

entered into a Memorandum of Understanding defining each agency or organization's role in developing, establishing, and enforcing standards or guidelines for responders' respiratory protective devices. NIST has initiated Interagency Agreements with NIOSH and SBCCOM to aid in the development of appropriate protection standards or guidelines. NIOSH has the lead in developing standards or guidelines to test, evaluate, and approve respirators.

NIOSH, SBCCOM, and NIST have hosted public meetings on April 17 and 18, 2001; June 18 and 19, 2002; October 16 and 17, 2002; and April 29, 2003, presenting their progress in assessing respiratory protection needs of responders to CBRN incidents. The methods or models for developing hazard and exposure estimates, and the status in evaluating test methods and performance standards that may be applicable as future CBRN respirator standards or guidelines were discussed at these meetings.

The Quality Assurance/Administrative update module had been under development prior to the introduction of the CBRN topics and has been previously presented in an open format, the last of which were public meetings held on August 8, 2000, in Washington, DC, and on August 16, 2000, in San Francisco, California. More recent developments have necessitated revisions that will be highlighted at this meeting.

FOR FURTHER INFORMATION CONTACT:

Event Management, P.O. Box 880, 3610 Collins Ferry Road, Morgantown, WV 26507, Telephone 304-285-4750, Fax 304-285-4459, E-mail confserv@netl.doe.gov.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** Notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: May 29, 2003.

Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-5003-N]

RIN 0938-ZA39

Medicare Program; Demonstration: End-Stage Renal Disease—Disease Management

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice informs interested parties of an opportunity to apply for a waiver allowing them to participate in the End-Stage Renal Disease (ESRD) Disease Management Demonstration. We are planning a demonstration that will increase the opportunity for Medicare beneficiaries with ESRD to receive integrated disease management services and to test the effectiveness of paying for services received by these beneficiaries in a new way. The demonstration aims to test the effectiveness of disease management models to increase quality of care for ESRD patients while ensuring that this care is provided more effectively and efficiently. The demonstration features two distinct payment options: (1) Capitation, and (2) a fee-for-service bundled payment option. Organizations participating under the capitation payment option will be responsible for providing all Medicare covered services for beneficiaries who choose to participate in the demonstration. We plan to use risk-adjusted ESRD capitation rates being developed for use in the demonstration. A similar system of payment rates for ESRD is planned for the M+C program in 2005.

Organizations participating under the fee-for-service bundled payment model will provide disease management services and dialysis services. They will receive payment for an expanded set of dialysis services, which includes items additional to those included under the current composite rate for outpatient dialysis services. Organizations under this option will be required through disease management to coordinate non-ESRD services, but will not have to provide or contract for these services directly.

Organizations under both capitation and fee-for-service bundled payment models will be subject to a reconciliation around the risk-adjusted ESRD payment rate. Organizations under the capitation model will be able to propose risk-sharing arrangements,

which would allow them to share any losses or gains with us. Applicants under the fee-for-service bundled payment model will share 50 percent/50 percent on gains and losses (or a similar arrangement to assure budget neutrality). The maximum amount of the incurred gain or loss for the applicant under the fee-for-service bundled payment model will be the amount of the additional payment for the expanded set of dialysis services.

A competitive application process will be used to select organizations to participate in this demonstration. The demonstration is planned for 4 years.

DATES: Applications will be considered timely if we receive them on or before September 2, 2003.

ADDRESSES: Mail applications to: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of Research, Development, and Information, Division of Demonstration Programs, Attn: Sid Mazumdar, Mail Stop: C4-17-27, 7500 Security Boulevard, Baltimore, Maryland 21244. Applications must be typed for clarity and should not exceed 40 double-spaced pages, exclusive of the executive summary, resumes, forms, and documentation supporting the cost proposal. Because of staffing and resource limitations, we cannot accept applications by facsimile (FAX) transmission. Applications postmarked after the closing date, or postmarked on or before the closing date but not received in time for panel review, will be considered late applications.

FOR FURTHER INFORMATION CONTACT: Sid Mazumdar, CMS Project Officer, at (410) 786-6673, or smazumdar@cms.hhs.gov.

Eligible Organizations

Potentially qualified applicants are companies experienced with providing services to ESRD patients. The demonstration will be especially appropriate for dialysis providers and disease management organizations. It will also be open to Medicare+Choice organizations and integrated health care systems.

SUPPLEMENTARY INFORMATION:

I. Background

A. Problem

Many Medicare+Choice organizations and private insurers have realized the importance of the effective coordination of care for persons with chronic conditions. The quality and cost of the care generally can be improved through better integration of the delivery system. The Medicare program is evaluating payment methods to create incentives to improve the quality of care, encourage