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 CMS 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 \( \frac{5}{12} \) (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:

<table>
<thead>
<tr>
<th>Cost reporting year ending</th>
<th>Rate of return on equity capital (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec. 31, 1970</td>
<td>4.538</td>
</tr>
<tr>
<td>Dec. 31, 1971</td>
<td>8.969</td>
</tr>
<tr>
<td>Dec. 31, 1972</td>
<td>8.891</td>
</tr>
<tr>
<td>Dec. 31, 1973</td>
<td>9.969</td>
</tr>
<tr>
<td>Total</td>
<td>32.367</td>
</tr>
</tbody>
</table>

(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 program reimbursement purposes other than for determining the provider’s equity capital.


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), (b)(4), (b)(7), and (b)(12) through (b)(14) of the Act by—

(a) Setting forth the principles and authorities under which CMS is authorized to establish a prospective payment system for outpatient maintenance dialysis services in or under the supervision of an ESRD facility that meets the conditions of coverage in part 494 of this chapter and as defined in §413.171(c).

(b) Providing procedures and criteria under which a pediatric ESRD facility (an ESRD facility with at least a 50 percent pediatric patient mix as specified in §413.184 of this subpart) may receive an exception to its prospective payment rate prior to January 1, 2011; and

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


§ 413.171 Definitions.

For purposes of this subpart, the following definitions apply:

Base rate. The average payment amount per-treatment, standardized to remove the effects of case-mix and area wage levels and further reduced for budget neutrality and the outlier percentage. The base rate is the amount to which the patient-specific case-mix adjustments and any ESRD facility adjustments, if applicable, are applied.

Composite Rate Services. Items and services used in the provision of outpatient maintenance dialysis for the treatment of ESRD and included in the composite payment system established under section 1881(b)(7) and the basic case-mix adjusted composite payment system established under section 1881(b)(12) of the Act.
§ 413.172 Principles of prospective payment.

(a) Payment for renal dialysis services as defined in § 413.171 and home dialysis services as defined in § 413.217 of this chapter are based on payment rates set prospectively by CMS.

(b) All approved ESRD facilities must accept the prospective payment rates established by CMS as payment in full for covered renal dialysis services as defined in § 413.171 or home dialysis services. Approved ESRD facility means—

1. Any independent ESRD facility or hospital-based provider of services (as defined in § 413.174(b) and (c) of this part) that has been approved by CMS to participate in Medicare as an ESRD supplier; or

2. Any approved independent facility with a written agreement with the Secretary. Under the agreement, the independent ESRD facility agrees—

   (i) To maintain compliance with the conditions for coverage set forth in part 494 of this chapter and to report promptly to CMS any failure to do so; and

   (ii) Not to charge the beneficiary or any other person for items and services for which the beneficiary is entitled to have payment made under the provisions of this part.

(c) CMS publishes the methodology used to establish payment rates and 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. CMS establishes prospective payment rates for ESRD facilities using a methodology that—

1. Differentiates between hospital-based providers of services and independent ESRD facilities for items and services furnished prior to January 1, 2009;