

(ii) Otherwise interfere with the efficient administration of the Medicare program.

[50 FR 1375, Jan. 10, 1985, as amended at 57 FR 8202, Mar. 6, 1992; 58 FR 38081, July 15, 1993; 59 FR 49843, Sept. 30, 1994; 59 FR 59943, Nov. 21, 1994; 77 FR 22166, Apr. 12, 2012]

§ 417.802 Allowable costs.

(a) *General rule.* The costs that are considered allowable for HCPP reimbursement are the same as those for reasonable cost HMOs and CMPs specified in subpart O of this part, except those in §§ 417.531, 417.532 (a)(3) and (c) through (g), 417.536 (l) and (m), 417.546, 417.548, and 417.550(b)(2).

(b) *Physicians' services and other Part B supplier services furnished under arrangements—*(1) *Principle.* The amount paid by an HCPP for physicians' services and other Part B supplier services furnished under arrangements is an allowable cost to the extent it is reasonable.

(2) *Application: Payment on other than a fee-for-service basis.* If the HCPP pays for physicians' services and other Part B supplier services on other than a fee-for-service basis—

(i) Except as specified in paragraph (b)(2)(ii) of this section, the costs incurred by the HCPP may be 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 and other suppliers in the same or a similar locality.

(ii)(A) If a physician group to whom the HCPP makes payment compensates its physicians on a fee-for-service basis, the HCPP's payment to the group may not exceed the reasonable charges for those services, as defined in subpart E of part 405 of this chapter.

(B) Payment in excess of the limits specified in paragraph (b)(2)(ii)(A) of this section is allowable if the group has procedures under which members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount paid by the HCPP is considered reasonable if it meets the

conditions specified in paragraph (b)(2)(i) of this section.

(3) *Application: Payment on a fee-for-service basis.* If the HCPP pays for physicians' services and other Part B supplier services on a fee-for-service basis—

(i) Except as specified in paragraph (b)(3)(ii) of this section, the costs incurred by the HCPP are considered reasonable if they do not exceed—

(A) The reasonable charges for those services, as defined in subpart E of part 405 of this chapter; and

(B) The amount that CMS would pay for those services if they were furnished to beneficiaries who are not enrolled in the HCPP and who receive the services from sources other than providers of services or other entities that are reimbursed on a reasonable cost basis.

(ii) Payment to a physician group organized on an individual-practice basis is not subject to the paragraph (b)(3)(i) of this section if the group pays its physicians on a fee-for-service basis and has procedures under which the members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In these cases, the amount paid by an HCPP is considered reasonable if it meets the conditions specified in paragraph (b)(2)(i) of this section.

[50 FR 1375, Jan. 10, 1985, as amended at 58 FR 38081, July 15, 1993]

§ 417.804 Cost apportionment.

(a) The HCPP follows the cost apportionment principles specified in §§ 417.552 through 417.566, except for provisions on provider costs and provisions on departmental apportionment.

(b) The HCPP may 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.

§ 417.806 Financial records, statistical data, and cost finding.

(a) The principles specified in § 417.568 apply to HCPPs, except those in paragraph (c) of that section.

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(b) The HCPP may 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.

(c) An HCPP must permit the Department and the Comptroller General to audit or inspect any books and records of the HCPP and of any related organization that pertain to the determination of amounts payable for covered Part B services furnished its Medicare enrollees. For purposes of this requirement, the principles specified in § 417.486 apply to HCPPs.

[50 FR 1375, Jan. 10, 1985, as amended at 58 FR 38081, July 15, 1993]

§ 417.808 Interim per capita payments.

The HCPP follows the principles specified in §§ 417.570 and 417.572 on interim per capita payments, except for the following:

(a) When applying these principles to HCPPs, the term “reporting period” should be used instead of the term “contract period” contained in that section.

(b) An HCPP must submit to CMS an annual operating budget and enrollment forecast, in the form and detail specified by CMS, at least 60 days before the beginning of each reporting period. A reporting period must be 12 consecutive months, except that the HCPP’s initial reporting period for participating in Medicare may be as short as 6 months or as long as 18 months.

(c) An HCPP must submit to CMS an interim cost report and enrollment data applicable to the first 6-month period of the HCPP’s reporting period in the form and detail specified by CMS. The interim cost report must be submitted not later than 45 days after the close of the first 6-month period of the HCPP’s reporting period.

(d) In lieu of an interim payment based on the actual monthly enrollment in an HCPP, CMS and the HCPP may agree to a uniform monthly interim reimbursement rate for a reporting period. This interim rate is based on the HCPP’s budget and enrollment forecast, if CMS is satisfied that the rate is consistent with efficiency and

economy, and will not result in excessive adjustment at the end of the reporting period.

§ 417.810 Final settlement.

(a) *General requirement.* CMS and an HCPP must make a final settlement, and payment of amounts due either to the HCPP or to CMS, following the submission and review of the HCPP’s annual cost report and the supporting documents specified in paragraph (b) of this section.

(b) *Annual cost report as basis for final settlement—*(1) *Form and due date.* An HCPP must submit to CMS a cost report and supporting documents in the form and detail specified by CMS, no later than 120 days following the close of a reporting period.

(2) *Contents.* The report must include—

(i) The HCPP’s per capita incurred costs of providing covered Part B services to its Medicare enrollees during the reporting period, including any costs incurred by another organization related to the HCPP by common ownership or control;

(ii) The HCPP’s methods of apportioning costs among its Medicare enrollees, enrollees who are not Medicare beneficiaries, and other nonenrollees, including Medicare beneficiaries receiving health care services on a fee-for-service or other basis; and

(iii) Information on enrollment and other data as specified by CMS.

(3) *Extension of time to submit cost report.* CMS may grant an HCPP an extension of time to submit a cost report for good cause shown.

(4) *Failure to report required financial information.* If an HCPP does not submit the required cost report and supporting documents within the time specified in paragraph (b)(1) of this section, and has not requested and received an extension of time for good cause shown, CMS may—

(i) Regard the failure to report this information as evidence of likely overpayment and reduce or suspend interim payments to the HCPP; and

(ii) Determine that amounts previously paid are overpayments, and make appropriate recovery.

(c) *Determination of final settlement.* Following the HCPP’s submission of