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)(i), (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:

(1) 100 percent for the first and second residency training years;

(2) 75 percent for the third year;

(3) 50 percent for the fourth year; and

(4) 25 percent for the fifth year.

(j) *Payments to qualifying entities.* Annual incentive payments through cost reports will be made to each hospital that is or is part of a qualifying entity over the 5-year reduction period if the qualifying entity meets the annual and cumulative reduction targets specified in its voluntary reduction plan.

(k) *Penalty for noncompliance*—(1) *Nonpayment.* No incentive payment may be made to a qualifying entity for a residency training year if the qualifying entity has failed to reduce the number of FTE residents according to its voluntary residency reduction plan.

(2) *Repayment of incentive amounts.* The qualifying entity is liable for repayment of the total amount of incentive payments it has received if the qualifying entity—

(i) Fails to reduce the base number of residents by the percentages specified in paragraphs (g)(2) and (g)(3) of this section by the end of the fifth residency training year; or

(ii) Increases the number of FTE residents above the number of residents permitted under the voluntary residency reduction plan as of the completion date of the plan.

(l) *Postplan determination of FTE caps for qualifying entities*—(1) *No penalty imposed.* Upon completion of a voluntary residency reduction plan, if no penalty is imposed, the qualifying entity's 1996 FTE count is permanently adjusted to equal the unweighted FTE count used for direct GME payments for the last residency training year in which a qualifying entity participates.

(2) *Penalty imposed.* Upon completion of the voluntary residency reduction plan—

(i) *During repayment period.* If a penalty is imposed under paragraph (k)(2) of this section, during the period of repayment, the qualifying entity's FTE count is as specified in paragraph (l)(1) of this section.

(ii) *After repayment period.* Once the penalty repayment is completed, the qualifying entity's FTE reverts back to its original 1996 FTE cap.

[64 FR 44855, Aug. 18, 1999, as amended at 69 FR 49265, Aug. 11, 2004]

§ 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 coinsurance amounts are reimbursable under the program.

(b) *Definitions*—(1) *Bad debts.* (i) For cost reporting periods beginning before October 1, 2020:

(A) ''Bad debts'' are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services.

(B) ''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.

(ii) For cost reporting periods beginning on or after October 1, 2020, ''bad debts'' are amounts considered to be uncollectible from patient accounts that were created or acquired in providing services and are categorized as implicit price concessions for cost reporting purposes and are recorded in the provider's accounting records as a component of net patient revenue.

(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.* (1) For cost reporting periods beginning before October 1, 2020:

(i) 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 as these costs have already been incurred in the production of the services.

(ii) Medicare bad debts must not be written off to a contractual allowance account but must be charged to an expense account for uncollectible accounts.

(2) For cost reporting periods beginning on or after October 1, 2020:

(i) Bad debts, also known as ''implicit price concessions,'' 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 as these costs have already been incurred in the production of the services.

(ii) Medicare bad debts must not be written off to a contractual allowance account but must be recorded as an implicit price concession that results in a reduction in revenue.

(d) *Requirements for Medicare.* Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs.

(e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

(2) The provider must be able to establish that reasonable collection efforts were made.

(i) *Non-indigent beneficiary.* A non-indigent beneficiary is a beneficiary who has not been determined to be categorically or medically needy by a State Medicaid Agency to receive medical assistance from Medicaid, nor have they been determined to be indigent by the provider for Medicare bad debt purposes. To be considered a reasonable collection effort for non-indigent beneficiaries, all of the following are applicable:

(A) A provider's collection effort or the effort of a collection agency acting on the provider's behalf, or both, to collect Medicare deductible or coinsurance amounts must consist of all of the following:

(*1*) Be similar to the collection effort put forth to collect comparable amounts from non-Medicare patients.

(*2*) For cost reporting periods beginning before October 1, 2020, involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or shortly after discharge or death of the beneficiary.

(*3*) For cost reporting periods beginning on or after October 1, 2020, involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or before 120 days after the latter of one of the following:

(*i*) The date of the Medicare remittance advice that results from processing the claim for services furnished to the beneficiary and generates the beneficiary's cost sharing amounts.

(*ii*) The date of the remittance advice from the beneficiary's secondary payer, if any.

(*iii*) The date of the notification that the beneficiary's secondary payer does not cover the service furnished to the beneficiary.

(*4*) Include other actions such as subsequent billings, collection letters, and telephone calls, emails, text messages, or personal contacts with this party.

(*5*)(*i*) Last at least 120 days after paragraph (e)(2)(i)(A)(*2*) or (*3*) of this section is met before being written off as uncollectible under paragraph (e)(3) of this section.

(*ii*) Start a new 120-day collection period each time a payment is received within a 120-day collection period.

(*6*) Maintaining and, upon request, furnishing verifiable documentation to its contractor that includes all of the following:

(*i*) The provider's bad debt collection policy which describes the collection process for Medicare and non-Medicare patients.

(*ii*) The patient account history documents which show the dates of various collection actions such as the issuance of bills to the beneficiary, follow-up collection letters, reports of telephone calls and personal contact, etc.

(*iii*) The beneficiary's file with copies of the bill(s) and follow-up notices.

(B) A provider that uses a collection agency to perform its collection effort must do all of the following:

(*1*) Reduce the beneficiary's account receivable by the gross amount collected.

(*2*) Include any fee charged by the collection agency as an administrative cost.

(*3*) Before claiming the unpaid amounts as a Medicare bad debt, cease all collection efforts, including the collection agency efforts, and ensure that the collection accounts have been returned to the provider from the agency.

(ii) *Indigent non-dual eligible beneficiary*. An indigent non-dual eligible beneficiary is a beneficiary who is determined to be indigent or medically indigent by the provider and is not eligible for Medicaid as categorically or medically needy.

(A) To determine a beneficiary to be an indigent non-dual eligible beneficiary, the provider—

(*1*) Must not use a beneficiary's declaration of their inability to pay their medical bills or deductibles and coinsurance amounts as sole proof of indigence or medical indigence;

(*2*) Must take into account the analysis of both the beneficiary's assets (only those convertible to cash and unnecessary for the beneficiary's daily living) and income;

(*3*) May consider extenuating circumstances that would affect the determination of the beneficiary's indigence or medical indigence which may include an analysis of both the beneficiary's liabilities and expenses, if indigence is unable to be determined under paragraph (e)(ii)(A)(*2*) of this section;

(*4*) Must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill, such as a legal guardian or State Medicaid program; and

(*5*) Must maintain and, upon request, furnish its contractor its indigence policy describing the method by which indigence or medical indigence is determined and all the verifiable beneficiary specific documentation which supports the provider's determination of each beneficiary's indigence or medical indigence.

(B) Once indigence is determined the bad debt may be deemed uncollectible without applying a collection effort under paragraph (e)(2)(i)(A) or (B) of this section.

(iii) *Indigent dual-eligible beneficiaries (including qualified Medicare beneficiaries)*. Providers may deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid under a State's Title XIX Medicaid program as either categorically needy individuals or medically needy individuals. To be considered a reasonable collection effort for dual-eligible beneficiaries:

(A) When a State permits a Medicare provider's Medicaid enrollment for the

purposes of processing a beneficiary's claim, to determine the State's liability for the beneficiary's Medicare cost sharing, the provider—

(*1*) Must determine whether the State's Title XIX Medicaid Program (or a local welfare agency, if applicable) is responsible to pay all or a portion of the beneficiary's Medicare deductible or coinsurance amounts;

(*2*) Must submit a bill to its Medicaid/Title XIX agency (or to its local welfare agency) to determine the State's cost sharing obligation to pay all or a portion of the applicable Medicare deductible and coinsurance;

(*3*) Must submit the Medicaid remittance advice received from the State to its Medicare contractor;

(*4*) Must reduce allowable Medicare bad debt by any amount that the State is obligated to pay, either by statute or under the terms of its approved Medicaid State plan, regardless of whether the State actually pays its obligated amount to the provider; and

(*5*) May include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

(B) When, through no fault of the provider, a provider does not receive a Medicaid remittance advice because the State does not permit a Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, or because the State does not generate a Medicaid remittance advice, the provider—

(*1*) Must submit to its contractor, all of the following auditable and verifiable documentation:

(*i*) The State's Medicaid notification stating that the State has no legal obligation to pay the provider for the beneficiary's Medicare cost sharing.

(*ii*) A calculation of the amount the State owes the provider for Medicare cost sharing.

(*iii*) Verification of the beneficiary's eligibility for Medicaid for the date of service;

(*2*) Must reduce allowable Medicare bad debt by any amount the State is obligated to pay, regardless of whether the State actually pays its obligated amount to the provider; and

(*3*) May include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) *Reporting period for writing off bad debts and reporting of recoveries of bad debts reimbursed in prior periods.* For cost reporting periods beginning before, on, or after October 1, 2020, the deductible and coinsurance amounts uncollected from beneficiaries are to be written off and recognized as allowable bad debts in the cost reporting period in which the accounts are deemed to be worthless.

(1) Any payment on the account made by the beneficiary or a responsible party, after the write-off date but before the end of the cost reporting period, must be used to reduce the final bad debt for the account claimed in that cost report.

(2) In some cases an amount written off as a bad debt and reimbursed by the program in a prior cost reporting period may be recovered in a subsequent period.

(i) In situations described in this paragraph (f)(2), the recovered amount must be used to reduce the provider's reimbursable costs in the period in which the amount is recovered.

(ii) The amount of reduction in the period of recovery (as specified in paragraph (f)(2)(i) of this section) must not exceed the actual amount reimbursed by the program for the related bad debt in the applicable prior cost reporting period.

(g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs. These charity allowances include the costs of uncompensated services furnished under a Hill-Burton obligation. (Note: In accordance with section 106(b) of Pub. L. 97–248 (enacted September 3, 1982), this sentence is effective with respect to any costs incurred under Medicare except that it does not apply to costs

which have been allowed prior to September 3, 1982, pursuant to a final court order affirmed by a United States Court of Appeals.) The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

(h) *Limitations on bad debts*—(1) *Hospitals.* In determining reasonable costs for hospitals, the amount of allowable bad debt (as defined in paragraph (e) of this section) is reduced:

(i) For cost reporting periods beginning during fiscal year 1998, by 25 percent;

(ii) For cost reporting periods beginning during fiscal year 1999, by 40 percent;

(iii) For cost reporting periods beginning during fiscal year 2000, by 45 percent; and

(iv) For cost reporting periods beginning during fiscal years 2001 through 2012, by 30 percent.

(v) For cost reporting periods beginning during a subsequent fiscal year, by 35 percent.

(2) *Skilled nursing facilities and swing bed hospitals.* For the purposes of this paragraph (h)(2), a dual eligible individual is defined as an individual that is entitled to benefits under Part A of Medicare and is determined eligible by the State for medical assistance under Title XIX of the Act as described under paragraph (2) of the definition of a ''full-benefit dual eligible individual'' at § 423.772 of this chapter. In determining reasonable costs for a skilled nursing facility and for post-hospital SNF care furnished in a swing bed hospital, as defined in § 413.114(b), the amount of allowable bad debt (as defined in paragraph (e) of this section) is reduced:

(i) *For non-dual eligible individuals*—(A) For cost reporting periods beginning during fiscal years 2006 through 2012, by 30 percent, for a patient in a skilled nursing facility.

(B) For cost reporting periods beginning during a subsequent fiscal year, by 35 percent, for a patient in a skilled nursing facility or receiving post-hospital SNF care in a swing bed hospital.

(ii) *For dual eligible individuals*—(A) For cost reporting periods beginning during fiscal year 2013, by 12 percent, for a patient in a skilled nursing facility or a patient receiving post-hospital SNF care in a swing bed hospital.

(B) For cost reporting periods beginning during fiscal year 2014, by 24 percent, for a patient in a skilled nursing facility or a patient receiving post-hospital SNF care in a swing bed hospital.

(C) For cost reporting periods beginning during a subsequent fiscal year, by 35 percent, for a patient in a skilled nursing facility or a patient receiving post-hospital SNF care in a swing bed hospital.

(3) *End-stage renal dialysis facilities.* In determining reasonable costs for an end-stage renal dialysis facility, the amount of allowable bad debt (as defined in paragraph (e) of this section) is:

(i) For cost reporting periods beginning before October 1, 2012, reimbursed up to the facility's costs.

(ii) For cost reporting periods beginning on or after October 1, 2012 and before January 1, 2013, reduced by 12 percent with the resulting amount reimbursed up to the facility's costs.

(iii) For cost reporting periods beginning on or after January 1, 2013 and before October 1, 2013, reduced by 12 percent.

(iv) For cost reporting periods beginning during fiscal year 2014, reduced by 24 percent.

(v) For cost reporting periods beginning during a subsequent fiscal year, reduced by 35 percent.

(4) *All other providers.* In determining reasonable costs for all other providers, suppliers and other entities not described elsewhere in paragraph (h) of this section that are eligible to receive reimbursement for bad debts under this section, the amount of allowable bad debts (as defined in paragraph (e) of this section) is reduced:

(i) For cost reporting periods beginning during fiscal year 2013, by 12 percent.

(ii) For cost reporting periods beginning during fiscal year 2014, by 24 percent.

(iii) For cost reporting periods beginning during a subsequent fiscal year, by 35 percent.

(i) *Exceptions applicable to bad debt reimbursement.* (1) Bad debts arising from covered services paid under a reasonable charge-based methodology or a fee

schedule are not reimbursable under the program.

(2) For end-stage renal dialysis services furnished on or after January 1, 2011 and paid for under the end-stage renal dialysis prospective payment system described in §413.215, bad debts arising from covered items or services that, prior to January 1, 2011 were paid under a reasonable charge-based methodology or a fee schedule, including but not limited to drugs, laboratory tests, and supplies are not reimbursable under the program.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 33898, July 31, 1992; 60 FR 63189, Dec. 8, 1995; 63 FR 41005, July 31, 1998; 66 FR 32195, June 13, 2001. Redesignated at 69 FR 49254, Aug. 11, 2004, and amended at 71 FR 48142, Aug. 18, 2006; 71 FR 69785, Dec. 1, 2006; 75 FR 49198, Aug. 12, 2010; 77 FR 67350, Nov. 9, 2012; 85 FR 59023, Sept. 18, 2020]

§ 413.90 Research costs.

(a) *Principle.* Costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

(b) *Application.* (1) There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many Federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies, and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs. A further consideration is that quality review should be assured as a condition of governmental support for research. Provisions for such review would introduce special difficulties in the Medicare programs.

(2) If research is conducted in conjunction with, and as a part of, the care of patients, the costs of usual patient care and studies, analyses, surveys, and related activities to serve the provider's administrative and program needs are allowable costs in the determination of payment under Medicare.

[51 FR 34793, Sept. 30, 1986, as amended at 61 FR 63748, Dec. 2, 1996]

§ 413.92 Costs of surety bonds.

Costs incurred by a provider to obtain a surety bond required by part 489, subpart F of this chapter are not included as allowable costs.

[63 FR 310, Jan. 5, 1998]

§ 413.94 Value of services of nonpaid workers.

(a) *Principle.* The value of services in positions customarily held by full-time employees performed on a regular, scheduled basis by individuals as nonpaid members of organizations under arrangements between such organizations and a provider for the performance of such services without direct remuneration from the provider to such individuals is allowable as an operating expense for the determination of allowable cost subject to the limitation contained in paragraph (b) of this section. The amounts allowed are not to exceed those paid others for similar work. Such amounts must be identifiable in the records of the institutions as a legal obligation for operating expenses.

(b) *Limitations: Services of nonpaid workers.* The services must be performed on a regular, scheduled basis in positions customarily held by full-time employees and necessary to enable the provider to carry out the functions of normal patient care and operation of the institution. The value of services of a type for which providers generally do not remunerate individuals performing such services is not allowable as a reimbursable cost under the Medicare program. For example, donated services of individuals in distributing books and magazines to patients, or in serving in a provider canteen or cafeteria or in a provider gift shop, would not be reimbursable.

(c) *Application.* The following illustrates how a provider would determine an amount to be allowed under this principle: The prevailing salary for a lay nurse working in Hospital A is $5,000 for the year. The lay nurse receives no maintenance or special perquisites. A sister working as a nurse engaged in the same activities in the same hospital receives maintenance and special perquisites which cost the hospital $2,000 and are included in the