

§ 413.50

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Subpart D—Apportionment

§ 413.50 Apportionment of allowable costs.

(a) Consistent with prevailing practice in which third-party organizations pay for health care on a cost basis, reimbursement under the Medicare program involves a determination of—

(1) Each provider's allowable costs for producing services; and

(2) The share of these costs which is to be borne by Medicare. The provider's costs are to be determined in accordance with the principles reviewed in the preceding discussion relating to allowable costs. The share to be borne by Medicare is to be determined in accordance with principles relating to apportionment of cost.

(b) In the study and consideration devoted to the method of apportioning costs, the objective has been to adopt methods for use under Medicare that would, to the extent reasonably possible, result in the program's share of a provider's total allowable costs being the same as the program's share of the provider's total services. This result is essential for carrying out the statutory directive that the program's payments to providers should be such that the costs of covered services for beneficiaries would not be passed on to nonbeneficiaries, nor would the cost of services for nonbeneficiaries be borne by the program.

(c) A basic factor bearing upon apportionment of costs is that Medicare beneficiaries are not a cross section of the total population. Nor will they constitute a cross section of all patients receiving services from most of the providers that participate in the program. Available evidence shows that the use of services by persons age 65 and over differs significantly from

other groups. Consequently, the objective sought in the determination of the Medicare share of a provider's total costs means that the methods used for apportionment must take into account the differences in the amount of services received by patients who are beneficiaries and other patients serviced by the provider.

(d) The method of cost reimbursement most widely used at the present time by third-party purchasers of inpatient hospital care apportions a provider's total costs among groups served on the basis of the relative number of days of care used. This method, commonly referred to as average-per-diem cost, does not take into account, variations in the amount of service which a day of care may represent and thereby assumes that the patients for whom payment is made on this basis are average in their use of service.

(e) In considering the average-per-diem method of apportioning cost for use under the program, the difficulty encountered is that the preponderance of presently available evidence strongly indicates that the over-age 65 patient is not typical from the standpoint of average-per-diem cost. On the average this patient stays in the hospital twice as long and therefore the ancillary services that he uses are averaged over the longer period of time, resulting in an average-per-diem cost for the aged alone, significantly below the average-per-diem for all patients.

(f) Moreover, the relative use of services by aged patients as compared to other patients differs significantly among institutions. Consequently, considerations of equity among institutions are involved as well as that of effectiveness of the apportionment method under the program in accomplishing the objective of paying each provider fully, but only for services to beneficiaries.

(g) A further consideration of long-range importance is that the relative use of services by aged and other patients can be expected to change, possibly to a significant extent in future years. The ability of apportionment methods used under the program to reflect such change is an element of flexibility which has been regarded as

important in the formulation of the cost reimbursement principles.

(h) An alternative to the relative number of days of care as a basis for apportioning costs is the relative amount of charges billed by the provider for services to patients. The amount of charges is the basis upon which the cost of hospital care is distributed among patients who pay directly for the services they receive. Payment for services on the basis of charges applies generally under insurance programs in which individuals are indemnified for incurred expenses, a form of health insurance widely held throughout the United States. Also, charges to patients are commonly a factor in determining the amount of payment to hospitals under insurance programs providing service benefits, many of which pay “costs or charges, whichever is less” and some of which pay exclusively on the basis of charges. In all of these instances, the provider’s own charge structure and method of itemizing services for the purpose of assessing charges is utilized as a measure of the amount of services received and as the basis for allocating responsibility for payment among those receiving the provider’s services.

(i) An increasing number of third-party purchasers who pay for services on the basis of cost are developing methods that utilize charges to measure the amount of services for which they have responsibility for payment. In this approach, the amount of charges for such services as a proportion of the provider’s total charges to all patients is used to determine the proportion of the provider’s total costs for which the third-party purchaser assumes responsibility. The approach is subject to numerous variations. It can be applied to the total of charges for all services combined or it can be applied to components of the provider’s activities for which the amount of costs and charges are ascertained through a breakdown of data from the provider’s accounting records.

(j) For the application of the approach to components, which represent types of services, the breakdown of total costs is accomplished by “cost-finding” techniques under which indirect costs and nonrevenue activities

are allocated to revenue producing components for which charges are made as services are furnished.

§ 413.53 Determination of cost of services to beneficiaries.

(a) *Principle.* Total allowable costs of a provider will be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. The methods of apportionment are defined as follows:

(1) *Departmental method—(i) Methodology.* Except as provided in paragraph (a)(1)(ii) of this section with respect to the treatment of the private room cost differential for cost reporting periods starting on or after October 1, 1982, the ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department; to this is added the cost of routine services for program beneficiaries, determined on the basis of a separate average cost per diem for general routine patient care areas as defined in paragraph (b) of this section, taking into account, in hospitals, a separate average cost per diem for each intensive care unit, coronary care unit, and other intensive care type inpatient hospital units.

(ii) *Exception: Indirect cost of private rooms.* For cost reporting periods starting on or after October 1, 1982, except with respect to a hospital receiving payment under part 412 of this chapter (relating to the prospective payment system), the additional cost of furnishing services in private room accommodations is apportioned to Medicare only if these accommodations are furnished to program beneficiaries, and are medically necessary. To determine routine service cost applicable to beneficiaries—

(A) Multiply the average cost per diem (as defined in paragraph (b) of this section) by the total number of Medicare patient days (including private room days whether or not medically necessary);

(B) Add the product of the average per diem private room cost differential