

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.

(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]

§ 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 contractor 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.