CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11516	**Date: July 28, 2022**
	Change Request 12771

SUBJECT: Monthly Report of Performance Payment Adjustment (PPA) Claims - Addition to Change Request (CR) 12404 - Implementation CR

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to request a report about the total dollars and claims processed under the payment adjustment Managing Clinicians' (MC) Performance Payment Adjustment (PPA) of the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model (Demo code 94).

CR 12404 is a split CR that was implemented across the January and April 2022 cycles. It implemented the Managing Clinicans PPA for the ETC model. This CR is an additional request for a report based on the claims adjustment implementing through CR 12404.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Demonstrations

Attachment - Demonstrations

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I. GENERAL INFORMATION

A. Background: The ESRD Treatment Choices (ETC) Model is a mandatory model (demo code: 94) for which about a third of the nation's nephrologists and other clinicians who manage dialysis patients, referred to as Managing Clinicians (MC), will be required to participate based on zip code. The ETC Model started on January 1, 2021, and ends on June 30, 2027. CR 12404 implemented two different models' payment adjustments. The payment adjustment part of the ETC model (Performance Payment Adjustment (PPA)) is the one referred to in this CR.

This CR primarily focuses on creating a monthly report that identifies the total dollar amounts, claims, etc. that were adjusted based on the ETC model's payment adjustment MC PPA.

B. Policy: CR 12404 implemented the following for the ETC model:

- **Home Dialysis Payment Adjustment (HDPA):** is an upward adjustment on home dialysis and home dialysis related claims with claim service dates between January 1, 2021 and December 31, 2023. This adjustment is based on zip codes and was implemented in January 2021 and then corrected.
- **Performance Payment Adjustment (PPA):** is an upward or downward payment adjustment made on all dialysis and dialysis-related claims between July 1, 2022 and June 30, 2027. This is dependent on participants' performance on home dialysis rates and transplant rates and applies to both participating ESRD facilities and Managing Clinicians.
    - The PPA for Managing Clinicians is an adjustment to MCP claims.
    - The PPA for ESRD Facilities is an adjustment through the ESRD Prospective Payment System (PPS)

Payment Adjustments:

The ETC model's HDPA applies only to the home MCP codes 90965 and 90966, and it applies only to the claims that are within selected zip codes (adjustments based on the range of zip codes and details on how to apply were implemented in January 2021 and then corrected).

The PPA applies to all MCP codes (90957-90962, 90965-90966), and it applies only to the claims submitted by providers who are aligned to the ETC model. This list of providers will be generated for the Shared System Maintainers (SSMs) a month prior and every six months thereafter.

The HDPA and PPA apply to the home-dialysis claims. For claims subject to these payment adjustments, depending on which group(s) the claim falls under, one or more of these payment adjustments may be applied.

ETC PPA Reprocessing –

ETC PPA requires an appeals process, referred to as Targeted Review, in which participants have a 90-day period to identify calculation errors in PPA score reports. Each Targeted Review period will start about 1 month prior to the related PPA period and will extend about 2 months into the related PPA period. As a result, ETC will pay the PPA based on score reports that participants may later successfully appeal, so that claims submitted by participants with successful appeals will need to be reprocessed. These claims can be reprocessed in a batch. CMMI and its contractors will need about 3 months for administration after the Targeted Review period closes, so the reprocessing effort will take place towards the end of the related PPA period and/or the beginning of the subsequent PPA period.

***Process*:**

The ETC provider file contains the provider details, the date ranges and the appropriate PPA % that needs to be applied to the claims. For reprocessing, the same set of information (provider details, date ranges and the appropriate PPA %) will be provided. However, the PPA % sent in the prior ETC provider file will be updated in the reprocessing information provided. During the reprocessing of these specific claims, **ONLY** the PPA should be updated with the updated PPA %. If the claim was eligible for HDPA as well, then this should not change or be updated. Below is an example of the timeline when PPA and reprocessing of PPA claims information will be provided. Also, as noted by MCS a complete replacement file will be provided for the reprocessing information.

***Timeline Example*:**

ETC Provider File for PPA Period 1 will be provided in June 2022.

Reprocessing information of PPA Period 1 claims will be provided in December 2022 (after the administration period).

ETC Provider File for PPA Period 2 will be provided in December 2022.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12771.1	The contractor shall generate a Demo Code 94 claim for HDPA/PPA or PPA only processing report as a CSV file with the proposed following fields. Populate new report with the following fields on a monthly basis and grouped by quarter. The CSV file should include dates of service paid on or after July 1st, 2022. The CSV file shall be one single consolidated file.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Totals • Year-Quarter • Provider Type • Medicare Beneficiary ID (MBI) • Beneficiary Health Insurance Claim Number (HICN) • National Provider Identifier (NPI) • Taxpayer Identification Number (TIN) • PPA Percentage Amount • Total Number of Claims Paid • Total Claims Paid Amount • Total Allowed Amount • Total Cost Sharing Amount • Total PPA Amount • Total HDPA Amount • Total Paid Amount • Date of Service Range • Claim Paid Date Please note the following for the report: • The totals computed in the report should be at the beneficiary level for NPI/TIN combination • The totals should be for a given quarter • Grand total for the year is not needed • If a claim adjustment is performed on a previously reported claim (ex:reprocessing of the claim), use the adjustment claim to update the report. • Always use the most recent information available to update the report									
12771.2	The contractors shall send the CSV file monthly to CMS.						X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Manasa Peddy, manasa.peddy@cms.hhs.gov , Heather Maldonado, heather.maldonado@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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