

(1) *Step one.* Each calendar year, determine the hospital's total nursing and allied health education program payments from its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

(2) *Step two.* Determine the ratio of the hospital's payments from step one to the total of all nursing and allied health education program payments across all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.

(3) *Step three.* Multiply the ratio calculated in step two by the amount determined in accordance with paragraph (e) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

(e) *Calculation of the payment "pool."*

(1) Subject to paragraph (e)(3) of this section, each calendar year, HCFA will calculate a Medicare+Choice nursing and allied health payment "pool" according to the following steps:

(i) Determine the ratio of projected total Medicare+Choice direct GME payments made in accordance with the provisions of § 413.86(d)(3) across all hospitals in the current calendar year to projected total direct GME payments made across all hospitals in the current calendar year.

(ii) Multiply the ratio calculated in paragraph (e)(1)(i) of this section by projected total Medicare nursing and allied health education reasonable cost payments made across all hospitals in the current calendar year.

(2) The resulting product of the steps under paragraph (e)(1)(i) and (e)(1)(ii) of this section is the 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.

[65 FR 47051, Aug. 1, 2000]

§ 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 de-

velop 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 § 413.86(b) of this chapter; or

(2) Two or more hospitals that are operating approved medical residency training programs as defined in § 413.86(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

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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 HCFA 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 HCFA;

(7) For a qualifying entity that is a member of an affiliated group as defined in § 413.86(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 during each year of 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 fiscal intermediary, with a copy to HCFA.

(f) *Effective dates of plans.* Residency reduction plans that are submitted to the fiscal intermediary 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 § 413.86(g)) 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 § 413.86(g)) for any subsequent residency training year that ends before the date the entity submits its plan to the fiscal intermediary and HCFA.

(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 of the base number.

(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:

(i) *Step 1.* Determine the amount (if any) by which the payment amount that would have been made under § 413.86(d) 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 § 413.86(d) 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)(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.

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(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]

§ 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

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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