least 20 percent.

(4) *Treatment of rotating residents.* A qualifying entity will not be eligible for incentive payments for a reduction in the base number of residents if the reduction is a result of the entity rotating residents to another hospital that is not a part of its voluntary residency reduction plan.

(5) *Updates to annual and cumulative targets* (i) Except as provided in paragraph (g)(5)(ii) of this section an entity with an approved voluntary residency reduction plan may not change the annual and cumulative reduction targets

that are specified in its plan in accordance with paragraphs (g)(2) and (g)(3) of this section.

(ii) An entity may update annual reduction targets specified in its plan only if—

(A) It has failed to meet a specified annual target for a plan year in the 5-year period; and

(B) It wishes to adjust future annual targets for the remaining years of the plan in order to comply with its cumulative target.

(iii) An updated plan allowed under paragraph (g)(5)(ii) of this section must be submitted prior to the beginning of each July 1 medical residency training year during the plan years.

(h) *Computation of incentive payment amount.* (1) Incentive payments to qualifying entities that meets the requirements and conditions of paragraphs (d) and (g) of this section will be computed as follows:

(i) *Step 1.* Determine the amount (if any) by which the payment amount that would have been made under § 413.76 if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the amount of payment that would have been made under § 413.76 in each year under the voluntary residency reduction plan, taking into account the reduction in the number of FTE residents under the plan.

(ii) *Step 2.* Determine the amount (if any) by which the payment amount that would have been made under § 412.105 of this chapter if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the payment amount made under § 412.105 of this chapter in each year under the voluntary residency reduction plan, taking into account the actual reduction in the number of FTE residents.

(iii) *Step 3.* Determine the amount (if any) by which the payment amount that would have been made under § 412.322 of this chapter if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs

of the hospital as of June 30, 1997, exceeds the payment amount made under § 412.322 of this chapter in each year under the voluntary residency reduction plan, taking into account the actual reduction in the number of FTE residents.

(iv) *Step 4.* Multiply the sum of the amounts determined under paragraph (h)(i), (ii), and (iii) of this section by the applicable hold harmless percentages specified in paragraph (i) of this section.

(2) The determination of the amounts under paragraph (h)(1) of this section for any year is based on the applicable Medicare statutory provisions in effect on the application deadline date for the voluntary reduction plan specified under paragraph (e) of this section.

(i) *Applicable hold-harmless percentage.* The applicable hold-harmless percentages for each year in which the residency reduction plan is in effect are as follows:

- (1) 100 percent for the first and second residency training years;
- (2) 75 percent for the third year;
- (3) 50 percent for the fourth year; and
- (4) 25 percent for the fifth year.

(j) *Payments to qualifying entities.* Annual incentive payments through cost reports will be made to each hospital that is or is part of a qualifying entity over the 5-year reduction period if the qualifying entity meets the annual and cumulative reduction targets specified in its voluntary reduction plan.

(k) *Penalty for noncompliance—(1) Nonpayment.* No incentive payment may be made to a qualifying entity for a residency training year if the qualifying entity has failed to reduce the number of FTE residents according to its voluntary residency reduction plan.

(2) *Repayment of incentive amounts.* The qualifying entity is liable for repayment of the total amount of incentive payments it has received if the qualifying entity—

(i) Fails to reduce the base number of residents by the percentages specified in paragraphs (g)(2) and (g)(3) of this section by the end of the fifth residency training year; or

(ii) Increases the number of FTE residents above the number of residents permitted under the voluntary resi-

dency reduction plan as of the completion date of the plan.

(1) *Postplan determination of FTE caps for qualifying entities—(1) No penalty imposed.* Upon completion of a voluntary residency reduction plan, if no penalty is imposed, the qualifying entity's 1996 FTE count is permanently adjusted to equal the unweighted FTE count used for direct GME payments for the last residency training year in which a qualifying entity participates.

(2) *Penalty imposed.* Upon completion of the voluntary residency reduction plan—

(i) *During repayment period.* If a penalty is imposed under paragraph (k)(2) of this section, during the period of repayment, the qualifying entity's FTE count is as specified in paragraph (1)(1) of this section.

(ii) *After repayment period.* Once the penalty repayment is completed, the qualifying entity's FTE reverts back to its original 1996 FTE cap.

[64 FR 44855, Aug. 18, 1999, as amended at 69 FR 49265, Aug. 11, 2004]

§ 413.89 Bad debts, charity, and courtesy allowances.

(a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost. However, subject to the limitations described under paragraph (h) of this section and the exception for services described under paragraph (i) of this section, bad debts attributable to the deductibles and co-insurance amounts are reimbursable under the program.

(b) *Definitions—(1) Bad debts.* (i) For cost reporting periods beginning before October 1, 2020:

(A) “Bad debts” are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services.

(B) “Accounts receivable” and “notes receivable” are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

(ii) For cost reporting periods beginning on or after October 1, 2020, “bad debts” are amounts considered to be uncollectible from patient accounts that were created or acquired in providing services and are categorized as

implicit price concessions for cost reporting purposes and are recorded in the provider's accounting records as a component of net patient revenue.

(2) *Charity allowances.* Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

(3) *Courtesy allowances.* Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) *Normal accounting treatment: Reduction in revenue.* (1) For cost reporting periods beginning before October 1, 2020:

(i) Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services as these costs have already been incurred in the production of the services.

(ii) Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts.

(2) For cost reporting periods beginning on or after October 1, 2020:

(i) Bad debts, also known as "implicit price concessions," charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services as these costs have already been incurred in the production of the services.

(ii) Medicare bad debts must not be written off to a contractual allowance account but must be recorded as an implicit price concession that results in a reduction in revenue.

(d) *Requirements for Medicare.* Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of

services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs.

(e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

(2) The provider must be able to establish that reasonable collection efforts were made.

(i) *Non-indigent beneficiary.* A non-indigent beneficiary is a beneficiary who has not been determined to be categorically or medically needy by a State Medicaid Agency to receive medical assistance from Medicaid, nor have they been determined to be indigent by the provider for Medicare bad debt purposes. To be considered a reasonable collection effort for non-indigent beneficiaries, all of the following are applicable:

(A) A provider's collection effort or the effort of a collection agency acting on the provider's behalf, or both, to collect Medicare deductible or coinsurance amounts must consist of all of the following:

(1) Be similar to the collection effort put forth to collect comparable amounts from non-Medicare patients.

(2) For cost reporting periods beginning before October 1, 2020, involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or shortly after discharge or death of the beneficiary.

(3) For cost reporting periods beginning on or after October 1, 2020, involve the issuance of a bill to the beneficiary

or the party responsible for the beneficiary's personal financial obligations on or before 120 days after the latter of one of the following:

(i) The date of the Medicare remittance advice that results from processing the claim for services furnished to the beneficiary and generates the beneficiary's cost sharing amounts.

(ii) The date of the remittance advice from the beneficiary's secondary payer, if any.

(iii) The date of the notification that the beneficiary's secondary payer does not cover the service furnished to the beneficiary.

(4) Include other actions such as subsequent billings, collection letters, and telephone calls, emails, text messages, or personal contacts with this party.

(5)(i) Last at least 120 days after paragraph (e)(2)(i)(A)(2) or (3) of this section is met before being written off as uncollectible under paragraph (e)(3) of this section.

(ii) Start a new 120-day collection period each time a payment is received within a 120-day collection period.

(6) Maintaining and, upon request, furnishing verifiable documentation to its contractor that includes all of the following:

(i) The provider's bad debt collection policy which describes the collection process for Medicare and non-Medicare patients.

(ii) The patient account history documents which show the dates of various collection actions such as the issuance of bills to the beneficiary, follow-up collection letters, reports of telephone calls and personal contact, etc.

(iii) The beneficiary's file with copies of the bill(s) and follow-up notices.

(B) A provider that uses a collection agency to perform its collection effort must do all of the following:

(1) Reduce the beneficiary's account receivable by the gross amount collected.

(2) Include any fee charged by the collection agency as an administrative cost.

(3) Before claiming the unpaid amounts as a Medicare bad debt, cease all collection efforts, including the collection agency efforts, and ensure that the collection accounts have been re-

turned to the provider from the agency.

(ii) *Indigent non-dual eligible beneficiary.* An indigent non-dual eligible beneficiary is a beneficiary who is determined to be indigent or medically indigent by the provider and is not eligible for Medicaid as categorically or medically needy.

(A) To determine a beneficiary to be an indigent non-dual eligible beneficiary, the provider—

(1) Must not use a beneficiary's declaration of their inability to pay their medical bills or deductibles and coinsurance amounts as sole proof of indigence or medical indigence;

(2) Must take into account the analysis of both the beneficiary's assets (only those convertible to cash and unnecessary for the beneficiary's daily living) and income;

(3) May consider extenuating circumstances that would affect the determination of the beneficiary's indigence or medical indigence which may include an analysis of both the beneficiary's liabilities and expenses, if indigence is unable to be determined under paragraph (e)(ii)(A)(2) of this section;

(4) Must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill, such as a legal guardian or State Medicaid program; and

(5) Must maintain and, upon request, furnish its contractor its indigence policy describing the method by which indigence or medical indigence is determined and all the verifiable beneficiary specific documentation which supports the provider's determination of each beneficiary's indigence or medical indigence.

(B) Once indigence is determined the bad debt may be deemed uncollectible without applying a collection effort under paragraph (e)(2)(i)(A) or (B) of this section.

(iii) *Indigent dual-eligible beneficiaries (including qualified Medicare beneficiaries).* Providers may deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid

under a State's Title XIX Medicaid program as either categorically needy individuals or medically needy individuals. To be considered a reasonable collection effort for dual-eligible beneficiaries:

(A) When a State permits a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, to determine the State's liability for the beneficiary's Medicare cost sharing, the provider—

(1) Must determine whether the State's Title XIX Medicaid Program (or a local welfare agency, if applicable) is responsible to pay all or a portion of the beneficiary's Medicare deductible or coinsurance amounts;

(2) Must submit a bill to its Medicaid/ Title XIX agency (or to its local welfare agency) to determine the State's cost sharing obligation to pay all or a portion of the applicable Medicare deductible and coinsurance;

(3) Must submit the Medicaid remittance advice received from the State to its Medicare contractor;

(4) Must reduce allowable Medicare bad debt by any amount that the State is obligated to pay, either by statute or under the terms of its approved Medicaid State plan, regardless of whether the State actually pays its obligated amount to the provider; and

(5) May include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

(B) When, through no fault of the provider, a provider does not receive a Medicaid remittance advice because the State does not permit a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, or because the State does not generate a Medicaid remittance advice, the provider—

(1) Must submit to its contractor, all of the following auditable and verifiable documentation:

(i) The State's Medicaid notification stating that the State has no legal obligation to pay the provider for the beneficiary's Medicare cost sharing.

(ii) A calculation of the amount the State owes the provider for Medicare cost sharing.

(iii) Verification of the beneficiary's eligibility for Medicaid for the date of service;

(2) Must reduce allowable Medicare bad debt by any amount the State is obligated to pay, regardless of whether the State actually pays its obligated amount to the provider; and

(3) May include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) *Reporting period for writing off bad debts and reporting of recoveries of bad debts reimbursed in prior periods.* For cost reporting periods beginning before, on, or after October 1, 2020, the deductible and coinsurance amounts uncollected from beneficiaries are to be written off and recognized as allowable bad debts in the cost reporting period in which the accounts are deemed to be worthless.

(1) Any payment on the account made by the beneficiary or a responsible party, after the write-off date but before the end of the cost reporting period, must be used to reduce the final bad debt for the account claimed in that cost report.

(2) In some cases an amount written off as a bad debt and reimbursed by the program in a prior cost reporting period may be recovered in a subsequent period.

(i) In situations described in this paragraph (f)(2), the recovered amount must be used to reduce the provider's reimbursable costs in the period in which the amount is recovered.

(ii) The amount of reduction in the period of recovery (as specified in paragraph (f)(2)(i) of this section) must not exceed the actual amount reimbursed by the program for the related bad debt in the applicable prior cost reporting period.

(g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs. These charity

allowances include the costs of uncompensated services furnished under a Hill-Burton obligation. (Note: In accordance with section 106(b) of Pub. L. 97–248 (enacted September 3, 1982), this sentence is effective with respect to any costs incurred under Medicare except that it does not apply to costs which have been allowed prior to September 3, 1982, pursuant to a final court order affirmed by a United States Court of Appeals.) The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

(h) *Limitations on bad debts*—(1) *Hospitals*. In determining reasonable costs for hospitals, the amount of allowable bad debt (as defined in paragraph (e) of this section) is reduced:

- (i) For cost reporting periods beginning during fiscal year 1998, by 25 percent;
- (ii) For cost reporting periods beginning during fiscal year 1999, by 40 percent;
- (iii) For cost reporting periods beginning during fiscal year 2000, by 45 percent; and
- (iv) For cost reporting periods beginning during fiscal years 2001 through 2012, by 30 percent.
- (v) For cost reporting periods beginning during a subsequent fiscal year, by 35 percent.

(2) *Skilled nursing facilities and swing bed hospitals*. For the purposes of this paragraph (h)(2), a dual eligible individual is defined as an individual that is entitled to benefits under Part A of Medicare and is determined eligible by the State for medical assistance under Title XIX of the Act as described under paragraph (2) of the definition of a “full-benefit dual eligible individual” at § 423.772 of this chapter. In determining reasonable costs for a skilled nursing facility and for post-hospital SNF care furnished in a swing bed hospital, as defined in § 413.114(b), the amount of allowable bad debt (as defined in paragraph (e) of this section) is reduced:

- (i) *For non-dual eligible individuals*—(A) For cost reporting periods beginning during fiscal years 2006 through 2012, by 30 percent, for a patient in a skilled nursing facility.

(B) For cost reporting periods beginning during a subsequent fiscal year, by 35 percent, for a patient in a skilled nursing facility or receiving post-hospital SNF care in a swing bed hospital.

(ii) *For dual eligible individuals*—(A) For cost reporting periods beginning during fiscal year 2013, by 12 percent, for a patient in a skilled nursing facility or a patient receiving post-hospital SNF care in a swing bed hospital.

(B) For cost reporting periods beginning during fiscal year 2014, by 24 percent, for a patient in a skilled nursing facility or a patient receiving post-hospital SNF care in a swing bed hospital.

(C) For cost reporting periods beginning during a subsequent fiscal year, by 35 percent, for a patient in a skilled nursing facility or a patient receiving post-hospital SNF care in a swing bed hospital.

(3) *End-stage renal dialysis facilities*. In determining reasonable costs for an end-stage renal dialysis facility, the amount of allowable bad debt (as defined in paragraph (e) of this section) is:

- (i) For cost reporting periods beginning before October 1, 2012, reimbursed up to the facility’s costs.
- (ii) For cost reporting periods beginning on or after October 1, 2012 and before January 1, 2013, reduced by 12 percent with the resulting amount reimbursed up to the facility’s costs.
- (iii) For cost reporting periods beginning on or after January 1, 2013 and before October 1, 2013, reduced by 12 percent.

(iv) For cost reporting periods beginning during fiscal year 2014, reduced by 24 percent.

(v) For cost reporting periods beginning during a subsequent fiscal year, reduced by 35 percent.

(4) *All other providers*. In determining reasonable costs for all other providers, suppliers and other entities not described elsewhere in paragraph (h) of this section that are eligible to receive reimbursement for bad debts under this section, the amount of allowable bad debts (as defined in paragraph (e) of this section) is reduced:

- (i) For cost reporting periods beginning during fiscal year 2013, by 12 percent.

(ii) For cost reporting periods beginning during fiscal year 2014, by 24 percent.

(iii) For cost reporting periods beginning during a subsequent fiscal year, by 35 percent.

(i) *Exceptions applicable to bad debt reimbursement.* (1) Bad debts arising from covered services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.

(2) For end-stage renal dialysis services furnished on or after January 1, 2011 and paid for under the end-stage renal dialysis prospective payment system described in § 413.215, bad debts arising from covered items or services that, prior to January 1, 2011 were paid under a reasonable charge-based methodology or a fee schedule, including but not limited to drugs, laboratory tests, and supplies are not reimbursable under the program.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 33898, July 31, 1992; 60 FR 63189, Dec. 8, 1995; 63 FR 41005, July 31, 1998; 66 FR 32195, June 13, 2001. Redesignated at 69 FR 49254, Aug. 11, 2004, and amended at 71 FR 48142, Aug. 18, 2006; 71 FR 69785, Dec. 1, 2006; 75 FR 49198, Aug. 12, 2010; 77 FR 67350, Nov. 9, 2012; 85 FR 59023, Sept. 18, 2020]

§ 413.90 Research costs.

(a) *Principle.* Costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

(b) *Application.* (1) There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many Federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies, and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs. A further consideration is that quality review should be assured as a condition of governmental support for research. Provisions for such review would introduce special difficulties in the Medicare programs.

(2) If research is conducted in conjunction with, and as a part of, the

care of patients, the costs of usual patient care and studies, analyses, surveys, and related activities to serve the provider's administrative and program needs are allowable costs in the determination of payment under Medicare.

[51 FR 34793, Sept. 30, 1986, as amended at 61 FR 63748, Dec. 2, 1996]

§ 413.92 Costs of surety bonds.

Costs incurred by a provider to obtain a surety bond required by part 489, subpart F of this chapter are not included as allowable costs.

[63 FR 310, Jan. 5, 1998]

§ 413.94 Value of services of nonpaid workers.

(a) *Principle.* The value of services in positions customarily held by full-time employees performed on a regular, scheduled basis by individuals as nonpaid members of organizations under arrangements between such organizations and a provider for the performance of such services without direct remuneration from the provider to such individuals is allowable as an operating expense for the determination of allowable cost subject to the limitation contained in paragraph (b) of this section. The amounts allowed are not to exceed those paid others for similar work. Such amounts must be identifiable in the records of the institutions as a legal obligation for operating expenses.

(b) *Limitations: Services of nonpaid workers.* The services must be performed on a regular, scheduled basis in positions customarily held by full-time employees and necessary to enable the provider to carry out the functions of normal patient care and operation of the institution. The value of services of a type for which providers generally do not remunerate individuals performing such services is not allowable as a reimbursable cost under the Medicare program. For example, donated services of individuals in distributing books and magazines to patients, or in serving in a provider canteen or cafeteria or in a provider gift shop, would not be reimbursable.

(c) *Application.* The following illustrates how a provider would determine an amount to be allowed under this

principle: The prevailing salary for a lay nurse working in Hospital A is \$5,000 for the year. The lay nurse receives no maintenance or special perquisites. A sister working as a nurse engaged in the same activities in the same hospital receives maintenance and special perquisites which cost the hospital \$2,000 and are included in the hospital's allowable operating costs. The hospital would then include in its records an additional \$3,000 to bring the value of the services rendered to \$5,000. The amount of \$3,000 would be allowable if the provider assumes obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by the provider for the services.

§ 413.98 Purchase discounts and allowances, and refunds of expenses.

(a) *Principle.* Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

(b) *Definitions*—(1) *Discounts.* Discounts, in general, are reductions granted for the settlement of debts.

(2) *Allowances.* Allowances are deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.

(3) *Refunds.* Refunds are amounts paid back or a credit allowed on account of an overcollection.

(c) *Normal accounting treatment—Reduction of costs.* All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. If they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, if they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

(d) *Application.* (1) Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before

consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

(2) As with discounts, allowances, and rebates received from purchases of goods or services, refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party payment organizations paying on the basis of cost.

§ 413.99 Qualified and Non-Qualified Deferred Compensation Plans.

(a) *Statutory basis, scope, and definitions*—(1) *Basis.* All payments to providers of services must be based on the reasonable cost of services covered under Title XVIII in accordance with section 1861(v) of the Act and the regulations in this part.

(2) *Scope.* This section and § 413.100(c)(2)(vii) apply to Medicare's treatment of the costs incurred for Qualified and Non-Qualified Deferred Compensation Plans.

(3) *Definitions.* As used in this section the following definitions apply:

Deferred Compensation means remuneration currently earned by an employee that is not received until a subsequent period, usually after retirement.

Employee Retirement Income Security Act of 1974 (ERISA) is a Federal law that sets standards of protection for individuals in most voluntarily established, private-sector retirement plans.

The law is set forth in Title 29, Chapter 18 of the U.S. Code.

Funded Plan means a plan in which assets have been irrevocably and unconditionally set aside with a third party for the payment of plan benefits (for example, in a trust or escrow account), and those assets are beyond the reach of the employer or its general creditors.

Non-Qualified Deferred Compensation Plan (NQDC) means an elective or non-elective plan, agreement, method, or arrangement between an employer and an employee to pay the employee compensation in the future. In comparison with qualified plans, nonqualified plans do not provide employers and employees with the tax benefits associated with qualified plans because NQDC plans do not satisfy all the requirements of 26 U.S.C. 401(a).

Non-Qualified Defined Benefit Plan (NQDB) means a type of NQDC that is established and maintained by the employer primarily to provide definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Such benefits are generally measured by, and based on, such factors as age of employees, years of service, and compensation received by the employees.

Pension Benefit Guaranty Corporation (PBGC) is a Federal agency created by ERISA to protect benefits in private-sector QDBP plans described in section 3(35) of ERISA.

Qualified Defined Benefit Plan (QDBP) means a type of Qualified Deferred Compensation Plan that is established and maintained by the employer primarily to provide definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Such benefits are generally measured by, and based on, such factors as age of employees, years of service, and compensation received by the employees. A QDBP meets the applicable requirements of ERISA, as amended, and the requirements for a QDBP under 26 U.S.C. 401(a). Under a qualified plan, employers are entitled to deduct expenses in the year the employer makes contributions even though employees will not recognize income until the receipt of distributions.

Qualified Defined Contribution or Individual Account Plan (QDCP) means a type of Deferred Compensation Plan in which the employee, the employer, or both, contribute to an employee's individual account under the plan. The amount in the account at distribution includes the contributions and investment gains or losses, minus any investment and administrative fees. The value of the account changes based on contributions and the value and performance of the investments. A QDCP meets the applicable requirements of ERISA, as amended, and the requirements set forth in 26 U.S.C. 401(a), and, if applicable 26 U.S.C. 401(k).

Unfunded Plan means a plan in which benefits are supported by assets that have not been set aside (that is, a "pay as you go" plan), or by assets that have been set aside, but remain subject to the claims of the employer's general creditors.

(b) *Principle requirements*—(1) *General*. Deferred Compensation contributions or payments must be made by a provider of services, or an employee of the provider of services, to a Qualified or Non-Qualified Deferred Compensation Plan, established and maintained by the provider of services to provide retirement income to employees or to result in the deferral of income by employees for periods extending to the termination of covered employment or beyond. Contributions or payments made by a provider of services for the benefit of its employees to a Qualified or Non-Qualified Deferred Compensation Plan are allowable, when, and to the extent that, such costs are actually incurred by the provider of services and found to be reasonable and necessary under the principles of reasonable cost.

(2) *Deferred Compensation for provider-based physicians services in a hospital or SNF*. Costs incurred by a hospital or SNF to fund a Qualified or Non-Qualified Deferred Compensation Plan for a provider-based physician must meet the following requirements to be allowable under the program:

(i) The allocation of physician compensation costs required under §415.60 of this chapter does not attribute the provider-based physician's Deferred Compensation entirely to one category

of service and his current compensation to another.

(ii) Contributions or payments toward the Qualified or Non-Qualified Deferred Compensation Plan do not include any cost excluded from the definition of physician compensation at § 415.60(a) of this chapter.

(iii) The amount of Deferred Compensation does not exceed the amount specified in the agreement required by § 415.60(g) of this chapter.

(iv) An arrangement between a physician and a provider of services under which the physician is reimbursed for patient charges, but the provider of services does the billing as a Deferred Compensation agreement, is not allowed.

(v) The costs incurred for physician guaranteed arrangements for hospital emergency room availability services, must meet the following additional requirements:

(A) The terms of both the guarantee arrangements and the Deferred Compensation Plan establish the amounts to be included at the beginning of the hospital's cost reporting period.

(B) The amount of Deferred Compensation is included in the guaranteed amount.

(C) The hospital contributes to the Deferred Compensation Plan from its own funds.

(D) The amount of Deferred Compensation that is allowable is limited to the amount by which the guarantee, including Deferred Compensation, exceeds the total billed by the hospital to all patients for the physician's patient care services.

(E) When the physician's charges to all patients equal or exceed the amount guaranteed by the hospital, the program does not recognize a Deferred Compensation contribution/payment.

(c) *Requirements for Non-Qualified and Qualified Deferred Compensation Plans—*
(1) *NQDC requirements.* In order for contributions or payments by a provider of services to an NQDC as defined at paragraph (a)(3) of this section to be allowable under the program, the NQDC must meet the general requirements at paragraph (c)(1)(i) of this section, and it must either meet the requirements for a funded NQDC at paragraph (c)(1)(ii) of this section or the require-

ments for an unfunded NQDC at paragraph (c)(1)(iii) of this section, as applicable.

(i) *General requirements.* An NQDC must satisfy the requirements for document compliance and operational compliance set forth in 26 U.S.C. 409A.

(ii) *Funded NQDCs.* A funded NQDC must meet the definition of a Funded Plan in paragraph (a)(3) of this section and comply with the requirements in paragraph (c)(5) of this section.

(iii) *Unfunded NQDCs.* An NQDC that is unfunded must meet the definition of an Unfunded Plan in paragraph (a)(3) of this section, and there must be no constructive receipt of income for employees from a NQDC as a result of contributions made by a provider of services.

(2) *QDCP requirements.* A QDCP must meet the applicable requirements of ERISA, as amended, and the requirements set forth in 26 U.S.C. 401(a), and if applicable 26 U.S.C. 401(k). A QDCP must meet the definition of a Funded Plan in paragraph (a)(3) of this section and comply with the requirements in paragraph (c)(5) of this section.

(3) *QDBP requirements.* A QDBP must meet the applicable requirements of ERISA, as amended, and the requirements for a defined benefit plan under 26 U.S.C. 401(a). A QDBP must meet the definition of a Funded Plan in paragraph (a)(3) of this section and comply with the requirements in paragraph (c)(5) of this section.

(4) *NQDB requirements.* In order for contributions or payments by a provider of services to an NQDB as defined at paragraph (a)(3) of this section to be allowable under the program, the NQDB must meet the general requirements at paragraph (c)(4)(i) of this section, and it must either meet the requirements for a funded NQDB at paragraph (c)(4)(ii) of this section or the requirements for an unfunded NQDB at paragraph (c)(4)(iii) of this section, as applicable.

(i) *General requirements.* An NQDB must satisfy the requirements for document compliance set forth in 26 U.S.C. 409A and operational compliance set forth in 26 U.S.C. 409A(a).

(ii) *Funded NQDBs.* An NQDB that is funded must meet the definition of a Funded Plan in paragraph (a)(3) of this

section and comply with the requirements in paragraph (c)(5) of this section.

(iii) *Unfunded NQDBs*. An NQDB that is unfunded must meet the definition of an Unfunded Plan in paragraph (a)(3) of this section, and there must be no constructive receipt of income for employees from a NQDB as a result of contributions made by a provider of services.

(5) *Funded Plan requirements*—(i) *Acceptable funding mechanism*. Both provider of services contributions and employee contributions must be used either to purchase an insured plan with a commercial insurance company, to establish a custodial bank account, or to establish a trust fund administered by a trustee.

(ii) *Life insurance contracts*. The purchase of an ordinary life insurance contract (for example, whole life, straight life, or other) is not a deferral of compensation and is not recognized as a funding mechanism, even where it is convertible at the normal retirement date specified in the policy to an annuity payable over the remaining life of the employee.

(iii) *Sole benefit of participating employees*. Regardless of the funding mechanism utilized, all provider of services and employee contributions to the fund established under the Deferred Compensation Plan and income therefrom must be used for the sole benefit of the participating employees.

(d) *Recognition of contributions or payments to Qualified and Non-Qualified Deferred Compensation Plans*—(1) *General rule*. Except as provided for in paragraph (c)(1)(iii) of this section with respect to QDBPs and funded NQDBs, contributions to Qualified Deferred Compensation Plans or payments to plan participants from Non-Qualified Deferred Compensation Plans are recognized as allowable costs in accordance with paragraph (c)(1)(i) of this section (in the case of Unfunded Plans) and paragraph (c)(1)(ii) of this section (in the case of Funded Plans).

(i) *Unfunded Plans*. Contributions or payments made to an unfunded Deferred Compensation Plans (including unfunded NQDBs) by a provider of services on behalf of its employees are included in allowable costs only during

the cost reporting period in which an actual payment is made to the participating employees (or their beneficiaries) and only to the extent considered reasonable, in accordance with § 413.100(c)(2)(vii)(A).

(ii) *Funded Plans*. Reasonable provider of services payments made under funded Deferred Compensation Plans (specifically, funded Defined Contribution Plans, but excluding QDBPs and funded NQDBs) are included in allowable costs in accordance with § 413.100(c)(2)(vii)(B).

(iii) *Exception for QDBPs and funded NQDBs*. (A) QDBP and NQDB contributions are found to have been incurred only if paid directly to participants or beneficiaries under the terms of the plan or to the QDBP or NQDB.

(B) Payments to a QDBP or funded NQDB for a cost reporting period must be measured on a cash basis. A contribution or payment is deemed to occur on the date it is credited to the fund established for the QDBP or funded NQDB, or for provider of services payments made directly to a plan participant or beneficiary, on the date the provider of services account is debited.

(C) Payments or contributions made to fully fund a terminating QDBP or funded NQDB are to be included as funding on the date they are paid. Excess assets withdrawn from a QDBP or funded NQDB are to be treated as negative contributions on the date that they are withdrawn.

(D) QDBP and funded NQDB annual allowable costs are computed as follows:

(1) QDBP and funded NQDB costs and limits are computed in accordance with § 413.100(c)(2)(vii)(D).

(2) For purposes of determining the QDBP or funded NQDB cost limit under § 413.100(c)(2)(vii)(D)(2), provider of services contribution payments for each applicable cost reporting period must be determined on a cash basis without regard to any limit determined for the period during which the contributions were made, and excluding any contributions deposited in a prior period and treated as carry forward contributions.

(3) The averaging period used to determine the QDBP or funded NQDB cost limit must be determined without

regard to a provider of services period of participation in the Medicare program. Periods that are not Medicare cost reporting periods (for example, periods prior to the hospital's participation in the Medicare program) must be defined as consecutive 12-month periods ending immediately prior to the provider of services initial Medicare cost reporting period.

(4) The averaging period used to determine the QDBP or funded NQDB cost limit must exclude all periods ending prior to the initial effective date of the plan (or a predecessor plan in the case of a merger).

(5) In general, the current period defined benefit cost and limit is computed and applied separately for each QDBP or funded NQDB offered by a provider of services. In the case of a plan merger, the contributions or payments made by a provider of services to a predecessor QDBP or funded NQDB and reflected in the assets subsequently transferred to a successor plan are treated as contribution payments made to the successor plan.

(2) [Reserved]

(e) *Documentation requirements.* Documentation must be maintained by the provider of services in accordance with § 413.20 to substantiate the allowability of contributions or payments to Qualified and Non-Qualified Deferred Compensation Plan(s) that it has included in its cost reports.

(1) *Required documentation.* The provider of services must maintain and make available, upon request by the contractor or CMS, certain specified documentation, to substantiate the allowability of the contributions or payments to its Qualified or Non-Qualified Deferred Compensation Plan(s), or both:

(i) Documentation that demonstrates that the provider of services is in compliance with 26 U.S.C. 409A and 409A(a), and, if applicable, 26 U.S.C. 457.

(ii) Ledger accounts/account statements for each plan participant noting current year deferrals, distributions and loans, including any deferral election forms completed by employees, any change requests, and the approval of such requests.

(iii) Documentation that demonstrates the amount(s) and date(s) of

actual contributions or payments made to the Qualified or Non-Qualified Deferred Compensation Plan during the current cost reporting period.

(iv) Schedule SB of Form 5500 (tri-agency form (Department of Labor (DOL), Internal Revenue Service (IRS), and PBGC) that plans file with the DOL's "EFAST" electronic filing system) for a QDBP for the current cost reporting period, or any applicable prior periods.

(v) In the case of a system-wide (multiple employer) plan, the home office shall identify the contributions attributed to each participating provider of services. If the costs included in the cost report for a period differ from the contributions made during the reporting period (that is, as a result of carry forward contributions), the provider of services must also have data available to track and reconcile the difference.

(2) *Additional documentation.* The following additional documentation must be made available, upon request by the contractor or CMS, to substantiate the allowability of the payments/contributions by a provider of services to a Qualified or Non-Qualified Deferred Compensation Plan:

(i) The plan document, the trust document and all amendments related to the current cost reporting period.

(ii) If applicable, any Form 5330, Return of Excise Taxes Related to Employee Benefit Plans, for the cost reporting period.

(iii)(A) Supporting documents for all plan assets and liabilities, such as broker's statements, bank statements, insurance contracts, loan documents, deeds, etc.

(B) Verification of how assets are valued.

(iv)(A) Trustee or administrator reports.

(B) Ledgers.

(C) Journals.

(D) Trustee, administrator, and investment committee minutes.

(E) Certified audit report and other financial reports for the trust.

(F) Any other financial reports, including receipt and disbursement statements, a detailed income statement, and a detailed balance sheet.

(v) For each covered QDBP, documentation of the certified premium information and payments to the PBGC.

(f) *Administrative and other costs associated with Deferred Compensation Plans.* The provider of services shall file a cost report required under §§ 413.20 and 413.24(f) that is consistent with the policies set forth in this section.

(1) *Trustee and custodial fees.* Reasonable trustee or custodial fees, including PBGC premiums, paid by the provider of services are allowed as an administrative cost except where the plan provides that such fees are paid out of the corpus or earnings of the fund.

(2) *Vested benefits.* The forfeiture of an employee's benefits for cause (as defined in the plan) is recognized as an allowable cost provided that such forfeited amounts are used to reduce the provider of services contributions or payments to the plan during the cost reporting period in which the forfeiture occurs.

(3) *Benefits to be paid.* If an employee terminates participation in the Deferred Compensation Plan before their rights are vested, the applicable non-vested contributions/payments cannot be applied to increase the benefits of the surviving participants. Instead the non-vested contributions or payments should be used to reduce the provider of services contributions or payments to the Deferred Compensation Plan, in the cost reporting period in which the employee terminated participation in the Deferred Compensation Plan. Otherwise, the contributions/payments made by the provider of services must be applied to reduce the subsequent contributions or payments to the Deferred Compensation Plan in the next cost reporting period. If subsequent provider of services contributions/payments to the Deferred Compensation Plan are not made, then the provider of services costs are reduced by the contractor to the extent of such non-vested funds.

(4) *DOL, IRS, or PBGC penalties.* If the provider of services is assessed an excise tax or other remedy by the DOL, IRS, or PBGC for failure to follow DOL, IRS, or PBGC requirements under ERISA or any other penalty fee or penalty interest applicable to its Deferred Compensation Plan, the cost is

unallowable in accordance with section 1861(v)(8) of the Act.

(5) *Loans made from a Deferred Compensation Plan.* A provider of services cannot make a loan to itself from a Deferred Compensation Plan where ERISA or IRS rules prohibit such a transaction, except where specifically excepted.

(6) *Termination/discontinuation of a Deferred Compensation Plan.* If the provider of services declines to vest its outstanding required contributions or payments (that is, matching or non-elective) to a Deferred Compensation Plan as a result of a termination in full or in part or a discontinuation of contributions or payments to a Deferred Compensation Plan, then the provider of services total outstanding required contributions or payments to the Deferred Compensation Plan during the cost reporting period wherein such termination is initiated cannot be included in the provider of services allowable cost for the cost reporting period in which the termination is initiated, nor any future period.

(7) *Required offset against interest expense.* Investment income earned on a Deferred Compensation Plan after its termination but prior to liquidation of the plan's assets and distribution to the provider of services must be offset against the provider of services allowable interest expense under § 413.153.

(8) *Treatment of residual assets following termination of a Funded Plan.* (i) Residual assets arising from the termination of a funded Deferred Compensation Plan must be recouped in the year of the plan termination only against the cost center(s) in which the provider of services reported its plan contributions or payments, usually the administrative and general cost center.

(ii) Residual assets exceeding the amount in the administrative and general (or other) cost center are not further offset in the current or subsequent years.

(iii) The Medicare share of the reversion is based on the Medicare utilization rate in the year the reversion occurs (or the year the actuarial surplus is determined), and not Medicare's utilization in the years the contributions to the plan were made.

(g) *Treatment of costs associated with the PBGC.* Costs associated with the requirements set forth in ERISA and by the PBGC and incurred by a provider of services who sponsors a QDBP are allowable or unallowable under the program as provided for in this paragraph (g).

(1) *Costs paid out of the plan trust.* PBGC premiums and costs paid out of the corpus or earnings of the trust are included in the contributions allowed under paragraph (d)(1)(iii)(A) of this section, and are not allowable as separate costs.

(2) *Premium payments for single- and multi-employer plans.* The amount of PBGC premiums paid for basic benefits (flat rate or variable, excluding amounts paid out of the corpus or earnings of the trust) by a provider of services who sponsors a QDBP are allowable under the program.

(3) *Liability for missing participants or beneficiaries.* The total amount paid to the PBGC by a provider of services who sponsors a QDBP (excluding amounts paid out of the corpus or earnings of the trust) of the benefit transfer amount (as described in 29 CFR 4050.103(d)) for all missing participants or beneficiaries of the QDBP, is allowable under the program.

(4) *Plan termination due to distress.* For a defined benefit plan that terminated with insufficient assets to pay all of the plan benefits, which resulted in the PBGC making payment of vested benefits up to limits defined by law in accordance with 29 CFR part 4022, such amounts contributed to the QDBP by the provider of services who sponsors the QDBP are allowable. Benefits paid to the participants and beneficiaries of the QDBP by the PBGC are unallowable.

(5) *Restored plan payments.* If the PBGC issues or has issued a plan restoration order as described in 29 CFR part 4047, the amounts that the provider of services repays to the PBGC for guaranteed benefits and related expenses under the plan while the plan was in terminated status, and any administrative costs assessed by the PBGC, excluding penalties, are allowable.

[87 FR 49406, Aug. 10, 2022]

§ 413.100 Special treatment of certain accrued costs.

(a) *Principle.* As described in § 413.24(b)(2), under the accrual basis of accounting, revenue is reported in the period in which it is earned and expenses are reported in the period in which they are incurred. In the case of accrued costs described in this section, for Medicare payment purposes the costs are allowable in the year in which the costs are accrued and claimed for Medicare payment only under the conditions set forth in paragraph (c) of this section.

(b) *Definitions—*(1) *All-inclusive paid days off benefit.* An all-inclusive paid days off benefit replaces other vacation and sick pay plans. It is a formal plan under which, based on actual hours worked, all employees accrue vested leave or payment in lieu of vested leave for any combination of types of leave, such as illness, medical appointments, holidays, and vacations.

(2) *Self-insurance.* Self-insurance is a means by which a provider independently or as part of a group undertakes the risk of protecting itself against anticipated liabilities by providing funds in an amount equal to anticipated liabilities, rather than by purchasing insurance coverage.

(c) *Recognition of accrued costs—*(1) *General.* Although Medicare recognizes, in the year of accrual, the accrual of costs for which a provider has not actually expended funds during the current cost reporting period, for purposes of payment Medicare does not recognize the accrual of costs unless the related liabilities are liquidated timely.

(2) *Requirements for liquidation of liabilities.* For accrued costs to be recognized for Medicare payment in the year of the accrual, the requirements set forth below must be met with respect to the liquidation of related liabilities. If liquidation does not meet these requirements, the cost is disallowed, generally in the year of accrual, except as specified in paragraph (c)(2)(ii) of this section.

(i) *A short-term liability.* (A) Except as provided in paragraph (c)(2)(i)(B) of this section, a short-term liability, including the current portion of a long-term liability (for example, mortgage interest payments due to be paid in the

current year), must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.

(B) If, within the 1-year time limit, the provider furnishes to the contractor sufficient written justification (based upon documented evidence) for nonpayment of the liability, the contractor may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred.

(ii) *Vacation pay and all-inclusive paid days off.* (A) If the provider's vacation policy, or its policy for all-inclusive paid days off, is consistent for all employees, liquidation of the liability must be made within the period provided for by that policy.

(B) If the provider's vacation policy, or its policy for all-inclusive paid days off, is not consistent for all employees, liquidation of the liability must be made within 2 years after the close of the cost reporting period in which the liability is accrued.

(C) If payment is not made within the required time period or if benefits are forfeited by the employee, an adjustment to disallow the accrued cost is made in the current period (that is, the latest year in which payment should have been made or the year in which the benefits are forfeited) rather than in the period in which the cost was accrued and claimed for Medicare payment. However, an contractor may choose to require the adjustment in the period in which the cost was accrued and claimed for Medicare payment if the cost report for that period is open or can be reopened as provided in §405.1885 of this chapter, and if the contractor believes the adjustment is more appropriate in that period.

(iii) *Sick pay.* (A) If sick leave is vested and funded in a deferred compensation plan, liabilities related to the contributions to the fund must be liquidated, generally within 1 year after the end of the cost reporting period in which the liability is incurred. If, within the 1-year time limit, the provider furnishes to the contractor sufficient written justification (based upon documented evidence) for nonpayment of the liability, the contractor may grant

an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred. Contributions to the deferred compensation plan must be reduced to reflect estimated forfeitures. Actual forfeitures above or below estimated forfeitures must be used to adjust annual contributions to the fund.

(B) If the sick leave plan grants employees the nonforfeitable right to demand cash payment for unused sick leave at the end of each year, sick pay is includable in allowable costs, without funding, in the cost reporting period in which it is earned.

(C) Sick pay paid on any basis other than that specified in paragraphs (c)(2)(iii) (A) or (B) of this section can be claimed for Medicare payment only on a cash basis for the year in which the benefits are paid.

(iv) *Compensation of owners.* Accrued liability related to compensation of owners other than sole proprietors and partners must be liquidated within 75 days after the close of the cost reporting period in which the liability occurs.

(v) *Nonpaid workers.* Obligations incurred under a legally-enforceable agreement to remunerate an organization of nonpaid workers must be discharged no later than the end of the provider's cost reporting period following the period in which the services were furnished.

(vi) *FICA and other payroll taxes—(A) General rule.* The provider's share of FICA and other payroll taxes that the provider becomes obligated to remit to governmental agencies is included in allowable costs only during the cost reporting period in which payment (upon which the payroll taxes are based) is actually made to the employee. For example, payroll taxes applicable to vacation benefits are not to be accrued in the period in which the vacation benefits themselves are accrued but rather are allowable only in the period in which the employee takes the vacation.

(B) *Exception.* If payment would be made to an employee during a cost reporting period but for the fact the regularly scheduled payment date is after the end of the period, costs of accrued payroll taxes related to the portion of

payroll accrued through the end of the period, but paid to the employee after the beginning of the new period, are allowable costs in the year of accrual, subject to the liquidation requirements specified in paragraph (c)(2)(i) of this section.

(vii) *Deferred compensation.* (A) Reasonable provider payments made under unfunded deferred compensation plans are included in allowable costs only during the cost reporting period in which actual payment is made to the participating employee.

(B) Accrued liability related to contributions to a funded deferred compensation plan must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred. An extension, not to exceed 3 years beyond the end of the cost reporting year in which the liability was incurred, may be granted by the contractor for good cause if the provider, within the 1-year time limit, furnishes to the contractor sufficient written justification for non-payment of the liability.

(C) Postretirement benefit plans (including those addressed in Statement of Financial Accounting Standards No. 106 (December 1990)) are deferred compensation arrangements and thus are subject to the provisions of this section regarding deferred compensation and to applicable program instructions for determining Medicare payment for deferred compensation.

(D) Exception: Qualified defined benefit pension plans, which are funded deferred compensation arrangements, shall be reported on a cash accounting basis as follows:

(1) The allowable pension cost shall be equal to the amount of actual pension contributions funded during the hospital's current Medicare cost reporting period, plus any contributions funded in a prior period and carried forward, subject to the limit under paragraph (c)(2)(vii)(D)(2) of this section.

(2) Except as provided in paragraph (c)(2)(vii)(D)(3) of this section, the allowable pension cost shall not exceed 150 percent of the average contribution(s) funded during the three consecutive Medicare cost reporting periods that produce the highest average contribution(s), out of the five most re-

cent Medicare cost reporting periods (ending with the current cost reporting period). Contributions in excess of the limit may be carried forward to future period(s). In the case of a newly adopted pension plan, the 5-year look-back period and/or the 3-year averaging period will be limited to the number of cost reporting periods the provider sponsored a qualified defined benefit pension plan.

(3) A waiver of the limit imposed under paragraph (c)(2)(vii)(D)(2) of this section may be granted for a specific Medicare cost reporting period for all or a portion of the contributions in excess of the limit imposed under paragraph (c)(2)(vii)(D)(2) of this section if it is determined that such excess costs are reasonable and necessary for that period.

(viii) *Self-insurance.* Accrued liability related to contributions to a self-insurance program that are systematically made to a funding agency and that cover malpractice and comprehensive general liability, unemployment compensation, workers' compensation insurance losses, or employee health benefits, must be liquidated within 75 days after the close of the cost reporting period.

[60 FR 33136, June 27, 1995, as amended at 64 FR 51909, Sept. 27, 1999; 77 FR 53682, Aug. 31, 2012]

§ 413.102 Compensation of owners.

(a) *Principle.* A reasonable allowance of compensation for services of owners is an allowable cost provided that the services are actually performed in a necessary function.

(b) *Definitions—(1) Compensation.* Compensation means the total benefit received by the owner for the services he furnishes to the institution. It includes the following items:

(i) Salary amounts paid for managerial, administrative, professional, and other services.

(ii) Amounts paid by the institution for the personal benefit of the proprietor.

(iii) The cost of assets and services that the proprietor receives from the institution.

(iv) Deferred compensation.

(2) *Reasonableness.* Reasonableness requires that the compensation allowance—

(i) Be such an amount as would ordinarily be paid for comparable services by comparable institutions; and

(ii) Depend upon the facts and circumstances of each case.

(3) *Necessary.* Necessary requires that the function be—

(i) Such that had the owner not furnished the services, the institution would have had to employ another person to perform the services; and

(ii) Pertinent to the operation and sound conduct of the institution.

(c) *Application.* (1) Owners of provider organizations often furnish services as managers, administrators, or in other capacities. In such cases, it is equitable that reasonable compensation for the services furnished to be an allowable cost. To do otherwise would disadvantage such owners in comparison with corporate providers or providers employing persons to perform similar services.

(2) Ordinarily, compensation paid to proprietors is a distribution of profits. However, if a proprietor furnishes necessary services for the institution, the institution is in effect employing his services, and a reasonable compensation for these services is an allowable cost. In corporate providers, the salaries of owners who are also employees are subject to the same requirements of reasonableness. If the services are furnished on less than a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Reasonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.

§413.106 Reasonable cost of physical and other therapy services furnished under arrangements.

(a) *Principle.* The reasonable cost of the services of physical, occupational, speech, and other therapists, and services of other health specialists (other than physicians), furnished under arrangements (as defined in section 1861(w) of the Act) with a provider of

services, a clinic, a rehabilitation agency or a public health agency, may not exceed an amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by the provider or other organization had such services been performed by such person in an employment relationship, plus the cost of other reasonable expenses incurred by such person in furnishing services under such an arrangement. However, if the services of a therapist are required on a limited part-time basis, or to perform intermittent services, payment may be made on the basis of a reasonable rate per unit of service, even though this rate may be greater per unit of time than salary-related amounts, if the greater payment is, in the aggregate, less than the amount that would have been paid had a therapist been employed on a full-time or regular part-time salaried basis. Pursuant to section 17(a) of Public Law 93-233 (87 Stat. 967), the provisions of this section are effective for cost reporting periods beginning after March, 1975.

(b) *Definitions—*(1) *Prevailing salary.* The prevailing salary is the hourly salary rate based on the 75th percentile of salary ranges paid by providers in the geographical area, by type of therapy, to therapists working full time in an employment relationship.

(2) *Fringe benefit and expense factor.* The standard fringe benefit and expense factor is an amount that takes account of fringe benefits, such as vacation pay, insurance premiums, pension payments, allowances for job-related training, meals, etc., generally received by an employee therapist, as well as expenses, such as maintaining an office, appropriate insurance, etc., an individual not working as an employee might incur in furnishing services under arrangements.

(3) *Adjusted hourly salary equivalency amount.* The adjusted hourly salary equivalency amount is the prevailing hourly salary rate plus the standard fringe benefit and expense factor. This amount is determined on a periodic basis for appropriate geographical areas.

(4) *Travel allowance.* A standard travel allowance is an amount that is recognized, in addition to the adjusted hourly salary equivalency amount.

(5) *Limited part-time or intermittent services.* Therapy services are considered to be on a limited part-time or intermittent basis if the provider or other organization furnishing the services under arrangements requires the services of a therapist or therapists on an average of less than 15 hours per week. This determination is made by dividing the total hours of services furnished during the cost reporting period by the number of weeks in which the services were furnished in the cost reporting period regardless of the number of days in each week in which services were performed.

(6) *Guidelines.* Guidelines are the amounts published by CMS reflecting the application of paragraphs (b) (1) through (4) of this section to an individual therapy service and a geographical area. Other statistically valid data may be used to establish guidelines for a geographical area, provided that the study designs, questionnaires and instructions, as well as the resultant survey data for determining the guidelines are submitted to and approved in advance by CMS. Such data must be arrayed so as to permit the determination of the 75th percentile of the range of salaries paid to full-time employee therapists.

(7) *Administrative responsibility.* Administrative responsibility is the performance of those duties that normally fall within the purview of a department head or other supervisor. This term does not apply to directing aides or other assistants in furnishing direct patient care.

(c) *Application.* (1) Under this provision, CMS will establish criteria for use in determining the reasonable cost of physical, occupational, speech, and other therapy services and the services of other health specialists (other than physicians) furnished by individuals under arrangements with a provider of services, a clinic, a rehabilitation agency, or public health agency. It is recognized that providers have a wide variety of arrangements with such individuals. These individuals may be independent practitioners or employees

of organizations furnishing various health care specialists. This provision does not require change in the substance of these arrangements.

(2) If therapy services are performed under arrangements at a provider site on a full-time or regular part-time basis, the reasonable cost of such services may not exceed the amount determined by taking into account the total number of hours of services furnished by the therapist, the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished and a standard travel allowance.

(3) If therapy services are performed under arrangements on a limited part-time or intermittent basis at the provider site, the reasonable cost of such services is evaluated on a reasonable rate per unit of service basis, except that payment for these services, in the aggregate, during the cost reporting period, may not exceed the amount that would be determined to be reasonable under paragraph (c)(2) of this section, had a therapist furnished the provider or other organization furnishing the services under arrangements 15 hours of service per week on a regular part-time basis for the weeks in which services were furnished by the non-employee therapist.

(4) If an HHA furnishes services under arrangements at the patient's residence or in other situations in which therapy services are not performed at the provider's site, the reasonable cost of such services is evaluated as follows:

(i) *Time records available.* If time records of HHA visits are maintained by the provider, the reasonable cost of such services is evaluated on a unit-of-time basis, by taking into account the total number of hours of service furnished by the therapist, the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished, and a standard travel allowance for each visit. However, if the travel time of the therapist is accurately recorded by the therapist, and approved and maintained by the provider, the reasonable cost of such

services may be evaluated, at the option of the provider, by taking into account the total number of hours of service furnished by the therapist, including travel time, and the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished. This option does not apply to services furnished by HHAs under arrangements with providers other than HHAs.

(ii) *No time records available.* If time records are unavailable or found to be inaccurate, each HHA visit is considered the equivalent of one hour of service. In such cases, the reasonable cost of such services is determined by taking into account the number of visits made by the therapist under arrangements with such agency, the adjusted hourly salary equivalency amount appropriate for the particular therapy in the geographical area in which the services are furnished, and a standard travel allowance.

(iii) *Limited part-time or intermittent services.* If under paragraph (c)(4) (i) or (ii) of this section, the provider required therapy services on an average of less than 15 hours per week, the services are considered limited part-time or intermittent services, and the reasonable cost of such services is evaluated on a reasonable rate per unit of service basis as described in paragraph (c)(3) of this section.

(5) If therapy services are performed in situations where compensation to a therapist employed by the provider is based, at least in part, on a fee-for-service or on a percentage of income (or commission), the guidelines will apply. The entire compensation will be subject to the guidelines in cases where the nature of the arrangements is most like an under "arrangement" situation, although technically the provider may treat the therapists as employees. The intent of this section is to prevent an employment relationship from being used to circumvent the guidelines.

(6) These provisions are applicable to individual therapy services or disciplines by means of separate guidelines by geographical area and apply to costs incurred after issuance of the guidelines but no earlier than the be-

ginning of the provider's cost reporting period described in paragraph (a) of this section. Until a guideline is issued for a specific therapy or discipline, costs are evaluated so that such costs do not exceed what a prudent and cost-conscious buyer would pay for the given service.

(d) *Notice of guidelines to be imposed.* Prior to the beginning of a period to which a guideline will be applied, a notice will be published in the FEDERAL REGISTER establishing the guideline amounts to be applied to each geographical area by type of therapy.

(e) *Additional allowances.* (1) If a therapist supervises other therapists or has administrative responsibility for operating a provider's therapy department, a reasonable allowance may be added to the adjusted hourly salary equivalency amount by the contractor based on its knowledge of the differential between therapy supervisors' and therapists' salaries in similar provider settings in the area.

(2) If a therapist performing services under arrangements furnishes equipment and supplies used in furnishing therapy services, the guideline amount may be supplemented by the cost of the equipment and supplies, provided the cost does not exceed the amount the provider, as a prudent and cost-conscious buyer, would have been able to include as allowable cost.

(f) *Exceptions.* The following exceptions may be granted but only upon the provider's demonstration that the conditions indicated are present:

(1) *Exception because of unique circumstances or special labor market conditions.* An exception may be granted under this section by the contractor if a provider demonstrates that the costs for therapy services established by the guideline amounts are inappropriate to a particular provider because of some unique circumstances or special labor market conditions in the area.

(2) *Exception for services furnished by risk-basis HMO providers.* For special rules concerning services furnished to an HMO's enrollees who are Medicare beneficiaries by a provider owned or operated by a risk-basis HMO (see §417.201(b) of this chapter) or related to

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a risk-basis HMO by common ownership or control (see § 417.250(c) of this chapter).

(3) *Exception for inpatient hospital services.* Effective with cost reporting periods beginning on or after October 1, 1983, the costs of therapy services furnished under arrangements to a hospital inpatient are excepted from the guidelines issued under this section if such costs are subject to the provisions of § 413.40 or part 412 of this chapter. The contractor will grant the exception without request from the provider.

(g) *Appeals.* A request by a provider for a hearing on the determination of an contractor concerning the therapy costs determined to be allowable based on the provisions of this section, including a determination with respect to an exception under paragraph (f) of this section, is made to the contractor only after submission of its cost report and receipt of the notice of amount of program reimbursement reflecting such determination, in accordance with the provisions of subpart R of part 405 of this chapter.

[51 FR 34793, Sept. 30, 1986, as amended at 63 FR 5139, Jan. 30, 1998]

§ 413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.

(a) *Purpose and basis.* This section implements section 1883 of the Act, which provides for payment for posthospital SNF care furnished by rural hospitals and CAHs having a swing-bed approval.

(1) *Services furnished in cost reporting periods beginning prior to July 1, 2002.* Posthospital SNF care furnished in general routine inpatient beds in rural hospitals and CAHs is paid in accordance with the special rules in paragraph (c) of this section for determining the reasonable cost of this care. When furnished by rural and CAH swing-bed hospitals approved after March 31, 1988 with more than 49 beds (but fewer than 100), these services must also meet the additional payment requirements set forth in paragraph (d) of this section.

(2) *Services furnished in cost reporting periods beginning on and after July 1, 2002.* Posthospital SNF care furnished in general routine inpatient beds in rural hospitals (other than CAHs) is

paid in accordance with the provisions of the prospective payment system for SNFs described in subpart J of this part, except that for purposes of this paragraph, the requirements of § 413.343(a) must be met using the specific assessment instrument and data designated by CMS for this purpose. Posthospital SNF care furnished in general routine inpatient beds in CAHs is paid based on reasonable cost for cost reporting periods beginning on and after July 1, 2002 and before January 1, 2004, and is paid based on 101 percent of reasonable cost for cost reporting periods beginning on and after January 1, 2004, in accordance with the provisions of subparts A through G of this part (other than paragraphs (c) and (d) of this section).

(b) *Definitions.* For purposes of this section—

Availability date means with respect to a posthospital SNF care patient in a swing-bed hospital, the later of—

(i) Any date on which a bed is available for the patient in a Medicare-participating SNF located within the hospital's geographic region;

(ii) The date that a hospital learns that a bed is available in a Medicare-participating SNF; or

(iii) If the notice is prospective, the date that a bed will become available in a Medicare-participating SNF.

Geographic region means an area that includes the SNFs with which a hospital has traditionally arranged transfers and all other SNFs within the same proximity to the hospital. In the case of a hospital without existing transfer practices upon which to base a determination, the geographic region is an area that includes all the SNFs within 50 miles (as defined in § 412.92(c)(1) of this chapter) of the hospital unless the hospital can demonstrate that the SNFs are inaccessible to its patients. In the event of a dispute as to whether an SNF is within a hospital's geographic region or the SNF is inaccessible to hospital patients, the CMS Regional Office makes a determination.

Swing-bed hospital means a hospital or CAH participating in Medicare that has an approval from CMS to provide posthospital SNF care as defined in § 409.20 of this chapter, and meets the

requirements specified in §482.58 or §485.645 of this chapter, respectively.

(c) *Special rules for determining the reasonable cost of posthospital SNF care furnished in cost reporting periods beginning prior to July 1, 2002.* The reasonable cost of posthospital SNF care furnished by a swing-bed hospital is determined as follows:

(1) The reasonable cost of routine SNF services is based on the average Medicare rate per patient day for routine services provided in freestanding SNFs in the region where the swing-bed hospital is located. The rates are calculated using the regions as defined in section 1886(d)(2)(D) of the Social Security Act. The rates are based on the most recent year for which settled cost reporting period data are available, increased in a compounded manner, using the increase applicable to the SNF routine cost limits, up to and including the calendar year for which the rates are in effect. If the current Medicare swing-bed rate for routine extended care services furnished by a swing-bed hospital during a calendar year is less than the rate for the prior calendar year, payment is made based on the prior calendar year's rate.

(2) The reasonable cost of ancillary services furnished as posthospital SNF care is determined in the same manner as the reasonable cost of other ancillary services furnished by the hospital in accordance with §413.53(a)(1).

(d) *Additional requirements—(1) General rule.* For services furnished in cost reporting periods beginning prior to July 1, 2002, in order for Medicare payment to be made to a swing-bed hospital with more than 49 beds (but fewer than 100), the following payment requirements must be met:

(i) If there is an available SNF bed in the geographic region, a posthospital SNF care patient must be transferred within 5 days (excluding weekends and holidays) of the availability date, unless the patient's physician certifies within the 5-day period that transfer is not medically appropriate.

(ii) The number of patient days for posthospital SNF care in a cost reporting period does not exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the hospital in the pe-

riod. In those States that do not license their hospital beds, the hospitals must use the total number of hospital beds reported on their most recent Certificate of Need (CON), excluding bassinets. If during the cost reporting period, there is an increase or decrease in the number of "licensed" beds, the number of "licensed" beds for each part of the period is to be multiplied by the number of days for which that number of "licensed" beds was available. After totalling the results, compute 15 percent of the total available "licensed" bed days to determine the payment limitation.

(2) *Payment restrictions.* (i) The hospital must not seek payment for posthospital SNF care after the end of the 5 day period (excluding weekends and holidays) beginning on the availability date of a SNF bed unless the patient's physician has certified, within that 5 day period, that the transfer of the patient to the SNF was not medically appropriate.

(ii) The hospital must not seek payment for posthospital SNF care in a cost reporting period to the extent that they exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the period. In those States that do not license hospital beds, the hospital must use the average number of hospital beds reported on its most recent CON, excluding bassinets.

(3) *Payment exception.* Payment will continue to be made during the cost reporting period in which the 15 percent limit specified in paragraph (d)(1)(ii) of this section is reached for those patients who are receiving posthospital SNF care at the time the hospital reaches the limit.

[51 FR 34793, Sept. 30, 1986, as amended at 54 FR 37274, Sept. 7, 1989; 56 FR 54545, Oct. 22, 1991; 58 FR 30671, May 26, 1993; 61 FR 51616, Oct. 3, 1996; 62 FR 46037, Aug. 29, 1997; 66 FR 39600, July 31, 2001; 69 FR 49265, Aug. 11, 2004; 79 FR 27153, May 12, 2014; 85 FR 47633, Aug. 5, 2020]

§413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.

(a) *Basis and scope.* This section implements section 1833(a)(4) and (i)(3) of the Act and establishes the method for

determining Medicare payments for services related to covered ambulatory surgical center (ASC) procedures performed in a hospital on an outpatient basis. It does not apply to services furnished by an ASC operated by a hospital that has an agreement with CMS to be paid in accordance with §416.30 of this chapter. (For regulations governing ASCs see part 416 of this chapter.)

(b) *Definitions.* For purposes of this section—

Facility services are those items and services, as specified in §416.61 of this chapter, that are furnished by a hospital on an outpatient basis in connection with covered ASC surgical procedures, as described in §416.65 of this chapter.

Standard overhead amount means an amount equal to the prospectively determined payment rate that would be paid for the procedure if it had been furnished by an ASC in the same geographic area.

(c) *Payment principle.* The aggregate amount of payments for facility services, furnished in a hospital on an outpatient basis, that are related to covered ASC surgical procedures (covered under §416.65 of this chapter) is equal to the lesser of—

(1) The hospital's reasonable cost or customary charges, as determined in accordance with §413.13, reduced by deductibles and coinsurance; or

(2) The blended payment amount as described in paragraph (d) of this section, which is based on hospital-specific cost and charge data and rates paid to free-standing ASCs.

(d) *Blended payment amount.* (1) For cost reporting periods beginning on or after October 1, 1987 but before October 1, 1988, the blended payment amount is equal to the sum of—

(i) 75 percent of the hospital-specific amount (the lesser of the hospital's reasonable cost or customary charges, reduced by deductibles and coinsurance); and

(ii) 25 percent of the ASC payment amount (that is, 80 percent of the result obtained by subtracting the deductibles from the sum of the standard overhead amounts.)

(2) For the period of time beginning with the first day of a hospital's cost

reporting period that begins on or after October 1, 1988 and ends on December 31, 1990, the blended payment amount is equal to 50 percent of the hospital-specific amount and 50 percent of the ASC payment amount.

(3) For portions of cost reporting periods beginning on or after January 1, 1991, the blended payment amount is equal to 42 percent of the hospital-specific amount and 58 percent of the ASC payment amount.

(4) For cost reporting periods beginning on or after October 1, 1988 and before January 1, 1995, the blended payment amount is equal to the sum of 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount for a hospital that makes an application to its contractor and meets the following requirements.

(i) More than 60 percent of the hospital's inpatient hospital discharges, as described in §412.60 of this chapter, occurring during its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, are classified in diagnosis related groups 36 through 74.

(ii) During its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, more than 30 percent of the hospital's total revenues is derived from outpatient services.

(5) For portions of cost reporting periods beginning on or after October 1, 1997, for purposes of calculating the blended payment amount under paragraph (d)(4) of this section, the ASC payment amount is the sum of the standard overhead amounts reduced by deductibles and coinsurance as defined in section 1866(a)(2)(ii) of the Act.

(e) *Aggregation of cost, charges, and the blended amount.* For purposes of determining the correct payment amount under paragraphs (c) and (d) of this section, all reasonable costs and customary charges attributable to facility services furnished during a cost reporting period are aggregated and treated separately from the reasonable costs and customary charges attributable to

all other services furnished in the hospital.

[52 FR 36773, Oct. 1, 1987; 52 FR 37715, Oct. 8, 1987, as amended at 55 FR 33699, Aug. 17, 1990; 55 FR 34797, Aug. 24, 1990; 57 FR 36017, Aug. 12, 1992; 57 FR 45113, Sept. 30, 1992; 65 FR 18541, Apr. 7, 2000]

§413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

(a) *Basis and purpose.* (1) This section implements section 1833(n) of the Act and establishes the method for determining Medicare payments for radiology services and other diagnostic procedures performed by a hospital on an outpatient basis.

(2) For purposes of this section—

(i) Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services; and

(ii) Other diagnostic procedures are those identified by CMS, and do not include diagnostic radiology procedures or diagnostic laboratory tests.

(b) *Payment for hospital outpatient radiology services.* (1) The aggregate payment for hospital outpatient radiology services furnished on or after October 1, 1988 is equal to the lesser of the following:

(i) The hospital's reasonable cost or customary charges, as determined in accordance with §413.13, reduced by the applicable Part B annual deductible and coinsurance amounts.

(ii) The blended payment amount described in paragraph (b)(2) of this section.

(2) The blended payment amount for hospital outpatient radiology services furnished on or after October 1, 1988, but before October 1, 1989, is equal to the sum of—

(i) 65 percent of the hospital-specific amount (the hospital's reasonable cost or customary charges, whichever is less, reduced by the applicable Part B annual deductible and coinsurance amounts); and

(ii) 35 percent of a prevailing charge or fee schedule amount that is calculated as 80 percent of the amount determined by subtracting the applicable Part B annual deductible from 62 per-

cent of the prevailing charges (or for services furnished on or after January 1, 1989, the fee schedule amount established) for the same services when furnished by participating physicians in their offices in the same locality.

(3) For hospital outpatient radiology services furnished on or after October 1, 1989, the blended payment amount is equal to the sum of 50 percent of the hospital-specific amount and 50 percent of the fee schedule amount.

(4) For hospital outpatient radiology services furnished on or after January 1, 1991, the blended payment amount is equal to the sum of 42 percent of the hospital-specific amount and 58 percent of the fee schedule amount.

(5) For hospital outpatient radiology services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 42 percent of the hospital-specific amount; and

(ii) 58 percent of the fee schedule amount calculated as 62 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

(c) *Payment for other diagnostic procedures.* (1) The aggregate payment for other diagnostic procedures performed by a hospital on an outpatient basis on or after October 1, 1989 is equal to the lesser of the following:

(i) The hospital's reasonable cost or customary charges, as determined in accordance with §414.13, reduced by the applicable Part B annual deductible and coinsurance amounts.

(ii) The blended payment described in paragraph (c)(2) of this section.

(2) The blended payment amount for other diagnostic procedures furnished on or after October 1, 1989, but before October 1, 1990, is equal to the sum of—

(i) 65 percent of the hospital-specific amount (the hospital's reasonable cost or customary charges, whichever is less, reduced by the applicable Part B annual deductible and coinsurance amounts); and

(ii) 35 percent of a prevailing charge amount that is calculated as 80 percent of the amount determined by subtracting the applicable Part B annual

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deductible from 42 percent of the prevailing charges for the same services furnished by participating physicians in their offices in the same locality.

(3) For other diagnostic procedures performed by a hospital on or after October 1, 1990, the blended payment is equal to 50 percent of the hospital-specific amount and 50 percent of the prevailing charge amount.

(4) For other diagnostic services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 50 percent of the hospital-specific amount; and

(ii) 50 percent of the fee schedule amount calculated as 42 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

[56 FR 8842, Mar. 1, 1991, as amended at 57 FR 36017, Aug. 12, 1992; 65 FR 18542, Apr. 7, 2000]

§ 413.123 Payment for screening mammography performed by hospitals on an outpatient basis.

(a) *Basis and scope.* This section implements section 1834(c)(1)(C) of the Act and establishes the method for determining Medicare payment for screening mammographies performed by hospitals.

(b) *Payment to hospitals for outpatient services.* Payment to hospitals for screening mammography services performed on an outpatient basis is determined in accordance with the technical component billing requirements in § 405.534(d) of this chapter.

[55 FR 53522, Dec. 31, 1990, as amended at 59 FR 49834, Sept. 30, 1994]

§ 413.124 Reduction to hospital outpatient operating costs.

(a) Except for sole community hospitals, as defined in § 412.92 of this chapter, and critical access hospitals, the reasonable costs of outpatient hospital services (other than capital-related costs of these services) are reduced by 5.8 percent for services furnished during portions of cost reporting periods occurring on or after October 1, 1990 and until the first date that

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the prospective payment system under part 419 of this chapter is implemented.

(b) For purposes of determining the blended payment amounts of ambulatory surgical center approved surgical procedures performed in the hospital outpatient setting under § 413.118 and hospital outpatient radiology services and other diagnostic procedures under § 413.122, the reduction is applicable only to the hospital-specific portion of the blended payment amounts.

[57 FR 36017, Aug. 12, 1992, as amended at 59 FR 26960, May 25, 1994; 62 FR 46037, Aug. 29, 1997; 65 FR 18542, Apr. 07, 2000]

§ 413.125 Payment for home health agency services.

(a) For additional rules on the allowability of certain costs incurred by home health agencies, see §§ 409.46 and 409.49(b) of this chapter.

(b) The reasonable cost of outpatient rehabilitation services furnished by a home health agency to homebound patients who are not entitled to home health benefits may not exceed the amounts payable under the physician fee schedule for comparable services effective January 1, 1999.

[59 FR 65497, Dec. 20, 1994, as amended at 63 FR 58910, Nov. 2, 1998]

Subpart G—Capital-Related Costs

§ 413.130 Introduction to capital-related costs.

(a) *General rule.* Capital-related costs and an allowance for return on equity are limited to the following:

(1) Net depreciation expense as determined under §§ 413.134, 413.144, and 413.149, adjusted by gains and losses realized from the disposal of depreciable assets under § 413.134(f).

(2) Taxes on land or depreciable assets used for patient care.

(3) Leases and rentals, including license and royalty fees, for the use of depreciable assets or land, as described in paragraph (b) of this section.

(4) The costs of betterments and improvements as described in paragraph (c) of this section.

(5) The costs of minor equipment that are capitalized, rather than expensed, as described in paragraph (d) of this section.