

HMO's or CMP's geographic area and that is not related to the HMO or CMP by common ownership or control, payment of the provider's charges to the HMO or CMP (rather than the payment amounts determined under part 412 or part 413 of this chapter) may be justified in exchange for the advantages of not having to incur the administrative costs of determining the provider's reasonable cost and of making a more timely final settlement with the HMO or CMP. However, repayment of the provider's charges would be acceptable only if—

(1) The provider furnishes services to the HMO's or CMP's enrollees infrequently;

(2) The charges represent an insignificant portion of total Medicare reimbursement to the HMO or CMP; and

(3) The charges do not exceed the customary charges by the provider to its other patients for similar services.

[50 FR 1346, Jan. 10, 1985, as amended at 51 FR 34832, Sept. 30, 1986; 58 FR 38080, July 15, 1993; 60 FR 46230, Sept. 6, 1995]

§ 417.550 Special Medicare program requirements.

(a) *Principle.* CMS pays the full reasonable cost incurred by an HMO or CMP for activities that are solely for Medicare purposes and unique to Medicare contracts under section 1876 of the Act.

(b) *Application.* CMS pays the full reasonable cost of the following activities:

(1) Reporting increases and decreases in the number of Medicare enrollees.

(2) Obtaining independent certification of the HMO's or CMP's cost report to the extent that it is for Medicare purposes.

(3) Reporting special data that CMS requires solely for program planning and evaluation.

(c) *Prior approval requirement.* The costs specified in paragraph (b) of this section must be separately budgeted and approved by CMS before the contract period begins.

(d) *Limit on full payment.* Full payment is limited to the costs specified in paragraph (b) of this section. All other administrative costs must be apportioned in accordance with § 417.552.

[60 FR 46230, Sept. 6, 1995]

§ 417.552 Cost apportionment: General provisions.

(a) *Basic rule.* The HMO or CMP must apportion its total allowable direct and indirect costs among its Medicare enrollees, its other enrollees, and its non-enrolled patients—

(1) In accordance with this subpart; and

(2) Using methods approved by CMS.

(b) *Purpose of apportionment.* The purpose of apportionment is to ensure that—

(1) The cost of services furnished to Medicare enrollees is not borne by other enrollees and nonenrolled patients; and

(2) The cost of the services furnished to other enrollees and nonenrolled patients is not borne by Medicare.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 46230, Sept. 6, 1995]

§ 417.554 Apportionment: Provider services furnished directly by the HMO or CMP.

The Medicare share of the cost of covered services furnished to Medicare enrollees by providers that are owned or operated by the HMO or CMP or are related to the HMO or CMP by common ownership or control must be determined in accordance with the apportionment methods set forth in part 412, §§ 413.24, 413.55, and 415.55 of this chapter.

[51 FR 28574, Aug. 8, 1986, as amended at 51 FR 34832, Sept. 30, 1986; 58 FR 38082, July 15, 1993; 60 FR 46231, Sept. 6, 1995; 60 FR 63189, Dec. 8, 1995]

§ 417.556 Apportionment: Provider services furnished by the HMO or CMP through arrangements with others.

The Medicare share of the cost of covered services furnished to Medicare enrollees through arrangements with providers other than those specified in § 417.554 must be determined as follows:

(a) The Medicare share must be based on the cost the HMO or CMP pays the provider under their arrangement, to the extent that cost is reasonable and within the limits established by §§ 417.534 through 417.548.

(b) Except as specified in paragraph (c) of this section, apportionment must