

§ 413.230

§ 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);

(e) Any transitional add-on payment adjustment for new and innovative equipment and supplies under § 413.236(d); and

(f) Any add-on payment adjustment for new renal dialysis drugs or biological products in existing ESRD PPS functional categories after the payment period for the transitional drug add-on payment adjustment has ended, as described in § 413.234(c)(3) and (g).

[75 FR 49200, Aug. 12, 2010, as amended at 84 FR 60803, Nov. 8, 2019; 88 FR 76505, Nov. 6, 2023]

§ 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

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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 paragraphs (g)(4) and (5) 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, except as specified in paragraph (g)(6) of this section.

(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 its 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 determine 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 paragraphs (g)(4) and (5) 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 con-

secutive 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.

(5) For payment year 2024 and subsequent payment years, an ESRD facility may attest in the attestation specified in paragraph (e) of this section that it would have met the requirements of paragraph (b)(1) of this section, except that for one or more of the most recent

3 cost reporting years the facility furnished 4,000 or more treatments because of temporary patient-shifting as a result of the closure or operational disruption of another ESRD facility due to a disaster or other emergency. For the purposes of the exception in this paragraph (g)(5), temporary patient-shifting is defined as providing renal dialysis services to one or more displaced patient(s) at any time through the end of the CY following the 12-month period beginning when an ESRD facility first begins providing renal dialysis services to one or more displaced patients. 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 cost reporting year due to temporary patient-shifting as a result of the closure or operational disruption of an ESRD facility resulting from a disaster or other emergency;

(ii) The facility must request an exception under this paragraph (g)(5) from CMS, in the form and manner specified by CMS, no later than the attestation deadline specified in paragraph (e) of this section or 30 days after the end of the cost reporting year, whichever is later, for each cost reporting year that the facility furnishes treatments equal to or in excess of 4,000 due to temporary patient-shifting as a result of the closure or operational disruption of an ESRD facility resulting from a disaster or other emergency;

(iii) Within 30 days of CMS's receipt of the facility's request, CMS will review the request and either approve the request based on a determination that the ESRD facility furnished treatments equal to or in excess of 4,000 in the cost reporting year due to temporary patient-shifting as a result of the closure or operational disruption of an ESRD facility resulting from a disaster or other emergency, or deny the request, and will notify the facility and the MAC of its decision;

(iv) If CMS approves the request, the ESRD facility is paid the low-volume adjustment on claims for Medicare beneficiaries, on the basis of the exception in this paragraph (g)(5), during the payment year in which the temporary patient-shifting occurred, so long as all other requirements for the low-volume

adjustment are met. For any future payment year, the ESRD facility would not be prevented from receiving the low-volume adjustment if the ESRD facility meets or exceeds the 4,000 treatment threshold in a cost reporting year due to temporary patient-shifting as a result of the disaster or other emergency that resulted in another ESRD facility's closure or operational disruption, so long as all other requirements for the low-volume adjustment are met; and

(v) The facility must maintain documentation of the number of displaced patients treated and information about the ESRD facility or facilities that closed or experienced operational disruptions due to a disaster or other emergency and previously treated those patients, and must provide such supporting documentation to CMS and the MAC upon request.

(6) In the case of an ESRD facility that closes due to a disaster or other emergency and later reopens, the ESRD facility may attest in the attestation specified in paragraph (e) of this section that CMS has granted an exception to the requirements specified in paragraph (b)(2) of this section because it closed due to a disaster or other emergency. For any facility that so attests—

(i) The ESRD facility would need to request such an exception from CMS, in the form and manner specified by CMS, within 60 days of the facility's closure, and the ESRD facility must inform the MAC of this request in writing;

(ii) With 30 days of CMS's receipt of the facility's request, CMS will review the request and either approve the request based on a determination that the ESRD facility closed due to a disaster or other emergency, or deny the request, and will inform both the facility and the MAC of its decision; and

(iii) If CMS approves the request, the exception under this paragraph (g)(6) will be applicable for a period consisting of the remainder of the cost reporting year (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) in which the closure occurred and the following full 2 cost reporting

years. After this period the ESRD facility would follow the general attestation process for the low-volume adjustment specified in paragraph (e) of this section and this paragraph (g).

(iv) The ESRD facility that attests under this paragraph (g)(6) to have closed due to a disaster or other emergency would need to notify CMS and the MAC, in the form and manner specified by CMS, within 30 days reopening and providing renal dialysis services. Within 30 days of CMS's receipt of the facility's notification, CMS will confirm receipt to the facility and the MAC of the facility's notification and the ESRD facility will be able to receive the low-volume adjustment as of the date of reopening, so long as all other requirements for the low-volume adjustment are met.

(v) The ESRD facility must maintain documentation regarding its closure, and must provide such supporting documentation to CMS and/or the MAC upon request.

(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; 88 FR 76505, Nov. 6, 2023]

§ 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.

(iii) The new renal dialysis drug or biological product is paid for using the add-on payment adjustment described