

ESRD patients while containing costs. Organizations participating under capitation arrangements would be responsible for managing the care of ESRD patients and providing all Medicare covered services for enrolled beneficiaries. Participating organizations may propose to cover additional services that are not currently covered by Medicare. The following are examples of these additional services:

- Transportation.
- Nutritional services.
- Dental services.
- Prescription drugs (full or limited).
- Preventive care aimed at

comorbidities.

- Home care services.
- Exercise programs.
- Education on disease.
- Counseling (including spiritual).
- Diabetes management.
- Cardiovascular management.

Beneficiaries would agree, as a condition of participation in the demonstration, to receive services through the participating organization. Organizations responding must demonstrate capability to identify beneficiaries for the demonstration, and they must be licensed to bear risk. Organizations would be required to meet M+C conditions regarding access and availability of care.

#### *A. Managed Care Model*

The managed care delivery model may be attractive to organizations such as large dialysis providers and entities that currently offer M+C plans. The optimal approach for these organizations would consider arrangements with hospitals and other providers to service the entire range of health care needs for ESRD patients, including transplantation. These companies would coordinate referrals for the comorbidities of ESRD patients and therefore should be able to manage treatments to improve quality and reduce costs compared to fee-for-service. Care coordination has the potential to enhance the continuity of patient care, improve clinical outcomes, and improve patient satisfaction. Managed care organizations would contract with disease management entities or directly provide disease management to all participating beneficiaries.

Studies have reported the growth over the past decade of for-profit dialysis facilities and chains of dialysis facilities under common ownership. According to a recent report, the five largest dialysis corporations provide services to more than 70 percent of all dialysis patients in the U.S. (Source: United States Renal Data System). The capitation payment

model will provide an incentive for these companies to combine their services with those of other healthcare providers to create efficient systems for the care of ESRD patients. The demonstration also will capitalize on the clinical, financial, and organizational expertise of independent dialysis companies. Other companies, including single- or multi-site disease management companies, have shown potential for cost savings through clinical and organizational innovations. Networks that coordinate the entire range of patients' care will enhance the continuity of care for illnesses and conditions that impact ESRD patients. Since ESRD patients will choose whether to participate or remain in fee-for-service, companies already serving patients on a fee-for-service basis that participate in the managed care model of this demonstration will be required to continue these fee-for-service arrangements for patients who do not choose to participate in the demonstration. However, it is expected that many, if not all, will enroll.

#### *B. PACE-Type Model*

The PACE program provides for managed care services for very frail community dwelling elderly, most of who are dually eligible for Medicare and Medicaid. The PACE-type model is a variation of the managed care model described above, although with greater emphasis on patient care coordination. For the purposes of this project, the PACE-type model would be a delivery option, receiving no additional payment beyond the risk-adjusted ESRD rates. In the PACE-type model, the provider would ensure that all services, including those provided by contracted providers, would be controlled by an interdisciplinary team composed of professional and para-professional staff (for example, physicians, nurse practitioners, registered nurses, licensed practical nurses, occupational therapists, physical therapists, dietitians, day health center supervisors, recreation therapists, social workers, health workers, and drivers). The team would have responsibility for assessing participant needs, formulating care plans, directly delivering services, managing the care provided by contracted providers, and providing ongoing monitoring of treatment outcomes. Constant monitoring effectively would disclose potential needs for care plan adjustments. The team also would have the responsibility for maintaining high quality of care while simultaneously controlling program costs.

Organizations providing dialysis as well as other health care services exclusively to ESRD patients may base their delivery system on a variation of the PACE-type model emphasizing disease management protocols and multidisciplinary team management at one central site. Flexibility would be allowed in designing service delivery provisions, to be negotiated during the period before implementation. Organizations proposing the PACE-type model will not be required to only include dual eligible ESRD beneficiaries.

#### *C. Eligibility Requirements*

For the capitation model, an applicant organization must have at least preliminary arrangements with other organizations to assure the integrated provision of all Medicare-covered services. We expect organizations to select geographic areas where they will make arrangements with hospitals and other providers to service the entire range of Medicare covered health care needs of ESRD patients. All services should be geographically accessible to all ESRD patients in a service area (for example, within one hour or 50 miles of a patient's residence). However, special transportation arrangements may be needed to make transplant services available. Applications should include discussion of proximity of service providers, including hours of availability and other aspects of access. Maps would be useful. We encourage programs to allow a wide choice of modalities, while recognizing that for certain qualified applicants this choice is necessarily limited to in-center dialysis only.

All persons eligible for the Medicare ESRD benefit and in the service area would have the opportunity to participate on a voluntary basis except for patients who become eligible for the Medicare hospice benefit prior to enrolling in the demonstration. Demonstration sites could exclude patients according to particular criteria, including those under 18 years old, if justified. The demonstration organization would make clear that patient participation is entirely voluntary and that the ESRD beneficiary who chooses not to do so remains entitled to all Medicare-covered services.

Information provided by the provider to beneficiaries would include the network of providers who have contracted with the demonstration organization, including dialysis facilities, hospitals, and transplant surgeons, and that receiving services