

(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.

(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) *Charging of bad debts and bad debt recoveries.* The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

(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.* In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced—

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

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

(3) For cost reporting periods beginning during a subsequent fiscal year, by 45 percent.

(i) *Exception.* Bad debts arising from services for anesthetists paid under a fee schedule 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]

§ 413.85 Cost of educational activities.

(a) *Payment—(1) General rule.* Except as provided in paragraph (a)(2) of this section, a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section. The net cost is subject to apportionment based on Medicare utilization as described in § 413.50.

(2) *Exception.* For cost reporting periods beginning on or after July 1, 1985, payment to hospitals and hospital-based providers for approved residency programs in medicine, osteopathy, dentistry, and podiatry is determined as provided in § 413.86.

(b) *Definition—Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed if required by State law. If licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these

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costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

(d) *Activities not within the scope of this principle.* The costs of the following activities are not within the scope of this principle but are recognized as normal operating costs and are reimbursed in accordance with applicable principles—

(1) Orientation and on-the-job training;

(2) Part-time education for bona fide employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work;

(3) Costs, including associated travel expense, or sending employees to educational seminars and workshops that increase the quality of medical care or operating efficiency of the provider;

(4) Maintenance of a medical library;

(5) Training of a patient or patient's family in the use of medical appliances;

(6) Clinical training of students not enrolled in an approved education program operated by the provider; and

(7) Other activities that do not involve the actual operation of an approved education program including the costs of interns and residents in anesthesiology who are employed to replace anesthesiologists.

(e) *Approved programs.* Recognized professional and paramedical educational training programs now being conducted by provider institutions, and their approving bodies, include the following:

- (1) Cyto-technology. Committee on Allied Health, Education, and Accreditation in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
- (2) Dietetic internships. The American Dietetic Association.

- (3) Hospital administration residencies. Accrediting Commission on Education in Health Services Administration.
- (4) Inhalation therapy. Committee on Allied Health, Education, and Accreditation in collaboration with the Board of Schools of Inhalation Therapy.
- (5) Medical records. Committee on Allied Health, Education, and Accreditation in collaboration with the Committee on Education and Registration of the American Association of Medical Records Librarians.
- (6) Medical technology. Committee on Allied Health, Education, and Accreditation in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
- (7) Nurse anesthetists. The American Association of Nurse Anesthetists.
- (8) Professional nursing. Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
- (9) Practical nursing. Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
- (10) Occupational Therapy. Committee on Allied Health, Education, and Accreditation in collaboration with the Council on Education of the American Occupational Therapy Association.
- (11) Pharmacy residencies. American Society of Hospital Pharmacists.
- (12) Physical therapy. Committee on Allied Health, Education, and Accreditation in collaboration with the American Physical Therapy Association.
- (13) X-ray technology. Committee on Allied Health, Education, and Accreditation in collaboration with the American College of Radiology.

(f) *Other educational programs.* There may also be other educational programs not included in the foregoing in which a provider institution is engaged. Appropriate consideration will be given by the intermediary and HCFA to the costs incurred for those activities that come within the purview of the principle when determining the allowable costs for apportionment under the Medicare program.

(g) *Calculating net cost.* Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24.

(h) *Medicare+Choice organizations.* (1) Effective January 1, 1999, Medicare+Choice organizations may receive direct graduate medical education payments for the time that residents spend in nonhospital provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs.

(2) Medicare+Choice organizations may receive direct graduate medical education payments if all of the following conditions are met:

(i) The resident spends his or her time in patient care activities.

(ii) The Medicare+Choice organization incurs "all or substantially all" of the costs for the training program in the nonhospital setting as defined in § 413.86(b).

(iii) There is a written agreement between the Medicare+Choice organization and the nonhospital site that indicates the Medicare+Choice organization will incur the costs of the resident's salary and fringe benefits and provide reasonable compensation to the nonhospital site for teaching activities.

(3) A Medicare+Choice organization's allowable direct graduate medical education costs, subject to the redistribution and community support principles in § 413.85(c), consist of—

(i) Residents' salaries and fringe benefits (including travel and lodging where applicable); and

(ii) Reasonable compensation to the nonhospital site for teaching activities related to the training of medical residents.

(4) The direct graduate medical education payment is equal to the product of—

(i) The lower of—

(A) The Medicare+Choice organization's allowable direct graduate medical education costs per resident as defined in paragraph (h)(3) of this section; or

(B) The national average per resident amount; and

(ii) Medicare's share, which is equal to the ratio of the number of Medicare beneficiaries enrolled to the total number of individuals enrolled in the Medicare+Choice organization.

(5) Direct graduate medical education payments made to Medicare+Choice organizations under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

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§ 413.86 Direct graduate medical education payments.

(a) *Statutory basis and scope—*(1) *Basis.* This section implements section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section applies to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions.* For purposes of this section, the following definitions apply:

Affiliated group means—

(1) Two or more hospitals located in the same urban or rural area (as those terms are defined in § 412.62(f) of this subchapter) or in contiguous areas if individual residents work at each of the hospitals during the course of the program; or

(2) If the hospitals are not located in the same or a contiguous urban or