

from August 1, 1970. For example, if the allowable rates of return on equity capital for a provider are 9 percent for the first year (and such year started August 1, 1970), 8.5 percent for the second year, and 10.5 percent for the third year, the cumulative allowable return at the end of the third year would be 28 percent. After the cumulative allowable return equals 100 percent, the inclusion in equity capital of the excess is no longer allowable.

(4) *Computation of return on equity capital.* For purposes of computing the allowable return, the amount of equity capital is the average investment during the reporting period. The rate of return allowed, as derived from time to time based upon interest rates in accordance with this principle, is determined by HCFA and communicated through intermediaries. Return on investment as an element of allowable costs is subject to apportionment in the same manner as other elements of allowable costs.

Example of calculation of cumulative allowable return. X purchased a provider on July 1, 1969, paying \$100,000 in excess of the fair market value of the assets acquired. Provider X files its cost report on a calendar-year basis. The allowable rate of return on equity capital for August 1, 1970-December 31, 1970 (4.538 percent), is obtained by multiplying the allowable rate of return for the period ending December 31, 1970 (10.891) by 1/2 (a fraction of which the numerator is the number of months from August 1, 1970, to the end of the cost-reporting period and the denominator is the number of months in the cost-reporting period). The cumulative allowable return for Provider X for the period August 1, 1970-December 31, 1973, (32.367 percent) is computed as follows:

Cost reporting year ending	Rate of return on equity capital (percent)
Dec. 31, 1970	4.538
Dec. 31, 1971	8.969
Dec. 31, 1972	8.891
Dec. 31, 1973	9.969
Total	32.367

(The \$100,000 paid in excess of the fair market value of the assets acquired is included in equity capital until the sum of the allowable rate of return on equity capital equals 100 percent. Of course, no portion of the \$100,000 may be amortized as an allowable cost or is otherwise allowable for any pro-

gram reimbursement purposes other than for determining the provider's equity capital.

[51 FR 34793, Sept. 30, 1986, as amended at 52 FR 21225, June 4, 1987; 52 FR 23398, June 19, 1987; 52 FR 32921, Sept. 1, 1987; 53 FR 12017, Apr. 12, 1988; 57 FR 39830, Sept. 1, 1992; 59 FR 26960, May 25, 1994]

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services and Organ Procurement Costs

SOURCE: 62 FR 43668, Aug. 15, 1997, unless otherwise noted.

§ 413.170 Scope.

This subpart implements sections 1881 (b)(2) and (b)(7) of the Act by—

(a) Setting forth the principles and authorities under which HCFA is authorized to establish a prospective payment system for outpatient maintenance dialysis furnished in or under the supervision of an ESRD facility approved under subpart U of part 405 of this chapter (referred to as "facility" in this section). For purposes of this section and § 413.172 through § 413.198, "outpatient maintenance dialysis" means outpatient dialysis, home dialysis, self-dialysis, and home dialysis training, as defined in § 405.2102 (f)(2)(ii), (f)(2)(iii), and (f)(3) of this chapter, and includes all items and services specified in §§ 410.50 and 410.52 of this chapter.

(b) Providing procedures and criteria under which a facility may receive an exception to the prospective payment rates; and

(c) Establishing procedures that a facility must follow to appeal its payment amount under the prospective payment system.

§ 413.172 Principles of prospective payment.

(a) Payments for outpatient maintenance dialysis are based on rates set prospectively by HCFA.

(b) All approved ESRD facilities must accept the prospective payment rates established by HCFA as payment in full for covered outpatient maintenance dialysis.

(c) HCFA publishes the methodology used to establish payment rates and

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the changes specified in §413.196(b) in the FEDERAL REGISTER.

§413.174 Prospective rates for hospital-based and independent ESRD facilities.

(a) *Establishment of rates.* HCFA establishes prospective payment rates for ESRD facilities using a methodology that—

- (1) Differentiates between hospital-based facilities and independent ESRD facilities;
- (2) Effectively encourages efficient delivery of dialysis services; and
- (3) Provides incentives for increasing the use of home dialysis.

(b) *Determination of independent facility.* For purposes of rate-setting and payment under this section, HCFA considers any facility that does not meet all of the criteria of a hospital-based facility to be an independent facility. A determination under this paragraph (b) is an initial determination under §498.3 of this chapter.

(c) *Determination of hospital-based facility.* A determination under this paragraph (c) is an initial determination under §498.3 of this chapter. For purposes of rate-setting and payment under this section, HCFA determines that a facility is hospital-based if the—

- (1) Facility and hospital are subject to the bylaws and operating decisions of a common governing board. This governing board, which has final administrative responsibility, approves all personnel actions, appoints medical staff, and carries out similar management functions;
- (2) Facility's director or administrator is under the supervision of the hospital's chief executive officer and reports through him or her to the governing board;
- (3) Facility personnel policies and practices conform to those of the hospital;
- (4) Administrative functions of the facility (for example, records, billing, laundry, housekeeping, and purchasing) are integrated with those of the hospital; and
- (5) Facility and hospital are financially integrated, as evidenced by the cost report, which reflects allocation of overhead to the facility through the required step-down methodology.

(d) *Nondetermination of hospital-based facility.* In determining whether a facility is hospital-based, HCFA does not consider—

- (1) An agreement between a facility and a hospital concerning patient referral;
- (2) A shared service arrangement between a facility and a hospital; or
- (3) The physical location of a facility on the premises of a hospital.

(e) *Add-on amounts.* If all the physicians furnishing services to patients in an ESRD facility elect the initial method of payment (as described in §414.313(c) of this chapter), the prospective rate (as described in paragraph (a) of this section) paid to that facility is increased by an add-on amount as described in §414.313.

(f) *Erythropoietin/Epoietin (EPO).* (1) When EPO is furnished to an ESRD patient by a Medicare-approved ESRD facility or a supplier of home dialysis equipment and supplies, payment is based on the amount specified in paragraph (f)(3) of this section.

(2) The payment is made only on an assignment basis, that is, directly to the facility or supplier, which must accept, as payment in full, the amount that HCFA determines.

(3) HCFA determines the payment amount in accordance with the following rules:

(i) The amount is prospectively determined, as specified in section 1881(b)(11)(B)(ii) of the Act, reviewed and adjusted by HCFA, as necessary, and paid to hospital-based and independent dialysis facilities and to suppliers of home dialysis equipment and supplies, regardless of the location of the facility, supplier, or patient.

(ii) If HCFA determines that an adjustment to the payment amount is necessary, HCFA publishes a FEDERAL REGISTER notice proposing a revision to the EPO payment amount and requesting public comment.

(iii) Any increase in this amount for a year does not exceed the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce) for the second quarter of the preceding year over the implicit price deflator for the second quarter of the second preceding year.