

§ 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

be on the same approved basis that is used by the provider for Medicare beneficiaries who are not Medicare enrollees of the HMO or CMP, subject to the conditions and limitations set forth in § 417.548.

(c) If, because of the special nature or terms of the HMO's or CMP's arrangement with the provider, apportionment on the basis specified in paragraph (b) of this section would result in Medicare's bearing the costs of furnishing services to individuals other than the HMO's or CMP's Medicare enrollees, apportionment must be on another basis that is approved by CMS and that will ensure that Medicare does not pay any of the cost of furnishing services to individuals who are not Medicare enrollees of the HMO or CMP.

(d) If the HMO or CMP elects to have providers reimbursed by the HMO's or CMP's Medicare intermediary, the Medicare share is the amount the intermediary paid the provider.

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

§ 417.558 Emergency, urgently needed, and out-of-area services for which the HMO or CMP accepts responsibility.

(a) *Source of payment.* Either CMS or the HMO or CMP may pay a provider for emergency or urgently needed services or other covered out-of-area services for which the HMO or CMP accepts responsibility.

(b) *Limits on payment.* If the HMO or CMP pays, the payment amount may not exceed the amount that is allowable under part 412 or part 413 of this chapter.

(c) *Exception to limit on payment.* Payment in excess of the limit imposed by paragraph (b) of this section is allowable only if the HMO or CMP demonstrates to CMS's satisfaction that it is justified on the basis of advantages gained by the HMO or CMP, as set forth in § 417.548.

[60 FR 46231, Sept. 6, 1995]

§ 417.560 Apportionment: Part B physician and supplier services.

(a) *Medical services furnished directly by the HMO or CMP.* The total allowable cost of Part B physician and supplier services furnished by employees

or partners of the HMO or CMP or by a related entity of the HMO or CMP must be apportioned on the basis of the ratio of covered Part B services furnished to Medicare enrollees to total services furnished to all the HMO's or CMP's enrollees and nonenrolled patients. The HMO or CMP must use a method for reporting costs that is approved by CMS. CMS bases its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

(b) *Medical services furnished under arrangements made by the HMO or CMP.* When the HMO or CMP pays for Part B physician and supplier services on some basis other than fee-for-service, the reasonable cost the HMO or CMP pays under its financial arrangement with the physician or supplier must be apportioned between Medicare enrollees and others based on the ratio of covered services furnished to Medicare enrollees to the total services furnished to all enrollees and nonenrolled patients. If apportionment on this basis would result in Medicare bearing the cost of furnishing services to individuals who are not Medicare enrollees, the Medicare share must be determined on another basis (approved by CMS) to ensure that Medicare pays only for services furnished to Medicare enrollees.

(c) *Medical services furnished under an arrangement that provides for the HMO or CMP to pay on a fee-for-service basis.* The Medicare share of the cost of Part B physician and supplier services furnished to Medicare enrollees under arrangements, and paid for by the HMO or CMP on a fee-for-service basis, is determined by multiplying the total amount for all such services by the ratio of charges for covered services furnished to Medicare enrollees to the total charges for all such services.

(d) *Emergency services, urgently needed services, and other covered medical services for which the HMO or CMP assumes financial responsibility.* The Medicare share of the cost of Part B emergency or urgently needed services or other Part B services that are not furnished by a provider and for which the HMO or CMP accepts financial responsibility is

determined in accordance with paragraphs (b) and (c) of this section.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 34888, July 5, 1995]

§417.564 Apportionment and allocation of administrative and general costs.

(a) *Costs not directly associated with providing medical care.* Enrollment, marketing, and other administrative and general costs that benefit the total enrollment of the HMO or CMP and are not directly associated with furnishing medical care must be apportioned on the basis of a ratio of Medicare enrollees to the total HMO or CMP enrollment.

(b) *Costs significantly related to providing medical services.* (1) The following administrative and general costs, which bear a significant relationship to the services furnished, are not apportioned to Medicare directly; they must be allocated or distributed to the HMO or CMP components and then apportioned to Medicare in accordance with §§417.552 through 417.560:

- (i) Facility costs.
- (ii) Interest expense.
- (iii) Medical record costs.
- (iv) Centralized purchasing costs.
- (v) Accounting and data processing costs.
- (vi) Other administrative and general costs that are not included in paragraph (a) of this section.

(2) The allocation or distribution process must be as follows:

(i) If a separate entity or department of an HMO or CMP performs administrative functions the benefit of which can be quantitatively measured (such as centralized purchasing and data processing), the total allowable costs of this entity or department must be allocated or distributed to the components of the HMO or CMP in reasonable proportion to the benefits received by these components.

(ii) If a separate entity or department of an HMO or CMP performs administrative functions the benefit of which cannot be quantitatively measured (such as facility costs), the total allowable costs of this entity or department must be allocated or distributed to the components of the HMO or CMP