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of the cost and the FTE time that each will incur and count.

(ii) If hospitals already arrange payment to the nonhospital 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 nonhospital 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 nonhospital 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 nonhospital 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 nonhospital 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 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.

(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.

[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]

§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 ap-

propriate 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

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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 (c)(6) and (m) through (o) 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 application 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) If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section, the hospital's weighted FTE

count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, 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.

(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 fiscal intermediary 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 fiscal intermediary 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.

(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.

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

(5) If a hospital qualifies for an adjustment to the limit established under paragraph (c)(2) of this section for new medical residency programs 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.

(6)(i) 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.

(ii) If a hospital receives a permanent increase in its FTE resident cap under paragraph (o)(1) of this section due to redistribution of slots from a closed hospital, the displaced FTE residents that the hospital receives are added to the FTE count after applying the averaging rules only in the first cost reporting period in which the receiving hospital trains the displaced FTE residents. In subsequent cost reporting periods, the displaced FTE residents are included in the receiving hospital's rolling average calculation.

(7) Subject to the provisions under paragraph (k) of this section, effective for cost reporting periods beginning on or after April 1, 2000, 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).

(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 establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (c) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the 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 the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence 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(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's 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.

(iii) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(iv) Effective for affiliation agreements entered into on or after October 1, 2005, 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.

(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.

(2) If a 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 for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on 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 each program based on the minimum accredited length for the type of program.

(i) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence 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 adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of 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 hospital with allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, is located in a rural area (or other hospitals located in rural areas that added residents under paragraph (e)(1) of this section), the hospital's unweighted FTE limit may be adjusted in the same manner described in paragraph (e)(2) of this section to reflect the increase for residents in the new medical residency training programs established after August 5, 1997. For these hospitals, the limit will be adjusted for additional new programs but not for expansions of existing or previously existing programs.

(4) A hospital seeking an adjustment to the limit on its unweighted resident count policy must provide documentation to its fiscal intermediary justifying the adjustment.

(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 fiscal intermediary 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 fiscal intermediary 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 fiscal intermediary 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 two 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

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and indirect FTE caps that is offset by a negative adjustment to the home hospital's (or hospitals') direct and indirect 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 fiscal intermediary/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 intermediary/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 pursuant 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.

(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.

(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 fiscal intermediary 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

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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 fiscal intermediary 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 fiscal intermediary 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 fiscal intermediary 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 fiscal intermediary 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 fiscal intermediary 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 include in its FTE count residents in those rural tracks, in addition to the residents subject to its FTE cap specified under paragraph (c) of this section. An urban hospital with a rural track residency program may count residents in those rural tracks up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (k)(2) through (k)(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, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

(i) 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.

(ii) 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 or the rural hospital(s) 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, 2002, or for more than one-half of the duration of the program effective for cost reporting periods beginning on

or after October 1, 2003, and the number of years those residents are training at the urban hospital.

(2) If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital 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). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(i) 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 nonhospital site(s).

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

(A) 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—

(1) The urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital 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

(2) The rural nonhospital site(s); and

(B) 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.

(3) 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

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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 (if the rural track is not a new program under paragraph (e)(3) of this section, or if the rural hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

(4) If an urban hospital rotates residents in the rural track program to a rural nonhospital 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). 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:

(i) 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 nonhospital site(s).

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

(A) 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 nonhospital site(s) or are designated at the beginning of their training to be rotated to the rural nonhospital 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

(B) The length of time in which the residents are being training at the rural nonhospital site(s) only.

(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) An urban hospital may not include in its rural track FTE limitation or (assuming the urban 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) The 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.

(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) 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 resident 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 designations adopted by CMS.

(1) 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) CMS may determine whether a hospital has met the requirements under paragraph (n)(1) 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.

(iii) In a case where the Medicare contractor determines that a hospital did not meet the requirements 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.

[69 FR 49254, Aug. 11, 2004, as amended at 69 FR 60252, Oct. 7, 2004; 69 FR 78530, Dec. 30, 2004; 70 FR 47489, Aug. 12, 2005; 71 FR 18666, Apr. 12, 2006; 71 FR 38266, July 6, 2006; 71 FR 48142, Aug. 18, 2006; 72 FR 66932, Nov. 27, 2007; 73 FR 48756, Aug. 19, 2008; 74 FR 44001, Aug. 27, 2009; 75 FR 72263, Nov. 24, 2010; 76 FR 13524, Mar. 14, 2011]

§ 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