

## § 413.82

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 classification 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

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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: