

### §413.13

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]

### 42 CFR Ch. IV (10-1-02 Edition)

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

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

*Customary charges* means the regular rates that providers charge both beneficiaries and other paying patients for the services furnished to them.

*Fair compensation* means the reasonable cost of covered services.

*Nominal charge* means a charge equal to 60 percent or less of the reasonable cost of a service.

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

*Reasonable cost* means cost actually incurred, to the extent that cost is necessary for the efficient delivery of the service, and subject to the exclusions specified in paragraph (d) of this section.

(b) *Application of the lesser of costs or charges (LCC) principle.*—(1) *General rule.* Except as provided in paragraph (c) of this section, CMS pays providers the lesser of the reasonable cost or the customary charges for services furnished to Medicare beneficiaries. Reasonable cost and customary charges are compared separately for Part A services and Part B services.

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

(ii) The provider's customary charges for those services is \$110,000.

(iii) CMS pays the provider \$110,000 less the deductible and coinsurance amounts for which the beneficiaries are responsible.

(c) *Exceptions to the LCC principle.* (1) *Providers not subject to the LCC principle.*

CMS pays the following providers the fair compensation for the services they furnish:

(i) CORFs.

(ii) Public providers that furnish services free of charge or at a nominal charge.

(iii) Any provider that requests payment of fair compensation and 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 on the basis of their ability to pay.

(2) *Services not subject to the LCC principle.* The following services are not subject to the LCC principle:

(i) *Part A inpatient hospital services.* Inpatient hospital services are not subject to the LCC principle if they are subject to either of the following:

(A) The prospective payment system under part 412 of this chapter.

(B) The rate of increase limits set forth in § 413.40.

(ii) *Facility services related to ambulatory surgical procedures performed in outpatient hospital departments.* Facility services related to ambulatory surgical procedures performed in hospital outpatient departments are subject to the payment methodology set forth in § 413.118.

(iii) *Services furnished by a critical access hospital (CAH).* Inpatient and outpatient services furnished by a CAH are subject to the payment methodology set forth in § 413.70.

(iv) *Hospital outpatient radiology services.* Hospital outpatient radiology services are subject to the payment methodology set forth in § 413.122.

(v) *Other diagnostic procedures performed by a hospital on an outpatient basis.* Other outpatient diagnostic procedures are subject to the payment methodology set forth in § 413.122.

(vi) *Skilled nursing facility services.* Skilled nursing facility services subject to the payment methodology set forth in §§ 413.330 *et seq.*

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

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

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

(3) Amounts that result from disposition of depreciable assets, applicable to

prior cost reporting periods, as provided in § 413.134.

(4) Payments to funds for the donated services of teaching physicians, as provided in § 413.85.

(5) Except as provided in paragraph (f)(2)(iii) of this section for making nominal charge determinations in special situations, graduate medical education costs.

(e) *Reductions in customary charges.* 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, if the provider—

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

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

(f) *Nominal charge determinations.* In determining whether a provider's customary charges equal 60 percent or less of its reasonable costs, the following rules apply:

(1) *General rule.* The determination is based on charges actually billed to charge-paying, non-Medicare patients, and (except for clinical diagnostic laboratory tests that are paid under section 1833(h) of the Act) is made separately for Part A services and Part B services.

(2) *Determination in special situations.*

(i) *Charges based on ability to pay.* For providers that have a sliding scale or discounted charges based on patients' ability to pay, the determination—

(A) Is based on charges billed to all charge-paying patients;

(B) Uses the ratio of the sliding scale charges to the provider's full customary charges; and

(C) Applies the ratio to the discounted charges to equate those charges to customary charges.

(ii) *HHA services.* In determining nominal charges for HHAs, all Part A and Part B services, with the exception of DME, are considered together.

(iii) *Graduate medical education.* When making the nominal charge determination, graduate medical education payments (or the provider's reasonable costs for that education, if supported

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by appropriate data) are included in reasonable costs.

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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 organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost

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should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.

(d) *Exception.* (1) An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the fiscal intermediary (or, if the provider has not nominated a fiscal intermediary, CMS), that—

(i) The supplying organization is a bona fide separate organization;

(ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;

(iii) The services, facilities, or supplies are those that commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and

(iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(2) In such cases, the charge by the supplier to the provider for such services, facilities, or supplies is allowable as cost.

## Subpart B—Accounting Records and Reports

### § 413.20 Financial data and reports.

(a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and