

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

in paragraphs (c)(3) and (g) of this section, referred to as the post-transitional drug add-on payment adjustment (TDAPA) add-on payment adjustment.

(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 condition that the new renal dialysis drug or biological product is used to treat or manage;

(ii) The new renal dialysis drug or biological product is paid for using the transitional drug add-on payment adjustment described in paragraph (c)(2) of this section; and

(iii) The new renal dialysis drug or biological product is added to the ESRD PPS bundled payment following payment of the transitional drug add-on payment adjustment.

(c) *Transitional drug add-on payment adjustment.* A new renal dialysis drug or biological product is paid for using a transitional drug add-on payment adjustment, which is based on 100 percent of average sales price (ASP). If ASP is not available then the transitional drug add-on payment adjustment is based on 100 percent of wholesale acquisition cost (WAC) and, when WAC is not available, the payment is based on the drug manufacturer's invoice. Notwithstanding the provisions in paragraphs (c)(1) and (2) of this section, if CMS does not receive a full calendar quarter of ASP data for a new renal dialysis drug or biological product within 30 days of the last day of the 3rd calendar quarter after we begin applying the transitional drug add-on payment adjustment for the product, CMS will no longer apply the transitional drug add-on payment adjustment for that product beginning no later than 2-calendar quarters after we determine a full calendar quarter of ASP data is not available. If CMS stops receiving the latest full calendar quarter of ASP data for a new renal dialysis drug or biological product during the applicable

time period specified in paragraph (c)(1) or (2) of this section, CMS will no longer apply the transitional drug add-on payment adjustment for the product beginning no later than 2-calendar quarters after CMS determines that the latest full calendar quarter of ASP data is not available.

(1) A new renal dialysis drug or biological product that is considered included in the ESRD PPS base rate is paid the transitional drug add-on payment adjustment for 2 years.

(i) Following payment of the transitional drug add-on payment adjustment, the new renal dialysis drug or biological product is paid the post-TDAPA add-on payment adjustment as set forth in paragraphs (c)(3) and (g) of this section.

(ii) Following payment of the transitional drug add-on payment adjustment the ESRD PPS base rate will not be modified.

(2) A new renal dialysis drug or biological product that is not considered included in the ESRD PPS base rate is paid the transitional drug add-on payment adjustment until sufficient claims data for rate setting analysis for the new renal dialysis drug or biological product is available, but not for less than 2 years.

(i) Following payment of the transitional drug add-on payment adjustment the ESRD PPS base rate will be modified, if appropriate, to account for the new renal dialysis drug or biological in the ESRD PPS bundled payment.

(ii) [Reserved]

(3) For any new renal dialysis drug or biological product that is eligible for payment using the transitional drug add-on payment adjustment described in paragraphs (b)(1)(iii) and (c)(1) of this section, CMS applies a post-TDAPA add-on payment adjustment to all ESRD PPS claims that is calculated using the methodology set forth in paragraph (g) of this section. CMS will apply the post-TDAPA add-on payment adjustment beginning 8 calendar quarters after the first calendar quarter in which the transitional drug add-on payment adjustment is paid for the applicable product, and ending 12 calendar quarters after the end of the last

calendar quarter in which the transitional drug add-on payment adjustment is paid for the applicable product. If CMS stops receiving the latest full calendar quarter of ASP data for the applicable renal dialysis drug or biological product during the applicable time period specified in paragraph (c)(1) of this section or during the 3-year period following such applicable time period, CMS will not pay any post-TDAPA add-on payment adjustment for such product in any future year.

(d) *Oral-only drug determination.* An oral-only drug is no longer considered oral-only if an injectable or other form of administration of the oral-only drug is approved by the Food and Drug Administration.

(e) *Exclusion criteria for the transitional drug add-on payment adjustment.* A new renal dialysis drug used to treat or manage a condition for which there is an ESRD PPS functional category is not eligible for payment using the transitional drug add-on payment adjustment described in paragraph (c)(1) of this section if the drug is approved by FDA under section 505(j) of the Federal Food, Drug, and Cosmetic Act (FD&C Act) or the new drug application (NDA) for the drug is classified by FDA as Type 3, 5, 7, or 8, Type 3 in combination with Type 2 or Type 4, or Type 5 in combination with Type 2, or Type 9 when the parent NDA is a Type 3, 5, 7 or 8 as described in paragraphs (e)(1) through (7) of this section, respectively:

(1) Type 3 NDA—New Dosage Form.

(i) A *Type 3 NDA* is for a new dosage form of an active ingredient that has been approved or marketed in the United States (U.S.) by the same or another applicant but in a different dosage form. The indication for the drug product does not need to be the same as that of the already marketed drug product. Once a new dosage form has been approved for an active ingredient, subsequent applications for the same dosage form and active ingredient should be classified as a *Type 5 NDA*, as described in paragraph (e)(2) of this section.

(ii) [Reserved]

(2) Type 5 NDA—New Formulation or Other Differences.

(i) A *Type 5 NDA* is for a product, other than a new dosage form, that differs from a product already approved or marketed in the U.S. because of one of the following:

(A) The product involves changes in inactive ingredients that require either bioequivalence studies or clinical studies for approval and is submitted as an original NDA rather than as a supplement by the applicant of the approved product;

(B) The product is a duplicate of a drug product by another applicant (same active ingredient, same dosage form, same or different indication, or same combination), and

(1) Requires bioequivalence testing (including bioequivalence studies with clinical endpoints), but is not eligible for submission as a section 505(j) of the FD&C Act application; or

(2) Requires safety or effectiveness testing because of novel inactive ingredients; or

(3) Requires full safety or effectiveness testing because it is:

(i) Subject to exclusivity held by another applicant, or

(ii) A product of biotechnology and its safety and/or effectiveness are not assessable through bioequivalence testing, or

(iii) A crude natural product, or

(iv) Ineligible for submission under section 505(j) of the FD&C Act because it differs in bioavailability (for example, products with different release patterns); or

(4) The applicant has a right of reference to the application.

(C) The product contains an active ingredient or active moiety that has been previously approved or marketed in the U.S. only as part of a combination. This applies to active ingredients previously approved or marketed as part of a physical or chemical combination, or as part of a mixture derived from recombinant deoxyribonucleic acid technology or natural sources.

(D) The product is a combination product that differs from a previously marketed combination by the removal of one or more active ingredients or by substitution of a new ester or salt or other noncovalent derivative of an active ingredient for one or more of the

active ingredients. In the latter case, the NDA would be classified as a combination of a *Type 2 NDA* as described in paragraph (e)(5)(i) of this section, with a *Type 5 NDA* as described in paragraph (e)(2) of this section.

(E) The product contains a different strength of one or more active ingredients in a previously approved or marketed combination. A *Type 5 NDA*, as described in paragraph (e)(2) of this section, would generally be submitted by an applicant other than the holder of the approved application for the approved product. A similar change in an approved product by the applicant of the approved product would usually be submitted as a supplemental application.

(F) The product differs in bioavailability (for example, superbioavailable or different controlled-release pattern) and, therefore, is ineligible for submission as an abbreviated new drug application (ANDA) under section 505(j) of the FD&C Act.

(G) The product involves a new plastic container that requires safety studies beyond limited confirmatory testing (see 21 CFR 310.509, *Parenteral drug products in plastic containers*).

(ii) [Reserved]

(3) *Type 7 NDA—Previously Marketed But Without an Approved NDA.*

(i) A *Type 7 NDA* is for a drug product that contains an active moiety that has not been previously approved in an application, but has been marketed in the U.S. This classification applies only to the first NDA approved for a drug product containing this (these) active moiety(ies). *Type 7 NDAs* include, but are not limited to:

(A) The first post-1962 application for an active moiety marketed prior to 1938.

(B) The first application for an active moiety first marketed between 1938 and 1962 that is identical, related or similar (IRS) to a drug covered by a Drug Efficacy Study Implementation notice. Regulation at 21 CFR 310.6(b)(1) states that an identical, related, or similar drug includes other brands, potencies, dosage forms, salts, and esters of the same drug moiety as well as any of drug moiety related in chemical structure or known pharmacological properties.

(C) The first application for an IRS drug product first marketed after 1962.

(D) The first application for an active moiety that was first marketed without an NDA after 1962.

(ii) [Reserved]

(4) *Type 8 NDA—Prescription to Over-the-Counter (OTC).*

(i) A *Type 8 NDA* is for a drug product intended for OTC marketing that contains an active ingredient that has been approved previously or marketed in the U.S. only for dispensing by prescription (OTC switch). A *Type 8 NDA* may provide for a different dosing regimen, different strength, different dosage form, or different indication from the product approved previously for prescription sale.

(ii) If the proposed OTC switch will apply to all indications, uses, and strengths of an approved prescription dosage form (leaving no prescription-only products of that particular dosage form on the market), the application holder should submit the change as a supplement to the approved application. If the applicant intends to switch only some indications, uses, or strengths of the dosage form to OTC status (while continuing to market other indications, uses, or strengths of the dosage form for prescription-only sale), the applicant should submit a new NDA for the OTC products, which would be classified as a *Type 8 NDA*.

(5) *Combination of Type 3 NDA.* Type 3 NDA, as described in paragraph (e)(1) of this section, in combination with a Type 2 NDA, as described in paragraph (e)(5)(i) of this section, or in combination with a Type 4 NDA, as described in paragraph (e)(5)(ii) of this section;

(i) *Type 2 NDA—New Active Ingredient.*

(A) A *Type 2 NDA* is for a drug product that contains a new active ingredient, but not a new molecular entity (NME). A new active ingredient includes those products whose active moiety has been previously approved or marketed in the U.S., but whose particular ester, salt, or noncovalent derivative of the unmodified parent molecule has not been approved by FDA or marketed in the U.S., either alone, or as part of a combination product. Similarly, if any ester, salt, or noncovalent derivative has been marketed first, the

unmodified parent molecule would also be considered a new active ingredient, but not an NME. The indication for the drug product does not need to be the same as that of the already marketed product containing the same active moiety.

(B) If the active ingredient is a single enantiomer and a racemic mixture containing that enantiomer has been previously approved by FDA or marketed in the U.S., or if the active ingredient is a racemic mixture containing an enantiomer that has been previously approved by FDA or marketed in the U.S., the NDA will be classified as a *Type 2 NDA*.

(ii) *Type 4 NDA—New Combination.*

(A) A *Type 4 NDA* is for a new drug-drug combination of two or more active ingredients. An application for a new drug-drug combination product may have more than one classification code if at least one component of the combination is an NME or a new active ingredient. The new product may be a physical or chemical (for example, covalent ester or noncovalent derivative) combination of two or more active moieties.

(B) A new *physical combination* may be two or more active ingredients combined into a single dosage form, or two or more drugs packaged together with combined labeling. When at least one of the active moieties is classified as an NME, the NDA is classified as a combination of a *Type 1 NDA*, as described in paragraph (e)(5)(ii)(B)(1) of this section, with a *Type 4 NDA*, as described in paragraph (e)(5)(ii) of this section. When none of the active moieties is an NME, but at least one is a new active ingredient, the NDA is classified as a combination of a *Type 2 NDA*, as described in paragraph (e)(5)(i) of this section, with a *Type 4 NDA*, as described in paragraph (e)(5)(ii) of this section.

(1) *Type 1 NDA—New Molecular Entity.*

(i) A *Type 1 NDA* is for a drug product that contains an NME. An NME is an active ingredient that contains no active moiety that has been previously approved by FDA in an application submitted under section 505 of the FD&C Act or has been previously marketed as a drug in the U.S. A pure enantiomer

or a racemic mixture is an NME only when neither has been previously approved or marketed.

(ii) An NDA for a drug product containing an active moiety that has been marketed as a drug in the U.S., but never approved in an application submitted under section 505 of the FD&C Act, would be considered a *Type 7 NDA* as described in paragraph (e)(3) of this section, not a *Type 1 NDA*.

(iii) An NDA for a drug-drug combination product containing an active moiety that is an NME in combination with another active moiety that had already been approved by FDA would be classified as a new combination containing an NME (that is, *Type 1,4 NDA*, as described in paragraph (e)(5)(ii) of this section). For example, a drug-drug combination can include a fixed-combination drug product or a co-packaged drug product with two or more active moieties.

(iv) An active moiety in a radiopharmaceutical (or radioactive drug product) which has not been approved by the FDA or marketed in the U.S. is classified as an NME.

(v) In addition, if a change in isotopic form results in an active moiety that has never been approved by the FDA or marketed in the U.S., the active ingredient is classified as an NME.

(C) An NDA for an active ingredient that is a *chemical combination* of two or more previously approved or marketed active moieties that are linked by an ester bond is classified as a combination of a *Type 2 NDA* as described in paragraph (e)(5)(i) of this section, with a *Type 4 NDA* as described in paragraph (e)(5)(ii) of this section, if the active moieties have not been previously marketed or approved as a physical combination. If the physical combination has been previously marketed or approved, however, such a product would no longer be considered a *new combination* and the NDA would thus be classified as a *Type 2 NDA*, as described in paragraph (e)(5)(i) of this section.

(6) *Combination of Type 5 NDA.* Type 5 NDA, as described in paragraph (e)(2) of this section, in combination with a *Type 2 NDA*, as described in paragraph (e)(5)(i) of this section.

(7) *Type 9 NDA when the parent NDA is a Type 3, Type 5, Type 7, or a Type 8.* A

*Type 9 NDA*, as described in paragraph (e)(7)(i) of this section when the parent NDA is a *Type 3 NDA* as described in paragraph (e)(1) of this section or a *Type 5 NDA* as described in paragraph (e)(2) of this section or *Type 7 NDA* as described in paragraph (e)(3) of this section or a *Type 8 NDA* as described in paragraph (e)(4) of this section.

(i) *Type 9 NDA—New Indication or Claim, Drug Not to be Marketed under Type 9 NDA after Approval.*

(A) A *Type 9 NDA* is for a new indication or claim for a drug product that is currently being reviewed under a different NDA (the “parent NDA”), and the applicant does not intend to market this drug product under the *Type 9 NDA* after approval. Generally, a *Type 9 NDA* is submitted as a separate NDA so as to be in compliance with the guidance for industry on *Submitting Separate Marketing Applications and Clinical Data for Purposes of Assessing User Fees*.

(B) When the *Type 9 NDA* is submitted, it will be given the same NDA classification as the pending NDA. When one application is approved, the other will be reclassified as *Type 9* regardless of whether it was the first or second NDA actually submitted. After the approval of a *Type 9 NDA*, FDA will “administratively close” the *Type 9 NDA* and thereafter only accept submissions to the “parent” NDA.

(ii) [Reserved]

(f) *Methodology for modifying the ESRD PPS base rate to account for the costs of calcimimetics in the ESRD PPS bundled payment.* Beginning January 1, 2021, payment for calcimimetics is included in the ESRD PPS base rate using the following data sources and methodology:

(1) The methodology specified in paragraph (f)(2) of this section for determining the average per treatment payment amount for calcimimetics that is added to the ESRD PPS base rate uses the following data sources:

(i) Total units of oral and injectable calcimimetics and total number of paid hemodialysis-equivalent dialysis treatments furnished, as derived from Medicare ESRD facility claims, that is, the 837-institutional form with bill type 072X, for the third and fourth quarters

of calendar year 2018 and for the full calendar year 2019.

(ii) The weighted average ASP based on the most recent determinations by CMS.

(2) CMS uses the following methodology to calculate the average per treatment payment amount for calcimimetics that is added to the ESRD PPS base rate:

(i) Determines utilization of oral and injectable calcimimetics by aggregating the total units of oral and injectable calcimimetics in paragraph (f)(1) of this section.

(ii) Determines a price for each form of the drug by calculating 100 percent of the values from the most recent calendar quarter ASP calculations available to the public for the oral and injectable calcimimetic.

(iii) Calculates the total calcimimetic expenditure amount by multiplying the utilization of the oral and injectable calcimimetics determined in paragraph (f)(2)(i) of this section by their respective prices determined in paragraph (f)(2)(ii) of this section and adding the expenditure amount for both forms.

(iv) Calculates the average per treatment payment amount by dividing the total calcimimetic expenditure amount determined in paragraph (f)(2)(iii) of this section by the total number of paid hemodialysis-equivalent dialysis treatments in the third and fourth quarter of calendar year 2018 and the full calendar year 2019.

(v) Calculates the amount added to the ESRD PPS base rate by reducing the average per treatment payment amount determined in paragraph (f)(2)(iv) of this section by 1 percent to account for the outlier policy under § 413.237.

(g) *Post-TDAPA add-on payment adjustment methodology.* CMS uses the following methodology to calculate the post-TDAPA add-on payment adjustment described in paragraph (c)(3) of this section:

(1) CMS bases the calculation on the most recent 12-month period of utilization for the new renal dialysis drug or biological product and the most recent available full calendar quarter of ASP data. If the most recent full calendar quarter of ASP data reflects zero or

negative sales, then the calculation is based on 100 percent of WAC and, when WAC is not available, the payment is based on the drug manufacturer's invoice.

(2) CMS calculates the post-TDAPA add-on payment adjustment annually as the expenditure for the new renal dialysis drug or biological product divided by the total number of ESRD PPS treatments during the same period.

(3) CMS applies a reduction factor to the post-TDAPA add-on payment adjustment for case mix standardization to reflect estimated increases resulting from the application of the patient-level adjustments as described in paragraph (g)(5) of this section. This reduction factor is calculated based on the patient-level adjustments (as described in §413.235) applicable to the most recent 12-month period of utilization of ESRD PPS claims.

(4) The amount of the post-TDAPA add-on payment adjustment is equal to 65 percent of the amount calculated in paragraph (g)(2) of this section, multiplied by the reduction factor specified in paragraph (g)(3) of this section, and multiplied by the latest available forecast of annual growth in the ESRD bundled market basket composite price proxy for pharmaceuticals.

(5) The post-TDAPA add-on payment adjustment that is applied to an ESRD PPS claim is adjusted by any applicable patient-level case-mix adjustments under §413.235.

[80 FR 69077, Nov. 6, 2015, as amended at 83 FR 57070, Nov. 14, 2018; 84 FR 60803, Nov. 8, 2019; 85 FR 71485, Nov. 9, 2020; 88 FR 76506, Nov. 6, 2023]

EFFECTIVE DATE NOTE: At 87 FR 67302, Nov. 7, 2022, §413.234 paragraph (a) was amended by adding the word "functional" before the word "equivalent" in the definition of "Oral-only drug", effective Jan. 1, 2025.

#### §413.235 Patient-level adjustments.

Adjustments to the per-treatment base rate may be made to account for variation in case-mix. These adjustments reflect patient characteristics that result in higher costs for ESRD facilities.

(a) CMS adjusts the per treatment base rate for adults to account for patient age, body surface area, low body

mass index, onset of dialysis (new patient), and co-morbidities, as specified by CMS.

(b) CMS adjusts the per treatment base rate for Pediatric ESRD Patients in accordance with section 1881(b)(14)(D)(iv)(I) of the Act as follows:

(1) To account for patient age and treatment modality; and

(2) Beginning January 1, 2024, to provide a per-treatment transitional add-on payment adjustment of 30 percent of the per treatment payment amount under §413.230 for renal dialysis services furnished to Pediatric ESRD Patients during calendar years 2024, 2025, and 2026.

(c) CMS provides a wage-adjusted add-on per treatment adjustment for home and self-dialysis training.

[75 FR 49201, Aug. 12, 2010, as amended at 88 FR 76506, Nov. 6, 2023]

#### §413.236 Transitional add-on payment adjustment for new and innovative equipment and supplies.

(a) *Basis and definitions.* (1) Effective January 1, 2020, this section establishes an add-on payment adjustment to support ESRD facilities in the uptake of new and innovative renal dialysis equipment and supplies under the ESRD prospective payment system under the authority of section 1881(b)(14)(D)(iv) of the Social Security Act.

(2) For purposes of this section, the following definitions apply:

*Capital-related asset.* Asset that an ESRD facility has an economic interest in through ownership (regardless of the manner in which it was acquired) and is subject to depreciation. Equipment obtained by the ESRD facility through operating leases are not considered capital-related assets.

*Depreciation.* The amount that represents a portion of the capital-related asset's cost and that is allocable to a period of operation.

*Home dialysis machines.* Hemodialysis machines and peritoneal dialysis cyclers in their entirety (meaning that one new part of a machine does not make the entire capital-related asset new) that receive FDA marketing authorization for home use and when used in the home for a single patient.