CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11167	**Date: December 21, 2021**
	Change Request 12404

Transmittal 11108, dated November 5, 2021, is being rescinded and replaced by Transmittal 11167, dated, December 21, 2021 to update the policy section, update requirements 12404.35 and 12404.38, and to add testing requirements 12404.36.1, 12404.48, 12404.49, 12404.50, 12404.51 and 12404.52. All other information remains the same.

SUBJECT: ETC Managing Clinician PPA and KCF PBA Implementation

I. SUMMARY OF CHANGES: This Change Request (CR) will begin implementation of ETC's managing clinician PPA and KCF's PBA. The remainder of the work implementing those payment adjustments will be requested for implementation in April 2022.

The End Stage Renal Disease (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, will be required to participate based on zip code. The ETC Model started on January 1, 2021, and ends on June 30, 2027. The KCC Model includes two options, each with its own demo code: Comprehensive Kidney Care Contracting (CKCC) (demo code: 93) and CMS Kidney Care First (KCF) (demo code: 97). The Kidney Care Choices (KCC) Model begins on January 1, 2022, and ends on December 31, 2024, or optionally, December 31, 2026. This CR primarily focuses on two payment mechanisms: the Performance Payment Adjustment (PPA) from the ETC model and the Performance Based Adjustment (PBA) from the KCC model. These adjustments apply to ESRD Monthly Capitation Payment (MCP) claims and start from July 1, 2022. The ETC model has another payment adjustment called the Home Dialysis Payment Adjustment (HDPA), which overlaps with the PPA and PBA and is also mentioned in this CR for appropriate processing of the claims and adjustments.

EFFECTIVE DATE: January 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2022 - Implement all BRs related to ETC Managing Clinician Performance Payment Adjustment (PPA); April 4, 2022 - Implement all BRs related to KCF Performance Based Adjustment (PBA)

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

Pub. 100-19	Transmittal: 11167	Date: December 21, 2021	Change Request: 12404

Transmittal 11108, dated November 5, 2021, is being rescinded and replaced by Transmittal 11167, dated, December 21, 2021 to update the policy section, update requirements 12404.35 and 12404.38, and to add testing requirements 12404.36.1, 12404.48, 12404.49, 12404.50, 12404.51 and 12404.52. All other information remains the same.

SUBJECT: ETC Managing Clinician PPA and KCF PBA Implementation

EFFECTIVE DATE: January 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2022 - Implement all BRs related to ETC Managing Clinician Performance Payment Adjustment (PPA); April 4, 2022 - Implement all BRs related to KCF Performance Based Adjustment (PBA)

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, will be required to participate based on zip code. The ETC Model started on January 1, 2021, and ends on June 30, 2027. The KCC Model includes two options, each with its own demo code: Comprehensive Kidney Care Contracting (CKCC) (demo code: 93) and CMS Kidney Care First (KCF) (demo code: 97). The Kidney Care Choices (KCC) Model begins on January 1, 2022, and ends on December 31, 2024, or optionally, December 31, 2026. For this change request, we will focus on payment adjustments for the ETC Model and the KCF Option of the KCC Model. In addition, we will discuss implications for the CKCC model's Concurrent Care Benefit Enhancement (BE) because of planned overlap between the BE and MCP claims that will have the ETC payment adjustments applied.

This CR primarily focuses on two payment adjustments: the Performance Payment Adjustment (PPA) from the ETC model and the Performance Based Adjustment (PBA) from the KCC model. These adjustments apply to the ESRD Monthly Capitation Payment (MCP) claims and start from July 1, 2022. The ETC model has another payment adjustment called the Home Dialysis Payment Adjustment (HDPA), which overlaps with the PPA and PBA and is also mentioned in this CR for appropriate processing of the claims and adjustments.

B. Policy: This CR implements the following payment adjustments:

- **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).
- **Performance Based Adjustment (PBA):** is an upward or downward payment adjustment, which applies to only the KCF portion of the KCC model. It is an adjustment made on MCP claims between

July 1, 2023 and December 31, 2026. It is dependent on the participants' performance on quality and utilization measures.

Monthly Capitation Payment (MCP): Medicare pays physicians and other clinicians who manage dialysis care for beneficiaries receiving dialysis through the MCP. The per-beneficiary-per-month MCP is for all office and outpatient visit services related to managing the patient's dialysis, and the amount of the MCP varies based on several criteria: location where the beneficiary dialyzes (at home or in center), the number of face-to-face visits with the beneficiary if the patient dialyzes in center, and the age of the beneficiary.

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 PBA applies to all MCP codes (90957-90962, 90965-90966), and it applies only to the claims submitted by providers who are aligned to the KCF model and only for beneficiaries aligned to these providers. The KCF provider list is generated on a monthly basis, whereas the beneficiary list is generated on a quarterly basis. The first set of files, for July 2023 implementation, will be delivered in June 2023.

The HDPA, PPA, and PBA apply to three different but overlapping groups of claims. For claims subject to these payment adjustments, depending on which group(s) the claim falls under, one or more of these three payment adjustments may be applied. There are seven possible combinations of payment adjustments that may be applied to a given claim paid under this CR.

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 and/or PBA as well, then these 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.

CKCC Concurrent Care for Beneficiaries that Elect the Medicare Hospice Benefit (CKCC BE Indicator "B")

Generally, beneficiaries who elect hospice care waive their right to Medicare coverage for treatment of their terminal condition and related conditions when not provided by the designated hospice. That is, by electing hospice, beneficiaries waive Medicare coverage for services that are considered curative (sometimes referred to as "conventional care") in favor of receiving services that are more palliative in nature.

To ease care transitions and ensure hospice-eligible beneficiaries face a less stark transition and choice between electing or foregoing hospice care, the Comprehensive Kidney Care Contracting (CKCC) option of the Kidney Care Choices (KCC) Model aims to waive the requirement that beneficiaries who elect the Medicare hospice benefit give up their right to receive curative care as a condition of electing the hospice benefit. Under this waiver, Kidney Contracting Entities (KCEs) would work with their hospice providers, as well as non-hospice providers, to define and provide a set of concurrent care services related to a hospice enrollee's terminal condition and related conditions that are appropriate to provide on a transitional basis and align with the enrollee's wishes. For example, this may include the continuation of chemotherapy services, blood transfusions, or dialysis in the form of "bridge services" or permit an enrollee to conclude a course of therapy while transitioning into hospice. Of significance, this provision of concurrent care under the BE does not change the necessary criteria for hospice benefit eligibility or the requirement that the elected hospice provider provide all services and levels of care available under the hospice benefit.

Implementation Approach

Medicare would continue existing claims-based edits to prevent non-hospice claims from processing while a beneficiary is under hospice election, except with respect to those hospice and non-hospice organizations identified by the KCE. The Medicare FFS claims submitted by these organizations will be paid by Medicare if they are otherwise appropriate for payment absent the restriction for paying claims for a beneficiary that has elected hospice. The KCE would pay only for concurrent services provided by designated KCC Participants or Preferred Providers as specified in the beneficiary's plan of care. All expenditures incurred by Medicare on behalf of such beneficiaries, whether for hospice or other non-hospice services would be included as part of total cost of care for the relevant performance year.

Similar to the approach used for the 3-Day Skilled Nursing Facility Rule Waiver, KCEs would identify the hospices with which they would partner in this BE. Likewise, KCEs will be able to identify non-hospice providers included under this BE. These partner hospices and non-hospice providers must be either KCC Participant Providers or Preferred Providers.

Overlap between the Concurrent Care BE, the HDPA, and the PPA

Some MCPs newly covered by the CKCC Concurrent Care BE may be submitted in HDPA zip codes and/or may be submitted by providers on the ETC provider list, and so it is important that the Concurrent Care BE process correctly on these claims even though ETC will take precedence on the claims and ETC does not include requirements implementing CKCC's Concurrent Care BE. Claims eligible for the Concurrent Care BE

may be identified using the CKCC lists when the billing provider has benefit enhancement indicator “B” and the beneficiary is aligned to the same entity. In discussion with MCS and CWF, CWF noted that edit 5348 will prevent CKCC’s Concurrent Care BRs from processing correctly when an MCP claim billed using the Concurrent Care flexibility is also an ETC MCP claim. To prevent mispayment of the Concurrent Care flexibility, a system change will need to take place for CWF to remove the demo code restriction for edit 5348. The system change implementing that correction to edit 5348 will be planned for the January 2022 release, which should capture all of the claims that are eligible for CKCC's Concurrent Care BE that could potentially overlap with ETC payment adjustments.

Beneficiary Activation

Under the KCC model, beneficiaries are initially aligned based on their historical claims data, and once alignment occurs, the beneficiary remains aligned to the model for the performance year (PY) until a dealignment process occurs following 3 months of runout after the PY. However, when a beneficiary’s model eligibility or health status changes after initial alignment but before dealignment, KCC alignment uses a beneficiary activation status so that KCC PMs are paid correctly. When a beneficiary is initially aligned, they are considered active. However if a beneficiary subsequently loses model eligibility, for example, that beneficiary becomes inactive. Further, the same beneficiary may transition from active status, to inactive status, and back to active status, from one quarter to the next. Active KCC beneficiaries are eligible for KCC PMs and BEs, and inactive beneficiaries are eligible only for KCC BEs.

Because the current CR will implement payment adjustments for KCC, and upon further discussion from MCS, it was noted that having a PBA indicator for active beneficiaries would be the most helpful. A Y for this indicator will specify that the beneficiary is qualified for the PBA, whereas a blank will represent the beneficiary is not qualified for PBA. In addition, the blank for the PBA indicator will also indicate that the beneficiary is not eligible for the payment adjustment but is eligible for benefit enhancements.

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	
12404.1	Effective for dates of service on or after January 1, 2022 contractors shall prepare their systems to process Clinician Performance Payment Adjustment (Clinician PPA), and KCF Performance-Based Adjustment (KCF PBA) to the Monthly Capitation Payment (MCP) claims based on the ESRD Treatment Choices (ETC; demo code 94) and Kidney Care First (KCF; demo code 97) models.		X				X			
12404.2	Contractors shall accept and pay for the following procedure codes for PPA and PBA claims : **CPT Age Dialysis Location Visits** 90957 12 to 19 In Center 4 or more 90958 12 to 19 In Center 2 to 3 90959 12 to 19 In Center 1 90960 20 or Older In Center 4 or more 90961 20 or Older In Center 2 to 3 90962 20 or Older In Center 1 90965 12 to 19 Home N/A 90966 20 or Older Home N/A		X				X			
12404.3	Contractors shall accept and process the provider file, which will be in the format shown in the attachment Provider File Format for MCP_Final.		X				X			VDC
12404.4	CMS shall provide the provider and beneficiary alignment production files from the CMS mainframe on or about December 20, 2021.									CMS, VDC
12404.5	On or about December 20, 2021, the ACO-OS shall									CMS, VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	push the production files to the MACs and datacenters specific to their contractor workload(s).									
12404.6	SSMs shall produce response files via EFT acknowledging receipt of the provider and beneficiary production files.						X			CMS, VDC
12404.7	The VDCs shall transmit the provider and beneficiary alignment production file responses via EFT.									CMS, VDC
12404.8	CMS shall send the updated provider file on a monthly basis.									CMS, VDC
12404.9	SSMs shall process the updated aligned provider and aligned beneficiary files as full replacement files						X			
12404.10	MCS shall modify the Provider/Beneficiary Accountable Care Organization online screens, (NP and NB), to display the new KCF PBA participant records.						X			
12404.11	MCS shall modify the MCSDT Provider/Beneficiary Accountable Care Organization window to display the KCF PBA participating provider records.						X			
12404.12	MCS shall modify the MCSDT Provider/Beneficiary Accountable Care Organization window to display the KCF PBA participating beneficiary records.						X			
12404.13	MCS shall update the HXXTACO SPITAB table to add new benefit PBA.						X			
12404.14	MCS shall apply the KCF ACO ID, demonstration code 97 and benefit enhancement flag ‘G’ (PBA) to the claim when - • The detail procedure code is one of the procedures listed in the CR for the PBA; And • the rendering provider TIN/NPI is found on the provider alignment file with a KCF Model ID and the record type of ‘G’; And • the beneficiary HIC is present on the beneficiary alignment file, with the same KCF						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	model identifier, And • the bene record has a PBA indicator of "Y", And • the detail date of service is on or within the Effective Start and End Dates on the alignment record.									
12404.15	MCS shall NOT perform an adjustment for PBA claims when there is a change to the provider alignment file.						X			
12404.16	MCS shall update the CWF claims transmission record (HUBC) to report the PPA and/or PBA payment adjustment.						X			
12404.17	MCS shall add the new PPA and PBA percent, payment adjustment message, audit and other amount ind, and amount to the IDR daily claims file. The field will be mapped in Phases 2 and 3.						X			
12404.18	MCS shall include the cutback description and amount to the Beneficiary Research Document (BRD).						X			
12404.19	MCS shall display the PPA and PBA adjustment information on the HBDR2001 (Reimbursement Analysis) report.						X			
12404.20	MCS shall display the new PPA and PBA percent, payment adjustment message, audit and amount on the COBOL friendly history record.						X			
12404.21	MCS shall display the new PPA and PBA payment adjustment audit and amount on the CLMSDUMP.						X			
12404.22	CWF shall modify the HUBCCED program to accept New Values in the "Other Amount Indicator" field for the ETC-KCF Payment PPA (Performance Payment Adjustment) and PBA (Performance Based Adjustment) to populate the total reimburse amount.								X	
12404.23	CWF shall modify Part B consistency edit 92x5 to accept an addition and reduction to the reimbursement						X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	amount when Other Amount Indicator A6 (PPA addition), A7 (PPA reduction), A8 (PBA addition), and A9 (PBA reduction) is received.									
12404.24	CWF shall modify Part B consistency edit 97x1 to accept the new values in the Other Amount Indicator field.								X	
12404.25	CWF shall update the HCFACLM file (NCH) to accept the new values in the Other Amount Indicator field for the ETC-KCF Payment on the HUBC transmit record.								X	NCH
12404.26	CWF shall carry the New Values in the Other Amount Indicator field for the ETC-KCF Payment in HIMR for the Part B claim history (PTBH) when present on an accepted HUBC transmit record.								X	
12404.27	CWF shall use the existing auxiliary file/HIMR screen to display the beneficiary file data. The new field for PBA indicator shall be added to the ACOB Auxiliary file. The ICD indicates valid PBA values are blank for not qualified and 'Y' for qualified.								X	
12404.28	CWF shall accept and ensure the new benefit enhancement indicator 'G' will flow to the downstream systems, including but not limited to NCH, IDR, and CCW. 'G' - PBA-Performance Based Adjustment								X	NCH
12404.29	CWF shall carry the New Benefit enhancement value 'G' for PBA (Performance Based Adjustment) in HIMR for the Part B claim history (PTBH) when present on the detail line of an HUBC record.								X	
12404.30	CWF shall ensure the Performance Payment Adjustment (PPA) payment mechanism is applied to the MSP (Medicare Secondary Payer) claims.								X	
12404.31	SSMs shall create a response file using the layout in the attachment Provider File Format for MCP_Final that indicates specific records and fields that did not						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	pass the validation checks using defined error codes as defined in the ICD.									
12404.32	Effective for Dates of Service on or after the effective date, SSMs shall use the benefit enhancement indicator (record type) values identified in the Interface Control Document (ICD) to identify when a provider is subject to a benefit enhancement when processing Part A and Part B claims.						X			
12404.33	CMS shall include data elements on the aligned beneficiary file and provider file as identified in the ICD.									ACO OS, CMS
12404.34	SSMs shall perform limited editing to ensure the beneficiary file and provider files are well-formed. The validation checks will include: • the Header Record must be present and fields populated with valid information; • the Trailer Record must be present and fields populated with valid information; and • the actual count of detail records must match the count in the Trailer Record. **NOTE:** The ICD will define the response file layout and detailed error conditions.						X			
12404.35	MCS shall apply the ETC demonstration code of 94 to claims if the following criteria is met: • The detail procedure code is one of the procedures listed in the CR for the PPA; And • The detail rendering provider NPI/billing TIN is found on the ETC provider participation file; OR • There is not a matching rendering NPI/TIN combination on the PPA file, and there is a						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	matching rendering NPI without a TIN; AND • The detail DOS falls within the provider file effective and end dates.									
12404.36	MCS shall perform claim adjustments to ETC/PPA claims if the percentage adjustment field or end date have changed for a provider.						X			
12404.36.1	A/B MACs Part B shall use an appropriate Discovery Code and Reason Code 'O' when initiating the ETC/KCF overpayment adjustments.		X							
12404.37	MCS shall apply the appropriate PBA payment adjustment to the KCF/PBA model claims. • Calculate the PBA on the Medicare allowed amount before deductible and coinsurance are applied. • The PBA percentage is found in the KCF Participant provider file, Part B percentage adjustment field. • Calculate the deductible and coinsurance before applying the PBA adjustment so that cost sharing is not impacted. • Calculate MIPs on the approved to Pay amount (after cost sharing). • Apply PBA payment adjustment after applying deductible and coinsurance but before sequestration. (HDPA/PPA/PBA could all apply to the claim, apply all positive adjustments before applying negative adj so the full amount will be taken if any are negative.) Apply sequestration, and any other adjustments that the claim line would otherwise normally be subject, if applicable.						X			
12404.38	MCS shall apply the appropriate PPA payment adjustment to the ETC/PPA model claims.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Calculate the PPA adjustment based on the Medicare allowed amount before deductible and coinsurance are applied. • The individual providers PPA adjustment percentage for the NPI/TIN matching record is found in the ETC provider file, Provider Adjustment Percentage 1 field. If there isn't a matching NPI/TIN record, use the percentage from the NPI record that does not have a TIN. • Calculate the deductible and coinsurance before applying the PPA adjustment so that cost sharing is not impacted. • Calculate MIPs on the approved to Pay amount (after cost sharing). • Apply PPA payment adjustment after applying deductible and coinsurance but before sequestration. (HDPA/PPA/PBA could all apply to the claim, apply all positive adjustments before applying negative adj so the full amount will be taken if any are negative.) • Apply sequestration, and any other adjustments that the claim line would otherwise normally be subject, if applicable.									
12404.39	For claims with the PPA or HDPA applied, regardless of whether the PBA is applied, the SSMs shall set the Demo Code 94 in the first demo code field. If other demo codes are present on the claim, move Demo Code 94 to the first position, and move the remaining codes down one position. Note. The existing precedence established for ETC and KCF in other CRs still applies.						X			
12404.40	Contractors shall suppress ETC payment adjusted amounts from affected beneficiary EOMB notices.		X				X			
12404.41	The STC and the MACs shall provide to CMS the data to create the test file by September 10, 2021. To assist with the creation of the test file, the STC and MACs shall:		X							STC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Provide a list of at a minimum 5 to 15 providers as indicated by Tax Identification Number-iNational Provider Identifier (TIN-iNPI) for Part B MACs • These sample Providers shall be provided in a spreadsheet file using the attachment Provider File Layout for MCP_Final, and: • Send encrypted data to: • Rekha Varghese (Impaq) at RVarghese@impaqint.com									
12404.42	CMS shall transmit the test files to the Single Testing Contractor (STC) by November 1, 2021.									CMS, STC, VDC
12404.43	CMS shall push the test files to the Virtual Data Centers (VDCs) on or about December 1, 2021 and the Part B Medicare Administrative Contractors (MACs) shall test during User Acceptance Testing (UAT).		X							CMS, VDC
12404.44	SSMs shall create response files to acknowledge receipt of the provider and beneficiary test files and indicate any errors discovered during testing and transmit them to CMS. Note: Because of the availability of future year claims, testing may be dependent on files that may not be available during UAT. Such testing may need to occur after the implementation date, likely during the claims holding period following the implementation date.						X			CMS, VDC
12404.45	Contractors and SSMs shall participate in a single, one-hour long teleconference with CMS during the UAT testing period to discuss problems identified during testing at a date to-be-determined by CMS.		X				X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	This date will be communicated on a future Functional Workgroup (FWG) call. Note. • For STC, send the invite to STC-TCD-Team@dcca.com and STC-TCE-Team@dcca.com • CWF does not regularly attend FWGs and must be informed of the time/date of the UAT call separately.									
12404.46	CMS shall push the test files to the SSMs on or about October 1, 2021, and the SSMs shall test during User ALPHA testing.						X			CMS
12404.47	For all claims with the PPA and PBA adjustment, the contractor shall use the following line level message: CARC 132 – Prearranged demonstration project adjustment Group Code - CO MSN 60.4 - This claim is being processed under a demonstration project. Spanish language: Esta reclamación está siendo procesada bajo un projecto especial.		X							
12404.48	ACO-OS shall transmit the PBA test files to the Single Testing Contractor (STC) by February 1, 2022.									ACO OS, STC, VDC
12404.49	ACO-OS shall push the test files to the Virtual Data Centers (VDCs) on or about March 1, 2022 and the Part B Medicare Administrative Contractors (MACs) shall test during User Acceptance Testing (UAT).		X							ACO OS, VDC
12404.50	ACO-OS shall push the test files to the SSMs on or about January 1, 2022, and the SSMs shall test during User ALPHA testing.						X			ACO OS
12404.51	Contractors shall handle all ETC/KCF model claims		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(demo 94 and 97) and/or claim lines as non-935 eligible.									
12404.52	A/B MACs Part B shall ensure the 935 indicator is set to 'N' for these adjustment claims as they are not eligible for the Section 935 Appeals.		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):
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.

ATTACHMENTS: 0