similar physicians practicing in the same or a similar locality.

(2) Physician compensation may take various forms, but the aggregate compensation allowable must be reasonable in relation to the services personally furnished.

(3) If aggregate physician compensation costs exceed what is normally incurred, the excess is not a reasonable cost.

(b) *Application.* (1) In determining the allowability of the costs of physicians' services, the cost of personal services (for example, expenses attributable to salaries, wages, incentive payments, fringe benefits) must be distinguished from the cost of nonpersonal services (for example, expenses attributable to facilities, equipment, support personnel, supplies).

(2) To be allowable, compensation must be reasonable in relation to the personal services furnished.

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

§ 417.546 Physicians' services and other Part B supplier services furnished under arrangements.

General principle. The amount paid by an HMO or CMP for physicians' services and other Part B supplier services furnished under arrangements is an allowable cost to the extent it is reasonable. Costs are considered reasonable if they—

(a) Do not exceed those that a prudent and cost-conscious buyer would incur to purchase those services; and

(b) Are comparable to costs incurred for similar services furnished by similar physicians or other suppliers in the same or a similar geographic area.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 34887, July 5, 1995; 60 FR 45372, Aug. 31, 1995]

§ 417.548 Provider services through arrangements.

(a) *Principle.* The cost incurred by an HMO or CMP for covered services furnished under arrangement with a provider is allowable to the extent that it would be allowable and payable under parts 412 and 413 of this chapter, unless the HMO or CMP petitions CMS and demonstrates to HFCA's satisfaction that payment in excess of the amount authorized under parts 412 and 413 of this chapter is justified on the basis of advantages gained by the HMO or CMP.

(b) *Application.* An advantage gained must represent a real and tangible benefit received by the HMO or CMP for the excess cost incurred, and any excess payment is subject to other applicable requirements of parts 405, 412 and 413 of this chapter, including tests of reasonableness.

(c) *Example.* In the case of an arrangement an HMO or CMP has with a provider that is located outside the 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 nonenrolled 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