

§ 413.56

42 CFR Ch. IV (10-1-00 Edition)

(ii) The following illustrates how apportionment based on an average cost per diem for general routine services is determined.

HOSPITAL E

Facts	Private accommodations	Semi-private accommodations	Total
Total charges	\$20,000	\$175,000	\$195,000
Total days	100	1,000	1,100
Programs days	70	400	470
Medically necessary for program beneficiaries	20		20
Total general routine service costs			165,000
Average private room per diem charge (\$20,000 private room charges ÷ 100 days)			¹ \$200
Average semi-private room per diem charge (\$175,000 semi-private charge ÷ 1,000 days)			¹ \$175

¹ Per diem.
Average per diem private room cost differential.
 1. Average per diem private room charge differential (\$200 private room per diem—\$175, semi-private room per diem), \$25.
 2. Inpatient general routine cost/charge ratio (\$165,000 total costs ÷ \$195,000 total charges), 0.8461538.
 3. Average per diem private room cost differential (\$25 charge differential × .8461538 cost/charge ratio), \$21.15.
Average cost per diem for inpatient general routine services.
 4. Total private room cost differential (\$21.15 average per diem cost differential × 100 private room days), \$2,115.
 5. Total inpatient general routine service costs net of private room cost differential (\$165,000 total routine cost — \$2,115 private room cost differential), \$162,885.
 6. Average cost per diem for inpatient general routine services (\$162,885 routine cost net of private room cost differential ÷ 1,100 patient days), \$148.08.
Medicare general routine service cost.
 7. Total routine per diem cost applicable to Medicare (\$148.08 average cost per diem × 470 Medicare private and semi-private patient days), \$69,598.
 8. Total private room cost differential applicable to Medicare (\$21.15 average per diem private room cost differential × 20 medically necessary private room days), \$423.
 9. Medicare inpatient general routine service cost (\$423 Medicare private room cost differential + \$69,598 Medicare cost of general routine inpatient services), \$70,021.

(2) *Carve out method.* The following illustrates how apportionment is determined in a hospital reimbursed under the carve out method (subject to the private room differential provisions of paragraph (a)(1)(ii) of this section):

HOSPITAL K

[Determination of cost of routine SNF-type and ICF-type services and general routine hospital services¹]

Facts	Days of care		
	General routine hospital	SNF-type	ICF-type
Total days of care	2,000	400	100
Medicare days of care ...	600	300	
Average Medicaid rate ..	N/A	\$35	\$20
Total inpatient general routine service costs: \$250,000			

Calculation of cost of routine SNF-type services applicable to Medicare:
 $\$35 \times 300 = \$10,500$
 Calculation of cost of general routine hospital services:
 Cost of SNF-type services: $\$35 \times 400 = \$14,000$
 Cost of ICF-type services: $\$20 \times 100 = 2,000$
 Total \$16,000
 Average cost per diem of general routine hospital services:
 $\$250,000 \div \$16,000 \div 2,000 \text{ days} = \117
 Medicare general routine hospital cost:
 $\$117 \times 600 = \$70,200$
 Total Medicare reasonable cost for general routine inpatient days:
 $\$10,500 + \$70,200 = \$80,700$

[51 FR 34793, Sept. 30, 1986, as amended at 59 FR 45401, Sept. 1, 1994; 61 FR 51616, Oct. 3, 1996; 61 FR 58631, Nov. 18, 1996]

§ 413.56 [Reserved]

Subpart E—Payments to Providers

§ 413.60 Payments to providers: General.

(a) The fiscal intermediaries will establish a basis for interim payments to each provider. This may be done by one of several methods. If an intermediary is already paying the provider on a cost basis, the intermediary may adjust its rate of payment to an estimate of the result under the Medicare principles of reimbursement. If no organization is paying the provider on a cost basis, the intermediary may obtain the previous year's financial statement from the provider and, by applying the principles of reimbursement, compute or approximate an appropriate rate of payment. The interim payment may be related to the last year's average per diem, or to charges, or to any other ready basis of approximating costs.

(b) At the end of the period, the actual apportionment, based on the cost finding and apportionment methods selected by the provider, determines the

Medicare reimbursement for the actual services provided to beneficiaries during the period.

(c) Basically, therefore, interim payments to providers will be made for services throughout the year, with final settlement on a retroactive basis at the end of the accounting period. Interim payments will be made as often as possible and in no event less frequently than once a month. The retroactive payments will take fully into account the costs that were actually incurred and settle on an actual, rather than on an estimated basis.

§ 413.64 Payments to providers: Specific rules.

(a) *Reimbursement on a reasonable cost basis.* Providers of services paid on the basis of the reasonable cost of services furnished to beneficiaries will receive interim payments approximating the actual costs of the provider. These payments will be made on the most expeditious schedule administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of a reporting period.

(b) *Amount and frequency of payment.* Medicare states that providers of services will be paid the reasonable cost of services furnished to beneficiaries. Since actual costs of services cannot be determined until the end of the accounting period, the providers must be paid on an estimated cost basis during the year. While Medicare provides that interim payments will be made no less often than monthly, intermediaries are expected to make payments on the most expeditious basis administratively feasible. Whatever estimated cost basis is used for determining interim payments during the year, the intent is that the interim payments shall approximate actual costs as nearly as is practicable so that the retroactive adjustment based on actual costs will be as small as possible.

(c) *Interim payments during initial reporting period.* At the beginning of the program or when a provider first participates in the program, it will be necessary to establish interim rates of payment to providers of services. Once a provider has filed a cost report under the Medicare program, the cost report

may be used as a basis for determining the interim rate of reimbursement for the following period. However, since initially there is no previous history of cost under the program, the interim rate of payment must be determined by other methods, including the following:

(1) If the intermediary is already paying the provider on a cost or cost-related basis, the intermediary will adjust its rate of payment to the program's principles of reimbursement. This rate may be either an amount per inpatient day, or a percent of the provider's charges for services furnished to the program's beneficiaries.

(2) If an organization other than the intermediary is paying the provider for services on a cost or cost-related basis, the intermediary may obtain from that organization or from the provider itself the rate of payment being used and other cost information as may be needed to adjust that rate of payment to give recognition to the program's principles of reimbursement.

(3) If no organization is paying the provider on a cost or cost-related basis, the intermediary will obtain the previous year's financial statement from the provider. By analysis of such statement in light of the principles of reimbursement, the intermediary will compute an appropriate rate of payment.

(4) After the initial interim rate has been set, the provider may at any time request, and be allowed, an appropriate increase in the computed rate, upon presentation of satisfactory evidence to the intermediary that costs have increased. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(d) *Interim payments for new providers.*

(1) Newly-established providers will not have cost experience on which to base a determination of an interim rate of payment. In such cases, the intermediary will use the following methods to determine an appropriate rate:

(i) If there is a provider or providers comparable in substantially all relevant factors to the provider for which the rate is needed, the intermediary will base an interim rate of payment on the costs of the comparable provider.