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(2) For cost reporting periods beginning on or after January 1, 2005, payment is made in accordance with regulations governing inpatient psychiatric facilities at subpart N (§412.400 through §412.432) of Part 412 of this subchapter.

(3) Payment for inpatient services of distinct part rehabilitation units of CAHs is made in accordance with regulations governing the inpatient rehabilitation facilities prospective payment system at Subpart P (§412.600 through §412.632) of Part 412 of this subchapter.

[65 FR 47109, Aug. 1, 2000, as amended at 66 FR 32195, June 13, 2001; 66 FR 39936, Aug. 1, 2001; 67 FR 50118, Aug. 1, 2002; 68 FR 45471, Aug. 1, 2003; 69 FR 49252, Aug. 11, 2004; 69 FR 66981, Nov. 15, 2004; 74 FR 44000, Aug. 27, 2009; 75 FR 44564, July 28, 2010; 75 FR 50417, Aug. 16, 2010; 75 FR 73616, Nov. 29, 2010; 76 FR 51783, Aug. 18, 2011; 77 FR 54147, Sept. 4, 2012]

§413.74 Payment to a foreign hospital.

(a) *Principle.* Section 1814(f) of the Act provides for the payment of emergency and nonemergency inpatient hospitals 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]

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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)(6). 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, respectively, 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

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(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 primary 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 may include in its FTE count and that is in addition to the number of FTE residents already included in the hospital's FTE cap.

Rural track or integrated rural track means an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or a rural nonhospital site(s).

Shared rotational arrangement means a residency training program under which a resident(s) participates in training at two or more hospitals in that program.

(c) *Payment for GME costs—General rule.* Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved GME programs as described in §§ 413.76 through 413.83.

(d) *Documentation requirements.* To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(1) The name and social security number of the resident.

(2) The type of residency program in which the individual participates and the number of years the resident has

completed in all types of residency programs.

(3) The dates the resident is assigned to the hospital and any hospital-based providers.

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

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

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

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

[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]

§ 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;