

other enrollees, and nonenrolled patients, which are typical “provider” costs, and costs (such as marketing, enrollment, membership, and operation of the HMO or CMP) that are peculiar to health care prepayment organizations.

(b) *Basic rules.* (1) The allowability of an HMO’s or CMP’s costs for furnishing services is generally determined in accordance with principles applicable to provider costs, as set forth in §417.536.

(2) The allowability of other costs is determined in accordance with principles set forth in §§417.538 through 417.550.

(3) Costs for covered services for which Medicare is not the primary payor, as described in §417.528, are not allowable.

(c) *Medicare Part D program costs.* To the extent that an HMO or CMP provides qualified prescription drug coverage to enrollees under Part D, no costs related to the offering or provision of Part D benefits are reimbursed under this part. These costs are reimbursed solely under the applicable provisions of part 423 of this chapter.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 70 FR 4525, Jan. 28, 2005]

§417.536 Cost payment principles.

(a) *Applicability.* Unless otherwise specified in this subpart, the principles set forth in parts 412 and 413 of this chapter are applicable to the costs incurred by an HMO or CMP or by providers and other facilities owned or operated by the HMO or CMP or related to it by common ownership or control. The most common examples of these costs are set forth in this section.

(b) *Depreciation.* An appropriate allowance for depreciation on buildings and equipment is an allowable cost, in accordance with §§413.134, 413.144, and 413.149 of this chapter.

(c) *Interest expense.* Necessary and proper interest on both current and capital indebtedness is an allowable cost, in accordance with §413.153 of this chapter.

(d) *Cost of educational activities.* An appropriate part of the net cost of approved educational activities of a provider or other health care facility owned or operated by an HMO or CMP

is an allowable cost in accordance with §413.85 of this chapter.

(e) *Compensation of owners.* An appropriate amount of compensation for services of owners is an allowable cost, if the services are actually performed and are necessary, as specified in §413.102 of this chapter.

(f) *Bad debts.* (1) Bad debts attributable to Medicare deductible and coinsurance amounts are allowable only if the requirements of §413.89 of this chapter are met, subject to the limitations described under §413.89(h) and the exceptions for services described under §413.89(i).

(2) If all or part of the deductible and coinsurance amounts is payable through a monthly premium or other periodic payment, the amount allowed as a bad debt may not exceed three times the monthly rate for the actuarial value of the deductible and coinsurance amounts, or its equivalent, if the periodic payment is on other than a monthly basis.

(3) Any bad debt related to a service furnished to a Medicare enrollee of the HMO or CMP, and claimed on a cost report submitted for payment by a provider or other facility reimbursed on a cost basis, may not be claimed as a bad debt by the HMO or CMP.

(g) *Charity and courtesy allowances.* As specified in §413.89 of this chapter, charity and courtesy allowances are deductions from revenue and may not be included as allowable costs.

(h) *Research costs.* As specified in §413.90 of this chapter, costs incurred for research purposes, over and above patient care, are not allowable costs.

(i) *Value of services of nonpaid workers.* The value of services of nonpaid workers of an organization is not an allowable cost, except as provided in §413.94 of this chapter.

(j) *Purchase discounts and allowances and refund of expenses.* Discounts and allowances that an HMO or CMP receives on purchases of goods and services and refunds of previous expense payments must be deducted from the costs to which they relate, in accordance with §413.98 of this chapter.

(k) *Cost to related entities.* (1) The costs of services, facilities, or supplies furnished to an HMO or CMP by a related entity are allowable at the cost

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to the related entity in accordance with § 413.17 of this chapter.

(2) An entity is not considered related to the HMO or CMP merely because—

(i) It has a risk or incentive agreement under which the HMO or CMP reimburses or compensates the entity for services it furnishes to the HMOs' or CMPs' enrollees; or

(ii) Substantially all the services the entity furnishes are furnished to the HMO's or CMP's enrollees.

(3) However, an entity described in paragraph (k)(2) of this section and an HMO or CMP are considered related if either of them is in a position to exercise significant management or ownership influence or control over the other.

(1) *Return on equity capital of proprietary providers owned by the HMO or CMP.* An allowance for a reasonable return on equity capital invested and used in providing services is allowable in addition to the reasonable cost of services furnished by a proprietary provider owned by the HMO or CMP. The amount of the allowance is determined in accordance with § 413.157 of this chapter.

(m) *Limitations on payment.* Medicare payment for covered services furnished by entities owned by or operated by, or related to, an HMO or CMP paid on a reasonable cost basis is subject to certain provisions of parts 412 and 413 of this chapter that pertain to reasonable cost and reasonable charge. Those provisions include, but are not necessarily limited to, the following:

(1) For ESRD treatment, the limitations authorized under § 413.170 of this chapter.

(2) For services of physical, occupational, and speech therapists and other therapists and nonphysician health specialists, the limitations set forth in § 413.106 of this chapter.

(3) For drugs, the allowable cost as determined under §§ 405.517 and 410.29 of this chapter.

(4) The overall cost limits established in accordance with § 413.30 of this chapter.

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(5) The limitation to the lesser of reasonable cost or customary charges, as set forth in § 413.13 of this chapter.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 51 FR 34832, Sept. 30, 1986; 51 FR 37398, Oct. 22, 1986; 58 FR 38080, July 15, 1993; 60 FR 46230, Sept. 6, 1995; 77 FR 67531, Nov. 9, 2012; 85 FR 59025, Sept. 18, 2020]

§ 417.538 Enrollment and marketing costs.

(a) *Principle.* Costs incurred by an HMO or CMP in performing the enrollment and marketing activities described in subpart k of this part are allowable.

(b) *Included costs.* Allowable enrollment and marketing costs are those necessary and proper costs incurred in offering the HMO's or CMP's plan to potential enrollees in accordance with this part. Those costs include selling, advertising, promotional, and other marketing costs and may not exceed an amount that would be incurred by a prudent and cost-conscious management.

(c) *Application.* Enrollment and marketing costs are allowable, whether incurred directly by HMO or CMP staff or under contract with marketing specialists or other outside consultants.

(d) *Limitation on payment.* The relatively higher costs that an HMO or CMP is likely to incur in initially offering its plan to Medicare beneficiaries are taken into account in determining whether enrollment and marketing costs are reasonable in amount. However, if those costs exceed amounts that would be paid by prudent management, the excess is not allowable.

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

§ 417.540 Enrollment costs.

(a) *Principle.* Enrollment costs are allowable if incurred in maintaining and servicing subscriber contracts for prepayment enrollees.

(b) *Kind of costs included.* Enrollment costs include, but are not limited to, reasonable costs incurred in connection with maintaining statistical, financial, and other data on enrollees.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]