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patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

(c) *Application.* (1) It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.

(2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

(3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

[51 FR 34795, Sept. 30, 1986; 51 FR 37398, Oct. 22, 1986]

§413.13 Amount of payment if customary charges for services furnished are less than reasonable costs.

(a) *Definitions.* As used in this section—

Fair compensation means, for the purpose of providers that meet the nominal charge provisions in paragraph (f) of this section, the reasonable cost of covered services furnished to beneficiaries.

New provider means a provider that has operated as the type of facility for which it has been approved for participation in the Medicare program (for example, as a SNF or an HHA) under present and previous ownership for less than three full years.

Provider with a significant portion of low-income patients means a nonpublic provider whose charges are 60 percent or less of the reasonable cost represented by the charges, and that demonstrates, as required under paragraph (c)(1)(iii) of this section, that its charges are less than costs because its customary practice is to charge patients based on their ability to pay.

Public provider means a provider operated by a Federal, State, county, city, or other local government agency or instrumentality.

(b) *Application of the principle of lesser of costs or charges*—(1) *General rule.* Except as provided in paragraph (c) of this section, effective with cost reporting periods beginning on or after January 1, 1974, hospitals, SNFs, HHAs, OPTs, and CMHCs but only for purposes of providing partial hospitalization services, are paid the lesser of the reasonable cost (as described in paragraph (d) of this section) of covered services furnished to beneficiaries or the customary charges (as defined in paragraph (e) of this section) made by the provider for the same services. The carryover of unreimbursed reasonable costs from previous cost reporting periods is recognized, in accordance with the provisions of paragraph (h) of this section.

(2) *Example.* A provider's reasonable cost for covered services furnished to Medicare beneficiaries during a cost reporting period is \$125,000. The customary charges to those beneficiaries

for these services is \$110,000. The provider is to be reimbursed \$110,000 less deductible and coinsurance amounts that the beneficiaries are charged.

(c) *Providers and services not subject to the principle*—(1) *Providers*—(i) *CORFs*. Payment to CORFs is based on the reasonable cost of the services.

(ii) *Public providers*. Public providers furnishing services free of charge or at a nominal charge (as specified in paragraph (f) of this section) are paid fair compensation for services furnished to beneficiaries.

(iii) *Providers furnishing services to a significant portion of low-income patients*. Effective with cost reporting periods beginning on or after October 1, 1984, a provider furnishing services at a nominal charge (as specified in paragraph (f) of this section) is paid fair compensation, upon request, for services furnished to beneficiaries if the provider can demonstrate to its intermediary that a significant portion of its patients are low income and that its charges are less than costs because its customary practice is to charge patients based on their ability to pay.

(2) *Services*—(i) *Part A inpatient hospital services*. The lesser of costs or charges principle does not apply to Part A inpatient hospital services subject to—

(A) The rate-of-increase limits under §413.40, effective with cost reporting periods beginning on or after October 1, 1982; or

(B) The prospective payment system under Part 412 of this chapter, effective with cost reporting periods beginning on or after October 1, 1983.

(ii) *Special rule for facility services related to ambulatory surgical procedures performed in outpatient hospital departments*. Effective for hospitals with cost reporting periods beginning on or after October 1, 1987, reasonable costs and customary charges for those services relating to ambulatory surgical procedures that are subject to the payment methodology described in §413.118 are aggregated and treated separately from all other hospital costs and charges incurred during the cost reporting period.

(iii) *Durable medical equipment furnished by HHAs*—(A) *General*. Except as provided in paragraph (c)(2)(iii)(B) of

this section, for durable medical equipment furnished by an HHA as a home health service on or after July 18, 1984, the HHA is paid the lesser of the reasonable cost of the equipment or the customary charges (less a 20 percent coinsurance as provided in section 1866(a)(2)(A)(ii) of the Act), not to exceed 80 percent of the reasonable cost of the equipment. The lesser of cost or charges determination for durable medical equipment is made separately from all other items or services furnished in an HHA regardless of whether the equipment is furnished under Part A or Part B.

(B) *HHAs meeting the nominal charge provisions*. A public HHA, or an HHA that demonstrates that a significant portion of its patients are low-income patients under the nominal charge provisions, as provided in paragraph (f)(2) of this section, are paid 80 percent of fair compensation for durable medical equipment furnished as a home health service on or after July 18, 1984.

(iv) *Critical access hospital (CAH) services*. The lesser of costs or charges principle does not apply in determining payment for inpatient or outpatient services furnished by a CAH under §413.70.

(3) *Hospital outpatient radiology services*. The reasonable costs and customary charges for hospital outpatient radiology services furnished on or after October 1, 1988, that are subject to the payment method described in §413.122, are aggregated and treated separately from all other hospital costs and charges incurred during the cost reporting period.

(4) *Other diagnostic procedures performed by a hospital on an outpatient basis*. The reasonable costs and customary charges for other diagnostic procedures identified by HCFA, that are performed on an outpatient basis by a hospital on or after October 1, 1989, and that are subject to the payment method described in §413.122, are aggregated and treated separately from all other hospital costs or charges incurred during the cost reporting period.

(d) *Exclusions from reasonable cost*. For purposes of comparison with customary charges under this section, reasonable cost does not include—

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(1) Payments made to a provider as reimbursement for bad debts arising from noncollection of Medicare deductible and coinsurance amounts (§413.80);

(2) Amounts that represent the recovery of excess depreciation resulting from termination in the Medicare program or a decrease in Medicare utilization (§413.134(d)(3)) applicable to prior cost reporting periods;

(3) Amounts that result from a disposition of depreciable assets (§413.134(f)), applicable to prior cost reporting periods;

(4) Payments to funds for the donated services of teaching physicians (§413.85); and

(5) Graduate medical education costs for cost reporting periods beginning on or after July 1, 1985.

(e) *Customary charges*—(1) *General*. As used in this paragraph (e), customary charges means the charges for services, as defined in §413.53(b), furnished to beneficiaries. These charges must be recorded on all bills submitted for program reimbursement.

(2) *Special situations in which customary charges are reduced*. Customary charges are reduced in proportion to the ratio of the aggregate amount actually collected from charge-paying non-Medicare patients to the amount that would have been realized had customary charges been paid and the provider—

(i) Did not actually impose charges in the case of most patients liable for payment for its services on a charge basis; or

(ii) Failed to make a reasonable effort to collect those charges.

(f) *Nominal charges*—(1) *Cost reporting periods beginning before October 1, 1984*. Except for durable medical equipment furnished by HHAs as provided in paragraph (c)(2)(iii) of this section, if a public provider's total charges, for cost reporting periods beginning before October 1, 1984, are less than one-half of the reasonable cost of services or items represented by these charges, then the provider is reimbursed fair compensation.

(2) *Cost reporting periods beginning on or after October 1, 1984*. For cost reporting periods beginning on or after October 1, 1984, the following provisions apply in determining nominal charges:

(i) *Reimbursement of fair compensation*. Except for the limitations on reimbursement for durable medical equipment furnished by HHAs as provided in paragraph (c)(2)(iii) of this section, public providers, and providers with a significant portion of low-income patients that request payment under this paragraph are reimbursed fair compensation if total charges are 60 percent or less of the reasonable cost of services or items represented by these charges.

(ii) *Separate determination of nominal charges*. Except as provided in paragraph (f)(2)(iii) of this section, the determination of nominal charges, which is based on charges actually billed to charge-paying, non-Medicare patients, is made separately with respect to inpatient and outpatient services (other than clinical diagnostic laboratory tests that are paid under section 1833(h) of the Act).

(iii) *Determination of nominal charges in special situations*. (A) For providers that have a sliding scale or discounted schedule of charges based on patients' ability to pay, the determination of nominal charges is based on charges billed to all charge-paying patients. This determination is made using the ratio of sliding scale or discounted charges to the provider's full customary charges. For determining nominal charges, the ratio is applied to the provider's Medicare charges to equate those charges to customary charges.

(B) For HHAs, the determination of nominal charges for all items and services other than durable medical equipment is made on an aggregate basis. The nominal charge determination for durable medical equipment is made separately from other items or services furnished by HHAs.

(C) For cost reporting periods beginning on or after July 1, 1985, graduate medical education payments (or a provider's graduate medical education reasonable costs if supported by appropriate data) are included in reasonable costs when making the nominal charge determination.

(g) *The aggregation method*—(1) *Cost reporting periods beginning before October 1, 1984—Application*. In comparing costs and charges under the lesser of costs or

charges principle for cost reporting periods beginning before October 1, 1984, the reasonable cost for items and services and the customary charges for those same items and services are to be aggregated (that is, totalled and compared) without regard to whether the services are reimbursable under Part A or Part B of Medicare. This aggregation method is to be applied after the provider's charges and costs have been adjusted to exclude the amounts described in paragraph (d) of this section and to exclude—

(i) Any amounts attributable to physician services not reimbursable to the provider on a reasonable cost basis as described in §§ 415.55 through 415.70 of this chapter; and

(ii) All costs and charges for non-covered provider services.

(2) *Cost reporting periods beginning on or after October 1, 1984.* Effective with cost reporting periods beginning on or after October 1, 1984, the aggregation method used for computing the lesser of costs or charges, as set forth in paragraph (g)(1) of this section, may not be used. For covered items and services furnished during these periods, total reasonable cost of covered items and services is compared with total customary charges for those items and services, separately for Part A and for Part B.

(h) *Accumulation of unreimbursed costs and carryover to subsequent periods—(1) General rule.* A provider whose charges are lower than its reasonable cost for those services in any cost reporting period beginning on or after January 1, 1974 but before April 28, 1988, may carry forward costs that are unreimbursed under paragraph (b) of this section for the two succeeding cost reporting periods. However, no recovery may be made in any period in which costs are unreimbursed because a provider's costs exceed the limitations on reimbursable costs (§ 413.30) or the ceiling on the rate of hospital cost increases (§ 413.40).

(2) *Reimbursement as a result of carryover.* The provider is reimbursed for the costs that are carried forward to a succeeding cost reporting period—

(i) If total charges for services provided in that subsequent period exceed

the total reasonable cost of the services; and

(ii) To the extent that accumulation of the costs being carried forward and the costs for the services provided in that subsequent period do not exceed the customary charges for those services.

(3) *Two succeeding periods less than 24 months.* If the two succeeding cost reporting periods are less than 24 full calendar months, the provider may carry forward the unreimbursed costs for one additional cost reporting period.

(4) *Example.* In the cost reporting period ending September 30, 1982, a provider's reasonable costs were \$100,000. The provider's customary charges for those services were \$90,000. The provider is reimbursed \$90,000 less any deductible and coinsurance amounts but is permitted to carry forward the unreimbursed reasonable costs of \$10,000 for the next two succeeding cost reporting periods. If, in the cost reporting period ending September 30, 1983, customary charges to beneficiaries exceeded the reasonable costs for those services by \$10,000 or more, and the provider had no costs unreimbursed under § 413.30 or § 413.40, the provider would recover the entire \$10,000 previously not reimbursed. If, however, beneficiary charges for that cost reporting period exceeded costs by only \$8,000, this amount (\$8,000) would be added to the provider's reimbursable costs for this period. The balance of the unreimbursed amount (\$2,000) would be carried forward to the next cost reporting period.

(5) *New providers.* (i) *General rule.* A new provider whose cost reporting period begins before April 28, 1988, may carry forward costs that are unreimbursed from previous periods, as described in paragraph (b) of this section, during a provider's base period. The base period includes any cost reporting period beginning on or after January 1, 1974, and ending on or before the last day of its third year of operation. The unreimbursed costs may be carried forward for the five succeeding cost reporting periods. However, no recovery may be made in any period in which costs are unreimbursed because a provider's costs exceed the limitations on

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reimbursable costs (§413.30) or the ceiling on the rate of hospital cost increases (§413.40).

(ii) *Reimbursement as a result of carry-over.* The new provider is reimbursed for the costs that are carried forward to a succeeding cost reporting period—

(A) If total charges for the services provided in that subsequent period exceed the total reasonable cost of the services; and

(B) To the extent that accumulation of the costs being carried forward and the costs for the services provided in that subsequent period do not exceed the customary charges for those services.

(iii) *Five succeeding periods less than 60 months.* If the five succeeding cost reporting periods are less than 60 full calendar months, the provider may carry forward the unreimbursed costs for one additional cost reporting period.

(iv) *Example.* A provider begins its operations on March 5, 1972. However, it begins to participate in the Medicare program as of January 1, 1973, and reports on a calendar year basis. Because the provider would be subject to the lesser of cost or charges principle for its cost reporting period beginning with January 1, 1974, it would be permitted to accumulate any unreimbursed costs (excess of costs over its charges) incurred during this reporting period. Therefore, because this cost reporting period ends before the end of the third year of operation, its carry-over period would be the succeeding five cost reporting periods ending with December 31, 1979. If this provider had begun its operation on July 1, 1973, and become a participating provider as of the same date (with a fiscal year ending June 30), it would have been able to accumulate any unreimbursed costs for the two cost reporting periods ending June 30, 1975, and June 30, 1976. Its carry-over period would then be the five cost reporting periods ending no later than June 30, 1981, in the case of costs unreimbursed in either of the reporting

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periods ending June 30, 1975, or June 30, 1976.

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§413.17 Cost to related organizations.

(a) *Principle.* Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

(b) *Definitions.* (1) *Related to the provider.* Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) *Common ownership.* Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

(3) *Control.* Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(c) *Application.* (1) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence, and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance, and other ways.

(2) If the provider obtains items of services, facilities, or supplies from an