

(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

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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 education 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 report-

ing 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;