DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

June 2022

Contact: ETC Model Team
ETC-CMMI@cms.hhs.gov

End-Stage Renal Disease Treatment Choices (ETC) Model Performance Payment Adjustment Report User Guide (Measurement Years 1-2)

Disclaimer: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Centers for Medicare & Medicaid Services
End-Stage Renal Disease Treatment Choices (ETC) Model

Performance Payment Adjustment (PPA) Report User Guide
(Measurement Years 1-2)

Prepared for:

Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Prepared by:

American Institutes for Research
1400 Crystal Drive, 10th Floor
Arlington, VA 22202-3289

JUNE 2022

Reference Documents

Title
Specialty Care Models To Improve Quality of Care and Reduce Expenditures Final Rule (85 FR 61114)
End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model Final Rule (86 FR 61874)

Acronyms

Acronym	Explanation
AKI	Acute Kidney Injury
BY	Benchmark Year
CMS	Centers for Medicare & Medicaid Services
CPT®	Current Procedural Terminology[1]
ESRD	End-Stage Renal Disease
ETC	ESRD Treatment Choices
HCC	Hierarchical Condition Category
HRR	Hospital Referral Region
LDT	Living Donor Transplant
LVT	Low Volume Threshold
MCP	Monthly Capitation Payment
MPS	Modality Performance Score
MY	Measurement Year
NPI	National Provider Identifier
PECOS	Provider Enrollment, Chain, and Ownership System
PPA	Performance Payment Adjustment
SNF	Skilled Nursing Facility
SRTR	Scientific Registry of Transplant Recipients
TIN	Taxpayer Identification Number

[1] Throughout this document, we use CPT® codes and descriptions to refer to a variety of services. We note that CPT® codes and descriptions are copyright 2020 American Medical Association. All Rights Reserved. CPT® is a registered trademark of the American Medical Association (AMA). Applicable Federal Acquisition Regulations (FAR) and Defense Federal Acquisition Regulations (DFAR) apply.

Contents

Exhibits

I. Overview of ETC Model's Performance Payment Adjustment

The End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model is a mandatory payment model intended to encourage greater use of home dialysis and kidney transplants for Medicare beneficiaries with ESRD, while reducing Medicare expenditures and preserving or enhancing the quality of care furnished to beneficiaries with ESRD.[2] The Centers for Medicare & Medicaid Services (CMS) randomly selects Hospital Referral Regions (HRRs) for inclusion in the ETC Model. All eligible ESRD facilities and clinicians who manage dialysis patients (Managing Clinicians) located in selected HRRs (Selected Geographic Areas) are required to participate in the ETC Model.

Following each Measurement Year (MY), CMS separately calculates the home dialysis rate and the transplant rate at the ESRD facility and Managing Clinician aggregation group levels using the methodologies described in the Specialty Care Models To Improve Quality of Care and Reduce Expenditures final rule (85 FR 61114), referred to herein as the Specialty Care Models final rule.[3]

CMS compares the aggregation group's home dialysis rate and transplant rate to their applicable achievement and improvement benchmarks and assigns a Modality Performance Score (MPS). CMS will determine the magnitude of the aggregation group's Performance Payment Adjustment (PPA) based on the MPS according to the schedule in the Specialty Care Models final rule. The PPA applies to all aggregation groups located within Selected Geographic Areas in both the Benchmark Year (BY) and the corresponding MY with at least 11 attributed beneficiary years or 132 attributed beneficiary months during the MY.

As described in § 512.390(a) (Notification) of the Specialty Care Models final rule, CMS will notify ETC Participants of their performance benchmarks and rates, MPS, and PPA in advance of a PPA Period. Each ETC Participant's performance is summarized in a customized PPA Report which will be provided to the Participant no later than one month before the start of the applicable PPA Period. This guide accompanies the ETC Participant PPA Report and describes the methods that CMS uses to calculate the achievement and improvement benchmarks and measurement year home dialysis rate and transplant rate, and how these performances translate into aggregation group level MPS and PPA.

[2] https://innovation.cms.gov/innovation-models/esrd-treatment-choices-model

[3] https://www.federalregister.gov/documents/2020/09/29/2020-20907/medicare-program-specialty-care-models-to-improve-quality-of-care-and-reduce-expenditures

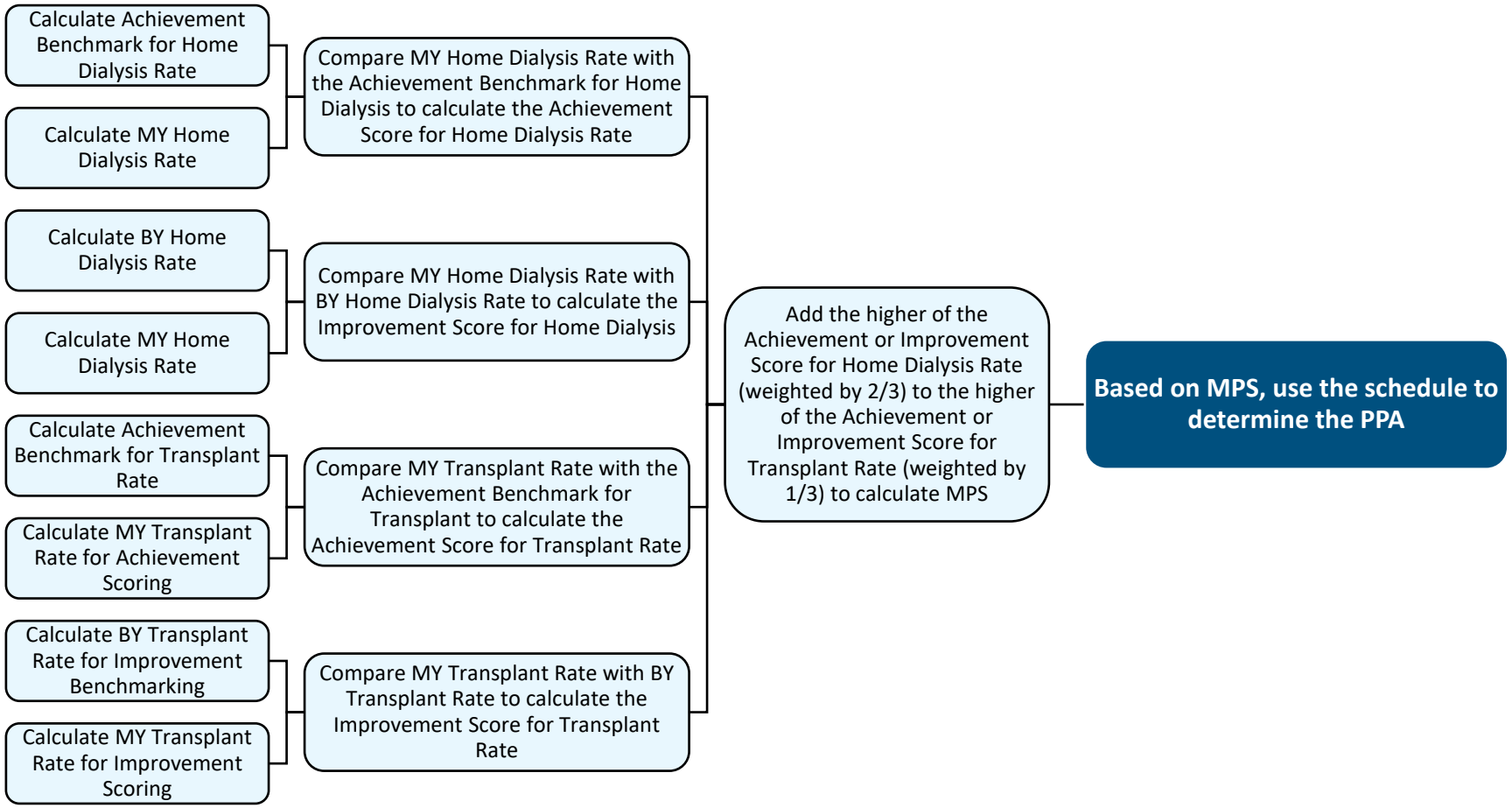
This user guide is for Measurement Years 1 and 2 and corresponding ETC Participant PPA reports.[4] A crosswalk between the sections of the user guide and the tabs of the PPA report is included in the Appendix. ETC Participants without any attributed beneficiaries during an MY or BY will not receive a Performance Payment Adjustment (PPA) for that MY and will be notified through a PPA Report containing only a ReadMe section that displays the associated PPA Period, Measurement Year and Benchmark Year.

The remainder of this guide is organized as follows: Section II displays the PPA calculation process using a flow diagram. Section III provides the benchmark and measurement years, and PPA periods. Beneficiary attribution and aggregation groups are described in Sections IV and V. Sections VI and VII describe the calculation of the home dialysis rate and transplant rate. Achievement benchmarking and scoring process is described in Section VIII, and improvement benchmarking and scoring process is described in Section IX. Sections X and XI explain how achievement and improvement scoring translate into MPS and PPA. Section XII provides the reasons why MPS and PPA might be missing for some ETC Participants. Section XIII describes the targeted review process. The Appendix provides the user guide - ETC Participant PPA report crosswalk.

[4] CMS will update the guide when there are changes in the methodology or implementation of the ESRD ETC Model in future MYs. The guide accompanying the ETC Participant PPA Report for Measurement Year 3 will reflect the changes to the ESRD ETC Model implemented in the End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals With Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model final rule (86 FR 61874). https://www.federalregister.gov/documents/2021/11/08/2021-23907/medicare-program-end-stage-renal-disease-prospective-payment-system-payment-for-renal-dialysis

II. PPA Calculation

Exhibit 1. PPA Calculation Flow Diagram



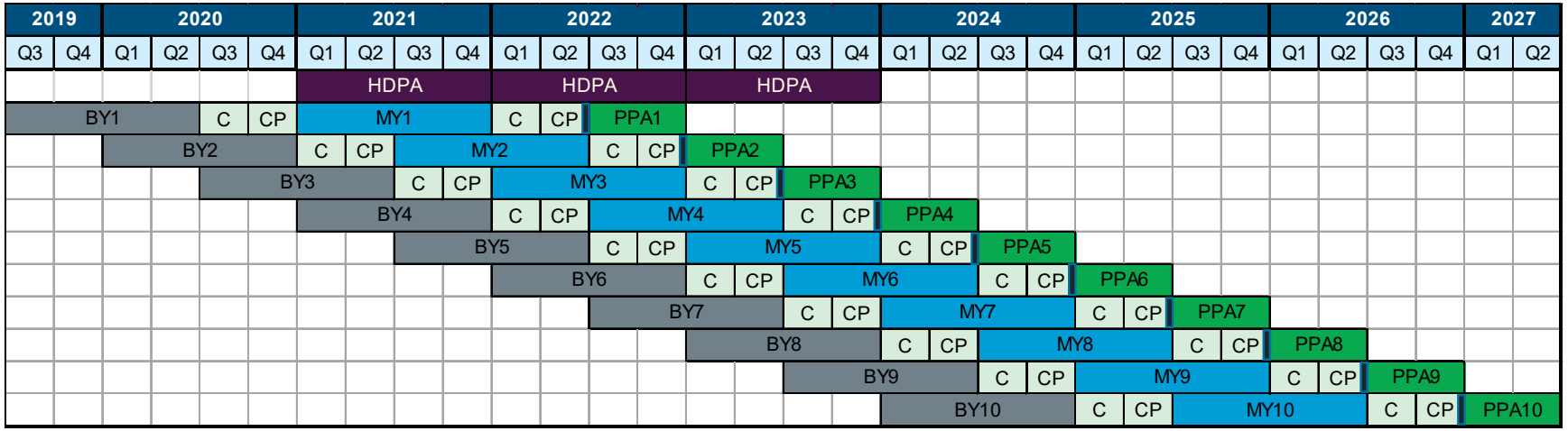
III. Benchmark Year, Measurement Year, and PPA Period

As described in § 512.310 (Definitions) of the Specialty Care Models final rule, Benchmark Year (BY) means the 12-month period that begins 18 months prior to the start of a given Measurement Year (MY) from which data are used to construct benchmarks against which to score an ETC Participant's aggregation group's achievement and improvement on the home dialysis rate and transplant rate for the purpose of calculating the ETC Participant's MPS. As described in § 512.355(a) (Measurement Years) of the Specialty Care Models final rule, CMS assesses ETC Participant's aggregation group's performance on the home dialysis rate and the transplant rate during each of the MYs. The first MY begins on January 1, 2021, and the final MY ends on June 30, 2026. As described in § 512.355(b) (Performance Payment Adjustment Period) of the Specialty Care Models final rule, CMS adjusts certain payments to ETC Participants by the PPA during each of the PPA Periods, each of which corresponds to a MY. The first PPA Period begins on July 1, 2022, and the final PPA Period ends on June 30, 2027. Exhibit 2a and 2b display the BY, MY and PPA Period schedule, as described in § 512.355(c) (Measurement Years and Performance Payment Adjustment Periods) of the Specialty Care Models final rule.

Exhibit 2a. ETC Model Schedule of BYs, MYs and PPA Periods

BY	MY	PPA Period
BY 1 - 7/1/2019 through 6/30/2020	**MY 1** - 1/1/2021 through 12/31/2021	**PPA Period 1** - 7/1/2022 through 12/31/2022
BY 2 - 1/1/2020 through 12/31/2020	**MY 2** - 7/1/2021 through 6/30/2022	**PPA Period 2** - 1/1/2023 through 6/30/2023
BY 3 - 7/1/2020 through 6/30/2021	**MY 3** - 1/1/2022 through 12/31/2022	**PPA Period 3** - 7/1/2023 through 12/31/2023
BY 4 - 1/1/2021 through 12/31/2021	**MY 4** - 7/1/2022 through 6/30/2023	**PPA Period 4** - 1/1/2024 through 6/30/2024
BY 5 - 7/1/2021 through 6/30/2022	**MY 5** - 1/1/2023 through 12/31/2023	**PPA Period 5** - 7/1/2024 through 12/31/2024
BY 6 - 1/1/2022 through 12/31/2022	**MY 6** - 7/1/2023 through 6/30/2024	**PPA Period 6** - 1/1/2025 through 6/30/2025
BY 7 - 7/1/2022 through 6/30/2023	**MY 7** - 1/1/2024 through 12/31/2024	**PPA Period 7** - 7/1/2025 through 12/31/2025
BY 8 - 1/1/2023 through 12/31/2023	**MY 8** - 7/1/2024 through 6/30/2025	**PPA Period 8** - 1/1/2026 through 6/30/2026
BY 9 - 7/1/2023 through 6/30/2024	**MY 9** - 1/1/2025 through 12/31/2025	**PPA Period 9** - 7/1/2026 through 12/31/2026
BY 10 - 1/1/2024 through 12/31/2024	**MY 10** - 7/1/2025 through 6/30/2026	**PPA Period 10** - 1/1/2027 through 6/30/2027

Exhibit 2b. ETC Model Schedule of BYs, MYs and PPA Periods (Gantt Chart)



HDPA	Home Dialysis Payment Adjustment
BY	Benchmark Year used to calculate historical rates for benchmarks
C	3-month claims run-out
CP	Calculation Period
MY	Measurement Year
PPA	Performance Payment Adjustment
	PPA Reports available to ETC Participants

IV. Beneficiary Attribution for PPA Calculation

An ETC Participant's (ESRD facility or Managing Clinician) PPA is calculated based on the beneficiaries attributed to the Participant during the MY.[5] As specified in § 512.360 (Beneficiary population and attribution) of the Specialty Care Models final rule, CMS attributes ESRD beneficiaries to an ETC Participant for each month during a MY based on the ESRD Beneficiary's receipt of ESRD-related services (non-AKI 72X claims for ESRD facilities and Monthly Capitation Payment (MCP) claims for Managing Clinicians) during the month. Beneficiaries who meet one or more of the exclusion criteria listed in § 512.360(b) (Exclusions from attribution) of the Specialty Care Models final rule during a month is not attributed in the given month. CMS does not attribute an ESRD Beneficiary or Pre-emptive LDT Beneficiary to an ETC Participant for a month if, at any point during the month, the beneficiary —

- Is not enrolled in Medicare Part B;
- Is enrolled in Medicare Advantage, a cost plan, or other Medicare managed care plan;
- Does not reside in the United States;
- Is younger than 18 years of age before the first day of the month of the claim service date;
- Has elected hospice;
- Is receiving dialysis only for any acute kidney injury (AKI);
- Has a diagnosis of dementia at any point during the month of the claim service date or the preceding 12 months, as identified using the most recent dementia-related criteria at the time of beneficiary attribution, using the CMS-HCC (Hierarchical Condition Category) Risk Adjustment Model ICD-10-CM Mappings; or
- Is residing in or receiving dialysis in a skilled nursing facility (SNF) or nursing facility.

CMS also attributes Pre-emptive Living Donor Transplant (Pre-emptive LDT) Beneficiaries to Managing Clinicians for one or more months during a MY based on the Beneficiary's receipt of services as specified in § 512.360(c)(2)(ii) (Managing Clinician Beneficiary attribution) of the Specialty Care Models final rule. Pre-emptive LDT Beneficiaries who meet one or more of the exclusion criteria, as specified in § 512.360(b) (Exclusions from attribution) of the Specialty Care Models final rule and listed above, are not attributed for the ETC Model.

As specified in § 512.360 (Beneficiary population and attribution) of the Specialty Care Models final rule, CMS attributes an ESRD Beneficiary to no more than one ESRD facility and no more

[5] Beneficiaries attributed to Participants during BYs also affect the PPA process through improvement benchmarking and scoring.

than one Managing Clinician for a given month during a given MY. CMS attributes a Pre-emptive LDT Beneficiary to no more than one Managing Clinician for a given MY.

CMS makes available to each ETC Participant the list of Beneficiaries and Beneficiary-months attributed to them for the MY through a Beneficiary-level Attribution Report. This report is available for a PPA Period no later than one month before the start of the applicable PPA Period. The report includes identifiable details of each attributed Beneficiary and other Beneficiary data (e.g., whether the Beneficiary received home dialysis in a month).

V. Aggregation Groups

As described in § 512.365(e)(1) (Aggregation of ESRD facilities) of the Specialty Care Models final rule, an ESRD facility's home dialysis rate and transplant rate are aggregated to the ESRD facility's aggregation group for performance assessment. The aggregation group for a Subsidiary ESRD facility includes all ESRD facilities owned in whole or in part by the same legal entity located in the HRR in which the ESRD facility is located. An ESRD facility that is not a Subsidiary ESRD facility is not included in an aggregation group.

Subsidiary ESRD facilities within an aggregation group are primarily identified using the Chain Taxpayer Identification Number (TIN) and the Chain Legal Name documented in Centers for Medicare & Medicaid Services' (CMS) Medicare Provider Enrollment, Chain, and Ownership System (PECOS). CMS also uses data from CROWNWeb and other CMS data sources to correct typographical errors and resolve ambiguities in PECOS records. CMS sends an aggregation group notification letter regarding a facility's status as a Subsidiary ESRD facility at the beginning of each MY. This letter includes a list of the facility and, if applicable, other facilities in the facility's aggregation group during the associated BY. If the list of facilities includes only the facility, then the facility is not part of an aggregation group because CMS has determined that it is either not a Subsidiary ESRD facility or that there is no other ESRD facility owned in whole or in part by the same company within the same HRR.

As described in § 512.365(e)(2) (Aggregation for Managing Clinicians) of the Specialty Care Models final rule, the aggregation group for Managing Clinicians in a group practice, as identified by practice Tax Identification Number (TIN), includes all Managing Clinicians within the HRR in which the group practice is located. Managing Clinicians who are solo practitioners, as identified by individual National Provider Identifier (NPI) and TIN, are not aggregated. The identification of aggregation groups for Managing Clinicians is based only on NPI and TIN and does not require additional data sources or processes as in the case of ESRD facilities. Therefore, CMS does not send aggregation letters to Managing Clinicians at the beginning of each MY.

Aggregation groups will be reassessed after the end of the MY and may change over time for various reasons (e.g., due to facilities that open, close, or change affiliation). The updated list produced after the end of the MY will be used for calculating the Participant's performance rates, MPS and PPA. The "**4.AG_Participant_List**" tab of the PPA Report provides the final list of ETC Participants at the end of the MY in the ETC Participant's aggregation group.

VI. Home Dialysis Rate

As described in § 512.365(b) (Home dialysis rate) of the Specialty Care Models final rule, CMS calculates the home dialysis rate for ESRD facilities and Managing Clinicians as follows.

$$Home\ Dialysis\ Rate = \frac{\begin{matrix} Number\ of\ attributed \\ ESRD\ Beneficiary\ months + \\ in\ MY\ with\ home\ dialysis \end{matrix} \left(\begin{matrix} Number\ of\ attributed \\ 0.5 * ESRD\ Beneficiary\ months \\ in\ MY\ with\ self\ dialysis \end{matrix} \right)}{Total\ number\ of\ attributed\ ESRD\ Beneficiary\ months\ in\ MY}$$

Home Dialysis Rate for ESRD facilities

The denominator is the total dialysis treatment beneficiary years for attributed ESRD Beneficiaries during the MY. Dialysis treatment beneficiary years included in the denominator are composed of those months during which an attributed ESRD Beneficiary received maintenance dialysis at home or in an ESRD facility, such that one beneficiary year is composed of 12 beneficiary months. Months during which attributed ESRD Beneficiaries received maintenance dialysis are identified by claims with Type of Bill 072X.

The numerator is the total number of home dialysis treatment beneficiary years plus one half the total number of in center self-dialysis treatment beneficiary years for attributed ESRD Beneficiaries during the MY.

Home dialysis treatment beneficiary years included in the numerator are composed of those months during which attributed ESRD Beneficiaries received maintenance dialysis at home, such that one beneficiary year is comprised of 12 beneficiary months. Months in which an attributed ESRD Beneficiary received maintenance dialysis at home are identified by claims with Type of Bill 072X and condition codes 74 or 76.

In center self-dialysis treatment beneficiary years included in the numerator are composed of those months during which attributed ESRD Beneficiaries received self-dialysis in center, such that one beneficiary year is comprised of 12 beneficiary months. Months in which an attributed ESRD Beneficiary received in center self-dialysis are identified by claims with Type of Bill 072X

and condition code 72. If a patient receives both home dialysis and in center self-dialysis in a month, that month will be included as home dialysis in the numerator of the home dialysis rate.

Information used to calculate the ESRD facility home dialysis rate includes Medicare claims data and Medicare administrative data.

The ESRD facility home dialysis rate is aggregated to the facility's aggregation group, as described in Section V.

Home Dialysis Rate for Managing Clinicians

The denominator is the total dialysis treatment beneficiary years for attributed ESRD Beneficiaries during the MY. Dialysis treatment beneficiary years included in the denominator are composed of those months during which an attributed ESRD Beneficiary received maintenance dialysis at home or in an ESRD facility, such that one beneficiary year is comprised of 12 beneficiary months. Months during which an attributed ESRD Beneficiary received maintenance dialysis are identified by claims with CPT® codes 90957, 90958, 90959, 90960, 90961, 90962, 90965, or 90966.

The numerator is the total number of home dialysis treatment beneficiary years for attributed ESRD Beneficiaries during the MY plus one half the total number of in center self-dialysis treatment beneficiary years.

Home dialysis treatment beneficiary years included in the numerator are composed of those months during which an attributed ESRD Beneficiary received maintenance dialysis at home, such that one beneficiary year is comprised of 12 beneficiary months. Months in which an attributed ESRD Beneficiary received maintenance dialysis at home are identified by claims with CPT® codes 90965 or 90966.

In center self-dialysis treatment beneficiary years included in the numerator are composed of those months during which an attributed ESRD Beneficiary received self-dialysis in center, such that one beneficiary year is comprised of 12 beneficiary months. Months in which an attributed ESRD Beneficiary received in center self-dialysis are identified by claims with Type of Bill 072X and condition code 72.

Information used to calculate the Managing Clinician home dialysis rate includes Medicare claims data and Medicare administrative data.

The Managing Clinician home dialysis rate is aggregated to the Managing Clinician's aggregation group, as described in Section V.

VII. Transplant Rate

As described in § 512.365(c) (Transplant rate) of the Specialty Care Models final rule, CMS calculates the transplant rate for ESRD facilities and Managing Clinicians as follows.

$$Transplant\ Rate = \begin{matrix} Risk\ Adjusted \\ Transplant\ Waitlist\ Rate\ in\ MY \end{matrix} + \begin{matrix} Living\ Donor \\ Transplant\ Rate\ in\ MY \end{matrix}$$

$$\begin{matrix} Risk\ Adjusted \\ Transplant\ Waitlist\ Rate\ in\ MY \end{matrix} = \frac{\begin{matrix} Observed\ Transplant \\ Waitlist\ Rate\ in\ MY \end{matrix}}{\begin{matrix} Expected\ Transplant \\ Waitlist\ Rate\ in\ MY \end{matrix}} * \begin{matrix} Reference\ Transplant \\ Waitlist\ Rate\ in\ BY \end{matrix}$$

$$\begin{matrix} Living\ Donor \\ Transplant\ Rate\ in\ MY \end{matrix} = \frac{\begin{matrix} Number\ of\ Living\ Donor\ Transplant \\ Beneficiary\ months\ for\ ESRD\ Beneficiaries\ in\ MY \end{matrix}}{\begin{matrix} Total\ Number\ of \\ attributed\ ESRD\ Beneficiary\ months\ in\ MY \end{matrix}}$$

As described in § 512.365(d) (Risk adjustment) of the Specialty Care Models final rule, CMS risk adjusts the transplant waitlist rate based on beneficiary age with separate risk coefficients for the following age categories of beneficiaries, with age computed on the last day of each month of the MY: 18 to 55, 56 to 70, and 71 to 74. The transplant waitlist rate risk-adjustment is described below in "Risk Adjustment of transplant waitlist rate for ESRD facilities."

Transplant Rate for ESRD facilities

The transplant rate for ESRD facilities is the sum of the transplant waitlist rate for ESRD facilities and the living donor transplant (LDT) rate for ESRD facilities, as described below.

Transplant waitlist rate for ESRD facilities

The denominator is the total dialysis treatment beneficiary years for attributed ESRD Beneficiaries during the MY. Dialysis treatment beneficiary years included in the denominator are composed of those months during which an attributed ESRD beneficiary received maintenance dialysis at home or in an ESRD facility, such that one beneficiary year is comprised of 12 beneficiary months. Months during which an attributed ESRD Beneficiary received maintenance dialysis are identified by claims with Type of Bill 072X, excluding claims for beneficiaries who were 75 years of age or older at any point during the month.

The numerator is the total number of attributed beneficiary years for which attributed ESRD Beneficiaries were on the kidney transplant waitlist. Months during which an attributed ESRD

Beneficiary was on the kidney transplant waitlist are identified using data from the Scientific Registry of Transplant Recipients (SRTR) database.

Risk Adjustment of transplant waitlist rate for ESRD Facilities

The transplant waitlist rate is calculated as a risk adjusted rate to account for variation in transplant waitlisting related to age and to ensure that the performance of ESRD facility aggregation groups that differ in terms of the age distributions of their attributed ESRD Beneficiaries can be accurately compared. As described in § 512.365(d) (Risk adjustment) of the Specialty Care Models final rule, CMS risk adjusts the transplant waitlist rate based on beneficiary age with separate risk coefficients for the following age categories of beneficiaries, with age computed on the last day of each month of the MY: 18 to 55, 56 to 70, and 71 to 74. CMS estimates the risk coefficients based on the

- ETC non-participant experience during the BY for achievement scoring, and
- ETC participant experience during the BY for improvement scoring.

Due to differences in reference population for the risk-adjusted transplant waitlist rate in MY, the transplant rate in MY for achievement scoring may be slightly different from the transplant rate in MY for improvement scoring.

CMS uses these risk coefficients to calculate a predicted probability of attributed ESRD beneficiary months spent on a transplant waitlist during the MY.

The risk-adjusted transplant waitlist rate in the MY is calculated as follows:

$$\begin{matrix} Risk\ Adjusted \\ Transplant\ Waitlist\ Rate\ in\ MY \end{matrix} = \frac{\begin{matrix} Observed\ Transplant \\ Waitlist\ Rate\ in\ MY \end{matrix}}{\begin{matrix} Expected\ Transplant \\ Waitlist\ Rate\ in\ MY \end{matrix}} * \begin{matrix} Reference\ Transplant \\ Waitlist\ Rate\ in\ BY \end{matrix}$$

The observed rate varies by aggregation group. It is the percent of ESRD Beneficiary months attributed to an ESRD facility aggregation group that were represented on a transplant waitlist during the MY.

The expected rate also varies by aggregation group. It is the predicted percent of ESRD Beneficiary months during which an ESRD Beneficiary attributed to an ESRD facility aggregation group was represented on a transplant waitlist during the MY. The prediction is based on the expected experience in the BY of the relevant reference population if it were to treat ESRD Beneficiaries with the same age-mix as that of the ESRD facility aggregation group.

The reference population varies for achievement scoring and improvement scoring. The reference rate is the observed rate for all ESRD beneficiaries attributed

- to all non-participating ESRD facility aggregation groups during the BY for achievement scoring, and
- to all participating ESRD facility aggregation groups during the BY for improvement scoring.

Living donor transplant rate for ESRD facilities

The denominator is the total dialysis treatment beneficiary years for attributed ESRD Beneficiaries during the MY. Dialysis treatment beneficiary years included in the denominator are composed of those months during which an attributed ESRD Beneficiary received maintenance dialysis at home or in an ESRD facility, such that one beneficiary year is comprised of 12 beneficiary months. Months during which an attributed ESRD Beneficiary received maintenance dialysis are identified by claims with Type of Bill 072X, excluding claims for beneficiaries who were 75 years of age or older at any point during the month.

The numerator is the total number of attributed beneficiary years for LDT Beneficiaries during the MY. Beneficiary years for LDT Beneficiaries included in the numerator are composed of those months between the beginning of the MY up to and including the month of the transplant for LDT Beneficiaries attributed to an ESRD facility during the month of the transplant. LDT Beneficiaries are identified using information about living donor transplants from the SRTR Database and Medicare claims data.

Transplant Rate for Managing Clinicians

The transplant rate for Managing Clinicians is the sum of the transplant waitlist rate for Managing Clinicians and the living donor transplant rate for Managing Clinicians, as described below. For Managing Clinicians, the Pre-emptive LDT beneficiary years are included in the living donor transplant rate.

Transplant waitlist rate for Managing Clinicians

The denominator is the total dialysis treatment beneficiary years for attributed ESRD Beneficiaries during the MY. Dialysis treatment beneficiary years included in the denominator are composed of those months during which an attributed ESRD Beneficiary received maintenance dialysis at home or in an ESRD facility, such that one beneficiary year is comprised of 12 beneficiary months. Months during which an attributed ESRD Beneficiary received maintenance dialysis are identified by claims with CPT® codes 90957, 90958, 90959, 90960, 90961, 90962, 90965, or 90966, excluding claims for beneficiaries who were 75 years of age or older at any point during the month.

The numerator is the total number of attributed beneficiary years for which attributed ESRD Beneficiaries were on the kidney transplant waitlist. Months during which an attributed ESRD Beneficiary was on the kidney transplant waitlist are identified using data from the SRTR database.

Risk Adjustment of transplant waitlist rate for Managing Clinicians

CMS uses the same process to risk adjust the transplant waitlist rate for ESRD facilities and Managing Clinicians. This process is described earlier in "Risk Adjustment of transplant waitlist rate for ESRD Facilities."

Living donor transplant rate for Managing Clinicians

The denominator is the sum of the total dialysis treatment beneficiary years for attributed ESRD Beneficiaries during the MY and the total Pre-emptive LDT beneficiary years for attributed beneficiaries during the MY.

Dialysis treatment beneficiary years included in the denominator are composed of those months during which an attributed ESRD Beneficiary received maintenance dialysis at home or in an ESRD facility, such that one beneficiary year is comprised of 12 beneficiary months. Months during which an attributed ESRD Beneficiary received maintenance dialysis are identified by claims with CPT® codes 90957, 90958, 90959, 90960, 90961, 90962, 90965, or 90966, excluding claims for beneficiaries who were 75 years of age or older at any point during the month.

Pre-emptive LDT beneficiary years included in the denominator are composed of those months during which a Pre-emptive LDT Beneficiary is attributed to a Managing Clinician, from the beginning of the MY up to and including the month of the living donor transplant. Pre-emptive LDT Beneficiaries are identified using information about living donor transplants from the SRTR Database and Medicare claims data.

The numerator is the sum of the total number of attributed beneficiary years for LDT Beneficiaries during the MY and the total number of attributed beneficiary years for Pre-emptive LDT Beneficiaries during the MY.

Beneficiary years for LDT Beneficiaries included in the numerator are composed of those months during which an LDT Beneficiary is attributed to a Managing Clinician, from the beginning of the MY up to and including the month of the transplant. LDT Beneficiaries are identified using information about living donor transplants from the SRTR Database and Medicare claims data.

Beneficiary years for Pre-emptive LDT Beneficiaries included in the numerator are composed of those months during which a Pre-emptive LDT Beneficiary is attributed to a Managing Clinician,

from the beginning of the MY up to and including the month of the transplant. Pre-emptive LDT Beneficiaries are identified using information about living donor transplants from the SRTR Database and Medicare claims data.

VIII. Achievement Benchmarking and Scoring

As described in § 512.370(b) (Achievement scoring) of the Specialty Care Models final rule, CMS assesses ETC Participant performance at the aggregation group level on the home dialysis rate and transplant rate against benchmarks constructed based on the home dialysis rate and transplant rate among aggregation groups of ESRD facilities and Managing Clinicians located in Comparison Geographic Areas, i.e., HRRs that were not selected to participate in the ETC Model, during the Benchmark Year.

Achievement Benchmarks

Achievement benchmarks for the ETC Model are based on historical home dialysis rate and transplant rate of non-participating ESRD facilities and Managing Clinicians who provide care in Comparison Geographic Areas. Achievement benchmarks are based on a 12-month time period, referred to as the BY, that begins 18 months before the start of the MY and ends 6 months prior to the MY.

CMS calculates BY home dialysis rate and transplant rate for ESRD facilities and Managing Clinicians in Comparison Geographic Areas at the aggregation group level as described in § 512.370(b) (Achievement scoring) of the Specialty Care Models final rule. CMS then calculates the 30th, 50th, 75th and 90th percentiles of the distributions of home dialysis rate and transplant rate. The rates corresponding to each percentile cut-point will serve as benchmarks for assessing the performance of aggregation groups of ETC Participants during the MY. All ETC Participants are subject to the same achievement benchmarks.[6] CMS publishes the applicable achievement benchmarks on the ETC Model website in advance of each MY.[7] Achievement benchmarks for the MY are also displayed on the **"5.Achievement_Benchmarks"** tab of the PPA Report.

MY Rates

Following the end of the MY, CMS calculates the MY home dialysis rate and transplant rate for each aggregation group of ETC Participants.

[6] By contrast, improvement benchmarks are ETC Participant aggregation group-specific, and based on the ETC Participant's own historical performance in the BY.

[7] https://innovation.cms.gov/innovation-models/esrd-treatment-choices-model

The home dialysis rate in the MY for achievement scoring is displayed on the **"2.HDR_AG"** tab of the PPA report (cell **B5** for ESRD facilities and cell **B6** for Managing Clinicians).

The transplant rate in the MY for achievement scoring and its components, including the risk adjusted transplant waitlist rate and living donor transplant rate, are displayed on the **"3.TR_AG"** tab of the PPA report (cells from **B4** to **B17** for ESRD Facilities and cells from **B5** to **B20** for Managing Clinicians).

Achievement Scores

CMS compares ETC Participants' MY rates to the percentile-based benchmarks and assigns points using the achievement score scale for MY shown in **Exhibit 3** below. An ETC Participant may receive up to 2.0 points when its aggregation group's MY home dialysis rate or transplant rate is at or above the 30th percentile of the corresponding benchmark distribution. If the aggregation group's rate for a given measure is below the 30th percentile, it receives zero points for that rate.

The achievement scores for Home Dialysis and Transplant are shown on the **"1.MPSPPA_AG"** tab of the PPA report (cells **B9** and **B10** for ESRD facilities and cells **B10** and **B11** for Managing Clinicians).

Exhibit 3. Achievement Score Scale and Applicable Points

Achievement Score Scale	Points
90th + percentile of rates for Comparison Geographic Areas during the Benchmark Year	2
75th + percentile of rates for Comparison Geographic Areas during the Benchmark Year	1.5
50th + percentile of rates for Comparison Geographic Areas during the Benchmark Year	1
30th + percentile of rates for Comparison Geographic Areas during the Benchmark Year	0.5
<30th percentile of rates for Comparison Geographic Areas during the Benchmark Year	0

IX. Improvement Benchmarking and Scoring

As described in § 512.370(c) (Improvement scoring) of the Specialty Care Models final rule, CMS assesses ETC Participant's aggregation group's improvement on the home dialysis rate and transplant rate against benchmarks constructed based on the ETC Participant's aggregation group's historical performance on the home dialysis rate and transplant rate during the BY. To determine improvement scores for ETC Participants, CMS calculates the percent improvement from BY to MY at the aggregation group level and then assigns improvement points based on the improvement score sliding scale.

Improvement Benchmarks

CMS assesses the home dialysis rate and transplant rate for each ETC Participant in the MY against the BY rates to calculate an improvement score. Improvement in the ETC Model is assessed based on historical rates of the ETC Participant's aggregation group's own home dialysis rate and transplant rate during the BY. Improvement benchmark rates are based on 12 months of data (BY) beginning 18 months before the start of the MY and ending 6 months prior to the MY.

The home dialysis rate in the BY for improvement benchmarking is on the **"2.HDR_AG"** tab (cell **B4** for ESRD facilities and cell **B5** for Managing Clinicians). The transplant rate in the BY for improvement benchmarking along with its components are on the **"3.TR_AG"** tab of the PPA report (cells from **B18** to **B31** for ESRD facilities and cells from **B21** to **B36** for Managing Clinicians).

MY Rates

The home dialysis rate in the MY for improvement scoring is the same as the MY Home Dialysis Rate for Achievement Scoring, which was described in Section VIII.

The home dialysis rate in the MY for improvement scoring is displayed on the **"2.HDR_AG"** tab of the PPA report (cell **B5** for ESRD facilities and cell **B6** for Managing Clinicians).

The transplant rate in the MY for improvement scoring differs from the transplant rate in the MY for achievement scoring, which is described in Section VIII, in the way the transplant waitlist rate is risk adjusted. The reference population rate in the risk-adjustment formula for improvement scoring equals the observed rate for all ESRD beneficiaries attributed to participating providers, instead of non-participating providers as in the achievement scoring, during the BY.

The transplant rate in the MY for improvement scoring and its components are displayed on the **"3.TR_AG"** tab of the PPA report (cells from **B32** to **B45** for ESRD facilities and cells from **B37** to **B52** for Managing Clinicians).

Percent Improvement

CMS calculates the percent improvement as follows:

$$Percent\ Improvement = \frac{(MY\ Rate - BY\ Rate)}{BY\ Rate} \times 100$$

The percent improvement for Home Dialysis is displayed on the **"2.HDR_AG"** tab (cell **B6** for ESRD facilities and cell **B7** for Managing Clinicians) and the percent improvement for Transplant is displayed on the **"3.TR_AG"** tab of the PPA report (cell **B46** for ESRD facilities and cell **B53** for Managing Clinicians).

Improvement Scores

CMS uses the scoring scale in **Exhibit 4** to assign improvement points. Under the improvement score sliding scale, an ETC Participant receives up to 1.5 points based on its aggregation group's percentage of improvement from its rate in the corresponding BY. For example, if an ETC Participant's aggregation group achieves a 3% improvement on the home dialysis rate relative to its BY rate, it would receive 0.5 improvement points. An aggregation group with an MY rate less than or equal to the BY rate receives zero points for improvement on that measure.

Exhibit 4. Improvement Score Scale and Applicable Points

Improvement Score Scale	Points
>10% improvement relative to the Benchmark Year rate	1.5
>5% improvement relative to the Benchmark Year rate	1
>0% improvement relative to the Benchmark Year rate	0.5
≤ the Benchmark Year rate	0

The improvement scores for Home Dialysis and Transplant are given on the **"1.MPSPPA_AG"** tab of the PPA report (cells **B11** and **B12** for ESRD facilities and cells **B12** and **B13** for Managing Clinicians).

X. Modality Performance Score

The Modality Performance Score (MPS) is the numeric performance score calculated for an ESRD facility or Managing Clinician based on their aggregation group's home dialysis rate and transplant rate which is used to determine the performance payment adjustment. Every member of an aggregation group receives the same MPS.

As described in §512.370(d) (Modality Performance Score) of the Specialty Care Models final rule, CMS calculates the ETC Participant's MPS as the higher of ETC Participant's achievement score or improvement score for the home dialysis rate, together with the higher of the ETC Participant's achievement score or improvement score for the transplant rate, weighted such that the ETC Participant's score for the home dialysis rate constitutes 2/3 of the MPS and the ETC Participant's score for the transplant rate constitutes 1/3 of the MPS. CMS uses the following formula to calculate the ETC Participant's MPS:

$$MPS = 2 * \left(\begin{array}{c} The\ higher\ of\ the \\ home\ dialysis\ achievement\ score\ or \\ home\ dialysis\ improvement\ score \end{array} \right) + \left(\begin{array}{c} The\ higher\ of\ the \\ transplant\ achievement\ score\ or \\ transplant\ improvement\ score \end{array} \right)$$

The MPS is shown on the **"1.MPSPPA_AG"** tab (cell **B13** for ESRD facilities and cell **B14** for Managing Clinicians).

XI. Performance Payment Adjustment

As described in § 512.375(a) (Facility PPA) of the Specialty Care Models final rule, CMS adjusts the Adjusted ESRD PPS per Treatment Base Rate by the Facility PPA on claim lines with Type of Bill 072X, when the claim is submitted by an ETC Participant that is an ESRD facility and the beneficiary is at least 18 years old before the first day of the month, on claims with claim service dates during the applicable PPA Period as described in §512.355(c) (Measurement Years and Performance Payment Adjustment Periods) of the Specialty Care Models final rule.

As described in § 512.375(b) (Clinician PPA) of the Specialty Care Models final rule, CMS adjusts the amount otherwise paid under Medicare Part B with respect to MCP claims on claim lines with CPT® codes 90957, 90958, 90959, 90960, 90961, 90962, 90965 and 90966 by the Clinician PPA when the claim is submitted by an ETC Participant who is a Managing Clinician and the beneficiary is at least 18 years old before the first day of the month, on claims with claim service dates during the applicable PPA Period as described in § 512.355(c) (Measurement Years and Performance Payment Adjustment Periods) of the Specialty Care Models final rule.

As described in § 512.380 (PPA Amounts and schedules) of the Specialty Care Models final rule, CMS adjusts the payments described in § 512.375 (Payments subject to adjustment) based on the ETC Participant's MPS calculated as described in § 512.370(d) (Modality Performance Score) according to the following amounts and schedules in Table 1 and Table 2 to § 512.380 (PPA Amounts and schedules) of the Specialty Care Models final rule as shown in Exhibit 5 and 6, respectively. These tables are also displayed on the **"6.PPA_Rubric"** tab of the PPA Report.

Exhibit 5. Facility PPA Amounts and Schedule

		Performance Payment Adjustment Period				
	MPS	**1 and 2**	**3 and 4**	**5 and 6**	**7 and 8**	**9 and 10**
Facility Performance Payment Adjustment	≤ 6	+4.0%	+5.0%	+6.0%	+7.0%	+8.0%
	≤ 5	+2.0%	+2.5%	+3.0%	+3.5%	+4.0%
	≤ 3.5	0%	0%	0%	0%	0%
	≤ 2	-2.5%	-3.0%	-3.5%	-4.5%	-5.0%
	≤ .5	-5.0%	-6.0%	-7.0%	-9.0%	-10.0%

Exhibit 6. Clinician PPA Amounts and Schedule

		Performance Payment Adjustment Period				
	MPS	**1 and 2**	**3 and 4**	**5 and 6**	**7 and 8**	**9 and 10**
Clinician Performance Payment Adjustment	≤ 6	+4.0%	+5.0%	+6.0%	+7.0%	+8.0%
	≤ 5	+2.0%	+2.5%	+3.0%	+3.5%	+4.0%
	≤ 3.5	0%	0%	0%	0%	0%
	≤ 2	-2.5%	-3.0%	-3.5%	-4.0%	-4.5%
	≤ .5	-5.0%	-6.0%	-7.0%	-8.0%	-9.0%

An ESRD facility that is an ETC Participant in an MY will receive a single PPA rate for the corresponding PPA Period.

A Managing Clinician that is an ETC Participant may receive different PPA rates for a PPA Period. This is because PPA is calculated at the billing TIN-level for Managing Clinicians and it is possible for a Managing Clinician (individual NPI) to bill MCP claims through multiple TINs during a MY. A Managing Clinician who billed through multiple TINs in a MY may, therefore, receive separate PPA rates for its various NPI-TIN combinations. If a Managing Clinician has several NPI-TIN combinations in a MY with corresponding PPA rates, CMS will follow the methodology described below to implement the PPA.

This methodology is illustrated with an example where there are three TINs for an NPI:

- TIN1 and TIN2 through which the NPI billed in both the BY and MY and have PPA rates calculated
- TIN3 through which the NPI started billing in the PPA Period.

A similar approach will be used if there are more than three TINs associated with one NPI.

If NPI-TIN1 and NPI-TIN2 combinations exist in both the BY and MY, and also exist in the PPA Period, then, during the PPA period, the claims from NPI-TIN1 will be adjusted using the PPA rate of NPI-TIN1 and claims from NPI-TIN2 will be adjusted using the PPA rate of NPI-TIN2. If claims from NPI-TIN3, a combination which was not present during the BY or MY, and, hence, did not have a PPA rate calculated based on its previous performance, appeared in the PPA Period, its payments will be adjusted using the PPA rate for the TIN (TIN1 or TIN2) that had the most attributed beneficiary-months in the MY. In the case of a tie in terms of the number of attributed beneficiary months, CMS will use the more favorable PPA rate of the two.

CMS will provide the Managing Clinician with a separate PPA report for each of its NPI-TIN combination.

The PPA is shown on the **"1.MPSPPA_AG"** tab (cell **B14** for ESRD facilities and cell **B15** for Managing Clinicians).

XII. Missing PPA

An ETC Participant may not receive a PPA in an MY because of two possible reasons, which are displayed on the **"1.MPSPPA_AG"** tab (cell **B15** for ESRD facilities and cell **B16** for Managing Clinicians), if applicable.

1. The aggregation group did not meet the Low Volume Threshold (LVT).
    a. ESRD Facilities: As described in §512.385(a) (ESRD Facilities) of the Specialty Care Models final rule, CMS excludes an aggregation group (as described in Section V) of Subsidiary ESRD facilities with fewer than 11 attributed ESRD beneficiary years (132 attributed ESRD beneficiary months) during a MY from the applicability of

the Facility PPA for the corresponding PPA Period. CMS excludes ESRD facilities that are not Subsidiary ESRD facilities with fewer than 11 attributed ESRD beneficiary years (132 attributed ESRD beneficiary months) during a MY from the applicability of the Facility PPA for the corresponding PPA Period.

b. Managing Clinicians: As described in §512.385(b) (Managing Clinicians) of the Specialty Care Models final rule, CMS excludes an aggregation group (as described in in Section V) of Managing Clinicians with fewer than 11 attributed ESRD beneficiary years during an MY from the applicability of the Clinician PPA for the corresponding PPA Period.

The status of the aggregation groups in terms of LVT is shown on the **"1.MPSPPA_AG"** tab (cell **B8** for ESRD facilities and cell **B9** for Managing Clinicians).

2. The ETC Participant is not "fully stable". If an ETC Participant changes its organizational status through closure, or changes parent affiliation, or did not exist in both BY and MY, it is not considered fully stable across BY and MY.

    a. A fully stable ESRD facility is an ESRD facility that exists in both the BY and the MY and satisfies one of the three below conditions:

        i. The ESRD facility (subsidiary or independent) appears in the same aggregation group in both the BY and the MY.

        ii. The subsidiary ESRD facility maintains the same affiliation with a chain in both the BY and the MY but moves from one participating HRR in the BY to another participating HRR in the MY. For such ESRD facilities, the BY rate of the old aggregation group is used for the applicable improvement benchmark rate, and the MY rate of the new aggregation group is used for the applicable improvement scoring rate.

        iii. The independent ESRD facility remains independent in both the BY and the MY but moves from one participating HRR in the BY to another participating HRR in the MY. For such ESRD facilities, the BY rate of the old aggregation group is used for the applicable improvement benchmark rate, and the MY rate of the new aggregation group is used for the applicable improvement scoring rate.

    b. A fully stable Managing Clinician is a Managing Clinician (NPI-TIN) who exists in both the BY and the MY and satisfies one of the three below conditions:

        i. The Managing Clinician (solo practitioner or group practice) appears in the same aggregation group in both the BY and the MY.

ii. The Managing Clinician in a group practice maintains the same affiliation with that group practice (TIN) in both the BY and the MY but moves from one participating HRR in the BY to another participating HRR in the MY. For such Managing Clinicians, the BY rate of the old aggregation group is used for the applicable improvement benchmark rate, and the MY rate of the new aggregation group is used for the applicable improvement scoring rate.

iii. The solo practitioner Managing Clinician continues to be a solo practitioner in both the BY and the MY but moves from one participating HRR in the BY to another participating HRR in the MY. For such Managing Clinicians, the BY rate of the old aggregation group is used for the applicable improvement benchmark rate, and the MY rate of the new aggregation group is used for the applicable improvement scoring rate.

c. Only ESRD facilities and Managing Clinicians that are fully stable will get PPA. Furthermore, for ETC Participants that are not fully stable the MPS will also be missing. The parameters related to stability, including the ESRD facility's and Managing Clinician's HRR number and aggregation group affiliation during BY and MY are displayed on the **"1.MPSPPA_AG"** tab (cells from **B4** to **B7** for ESRD facilities and cells from **B5** to **B8** for Managing Clinicians). The **"4.AG_Participant_List"** tab indicates which ESRD facilities (**Column D**) or Managing Clinicians (**Column C**) in a Participant's aggregation group are "fully stable" during the BY and the MY of the associated PPA period.

XIII. Targeted Review

As described in § 512.390(b) (Targeted review process) of the Specialty Care Models final rule, an ETC Participant may request a targeted review of the calculation of the MPS. Requests for targeted review are limited to the calculation of the MPS and may not be submitted in regards to: The methodology used to determine the MPS; or the establishment of the home dialysis rate methodology, transplant rate methodology, achievement and improvement benchmarks and benchmarking methodology, or PPA amounts.

CMS will respond to each request for targeted review timely submitted and determine whether a targeted review is warranted. If, upon completion of a targeted review, CMS finds that there was an error in the calculation of the ETC Participant's MPS such that an incorrect PPA has been applied during the PPA period, CMS shall notify the ETC Participant and must resolve any resulting discrepancy in payment that arises from the application of an incorrect PPA in a time

and manner determined by CMS. Decisions based on targeted review are final, and there is no further review or appeal.

ETC Participants must send their targeted review request to the ETC help desk: ETC-CMMI@cms.hhs.gov. ETC Participants have 90-days from the day the PPA reports are posted on 4i to contest their scores. CMS will not process requests received after the 90-day window has closed.

- For ESRD Facilities, the following details MUST be included in the targeted review request:
    - "ETC Targeted Review" in the subject line of the help desk ticket/email
    - Legal Business Name of the ESRD facility
    - CCN
    - HRR
    - The PPA Period for which the request is being submitted
    - A complete outline/detail for the targeted review request
    - Ticket Number of the original request if there are any follow-up tickets.
        - Please note – the decision made through the targeted review is final and there will be no re-appeal requests, however, if there are additional questions or follow-up that can be requested through another ticket.
- For Managing Clinicians, the following details MUST be included in the targeted review request:
    - "ETC Targeted Review" in the subject line of the help desk ticket/email
    - Name of the Managing Clinician
    - NPI
    - TIN
    - HRR
    - The PPA Period for which the request is being submitted
    - A complete outline/detail for the targeted review request
    - Ticket Number of the original request if there are any follow-up tickets.
        - Please note – the decision made through the targeted review is final and there will be no re-appeal requests, however, if there are additional questions or follow-up that can be requested through another ticket.
- Any additional information that the ETC Participant feels is important to both identify the issue and allow CMS to conduct the review appropriately may be included.

Failure to include the above-mentioned details in the help desk tickets can result in an end to the review process as these are minimum required details to appropriately identify the targeted review request. If additional information is requested by CMS then the ETC Participant has

30-days to reply to that request. Failure to respond to the request will result in the termination of the targeted review.

CMS will inform the ETC Participant whether their request was accepted for further review or not within 60-days of receipt of the original appeal request. CMS will provide updates and the progress of the review through the help desk ticket. Please include all inquiries and follow-up within the help desk ticket. Please include the original ticket number if it is closed for any reason for tracking purposes.

After the review has completed, CMS will notify the ETC Participant within 30-days whether there is a change in their score and if this affects any of the claims already processed. CMS will provide updates about the reprocessing of claims through either the help desk ticket or the ETC newsletter.

XIV. Appendix

Exhibit 7. Crosswalk between the PPA Report User Guide and PPA Report[8]

Information	User Guide Section	Report Tab	Cell for ESRD Facilities	Cell for Managing Clinicians
List of ETC Participants at the end of the MY in the ETC Participant's aggregation group	V. Aggregation Groups	4.AG_Participant_List	-	-
Achievement Benchmarks for the MY	VIII. Achievement Benchmarking and Scoring	5.Achievement_Benchmarks	-	-
Home Dialysis Rate in the MY for Achievement Scoring	VIII. Achievement Benchmarking and Scoring	2.HDR_AG	B5	B6
Transplant Rate in the MY for Achievement Scoring and its components	VIII. Achievement Benchmarking and Scoring	3.TR_AG	B4-B17	B5-B20
Achievement Scores for Home Dialysis and Transplant	VIII. Achievement Benchmarking and Scoring	1.MPSPPA_AG	B9-B10	B10-B11
Home Dialysis Rate in the BY for Improvement Benchmarking	IX. Improvement Benchmarking and Scoring	2.HDR_AG	B4	B5
Transplant Rate in the BY for Improvement Benchmarking and its components	IX. Improvement Benchmarking and Scoring	3.TR_AG	B18-B31	B21-B36
Home Dialysis Rate in the MY for Improvement Scoring	IX. Improvement Benchmarking and Scoring	2.HDR_AG	B5	B6
Transplant Rate in the MY for Improvement Scoring and its components	IX. Improvement Benchmarking and Scoring	3.TR_AG	B32-B45	B37-B52
Percent Improvement for Home Dialysis	IX. Improvement Benchmarking and Scoring	2.HDR_AG	B6	B7
Percent Improvement for Transplant	IX. Improvement Benchmarking and Scoring	3.TR_AG	B46	B53
Improvement Scores for Home Dialysis and Transplant	IX. Improvement Benchmarking and Scoring	1.MPSPPA_AG	B11-B12	B12-B13
Modality Performance Score (MPS)	X. Modality Performance Score	1.MPSPPA_AG	B13	B14
PPA Amounts and Schedules	XI. Performance Payment Adjustment	6.PPA_Rubric	-	-
Performance Payment Adjustment (PPA)	XI. Performance Payment Adjustment	1.MPSPPA_AG	B14	B15
Reason(s) for Missing PPA	XII. Missing PPA	1.MPSPPA_AG	B15	B16
Low Volume Threshold (LVT) Status	XII. Missing PPA	1.MPSPPA_AG	B8	B9
Parameters related to Stability	XII. Missing PPA	1.MPSPPA_AG	B4-B7	B5-B8
List of "fully stable" participants in an aggregation group during the MY and the BY	XII. Missing PPA	4.AG_Participant_List	Column D	Column C

[8] The order of the crosswalk is based on the appearance of the information in the PPA Report User Guide.