

§ 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 § 413.174(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.

[62 FR 43668, Aug. 15, 1997, as amended at 73 FR 20474, Apr. 15, 2008; 75 FR 49198, Aug. 12, 2010]

§ 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;

(2) Does not differentiate between hospital-based providers of services and independent ESRD facilities for items and services furnished on or after January 1, 2009; and

(3) Requires the labor share be based on the labor share otherwise applied to independent ESRD facilities when applying the geographic index to hospital-based ESRD providers of services, on or after January 1, 2009.

(b) *Determination of independent facility.* For purposes of rate-setting and payment under this section, CMS 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. CMS 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, CMS 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.