

Centers for Medicare & Medicaid Services, HHS

§ 413.232

of enrollment and price growth from total expenditures for 2007, 2008 or 2009 to determine the year with the lowest per patient utilization.

(2) *Update of per treatment base rate to 2011.* CMS updates the per-treatment base rate under the ESRD prospective payment system in order to reflect estimated per treatment costs in 2011.

(3) *Standardization.* CMS applies a reduction factor to the per treatment base rate to reflect estimated increases resulting from the facility-level and patient-level adjustments applicable to the case as described in § 413.231 through § 413.235 of this part.

(4) *Outlier percentage.* CMS reduces the per treatment base rate by 1 percent to account for the proportion of the estimated total payments under the ESRD prospective payment system that are outlier payments as described in § 413.237 of this part.

(5) *Budget neutrality.* CMS adjusts the per treatment base rate so that the aggregate payments in 2011 are estimated to be 98 percent of the amount that would have been made under title XVIII of the Social Security Act if the ESRD prospective payment system described in section 1881(b)(14) of the Act were not implemented.

(6) *First 4 Years of the ESRD prospective payment system.* During the first 4 years of ESRD prospective payment system (January 1, 2011 to December 31, 2013), CMS adjusts the per-treatment base rate in accordance with § 413.239(d).

[75 FR 49200, Aug. 12, 2010]

§ 413.230 Determining the per treatment payment amount.

The per-treatment payment amount is the sum of:

(a) The per treatment base rate established in § 413.220, adjusted for wages as described in § 413.231, and adjusted for facility-level and patient-level characteristics described in §§ 413.232 and 413.235 of this part;

(b) Any outlier payment under § 413.237;

(c) Any training adjustment add-on under § 413.235(c);

(d) Any transitional drug add-on payment adjustment under § 413.234(c); and

(e) Any transitional add-on payment adjustment for new and innovative

equipment and supplies under § 413.236(d).

[75 FR 49200, Aug. 12, 2010, as amended at 84 FR 60803, Nov. 8, 2019]

§ 413.231 Adjustment for wages.

(a) CMS adjusts the labor-related portion of the base rate to account for geographic differences in the area wage levels using an appropriate wage index (established by CMS) which reflects the relative level of hospital wages and wage-related costs in the geographic area in which the ESRD facility is located.

(b) The application of the wage index is made on the basis of the location of the ESRD facility in an urban or rural area as defined in this paragraph (b).

(1) *Urban area* means a Metropolitan Statistical Area or a Metropolitan division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by OMB.

(2) *Rural area* means any area outside an urban area.

(c) Beginning January 1, 2023, CMS applies a cap on decreases to the wage index, such that the wage index applied to an ESRD facility is not less than 95 percent of the wage index applied to that ESRD facility in the prior calendar year.

(d) Beginning January 1, 2023, CMS applies a floor of 0.6000 to the wage index, such that the wage index applied to an ESRD facility is not less than 0.6000.

[75 FR 49200, Aug. 12, 2010, as amended at 87 FR 67302, Nov. 7, 2022]

§ 413.232 Low-volume adjustment.

(a) CMS adjusts the base rate for low-volume ESRD facilities, as defined in paragraph (b) of this section.

(b) A low-volume facility is an ESRD facility that, as determined based on the documentation submitted pursuant to paragraph (g) of this section:

(1) Furnished less than 4,000 treatments in each of the 3 cost reporting years (based on as-filed or final settled 12-consecutive month cost reports, whichever is most recent, except as specified in paragraph (g)(4) of this section) preceding the payment year; and

(2) Has not opened, closed, or received a new provider number due to a change in ownership (except where the change in ownership results in a change in facility type) in the 3 cost reporting years (based on as-filed or final settled 12-consecutive month cost reports, whichever is most recent) preceding the payment year.

(c) For the purpose of determining the number of treatments under paragraph (b)(1) of this section, the number of treatments considered furnished by the ESRD facility shall equal the aggregate number of treatments furnished by the ESRD facility and the number of treatments furnished by other ESRD facilities that are both:

(1) Under common ownership with, and

(2) Five (5) road miles or less from the ESRD facility in question.

(d) Common ownership means the same individual, individuals, entity, or entities, directly, or indirectly, own 5 percent or more of each ESRD facility.

(e) Except as provided in paragraph (f) of this section and unless extraordinary circumstances justify an exception, to receive the low-volume adjustment an ESRD facility must provide an attestation statement, by November 1st of each year preceding the payment year, to its Medicare Administrative Contractor (MAC) that the facility meets all the criteria established in this section, except that:

(1) For payment year 2012, the attestation must be provided by January 3, 2012;

(2) For payment year 2015, the attestation must be provided by December 31, 2014;

(3) For payment year 2016, the attestation must be provided by December 31, 2015; and

(4) For payment year 2021, the attestation must be provided by December 31, 2020.

(f) The low-volume adjustment applies only for dialysis treatments provided to adults (18 years or older).

(g) To receive the low-volume adjustment, an ESRD facility must include in their attestation provided pursuant to paragraph (e) of this section a statement that the ESRD facility meets the definition of a low-volume facility in paragraph (b) of this section. To deter-

mine eligibility for the low-volume adjustment, the MAC on behalf of CMS relies upon as filed or final settled 12-consecutive month cost reports, except as specified in paragraph (g)(4) of this section, for the 3 cost reporting years preceding the payment year to verify the number of treatments, except that:

(1) In the case of a hospital-based ESRD facility as defined in § 413.174(c), the MAC relies upon the attestation submitted pursuant to paragraph (e) of this section and may consider other supporting data in addition to the total treatments reported in each of the 12-consecutive month cost reports for the 3 cost reporting years preceding the payment year to verify the number of treatments that were furnished by the individual hospital-based ESRD facility seeking the adjustment; and

(2) In the case of an ESRD facility that has undergone a change of ownership wherein the ESRD facility's Medicare billing number does not change or changes due to a reclassification of facility type, the MAC relies upon the attestation and if the change results in two non-standard cost reporting periods (less than or greater than 12 consecutive months) does one of the following for the 3 cost reporting years preceding the payment year to verify the number of treatments:

(i) Combines the two non-standard cost reporting periods of less than 12 months to equal a full 12-consecutive month period; and/or

(ii) Combines the two non-standard cost reporting periods that in combination may exceed 12-consecutive months and prorates the data to equal a full 12-consecutive month period.

(3) In the case of an ESRD facility that has changed its cost reporting period, the MAC relies on the attestation and does one or both of the following for the 3-cost reporting years preceding the payment year to verify the number of treatments:

(i) Combines the two non-standard cost reporting periods of less than 12 months to equal a full 12-consecutive month period; and/or

(ii) Combines the two non-standard cost reporting periods that in combination may exceed 12-consecutive months and prorates the data to equal a full 12-consecutive month period.

(4) For payment years 2021, 2022, and 2023, the attestation specified in paragraph (e)(4) of this section must indicate that the ESRD facility meets all the criteria specified in this section, except that, for a facility that would not otherwise meet the number of treatments criterion specified in paragraph (b)(1) of this section because of the COVID-19 PHE, the facility may attest that it furnished less than 2,000 treatments in any six months during the cost-reporting period ending in 2020. For any facility that so attests—

(i) The facility must also attest that it furnished treatments equal to or in excess of 4,000 in the payment year due to temporary patient shifting as a result of the COVID-19 PHE; and

(ii) The MAC relies on the attestation and multiplies the total number of treatments for the 6-month period by 2.

(h) When an ESRD facility provides an attestation in accordance with paragraph (e) of this section, for the third eligibility year, the MAC verifies the as-filed cost report and takes one of the following actions:

(1) If the MAC determines an ESRD facility meets the definition of a low-volume facility as described in paragraph (b) of this section, CMS adjusts the low-volume facility's base rate for the entire payment year; or

(2) If the MAC determines an ESRD facility does not meet the definition of a low-volume facility as described in paragraph (b) of this section, the MAC reprocesses claims and recoups low-volume adjustments paid during the payment year.

[75 FR 49200, Aug. 12, 2010, as amended at 76 FR 70314, Nov. 10, 2011; 79 FR 66262, Nov. 6, 2014; 80 FR 69076, Nov. 6, 2015; 83 FR 57069, Nov. 23, 2018; 85 FR 71485, Nov. 9, 2020]

§ 413.233 Rural facility adjustment.

CMS adjusts the base rate for facilities in rural areas, as defined in § 413.231(b)(2).

[80 FR 69077, Nov. 6, 2015]

§ 413.234 Drug designation process.

(a) *Definitions.* For purposes of this section, the following definitions apply:

ESRD PPS functional category. A distinct grouping of drugs or biological

products, as determined by CMS, whose end action effect is the treatment or management of a condition or conditions associated with ESRD.

New renal dialysis drug or biological product. An injectable, intravenous, oral or other form or route of administration drug or biological product that is used to treat or manage a condition(s) associated with ESRD. It must be approved by the Food and Drug Administration (FDA) on or after January 1, 2020, under section 505 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act, commercially available, have an HCPCS application submitted in accordance with the official Level II HCPCS coding procedures, and designated by CMS as a renal dialysis service under § 413.171. Oral-only drugs are excluded until January 1, 2025.

Oral-only drug. A drug or biological product with no injectable equivalent or other form of administration other than an oral form.

(b) *Drug designation process.* New renal dialysis drugs or biological products are included in the ESRD PPS bundled payment using the following drug designation process:

(1) If the new renal dialysis drug or biological product is used to treat or manage a condition for which there is an ESRD PPS functional category, the new renal dialysis drug or biological product is considered included in the ESRD PPS bundled payment and the following steps occur:

(i) The new renal dialysis drug or biological product is added to an existing ESRD PPS functional category.

(ii) Except as provided in paragraph (e) of this section, the new renal dialysis drug or biological product is paid for using the transitional drug add-on payment adjustment described in paragraph (c)(1) of this section.

(2) If the new renal dialysis drug or biological product is used to treat or manage a condition for which there is not an ESRD PPS functional category, the new renal dialysis drug or biological product is not considered included in the ESRD PPS bundled payment and the following steps occur:

(i) An existing ESRD PPS functional category is revised or a new ESRD PPS functional category is added for the