

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

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

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

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

[69 FR 49254, Aug. 11, 2004, as amended at 70 FR 47489, Aug. 12, 2005; 71 FR 18666, Apr. 12, 2006; 71 FR 48141, Aug. 18, 2006; 72 FR 26995, May 11, 2007; 72 FR 47412, Aug. 22, 2007; 72 FR 66931, Nov. 27, 2007; 75 FR 50418, Aug. 16, 2010; 75 FR 72262, Nov. 24, 2010; 79 FR 50357, Aug. 22, 2014; 86 FR 73512, Dec. 27, 2021; 87 FR 49405, Aug. 10, 2022; 89 FR 69912, Aug. 28, 2024]

#### **§ 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.

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**§ 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