Please stand by for realtime captions.

>> Hello, everyone. Welcome to today's webinar. We are going to give people one minute and we will be starting shortly. >> I have with me the ETC model team. My name is Ms. Blackwell. To take questions during today's webinar, we will be using the Q&A future in June. If you have a question at any time during the presentation, please enter the question into the Q&A box. For most of you, the Q& A is the button at the bottom of the zoom window. Please do not use the chat feature to ask questions. We will respond to questions as we can during the presentation. Time permitted we will answer the rest of the questions at the end of the presentation. We will not be taking questions verbally at the end of the presentation. If we do not get to your presentation today, or if you have any questions after the webinar, please email the ETC model helpdesk. The email address for the help desk is in the chat. There will be several other links I will refer to throughout the presentation.

Here is the disclaimer for today's presentation. The contents of this presentation do not have the force and effect of law and are not meant by the the public to be binding in any way unless expressively incorporated into a contract. This document is intended to provide clarity to the public regarding existing requirements under the law. The government document is the specialty care models to improve quality of care and reduce expenditures final rule. Published on September 29th, 2020. The rule is available on the FR website at the link in the chap, and there is also a common model website.

The ETC model is part of the presidents advancing kidney care initiative.

The initiative has three goals. Fewer patients developing kidney disease, fewer Americans receiving dialysis and dialysis is an more kidneys available for transplant. The ETC model is focused on the second role. . Dialysis rates in the U.S. are low in comparison to other countries. Surveys suggest that many more Americans currently dialyzed at home would prefer to do though if they have the necessary education and support. Similarly, patients report per indication about the transplant options. The transplant processes come Plex and patients may need more's support than they currently receive. Additionally home dialysis and parents plantation are associated with better quality of life and better out comes of health. In center hemodialysis is the default treatment for people who need renal therapy. This means patients may not be able to choose the form of renal therapy that they prefer. The EDC model is just one part of the advancing kidney health initiative. We will not cover other parts of the initiative during today's presentation.

However, if you are interested in learning more, you can find additional information in the chat.. The EDC model is run by the CMS innovation center. For those of you who are on familiar. The innovation center

develops new payment and service models . We design models aimed at improving quality care and asked
reducing expenditures and then we testing. We evaluate each model to see if they work as intended. If it include an improved quality without increasing costs, or if it did both, the model can be considered for expansion into the permanent Medicare program.

If you would like to learn more about the innovation center, please visit our website at the link in the chat.

Before we move into the content of the model. I'd like to remind everyone how the Q&A will work for the presentation. If you have questions during the presentation, please
enter them in the Q&A feature in Zoom. For most of you, the Q&A features a button at the bottom of the zoom window. We will try to answer as many questions as we can as they come in, and time permitting, we will read and answer some questions at the end of the presentation.

If we don't get to your question, please email the EDC model help desk at the address in the chat, now I'm gonna walk through the ETC Model. It is a mandatory payment model for ERSD facilities and managing collations and 30% of the country. It's implemented through the specialty care models to improve quality Guare and reduce expenditures rule. It will begin January 1st , 2021, and will in June 30th, 2027. The goal is to improve and maintain quality of care while reducing Medicare expenditures while increasing rates of home dialysis and transplantation for Medicare beneficiaries with ERSD. Before we talk about the model's payments adjustment, and let's talk about how we are selected participants.

The ETC Model has two types of participants. Managing collations and ERSD facilities. Managing physicians are clinicians who manage dialysis patients for the dialysis they received, this includes nephrologist's, but other physicians also. In the ETC Model,
we define a Medicare enrolled physician or not the physician practitioner identified far in PI who furnishes and builds the monthly payments for one or more adults as beneficiaries.

There are a couple of things to note about this definition of what it means for you.

First, we identify and select managing clinicians as participants at the MPI level, not the 10 level. So it's possible for some managing clinicians in the same practice or billing under the same tend to be in the model. And other clinicians in a practice not to be in the model. Second, we identify and select managing clinicians based on adult ERSD beneficiaries. So 18 years or older.

If you see only patients under age 18, then you are not in the ETC Model model. If you see a mix of patients under age 18, and 18 years or older during the course of the model, you can be in the model. But only claims for patients of 18 years or older will be included in

performance assessments and payment adjustments which we will discuss later.

ERSD facilities are more straightforward. Did the ETC Model model uses an independent hospital provider services and furnishes us institutional diacetyl dialysis institutional services of implied supplies.

Of Chile, this means that we build 70 2X claims for services included in the ERSD EPS. As I mentioned it will include ES RD facilities and clinicians at a thought at 30% of the country. The unit of geography at is selected and our uses are hospital referral regions or H are ours. They are collections of ZIP Codes derived from Medicare dated based on data. We refer to hospital referral agents that have been selected to be dissipate and we refer to all other regions as comparison geographic areas.

Of note, the U.S. territories including Puerto Rico , are not included in the selected geographic areas for the comparative geographic areas.
>> We have randomly selected 30% of hospital referral regions, stratified by the four geographic read actions participating in the model. We also select all hospital referral regions of ZIP Codes in Maryland in conjunction with the Maryland total cost of care model. The list of selected geographic areas and including ZIP Codes is a available on the model website. It's available at the link in the chat.
>> The file at the Lincolnton salt ZIP Codes that have been selected to participate as well is the name and state affiliated with each HR are, hospital referral regions can and do include more than locality and cross state lines. So instead of looking at city or state, you should look up yours of code. ER Sardi physicians are using the ZIP Code of the practice location address listed. If the managing clinician has multiple practices and locations listed, we use the address for which the managing clinician bills the plurality of their claims. Put another way, if you are managing collations who seems dialysis patient is several location, this is the place where you see the most dialysis patients. We determine your address and whether you are listed in the selected geographic area.

Participation in the
ETC Model is mandatory if you are a ERSD or managing clinician in the selected geographic area. You cannot opt out of participating. You cannot into participating if you're not in the area. See you also
are petition patient and another Medicare program or model does not exempt you from participating in ETC Model. In particular participating in the kidney care choices model does not exempt you in the ETC Model model.
If you are selected in the geographic area, you will be participating in both the KCC and ETC Model model. However your participation status can change over time because participation is based on your location, the types of Clintonville, and the patient you see. If any of those change during the course of the model, you can start or stop being a DTC participant. If you move into a geographic area during the model, then you become a participant similarly, if you stop or stop dividing dialysis or dialysis management to adult

beneficiaries in your participation status will change accordingly. A couple of weeks ago,

CMS and notification letters to facilities and clinicians that are likely to be ETC participants when the model begins. However, receipt of a letter or not receipt of a letter does not guarantee that you are, or are not a ETC participant. As I described, participation is based on anticipation and claims during the model, and based on current information. You should use the hospital referral regions ZIP Code list available on the model website and in the chat to determine whether or not you are located in the ZIP Code in the selected geographic area. To review, there are two types of participants in the ET C model. This facilities identified at the level and clinicians or dialysis patients or managing clinicians identified at the level. Facilities and managing clinicians or participants if their primary practice location active address is in a location of the selected geographic areas. The list is located on a website and you should use your ZIP Code to look up whether or not you and your HRR are on the list of areas. If your locations change during the close of the model, your status as a participant can change. >> The model is designed to minimize the administrative burden of being selected to participate.

The model will run primarily on the claims that you already submit. You do not need to change the way you bill Medicare for the ETC Model model. You also do not need to submit any additional data to CMS for us to calculate your transplants rate which we will discuss rater. What did you will need to do starting January 21st 2021, is both a slide notifying beneficiaries that you participating in the model at locations where you are receiving beneficiaries. The beneficiaries notification form is located on the website at the link of the chat. The first page of the document's instructions.

This includes where you need to pose a form, and what additional content you are allowed to provide. The second page of the document is the form itself. Of note, if you are managing clinician and you provide dialysis management services at local multiple

locations you must post at all locations.

Before we move on to talking about the ETC Model payment adjustments, I want to take some time to talk about how the ETC Model team will be communicating with you, and how you will communicate with us. If you haven't already find the website, the link is in the chat. We will post information and updates to them model website as they occur. For example, right now you can find links to the final rule, the least of selected geographic areas, the beneficiary notification form and the achievement websites on the website. We will continue to disseminate operational information about the model via the website.

Also in the website, is a link to sign up for the ETC Model listserv. We use it to send out updates and reminders. I strongly encourage all participants to sign up for the listserv to stay up-to-date with the model.

For now, mainly we will communicate with the model T was through the helpdesk. If you have questions about the model, you should email the help desk. Again, the helpdesk email is available on our website and in the chat .

In the future, the ETC Model model team will also share particular information model participant using the four innovation platform. Or for eye. We will use for I too share beneficiary less of dialysis and transplant rates and payment adjustments with participants after the first of the measurement year and start of the first performance adjustment. And in the spring of 2022. In two early 2010 to 2 we will share more information about participants and what you will need to do to gain access to for I. Also the ETC Model will undergo additional rulemaking in the future. It will make land updates and structure to the model such as the benchmarking methodology. We describe this in the final rule. If you have ideas, comments or concerns about any future proposed rule, please submit those to via the Federal Register during the comment period.

Moving on to the payment adjustments. The ET C model has two payment adjustment , the home dialysis payment adjustment and the performance payment adjustment. The home and dialysis payment adjustment is a positive adjustments on all home dialysis and related claims for ETC participants during the years of the model. The purpose of the payment adjustment is to incentivize investment in home dialysis infrastructure.

Claim subject to adjustment by the H DPA for participants is as follows. For managing clinicians, it will apply to MCP dialysis claims with dates of service during the calendar year for beneficiaries who are 18 years or older. In particular, this will be the claims for CPT codes 90965 and 90966. >> The H DPA will be applied to claims automatically. You do not need to change the way you feel to receive it. >> In particular, this will be claim aligned to Bill -type 72X or 70 2X claims with condition called 74, or 76. For managing clinicians the HDPA will be applied to claim subject to adjustment automatically, and you do not need to change the way you bill to receive it .

Of note, the adjusted ERSD PPS per base rate includes patient and facility level adjustments to the base rate but does not include any applicable training adjustment at on payment amount, outlier payment amount, to Napa amount, or to phone this amount, put another way. It applies to a portion of the payment and does not apply to add on amounts.

There are no exclusions from the HDPA. The HDPA will be 3% and 2021, 2% in 2022, and 100 percent in 2023, to clarify, the date ranges to refer to the dates of service on the claim, not the date on which the claim was paid. So if a claim was subject to adjustment has a Dave of service and 22 in one and was paid in 2022, the claim will have the 2021 HDPA amount or 3% not the 2022 HDPA amount. To summarize, positive adjustment on claims submitted by participants during the first three years of the model for adult Medicare beneficiaries to dialyzed at home. >> [Silence]

The second payment adjustment in the model is the performance payment adjustment the performance payment adjustment is an upward or downward payment adjustment for ERSD facilities and clinicians based on the participants rate of home dialysis and the rate of transplant weightlifting and living donor transplants.

For some gonna walk through how to CMS determines each payment adjustment including how we calculate the home dialysis and transplant rate and how we score performance including achievement and improvement, and how we determine payment adjustments. Then I will walk through the timeline for performance and adjustments using measurement year one is an example including what information you will receive from CMS.

At a high level, the performance payment adjustment operates on a 24 month cycle which restarts every six months. The PPA cycle starts with the measurement year which is a 12 month year where we evaluate transplant home performance. At the end of the year, we evaluate three months of claim to account for the time it takes for things to be submitted, process and to show us as data. Then CMS has a two month calculation. Where we calculate ETC home dialysis rate, trance work plant rate, modality performance score and performance payment adjustment as well. After calculating, CMS notifies ETC participants of their payment adjustments no later than one more month than the payment adjustment takes place. Finally, to begin six months after the measurement urine applies to claims for the next six months.

Measurement years over map overlapped by six months. They are the same as the first six months of your measurement year two, etc. The ETC Model contains PPA cycles. Let's walk to the process. The first step is determining a participant is PPA is beneficiary attribution. >> This is based on claims. After the measurement year, CMS will look back at claims for services during the measurement year to attribute beneficiaries to ERSD and clinicians. A month by month basis, can only be attributed to one managing clinician and one ERSD facility per month during the measurement year. However it can be attributed to a different commission and additional ESR D facility in a month. To be eligible for attribution at a given month they must be enrolled in Medicare part B, live in the United States, and be age 18 years or older during that month.

Also a beneficiary will be excluded from attribution for a given month if they are enrolled in Medicare advantage or another Medicare managed plan if they have elected hospice, if they reside or receive dialysis in a SNF, if they receive dialysis only for HII, or have they have diagnosis of dementia in the past year.

For ERSD facilities we attribute the beneficiary to the facility at which they had a polarity of their dialysis treatments in the given month. We use 70 2X claims with service dates during the month. For example if in January, 2021 a beneficiary at nine dialysis treatment at facility A, and three at facility B, that beneficiaries attributed to facility a for January.

However, if the beneficiary had all of their treatments at facility B in February, that beneficiary would be attributed to facility B in February.

For managing clinicians, CMS attributes beneficiary to the managing clinician who billed the beneficiary and that month. CMS also attributes beneficiary to receive a living donor transplant before beginning dialysis or preemptive during the message Mayor . >> Rather than being attributed on a month-to-month basis, CMS attributes preemptive living donor transplant beneficiaries to the managing clinician with whom the beneficiary had the most claims between the start of the measurement year, and the month and with the beneficiary receive their transplant.

For all months between the start of the measurement year, and the month of the transplant, so, if a beneficiary has a preemptive living donor transplant in June 2021, that beneficiary would be attributed to the managing clinician for six months from January through June of measurement year one. >> The second step in calculating the home dialysis rate, the trend transplant waitlist rate . The home dialysis rate is where beneficiaries dialyzed at home or practice self dialysis during the measurement year. The denominator for the home dialysis rate is the total dialysis treatment inefficiently rears for attributed ESR D beneficiaries during the measurement year. To clarify, 12 months are equal to one beneficiary rear year. For managing clinician dismissal denominator is the total number of beneficiary nonsense repeated who receive maintenance dialysis as identified by claims with CPT codes 90957 through nine of nine 62, 90965, and 90966.

For EO ST facilities,
the new dominator is the total number of beneficiary months for attributed ESR D Anna fishers who receive dialysis as identified by claims with types of bill 720 ex. >> The numerator for the home dialysis rate is the total home dialysis treatment beneficiary years, +1/2 of the self dialysis treatment beneficiary years during the year.

For managing clinicians, this means that the numerator is the sum of months for attributed user beneficiaries where the beneficiary dialyzed at home, as identified by claims with CT peak
codes 90965 and 90966, and one half of the months are attributed ESR D beneficiaries a participating self dialysis as identified by 702X and condition code 72. We are using dialysis claims, not MPC claims to identify dialysis for clinicians. This is no separate code for self dialysis.

Similarly, for ERSD facilities this means that the numerators is the sum of months for user ERSD beneficiaries where they
dialyzed at home as identified by 72 2X and condition code 72 four and 72 six. Half of months are attributed to beneficiaries where the beneficiary is engaged in self dialysis as identified by claims was 70 2X and condition code 72.

Of note, the home dialysis rate is not risk adjusted.

To summarize, the home dialysis rate is the number of home dialysis beneficiary years +1/2 of the numbers self
dialysis beneficiary years divided by the total number of dialysis using beneficiary years for attributed ERSD beneficiaries.

Moving from the home dialysis rate to the transplant rate. The transplant rate is the sum of the transplant waitlist rate and the living donor transplant rate. The waitlist rate is the rate that which attributed ERSD beneficiaries are on the waitlist during the measured year. The denominator for the transplant waitlist rate is a total dialysis beneficiary years for attributed ERSD during the measured year. This is very similar to the denominator for the home dialysis rate but with one exception. NFS shares are who are 75 years of age or older, they are excluded from the transplant waitlist rate . >> The numerator for their transplant waitlist rate is the total attributed to the fish areas in which it rooted beneficiaries are on the transplant waitlist during the measured year. This includes the visionaries who are active on the waitlist, and beneficiaries who are inactive on the waitlist.

Again visionaries who are beneficiaries 75 years or older are excluded.

The transplant waitlist rate is risk-adjusted based on an officiates.
To summarize, the transplant waitlist rate is the number of transplant waitlist beneficiary rears divided by the total number of dialysis beneficiary years for participants attributed as ERSD beneficiaries. This excludes an officiates that are excluded 75 years or older. >> The living donor transplant rate is the rate at which attributed ERSD visionaries and preempted and managing clinicians receive living donor transplants during the measure year. For ERSD facilities the denominator for the living donor transplant Greg is a total dialysis beneficiary years [Indiscernible] . As with the transplant waitlist beneficiary 75 years or older are excluded from this measure. For facilities, the numerator is the total number of attributed beneficiary years. For ERSD beneficiaries to receive a living donor transplant during the measurement year. We count living donor transplant months from the beginning of the measurement year to the month in which the ERSD beneficiary receive the living donor transplant. So if a inefficiently received a transplant in November of the first measurement year, that an officiates what attribute 11 months to the new year. >> For managing clinicians, the denominator for the living donor transplant rate is the sum of the total dialysis treatment beneficiary years for attributed ESR D beneficiaries and for preemptive living donor transplant beneficiaries during the measurement year. As I described earlier, the visionaries who receive a preemptive living donor transplant performing dialysis are also to debited to a managing clinicians for the purposes of calculating this rate. As with the transplant waitlist rate, beneficiaries who are 75 years or older are exempt.

For clinicians, the numerator for the total, is the total to be issued to share years for beneficiaries to receive the living donor transplant for both

preempting living donor transplant beneficiaries and ERSD beneficiaries. As with the facility rate, we count living donor transplant months from the beginning of the measurement year to the month in which the ERSD beneficiary recently received the living donor transplant. The transplant rate is not risk-adjusted. >> So then the transplant rate as a whole, is the sum of the transplant waitlist rate and the living donor transplant rate. >> The third step is aggregating the home dialysis and transplant rates for participants who are in and in aggregation group.

After we calculate each trend 39 rate we aggregate the rates for clinicians and facilities for others in their aggregation group took account for specialization and on dialysis, another practice or a group of facilities owned by the same parent company.

For ERSD facilities we aggregate together the performance of all the facilities in owned in whole or in part by the same legal entity in the same hospital or program. An independent ERSD that is one not basic subsidiary to the entities of another's a facility will not be cut included in an aggregation group and their performance will be scored on its own. Of note, office facilities and an abrogation group must be located in the same HHR, that means that facilities owned by the same parent company can be in more than one aggregation group and will not include facilities that are not in selected geographic areas. >> For managing clinicians, we aggregate together the performance of all managing clinicians in the same practice, or all MPI's that go through the same 10. So practices do not go through the same 10 as other managing clinicians are not in an aggregation group.

The four step is scoring the home dialysis and transplant rates. Against the agenda this March, we score against their beneficiaries past performance to performance the modality performance score. Once we've calculated it, we score their performance in two ways. The first kind of scoring is achievements going. We score product discipline achievement on home dialysis rate and the transplant rate separately against a set of percentile based mentioned marks. The benchmarks are based on performance by ERSD facilities are managing can clinicians located in geographic areas and not participating in the ETC Model. There is one set of achievement benchmarks for ESR D facilities and a separate one for managing clinicians. In order to [Inaudible - static] we used data from the benchmark year for 12 month period that begins 18 months before the start of the measurement year.

Achievement business are set at the 30th, 50th, 75th, and 90th for percentile of performance in geographic areas. Is percentile range corresponds with the point value. The maximum possible achievement score is being 2-point.

So, if your rate is above the 90th percentile, then you received two points. If you are between the 75th and 90th percentile you received parts Five Points. If you are between the 50th and 70 percentile, you received one point. The 30th and 50th, you received .5 points, and below, you receive zero points.

That kind of scoring is improvement scoring. We score improvement on the home dialysis rate and participant dialysis separately. >>

We compare your performance in the measurement year to your procurements in the benchmark year again in a 12 month period that begins 18 months before the start of the measurement year.

Your present improvement from the benchmark year to the measurement year determines your improvement score. If you improve more than 10% relative to the benchmark year, you received 1.5 points. If you improve more than 5%, you and received five point, more than 0% you received Five Points, and if you do not improve or decreased relative to the benchmark year, you receive zero points. The maximum improvement score is 1.5 points. >> Once we give a determination of your improvement scores, for the home dialysis rate and transplant rate we use them to determine your modality performance score. This will determine your payment adjustment.

We use the higher of your achievement scores and improvement score for each rate to calculate your modality performance score. The modality performance course two times your home dialysis score plus your transplant score. For,

that say the home dialysis rate, your achievement score was only Five Points, and your achievement score was zero. Among the transplant rate was .5 and your improvement score was one. We would take your achievement score up 1.5 for the home dialysis rate because it was higher than your improvement score of zero. And we would take your improvement score of .1 of the transplant because it is higher than your achievement score of 1.5 that means that your modality performance score would be to design your dialysis achievement score of 1.5 or three point. Plus your translated improvement score of one which would equal four. >> Put another way, the amount of your performance payment adjustment is determined by your modality performance score. Your modality performance scores comprise of the higher of your achievement score for the home dialysis rate in the transplant rate and home dialysis rates score is worth more than twice as much of the home dialysis score. This increases over the course of the model. For example, the first measurement year, in the performance payment adjustment. That response, the Max word maximum upward adjustment is 4% in the maximum adjustment downward is 5%. It is for clinicians and facilities. The last year of the payment adjustment. Is 8% for donations and facilities in the maximum downward is 9% for clinicians or 10% for the salinities. >> These are the maximum upward and downward adjustments by year. Depending on your modality performance score, you could receive the maximum positive and negative adjustment, a smaller negative or positive adjustment or no payment adjustment, or zero adjustment. >> The fifth step is notifying participants of the performance and upcoming payment adjustments.

As I mentioned earlier, CMS will notify participants and their beneficiaries if their home dialysis entrance plant rates and PPA amounts no later than one month after the start of the period. This will be provided via a secure portal. We will provide more information about the portal before the first set of reports in 2022. >> If you believe that CMS has made a mathematical area in the computation of the

modality performance score, you can request a targeted review. You have 90 days after receiving your modality performance score to submit a targeted review request. We will provide additional information about it before the first set of PPA reports in 2022.

The final step is applying the performance payment adjustment to claims. Just like with a home dialysis payment adjustment, ERSD participants will continue to submit claims since they already do. You do not need to make changes to how you built to receive the payment adjustment. For managing clinicians the PPA applies to claims 18 years of older that declare during the PPA period.

This would include lines of C codes 909579 0562, 90965, and 90966. For ERSD the PPA applies to the base rate on claim lines of 072X for claims of the inefficient 18 years of older that occur during the PPA. . Note that the PPA applies to beneficiaries in beneficiaries aged 18 years or older. Of note, the PPA does include a low-volume exclusion. If you are so low managing clinician, and independent ERSD facility or Internet aggregation group or 132 beneficiaries month during the beneficiary you are not subject to the PPA for that measurement year.

To summarize, the performance payment adjustment is based on ETC, and aggression groups, or individuals home dies dialysis or transplantation rates. This is compared to a benchmark its own past performance to determine the groups modality performance score. >> And this modality performance score in turn determines the magnitude of the PPA for participants. CMS will notify participants of their performance payment adjustments no moral later than one month after the adjustment is applied. For ERSD it applies to all claims for beneficiaries.

For men averaging fisheries it applies to all adult beneficiaries. >> Now and go to walk through the PPA timeline for measurement year one. The Belgian benchmark year was July 2019 to June 2020. UBS is looking at geographic areas we posted those to the UTC model website on November 30th, 2020. If you have not reviewed the measurement year, the link is in the chat .

Measurement year one will begin January 1st 2021, and will run through December 21st, 2021. Of note, measurement year two will begin July 1st, before measurement year one has ended. Achievements will be allowable no later than June 1st, 22 to 1. In January, 2220 through March 2022 CMS will allow for the claims run out. To allow time for claim submission processing.

In April and May of 22 to CMS will attribute beneficiaries, alkylate rates, modality performance scores and PPA amounts for ETC participants. Also around this time , we will provide participants with information about how to get access to our web platforms are participants will be ready to receive their PPA reports when they are available. We will also provide additional information about the targeted review process at this time.

By June 1st, 2022, CMS will provide ETC with their PPA reports including beneficiary list, home dialysis transplant rates and scores in their PPA amounts. This will also be given an I.D. would day window for ETC participants to submit a targeted review request if they believe a computational area has occurred. Finally the first. Will begin applying PPA based on perforation in measurement year one. They will be dates of service in July 1st, 2022, and December 1st, 2022.

To summarize, the ETC model has two payment adjustment, the home dialysis payment adjustment and the transportation form is adjustment. It applies the first three years of the model 2021, through 2023. The performance payment adjustment is based on the participants home dialysis and transplant rates and will apply to all dialysis and dialysis related claims. The PPA will apply to claims from July, 2022 to June, of 2027 and the amount will be updated every six months.

[Silence]

To close, I'm going to talk about two additional tools in the ETC Model health beneficiary meant to choose alternative races for home dialysis. We have the kidney disease education benefit waiver. It waived certain requirements for requirements for billing the benefit did the waiver does the following. The waiver waives the requirement that the doctors, physician assistants, nurse practitioners, and clinical nurse specialist can furnish KDE furnaces so that they can be provided by clinical staff under the directive and incident to the services of a managing clinician who is a ETC participant. This increases the types of come clinicians who can furnish and Bill . It encloses licensed social workers, registered dietitians and nutrition professionals and clinical group practices.

The waiver waives the requirement that the KDE is only covered for beneficiaries with CK D stage four. Or in the first six months of ERSD. The waiver waives the requirement that the content include the management of comorbidities including the delay of need for dialysis. When that is furnished, the beneficiaries will see KDE five in the first six months of the dialysis unless it's relevant for the beneficiary. The waiver waives the requirement that an outcomes assessment designs to measure beneficiary knowledge about KDE and beneficiary such that the outcome assessment can be performed within one month within the final KDE session. Of note, this waiver applies to managing clinicians who are ETC participants it does not include facilities. And it doesn't include managers of facilities that are not participants. Second, we have the UTC learning collaborative. The collaborative is the CCS Q or the HRS letter a. This is organ procurement organization transplant providers and model participants. That is to increase the number of kidney transplants by increasing the size supply of increased Diggs D ceased donors. The learning collaborative is not limited to two ETC model participants. All recommend that brings us to the other the presentation. I see there has been a lot of activity in the Q&A. So, I would like to ask my team if there are any questions that they would like to answer verbally at this time? >> [Silence]

>> We have some questions from folks, obviously you can covered a lot of content in the webinar. And the slides didn't cover everything that was said, but the recording of the transcript will be posted, so I would recommend so folks do that on the red website, this is also in the final rule. Rules are not written and it is laid out in there. I would recommend reading that a following up with that.

We got questions about overlap , does that include exclude beneficiaries and do the expenditures count? Karthik what we can say that that overlap is allowed between the ETC Model models and ECL models, so beneficiaries could be both. Any payment adjustments would count as payment adjustments for the four that relevant ACL model.

I am pulling out some other questions here. So we got questions about some of the folks saying that why did they get a letter? Because they may not be in an outpatient dialysis facility. I think what we would say is that, receiving a letter does not definitively mean that you are a participant or non-participant. Because it faces selection on past claims, but if select is you can opt out of the ETC Model for any reason. So it's gonna be claims based rather than based on the letter. We all realize that people operate that may be included in the roles. But if you do not actually deliver patient dialysis in Genesis, you will not get any claims adjusted. If you are managing clinician, who or, a physician who does not deliver MCPs, then you will not get your claims adjusted there.

>> So we recognize that that has caused some confusion he just wanted to clarify that for folks. We got questions about people unsure about if they are in the model or not. Maybe they got the letter or not so in general we sent the letters based off the addresses in the Medicare system that folks signed up for their. If you're not sure, please go to the website or link to the chat there where we can see the ZIP Codes or what is included. If you are practicing and officially Medicare enrolled in that ZIP Code, you would be included so please look up that way and that is how we look up whether you're officially enrolled in Medicare.

And to questions about which address we are used to, since there are many address is, is the practice location address? We are not using addresses.

[Silence]

One other general pitch that I want to make , I see several questions about things that are not in the final role. They are not in the model right now. So this will sent being rule-making. This model says any changes to the role would have to come being a future

model linking. We are not necessarily committing two throw at this time, but if you have any thoughts about potential future changes to please send those into the inbox. Again, to that letter there. We are certain about thinking, gathering leadership about future potential model. Okay, with that being said, any changes cannot happen

administratively on our end. They would have to happen through future rounds of rulemaking. So please do that. That could be if you want to expand or expand beneficiary limit rules or something like that, it would have to come in through there. >>'s we have questions about sort of the future of the ETC Model , I think what would we say, this is a effort that we would see what the results look like, honestly we don't have results yet, because adjustments haven't gone in. It's a pretty natural comparison group to compare 30 is percent of those that are selected into the model of the 70% that are not. Based off those as result and the effects of quality of care and the effects of home dialysis and transplant rates are also the effects of some of the other reforms that are advancing the American kidney and health recess. I think that would reside if the model could be expected further or how to make changes in the permanent program. Yeah -- That is where it would go it would go to 2027. And we will see how it goes at the time. We got questions about the pandemic and COVID-19 that is happening right now it is happening during the base period here. That is something we will closely monitoring. We were saying that home dialysis was a been relatively steady during this time as well as the idea that transplant rates obviously had a dip and a dip but are relatively similar to where they were in the pretend pandemic levels but I think it's something that we will monitor over time. But the model, the payment incentives for the model are going into effect on January 1st of 2021.

And I think, I'll just sort of ends with how do we get more information, with that information of how do we get more information, there is a sling to sign up for the listserv which I believe is in the chat as well as any question as well as looking at the website, look listening to this recording, following up on the slides here all of which will be posted here, and going through that way, so there will be more information there is not, and there is not immediate action required. Just submit claims as normal, we would do the adjustments on our side based off of our data there. That, eventually folks will have to log into a system there to the for innovation in the system that was referenced area, we wish her reports, but that's not going to happen in 2021. >> All right, so that's gonna bring us to the end of the hour, thank you. For all of your questions, we will answer a bunch of questions to the chat. 11 more questions we couldn't get to today. We didn't get to your question or if you have detailed questions. [Event Concluded] [Event has exceeded scheduled time. Captioner must proceed to next scheduled event. Disconnecting at (put in time) .] [Event Concluded]