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(vii) For cost reporting periods beginning on or after January 1, 2002, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals) that meet the conditions of §412.604 of this chapter is based on prospectively determined rates under subpart P of part 412 of this subchapter.

(viii) For cost reporting periods beginning before October 1, 2002, payment to long-term care hospitals that are excluded under subpart B of Part 412 of this subchapter from the prospective payment systems is on a reasonable cost basis, subject to the provisions of §413.40.

(ix) For cost reporting periods beginning on or after October 1, 2002, payment to the long-term hospitals that meet the condition for payment of §§412.505 through 412.511 of this subchapter is based on prospectively determined rates under subpart O of Part 412 of this subchapter.

(e) *State reimbursement control systems.* Beginning October 1, 1983, Medicare reimbursement for inpatient hospital services may be made in accordance with a State reimbursement control system rather than under the Medicare reimbursement principles set forth in this part, if the State system is approved by CMS. Regulations implementing this alternative reimbursement authority are set forth in subpart C of part 403 of this chapter.

(f) *Services of qualified nonphysician anesthetists.* For cost reporting periods, or any part of a cost reporting period, beginning on or after January 1, 1989, costs incurred for the services of qualified nonphysician anesthetists are not paid on a reasonable cost basis unless the provisions of §412.113(c)(2) of this chapter apply. These services are paid under the special rules set forth in §405.553 of this chapter.

(g) *Payment for services furnished in SNFs.* (1) Except as specified in paragraph (g)(2)(ii) of this section, the amount paid for services furnished in cost reporting periods beginning before July 1, 1998, is determined on a reasonable cost basis or, where applicable, in accordance with the prospectively determined payment rates for low-volume SNFs established under section

1888(d) of the Act, as set forth in subpart I of this part.

(2) The amount paid for services (other than those described in §411.15(p)(2) of this chapter)—

(i) That are furnished in cost reporting periods beginning on or after July 1, 1998, to a resident who is in a covered Part A stay, is determined in accordance with the prospectively determined payment rates for SNFs established under section 1888(e) of the Act, as set forth in subpart J of this part.

(ii) That are furnished on or after July 1, 1998, to a resident who is not in a covered Part A stay, is determined in accordance with any applicable Part B fee schedule or, for a particular item or service to which no fee schedule applies, by using the existing payment methodology utilized under Part B for such item or service.

(h) *Payment for services furnished by HHAs.* The amount paid for home health services as defined in section 1861(m) of the Act (except durable medical equipment and the covered osteoporosis drug as provided for in that section) that are furnished beginning on or after October 1, 2000 to an eligible beneficiary under a home health plan of care is determined according to the prospectively determined payment rates for HHAs set forth in part 484, subpart E of this chapter.

[51 FR 34793, Sept. 30, 1986, as amended at 57 FR 33898, July 31, 1992; 57 FR 39829, Sept. 1, 1992; 58 FR 30670, May 26, 1993; 59 FR 6578, Feb. 11, 1994; 60 FR 33136, June 27, 1995; 60 FR 37594, July 21, 1995; 60 FR 50441, Sept. 29, 1995; 62 FR 31, Jan. 2, 1997; 62 FR 46032, 46037, Aug. 29, 1997; 63 FR 26309, May 12, 1998; 65 FR 18537, Apr. 7, 2000; 65 FR 40535, June 30, 2000; 65 FR 41211, July 3, 2000; 65 FR 46796, July 31, 2000; 66 FR 41394, Aug. 7, 2001; 67 FR 44077, July 1, 2002; 67 FR 56055, Aug. 30, 2002; 69 FR 66981, Nov. 15, 2004]

§413.5 Cost reimbursement: General.

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share

of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution. However, payments to providers of services for services furnished Medicare beneficiaries are subject to the provisions of §§413.13 and 413.30.

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the provider that takes account of the actual use of services by the beneficiaries of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of development of recordkeeping.

(5) That the principles should result in the equitable treatment of both non-profit organizations and profit-making organizations.

(6) That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

(c) As formulated herein, the principles given recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital (in the case of certain proprietary providers). With respect to allowable costs some items of inclusion and exclusion are:

(1) An appropriate part of the net cost of approved educational activities will be included.

(2) Costs incurred for research purposes, over and above usual patient care, will not be included.

(3) [Reserved]

(4) The value of services provided by nonpaid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish such services, is includable in the amount that would be paid others for similar work.

(5) Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

(6) Bad debts growing out of the failure of a beneficiary to pay the deductible, or the coinsurance, will be reimbursed (after bona fide efforts at collection).

(7) Charity and courtesy allowances are not includable, although "fringe benefit" allowances for employees under a formal plan will be includable as part of their compensation.

(8) A reasonable allowance of compensation for the services of owners in profitmaking organizations will be allowed providing their services are actually performed in a necessary function.

(9) Reasonable cost of physicians' direct medical and surgical services (including supervision of interns and residents in the care of individual patients) furnished in a teaching hospital may be reimbursed as a provider cost (as described in §415.162 of this chapter) if elected as provided for in §415.160 of this chapter.

(d) In developing these principles of reimbursement for the Medicare program, all of the considerations inherent in allowances for depreciation were studied. The principles, as presented, provide options to meet varied situations. Depreciation will essentially be

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on an historical cost basis but since many institutions do not have adequate records of old assets, the principles provide an optional allowance in lieu of such depreciation for assets acquired before 1966. For assets acquired after 1965, the historical cost basis must be used. All assets actually in use for production of services for Medicare beneficiaries will be recognized even though they may have been fully or partially depreciated for other purposes. Assets financed with public funds may be depreciated. Although funding of depreciation is not required, there is an incentive for it since income from funded depreciation is not considered as an offset which must be taken to reduce the interest expense that is allowable as a program cost.

(e) A return on the equity capital of proprietary facilities, as described in §413.157, is an allowance in addition to the reasonable cost of covered services furnished to beneficiaries.

(f) Renal dialysis items and services furnished under the ESRD provision are reimbursed and reported under §§413.170 and 413.174 respectively. For special rules concerning health maintenance organizations (HMOs), and providers of services and other health care facilities that are owned or operated by an HMO, or related to an HMO by common ownership or control, see §§417.242(b)(14) and 417.250(c) of this chapter.

[51 FR 34793, Sept. 30, 1986; 51 FR 37398, Oct. 22, 1986, as amended at 52 FR 21225, June 4, 1987; 52 FR 23398, June 19, 1987; 57 FR 39829, Sept. 1, 1992; 60 FR 63189, Dec. 8, 1995; 61 FR 63748, Dec. 2, 1996]

§413.9 Cost related to patient care.

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under Medicare and furnished to program beneficiaries or

the customary charges to the general public for such services, as provided for in §413.13.

(b) *Definitions—*(1) *Reasonable cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.

(2) *Necessary and proper costs.* Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of 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.