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## 42 C.F.R. § 413.79

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### Direct GME payments: Determination of the weighted number of FTE residents.

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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 appropriate 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 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 (6) and (m) through (p) 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) Effective for cost reporting periods beginning on or after October 1, 2001, if the hospital's unweighted number of FTE residents exceeds the limit described in this section, and the number of weighted FTE residents in accordance with paragraph (b) of this section also exceeds that limit, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the limit. If the number of FTE residents weighted in accordance with paragraph (b) of this section does not exceed that limit, then the allowable weighted FTE count is the actual weighted FTE count.

(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 contractor 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.

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(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 contractor 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 withdraw 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. Effective October 1, 2014, if a rural hospital is redesignated as urban due to the most recent OMB standards for delineating statistical areas adopted by CMS, the redesignated urban hospital may retain any existing increases to its FTE resident cap that it had received prior to when the redesignation became effective. Effective October 1, 2014, if a rural hospital is redesignated as urban due to the most recent OMB standards for delineating statistical areas adopted by CMS, the redesignated urban hospital may receive an increase to its FTE resident cap for a new program, in accordance with paragraph (e) of this section, if it received a letter of accreditation for the new program and/or started training residents in the new program prior to the redesignation becoming effective.

(d) *Weighted FTE counts.* Subject to the provisions of § 413.81, for purposes of determining direct GME payment

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