(3) Step three. CMS will determine, using the best available data, for all eligible hospitals the total of all—
   (i) Nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year;
   (ii) Inpatient days from those same cost reporting periods; and
   (iii) Medicare+Choice inpatient days for those same cost reporting periods.

(4) Step four. Using the data from step three, CMS will determine the ratio of the total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year, to the total of all inpatient days from those same cost reporting periods. CMS will multiply this ratio by the total of all Medicare+Choice inpatient days for those same cost reporting periods.

(5) Step 5. Calculate the ratio of the product determined in step two to the product determined in step four.

(6) Step 6. Multiply the ratio calculated in step five by the amount determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital’s additional payment amount.

Calculation of the payment “pool.”

(1) Subject to paragraph (f)(3) of this section, each calendar year, CMS will calculate a Medicare+Choice nursing and allied health payment “pool” for the current calendar year.

(3) The payment pool may not exceed $60 million in any calendar year.

§413.88 Incentive payments under plans for voluntary reduction in number of medical residents.

(a) Statutory basis. This section implements section 1886(h)(6) of the Act, which establishes a program under which incentive payments may be made to qualifying entities that develop and implement approved plans to voluntarily reduce the number of residents in medical residency training.

(b) Qualifying entity defined. “Qualifying entity” means:
   (1) An individual hospital that is operating one or more approved medical residency training programs as defined in §413.75(b) of this chapter; or
   (2) Two or more hospitals that are operating approved medical residency training programs as defined in §413.75(b) of this chapter and that submit a residency reduction application as a single entity.

(c) Conditions for payments.
   (1) A qualifying entity must submit an application for a voluntary residency reduction plan that meets the requirements and conditions of this section in order to receive incentive payments for reducing the number of residents in its medical residency training programs.
   (2) The incentive payments will be determined as specified under paragraph (g) of this section.

(d) Requirements for voluntary plans.
   In order for a qualifying entity to receive incentive payments under a voluntary residency reduction plan, the qualifying entity must submit an application that contains the following information, documents, and agreements—
   (1) A description of the operation of a plan for reducing the full-time equivalent (FTE) residents in its approved medical residency training programs, consistent with the percentage reduction requirements specified in paragraphs (g)(2) and (g)(3) of this section;
   (2) An election of the period of residency training years during which the
reductions will occur. The reductions must be fully implemented by not later than the fifth residency training year in which the plan is effective;

(3) FTE counts for the base number of residents, as defined in paragraph (g)(1) of this section, with a breakdown of the number of primary care residents compared to the total number of residents; and the direct and indirect FTE counts of the entity on June 30, 1997. For joint applicants, these counts must be provided individually and collectively;

(4) Data on the annual and cumulative targets for reducing the number of FTE residents and the ratios of the number of primary care residents to the total number of residents for the base year and for each year in the 5-year reduction period. For joint applicants, these data must be provided individually and collectively;

(5) An agreement to not reduce the proportion of its primary care residents to its total number of residents below the proportion that exists in the base year, as specified in paragraph (g)(1) of this section;

(6) An agreement to comply with data submission requirements deemed necessary by CMS to make annual incentive payments during the 5-year residency reduction plan, and to fully cooperate with additional audit and monitoring activities deemed necessary by CMS;

(7) For a qualifying entity that is a member of an affiliated group as defined in §413.75(b), a statement that all members of the group agree to an aggregate FTE cap that reflects—

(i) The reduction in the qualifying entity’s FTE count as specified in the plan; and

(ii) The 1996 FTE count of the other hospital(s) in the affiliated group.

(8) A statement indicating voluntary participation in the plan under the terms of this section, signed by each hospital that is part of the applying entity.

(e) Deadline for applications. A qualifying entity must submit an application that meets the requirements of paragraph (d) of this section at least one day prior to the first day of the period to which the plan would be effective but no later than November 1, 1999.

The application must be submitted to the contractor, with a copy to CMS.

(f) Effective dates of plans. Residency reduction plans that are submitted to the contractor on or after September 17, 1999 but on or before November 1, 1999, may be effective for portions of cost reporting periods beginning no earlier than the day after the date of the application.

(g) Residency reduction requirements—

(1) Base number of residents defined. (i) “Base number of residents” means the lesser of—

(A) The number of FTE residents in all approved medical residency training programs of the qualifying entity (before application of weighting factors under §413.79) for the most recent residency training year ending June 30, 1996; or

(B) The number of FTE residents in all approved medical residency training programs of the qualifying entity (before application of weighting factors under §413.79) for any subsequent residency training year that ends before the date the entity submits its plan to the contractor and CMS.

(ii) The residency training year used to determine the base number of residents is the “base year” for determining reduction requirements.

(iii) The qualifying entity’s base number of residents may not be adjusted to reflect adjustments that may otherwise be made to the entity’s FTE caps for new medical residency training programs.

(2) Qualifying entity consisting of individual hospital. The base number of FTE residents in all the approved medical residency training programs operated by or through a qualifying entity consisting of an individual hospital must be reduced as follows:

(i) If the base number of residents exceeds 750, residents, by at least 20 percent.

(ii) If the base number of residents exceeds 600 but is less than or equal to 750 residents—

(A) By 150 residents; or

(B) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number by at least 20 percent.

(iii) If the base number of residents is 600 or less residents—
(A) By 25 percent; or
(B) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number of residents by at least 20 percent.

(3) Qualifying entity consisting of two or more hospitals. The base number of FTE residents in the aggregate for all the approved medical residency training programs operated by or through a qualifying entity consisting of two or more hospitals must be reduced—
(i) By 25 percent; or
(ii) By 20 percent, if the qualifying entity increases the number of primary care residents included in the base number of residents by at least 20 percent.

(4) Treatment of rotating residents. A qualifying entity will not be eligible for incentive payments for a reduction in the base number of residents if the reduction is a result of the entity rotating residents to another hospital that is not a part of its voluntary residency reduction plan.

(5) Updates to annual and cumulative targets
(i) Except as provided in paragraph (g)(5)(ii) of this section an entity with an approved voluntary residency reduction plan may not change the annual and cumulative reduction targets that are specified in its plan in accordance with paragraphs (g)(2) and (g)(3) of this section.
(ii) An entity may update annual reduction targets specified in its plan only if—
(A) It has failed to meet a specified annual target for a plan year in the 5-year period; and
(B) It wishes to adjust future annual targets for the remaining years of the plan in order to comply with its cumulative target.
(iii) An updated plan allowed under paragraph (g)(5)(ii) of this section must be submitted prior to the beginning of each July 1 medical residency training year during the plan years.

(h) Computation of incentive payment amount.
(1) Incentive payments to qualifying entities that meets the requirements and conditions of paragraphs (d) and (g) of this section will be computed as follows:

(1) Step 1. Determine the amount (if any) by which the payment amount that would have been made under §413.76 if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the amount of payment that would have been made under §413.76 in each year under the voluntary residency reduction plan, taking into account the reduction in the number of FTE residents under the plan.

(ii) Step 2. Determine the amount (if any) by which the payment amount that would have been made under §412.105 of this chapter if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the payment amount made under §412.105 of this chapter in each year under the voluntary residency reduction plan, taking into account the actual reduction in the number of FTE residents.

(iii) Step 3. Determine the amount (if any) by which the payment amount that would have been made under §412.322 of this chapter if there had been a 5-percent reduction in the number of FTE residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds the payment amount made under §412.322 of this chapter in each year under the voluntary residency reduction plan, taking into account the actual reduction in the number of FTE residents.

(iv) Step 4. Multiply the sum of the amounts determined under paragraph (h)(1), (ii), and (iii) of this section by the applicable hold harmless percentages specified in paragraph (i) of this section.

(2) The determination of the amounts under paragraph (h)(1) of this section for any year is based on the applicable Medicare statutory provisions in effect on the application deadline date for the voluntary reduction plan specified under paragraph (e) of this section.

(i) Applicable hold-harmless percentage.
The applicable hold-harmless percentages for each year in which the residency reduction plan is in effect are as follows:
§ 413.89 Bad debts, charity, and courtesy allowances.

(a) Principle. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost. However, subject to the limitations described under paragraph (h) of this section and the exception for services described under paragraph (i) of this section, bad debts attributable to the deductibles and co-insurance amounts are reimbursable under the program.

(b) Definitions—(1) Bad debts. Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. “Accounts receivable” and “notes receivable” are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

(2) Charity allowances. Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

(3) Courtesy allowances. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) Normal accounting treatment: Reduction in revenue. Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

(d) Requirements for Medicare. Under Medicare, costs of covered services furnished beneficiaries are not to be borne